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IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

DEBORAH JUDITH WALDMAN

PETITIONER

AND:

THE MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA and THE ATTORNEY GENERAL OF BRITISH COLUMBIA

RESPONDENTS

AND:

THE BRITISH COLUMBIA MEDICAL ASSOCIATION, and PROFESSIONAL ASSOCIATION OF RESIDENTS OF BRITISH COLUMBIA

INTERVENORS
(RESPONDENTS)

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

ANITA KAFAI WONG and ANDREW BIRO

PETITIONER

AND:

THE MEDICAL SERVICES COMMISSION OF BRITISH COLUMBIA and THE ATTORNEY GENERAL OF BRITISH COLUMBIA

RESPONDENTS

AND:

THE BRITISH COLUMBIA MEDICAL ASSOCIATION

INTERVENOR
(RESPONDENT)

REASONS FOR JUDGMENT

OF THE

HONOURABLE MADAM JUSTICE LEVINE

Representative for the Petitioner, Waldman:	L. Waldman
Counsel for the Petitioners, Wong and Biro and the Intervenor, Professional Association of Residents of B.C.:	A.M. Grant P. Norell
Counsel for the Respondents, The Medical Services Commission of B.C. and The Attorney General of B.C.:	G.H. Copley, Q.C. J.M. Walters
Counsel for the Intervenor, The British Columbia Medical Association:	R.A. Skolrood K.A. Pepper
Date and Place of Hearing:	September 16-20, November 25-29, December 2-6, 1996 and June 23, 1997 Vancouver B.C.

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I. INTRODUCTION

[1] The petitioners, Dr. Deborah Waldman, Dr. Anita Kafai Wong and Dr. Andrew Biro, are medical doctors. They applied after February 11, 1994 to the Medical Services Commission of British Columbia to be issued billing numbers entitling them to bill the Medical Services Plan of British Columbia for medical services provided by them to patients. Under various "Minutes" of the Commission made since that date, they have been issued restricted billing numbers. Drs. Waldman and Wong are entitled to bill the Plan 50% of the fees established by the Commission for services provided to patients or to practise as *locum tenens* in place of established doctors. Dr. Biro may bill the Plan 100% of the fee schedule but only for services he provides to patients at the Prince George Regional Hospital.

[2] The petitioners, supported by the intervenor, the Professional Association of Residents of British Columbia, challenge the validity of the billing restrictions imposed by the Commission. They say that the measures imposed by the Minutes enacted by the Commission are beyond its jurisdiction and violate their rights under sections 6 (mobility rights), 7 (rights to life, liberty and security of the person) and 15 (equality rights) of the ***Charter of Rights and Freedoms***.

[3] The respondents, the Commission and the Attorney-General of British Columbia, supported by the intervenor, the British Columbia Medical Association, say the measures are a valid exercise of the authority of the Commission to manage the medical care system in British Columbia and do not infringe the petitioners' rights under the ***Charter***. Alternatively, if the petitioners' ***Charter*** rights are infringed, they submit that the measures are "demonstrably justified" under section 1 of the ***Charter*** to be "reasonable limits prescribed by law...in a free and democratic society".

[4] As elaborated in the reasons that follow, I find that the measures fail on both administrative law grounds and under the ***Charter***. The measures were beyond the statutory authority of the Commission when they were enacted and their reenactment on a retroactive basis is invalid. They also violate the ***Canada Health Act*** and for that reason are not authorized by the ***Medicare Protection Act*** from which the Commission derives its powers. The measures infringe the petitioners' mobility rights undersection 6 and their equality rights under section 15 of the ***Charter*** and the respondents have not demonstrated that they impose reasonable limits that are justified in a free and democratic society.

II. THE MEASURES

[5] The measures to which the petitioners object are contained in a series of "Minutes" enacted by the Commission between February 10, 1994 and September 27, 1996. The measures in effect until October 1, 1996 are called the "interim measures" and the measures in effect from October 1, 1996 are called the "permanent measures".

A. The Interim Measures

[6] Minute 1033, effective February 11, 1994, created a category of "new billers" for the purposes of establishing a payment schedule for services provided to beneficiaries under the Plan. "New billers" were medical practitioners who applied to the Commission for billing numbers after that date. The payment schedule for "new billers" was set at 50% of the relevant payment schedule for the services provided by that medical practitioner. Exemptions were established for medical practitioners practising as *locums*, those in pre-licensure training programs in B.C. who qualified to practise during the term of the interim measure (initially February 11 to July 1, 1994) and those who could demonstrate a medical need for their services in a particular community.

[7] Under Minute 1059, passed June 29 and effective July 2, 1994, the measures established by Minute 1033, referred to as "the physician supply measures" and named the "Physician Supply Management System", were extended pending the development of permanent measures. A Physician Supply Advisory Committee to the Commission was established, composed of three representatives of the Ministry of Health and three representatives of the B.C.M.A.

[8] Minute 1080, passed October 6, 1994, continued the Physician Supply Management System enacted in Minutes 1033 and 1059. It added an additional exemption for medical practitioners engaged in specialty residency programs in B.C. that began prior to October 6, 1994 and who became qualified as general practitioners during their specialty residency program, for the duration of the program.

[9] Minute 1093, passed December 15, 1994, included in the exemption for practitioners in pre-licensure training programs in B.C. on February 11, 1994, practitioners who were matched to pre-licensure training programs outside of B.C. prior to February 11, 1994 and who completed their pre-licensure training during the term of the interim measures.

[10] On June 12, 1996, the Commission passed Minute 96-0033 which consolidated the previous interim measures with some amendments.

It applied to "new billers", defined as "all medical practitioners applying for and receiving a billing number on or after July 2, 1994".

[11] Thus, the interim measures restricted "new billers" to 50% billing numbers unless they fell within one of the exemptions. The exemptions allowed a new biller to practise as a *locum* or in a community in which the medical practitioner could demonstrate a medical need for his or her services. Physicians in training programs in B.C. at the time the interim measures were first enacted were exempted from the restrictions.

B. <u>The Permanent Measures</u>

[12] Minute 96-0015, passed by the Commission on April 4, 1996, establishes the terms of the permanent measures, called the "Physician Supply Measures", which became effective October 1, 1996.

[13] The preamble to Minute 96-0015 states the Physician Supply Measures are adopted:

> In order to ensure more equitable access to medical services and more equitable distribution of physician resources based on population needs and to assist in the better management of the provincial health care budget...

[14] Under this Minute, which applies only to physicians receiving fee-for-service payments for their services, 13 categories of medical practitioners are established, for which payment schedules vary. All but one of the categories apply to practitioners who applied for billing numbers on or after February 11, 1994.

[15] All "new billers" are assigned to one of categories 3.1 through 3.3, unless the practitioner applies for and receives an exemption or is grandfathered under one of the other categories.

[16] Under categories 3.1, 3.2. and 3.3, the payment schedule is 100%, 75% or 50% of the fee-for-service payment schedule under the Plan, depending on whether the practitioner practises in an under-serviced, adequately-serviced or over-serviced geographic region of the province. The Minute provides for the semi-annual production of a Physician Supply Plan, including a supply template which will designate each region of the province as under, adequately or over-supplied, based on the population demographics of each region, population to physician ratios and other factors. The

Physician Supply Plan will be produced by the Commission on the advice of the Physician Supply Advisory Committee, the composition and terms of reference for which are set out in Minute 96-0016 of the Commission, passed May 1, 1996.

[17] Categories 3.5 through 3.8 provide 100% billing numbers, and therefore exemptions from categories 3.1. through 3.3., for practitioners appointed to designated positions at the University of British Columbia; practising as *bona fide locums*; filling pre-approved positions in institutions, otherwise able to demonstrate a medical need for their services in a particular community or filling positions in a community that receives a Northern and Isolation Allowance (NIA); and returning to practise in the province after an absence of 24 months or less for educational, sabbatical or humanitarian purposes.

[18] Categories 3.9 through 3.13 are headed "grandfathering". Categories 3.9 and 3.11 through 3.13 provide 100% billing numbers, and therefore exemptions from categories 3.1 through 3.3, for B.C.-trained practitioners. These include those who were in specialty residency programs in B.C. as of June 30, 1995 and become qualified as general practitioners during their programs, for the duration of their programs and, provided they apply within one year of completion of their training, those in or accepted into post-graduate training programs in B.C. as of June 30, 1995, UBC medical graduates in post-graduate training either in or out of B.C. as of June 30, 1995 and UBC medical students up to and including the 1995/96 entry class.

[19] Category 3.10 provides for 100% billing numbers for all

practitioners in active practice in B.C. as of February 11, 1994. Thus, all established physicians, as of February 11, 1994, are exempted from these measures.

[20] Minute 96-0015 also establishes a point system for "new billers". Each new biller will earn at least 20 points for each full year of active practice in B.C. Practitioners who serve in communities with NIA status may earn additional points each year. Once a practitioner earns 100 points, he or she will be entitled to a 100% billing number without geographic restriction. Category 3.4 covers practitioners who have earned 100 points through the point system.

[21] Minute 96-0015 provides for the mandatory retirement of medical practitioners at the age of 75 and conditions for the enrollment of foreign medical graduates in the Plan. It also sets out the procedures the Commission will follow in enrolling (that is, issuing billing numbers to) medical practitioners.

[22] Minute 96-0054, passed September 27, 1996, amends certain details of the Physician Supply Measure as established by Minute 96-0015.

[23] The full texts of Minute 96-0033 (the interim measures) and a consolidation of Minutes 96-0015 and 96-0054 (the permanent measures) are attached as Appendices "A" and "B" to these reasons for judgment.

III. LEGISLATIVE FRAMEWORK

A. Medicare Protection Act

[24] The management by the Commission of the B.C. medical care system is governed by the ***Medicare Protection Act*** (formerly the ***Medical and Health Care Services Act***), S.B.C. 1992, c. 76, as amended. This ***Act*** replaced the***Medical Services Act***, R.S.B.C. 1979, c. 255. Effective September 30, 1995, the name of the ***Act*** was changed to the ***Medicare Protection Act*** and a preamble and purpose statement were added (***Medical and Health Care Services Amendment Act, 1995 (An Act to Protect Medicare)***, S.B.C. 1995, c. 52).

1. Preamble and Purpose

[25] The preamble to the ***Act*** states the following:

> 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;.

[26] The purpose of the ***Act*** is stated as follows:

Purpose

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

2. The Commission

[27] Part I of the ***Act*** sets out the structure, responsibilities and duties of the Commission.

[28] Under section 2(1) of the ***Act***, the Commission consists of nine members appointed by the Lieutenant Governor in Council. Three members are appointed from nominees of the B.C.M.A., three are appointed on the joint recommendation of the Minister of Health and the B.C.M.A. to represent beneficiaries of the Plan and three are appointed to represent the government.

[29] The Plan is continued under section 2(2) of the ***Act***. The function of the Commission is to facilitate, in the manner provided for in the ***Act***, reasonable access, throughout B.C., to quality medical care, health care and diagnostic facility services for residents of B.C. under the Plan.

3. Responsibilities and Powers of the Commission

[30] The responsibilities and powers of the Commission are set out in section 4 of the ***Act***. Those that are relevant to this matter include the following:

4. 1) The commission may

(a) administer this Act on a non-profit basis,

...

(c) determine the services rendered by an enrolled medical practitioner, or performed in an approved diagnostic facility, that are not benefits under this Act,

(d) determine the manner by which claims for payment of benefits rendered in or outside British Columbia to beneficiaries are made,

(e) determine the information required to be provided by beneficiaries and practitioners for the purpose of assessing or reassessing claims for payment of benefits rendered to beneficiaries,

(f) investigate and determine whether a person is a resident and, for this purpose, require the person to provide the commission with evidence, satisfactory to the commission, that residency has been established,

...

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

...

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

(k) determine before or after a service is rendered outside British Columbia whether the service would be a benefit if it were rendered in British Columbia,

...

(m) monitor and assess the effectiveness and efficiency of benefits,

(n) enter, with the prior approval of the Lieutenant Governor in Council, into agreements on behalf of the government with Canada, a province, another jurisdiction outside Canada or a person in or outside British Columbia for the purposes of this Act,

(o) establish advisory committees, including pattern of practice committees, to advise and assist the commission in exercising its powers, functions and duties under this Act, and may remunerate members of a committee at a rate fixed by the commission and pay reasonable and necessary travelling and living expenses incurred by members of a committee in the performance of their duties,
(p) authorize surveys and research programs to obtain information for purposes related to the provision of benefits,

(q) enter into arrangements and make payment for the costs of rendering benefits that will be provided on a fee for service or other basis,

(r) provide to a person or body prescribed by the Lieutenant Governor in Council, for the purpose of an audit or investigation of a practitioner's pattern of practice or billing, information concerning claims submitted by that practitioner to the commission,

(r.1) apply section 21 for supply management and optimum distribution of medical care, health care and diagnostic services throughout British Columbia (added by section 10 of the ***Health Statutes Amendment Act, 1995,*** S.B.C. 1995, c. 26, in force July 14, 1995)

(s) establish guidelines setting the number of practitioners that a beneficiary may consult respecting the same medical condition within the period specified in the guidelines, or

(t) 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 theCanada Health Act (Canada).

4. Enrollment of Practitioners

[31] Part 3 of the ***Act*** deals with practitioners. Section 12 provides for the enrollment of practitioners as follows:

12. (1) A medical practitioner or health care practitioner who wishes to be enrolled as a practitioner must apply to the commission in the manner required by the commission.

(2) On receiving an application under subsection (1), the commission must enroll the applicant if the commission is satisfied that the applicant is in good standing with the appropriate licensing body and is not a person in respect of whom enrollment has been cancelled under section 14(2).

(3) A practitioner who renders benefits to a beneficiary is, if this Act and the regulations made under it are complied with, eligible to be paid for his or her services in accordance with the appropriate payment schedule, less any applicable patient visit charge or reduction made under section 19(2).

5. Payments by the Commission

[32] Part 4 of the ***Act*** deals with payments by the Commission.

Interpretation

18. (1) In this Part

"appropriation" means an appropriation as defined in the *Financial Administration Act* for the operation of

(a) the commission, or

(b) the plan;

"available amount" means, for a category, the available amount set under section 20(1) for that category for a fiscal year;

"category" means a category established under section 21;

"fiscal year" means, for an adjustment under this Part, the 12 month period ending March 31 in any given year during which the benefits were rendered for which the adjustment in payments is being calculated.

Limitations on payments

19. (1) All reasonable and practical measures must be taken by the commission to ensure that the total of payments made under sections 21 and 22 for a fiscal year does not exceed the appropriations for the fiscal year for those payments and these measures may include the establishment of public or professional educational programs, the establishment or limitation of benefits, the establishment of guidelines for the rendering of

benefits or the making of adjustments under subsection (2).

(2) If the commission considers that payment for a fiscal year under all payment schedules to practitioners in a category will be greater than or less than the available amount for that category, the commission may adjust its payments to the practitioners in the category under the payment schedules to a level that the commission considers appropriate to remain within the available amount for the fiscal year.

(3) If the commission considers that the special circumstances of a practitioner's patients so warrant, the commission may order that a reduction calculated under subsection (2) does not apply, or applies to a limited extent, to payments to the practitioner.

Available amount

20. (1) The commission may set the available amount for a category that may be paid under all payment schedules to practitioners in the category for rendering benefits under this Act in the fiscal year specified by the commission.

(2) The total amount that may be paid by the commission to all practitioners in a category for rendering benefits under this Act in a fiscal year must not exceed the available amount for the fiscal year.

Payment schedules and benefit plans

21. (1) The commission 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 may establish different categories of practitioners for the purposes of those payment schedules.

(2) The payment schedules may

(a) be different for different categories of practitioners,

(b) treat professional and other aspects of services differently for the purposes of payments under this Part,

(c) include, for specified benefits, extra payments that may be made in special circumstances that the commission establishes, or

(d) in respect of a particular benefit or class of benefits, be different for different geographical areas of British Columbia, as specified by the commission.

(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.

(5) The commission may act retroactively under this section to

(a) include or increase payment for a benefit in a payment schedule, or

(b) determine that a service is a benefit and establish a payment schedule item for this benefit.

(6) The commission may continue or establish a practitioner educational program, a disability insurance program or other practitioner benefit plan for practitioners and the plans may be different for different categories of practitioners.

(7) The commission may, out of an appropriation for that purpose, pay money to fund practitioner benefit plans.

(8) No category may be established under this section on the basis of age or gender of practitioners.

[33] Prior to amendments made to the ***Act*** effective August 26, 1994 (***Medical and Health Care Services Amendment Act, 1994***, S.B.C. 1994, c. 48), section 21(1) of the ***Act*** included at the end of the paragraph the following words:

> on the basis of past service levels, of estimated future service levels from payments for rendering benefits, of pattern of practice or type of practice or specialty.

Section 21(9), which was repealed, stated:

> No category based on fee for service may be established under this section on the basis of years of practice as a member of the appropriate licensing body.

The definition of "appropriation" was added to section 18(1) on the same date.

B. Canada Health Act

[34] The ***Canada Health Act***, R.S.C. 1985, Chap. C-6 is also relevant to the management of health care in the province. Under that ***Act***, the federal government makes cash contributions to each province in respect of the cost of insured health services provided under the health care insurance plan of the province. Section 7 of the ***Act*** requires that a province satisfy certain criteria described in sections 8 to 12 of the ***Act*** in order to qualify for a full cash contribution. The criteria relate to public administration, comprehensiveness, universality, portability and accessibility.

[35] Section 12 establishes the criteria governing accessibility. Section 12(1)(c) requires a health care plan of a province to "provide for reasonable compensation for all insured health services rendered by medical practitioners..." Section 12(2) deems section 12(1)(c) to be complied with:

> if the province has chosen to enter into, and has entered into, an agreement with the medical practitioners and dentists of the province that provides
>
> > (a) for negotiations relating to compensation for insured health services between the province and

provincial organizations that represent practising medical practitioners or dentists in the province;

(b) for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations referred to in paragraph (a), conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman; and

(c) that a decision of a panel referred to in paragraph (b) may not be altered except by an Act of the legislature of the province.

IV. BACKGROUND TO THE MEASURES

[36] There is no dispute among the parties that physician supply management has been an issue for the B.C. medical care system for decades. Numerous reports and studies have documented an increasing oversupply of physicians relative to the population and have expressed concern about the effects of the oversupply on
the costs of administering the system and the quality of medical care delivered. Despite the increasing numbers of physicians in the province, some rural communities are chronically under-served.

[37] B.C. has undertaken a number of initiatives to address the related issues of physician supply and distribution. In 1978, it established the NIA Program which provides a fee premium to fee-for-service physicians practising in eligible northern and isolated communities. The Alternative Payments Branch (APB) funds agencies to retain physicians on a non-fee-for-service basis. Both of these programs remain in place with the Physician Supply Measures. The NIA Program premiums override the regionally-based billing restrictions imposed by the interim and permanent measures provided the practitioner applying for a billing number in an NIA community has written confirmation of community support. The Physician Supply Measures do not apply to APB physicians as they are not paid on a fee-for-service basis.

[38] In the 1980's, the province twice instituted restrictions on the issuance of billing numbers to physicians in an effort to regulate physician supply and distribution. In 1983, the Commission introduced an administrative scheme which was challenged and found to be administratively invalid and in violation of the petitioner's rights under sections 6 and 7 of

the ***Charter*** (***Mia v. Medical Services Commission of B.C.*** (1985), 61 B.C.L.R. 273 (S.C.)). In 1985, the***Medical Service Act*** was amended to provide legislative authority to the Commission to control the issuance of practitioner numbers. The legislation was upheld by the B.C. Supreme Court but the Court of Appeal held that it violated section 7 of the ***Charter***. Leave to appeal to the Supreme Court of Canada was denied (***Wilson v. Medical Services Commission of B.C.*** (1986), 9 B.C.L.R. (2d) 350 (S.C.), reversed (1988), 30 B.C.L.R. (2d) 1 (C.A.), application for leave to appeal denied [1988] 2 S.C.R. viii).

[39] After the decision of the Court of Appeal in ***Wilson*** until February 1994, when the interim measures were introduced, there was no physician supply management program in place in B.C.

[40] In the early 1990s, the issue of physician supply management took on renewed importance to the B.C. and other provincial governments. Federal and provincial governments grew concerned over increases in the proportion of government budgets allocated to health care. Statistics indicate that of those increases, an increasing amount was spent on physician services.

[41] The respondents provided two reports, dated August 2 and November 16, 1996, prepared by Dr. Peter Coyte, a professor of health economics at the University of Toronto, who was accepted by all parties and was qualified as an expert. The petitioners objected to certain of the opinions expressed by Dr. Coyte, but accepted the statistical information he provided.

[42] Dr. Coyte's reports contain the following information concerning health expenditures in Canada and B.C.:

[43] Health expenditures in B.C. increased from $1.93 billion in 1980 to $6.56 billion in 1994. (Provincial government estimates for 1996/97 provided by the respondent Commission show that approximately $6.9 billion was allocated to the Ministry of Health for this fiscal year.) This represents an average annual rate of increase of 1.93% when adjusted for both inflation and population growth. On an annual basis, the growth in nominal health expenditures in B.C. was faster than in Canada generally: 9.11% vs. 8.14%. Economic statistics show that the proportion of B.C.'s Gross Domestic Product allocated to health grew from 7.7% in 1980 to 9.7% in 1994.

[44] In the same period, provincial government expenditures on physicians increased at an average annual rate of 8.77%. A portion of the increase was attributable to population growth, which increased at an average annual rate of 2.07%, and a higher schedule of benefits for physician services, averaging

2.7% per annum, while 4.0% is attributed to increased utilization of physician services.

[45] When Dr. Coyte adjusts his statistics on the growth in the number of physicians between 1982 and 1992 (2.92% average annual rate of growth) for population growth and the effect of the ageing of the population, the average annual rate of growth of the number of physicians related to population is actually 0.6% (excluding interns and residents). He projects that a growth rate of 2.3% would result in no change to the present physician to population ratio by the year 2016. At the growth rate of 2.9%, the ratio will increase by 0.56% per year, the same as in the decade from 1982 to 1992.

[46] Other affidavit evidence provided by the respondents (admitted without objection and adopted in part by the petitioners) shows that B.C. has been a net receiver of migrating physicians in Canada. Dr. Norman Finlayson, executive director of the B.C.M.A. and Dr. Stephen Gray, a medical policy consultant with the B.C. Ministry of Health, provide data which show that since 1977, B.C. has consistently taken in more physicians annually from other provinces than have migrated to other provinces from B.C. Between 1990 and 1992, B.C. was the largest net receiver of physicians from other parts of Canada of any province. In 1993, the year in which Ontario implemented supply control measures, more physicians migrated into B.C. than into Ontario.

[47] These affidavits also refer to a number of studies that have noted a correlation between an increasing number of physicians and the rising cost of providing adequate medical services. Dr. Finlayson cites a study published by the Organization for Economic Cooperation and Development, using data from 1970 and 1981, which estimates that physicians receive less than 25% of all health expenditures but their decisions affect 70-80% of all spending.

[48] These statistics provide some background against which physician supply measures have been developed. Governments seek ways to control their health care expenditures while continuing to provide access to health care. They have been convinced that managing the number and distribution of physicians is an important component of managing these two issues.

[49] A number of specific initiatives led to the development of the interim and permanent measures in B.C.

[50] In 1991, the B.C. Royal Commission on Health Care and Costs (the Seaton Commission), in its report "Closer to Home", recommended that the Ministry of Health and the B.C.M.A. give priority to the joint development of a program to limit the number of physicians.

[51] In a report prepared by Professors Morris Barer and Greg Stoddart for a January 1992 Federal/Provincial/Territorial Conference of Ministers of Health, the authors identified several problem areas with physician supply management in Canada, including increases in physician supply in excess of population growth without any compelling justification, a maldistribution of specialist and residency training programs that was out of balance with population needs and a significant geographic variation in physician supply which affected timely and convenient access to necessary services.

[52] Following their conference, the Ministers published a paper entitled "Strategic Directions for Canadian Physician Resource Management" which stated as its primary objective:

> To meet those health needs of the population that can be most efficiently met by individuals with training as MDs, subject to societal decisions about the resources it is willing to commit to meeting those needs.

The Ministers recognized a comprehensive physician supply management system as an essential ingredient to obtaining that objective.

[53] In 1993, the provincial and territorial Ministers of Health endorsed the use of regional billing numbers and fee discount schemes as part of a supply management strategy. The Ministers further agreed that selection of new entrants to practice based on province of training was an appropriate transitional measure but they committed to negotiate the removal of province of training as a criterion by the spring of 1996. This has not occurred and a majority of provinces have imposed some form of billing restrictions.

[54] In 1993, the Ontario government imposed a moratorium on the issuance of billing numbers to non-Ontario trained physicians. The moratorium was lifted in March 1996 and replaced with geographically-based restrictions in the fall of 1996.

[55] In 1992, the B.C. government introduced amendments to the ***Medical and Health Care Services Act*** empowering the Commission to establish a "cap" on the total amount of money available during any fiscal year for payment by the Commission for fee-for-service physician services under the Plan. This amount is defined as the "available amount" in sections 18 and 20 of the ***Act***. Other provinces and territories have adopted similar caps to payments under their medical plans.

V. THE INVOLVEMENT OF THE B.C.M.A.

[56] The B.C.M.A. is a society incorporated under the ***Society Act***, R.S.B.C. 1979, c. 390. Its purposes include advancing the scientific, educational, professional and economic welfare of all

members of the medical profession in B.C.; promoting the highest quality health care delivery for the people of B.C.; acting as an agent for members of the medical profession, or some of them, in collective bargaining regarding conditions in which medical services are rendered, remuneration for medical services and similar or related matters; and performing such other lawful things as are incidental or conducive to the purposes of the B.C.M.A., the welfare of the public and of the medical and allied professions whether inside or outside B.C.

[57] Membership in the B.C.M.A. is voluntary. It comprises the majority of physicians licensed to practice medicine in B.C.

[58] The developments leading to the recognition of the need for physician supply measures, in particular the capping of payments for physician services and restrictive measures adopted by other provinces, caused the B.C.M.A. to get involved with the government in the management of the health care system.

[59] The B.C.M.A., the B.C. government and the Commission entered into a Master Agreement dated December 21, 1993 for the stated purpose of establishing an ongoing relationship "as partners in the health care system". The objectives of the relationship include:

> 4. To ensure that physicians are appropriately compensated for providing services covered by the Medical Services Plan...
>
> 6. To contribute to the achievement of a mix and distribution of physicians based upon British Columbia's needs.

[60] Under the Master Agreement, the B.C.M.A. is granted the sole and exclusive right to represent physicians who practice medicine on a fee-for-service basis. The parties agree to consult with respect to the distribution and mix of physicians in the province and the determination and allocation of the "available amount".

[61] The Master Agreement contemplates that the parties will from time to time enter into working agreements to establish the mechanism to determine the available amount, changes to fee schedules and other programs agreed upon by the parties. The parties entered into a Working Agreement dated December 21, 1993 to co-manage a number of initiatives to contain total fee-for-service payments within the available amount.

[62] The Working Agreement states in Article 8 that physician supply management measures must be initiated to implement the initiatives. A Physician Supply Management Task Force was established to recommend strategies to manage physician supply in the province on a long-term basis. An interim measures committee was established to develop short-term measures. According to Dr. Gray's affidavit, the short-term measures were required to meet an expected influx of physicians into B.C. as a result of the Ontario restrictions on entry to practice of non-Ontario trained physicians.

[63] The recommendations of the interim measures committee, which included representatives of the government, the B.C.M.A. and the Professional Association of Residents of British Columbia (PAR-BC), were implemented in the interim measures adopted first in Commission Minute 1033 and later extended and clarified in Minutes 1059, 1080, 1093 and 96-0033. Dr. Don Young, president of PAR-BC, states that the interim measures were formulated and approved by the B.C.M.A. and the government. His organization did not participate in the report and recommendations of the interim measures committee. Dr. Eric Webber, then the president of PAR-BC, wrote to the Minister of Health and the President of the B.C.M.A. on February 11, 1994, protesting the implementation of the measures.

[64] The Task Force on Physician Supply established under Article 8 of the Working Agreement tabled a report on May 13, 1994 which included 21 options for managing physician supply. All of the members of the Task Force voted against the two options of having no physician supply measures and extending the interim measures. None of the members approved of a point system (as was ultimately adopted in the permanent measures); the government and the

B.C.M.A. were neutral, while PAR-BC voted against that option.

[65] The B.C.M.A.'s own Physician Supply Committee made recommendations to the B.C.M.A. Board of Directors on June 1, 1994, in the form of a report entitled "Managing the Physician Supply Life Cycle in British Columbia". The B.C.M.A. Committee recommended implementing the point system, which included establishing a schedule of percentage rates of the payment schedule for various geographic regions of the province. The B.C.M.A Board of Directors adopted its Committee's report.

[66] A joint government/B.C.M.A. committee was established in October 1994 to examine long-term alternatives to managing physician supply in B.C. PAR-BC was included on the committee at its request in 1995. According to Dr. Gray, by February 1996, it had restricted its discussions to implementation of the supply management strategy of the B.C.M.A. Board of Directors.

[67] On November 25, 1995, the B.C.M.A. Board of Directors issued its own report on implementing the point system. On January 18, 1996, it presented a formal proposal to the Commission which was approved by the Commission in principle on February 1, 1996.

[68] Minute 96-0015, establishing the permanent measures, was passed by the Commission on April 4, 1996 and implemented October 1, 1996.

[69] Minute 96-0015 was ratified by the B.C.M.A. membership in conjunction with approval of a new Working Agreement effective April 1, 1996.

VI. THE PETITIONERS

[70] All of the petitioners are physicians licensed to practise medicine in British Columbia. All completed residency programs in family medicine in Ontario. All applied to the Commission for billing numbers after February 11, 1994 and have been issued restricted billing numbers pursuant to the interim measures in force at the date they applied.

A. Dr. Waldman

[71] Dr. Deborah Waldman was born in Toronto in 1967. She obtained her medical degree at Queen's University in Kingston, Ontario in 1993 and completed her residency in family medicine at North York General Hospital, Ontario in June 1995.

[72] Dr. Waldman moved to Vancouver to be with her husband in July 1995 and became a member of the College of Physicians and Surgeons. On July 1, 1995 she applied to the Commission for a

billing number. She was granted a "new billing number", which allows her to bill 50% of the fee schedule unless she falls within one of the exemptions. She did not qualify for exemption except for practising as a *locum tenens*, which she was doing, in Vancouver, at the date of hearing. Her evidence is that her remuneration as a *locum* is equal to or exceeds what it would be if she were practising under a 100% billing number.

[73] Dr. Waldman wishes to settle in Vancouver, where her husband practises law. She says she is effectively prohibited from establishing herself in her profession by commencing a practice and developing on-going relationships with her patients and colleagues. She maintains that she does not have the choice to move to a community that might need her services in order to increase her percentage rate of billings because she is Jewish and in order to practise her religion she must live in a community with a Jewish population sufficient to support religious institutions such as a synagogue and schools.

B. Dr. Wong

[74] Dr. Anita Kafai Wong was born in Thunder Bay, Ontario in 1966. She completed her medical degree at the University of Manitoba in 1991 and her family residency program in Hamilton, Ontario in June 1993. She is qualified to practise and maintains billing numbers in Ontario and Alberta.

[75] In June 1994, Dr. Wong moved to the Lower Mainland to join her parents who had retired here. She qualified to practise medicine in B.C. upon becoming a permanent resident and applied to the Commission for a billing number. On June 7, 1994 the Commission advised her they were granting her a 50% billing number under the interim measures. She has been working as a *locum tenens* in the Lower Mainland of B.C. since June 1994. She wishes to work in the Lower Mainland to be close to her family. She believes there is a particular need for her services for the Cantonese-speaking Chinese population.

C. Dr. Biro

[76] Dr. Andrew Biro was born in Hamilton, Ontario in 1958. He lived in Vancouver from 1979 to 1989, during which period he studied at Simon Fraser University and the University of British Columbia. He obtained his medical degree from McMaster University in Hamilton, Ontario in 1992 and completed his family residency in Hamilton in June 1994. Dr. Biro is qualified to practise medicine in Ontario and practised there from 1993 to 1995.

[77] Dr. Biro moved to Prince George, B.C. in April 1995. He qualified to practise medicine in B.C. on May 1, 1995, but had been granted only a 50% billing number by the Commission. He commenced work as a *locum tenens* in Prince George. In May 1995, he was offered a contract to provide services to the Prince George Regional Hospital which had received a 100% billing number tied to the hospital. He has worked there, with the exception of*locum tenens* positions, since then.

[78] Dr. Biro's wife, Dr. Marlene Van der Weyde, will complete her family residency program in Prince George in June 1997. Upon completion of her residency, she and Dr. Biro wish to move to a smaller community in B.C. Dr. Biro says he cannot freely move because he will lose his 100% billing number, which is tied to Prince George Regional Hospital.

[79] All of Drs. Waldman, Wong and Biro challenge the interim and permanent measures on administrative law grounds and on the grounds that they violate sections 6, 7 and 15 of the ***Charter***. All of them claim that their rights under section 15 of the ***Charter*** are breached on the grounds of age and province of residence. Dr. Waldman says her rights under section 15 are also violated on the grounds of sex and religion.

VII. THE EFFECT OF A 50% BILLING NUMBER

[80] The petitioners presented evidence concerning the effect of a 50% billing number on their ability to carry on the practice of medicine in the form of the opinion of Brian Galloway, C.G.A., of Mcconnell Galloway Botteselle, dated May 22, 1996. Mr. Galloway has 22 years of public practice accounting experience with an emphasis on medical and dental practices. Neither the respondents nor the B.C.M.A. objected to his evidence.

[81] Mr. Galloway sampled 23 representative medical practices located in B.C. for the 1995 year. He determined that the average overhead expense factor was 44.3% and the weighted average overhead expense factor was 42.8% for fiscal years ending in 1995. In his opinion and experience, these overhead averages were representative of the overheads of medical practices with which he had been involved.

[82] Mr. Galloway's opinion is that:

> a "50% billing number" would result in medical practices having similar overhead costs becoming not viable financially. The reduction to 50% of professional fees billed would result in the overhead expense factor of the practices rising from 44.3% (average) to 85.6%. Such a restriction on the professional fees earned would result in a very low level of net earnings. For example, using a gross billings total of approximately $274,000 and applying a 50% billing rate to this total would reduce the gross revenues of the practice to $135,000 per year with no reduction in the total expenses of the practice, which average approximately $117,000. Therefore the net earnings of the practice would be reduced to approximately $20,000 for the year.

[83] I accept Mr. Galloway's evidence and find as a fact that practising medicine under a "50% billing number" is not financially viable. A physician who holds a 50% billing number is effectively prevented from practising medicine in his or her own practice on a fee-for-service basis.

VIII. ADMINISTRATIVE LAW ARGUMENTS

[84] The petitioners challenge the interim and permanent measures on the grounds that the Commission exceeded its jurisdiction in enacting them. They say that the measures were

enacted for an improper purpose, the preservation of the incomes of established physicians; they effectively prohibit the petitioners from practising medicine in the province and establish categories of medical practitioners, neither of which is authorized by the legislation; and they discriminate between resident and non-resident physicians, which is beyond the jurisdiction of the Commission and is *ultra vires* the powers of the province. Further, they argue that the permanent measures offend the ***Canada Health Act*** and in enacting them the Commission has acted in excess of its jurisdiction by failing to comply with section 4(2) of the ***Medicare Protection Act***.

[85] The respondents and the B.C.M.A. say the jurisdiction of the Commission is governed by the ***Medicare Protection Act*** and whether it has acted within the powers granted it by the ***Act*** or exceeded its jurisdiction is a matter of statutory interpretation. They deny that the Commission acted for an improper purpose. Furthermore, they say that the province has the jurisdiction to authorize the Commission to enact measures to contain the costs of and improve access to medical care and the court should not interfere with the exercise of this legislative power by the Commission.

[86] The petitioners do not challenge the measures on procedural grounds, as was the case in both ***Mia*** and ***Wilson***.

A. The Purposes of the Measures

[87] The petitioners take the position that the real purpose of the measures is to preserve the incomes of established physicians from competition primarily from out-of-province physicians and not, as maintained by the respondents and the B.C.M.A., to meet the objectives set out in the preamble to Minute 96-0015:

> ..to ensure more equitable access to medical services and more equitable distribution of physician resources based on population needs and to assist in the better management of the provincial health care budget...

[88] The petitioners cite the involvement of the B.C.M.A. in the formulation and implementation of both the interim and permanent measures as evidence of the real purpose of the measures. Correspondence between members of the executive of the B.C.M.A., Dr. Young and others indicate the concern of the B.C.M.A. to protect the incomes of physicians in the province by limiting the numbers of new physicians allowed to practise on an unrestricted basis. This was of particular concern because of the "cap" on global physician incomes by the fixing of the available amount. The petitioners say the private interests of the established members of the B.C.M.A.

improperly influenced the development of the measures, through the cooperative management of the health care system by the government and the B.C.M.A. under the Master Agreement, the Working Agreement and the various task forces and advisory committees.

[89] The petitioners also point to other evidence that the measures were developed to protect established physicians at the expense of "new billers". Dr. Gray states that the interim measures were a short-term response to the concern that B.C. would experience an influx of doctors following the restrictions enacted in Ontario in 1993. The June 1, 1994 B.C.M.A. Report, "Managing the Physician Supply Life Cycle in British Columbia" stated that the rationale for managing physician supply in B.C. included the concern that "Clearly, historical physician

migration patterns cannot be sustained within this limited budget environment". In introducing the addition of section 4(1)(r.1) to the ***Medicare Protection Act***, the Minister of Health said to the legislature (*British Columbia Debates* (13 June 1995) at 15419):

> The member may recall that around this time last spring we first brought into force what we called interim supply measures, where we said to physicians who were new to the province and seeking a billing number that if they wished to practise where their services were needed, we would pay them 100 percent of fees. If they wished to work in an over-serviced area, we'd pay them 50 percent of fees....We are now looking at moving ahead with more permanent supply measures, and we want to ensure that we have legal authority in the act to do so without being challenged.

[90] The respondents and the B.C.M.A. both submitted that the grandfathering of "trained-in-B.C." physicians, but not established physicians, could be severed from the permanent measures; the petitioners argue that this further underlines the priority given to the protection of established physicians.

[91] The respondents and the B.C.M.A. say that the purposes of the measures are found in the preamble to Minute 96-0015. The respondents point out that in ***Shell Canada Products Ltd. v. Vancouver (City)***, [1994] 3 W.W.R. 609 at 623 (S.C.C.), Sopinka J. referred to the preambles to the impugned resolutions of the City Council to establish the purpose of the resolutions. Furthermore, they argue that if one accepts that the predominant objective of the B.C.M.A. is the protection of established physicians, there is no evidence that in enacting the measures the Commission was improperly influenced by the priorities of the B.C.M.A. If the Commission did take into account the interests of established physicians, they say it was justified in doing so in the context of its responsibility to protect and preserve medicare.

[92] The petitioners attack the measures on the basis of the motives that led to their adoption. In ***Shell Canada Products Ltd.*** at p. 638, McLachlin J. (though in dissent, she was in agreement with the majority on the applicable legal principles) stated:

> At this point, we must inquire into the legal principles relevant to review of municipal decisions on the basis of motive. The actions of a statutory body or

municipality can be said to be beyond its powers in one of two ways. First, it may be alleged that the *action* itself is beyond the authority's powers. Second, it may be alleged that while the action is within the municipality's powers, the *purpose*for which the action was taken was outside the municipality's powers, thereby rendering the action itself invalid. This case falls into the second category.

The law governing review under this head is sometimes referred to as the "doctrine of improper purposes." The rule was first set out in an expropriation case, *Galloway v. London Corp.* (1866), L.R. 1 H.L. 34, per Lord Cranworth (at p. 43):

> ...when persons embarking in great undertakings, for the accomplishment of which those engaged in them have received authority from the Legislature to take compulsorily the lands of others, making to the latter proper compensation, the persons so authorized cannot be allowed to exercise the powers conferred on them for any collateral object; that is, for any purposes except those for which the Legislature has invested them with extraordinary powers.

This doctrine has been applied to municipalities as well as to administrative agencies...

[93] McLachlin J. went on at p. 639 to say: "A number of Canadian courts have rejected the notion that municipal legislation, short of evidence of bad faith, should be invalidated on the ground that it was passed for improper purposes...", but proceeds to decide the case on the basis that the motives of the City did not exceed its powers.

[94] I am similarly satisfied that the Commission's motives in enacting the interim and permanent measures were not outside its powers. I am of the view that the purposes of the Commission in enacting the measures are as stated in the preamble to Minute 96-0015 and those stated purposes are not a guise for another, improper, purpose. The B.C.M.A.'s purposes may differ from those of the Commission. It is clear that the B.C.M.A. was instrumental in developing both the interim and permanent measures. There is no evidence, however, that the Commission acted improperly or in bad faith in adopting the measures.

B. Prohibition on Practice

[95] The petitioners argue that the interim and permanent measures effectively prohibit them from practising medicine in

the province. Such a prohibition, they say, is not expressly authorized by the ***Medicare Protection Act*** and in the absence of express and clear authorization, the Commission's power to regulate the provision of medical care in the province does not include the power to prohibit (***City of Toronto* v. *Virgo***, [1896] A.C. 88 (P.C.); ***Re Dental Technicians Act and Regulations Re Stillings Application*** (1961), 35 W.W.R. 164 (B.C.S.C.)).

[96] The petitioners' ability to practise medicine in B.C. is severely restricted by the measures. I have found that practising under a 50% billing number is not financially viable. The respondents suggested a physician can choose to "opt out" of the Plan. No evidence or submissions were presented to me concerning the legal or practical restrictions on physicians who may wish to practise outside of the Plan, but I believe the comments of McEachern C.J.S.C., as he then was, in ***Mia*** at pp. 286-7 are equally applicable today: "It is unreal to say that the petitioner is able to practise because her patients, who are insured for such services, may pay her directly. Why would they do so?" I find that it is not financially viable or practical for a physician to practise in B.C. outside of the Plan.
[97] That leaves the exceptions allowed in the measures: practising as a*locum tenens*, in a community in which a medical need for the physician's services can be demonstrated, in an NIA community, in an under-serviced community, or in a pre-approved position.

[98] Dr. Waldman's evidence is that practising as a *locum tenens* is economically viable. She earns 60% of her billings, which is more than she would earn if she were practising independently with a 100% billing number. I assume Dr. Wong is in the same position. Dr. Biro practises under a 100% billing number at Prince George Regional Hospital. Thus none of the petitioners are prohibited from practising medicine, though they are effectively prohibited from practising medicine in the manner or location of their choice.

[99] In my view, the measures do not amount to the type of prohibition addressed by the cases cited by the petitioners. The measures do not fail on this ground.

C. Categories of Practitioners

[100] The petitioners argue that, as a matter of statutory interpretation, the Commission does not have the authority under section 21 of the***Medicare Protection Act*** to establish a category

of "new billers", as created by the interim measures, or 13 separate categories of medical practitioners, as are established by the permanent measures. They say that the statutory powers of the Commission should be strictly construed; this is especially so where the exercise of their statutory powers affects the right of a person to carry on a business or trade (***Virgo v. City of Toronto***, [1894] 22 S.C.R. 447; ***Merritt v. City of Toronto***, [1895] 22 O.A.R. 205 (C.A.)).

[101] Section 18 of the ***Act*** defines "category" as "a category established under section 21".

[102] Section 21 provides that "The commission must establish payment schedules...and may establish different categories of practitioners for the purposes of those payment schedules."

[103] Sections 19 and 20 deal with setting the "available amount" and with limiting payments to the available amount "for a category". "Available amount" is defined in section 18 as "for a category, the available amount set under section 20(1) for that category for a fiscal year".

[104] The available amount for medical practitioners is one global amount. That is, for the purposes of the available amount, there is one category.
[105] Under the interim measures, there are at least two categories for the purposes of payment schedules, one for "new billers" and one for physicians who are not new billers. The exemptions from those measures may constitute additional categories.

[106] Under the permanent measures, there are 13 categories.

[107] The petitioners argue that the categories of "practitioners" for the purposes of sections 18 through 21 of the ***Act*** are established by the definition of "practitioner" in section 1:

> "practitioner" means
>
> > (a) a medical practitioner, or
> > (b) a health care practitioner who is enrolled under section 12;
>
> "medical practitioner" means a medical practitioner as defined insection 29 of the Interpretation Act. [This means a physician licensed to practise medicine by the College of Physicians and Surgeons.]

[108] A "health care practitioner" means a person registered, in each case under the appropriate Act, as a chiropractor, dentist, massage practitioner, naturopathic physician, optometrist, physiotherapist, podiatrist, or a member of a health care profession or occupation that may be prescribed.

[109] Under section 3 of the ***Act***, special committees have been established to exercise the powers of the Commission to set available amounts and payment schedules for health care practitioners. Available amounts have been established for each of the listed "health practitioners". In the case of dentists, separate available amounts have been set for different specialties. Thus, the powers of the Commission under sections 19 through 21 may be exercised only in respect of medical practitioners.

[110] The petitioners say that the Commission has exercised its authority to establish categories of medical practitioners by setting one global available amount for medical practitioners. By definition, a category for setting the available amount must be a category established for the purpose of establishing a payment schedule. The petitioners argue that by inverse reasoning, a category established for the purpose of establishing a payment schedule must be a category for setting the available amount.

[111] The petitioners appear to be correct in their reading of the statute as it applies to a category for setting an available amount under section 20. The statute appears to contemplate that the Commission will set an available amount under section 20 for each category of medical practitioner it establishes for the

purposes of establishing a payment schedule under section 21. That interpretation of the statute would require the Commission to set an available amount for the category of "new billers" established under the interim measures and for each of the 13 categories established under the permanent measures. How the Commission sets the available amount, however, is not in issue in this case.

[112] If the Commission has failed to set the available amount as provided in section 20, that does not, in my view, support the conclusion that it does not have the power to establish categories of medical practitioners under section 21. If the Commission was limited to the categories of practitioners defined in section 1 of the ***Act***, there would be no purpose for the power to establish categories given it in section 21. The categories would be fixed by the ***Act***.

[113] The Commission's authority to establish categories for the purposes of payment schedules established under section 21 of the ***Act*** is broad. Section 21(2)(a) authorizes the Commission to establish different payment schedules for different categories of practitioners. Section 21(3) allows the Commission to amend the payment schedules "in any manner that the commission considers necessary or advisable", by "increasing or decreasing any amount in a payment schedule". Under section 21(4), an increase or

decrease may apply to a category of practitioners.

[114] Section 4(1)(r.1) of the ***Act*** expressly gives the Commission the authority to establish payment schedules for different categories of medical practitioners for the purposes of supply management and medical care distribution. The repeal of the closing limiting words to section 21(1) and of section 21(9) indicate that the legislature intended that the Commission have broad authority to establish payment schedules with few restrictions.

[115] I accept the respondents' arguments that section 21 of the statute provides adequate authority to the Commission to establish categories of medical practitioners for the purposes of establishing payment schedules.

D. Administrative Discrimination

[116] My finding that the statute authorizes the Commission to establish categories does not determine that the Commission validly exercised its powers under the ***Act*** in enacting the interim and permanent measures. The question remains whether the powers of the Commission to establish categories may be exercised in a manner which discriminates between physicians on the grounds of the timing of application for enrollment in the Plan, place of training, province of residence or age. Section 4(1)(r.1) and the timing of its enactment are particularly relevant.

[117] In ***Shell Canada Products Ltd.*** at p. 645, McLachlin J. described the principle of discrimination in the administrative law sense:

> The rule pertaining to municipal discrimination is essentially concerned with the municipality's power. Municipalities must operate within the powers conferred on them under the statutes which create and empower them. Discrimination itself is not forbidden. What is forbidden is discrimination which is beyond the municipality's powers as defined by its empowering statute. Discrimination in this municipal sense is conceptually different from discrimination in the human rights sense; discrimination in the sense of the municipal rule is concerned only with the ambit of delegated power.
>
> It follows that when it is alleged that a municipality has improperly discriminated against a citizen, the question for the court is whether the discrimination was authorized by the statute from which the municipality draws its powers. If the legislation authorizes the impugned distinction, the rule is not breached: *R. v.*

> *Sharma*, [1993] 1 S.C.R. 650. As my colleague Sopinka J. puts it, "the appropriate question is whether discrimination is explicitly or impliedly authorized" (p. 25). [p. 627]

[118] The Commission is subject to the same rules as municipalities. It derives its powers from statute and must operate within the powers so conferred on it.

[119] The respondents concede that, for the purposes of the

question of discrimination in the administrative law sense, the interim and permanent measures discriminate on the basis of timing of application, and prior to the expiry of the grandfathering provisions in the permanent measures, on the basis of province of training. They do not concede discrimination on the basis of age or province of residence. They say that if the measures do discriminate among physicians, such discrimination is expressly or impliedly authorized by the ***Medicare Protection Act***.

1. Age

[120] The petitioners claim that most "new billers" will be recent graduates from medical training and will by definition be the youth of the profession. Assuming that to be true, it does not follow that the measures are discriminatory on the basis of age. The only evidence supporting the claim that the measures disproportionately affect physicians who are young indicates that approximately half of the physicians granted 50% billing numbers in 1995 were between ages 25 and 35. I agree with the respondents that the evidence does not show that the measures discriminate on the basis of age.

2. Province of Residence

[121] The petitioners claim that both the interim and the permanent measures discriminate between residents and non-residents.

[122] The respondents say that the exemptions in the interim measures and the grandfathering provisions in the permanent measures for B.C.-trained physicians discriminate on the basis of province of training, not province of residence. They say further that after the grandfathering provisions for B.C.-trained physicians expire, the permanent measures do not discriminate on the basis of either province of training or residence.

[123] The issue of whether the measures discriminate on the basis of province of residence is also relevant for the purposes of the analysis of section 6 of the ***Charter***. In my view, the question is properly determined on the same basis for both issues.

[124] There are two aspects to the question of discrimination on the basis of province of residence: first, whether province of training equates to province of residence, and second, whether province of residence is a relevant factor after the exemptions and grandfathering for B.C. training expire.

(a) Province of Training

[125] The petitioners say that when a physician is in training outside of B.C., he or she is a non-resident. In ***Mia***, McEachern C.J. said at pp. 299-300: "...I regard extra-provincial internship as an aspect of residence."

[126] The respondents say that the comments in ***Mia*** are obiter. Whether a person is a resident of a place is a question of fact. Physical presence is not required.

[127] The meaning of "residence" for the purposes of the ***Citizenship Act***was considered in ***In Re the Citizenship Act and in re Antonios E. Papadogiorgakis***, [1978] 2 F.C. 208 at 214 (T.D.):

> A person with an established home of his own in which he lives does not cease to be resident there when he leaves it for a temporary purpose whether on business or vacation or to pursue a course of study....It is, as Rand J. appears to me to be saying in the passage I have read, "chiefly a matter of the degree to which a person in mind and fact settles into or maintains or centralizes his ordinary mode of living with its accessories in social relations, interests and conveniences at or in the place in question".

[128] In ***Papadogiorgakis*** and ***In the matter of Jenann Tareq Ismael***, [1992] 3 F.C. 381 (T.D.)., the appellants were found to be residents of Canada despite physical absences to pursue their studies outside of Canada.

[129] The reference to Rand J. in the passage quoted from ***Papadogiorgakis***is to ***Thomson v. M.N.R.***, [1946] S.C.R. 209 at 224-5, a case which considered the meaning of "ordinarily resident" for the purposes of the ***Income Tax Act***. In the passage quoted, Rand J. considered the meaning of "residence" and went on to say:

> It may be limited in time from the outset, or it may be indefinite, or so far as it is thought of, unlimited. On the lower level, the expressions involving residence should be distinguished, as I think they are in ordinary speech, from the field of "stay" or "visit".

[130] For the purposes of determining if an enactment discriminates on the basis of province of residence, "residence" should be given a broad meaning. I am of the view that an enactment that discriminates based on the fact that a person lives or lived outside the province, though temporarily, discriminates on the basis of province of

residence. Residence in this sense is at the "lower level" referred to by Rand J. in ***Thomson***: a person is a resident of a place into which he or she has settled and has social relations, interests and conveniences, distinguished from a stay or visit.

[131] A physician who lives in a province for a two-year training program would, generally speaking, be a resident of that province. I agree with McEachern C.J. that extra-provincial training is "an aspect of residence" and can form the basis of a finding of discrimination on the basis of province of residence.

[132] In this case, all of the petitioners were residents of and trained in Ontario before coming to B.C. and applying for billing numbers.

[133] I find that the interim and permanent measures discriminate between residents and non-residents by exempting or grandfathering B.C.-trained physicians.

(b) Discrimination Based on Residency After Grandfathering of B.C.-Trained Physicians Expires

[134] The two stated purposes of the measures are to ensure access to medical services and distribution of physician resources and to control health care costs, but it is clear that they were intended and designed to limit the numbers of physicians living outside B.C. from coming here. The evidence of the background to the measures shows that they were developed to limit the historical level of migration of doctors to B.C. which was expected to increase as a result of restrictive measures adopted in other provinces.

[135] Furthermore, simple arithmetic shows that most "new billers" come from outside B.C. In 1995, 623 physicians applied for new billing numbers. There is no evidence about where they came from. However, Dr. Finlayson states that over the ten-year period preceding 1993, on average 400 new physicians came to B.C. every year from other provinces. Others came from outside of Canada. Dr. Young's evidence is that the University of British Columbia Medical School graduates 120 physicians annually. Of these, approximately 60% are matched to residency programs outside of B.C.; it may be assumed that some of those choose to settle outside of B.C. Dr. Young's evidence also indicates that in 1996 there were 108 positions available in B.C. for postgraduate training. In ***Mia*** at pp. 285-5, McEachern C.J. summarizes evidence provided by the Commission in that case that showed that more than 80% of non-postgraduate active physicians in the province as of September 1983 came from

outside B.C. and 65.91% were graduates of medical schools of other provinces.

[136] Thus, it is clear that a large proportion of new billers must come from outside of B.C. There is no evidence that the number of physicians trained in B.C. will increase. I find that the most new billers will likely continue to be physicians from outside B.C. after the grandfathering provisions for B.C.-trained physicians in the permanent measures expire.

[137] The permanent measures draw clear distinctions between residents and non-residents of B.C. Under paragraph 3(c) of Minute 96-0015, practitioners earn points for each year of active practice and residence in B.C. and become entitled to a 100% billing number once they attain 100 points as long as they maintain registration and permanent residence in B.C.

[138] Under category 3.8 practitioners who have previously been issued a 100% billing number but are absent from the province for a period of 24 months or less for educational, sabbatical or humanitarian purposes and who have maintained registration with the College of Physicians and Surgeons of British Columbia during their absence are entitled to a 100% billing number on their return. These practitioners are provided an express exemption from the restrictions imposed on other non-resident physicians.

[139] Category 3.10 provides a 100% billing number to physicians in active practice in B.C. as of February 11, 1994. These physicians must be permanent residents of B.C. in order to be registered under the ***Medical Practitioners Act*** as a member of the College of Physicians and Surgeons (***Medical Practitioners Act***, R.S.B.C. 1979, c. 254, section 29 and Rules made under the ***Act***, section 74(d)). A physician must be a member of the College to be licensed to practise medicine in B.C.

[140] I find that without the grandfathering provisions for B.C.-trained physicians, the permanent measures discriminate between resident and non-resident physicians.

3. The Commission's Power to Discriminate

(a) Express or Implied Authorization

[141] The petitioners say the Commission has no power to discriminate between residents and non-residents because the ***Medicare Protection Act***does not expressly authorize it to do so (***Montreal v. Arcade Amusements Inc.***, , [1985], 1 S.C.R. 368 at 404-406; ***Jonas v. Gilbert*** (1880), 5 S.C.R. 356 at 365; ***R. v. Paulowich***, [1940] 1 W.W.R. 537 (Man. C.A.); ***The***

Attorney General of Canada v. The Corporation of the City of Toronto (1893), 23 S.C.R. 514; ***R. v. Hoy*** (1963), 38 D.L.R. (2d) 201 (P.E.I.S.C.); ***Adams v. Cranbrook*** (1979), 11 B.C.L.R. 206 (S.C.)).

[142] The respondents take the position that sections 21(1) and 4(1)(r.1) of the ***Medicare Protection Act*** provide clear and unambiguous authority to the Commission to enact physician supply measures. The particulars were left to the discretion of the Commission. They argue further that, given the long history of the development of physician supply measures in B.C. and other provinces, the legislature must have had in mind the particular types of policies adopted by the Commission when authorizing the Commission under section 4(1)(r.1) to use payment schedules for the purposes of supply management and medical care distribution throughout B.C. Thus, they say the right to draw distinctions

between different classes of physicians was implicit in the enactment ofsection 4(1)(r.1). They say that the decision in ***Allard Contractors Ltd. v. The Corporation of the District of Coquitlam***, [1993] 4 S.C.R. 371 at 416 is authority that a municipality may enact discriminatory measures, though not expressly authorized by the statute, where the statute implicitly authorizes the discrimination. Implicit authorization may be derived from the context and history in which the statutory provisions in question were enacted.

[143] Apart from the specific authority they say is found in section 4(1)(r.1), the respondents say that the Commission may discriminate in favour of B.C. doctors in the exercise of its "business powers".

[144] In ***Shell Canada Products Ltd.***, the City of Vancouver passed resolutions not to do business with Shell Canada Products Ltd. or its parent company and to declare Vancouver "Shell Free" until the parent company withdrew from South Africa. Shell challenged the resolutions on the grounds, *inter alia*, that they were discriminatory and beyond the City's powers. The City argued that the discrimination was justified in the exercise of the City's business powers.

[145] The majority and minority of the Court agreed that in exercising its business powers, the City has the power to discriminate. Sopinka J. stated at p. 627 that:

> Obviously in carrying on the business of the City or acquiring property from suppliers or vendors, the City must make choices that can be said to discriminate. Discrimination for commercial or business reasons is a power that is incidental to the powers to carry on business or acquire property.

[146] McLachlin J. described the power to discriminate as follows at pp. 645-6:

> The exercise of a municipality's business powers, however, stands on a different footing. Here the presumption is that the municipality has the power to make distinctions between citizens and firms on a wide variety of grounds. In exercising its business powers a municipality may -- indeed must -- discriminate between the multitude of parties with whom it may buy, sell and otherwise transact commerce....Accordingly, the power to discriminate in the exercise of municipal business powers is readily inferred from general language authorizing a city to do business and to act for the good rule and government of the city.

[147] The majority held that the resolutions discriminated for non-business reasons not grounded in promoting the health, safety or welfare of the City's inhabitants. The minority took the opposite view. It held that promoting the health, safety or welfare of the City's inhabitants extended to expressing approval or disapproval of conduct, whether inside or outside of the City, and that the City had acted validly in discriminating under its "business powers".

[148] The respondents' position is that in "preferring" B.C. doctors over doctors from outside the province, the Commission is exercising its commercial power to choose to buy services from one group over another.

[149] It is clear from the judgments of both the majority and minority in***Shell Canada Products Ltd.*** that a municipality's "business powers" do not provide separate grounds for the municipality to discriminate. The question remains whether "discrimination is expressly or impliedly authorized" (Sopinka J. at p. 627).

(b) The Commission's Powers

[150] The powers given the Commission in section 21 of the ***Act*** to establish categories for the purposes of establishing payment schedules are broad. In my view, however, without the powers provided by section 4(1)(r.1), there is nothing that authorizes the Commission to discriminate between residents and non-residents. Indeed, it could be said that section 21(9), which was repealed effective August 26, 1994, implicitly prohibited such discrimination. It prohibited the Commission from establishing categories "on the basis of years of practice as a member of the appropriate licensing body". For medical practitioners, licensing by the College of Physicians and Surgeons includes the

requirement that the practitioner be a permanent resident of B.C. Thus, by implication, the Commission could not create categories that discriminated among medical practitioners on the basis of the years that they had been residents of B.C.

[151] Section 21(9) was repealed at the same time as provisions in section 21(1) which expressly allowed the Commission to create categories on the basis of "past service levels". The respondents argue that the interim measures were validly enacted by establishing a category of "new billers" based on "past service levels" that were nil. Following the repeal of that provision and of section 21(9), they say the Commission's powers to create categories was further broadened. The re-enactment and extension of the interim measures in Minute 1080, passed October 6, 1994 with effect from July 2, 1994, are justified under section 21 as amended.

[152] Section 21 does not expressly authorize the Commission to discriminate between residents and non-residents in establishing categories. Nor is there implied authorization in section 21, either before or after the amendments made in August 1994, which permits the Commission to enact measures which discriminate among medical practitioners on the basis of residence. In the face of the authorities which in strong terms deny the right of a delegated body to so discriminate absent express or implied authority, more than the general language of section 21 is required to provide that authority.

[153] In my view, section 4(1)(r.1) provides that authority. The background to the adoption of the physician supply measures makes clear the types of measures that were contemplated and that they would involve discrimination between categories of medical practitioners, including residents and non-residents. The concept of supply management in B.C. is almost a euphemism for restrictions on new physicians coming from outside the province. It is similar in most respects to the measures that the province adopted in the 1980s, considered in the ***Mia*** and ***Wilson*** cases. It is the type of measure discussed by all of the provincial ministers of health and adopted by a majority of provinces.

[154] At the time section 4(1)(r.1) was enacted, the interim measures were in place. The Minister of Health advised the legislature that those measures were directed to "physicians that were new to the province" and the amendment was made in anticipation of enacting permanent supply measures. He also told the legislature (*British Columbia Debates* (6 June 1995) at 15033):

> By this legislation, the commission is authorized to modify physician payment schedules to limit the overall

growth in the number of physicians practising in the province.

[155] I have previously commented on the evidence that shows that most new doctors come from outside the province. To limit the overall growth in the number of physicians practising in the province, greater numbers of those coming from outside had to be affected by the measures adopted by the Commission.

(c) Retroactive Effect of Section 4(1)(r.1)

[156] Section 4(1)(r.1) of the ***Act*** provides the statutory authority to the Commission to enact physician supply measures which discriminate among physicians on the basis of province of residence. All of the petitioners applied for and were granted restricted billing numbers under the interim measures that were enacted before July 14, 1995, the date that section 4(1)(r.1) came into force. In these circumstances, the following questions arise: what is the status of the interim measures enacted beforesection 4(1)(r.1) came into force and what is the effect of the permanent measures on those who applied for billing numbers before that date?

[157] If section 4(1)(r.1) was not enacted, both the interim measures and the permanent measures would be beyond the jurisdiction of the Commission and void.

[158] Minute 96-0033, which consolidated the interim measures

with effect from July 2, 1994, was passed on June 12, 1996, after the enactment and purportedly under the authority of section 4(1)(r.1) of the***Act***.

[159] The permanent measures were passed on April 4, 1996, also aftersection 4(1)(r.1) was added to the ***Act***, but they apply to all physicians who apply for billing numbers after February 11, 1994.

[160] Are Minutes 96-0033 and 96-0015 effective to restrict the billing numbers issued to practitioners who applied before July 14, 1995? Do they have retroactive effect?

[161] The petitioners argue that the Minutes are void as they affect the petitioners. They submit that there are presumptions of statutory interpretation against both the retroactive application of statutes and the delegation of statutory authority to enact retroactive measures. These presumptions can be rebutted only by express language or by necessary implication. They cite in support of their submissions Professor Sullivan in *Driedger on the Construction of Statutes* (3rd ed. 1994 at p. 551) and Me. Pierre-André Côté in *The Interpretation of Legislation in Canada* (2nd ed. 1992 at pp. 130-1). Me. Côté expresses the applicable principles as follows:

> The rule against retroactive operation of statutes has two distinct applications in public law. First, legislative enactments should be construed in such a way as to avoid giving them a retroactive effect, to the extent this is possible. Second, legislation delegating authority to a subordinate body should be interpreted as not granting the right to exercise the power retroactively.

[162] The petitioners say that neither explicit nor implicit authority to act retroactively can be found in sections 4(1)(r.1) or 21 of the ***Act***. They further submit that there is a presumption against interference with vested interests, which would be the effect if Minutes 96-0033 and 96-0015 are found to be retroactively effective to restrict the petitioners' rights to 100% billing numbers.

[163] The respondents and the B.C.M.A. do not quarrel with the principles of interpretation of statutes and of delegated statutory authority as outlined by the petitioners. They argue, however, that Minutes 96-0033 and 96-0015 are not retroactive because they speak to status rather than to timing. In the alternative, they argue that section 4(1)(r.1)

is declaratory legislation which implicitly authorizes retroactive action by the Commission.

[164] In support of their argument that the Minutes speak to status not to timing, the respondents cite ***Grigg v. British Columbia*** (1996), 138 D.L.R. (4th) 548 (B.C.S.C.) and***Benner v. Canada (Secretary of State)*** (1997), 143 D.L.R. (4th) 577 (S.C.C.), both of which dealt with the retroactive or retrospective application of section 15 of the ***Charter***.

[165] The issue in ***Benner*** was whether section 15 of the ***Charter*** applied to the requirement under the ***Citizenship Act*** that persons born abroad of a Canadian mother before February 15, 1977 (and therefore before the coming into force of section 15 on April 17, 1985) had to undergo a security check and swear an oath. Discrimination was alleged because persons born abroad of a Canadian father before February 15, 1977 did not have to undergo a security check and swear an oath.

[166] In ***Benner*** at p. 592-3, Iacobucci J. drew the distinction between retroactive and retrospective statutes, quoting E.A. Driedger in "*Statutes: Retroactive Retrospective Reflections*" (1978), 56 *Can. Bar Rev.*264, at pp. 268-9:

> A retroactive statute is one that operates as of a time prior to its enactment. A retrospective statute is one that operates for the future only. It is prospective, but it imposes new results in respect of the past event. A retroactive statute *operates backwards*. A retrospective statute *operates forwards*, but it looks backwards in that it attaches new consequences *for the future* to an event that took place before the statute was enacted. A retroactive statute changes the law from what it was; a retrospective statute changes the law from what it otherwise would be with respect to a prior event. [Emphasis in original.]

Iacobucci J. continued:

> The *Charter* does not apply retroactively and this Court has stated on numerous occasions that it cannot apply retrospectively [citations omitted].
>
> At the same time, however, the Court has also rejected a rigid test for determining when a particular application of the *Charter* would be retrospective, preferring to weigh each case in its own factual and legal context, with attention to the nature of the particular*Charter* right at issue.

[167] At p. 593, Iacobucci J. discussed the distinction drawn by the respondents between status and timing (or event), as follows:

> In considering the application of the *Charter* in relation to facts which took place before it came into force, it is important to look at whether the facts in question constitute a discrete event or establish an ongoing status or characteristic. As Driedger has written in *Construction of Statutes* (2nd ed. 1983), at p. 192:
>
>> These past facts may describe a status or characteristic, or they may describe an event. It is submitted that where the fact situation is a status or characteristic (the being something), the enactment is not given retrospective effect when it is applied to persons or things that acquired that status or characteristic before the enactment, if they have it when the enactment comes into force; but where the fact-situation is an event (the happening of or the becoming something), then the enactment would be given retrospective effect if it is applied so as to attach a new duty, penalty or disability to an event that took place before the enactment.

[168] Applying these principles to the present facts, I am of the view that to apply to the petitioners, the Minutes enacted after section 4(1)(r.1) was added to the ***Medicare Protection Act*** must

operate retroactively; that is, they must "operate backwards", to cause the petitioners to become "new billers" at the date they applied to the Commission for billing numbers. In the absence of statutory authority, the Commission could not validly enact the interim measures and establish the category and status of "new billers" with prospective effect from February 11, 1994. Only after July 14, 1995 could it attach new consequences to the event of a physician applying for a billing number and then only with retroactive effect to any physicians who applied for billing numbers before that date. Minutes 96-0033 and 96-0015 do not attach new consequences *for the future* to an event that took place before they were enacted; they purport to attach consequences *for the past*.

[169] It is my understanding that the distinction between status and timing is applicable to a statute that purports to be retrospective, not to one that is retroactive. If I am mistaken and the distinction is applicable to a statutory enactment such as section 4(1)(r.1) that purports to be retroactive, then I am of the view that the petitioners did not acquire the status or characteristic of "new billers" before the enactment of section 4(1)(r.1), but rather, to paraphrase *Driedger*, the fact situation is an event, their becoming "new billers". Section 4(1)(r.1) would be given retrospective effect if it applied so as to attach a new duty, penalty or disability to that event.
[170] I am therefore of the view that to apply section 4(1)(r.1) to the petitioners is to give it retroactive or retrospective effect, which is neither explicitly or implicitly authorized by the statute.

[171] The respondents argue, in the alternative, that section 4(1)(r.1) is declaratory of the intention of the legislature in enacting section 21 and by necessary implication must be given retroactive or retrospective effect. In support of their argument, they cite ***Quebec (Attorney-General) v. Healey*** [1987] 1 S.C.R. 158.

[172] In 1919, the Quebec legislature passed legislation amending an existing statute by substituting the words "in full ownership by the Crown" for "for fishing purposes", with the result that the amended statute read:

> Sales and free grants of lands belonging to the Crown are and have been since the 1st of June, 1884, subject to a reserve, in full ownership of the Crown, of three chains in depth of the lands bordering on non-navigable rivers and lakes in the Province.

[173] The question before the Court was whether the 1919 amendment was retroactive to 1884. At pp. 165-6, the Court quoted from *Rédaction et interprétation des lois* (1965) by Louis-Philippe Pigeon, in which he drew a distinction between declaratory and interpreting statutory provisions. He stated at pp. 49-50:

> One way of giving legislation retroactive effect is to make a statute declaratory....Unlike a body exercising delegated authority, non-retroactivity is only a rule of interpretation so far as the Legislature is concerned....if it expresses its intent with sufficient clarity the courts must comply....
>
> ...
>
> The interpreting provision is similar to the declaratory provision....interpreting legislation does not have retroactive effect unless it is made in the form of a declaratory statute....If the Legislature intends the courts to be bound by the legislative interpretation as to past events, it must make the statute declaratory: it is not declaratory simply because it is interpreting. If it is to be interpreting and declaratory, it must contain an unambiguous statement of the intent to impose the new meaning "ab initio".

[174] At p. 166, the Court cited *Craies on Statute Law* (7th ed. 1971), where it is stated at p. 58:

> For modern purposes a declaratory Act may be defined as an Act to remove doubts existing as to the common law, or the meaning or effect of any statute. Such Acts are usually held to be retrospective.
>
> The usual reason for passing a declaratory Act is to set aside what Parliament deems to have been a judicial error, whether in the statement of the common law or in the interpretation of statutes.

[175] In ***Healey***, there was no express provision in the 1919 amendment making it retroactive. The Court held at p. 177 that:

> However, the legislator's intent can be deduced from the purpose of the legislation and the circumstances in which it was adopted. It can also be manifested by the procedure employed by the legislator. Finally, it may be

inferred from the only possible interpretation which is likely to make sense of it.

[176] The Court decided that the only possible interpretation of the amendment in the circumstances in which it was made was that it was intended to have retroactive effect. At the time it was enacted, there was a debate about the legal nature of the government's reserve. If the amendment had only prospective effect, it would not resolve that debate nor would it have any application immediately after its enactment as all grants in respect of which reserves were claimed had been made. Furthermore, the amendment preserved the existing effective 1884 date, which would not have been necessary if the intention was to make the amendment prospective.

[177] The respondents suggest that a declaratory law can be made in the anticipation that the courts may make an error in the interpretation of a statute. They suggest that was the intention of the legislature in enacting section 4(1)(r.1): the legislature was concerned that a court might interpret the ***Medicare Protection Act*** as not providing the Commission the statutory authority to enact physician supply measures.

[178] The respondents cite the comments of the Minister of Health to the legislature on the introduction of the amendment to the ***Act*** to add section 4(1)(r.1) in support of their argument that its enactment was declaratory of the intention of the legislature in enacting section 21. They say that the Minister made it clear that it was to remove any doubt as to whether the Commission had the authority to enact the interim measures.

[179] I do not find that the Minister's statements clarify the legislature's intent as to the effective date of the interim measures. Certainly the interim measures were in place when section 4(1)(r.1) was enacted and the legislature can be taken to have known that. The Minister's comments indicate, however, that the government was looking forward to the implementation of more permanent supply measures.

[180] Unlike the circumstances in ***Healey***, the retroactive application ofsection 4(1)(r.1) is not the only possible interpretation of its effect. Clearly the permanent measures were anticipated at the time of its enactment. It is as possible that the legislature intended to clarify the authority of the Commission to enact those measures as it is possible that it intended to retroactively authorize the interim measures.

[181] In the result, I find that section 4(1)(r.1) is not simply declaratory of the Commission's powers under section 21. Rather, it expanded the Commission's powers to enact

measures for the purposes of "supply management and optimum distribution of medical care...". There is no necessary implication from the enactment of section 4(1)(r.1) that the legislature intended that it have retroactive effect.

[182] I find support in the words of the ***Act*** for my conclusion that the legislature did not intend that section 4(1)(r.1) have retroactive effect. The legislature has given specific powers to the Commission to act retroactively to establish payment schedules in section 21(5):

> 21.(5) The Commission may act retroactively under this section to
>
> (a) include or increase payment for a benefit in a payment schedule, or
>
> (b) determine that a service is a benefit and establish a payment schedule item for this benefit.

[183] The Commission also has the power under section 4(1)(k) of the ***Act***to "determine before or after a service is rendered outside British Columbia whether the service would be a benefit if it were rendered in British Columbia".

[184] Thus, where the legislature wishes to grant the Commission authority to act retroactively, it has done so expressly. That power is narrowly defined and is restricted to actions that would provide a financial benefit to a practitioner or a medical benefit to a beneficiary. If the legislature intended the Commission to have the power to retroactively reduce payment for a benefit in a payment schedule, in my view it would have done so expressly. I agree with the petitioners that the maxim*expressio unius est exclusio alterius*: to express one thing is to exclude another, applies. In *Driedger* at p. 168, it is stated:

> An expectation of express reference can arise in a number of ways. Most often it is grounded in presumptions relating to the way legislation is drafted or to the policies it is likely to express.

The presumption against retroactive application of statutes gives rise to the expectation that if the legislature has chosen to expressly provide for the Commission to exercise retroactive powers in certain specific circumstances, it has chosen to exclude all other circumstances from the ambit of that power.

[185] I therefore conclude that section 4(1)(r.1) does not apply to give the Commission the power to retroactively enact the interim or permanent measures which discriminate among practitioners based on their residence.

[186] What is the result? In *The Interpretation of Legislation in Canada*Me. Côté states at p. 131:

> Applied to acts of Parliament, the rule against retroactive operation is nothing more than a guide to legislative intent. But when applied to administrative acts, there is also a question of jurisdiction. Administrative agencies possess only those powers authorized by the statute. They cannot enact retroactively unless the statute so provides, either implicitly or explicitly.
>
> Unless such power is granted, administrative decisions with retroactive effect are void.

[187] In the result, I find that the interim measures are invalid because the Commission did not, at the time they were enacted, have the statutory authority to enact discriminatory rules and did not have the power, after being given that statutory authority, to retroactively re-enact invalid measures. I further find that the permanent measures are invalid to the extent that they are retroactive, as the Commission does not have the power to pass retroactive measures.

[188] Having found the interim measures to be invalid and the permanent measures to have no retroactive effect, the petitioners are entitled to be issued billing numbers as of the dates they applied on the basis of the rules in force prior to February 11, 1994.

[189] It is not necessary for me to decide the other issues before me; however, in the expectation that my decision may be reviewed on appeal and that the court of appeal may disagree with my decision thus far, I will provide reasons on the other issues raised and fully argued. All counsel asked that I do so.

E. *Ultra Vires* the Province

[190] The petitioners argue that the interim and permanent measures are constitutionally invalid because the province has no jurisdiction to legislate or affect rights of Canadian citizenship. The petitioners say that the actual objective of the measures is to keep outsiders out of the province and the

province has no power to authorize the Commission to enact such measures because they do not comply with the imperatives of the Canadian constitution.

[191] The petitioners cite ***Winner v. S.M.T. (Eastern) Ltd.***, [1951] S.C.R. 887 in support of their argument. In that case, the New Brunswick Motor Carrier Board licensed the appellant to operate a public bus service from Maine to Nova Scotia through New Brunswick, but restricted him from picking up or dropping off passengers inside New Brunswick. The appellant argued that the provisions were *ultra vires* the province.

[192] In his concurring reasons, Rand J. considered this issue at pp. 918-20:

> The claim made for provincial control is, in my opinion, excessive. The first and fundamental accomplishment of the constitutional Act was the creation of a single political organization of subjects of His Majesty within the geographical area of the Dominion, the basic postulate of which was the institution of a Canadian citizenship. Citizenship is membership in a state; and in the citizen inhere those rights and duties, the correlatives of allegiance and protection, which are basic to that status.
>
> The Act makes no express allocation of citizenship as the subject-matter of legislation to either the Dominion or the provinces; but as it lies at the foundation of the political organization, as its character is national, and by the implication of head 25, section 91, "Naturalization and Aliens", it is to be found within the residual powers of the Dominion: *Canada Temperance* case ([1946] A.C. 193), at p. 205. Whatever else might have been said prior to 1931, the Statute of Westminster, coupled with the declarations of constitutional relations of 1926 out of which it issued, creating, in substance a sovereignty, concludes the question.
>
> ...
>
> What this implies is that a province cannot, by depriving a Canadian of the means of working, force him to leave it: it cannot divest him of his right or capacity to remain and to engage in work there: that capacity inhering as a constituent element of his citizenship status is beyond nullification by provincial action. The contrary view would involve the anomaly that although British Columbia could not by mere prohibition deprive a naturalized foreigner of his means

> of livelihood, it could do so to a native-born Canadian. He may, of course, disable himself from exercising his capacity or he may be regulated in it by valid provincial law in other aspects. But that attribute of citizenship lies outside of those civil rights committed to the province, and is analogous to the capacity of a Dominion corporation which the province cannot sterilize.
>
> It follows, *a fortiori*, that a province cannot prevent a Canadian from entering it except, conceivably, in temporary circumstances, for some local reason as, for example, health. With such a prohibitory power, the country could be converted into a number of enclaves and the "union" which the original provinces sought and obtained disrupted. In a like position is a subject of a friendly foreign country; for practical purposes he enjoys all the rights of the citizen.
>
> Such, then, is the national status embodying certain inherent or constitutive characteristics, of members of the Canadian public, and it can be modified, defeated or destroyed, as for instance, by outlawry, only by Parliament.

[193] ***Winner*** was cited with approval in ***Black v. Law Society of Alberta***, [1989] 1 S.C.R. 591. In that case, LaForest J. recognized a form of mobility right existing independent of the ***Charter***. He stated at pp. 610-11:

> Before the enactment of the *Charter*, however, there was no specific constitutional provision guaranteeing personal mobility, but it is fundamental to nationhood, and even in the early years of Confederation there is some, if limited evidence that the courts would, in a proper case, be prepared to characterize certain rights as being fundamental to and flowing naturally from a person's status as a Canadian Citizen. In *Union Colliery Company of British Columbia v. Bryden*, [1899] A.C. 580, the Privy Council dealt with the validity of a British Columbia enactment that prohibited people of Chinese origin or descent from being employed in mines. The Privy Council found the provision to be *ultra vires* the provincial legislature and thus illegal. Lord Watson based his reasons on s. 91(25) of the *British North America Act*, which gives exclusive legislative authority over "naturalization and aliens" to the Parliament of Canada. "Naturalization," it was held at p. 586, includes, "the power of enacting... what shall be the rights and privileges pertaining to residents in Canada after they have been

> naturalized." Provincial interference with a residents's right to live and work in the province was thus not permitted; see also*Cunningham v. Homma*, [1903] A.C. 151, at p. 157.
>
> It was left to Rand J. in *Winner v. S.M.T. (Eastern) Ltd.*, [1951] S.C.R. 887, to spell out the full implications of the *Bryden* case for Canadian citizenship. Rand J. makes it clear that Canadian citizenship carries with it certain inherent rights, including some form of mobility right. The essential attributes of citizenship including the right to enter and the right to work in a province, he asserted, cannot be denied by the provincial legislatures.

[194] The petitioners submit that the principles expressed in ***Black*** are also expressed in recent Supreme Court of Canada cases which have established an overriding federal principle creating certain constitutional imperatives. In ***Morguard Investments Ltd. v. DeSavoye***, [1990] 3 S.C.R. 1077, the Court found that the long-standing rule that the courts of Canadian provinces treat judgments of other Canadian courts as foreign for the purposes of recognition and enforcement was outdated and out of step with the realities of the Canadian state. LaForest J. stated at p. 1099:

> In any event, the English rules seem to me to fly in the face of the obvious intention of the Constitution to create a single country. This presupposes a basic goal of stability and unity where many aspects of life are not confined to one jurisdiction. A common citizenship ensured the mobility of Canadians across provincial lines, a position reinforced today by s. 6 of the *Charter*; see *Black v. Law Society of Alberta*, [1989] 1 S.C.R. 591.

[195] In ***Hunt v. T&N PLC***, [1993] 4 S.C.R. 289, The Court confirmed that the principles expressed in ***Morguard*** "were constitutional imperatives, and as such apply to the provincial legislatures as well as to the courts." That case involved a demand for the production of documents from a Quebec corporate defendant by a plaintiff in a lawsuit in British Columbia. A Quebec statute prohibited the sending of business records outside the province, thereby preventing production of the documents. The Court found that the impugned statute offended against the principles of Canadian federalism, and ruled them to be "constitutionally inapplicable" outside Quebec. LaForest J. stated at p. 330:

> It is inconceivable that in devising a scheme of union comprising a common market stretching from sea to sea, the Fathers of Confederation would have contemplated a situation where citizens would be effectively deprived of access to the ordinary courts in their jurisdiction in respect of transactions flowing from the existence of that common market. The resultant higher transactional costs for interprovincial transactions constitute an infringement on the unity and efficiency of the Canadian marketplace (see Finkle and Labrecque, *supra*), as well as unfairness to the citizen.

[196] The petitioners say that the fact that restrictions on the movement of citizens between states within a federation are contrary to the principles of a federal union has been recognized by the courts of the United States (see ***Crandall v. Nevada***, S.C. 6 Wall 35 (1867)) and Australia (see ***R. v. Ex Parte Benson***, [1912] 16 C.L.R. 99 (H.C.A.)).

[197] The petitioners submit that in enacting measures which have the objective of keeping outsiders out of the province, the Commission has attempted to restrict rights of citizenship, thereby violating the principle expressed in ***Winner*** and ***Black*** and failing to comply with the constitutional imperatives enunciated in ***Morguard*** and ***Hunt***. The province has no jurisdiction, they say, to authorize the Commission to enact such measures.

[198] In response, the respondents submit that the law in this area is governed by ***Morgan v. A.G. Prince Edward Island*** (1975), 55 D.L.R. (3d) 527 (S.C.C.). In that case, Laskin C.J.C. found at p. 539 that a Prince Edward Island statute which restricted land ownership to residents was not*ultra vires* the province:

> In the present case, the residency requirement affecting both aliens and citizens alike and related to a competent provincial object, namely, the holding of land in the Province and limitations on the size of the holdings (relating as it does to a limited resource) can in no way be regarded as a sterilization of the general capacity of an alien or citizen who is a non-resident, especially when there is no attempt to seal off provincial borders against entry.

[199] Laskin C.J.C.'s reasoning appears to be that since neither citizens nor non-citizens are denied an opportunity to enter the province and become residents, thereby earning their right to own property in the province, the cases which held that the federal government's naturalization power prevents provinces from legislating in this area did not apply.

[200] The respondents submit that the impugned measures in the instant case do not "seal off" the border, as in ***Morgan***. Instead, doctors are free to come to the province and practise, albeit with various restrictions. Further, the respondents say that the principles stated in ***R. v. S.(S.)*** (1990), 57 C.C.C. (3d) 115, in which the Supreme Court of Canada allowed for differing benefits between young offenders in different provinces, amount to an effective affirmation of the principles in ***Morgan***. The respondents submit that as ***Morgan*** was cited with approval in ***Churchill Falls (Labrador) Corp. v. Newfoundland (Attorney-General)***, [1984] 1 S.C.R. 297, it is still good law post-***Charter***.

[201] The respondents say that ***Morguard*** and ***Hunt*** do not address the constitutional heads which support provincial legislation in health and medical care. Those cases dealt with issues regarding the Canada's justice system. The respondents submit that while ***Churchill Falls*** and ***Hunt*** state that provincial legislatures cannot enact legislation which reaches out and extinguishes or affects rights in other provinces, the impugned measures in the instant case have no effect in other provinces: they only affect property and civil rights within B.C.

[202] In my view, all of the petitioners' arguments that the measures are *ultra vires* the province are properly considered in an analysis of section 6 of the ***Charter***. Essentially, the petitioners argue that the Commission has restricted the ability of persons outside B.C. to enter and practise medicine in the province. The petitioners' submissions that this amounts to a constitutional violation independent of a violation of section 6 is not supported by a closer reading of the petitioners' authorities.

[203] As noted above, in ***Black***, LaForest J. suggested that before the enactment of the ***Charter***, courts would in limited circumstances recognize rights, including mobility rights, which attached to a person's Canadian citizenship. LaForest J. suggested, however that these rights were articulated and given express effect by section 6. He stated at pp. 611-12:

> During the constitutional exercise culminating in the entrenchment of the *Charter*, there was a wave of political and academic concern regarding the construction of numerous barriers to interprovincial economic activity. There was also a strong feeling that the integration of the Canadian economy, which had been only partially successful under the *British North America Act*, should be completed. The federal government in particular was concerned about the growing fragmentation of the Canadian economic union....
>
> These economic concerns undoubtedly played a part in the constitutional entrenchment of interprovincial mobility rights, under s. 6(2) of the *Charter*. But citizenship, and the rights and duties that inhere in it are relevant not only to state concerns for the proper structuring of the economy. It defines the relationship of citizens to their country and the rights that accrue to the citizen in that regard, a factor not lost on Rand J., as is evident from the passage already quoted. This approach is reflected in the language of s. 6 of the *Charter*, which is not expressed in terms of the structural elements of federalism, but in terms of the rights of the citizen and permanent residents of Canada. Citizenship and nationhood are correlatives. Inhering in citizenship is the right to reside wherever one wishes in the country and to pursue the gaining of a livelihood without regard for provincial boundaries. Under *Charter* disposition, that right is expressly made applicable to citizens and permanent residents alike. Like other individual rights guaranteed by the *Charter,* it must be interpreted generously to achieve its purpose to secure to all Canadians and permanent residents the rights that flow from membership or permanent residency in a united country.

[204] LaForest J. ties the pre-existing inability of provinces to limit mobility on federalism grounds to the current inability of provinces to limit mobility on ***Charter*** grounds. He seems to be saying in the passage above that the mobility rights inherent in the rights of citizenship, including the right to "reside wherever one wishes", are now guaranteed by the Charter, which will give the most generous protection of those rights. The fact that

the limits on the province's ability to control mobility on federalism grounds are not qualified by a "saving" provision such as section 1 of the ***Charter*** does not make the ***Charter*** right less effective, since the circumstances under which a court would invalidate provincial mobility laws on federalism grounds were limited to "a proper case" (***Black*** at p. 610).

[205] The petitioners' authorities, including ***Morguard*** and ***Hunt***, demonstrate that there are constitutional principles and requirements which are not provided for expressly in the ***Charter***. In appropriate cases, litigants can rely upon those principles to say that a provincial legislature has exercised a power it does not have. In this case, however, the petitioners' claims relate to mobility rights and are therefore properly disposed of in a consideration of section 6. The American and Australian cases relied upon by the petitioners are also entirely concerned with considerations of mobility rights.

[206] I therefore find that the "constitutional imperatives" relied upon by the petitioners are provided for by section 6 of the ***Charter*** and will deal with them in that context.

F. The Canada Health Act

[207] Section 4(1) of the ***Medicare Protection Act*** confers powers and responsibilities on the Commission including the power in section 4(1)(r.1) to "apply section 21 for supply management and optimum distribution of medical care, health care and diagnostic services throughout British Columbia." Section 4(2) provides, however, that "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***".

[208] Section 7 of the ***Canada Health Act*** requires that a province satisfy the criteria established in sections 8 through 12 before the province qualifies for a full cash contribution from the federal government in respect of the cost of insured health services under the provinces's health insurance plan.

[209] Section 12 deals with the criterion of accessibility. Section 12(1)(c) requires the health insurance plan of a province to "provide for reasonable compensation for all insured health services rendered by medical practitioners". Section 12(2) deems

section 12(1)(c) to be complied with by a province where extra-billing is not permitted (as is the case in B.C.) if the province has entered into an agreement with the medical practitioners of the province that provides for (a) negotiations relating to compensation for insured services between the province and provincial organizations that represent practising medical practitioners in the province; (b) settlement of disputes through conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman; and (c) that a decision of the panel may not be altered except by an Act of the legislature of the province.

[210] The petitioners say that a 50% billing number does not provide "reasonable compensation for all insured health services rendered by medical practitioners". As a question of fact, I agree with them. While the respondents do not concede the point, they say that medical practitioners who are subject to the permanent measures are not really restricted to a 50% billing number because of the other billing options available: *locum tenens* positions and the other options previously described. On the evidence, the petitioners are receiving reasonable compensation for the insured services they provide.

[211] Compliance with the ***Canada Health Act*** is a requirement imposed on the Commission in the exercise of its powers under the ***Medicare Protection Act***. It is not a requirement only in respect of these petitioners. The Commission cannot validly exercise its powers if it does so in a manner that does not satisfy section 12(1)(c) of the ***Canada Health Act***.

[212] The respondents submit that section 12(1)(c) of the ***Canada Health Act*** is deemed to be satisfied by the provisions of the Master Agreement made December 21, 1993, the Working Agreement made December 21, 1993 and the Renewed Working Agreement made as of April 1, 1996, all between the government, the Commission and the B.C.M.A. All of these agreements provide for negotiations relating to compensation for insured health services and for the settlement of disputes through arbitration. Article 19 of the Master Agreement, article 10 of the Working Agreement and article 9 of the Renewed Working Agreement provide for dispute resolution by arbitration pursuant to the ***Commercial Arbitration Act***, S.B.C. 1986, c. 3. If an arbitrator cannot be agreed upon within the time provided, the Chief Justice of the Supreme Court will be asked to appoint the arbitrator. Article 10 of the Working Agreement and article 9 of the Renewed Working Agreement provide that the arbitrator shall have the jurisdiction to issue a final and binding award resolving the dispute.

[213] Respondents' counsel suggests that the provision for a

single arbitrator satisfies the requirement of section 12(2)(b) of the***Canada Health Act*** that arbitration be by a "panel that is equally representative of the provincial organizations and the province." A single arbitrator would either be agreed upon by both parties or appointed by the Chief Justice of the Supreme Court and thus by definition would be equally representative. As the only arbitrator, he or she would also satisfy the requirement for an independent chairman.

[214] I do not accept the respondents' submission. It is clear to me that a "panel" with an "independent chairman" presupposes that there will be more than one arbitrator.

[215] Furthermore, the Master Agreement does not provide for binding arbitration and none of the agreements provides that the decision of the arbitration panel may not be altered except by an Act of the legislature. The ***Commercial Arbitration Act*** provides in section 30 that a court may set aside an award for "arbitral error" and in section 31 for an appeal to the court by a party on any question of law.

[216] Thus it appears that the permanent measures do not satisfy section 12 of the ***Canada Health Act***. A 50% billing number does not provide reasonable compensation as required by section 12(1)(c) and the arbitration clauses in the Master Agreement, the

Working Agreement and the Renewed Working Agreement do not meet the requirements of section 12(2) in order that section 12(1)(c) be deemed complied with.

[217] The respondents say that whether the Commission has complied with the provisions of the ***Canada Health Act*** is not a matter for the court but for consultation between the provincial and federal governments. The issue becomes justiciable only if the criteria are found, through the consultation process, not to be satisfied. They rely on the decision of the Ontario Divisional Court in ***Collett v. Ontario (Attorney General)*** (1995), 81 O.A.C. 85.

[218] In ***Collett***, the applicants challenged a regulation made under the Ontario ***Health Insurance Act*** on the grounds that it contravened section 45(1)(h) which required that "no schedule of payments shall be prescribed under this clause that would disqualify the Province of Ontario under theCanada Health Act, for contribution by the Government of Canada because the Plan would no longer satisfy the criteria under that Act".

[219] The majority of the Court held that it did not need to deal with the issue as to whether the regulation did or did not satisfy the criteria of the ***Canada Health Act*** because under sections 14 through 17 of that ***Act***, the consequence of any

failure to satisfy the criteria was a matter for consultation and ultimately within the discretion of the Governor-in-Council to decide whether to disqualify the Government of Ontario for contribution. It found that the application was premature.

[220] O'Leary J., in dissent, found at p. 94 that

> In my view, the plain meaning of the words of section 45(1)(h), just quoted, is that what is prohibited is the creation of a payment schedule that fails to satisfy the criteria set out in the federal Act. Regulation 489/94 is such a regulation and it is therefore void.

[221] The respondents also cite ***B.C. Civil Liberties Assn.*** v. ***B.C. (A.G.)*** (1988), 24 B.C.L.R. (2d) 189 at 192-3 (S.C.), in which McEachern C.J.S.C., as he then was, held with reference to the***Canada Health Act*** that

> the possibility that the impugned regulation may disqualify the British Columbia plan from federal funding, if such is the case, is of no consequence in deciding this administrative law question.

In that case, however, he was dealing with a regulation passed by the Cabinet, not the Commission. Furthermore, at that time the ***Medical Services Act*** did not contain a provision like section 4(2).

[222] What section 4(2) of the ***Medicare Protection Act*** prohibits is an act of the Commission that does not satisfy the criteria described in section 7 of the ***Canada Health Act***. There is no reference to whether the failure to satisfy the criteria will or will not result in a stoppage of contributions from the federal government. In adopting measures that do not provide for reasonable compensation for all insured health services rendered by medical practitioners, the Commission has acted in a manner that does not satisfy section 12 of the ***Canada Health Act***. The agreements between the government, the Commission and the B.C.M.A. do not satisfy the requirements that would deem reasonable compensation to be provided. In failing to meet the requirements of section 12, the Commission has acted in a manner that does not satisfy the criteria described in section 7.

[223] The respondents submit that the purpose of the ***Canada Health Act*** is to provide services to insured persons, not to guarantee reasonable compensation to practitioners. Section 12 provides criteria respecting accessibility to insured

health services by insured persons. Section 12(1)(c), the respondents say, provides for reasonable compensation for all services, not for all practitioners.

[224] In my view, section 12(1)(c) of the ***Canada Health Act*** clearly provides that medical practitioners must be provided reasonable compensation for the insured health services they render. Ensuring that medical practitioners are reasonably

compensated is a component of ensuring the accessibility to Canadians of health services. The respondents' suggested interpretation of section 12(1)(c) strains the purpose and the words of the ***Act*** beyond any sensible meaning.

[225] I find that in enacting the measures which provide that certain medical practitioners may bill only 50% of the established payment schedule for insured services rendered by them, the Commission has acted in a manner contrary to section 4(2) of the ***Medicare Protection Act*** and has exceeded its jurisdiction.

[226] While this may appear a technical flaw relative to the larger issues of improper purpose, prohibition, discrimination and *ultra vires*, the applicable principle is the same. The Commission can act only in accordance with its statutory powers. If it does not, its acts are void.

IX. THE CANADIAN CHARTER OF RIGHTS AND FREEDOMS

[227] The petitioners say that the interim and permanent measures violate their rights under sections 6, 7 and 15 of the ***Charter***. The respondents deny that the measures violate any of the petitioners' ***Charter*** rights, but say that if they do, the violations are "saved" by section 1 of the***Charter***.
[228] I will deal with each of the rights the petitioners allege has been infringed and lastly with the submissions relating to section 1.

A. Section 6 - Mobility Rights

[229] Section 6 of the ***Charter*** provides:

> Mobility Rights
>
> 6(1) Every citizen of Canada has the right to enter, remain in and leave Canada.
>
> (2) Every citizen of Canada and every person who has the status of a permanent resident of Canada has the right
>
> > (a) to move to and take up residence in any province; and
> >
> > (b) to pursue the gaining of a livelihood in any province.
>
> (3) The rights specified in subsection (2) are subject to

(a) any laws or practices of general application in force in a province other than those that discriminate among persons primarily on the basis of province of present or previous residence; and

(b) any laws providing for reasonable residency requirements as a qualification for the receipt of publicly provided social services.

(4) Subsections (2) and (3) do not preclude any law, program or activity that has as its object the amerlioration in a province of conditions of individuals in that province who are socially or economically disadvantaged if the rate of employment in that province is below the rate of employment in Canada.

[230] The issues that arise with respect to section 6 are the nature of the rights protected by section 6(2)(b) and the scope of the exception provided in section 6(3)(a).

1. Section 6(2)(b)

[231] Section 6(2)(b) guarantees the right of every citizen and permanent resident of Canada to pursue the gaining of a livelihood in any province. The cases that have considered this section make it clear that this right is not a free-standing right to work but rather protects the right of a citizen or permanent resident to enter any province and work there (***Law Society of Upper Canada v. Skapinker***, [1984] 1 S.C.R. 357; ***Black v. Law Society of Alberta***, [1989] 1 S.C.R. 591; ***McDermott v. Town of Nackawic*** (1988), 53 D.L.R. (4th) 150 (N.B.C.A.); ***Walker v. Prince Edward** Island* (1993), 107 D.L.R. (4th) 69 (P.E.I.C.A.), affirmed (1995), 124 D.L.R. (4th) 127 (S.C.C.)). Section 6(2)(a) and (b) are separate but not isolated rights; both require an element of mobility.

[232] In ***Black*** at pp. 609-12, La Forest J. reviewed the history of the protection of interprovincial mobility in Canada in the context of the fundamental rights flowing from a person's status as a Canadian citizen.

[233] At pp. 615-6, La Forest J. quoted with approval from ***Malartic Hygrade Gold Mines Ltd. v. The Queen in Right of Quebec*** (1982), 142 D.L.R. (3d) 512 at 520-21 (Que.S.C.), where Deschênes C.J.S.C. stated:

The purpose of this provision is undoubtedly to give Canadian citizenship its true meaning and to prevent artificial barriers from being erected between the provinces.

> In principle the *Charter* thus intends to ensure interprovincial mobility.

[234] Thus, section 6(2)(b) protects the rights of a citizen or permanent resident to earn a livelihood when *inter*-provincial mobility is involved. It does not provide or protect any rights to earn a livelihood related to*intra*-provincial mobility.

[235] Another issue raised by the cases is the scope of the claim for protection to earn a livelihood. In ***Black***, La Forest J. stated at pp. 617-8:

> Section 6(2)(b), in my view, guarantees not simply the right to pursue a livelihood, but more specifically the right to pursue the livelihood of choice to the extent and subject to the same conditions as residents.
>
> Denying non-residents access to some fields cannot be condoned, for the purposes of section 6(2)(b), by the fact that some job positions are still left open to non-residents. The right to pursue this livelihood of choice must remain a viable right and cannot be rendered practically ineffective and essentially illusory by the provinces.

[236] He went on to cite with approval the analysis of this issue in ***Mia***, in which McEachern C.J. "suggested that one need not be completely cut off from a particular livelihood for a violation to exist. It was sufficient if a person was disadvantaged in the pursuit of that livelihood" and construed "the phrase in s. 6(2)(b), 'to pursue the gaining of a livelihood'...to mean 'the right to practise on a viable economic basis'".

2. Application of Section 6(2)(b) to the Interim and Permanent Measures

[237] In my view, both the interim measures and the permanent measures violate section 6(2)(b) of the ***Charter***.

[238] The violation is clearer in the interim measures, which exempt B.C.-trained physicians, and in the grandfathering of B.C.-trained physicians in the permanent measures. By exempting physicians who receive their training in B.C., these measures clearly disadvantage those physicians who do not. The respondents say that place of training has nothing to do with place of residence. I have already rejected that argument. In any event, at this stage of the inquiry, it is mobility, not place of residence, which is the criterion on which the right rests. As La Forest J. pointed out in ***Black*** at p. 620:

> ...I would have thought that any relevant mobility protected by s. 6(2)(b) would be sufficient to pursue one's livelihood. The infrequent visits to Alberta of the Toronto partners of the respondents would, therefore, be enough. This flows from what I had to say earlier with respect to *Basile, supra.* Such movement, in my view gives a sufficient "taint of relevancy" to the element of mobility, to use Estey J.'s phrase in *Skapinker, supra*. It would pose an impossible task on courts to expect them to superintend precisely how much interprovincial movement an individual should engage in in order to be protected by s. 6(2)(b). That factor, indeed, suggests that s. 6(2)(b) should be approached on a broader basis.

[239] Thus, restrictions to earning their livelihood imposed on physicians coming into the province from other provinces, regardless of their previous place of residence, *prima facie* violate their rights under section 6(2)(b). The petitioners fall into this class.

[240] Although each of the petitioners is practising medicine in a financially viable way, they are clearly disadvantaged in their choice of the manner in which they earn that livelihood relative to physicians who have trained in B.C. None of the petitioners can earn a viable livelihood under a 50% billing number. Drs. Waldman and Wong are restricted to performing *locums*. Dr. Biro is restricted to practising at the Prince George Regional Hospital. Their equally-qualified but trained-in-B.C. colleagues can do what the petitioners are doing and can also choose to practise independently anywhere in the province.

[241] The respondents insist that there is a "myriad" of choices open to physicians who are subject to the interim and permanent measures: they can go to an NIA community; they can go to a community in which there is a demonstrated medical need for their services; they can be appointed to specific positions at UBC; they can go to regions where their particular specialty is under-supplied. The evidence shows, however, that the availability of these choices is extremely limited.

[242] On October 31, 1996, the Commission produced a document entitled "British Columbia Physician Supply Plan", which describes the components of the permanent measures, provides a list of pre-approved positions and NIA communities and provides the "Physician Supply Template" for the period October 1, 1996 through March 31, 1997. The Physician Supply

Template sets out the billing rates (that is, 50%, 75% or 100%) for the health regions in the province, by specialty.

[243] The document indicates that for the period April 1, 1996 to October 10, 1996 there were 27 vacant pre-approved positions in the province. Of these, 11 were for general practitioners. It was noted on the document that "Communities may have recruited physicians with unrestricted billing numbers into these positions the Physician Supply Unit would not be notified under this circumstance". The approvals are granted for six months from the date of approval. Thus, at the particular time a physician applies for a billing number, a pre-approved position may have

been taken by another physician, including one who is not subject to the billing restrictions and is free to move anywhere in the province, or the position may have expired.

[244] The Physician Supply Template indicates that there are no regions in the province in which a general practitioner can obtain a 100% billing number and only 5 out of 20 in which a 75% billing number is available.

[245] I find that the right of the petitioners to pursue their "livelihood of choice" has, for the purposes of section 6(2)(b), been rendered "practically ineffective and essentially illusory". Their rights under section 6(2)(b) are clearly violated.

[246] It is not so clear that section 6(2)(b) is violated after the grandfathering of B.C.-trained physicians expires. On their face, the measures no longer favour those who are in B.C. However, the evidence shows, and I find as a fact, that more "new billers" are likely to come from provinces outside of B.C. and the measures were designed to restrict this migration. The fact that physicians who reside in B.C. will be similarly restricted is, in my view, irrelevant to the application of section 6(2)(b). I therefore find that section 6(2)(b) applies to the permanent measures because physicians coming from provinces outside of B.C. are restricted in their ability to earn their livelihood.

3. Section 6(3)(a)

[247] Section 6(3)(a) qualifies the rights provided under section 6(2). Laws of general application that do not discriminate primarily (or, to translate from the French version, "distinguish principally") on the basis of province of present or previous residence are valid.

[248] The petitioners suggest that the word "principally" connotes "most important, consequential or influential" or "chiefly", while "primarily" means "first in importance". They say there can be more than one "principal" ground of discrimination or distinction, but only one "primary" ground.

[249] In ***R. v. Turpin***, [1989] 1 S.C.R. 1296 at 1314, Wilson J. considered the interpretation of the words of a statute in both English and French and concluded:

> To the extent that resort to the French text helps to resolve an ambiguity in the English text and particularly in a way which would appear to reflect better the purpose underlying the right, it seems to me that it should be adopted....In *R. v. Collins*, [1987] 1 S.C.R. 265, for example, my colleague Lamer J. adopted

the French text of s. 24(2) of the *Charter* stating at p. 287:

> As one of the purposes of s. 24(2) is to protect the right to a fair trial, I would favour the interpretation of s. 24(2) which better protects that right, the less onerous French text.

[250] Applying the same reasoning, I will use the French version, since it appears to provide a broader application to the section than the English and thus better protects the mobility rights at issue.

[251] I need not analyze the meaning of "laws of general application" to determine if section 6(3)(a) applies to the interim measures and to the permanent measures while the grandfathering of B.C.-trained physicians is in place.

[252] I have previously found that for the purposes of determining whether the measures discriminate, in the administrative law sense, on the basis of province of residence, "residence" should be given a broad meaning and a physician who lives in a province to receive medical training will generally be considered a resident of that province.

[253] The same principles apply in determining province of present or previous residence for the purposes of section 6 of the ***Charter***. This approach is consistent with a broad, generous interpretation of the***Charter***. It is also consistent with the nature of the right protected by section 6(2)(b): the earning of a livelihood in a province where some element of inter-provincial mobility is involved. To impose a narrow test of residency on the individual whose mobility right is violated, where the

element of mobility to attract the protection of the section does not require a change of residence but merely some entry into the province, is contradictory.

[254] I therefore find that the interim measures, which exempt B.C.-trained physicians, and the permanent measures, during the period that B.C.-trained physicians are grandfathered, discriminate on the basis of province of present or previous residence and are not validated by section 6(3)(a).

[255] As I noted in the discussion of section 6(2)(b), it is not so clear that section 6(3)(a) does not apply to the permanent measures after the grandfathering of B.C.-trained physicians expires. At that time, physicians who come to B.C. from other provinces will clearly be subject to the restrictions from earning a livelihood imposed by the permanent measures. B.C.-resident physicians who are "new billers" will be subject to the same restrictions. I have found that it is likely that most of the "new billers" will be physicians from outside of B.C.

[256] In light of those facts, can it be said that the permanent measures, absent the grandfathering of B.C.-trained physicians, distinguish principally on the basis of province of present or previous residence?

[257] In ***Black*** at pp. 625-6, La Forest J. examined the application of section 6(3)(a) to Rule 75B of the Alberta Law Society which provided that "No member [of the Law Society] shall be a partner in or associated for the practice of law with more than one law firm". He found that the rule was intertwined with Rule 154, passed at the same time, which clearly discriminated primarily on the basis of province of present or previous residence. He held that the purpose and effect of the rule had to be examined and if either the purpose or effect is unconstitutional, the rule is unconstitutional.

[258] On the evidence, he found at p. 626 that Rule 75B was aimed at prohibiting residents and non-resident members from associating for the practice of law, and that members of law firms that want to establish interprovincial connections would be most severely affected by the rule. In the result, Rule 75B was found to discriminate on the basis of residence.

[259] By the same reasoning, I find that the permanent measures, after the grandfathering of B.C.-trained doctors expires, will nevertheless continue to distinguish principally on the basis of province of present or previous residence. It is clear from the evidence that the measures were designed to restrict the numbers of physicians migrating to B.C. from other provinces and will most severely affect that group.

Thus, both the purpose and the effect are discriminatory, contrary to the provisions of section 6(3)(a).

[260] The permanent measures are not like the restriction imposed on the practice of accountancy in ***Walker v. Prince Edward Island***. In that case, section 14(1) of the ***Public Accounting and Auditing Act***, R.S.P.E.I. 1988, c. P-28 reserved to members of the Institute of Chartered Accountants the right to practise "public accounting and auditing". This restriction was challenged by two individuals who were certified general accountants on the grounds that it violated their rights under sections 2(b), 6(2) and 7 of the ***Charter***. The Court of Appeal held at p. 77 that section 6(2)(b) was not violated because the restriction had nothing to do with residency.

> It subjects all non-members of the Institute to the same restrictions and conditions whether they reside in the province or not. The decisions of the Supreme Court of Canada in ***Skapinker*** and***Black*** have established that s. 6 of the Charter does not prevent a province from regulating a profession so long as it does so without discriminating on the basis of place of residence.

[261] The respondents say that the restriction in ***Walker*** is fundamentally no different from the restrictions in the interim and permanent measures which require pre-licensure training in B.C. This argument is simply untenable. There is nothing in the measures in question here that has anything to do with licensure, nor does the Commission have any powers in relation to the licensing of physicians. That is the function of the College of Physicians and Surgeons. Under section 12(2) of the ***Medicare Protection Act***, the Commission is required to enroll an applicant who is in good standing with the College.

[262] The difference between ***Walker*** and this case is that there is evidence from which I have found as a fact that the measures are designed to and affect disproportionately those physicians who come from other provinces. Thus section 6(2)(b) of the ***Charter*** is applicable and section 6(3)(a) has no application.

[263] I am also of the view that the permanent measures are not "laws of general application".

[264] In ***Mia***, supra, McEachern C.J.S.C. considered the question of the meaning of "law of general application". He cited the test stated by Dickson J. (as he then was) in ***Kruger v. R.*** [1978], 1 S.C.R. 104 at 110 as follows (at p. 297):

> There are two *indicia* by which to discern whether or not a provincial enactment is a law of general application. It is necessary to look first to the territorial reach of the Act. If the Act does not extend uniformly throughout the territory, the inquiry is at an end and the question is answered in the negative. If the law does extend uniformly throughout the jurisdiction the intention and effects of the enactment need to be considered. The law must not be "in relation to" one class of citizens in object and purpose. But the fact that a law may have graver consequence to one person than to another does not, on that account alone, make the law other than one of general application. There are few laws which have a uniform impact. The line is crossed, however, when an enactment, though in relation to another matter, by its effect, impairs the status or capacity of a particular group. The analogy may be made to a law which in its effect paralyzes the status and capacities of a federal company,; see *Great West Saddlery Co. v. The King*, [1921] 2 A.C. 91.

[265] I am prepared to assume, as was McEachern C.J.S.C. in ***Mia***, that the permanent measures meet the territorial reach test. Do they impair the status or capacity of a particular group?

[266] In ***Mia***, the Court held that the practice there in issue was not one of general application because the legal right of Dr. Mia to practise was impaired relative to others with similar qualifications, based on criteria such as grandfathering, oversupply, medical training and years of residence in B.C.

[267] The right of a "new biller", whether B.C.-trained, a B.C. resident or from outside B.C., to practise under the permanent measures, after the grandfathering of B.C.-trained doctors expires, will be restricted primarily by the criterion of oversupply. The oversupply will be created by the numbers of existing physicians already practising in the province. Physicians who are established in practice at February 11, 1994 are permanently grandfathered under the permanent measures and are therefore unaffected by the criterion of oversupply.

[268] Do the measures only affect an individual or group adversely, or do they "cross the line" and impair the status or capacity of a particular group? In my view, though the measures are "in relation to" the matter of the management of physician supply, a matter within the competence of the Commission, they "cross the line" by, in their effect, impairing the capacity of "new billers" to practise medicine.

[269] The respondents and the B.C.M.A. argue that the grandfathering of established physicians is a fair and non-discriminatory method of determining who will be subject to the measures. They rely on the decision in ***The Queen v. Beauregard***, [1986] 2 S.C.R. 56, in which the Supreme Court of Canada decided that drawing a line between present incumbents and future appointees in determining which judges would be required to contribute to their pensions did not violate the equality rights provision of the ***Canadian Bill of Rights***. Grandfathering to take into account the settled expectations of earlier appointees was unobjectionable.

[270] The issue in ***Beauregard***, however, was not whether the law was of general application or impaired the status or capacity of a particular group. At issue was the amount certain judges would have to contribute to their pensions, not their constitutional right to earn their livelihood as judges. In this case, the

measures impair the capacity of qualified physicians to earn a livelihood in the province. In light of the considerations of the fundamental rights of citizenship that inform the analysis of section 6 of the ***Charter***, I find that "drawing a line" between new and established physicians draws the line between a law of general application and one that is not. The permanent measures are not laws of general application.

4. Conclusion on Section 6

[271] In summary, I find that petitioners' mobility rights under section 6 of the ***Charter*** are violated by the interim and permanent measures.

B. Section 7 - Life, Liberty and Security of the Person

[272] Section 7 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.

[273] In both ***Mia*** and in the Court of Appeal in ***Wilson***, the Courts found that the billing restrictions imposed by the Commission violated the right to liberty protected by section 7, which was held to include the right to practise a profession. Both Courts also found that the deprivation of the right did not accord with the principles of fundamental justice.

[274] The petitioners naturally submit that I am bound by these previous decisions which, they say, have not been expressly overruled by either the Court of Appeal or the Supreme Court of Canada. The respondents say that subsequent decisions of the Supreme Court of Canada, courts of appeal of other provinces, our Court of Appeal and of this Court have effectively reversed ***Wilson*** insofar as it can be said to stand for the proposition that the right to "liberty" under section 7 guarantees the right to practise a profession.

1. The ***Wilson*** case

[275] In ***Wilson***, the Court of Appeal considered the case of six doctors who challenged the restrictions on billing numbers imposed by the Medical Services Commission under the authority of the ***Medical Services Act*** and regulations as amended in 1985. The restrictions limited three of the doctors to practising in a specified geographic area of the province, one to practising as a *locum tenens* and two were denied the right

to practise on the grounds of their absence from the province for two years and their failure to reapply.

[276] On these facts, the Court said at p. 13:

> The question then arises whether "liberty" in s. 7 is broad enough to encompass the opportunity of a qualified and licensed doctor to practise medicine in British Columbia without restraint as to place, time or purpose, even though there is an incidental economic component to the right being asserted.

[277] On pp. 17-18, it answered its own question:

> To summarize: "Liberty" within the meaning of s. 7 is not confined to mere freedom from bodily restraint. It does not, however, extend to protect property or pure economic rights. It may embrace individual freedom of movement, including the right to choose one's occupation and where to pursue it, subject to the right of the state to impose, in accordance with the principles of fundamental justice, legitimate and reasonable restrictions on the activities of individuals.

[278] After reviewing the authorities on the applicability of section 7 to issues of economic rights and the right to work, the Court concluded at p. 24 that these rights

> ...had little to do with the important personal right of otherwise qualified professional people to have an opportunity to attempt to build a practice in their province and in their chosen communities.

[279] The Court also considered whether section 7 protected the freedom of mobility within a province and concluded at p. 26:

> Section 6 may or may not be restricted to guaranteeing the right of free movement from province to province. Whatever the answer to that question may be does not detract from the constitutional and fundamental importance of mobility as it affects the life, liberty and security of the person: "Liberty" must touch the right of free movement.
>
> We are of the opinion, therefore, that the geographic restrictions imposed by government on the right to practise medicine in British Columbia constitute a violation of the right to liberty protected bys. 7 *unless* that right has been removed in accordance with the principles of fundamental justice, or unless the

deprivation can be demonstrably justified under s. 1 of the Charter.

2. Post-***Wilson*** Jurisprudence

[280] The respondents say that the Court of Appeal's view that section 7guarantees the right to practise a profession has effectively been overruled. They rely on the comments of Lamer J. (as he then was) in***Reference re ss. 193 and 195.1(1)(c) of the Criminal Code*** (1990), 56 C.C.C.(3d) 65 (S.C.C.) (the "*Soliciting Reference*"), which have been followed in subsequent cases decided in the Federal Court of Appeal (***Canadian Association of Regulated Importers v. Canada***, [1992] 2 F.C. 130); the Court of Appeal of Prince Edward Island (***Walker v. Prince Edward Island***); and the Ontario Court of Appeal (***Kopyto v. Law Society of Upper Canada*** (1993), 107 D.L.R. (4th) 259, citing ***Biscotti v. Ontario Securities Commission*** (1991), 76 D.L.R. (4th) 762 (Ont.C.A.)). They also cite subsequent cases of the B.C. Court of Appeal (***Martinoff v. Dawson*** (1990), 57 C.C.C. (3d) 482;***R. v. Baig*** (1992), 78 C.C.C.(3d) 260) and of this Court (***Bennett***

v. British Columbia (Securities Commission) (1991), 82 D.L.R. (4th) 129) in which, they argue, the courts cast doubt on the validity of the decision in ***Wilson***.

[281] In the *Soliciting Reference* case, Lamer J. took the opportunity to express his view on the question of whether section 7 of the ***Charter***guarantees the right to practise a profession. In so doing, he specifically referred to the ***Wilson*** case and at pp. 99-100 questioned the conclusions of the Court of Appeal:

> In my view, it is not clear that the statement by the Chief Justice [in *Reference re Public Service Employee Relations Act* (1987), 38 D.L.R. (4th) 161 at 198-9)], quoted at length by the British Columbia Court of Appeal in *Wilson*, is support for the view that s. 7 of the Charter protects a "right to pursue a livelihood or profession" as distinct from a "right to work " which is not protected....There is no doubt that the non-economic or non-pecuniary aspects of work cannot be denied and are indeed important to a person's sense of identity, self-worth and emotional well-being. But it seems to me that the distinction sought to be drawn by the court between a right to work and a right to pursue a profession is, with respect, not one that aids in an understanding of the scope of "liberty" under s. 7 of the Charter.
>
> Further, it is my view that work is not the only activity which contributes to a person's self-worth or emotional well-being. If liberty or security of the person under s. 7 of the Charter were defined in terms of attributes such as dignity, self-worth and emotional well-being, it seems that liberty under s. 7 would be all inclusive. In such a state of affairs there would be serious reason to question the independent existence in the Charter of other rights and freedoms such as freedom of religion and conscience or freedom of expression.
>
> In short, then, I find myself in agreement with the following statement of McIntyre J. in *Reference re Public Service Employee Relations Act, supra,* at p. 231: "It is also to be observed that the Charter, with the possible exception of s. 6(2)(b) (right to earn a livelihood in any province) and s. 6(4), does not concern itself with economic rights".

[282] At p. 101, Lamer J. stated his reasons for commenting on the scope of section 7:

> While it is not essential to the disposition of this ground of appeal, I feel, having regard to some of the pronouncements of courts of appeal on the subject, that I should to some extent disclose my views as to the nature of the liberty and security of the person s. 7 is protecting. I pause to point out that the comments that follow are not designed to provide a definitive or exhaustive statement of what interests are protected by s. 7, but rather to put in a more positive way what s. 7 *does* protect as opposed to what it *does not* protect.

[283] He then went on at p. 102-3 to state his view of the nature of the interest protected by s. 7:

> In the *Motor Vehicle* reference, for example, this court said the following in respect of defining the principles of fundamental justice at p. 302:
>
>> Many have been developed over time as presumptions of *the common law*, others have found expression in the international conventions on human rights. All have been recognized as essential elements of a *system for the administration of justice* which is founded upon a belief in "the dignity and worth of the human person"... and on the "rule of law"...
>>
>> In other words, the principles of fundamental justice are to be found in the basic tenets of our *legal system. They do not lie in the realm of general public policy but in the inherent domain of the judiciary as guardian of the justice system.*
>
> (Emphasis added) [by Lamer J.] This passage is, in my view, instructive of the kind of life, liberty and security of the person sought to be protected through the principles of fundamental justice. The interests protected by s. 7 are those that are properly and have been traditionally within the domain of the judiciary.Section 7, and more specifically ss. 8 to 14, protect individuals against the state when it invokes the judiciary to restrict a person's physical liberty through the use of punishment or detention, when it restricts security of the person, or when it restricts other liberties by employing the method of sanction and punishment traditionally within the judicial realm.

[284] He summarized his views at p. 106:

> Put shortly, I am of the view that s. 7 is implicated when the state, by resorting to the justice system, restricts an individual's physical liberty in *any circumstances*. Section 7 is also implicated when the state restricts individuals' security of the person by interfering with, or removing from them, control over their physical or mental integrity. Finally, s. 7 is implicated when the state, either directly or through its agents, restricts certain privileges or liberties by using the threat of punishment in cases of non-compliance.

[285] He concluded at p. 107: "The rights under s. 7 do not extend to the right to exercise their chosen profession."

[286] Lamer J. agreed with the majority in the result, but he was alone in expressing his views as to the scope of the guarantee of liberty insection 7 and its application to the practice of a profession.
[287] Lamer J.'s views as to the scope of section 7 have been adopted by the courts of appeal in the cases cited above. In ***Walker***, the Prince Edward Island Court of Appeal stated at p. 78:

> ...as Lamer J. points out in *Reference re: ss. 193 and 195.1(1)(c) of the Criminal Code, supra*, at p. 102, the restrictions on liberty that s. 7 is concerned with are those that occur as a result of an individual's interaction with the justice system and its administration. He goes on to state at p. 107 that the rights unders. 7 do not extend to the right to exercise a chosen profession. The trial judge dismissed the statement by Lamer J. because the profession under consideration in that case was prostitution. However, I believe his words apply equally to the accounting or any other profession.

[288] In affirming the ***Walker*** case, the Supreme Court of Canada said the following at p. 128 of its very short reasons:

> In light of our previous decisions as regards ss. 2(b), 6 and 7 of*Canadian Charter of Rights and Freedoms*, we are all of the view that there has been no restriction to those rights in this case.

[289] In the ***Martinoff***, ***Baig*** and ***Bennett*** cases, the courts referred to Lamer J.'s comments in the *Soliciting*

Reference on ***Wilson*** and section 7. In all three cases, they held that section 7 was not violated.

[290] In ***Martinoff***, the appellant applied for a permit to possess restricted weapons. He wished to instruct others in the use of handguns outside of gun clubs, where he was already authorized to

instruct. He argued that he was restricted from practising his profession as a handgun instructor, contrary to section 7 of the ***Charter***. The Court of Appeal held that his rights were not violated because he could practise his profession at gun clubs. The respondents suggest that in so finding, the Court of Appeal effectively held that section 7 does not guarantee an individual the right to practise his profession in the location and style he chooses.

[291] In ***Baig***, the appellant was charged with practising medicine and psychology while not registered under the applicable statutes. He argued that the statutes violated his rights to practise his profession undersection 7 of the ***Charter***. The Court of Appeal distinguished this case from***Wilson*** on the grounds that in ***Baig*** the appellant's qualifications to practise psychology were in issue while in ***Wilson*** all of the appellants were fully qualified to practise medicine.

[292] In ***Bennett***, the petitioners had been subject to lengthy investigative, administrative and quasi-criminal proceedings relating to alleged insider trading. They brought a petition to have the Securities Commission prohibited from holding a further hearing into the matter. They alleged, among other things, that their rights under section 7 of the***Charter*** were violated. One of them alleged the violation on the grounds that he may become

subject to a penalty that would deprive him of the right to pursue a livelihood and profession as a director of his own company. After considering the relevant jurisprudence to that date, including ***Wilson*** and Lamer J.'s comments in the *Soliciting Reference*, Mr. Justice Melnick found that any penalties to which any of the petitioners could be subject were purely economic and section 7 had no application. He concluded at p. 182:

> A review of the cases I have referred to above, particularly the reasons of Mr. Justice Lamer where he states a p. 102 of *Reference re Sections 193 and 195.1(1)(c) of the Criminal Code* that "...the restrictions on liberty and security of the person that s. 7 is concerned with are those that occur as a result of an individual's interaction with the justice system, and its administration" leads me to conclude that, *Yong, supra,* and *Kodellas, supra,*notwithstanding, the weight of authority is against the application of s. 7 of the Charter to the specific administrative proceedings under s. 144 of the *Securities Act* that are before me. This is not a case where there will be any consequences to the petitioners' physical liberty and security. Nor does the evidence before me establish that any of the petitioner's mental integrity is being, or will be, affected.

3. Is ***Wilson*** Overruled?

[293] The comments of Lamer J. in the *Soliciting Reference*, the decisions of courts of appeal of other provinces and of the Federal Court of Appeal, the affirmation by the Supreme Court of Canada of the decision of the Prince Edward Island Court of Appeal in ***Walker*** and the decisions of our Court of Appeal and my colleague Mr. Justice Melnick all persuade me that the weight of authority, since ***Wilson***, is that section 7 does not protect the right of a person to practise a profession. The facts in ***Wilson*** and in this case are virtually indistinguishable. In my view, the Supreme Court of Canada, by adopting the reasoning of the Prince Edward Island Court of Appeal in ***Walker***, has effectively overruled ***Wilson***. The result is thatsection 7 has no application in this case.

4. Fundamental Justice

[294] As I have found that section 7 has no application, it is not necessary for me to consider whether the principles of fundamental justice apply.

5. Conclusion on Section 7

[295] The petitioners' rights are not violated under section 7 as it has no application in this case.

C. Section 15 - Equality Rights

[296] Section 15 provides:

> 15(1) 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.
>
> (2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

[297] All of the petitioners claim that the interim and permanent measures violate their rights not to be discriminated against on the basis of their age and province of previous residence. Dr. Waldman claims in addition that her rights not to be discriminated against on the basis of her sex and religion have been violated.

1. Principles of Analysis under Section 15(1)

[298] The starting point for the analysis of section 15(1) is ***Andrews v. Law Society of B.C.*** (1989), 56 D.L.R. (4th) 1 (S.C.C.), where McIntyre J. stated at p. 10:

> The concept of equality has long been a feature of Western thought. As embodied in section 15(1) of the Charter, it is an elusive concept and, more than any of the other rights and freedoms guaranteed in the Charter, it lacks precise definition....It is a comparative concept, the condition of which may only be attained or discerned by comparison with the condition of others in the social and political setting in which the question arises. It must be recognized at once, however, that every difference in treatment between individuals under the law will not necessarily result in inequality and, as well, that identical treatment may frequently produce serious inequality.

[299] Section 15(1) of the Charter is not meant to eliminate all distinctions, only those that are discriminatory. At p. 18, McIntyre J. defined discrimination as

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

[300] In determining whether a claimant's rights under section 15(1) have been violated, it must be shown that the alleged discrimination is based on one of the enumerated grounds or an analogous ground (***Andrews***, at pp. 23-24). The law may not be expressly or directly discriminatory; the concept of "adverse effect discrimination" is comprehended by section 15(1) (***Andrews*** at p. 17; ***Symes v. Canada*** (1993), 110 D.L.R. (4th) 470 at 552 (S.C.C.)) Furthermore, as stated by Wilson J. in***Turpin*** at p. 1331:

> In determining whether there is discrimination on grounds relating to the personal characteristics of the individual or group, it is important to look not only at the impugned legislation which has created a distinction that violates that right to equality but also to the larger social, political and legal context.

[301] In ***Symes***, Iacobucci J. analyzed the jurisprudence as it had developed to that time and outlined a three-step test to determine whether a law infringes the right to equality guaranteed by section 15(1) at pp. 556-7:

> As my summary of the s. 15(1) jurisprudence above demonstrates, the answer to this question must come in parts. First, it must be determined whether s. 63 establishes an inequality: does s. 63 draw a distinction (intentional or otherwise) between the appellant and others, based upon a personal characteristic? Second, if an inequality is found, it must be determined whether the inequality results in discrimination: does the distinction drawn by s. 63 have the effect of imposing a burden, obligation or disadvantage not imposed upon others or of withholding or limiting access to opportunities, benefits and advantages available to

> others? Finally, assuming that both an inequality and discrimination can be found, it must be determined whether the personal characteristic at issue constitutes either an enumerated or analogous ground for the purposes of s. 15(1) of the Charter.

[302] More recently, the Supreme Court of Canada considered the analytical approach to section 15(1) in a trilogy of cases: ***Miron v. Trudel***, [1995] 2 S.C.R. 418; ***Egan v. Canada***, [1995] 2 S.C.R. 513; and ***Thibaudeau v. Canada***,[1995] 2 S.C.R. 627. The divergent approaches of two groups of four judges (Gonthier, LaForest, Major JJ. and Lamer C.J. in one group and McLachlin, Cory, Iacobucci and Sopinka JJ. in the other group) and of L'Heureux-Dubé J. are summarized by Hunt J.A. in ***Vriend v. Alberta***(1996), 132 D.L.R. (4th) 595 at pp. 636-38 (Alta. C.A.) (leave to appeal to S.C.C. granted October 3, 1996), quoted in ***Grigg*** at pp. 558-60. Hunt J.A. summarized the trilogy as follows (***Grigg*** at p. 560):

> At the least, what is clear is that, according to all three approaches, to get under s. 15(1) there must be a distinction that gives rise to the interference with one of the four equality rights. Moreover, the distinction must be discriminatory. It is in the approach to "discrimination" that members of the Court appear to differ. One view (explained by La Forest and Gonthier JJ.) is that, if the distinction is relevant to the legislative goals, there will be no discrimination, unless those goals themselves can be said to offend Charter values. According to the approach articulated by McLachlin, Cory and Iacobucci JJ., a distinction that is relevant to the legislative goals may still be discriminatory, if it impacts upon the claimant in a way that is contrary to the purpose of s. 15(1), namely, if the distinction stereotypes rather than evaluates based upon individual merit.

[303] Hutchison J. found the major difference between the two majority approaches to be (***Grigg*** at p. 560):

> ...that the former group hold that it is proper under a s. 15analysis to consider whether the distinction that is made on s. 15grounds is relevant to the underlying values of the legislation. The latter group and L'Heureux-Dubé J. are of the opinion that all questions of relevance of the distinction should properly be addressed under a s. 1 analysis.

[304] Both the petitioners and the respondents submit that the test enunciated by Iacobucci J. in ***Symes*** is appropriate in this case. That test follows the approach taken in ***Andrews***, which is in turn consistent with that adopted by the second majority group in the trilogy. The respondents suggest, however, that the second majority group and L'Heureux-Dubé J. added a new focus on the protection of human dignity as the fundamental purpose or core value underlying section 15(1). In previous cases, the respondents say, the Court has stated that the primary purpose of section 15(1) was to remedy or prevent discrimination against groups suffering historical social, political and legal disadvantage.

[305] In ***Miron***, McLachlin J. rephrased the test derived from ***Andrews*** as follows at p. 485:

> The analysis under section 15(1) involves two steps. First, the claimant must show a denial of "equal protection" or "equal benefit" of the law, as compared with some other person. Second, the claimant must show that the denial constitutes discrimination. At this second stage, in order for discrimination to be made out, the claimant must show that the denial rests on one of the grounds enumerated in s. 15(1) or an analogous ground and that the unequal treatment is based on the stereotypical application of presumed group or personal characteristics. If the claimant meets the onus under this analysis, violation of s. 15(1) is established. The onus then shifts to the party seeking to uphold the law, usually the state, to justify the discrimination as "demonstrably justified in a free and democratic society" under s. 1 of the *Charter*.

[306] McLachlin J. went on at p. 486 to elaborate on the function of the enumerated or analogous grounds:

> These grounds serve as a filter to separate trivial inequities from those worthy of constitutional protection. They reflect the overarching purpose of the equality guarantee in the *Charter* -- to prevent the violation of human dignity and freedom by imposing limitations, disadvantages or burdens through the stereotypical application of presumed group characteristics, rather than on the basis of individual merit, capacity or circumstance.

[307] I propose to apply the test as enunciated by McLachlin J. in ***Miron***which in my view reflects the development of section 15(1) analysis from its roots in human rights jurisprudence as referred to in ***Andrews*** and***Symes*** and takes

into account the contextual approach emphasized by Wilson J. in ***Turpin*** and by Gonthier J. in ***Miron*** (at pp. 437-8). It also postpones the analysis of the "relevance" of the legislation to the consideration of section 1 of the ***Charter***, which is the manner in which the parties in this case presented their arguments. I note that in ***Benner***at p. 600 Iacobucci J. decided to apply McLachlin J.'s approach in ***Miron***, which he also ascribed to Cory J. and with which he had previously concurred.

2. Denial of "Equal Benefit" of the Law

[308] As outlined by McIntyre J. in ***Andrews*** at p. 14:

> Section 15 spells out four basic rights: (1) the right to equality before the law; (2) the right to equality under the law; (3) the right to equal protection of the law; and (4) the right to equal benefit of the law.

[309] The respondents complain that the petitioners have not specified which of these four equalities is alleged to have been violated. In my view, the petitioners have made it clear that

they claim they have been denied "equal benefit" of the law as compared with other persons. It is abundantly clear that they have been denied the benefit of a 100% billing number in comparison with all physicians who practised in B.C. before February 11, 1994 and, under the interim measures and the grandfathering of B.C.-trained physicians in the permanent measures, in comparison with B.C.-trained physicians. The question is whether the measures which deny the petitioners this benefit equally with other licensed and qualified physicians violate their rights under section 15(1).

3. Is the Denial Discriminatory?

(a) Direct and Adverse Effect Discrimination

[310] The petitioners claim that the interim and permanent measures discriminate against them by "adverse effect discrimination". That term was defined by McIntyre J. in ***Re Ontario Human Rights Com'n and Simpson-Sears Ltd.***, [1985] 2 S.C.R. 536 at 551, quoted in***Andrews*** at p. 17 and in ***Symes*** at p. 552:

> A distinction must be made between what I would describe as direct discrimination and the concept already referred to as adverse effect discrimination in connection with employment. Direct discrimination occurs in this connection where an employer adopts a practice which on its face discriminates on a prohibited ground. For example, "No Catholics or no women or no blacks employed here."...On the other hand, there is the concept of adverse effect discrimination. It arises where an employer for genuine business reasons adopts a rule or standard which is on its face neutral, and which will apply equally to all employees, but which has a discriminatory effect upon a prohibited ground on one employee or group of employees in that it imposes, because of some special characteristic of the employee or group, obligations, penalties, or restrictive conditions not imposed on other members of the work force.

[311] The reference to direct and adverse effect discrimination in the employment context is apt with respect to the interim and permanent measures. On their face, the exemptions in the interim measures and the grandfathering in the permanent measures for B.C.-trained physicians say, "No non B.C.-trained physicians practise here" (subject of course to the other exceptions in those measures). This is not direct discrimination on a prohibited ground, but, the petitioners argue, is discrimination on an analogous ground, province of residence.

[312] After the grandfathering of B.C.-trained physicians expires, the permanent measures are, on their face, neutral with respect to province of training or residence. The petitioners argue that they have a discriminatory effect on the analogous ground of province of residence, in that they impose on a group of physicians, new billers, most of whom are likely to come from provinces outside of B.C., obligations, penalties and restrictive conditions not imposed on established physicians (that is, those

who had billing numbers before February 11, 1994).

[313] Both the interim and permanent measures are facially neutral with respect to age, sex and religion. The petitioners allege adverse effect discrimination on the prohibited ground of age. Dr. Waldman alleges adverse effect discrimination on the prohibited grounds of sex and religion.

(b) Enumerated Grounds

[314] Section 15(1) prohibits discrimination on the basis of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability. The petitioners claim they are discriminated against on the basis of age. Dr. Waldman also alleges discrimination on the basis of sex and religion.

(i) Age

[315] As noted in the context of the consideration of the administrative law arguments, the evidence does not show that the interim or permanent measures discriminate against the petitioners on the basis of age. The petitioners concede that to be the case with respect to the interim measures, but suggest that the same evidence proves that the permanent measures do so discriminate. I fail to see how that argument can succeed.

(ii) Sex

[316] Dr. Waldman alleges that the measures discriminate against her as a female in two ways. First, as a female physician, she would like to be able to share a practice with another physician in order to reduce her work load and accommodate raising a family. Since she cannot carry on a private practice with a 50% billing number, she does not have the option of sharing a practice. Second, as a female patient, she and others are denied the opportunity to choose a female doctor. She claims that this flows from the measures because they restrict the inflow of female entrants into a traditionally male-dominated field.

[317] Even if I accept that the measures have the two effects complained of by Dr. Waldman, she has not provided any evidence that these effects have anything to do with her gender. Male physicians may equally wish to share a practice and male patients may also wish to choose a female physician. As stated in ***Symes*** at p. 559:

> If the adverse effects analysis is to be coherent, it must not assume that a statutory provision has an effect which is not proved. We must take care to distinguish between effects which are wholly caused, or are

contributed to, by an impugned provision, and those social circumstances which exist independently of such a provision.

[318] In this case, I am prepared to accept that the measures contribute to the inability of Dr. Waldman to share a practice; I have found as a fact that it is not economically viable to carry on a private practice of medicine with a 50% billing number. There is no evidence, however, that female physicians are disproportionately restricted by the measures in relation to male physicians. I find that the measures do not discriminate against Dr. Waldman on the basis of sex.

(iii) Religion

[319] Dr. Waldman claims that the measures discriminate against her on the basis of her religion. She alleges that as a Jew she cannot practise her religion except in a community that is large enough to support a synagogue and a religious school. She claims that only Vancouver and Victoria have these facilities. Because the measures restrict the manner in which she can practise medicine in these two communities and her religion restricts her from seeking to practise medicine in a smaller community in which she may be able to demonstrate a medical need for her services or that qualifies as an NIA community, she claims that she is required to choose between her career and her religion. She does not seek the establishment of synagogues and schools in every community, but requests that she not be limited to working in those communities that lack these facilities.
[320] In ***Adler v. Ontario***, [1996] S.C.R. 609, McLachlin and L'Heureux-Dubé JJ., in separate dissenting reasons, found that the failure of the Province of Ontario to fund independent religious schools infringed the rights of the religious minorities claiming equal funding to public schools. Both judges found on the evidence that public schools were not accessible to the children of the members of the religious communities in question because their religious convictions prevented them from sending their children to non-religious schools.

[321] I am sympathetic to Dr. Waldman's desire to live in a Jewish community that is large enough to support religious institutions. However, Dr. Waldman has not provided the evidence to prove that she cannot practise her religion in a community that does not have a synagogue and a religious school or that only Vancouver and Victoria have such facilities. She states in her affidavit that she attends synagogue on the high holidays. If this is so, I expect that she would be able to arrange to attend a synagogue in Vancouver or Victoria on those two or three days a year. At the date of this hearing she had no children, so the need for

Jewish educational facilities is a future need. Assuming she continues to perform *locums* and earns 20 points per year under the point system, she will be entitled to a 100% billing number in July 2000. At that time her youngest child would not be more than 2½ years old.

[322] Even if I accept that Dr. Waldman cannot practise her religion in the way she wishes in a small community, I find that she is not restricted by the measures from practising her religion. I have found that the options for practising medicine under the measures are limited, but they do not prohibit Dr. Waldman from practising both medicine and her religion. She has chosen to practise as a *locum* in Vancouver rather than apply for a position in a NIA community or a smaller community which may have a medical need for her services. If she were not restricted by the measures, she would have the option to practise medicine privately in Vancouver. Thus the restriction imposed on her is not on the practise of her religion but the manner in which she practises medicine.

[323] I find that the measures do not discriminate against Dr. Waldman on the basis of her religion.

(c) Analogous Ground - Province of Residence

(i) Denial of Benefit

[324] The petitioners are all subject to the interim measures and after their expiry to the permanent measures including in both cases the exemptions for B.C.-trained physicians. They are all denied the benefit of an unrestricted 100% billing number because they were not trained in B.C.

[325] The respondents argue that the distinction drawn between the petitioners and B.C.-trained physicians is not a distinction based on province of residence. I have already found that place of training is the equivalent of place of residence.

[326] The petitioners argue that even if the exemptions for B.C.-trained physicians were not contained in the measures, they are denied the benefit that established physicians are entitled to by virtue of the grandfathering provisions in the measures and that the denial is based on their province of residence.

[327] I have found that the measures disproportionately affect physicians coming from outside the province and that it is likely they will continue to have that effect after the exemptions for B.C.-trained physicians expire. Even if that were not the case, however, a physician who was denied a billing number because he or she was not resident and

practising in the province on February 11, 1994 is denied a benefit of the law compared with physicians who were resident and practising in B.C. on that date. The fact that other physicians who were resident here may be denied a billing number because they finished their training in B.C. after the exemptions for B.C.-trained physicians expire is irrelevant. It is not necessary to the determination of whether a

law denies a benefit to an individual or group that all those affected by the law are denied a benefit for the same reason. The question is whether the denial of the benefit falls within section 15(1) of the ***Charter***.

[328] I find that the petitioners are denied a benefit of the law on the basis of their province of residence.

(ii) Principles for Determination of an Analogous Ground

[329] In ***Miron***, McLachlin J. outlined the principles applicable to the determination of whether a ground of alleged discrimination not found insection 15(1) is an analogous ground. At p. 494, she stated:

> Our approach must be generous, reflecting the "continuing framework" of the constitution and the need for "'the unremitting protection' of equality rights": *Andrews, per* McIntyre J., at p. 175. *Andrews*instructs us that our approach must also reflect the human rights background against which the *Charter* was adopted.

[330] At p. 495, McLachlin J. outlined the logical framework for the determination of an analogous ground:

> The grounds of discrimination enumerated in s. 15(1) of the *Charter*identify group characteristics which often serve as irrelevant grounds of distinction between people. The history of the human rights movement is a history of reaction against persecution and denial of opportunity on the basis of irrelevant stereotypical group classifications like race, sex, and religion. It is not surprising therefore to see these as well as other common markers of irrelevant exclusion enumerated in s. 15(1). But the categories are not closed, as s. 15(1) recognizes. Analogous grounds of discrimination may be recognized. Logic suggests that in determining whether a particular group characteristic is an analogous ground, the fundamental consideration is whether the characteristic may serve as an irrelevant basis of exclusion and a denial of essential human dignity in the human rights tradition. In other words, may it serve as a basis for unequal treatment based on stereotypical attributes ascribed to the group, rather than on the true worth and ability or circumstances of the individual?

[331] McLachlin J. then summarized the qualities which judges have found to be associated with analogous grounds, at p. 496:

> One indicator of an analogous ground may be that the targeted group has suffered historical disadvantage, independent of the challenged distinction: *Andrews, supra,* at p. 152 *per* Wilson J.; *Turpin, supra,*at pp. 1331-32. Another may be the fact that the group constitutes a "discrete and insular minority": *Andrews, supra,* at p. 152 *per*Wilson J. and at p. 183 *per* McIntyre J.; *Turpin, supra,* at p. 1333. Another indicator is a distinction made on the basis of a personal characteristic; as McIntyre J. stated in *Andrews*, "[d]istinctions based on personal characteristics attributed to an individual solely on the basis of association with a group will rarely escape the charge of discrimination, while those based on an individual's merits and capacities will rarely be so classed" (pp. 174-75). By extension, if has been suggested that distinctions based on personal and immutable characteristics must be discriminatory within s. 15(1): *Andrews, supra,* at p. 195 *per* La Forest J. Additional assistance may be obtained by comparing the ground at issue with the grounds enumerated, or from recognition by legislators and jurists that the ground is discriminatory: see *Egan v. Canada, supra, per*Cory J.
>
> All of these may be valid indicators in the inclusionary sense that their presence may signal an analogous ground. But the converse proposition -- that any or all of them must be present to find an analogous ground -- is invalid. As Wilson J. recognized in *Turpin*(at p. 1333), they are but "analytical tools" which may be "of assistance".

(iii) Previous Jurisprudence

[332] Province of residence as an analogous ground has been considered by the Supreme Court of Canada in three cases: ***Turpin***; ***S.(S.)***; and ***Haig v. Canada***, [1993] 2 S.C.R. 995.

[333] In ***Turpin*** and ***S.(S.)***, the claimants alleged discrimination on the grounds that they were denied equality of treatment under the criminal law in comparison with accused persons in other provinces. In ***Turpin***, the accused, charged with murder in Ontario, was denied the opportunity accorded to a similar accused person in Alberta to elect trial by judge alone. In ***S.(S.)***, a young offender in Ontario did not have access to diversion programs for young offenders that were

available in the other provinces because Ontario had not adopted such measures. In both cases, the Court rejected the claims that the unequal treatment by virtue of their province of residence violated section 15(1) because the distinction was not based on a personal characteristic (***S.(S.)*** at p. 140; ***Turpin*** at pp. 1332-3).

[334] In both cases, the Court left open the question of whether province of residence could ever be an analogous ground under

section 15(1). In ***Turpin***, Wilson J. said at p. 1333:

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

[335] In ***S.(S.)***, Dickson C.J.C. said at p. 140:

> I agree with Wilson J. that in determining whether province-based distinctions which arise from the application of federal law contravene s. 15(1) of the Charter, a case-by-case approach is appropriate.

[336] ***R. v. Haig*** involved a challenge to the October 1992 referendum on the Canadian constitution. Mr. Haig moved from Ontario to Quebec in August 1992. As a result of the different requirements as to residency in the federal and Quebec legislation governing the separate referenda, he was not eligible to vote in the federal referendum because he was not resident in Ontario on the enumeration date or to vote in the Quebec referendum because he was not resident in Quebec for six months prior to the referendum as required under the Quebec law which governed the referendum in Quebec. The Court held that Mr. Haig's rights were not violated undersection 15(1) of the ***Charter*** because as a new resident of Quebec he was not a member of a "discrete and insular minority" suffering from stereotyping or social prejudice. At p. 1044, L'Heureux-Dubé J. stated:

> ...the appellants submit that a person's place of residence may be a personal characteristic which is analogous to those prohibited grounds listed in s. 15(1). Though this may well be true in a proper case, this case is not such a case.

[337] Thus the Supreme Court of Canada has so far rejected province of residence as an analogous ground, but has left the door open for a contrary finding in the appropriate case.

(iv) Analogous Ground

[338] I am of the view that this is the appropriate case. Following the principles outlined by McLachlin J. in ***Miron***, which elucidate those enunciated by McIntyre J. in ***Andrews***, I find that the petitioners are discriminated against on the basis of an "irrelevant stereotypical group classification" that has nothing to do with their worth, ability or

circumstances. Their previous province of residence is a personal characteristic attributed to each of them solely on the basis of their association with that group of persons, not on the basis of their merits and capacities. In the context of the measures, they may be considered a "discrete and insular minority": out-of-province physicians are not represented by the B.C.M.A. and have no voice in the determination of the policies and rules that govern their ability to practise medicine in B.C. Their previous province of residence is more immutable than religion and citizenship: they

cannot change where they previously lived. The situation of the petitioners is directly analogous to that of the appellants in ***Andrews***: they are denied the right to practise their profession not on the basis of their qualifications, training and ability but on the basis that they were at the relevant time not, in ***Andrews***, citizens, and in this case, residents of B.C.

[339] Furthermore, the denial to the petitioners of their right to practise medicine in B.C. on an equal basis with other equally trained and qualified physicians is the denial of a right which falls within the category of a "denial of essential human dignity in the human rights tradition" (***Miron*** at p. 495). That this is so was made clear by La Forest J. in ***Andrews***, in his consideration of whether the restriction imposed on the appellants' ability to practise law because they were not citizens violated section 15, at p. 40:

> By and large, the use in legislation of citizenship as a basis for distinguishing between persons, here for the purpose of conditioning access to the practice of a profession, harbours the potential for undermining the essential or underlying values of a free and democratic society that are embodied in s. 15.

At p. 43, in his consideration of whether the restrictions were justified under section 1 of the ***Charter*** he said:

> It is still an open question whether the right to earn a livelihood is a value constitutionally protected under the Charter, perhaps under s. 7. But whether or not such constitutional protection exists, no one would dispute that the "right" to earn a livelihood is an interest of fundamental importance to the individuals affected, and as such should not lightly be overridden.

[340] In ***McKinney v. University of Guelph*** (1990), 76 D.L.R. (4th) 545 at 646 (S.C.C.), cited by Gonthier J. in ***Miron*** at p. 439, La Forest J. quoted McIntyre J. in ***Reference re Public Service Employee Relations Act***, [1987] 1 S.C.R. 313, where he referred to work as "one of the most fundamental values of a person's life".

[341] That the right to practise a profession is a fundamental value animated the courts in ***Mia***, ***Wilson*** and ***Black***. Though these cases considered the right under sections 6 and 7 of the ***Charter*** and the Supreme Court of Canada has disagreed with the conclusions in ***Mia*** and ***Wilson*** thatsection 7 protects that right, the fundamental nature of the right was not doubted.

[342] This case is distinguishable from ***Turpin***, ***S.(S.),*** and ***Haig***. In the first two cases, the legislation in question gave different rights to persons resident in one province from those available to persons resident in another province. A hypothetical analogy is, for example, if B.C. provided higher fees for services rendered by physicians in B.C. than Ontario provided to its physicians. A physician in Ontario could not complain that his or her rights were violated under section 15 on the basis of province of residence. As described by Dickson C.J.C. in ***S.(S.)***

at p. 139:

> ...that unequal treatment which stems solely from the exercise, by provincial legislators, of their legitimate jurisdictional powers cannot be the subject of a s. 15(1) challenge on the basis only that it creates distinctions based upon province of residence.

Dickson C.J.C. cannot be understood to say that a person can never complain of unequal treatment as a result of otherwise valid provincial legislation. It goes without saying that the legislative power of the provinces is limited by the constitution, including the ***Charter***. The distinction that is relevant here is between the province legislating in a manner that is different from legislation in another province and the province legislating in a manner that discriminates against persons within the province on the basis of prior province of residence. The measures fall within the latter category.

[343] The principles applied in ***Haig*** are not as clear. In my view, however, the problem that presented itself in the context of the section 15 analysis in that case was that Mr. Haig was not part of a defined group. L'Heureux-Dubé referred to the group membership at p. 1044 as: "...highly fluid, with people constantly flowing in or out once they meet Quebec's residency requirements." The difficulties of the case are amply illustrated by the reasons offered by L'Heureux-Dubé, Cory, McLachlin and Iacobucci JJ., who pointed out at p. 1065 that "the appellant unfortunately fell between the legislative cracks...". While the failure to take into account the discriminatory effect of a law on a person is the essence of adverse effect discrimination, the legislative facts in this case are fundamentally different from those in ***Haig***. In this case, the Commission clearly had in mind the effect of the measures on out-of-province physicians and enacted the measures with the intention of limiting their entry into the medical care system in B.C.

[344] In summary, I find that province of residence is an analogous ground in the context of this case. As Gonthier J. makes clear in ***Miron*** at p. 439:

> Finally, it is worth stressing that a contextual analysis may lead to fundamentally different assessments as to whether distinctions drawn on the basis of the same ground will amount to discrimination. In other words, depending on the context, the same ground may be discriminatory with respect to certain classes of distinction but not with respect to others. For example, this Court recognized in *R. v. Turpin, supra*, that while

province of residence was not a ground of discrimination under the applicable legislative scheme in that case, it was nevertheless possible that in different circumstances a distinction based on province of residence could be discriminatory.

4. Conclusion on Section 15(1)

[345] Under the measures the petitioners are denied the benefit of an unrestricted 100% billing number as compared with other equally trained and qualified physicians because of their previous province of residence. This ground is an analogous ground under section 15(1). I find that discrimination under section 15(1) is established.

D. Section 1 - Guarantee of Rights and Freedoms

[346] Section 1 provides:

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

[347] Under section 1, the party (here, the respondents) defending a law that infringes another's rights under the ***Charter*** may save it from invalidity by establishing that the law is "reasonable" and "demonstrably justified a free and democratic society". The requirements to be satisfied were set out in ***R. v. Oakes***, [1986] 1 S.C.R. 103, and stated as follows in ***R. v. Edwards Books and Art***, [1986] 2 S.C.R. 713 at 768:

> First, the legislative object which the limitation is designed to promote must be of sufficient importance to warrant overriding a constitutional right. It must bear on a "pressing and substantial concern". Second, the means chosen to attain those objectives must be proportional or appropriate to the ends. The proportionality requirement, in turn, normally has three aspects: the limiting measures must be carefully designed, or rationally connected, to the objective; they must impair the right as little as possible; and their effects must not so severely trench on individual or group rights that the legislative objective, albeit important, is nevertheless outweighed by the abridgment of rights.

[348] In ***RJR-MacDonald Inc. v. Canada (Attorney-General)***, [1995] 3 S.C.R. 199 at 328, McLachlin J. summarized the

comparison of the importance of the objective of the law and the proportionality of the good which may be achieved by it with the infringement of rights it works in determining whether the law is reasonable and demonstrably justified:

> If the objective of a law which limits constitutional rights lacks sufficient importance, the infringement cannot be reasonable or justified. Similarly, if the good which may be achieved by the law pales beside the seriousness of the infringement of rights which it works, that law cannot be considered reasonable or justified.

[349] The section 1 jurisprudence has established that "the onus of proof is on the party seeking the limitation, and the standard of proof is the civil standard, proof by a preponderance of probabilities" (***Edwards Books***at p. 768; ***RJR-MacDonald Inc.*** at p. 333).

1. The Objectives of the Interim and Permanent Measures

[350] The respondents say that the objectives of the interim measures are quality health care (to address problems resulting from oversupply and maldistribution of physicians in the province) and control of health care costs. The objectives of the permanent measures are stated in the preamble to Minute 96-0015 as "more equitable access to medical services and more equitable distribution of physician resources based on population needs and to assist in the better management of the health care budget". In my view, this is simply a restatement of the objectives of the interim measures: quality health care and cost control.

[351] In their submissions with respect to the interim measures, the respondents included as an objective "restriction of potential large influx of practitioners from other provinces". They explain that controlling the number of physicians practising in B.C. was one of the means utilized under the interim measures of addressing the issue of oversupply of physicians, but submit that it is not utilized in the permanent measures. As outlined earlier in these reasons, I do not agree with the respondents that the permanent measures after the grandfathering expires are not intended to control the entry into B.C. of physicians from other provinces. It is on that basis that I have found the permanent measures infringe the petitioners' rights under the ***Charter***. In my view, the restriction on practitioners coming into B.C. from other provinces is properly viewed as one of the means chosen to achieve the objective of controlling health care costs.

[352] The petitioners do not quarrel with the importance of the two objectives of quality health care and cost control. They say that the respondents' submissions show that the real objective of the measures, however, is to protect the incomes of established physicians under a global cap on income by controlling the number of physicians practising in B.C. They argue that the exclusion from the province of physicians from other parts of Canada is *ultra vires* and outside the bounds of provincial jurisdiction. As such, they say, it cannot form the basis for the justification of a ***Charter*** infringement under section 1, citing the words of Dickson J. in ***R. v. Big M Drug Mart Ltd.***, [1985] 1 S.C.R. 295 at 353:

> While there is no authority on this point, it seems clear that Parliament cannot rely upon an *ultra vires* purpose under s. 1 of the*Charter*. This use of s. 1 would invite colourability, allowing Parliament to do indirectly what it could not do directly.

[353] I agree with the petitioners that if the objective of the measures was to violate the petitioners' ***Charter*** rights, the objective could not be said to have sufficient importance to meet the requirements of the first part of the inquiry under section 1. That would be so if the objective of the measures was simply to keep physicians from outside B.C. from coming here to practise. I am satisfied, however, that the restrictions on physicians from outside B.C. are one of the means chosen to meet the objectives of quality health care and cost control.

[354] In ***RJR-MacDonald Inc.*** at p. 335, McLachlin J. warned that:

> Care must be taken not to overstate the objective. The objective relevant to the s. 1 analysis is the objective of the infringing measure, since it is the infringing measure and nothing else which is sought to be justified. If the objective is stated too broadly, its importance may be exaggerated and the analysis compromised.

[355] The petitioners say that the objectives of the measures as stated by the respondents are too broad. The real purpose of the measures, they say, can be determined from the measures themselves and that is to protect the incomes of established B.C. physicians. The cut-off date of February 11, 1994 and the explicit grandfathering of established physicians in category 3.10 of the permanent measures demonstrate, they say, the true intent of the measures.

[356] I am satisfied that, though stated broadly, the objectives of the interim and permanent measures are quality health care and cost control and those objectives are pressing and substantial. The background to the enactment of the measures demonstrates the budgetary problems experienced by the province; the increase year-over-year in the number of physicians practising in B.C.; and the contribution by physicians, over and above their fees, to the costs of health care. That background also provides, in the various studies and reports, evidence of physician oversupply in some areas of the province and undersupply in others and the implications of those conditions to the quality of medical care. Oversupply is shown to lead to increased competition for patients, over-servicing of patient needs, less time for each patient. Undersupply results in lack of access to needed care.

[357] The means the Commission chose to achieve the objectives are to impose on new entrants to the medical profession in B.C. financial disincentives to practise in B.C. generally and in oversupplied areas in particular. These means are intended to have the effects of limiting the numbers of physicians commencing practice in B.C. and encouraging physicians new to practice in B.C. to practise in undersupplied areas. It is these means which I have found infringe the petitioners' rights undersections 6 and 15 of the ***Charter*** and which the respondents must show are proportional to the objectives and the effects of the measures.

2. Proportionality

(a) Rational Connection

[358] To paraphrase McLachlin J. in ***RJR-Macdonald Inc.*** at p. 339: As the first step in the analysis of proportionality, the respondents must show that the infringements of the rights of the petitioners to come to B.C. and practise their profession under the same conditions as B.C. residents are rationally connected to the goals of quality health care and cost control. The respondents must show that the restriction of rights serves the intended purposes.

[359] McLachlin J. also pointed out at p. 339:

> "Where...legislation is directed at changing human behavior...the causal relationship may not be scientifically measurable. In such cases, this Court has been prepared to find a causal connection between the infringement and benefit sought on the basis of reason or logic, without insisting on direct proof of a

> relationship between the infringing measure and the legislative objective...[cites omitted].

[360] That is clearly the case here. The respondents' objectives are to control costs and deliver quality medical care by reducing numbers of physicians and redistributing them within the province. The measures provide financial disincentives to influence the decisions of physicians relative to commencing the

practice of medicine in B.C. The underlying assumption is that these financial restrictions will result in fewer physicians deciding to commence practice in B.C. and in those who do decide to practise going to communities which are underserviced. The connection between the measures and the behavior of physicians is not scientifically measurable; at least no such scientific evidence was introduced. The causal connection has to be demonstrated on the basis of reason and logic.

[361] The respondents say that the measures are rationally connected to the objectives of cost control and quality medical care because the financial disincentives will contain the overall increase in the numbers of physicians and will encourage redistribution of physicians on the basis of medical need; the measures have ensured the cooperation of the B.C.M.A. in imposing the global cap on physicians' incomes thereby assisting in controlling costs without disrupting the delivery of medical care by physicians; they restrict the migration into B.C. of physicians trained in other provinces where entry into practice has been restricted; and they are similar to "generally accepted" policies adopted by other provinces on the advice of health economists, commissions and studies.

[362] The respondents provided a report prepared by Dr. Peter Coyte, referred to earlier in these reasons. The petitioners provided in reply a report prepared by Dr. Robin Hanvelt, an assistant professor and economist at the University of British Columbia. The petitioners objected to the admissibility of Dr. Coyte's report on the grounds that he expressed opinions on the ultimate legal issues that are for the Court to decide under section 1 and was argumentative and an advocate for the respondents. I admitted the report, with the exception of his conclusion that the measures "represent a rational set of policies that are reasonable in a democratic society".

[363] Drs. Coyte and Hanvelt differ in their views of whether the measures will work to achieve their intended purposes.

[364] In his report, Dr. Coyte outlines in some detail the issues that led to the enactment of the measures (some of which I have included earlier in these reasons) and the terms of the measures. After commenting that the measures provide financial incentives for physicians to locate their practices in regions where there is a defined health need, he concludes (at p. 9):

> By discounting fees in areas where physicians are plentiful (and services are heavily utilized), I am of the opinion that new billers will open practices in

areas where there is a shortage of physicians. This redistribution of physicians and the resulting shift in patterns of health service utilization are likely to result in more equitable access to medical services in British Columbia.

[365] At p. 11, he states:

> The physician supply management measures contained in Minute 96-0015, lowers the financial incentives to practice in the province of British Columbia, and more specifically, lowers the incentive for new billers to the provincial health insurance plan to practice in regions where physicians are in plentiful supply. These two consequences of Minute 96-0015 will help reduce the growth in health expenditures, in general, and physician expenditures, in particular, will reduce the overall provision of health care services, and may ensure more equitable access to health care services.

[366] Dr. Hanvelt was asked whether the permanent measures will be an economically efficient means of attaining the goals of cost control and better distribution of physicians in B.C. He analyzed the effects of the measures on the "micro-decisions" or choices of physicians entering the B.C. health care system as new billers and the implications for the decisions of grandfathered physicians on when, how and where they will practice in B.C. In his opinion, the incentives in the measures generate predictable outcomes from the rational economic behavior of individual physicians (p. 49).

[367] Dr. Hanvelt's opinion proceeds from a finding that physicians prefer to practise in an urban setting (p. 17). He concludes that the measures will fail to be an economically efficient tool to control the health care budget as they will not lead to physicians postponing their entry into practice or deciding to practise in rural areas and will likely lead to increased billings as a result of increased pressure in the market for*locum tenens* positions in urban areas. He also concludes that the measures will not be an economically efficient tool for better distribution of physicians in B.C. because they do not add incentives to the existing NIA Program and the point system provides incentives for physicians to practise in rural areas only for a short-term in order to accumulate sufficient points to return to an urban practice.

[368] While falling short of proving that the measures will achieve the intended results, both reports are useful in understanding the rationale and intended effects of the measures. It is clear that the measures operate primarily through financial disincentives, the primary purpose of which is to discourage physicians from commencing practise in B.C. As Dr. Hanvelt points out, there is no new incentive to practise in rural areas: the NIA Program overrides the measures and the only purpose for the incentive of accumulating additional points under the measures is to be

able to more quickly move to an area, likely urban, to carry on an unrestricted practice.

[369] An analysis of the measures reveals that a physician who wishes to practise in an area that is undersupplied has significant obstacles to overcome. The provisions that relate to practice in undersupplied communities are the physician supply

template which purportedly demonstrates areas of undersupply; the provisions for a 100% billing number for practice in a community with a demonstrated medical need; and the provisions for qualification for the NIA Program.

[370] The physician supply template for the period October 31, 1996 to March 31, 1997 indicates that there are no undersupplied areas in the province for general practitioners; that is, there is no area for which a general practitioner can obtain a 100% billing number. Furthermore, the values in the template may change every time a physician moves into or out of an area, including a physician not subject to the restrictions in the measures. Thus, the physician supply template does nothing to encourage general practitioners to leave oversupplied urban areas to practise, reinforcing Dr. Hanvelt's conclusion that these physicians will likely choose to practise as *locum tenens* in an urban area.

[371] Under the interim measures, a physician could receive a 100% billing number if he or she could demonstrate a medical need for his or her services in a community. The onus was on the applicant to prove such need. Under the permanent measures, only a regional health board, hospital or other agency can apply for a 100% billing number for a specific position. Physicians may apply for a pre-approved position. Where the position is added to an existing multi-practitioner group, the practitioners in the existing group must be consulted concerning the new applicant. Thus, the established physicians in the community determine whether the new applicant can establish a practice, though the medical need has been demonstrated.

[372] Under amendments to the permanent measures made by Minute 96-0054 on September 27, 1996, applicants for NIA Program positions are required to have "written confirmation of community support", defined as "the existence of a Hospital Work Force Plan or, in the absence of that, support of senior local government officials and local physicians". Thus, as is the case with applicants for positions in communities with a demonstrated medical need, applicants for an NIA Program position are subject to the approval of the established physicians in the community.

[373] Given these obstacles to establishing a practice in communities that are undersupplied, there appears to be no rational connection between the measures and the objective of quality health care through "more equitable access to medical services and more equitable distribution of physician resources". The measures are in fact contradictory to the stated objective.

[374] Are the measures rationally connected to the objective of cost control? It appears to be generally accepted by all of the

studies and commentators that if the number of physicians entering practice is reduced, there will be a corresponding reduction in the increase in health care costs. This is said to be true though there is a global cap on physicians' incomes, because fees paid to physicians are only one component of the health care budget. The costs resulting from the decisions physicians make with respect to diagnosis and treatment of patients are a greater component.

[375] In ***RJR MacDonald Inc.***, McLachlin J. described the reasoning process involved in justifying a measure under section 1 at p. 328:

> The question is...whether [the measure] can be justified by application of the processes of reason. In the legal context, reason imports the notion of inference from evidence or established truths. This is not to deny intuition its role, or to require proof to the standards required by science in every case, but it is to insist on a rational, reasoned defensibility.

[376] The respondents have provided no direct evidence that the financial disincentives contained in the measures will lead to reduced numbers of physicians establishing practices in B.C. Dr. Coyte assumes that the disincentives in the measures will reduce the provision of health care services and thereby costs by over time reducing the number of physicians practising in B.C. and particularly in overserviced regions. However, the measures create obstacles to practice in underserviced regions. Dr. Hanvelt demonstrates that the pressure from new billers to perform *locums*in urban areas will actually increase costs. Thus, it appears that there may be some increased control of the health care budget only if the measures in fact keep new billers out of B.C.

[377] Dr. Coyte appended to his opinion a paper authored by Morris L. Barer, Jonathan Lomas and Claudia Sanmartin, "Re-minding our Ps and Qs: Medical Cost Controls in Canada" (*Health Affairs*, Vol. 15, No. 2, Summer 1996, 216-234). In this paper, the authors review the policies adopted by the provinces and territories to control medical spending, including global expenditure caps and physician supply policies. At page 228, in answer to the question "do cost controls control costs?", they note that costs are growing less rapidly in Canada in the 1990's than they did over the previous decade, but warn that "this is, of course, rather cursory and descriptive information, and the global capping policies may under detailed empirical scrutiny turn out not to have had any independent effect on historical trends." They further note that "to date, no in-depth evaluations have been completed of the particular policies enacted in an individual

province", but that "a more detailed evaluation of the mix of policies that have been enacted in British Columbia is under way." Barer et al report that the study of B.C. policies focuses on a global expenditure cap and

billing numbers policy that was introduced by the mid-1980s (in the case of the billing numbers policy, invalidated in ***Mia*** and ***Wilson***). "Preliminary results suggest that the policy package did have a dampening effect on expenditure growth in this sector, relative to that in other provinces that introduced policies somewhat later." There is no evaluation in the paper of the effectiveness of physician supply measures in controlling costs or redistributing physicians from urban to rural areas.

[378] In his paper "Regulating Physician Supply: The Evolution of British Columbia's Bill 41" (*Journal of Health Politics, Policy and Law*, Vol. 13, No. 1, Spring 1988, 1-25 at 17-18), Barer provides some evidence that the numbers of billing numbers issued in 1984 (before the billing restrictions then imposed were invalidated in ***Mia***) were less than in the previous year, when no restrictions were in place. He qualifies this evidence on the grounds, among others, that the records kept by the Commission did not separate permanent and *locum tenens* numbers before the billing restrictions were imposed. He further points out that "the trend through 1987 in *locum tenens* numbers suggests also that the policy is inducing increasing proportions of the new graduates to choose *locum tenens*situations rather than rural practice", the fact noted by Dr. Hanvelt in his opinion.

[379] Dr. Coyte did not comment on the evidence provided in these

papers or offer other evidence from which to reason that the measures will meet the objective of controlling health care costs. His approach is intuitively appealing: one expects that physicians will react to the financial disincentives contained in the measures by deciding not to come to B.C. to practise. Even if he is correct, however, the respondents have provided no evidence of the significance of the savings expected or of the economic effects of these measures as compared with other cost-saving measures contemplated or implemented. In effect, the respondents' submissions, including Dr. Coyte's opinion, make a leap of logic from the pressing and substantial importance of controlling health care costs to the conclusion that restricting the rights of new entrants to the medical profession is rationally connected to that objective.

[380] Dr. Hanvelt disagrees with Dr. Coyte's conclusions that physicians will react to the measures by deciding not to come to B.C. to practise. He reasons (at pp. 16-17 of his report) that:

> For several reasons I believe it unlikely that physicians eligible to enter the system today will delay applying for a billing number. The uncertainty about additional financial and location restrictions on medical practice in British Columbia and other provinces and the flexibility of the existing policy instruments -- including the PPSM -- to implement more restrictive policy would induce a new physician to enter the system to establish their billing number as soon as possible.
>
> [He footnotes Barer, Lomas and Sanmartin's summary of restrictions on location of practice and remuneration implemented in virtually every province in Canada.]
>
> For example, the policy of "grandfathering" used in the PPSM may send a message to physicians that their practice will not be restricted once they are "in the system". Physicians would also want to begin accumulating points from the PPSM Physician Supply Point system to qualify for Category 3.4 of the PPSM. Category 3.4 provides a physician with a 100%, geographically unrestricted, billing number. Physicians can only gain points if they are practising medicine.

[381] Dr. Hanvelt's reasoning is supported by the facts of this case: the petitioners have not stayed away or postponed their entry into the system. They are practising medicine under the restrictions imposed by the measures. Their objection is that they are restricted and disadvantaged in ways that other equally-qualified physicians are not.

[382] I find that the respondents have failed to prove on the balance of probabilities that there is a rational connection between the objectives of quality medical care and controlling health care costs and the infringement of the petitioners' mobility and equality rights under the***Charter*.**

(b) Minimal Impairment

[383] Because I have decided that the measures do not meet the requirement that they be rationally connected to the infringement of the petitioners' rights, it is not necessary for me to proceed

to the analysis of the requirement that the measures impair those rights as little as reasonably possible. However, the respondents have raised, in the context of the minimal impairment requirement, the issue of deference and the role of the court in weighing the interests and claims of competing groups. Furthermore, the analytical approach to determining whether the requirement of rational connection is met does not directly address the question of proportionality by reference to the extent of the infringement and its impact on the petitioners. I will therefore provide my comments on this aspect of the section 1 analysis.

[384] Once again, McLachlin J. in ***RJR MacDonald Inc.*** provided a summary of the analysis the court is to undertake (at p. 342):

> As the second step in the proportionality analysis, the government must show that the measures at issue impair the right of free expression as little as reasonably possible in order to achieve the legislative objective. The impairment must be "minimal", that is, the law must be carefully tailored so that rights are impaired no more than necessary. The tailoring process seldom admits of perfection and the courts must accord some leeway to the legislator. If the law falls within a range of reasonable alternatives, the courts will not find it overbroad merely because they can conceive of an alternative which might better tailor objective to infringement [cites omitted].

[385] The respondents submit that the physician supply measures are social measures involving competition for scarce resources. They say that in such cases the courts have made it clear that if the government has a reasonable basis for concluding that it impaired the rights as little as possible given its pressing and substantial objectives, the decision is to be left to the legislative or, as in this case, administrative body: ***Irwin Toy Ltd. v. Quebec (A.G.)*** (1989), 58 D.L.R. (4th) 577 at 625-5 (S.C.C.); ***McKinney v. University of Guelph*** (1990), 76 D.L.R. (4th) 545 at 648 (S.C.C.);***Stoffman v. Vancouver General Hospital***, [1991] 1 W.W.R. 577 at 629-30 (S.C.C.); ***Eldridge v. British Columbia (Attorney-General)*** (1995), 125 D.L.R. (4th) 323 at 346-7 (B.C.C.A.), (appeal to S.C.C. heard and reserved April 24, 1997).

[386] McLachlin J. in ***RJR MacDonald Inc.*** clearly accepted the role of deference in this analysis. She pointed out, however, at p. 332:

> As with context, however, care must be taken not to extend the notion of deference too far. Deference must not be carried to the point of relieving the government of the burden which the *Charter* places upon it of demonstrating that the limits it has imposed on guaranteed rights are reasonable and justifiable. Parliament has its role: to choose the appropriate response to social problems within the limiting framework of the Constitution. But the courts also have a role; to determine, objectively and impartially, whether Parliament's choice falls within the limiting framework of the Constitution. The courts are no more permitted to abdicate their responsibility than is Parliament. To carry judicial deference to the point of accepting Parliament's view simply on the basis that the problem is serious and the solution difficult, would be to diminish the role of the courts in the constitutional process and to weaken the structure of rights upon which our constitution and our nation is founded.

[387] The respondents say that they have a reasonable basis for concluding that the measures impair as little as possible the petitioners' rights to practise medicine in B.C. on an equal basis with physicians trained in B.C. (under the interim measures and grandfathering of trained in B.C. physicians in the permanent measures) and established physicians (after the grandfathering of B.C. trained physicians expires). The interim measures were intended to be interim; both the interim and permanent measures provide numerous options to a practitioner to practise at the compensation level and location of choice; the point system in the permanent measures limits the time during which the limitations apply to a maximum of five years; and the physician supply template provides information as to areas of need and payment entitlements by region and specialty.

[388] These justifications do not, in my view, support the respondents' submissions that they are a reasonable basis for concluding that the measures impair the petitioners' rights as little as possible. The terms of the interim measures, though intended to be interim, have been extended and expanded in the permanent measures. The "numerous options" to practise in B.C. have been shown, for a variety of reasons, to be essentially limited to *locum tenens* positions. The five year duration of the

restrictions may be a small impairment if the physicians affected by these measures had not completed nine or more years of post-secondary education before being eligible to commence practice, but in the context of their lengthy training period, five years cannot be said to be minimal. The physician supply template is of no assistance to the petitioners: there is no location in B.C. where they can obtain a 100% billing number. If there were, that can change when the next template is produced in six months and may change as the result of grandfathered physicians taking an available position.

[389] In my view, the infringement of the petitioners' mobility and equality rights is not minimal. The nature of the rights infringed go to the root of the rights of an individual as a citizen or permanent resident of Canada to be free to move about the country and pursue his or her livelihood and to do so equally with other equally qualified individuals:***Black***; ***Andrews***.

[390] In their paper, "Re-minding our Ps and Qs", Barer, Lomas and Sanmartin note the effects of these and similar measures adopted by the provinces. At p. 221, they comment that supply control policies that use differential fees, as in the interim and permanent measures, "has the predictable effect of doing nothing more than redistributing costs among the provinces, without any national coordination, since most of these physicians

will choose to practice somewhere in Canada" and at p. 227 that "joint management initiatives [between provincial governments and medical associations] have served to erect a series of provincial 'tariffs' on the import of externally trained physicians." At p. 230 they suggest:

> Supply management and control are essential to long-term expenditure control, but if such policies are to avoid the unintended (and probably undesirable) redistributional effects we are witnessing in Canada, they should be developed within the context of national guidelines and regional objectives so as to avoid the artificial erection of state trade barriers or tariffs on the movement of what is, in the end, an indispensable national resource.

[391] The essential rationale for the measures is that it is believed to be necessary to reduce the number of physicians practising in B.C. in order to meet the objective of controlling health care costs. New entrants to the profession, particularly those from outside of the province because of their numbers, are an identifiable target group.

[392] It is unarguable that the role of the Commission and the government is to determine the policies that will govern the medical care system in the province. They have no power to enact measures to implement those policies, however, unless those measures comply with the constitution or they show why it is reasonable and justified that they are not required to do so.

(c) Proportionality between the Effects of the Measures and the Objectives

[393] Having decided that the measures meet neither of the first two requirements of the proportionality analysis, it is unnecessary for me to comment on the balance between the negative effects of the measures and their beneficial effect.

3. Conclusion on Section 1

[394] The respondents have failed to show that the infringements imposed by the measures are reasonable or justified in the free and democratic society that is guaranteed by the ***Charter***.

E. Severance

[395] The respondents and the B.C.M.A. submit that if it is found that the measures are not justified under section 1, the exemptions and grandfathering of non B.C.-trained physicians

should be severed, leaving the remaining portions intact and valid.

[396] Counsel quote Professor Hogg, *Constitutional Law of Canada* (3d ed. 1992 at pp. 37-8 - 37-10) as suggesting that in ***Charter*** cases, the courts will apply a presumption in favour of severance, consistent with section 52 of the ***Constitution Act, 1982*** which provides that "any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect."

[397] In ***Schacter v. Canada*** (1992), 93 D.L.R. (4th) 1 (S.C.C.), Lamer C.J.C. explained at p. 11 that the basis of the doctrine of severance was to ensure that courts interfere with the laws adopted by the legislature as little as possible. At p. 12 he said:

> Where the offending portion of a statute can be defined in a limited manner it is consistent with legal principles to declare inoperative only that limited portion. In that way, as much of the legislative purpose as possible may be realized....This concern is reflected in the classic statement of the test for severance in *A-G. Alta. v. A.-G. Can.*, [1947] 4 D.L.R. 1 at p. 11, [1947] A.C. 503, [1947] 2 W.W.R. 401 (P.C.).
>
>> The real question is whether what remains is so inextricably bound up with the part declared invalid that what remains cannot independently survive or, as it has sometimes been put, whether on a fair review of the whole matter it can be assumed that the Legislature would have enacted what survives without enacting the part that is *ultra vires* at all.

[398] I have found that the measures are unconstitutional not only because they exempt or grandfather B.C.-trained physicians, but also because they grandfather established physicians. Severing the portions of the measures that affect only B.C.-trained physicians would not save the measures from invalidity.

Severing the provisions that grandfather established physicians would remove the discriminatory aspects of the measures, but, following ***A.-G. Alta. v. A.-G. Can.***, on a fair review of the whole matter it cannot be assumed that the legislature would have enacted the measures without those provisions.

F. Conclusion on the ***Charter***

[399] I find the interim and permanent measures are inconsistent with the provisions of the Constitution as they violate the petitioners' rights under sections 6 and 15 of the ***Charter*** and are not justified under section 1. They are therefore of no force and effect.

X. CONCLUSIONS

[400] The interim and permanent measures are invalid on both administrative law grounds and under the ***Charter***.

[401] The Commission did not have the statutory authority to enact measures which discriminated, in the administrative law sense, between residents and non-residents of B.C., until section 4(1)(r.1) of the ***Medicare Protection Act*** was enacted effective July 14, 1995. This was after the petitioners had been issued restricted billing numbers under the interim measures. The

Commission re-enacted the interim measures on June 12, 1996 with effect from July 2, 1994 and enacted the permanent measures on April 4, 1996 with effect from October 1, 1996 but applicable to all physicians who applied for billing numbers after February 11, 1994. The Commission did not have the statutory authority to enact retroactive measures. The measures are void as they affect the petitioners.

[402] The measures also violate the ***Canada Health Act*** as they do not provide reasonable compensation for all insured services. The Commission does not have the statutory authority to enact measures that violate the***Canada Health Act*** and they are void for that reason.

[403] The measures restrict the rights of the petitioners to come to B.C. and pursue the gaining of their livelihood of choice to the extent and subject to the same conditions as residents and discriminate against the petitioners primarily on the basis of their province of previous residence. The measures violate the petitioners' mobility rights undersection 6 of the ***Charter***.

[404] Under the measures, the petitioners are denied the equal benefit of the law as compared with other equally trained and qualified physicians because of their previous province of residence. The measures violate the petitioners' equality rights under section 15 of the ***Charter***.

[405] The respondents have failed to demonstrate that the infringements of the petitioners' ***Charter*** rights brought about by the measures are rationally connected to the objectives sought by the Commission: quality health care and control of the health care budget. The measures are not "reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society", as provided by section 1 of the ***Charter***. The measures are therefore constitutionally invalid and of no force and effect.

APPENDIX "A": THE INTERIM MEASURES MINUTE OF THE COMMISSION

 96-0033

PHYSICIAN SUPPLY MANAGEMENT SYSTEM - AMENDMENT

The Commission approves the following amendments to the Physician Supply Management System. This amendment will remain in effect pending the joint implementation of the permanent measures by the Ministry of Health and the British Columbia Medical Association effective October 1, 1996.

1. A category of new billers is established under Section 21(1) of the *Medicare Protection Act*.

2. New billers are all medical practitioners applying for and receiving a billing number on or after July 2, 1996.

3. The payment schedule for new billers is set at 50 percent of the relevant payment schedule for that particular medical practitioner.

4. Exemptions will be granted by the Commission. Medical practitioners who are given an exemption will be paid at 100 percent of the relevant payment schedule.

5. Exemptions will be granted on the following basis:

    5.1 Medical practitioners who have successfully completed pre-licensure training programs in British Columbia after February 11, 1994, or medical practitioners in the British Columbia training system who were matched to pre-licensure training programs outside of the province and completed their pre-licensure training during the time the current supply measures are in effect.

    (a) Medical practitioners currently engaged in specialty residency programs in British Columbia and who are qualified, or who became qualified as general practitioners during their residency programs. This exemption is limited to practice as a general practitioner, and will be effective only for the duration of the specialty residency.

5.2 Medical practitioners practising as a bona fide locum. The practitioner must have entered into a written agreement with the original physician that is being replaced, and that agreement must state the reason for the locum and a specified period of time, not to exceed one year in length, during which the practitioner will be engaged as a locum. During the time that the locum is entitled to an exemption, the original physician must be absent and must not bill the Medical Services Plan. The locum must bill the Medical Services Plan using the original physician's payment number, and will be paid at the same rate at which the original physician would have been paid, had the original physician been the one performing the services to which the billing relate. If the locum does not bill the Medical Services Plan using the original physician's payment number, then the 50 percent rate will be applied to payment. Once the agreement expires, the practitioner's claims are subject to the 50 percent rate. An exemption will not be granted where, in the opinion of the Commission, the locum agreement expands the original physician's regular practice.

5.3 Medical practitioners who are able to demonstrate to the satisfaction of the Commission that there is a medical need for their services in a particular community.

(a) When the Commission assesses whether there is a demonstrated medical need for a medical practitioner's services in a particular community, the Commission will consider such factors as the following:

(i) Demographic factors, including number of general practitioners and specialists in the community, skill mix of existing medical practitioners in the community, distance from major medical community, road distance from major population centre, size of community and exceptional circumstances;

(ii) Whether the medical practitioner has been granted admitting and treatment privileges within a hospital; and

(iii) Whether the medical practitioner will be serving a unique patient population need (e.g., HIV patients).

(b) Medical need for an applicant's services in a particular community will not be established in the Commission's satisfaction, if the only information the applicant relies on is the fact the applicant intends to replace a physician, or to purchase an existing practice.

(c) An exemption under this section may be granted subject to conditions set by the Commission. A medical practitioner who has obtained such a conditional exemption is only entitled to 100 percent of the relevant payment schedule during the time that he or she fully complies with all of those conditions upon which the exemption was granted.

6. Medical practitioners presently in the category of new biller established under the current policy will remain in that category unless or until they apply for and are granted an exemption under this Minute.

7. Medical practitioners who were granted an exemption under Minute of the Commission 1033 will continue to be entitled to that exemption; as long as they comply with any conditions imposed by the Commission at the time the exemption was granted. Practitioners who breach any such condition will automatically lose their exemption, from the time of the breach.

8. The following procedures will be used by the Commission in enrolling medical practitioners while this policy is in effect:

8.1 Medical practitioners will be enrolled in the normal way by applying to the Commission under Section 12 of the *Medicare Protection Act*.

8.2 All medical practitioners being enrolled will fall within the category of new billers unless they apply for and receive an exemption based on the criteria outlined above.

8.3 The applications will be processed in the normal way and a notice will be sent to the applicant informing him or her about the 50 percent payment schedule and the exemptions.

9. The exemption queuing system will be based on the date of receipt of a complete application for a billing number with the Medical Services Plan or the date of licensure with the College of Physicians and Surgeons of British Columbia, whichever is the later date.

10. Where a medical practitioner has been granted an exemption on a locum, the original physician must confirm in writing to the Commission that a bona fide locum agreement is in existence and provide the Commission with sufficient information to enable it to monitor the conditions set out in paragraph 5(2).

11. A Physician Supply Advisory Committee to the Commission is established composed of three representatives of the Ministry of Health and three representatives of the British Columbia Medical Association.

12. Medical practitioners seeking an exemption on the basis of medical need and [Exemption 5(3)], will be asked to provide pertinent information for consideration of the Physician Supply Advisory Committee. The burden of proof will lie with the applicant.

13. The Physician Supply Advisory Committee will examine the requests submitted to it and make recommendations to the Commission.

14. Before the Commission makes a decision, the Commission will notify the applicant in writing of the Physician Supply Advisory Committee's recommendation within 90 days of receiving the complete application and will offer the applicant the right to a hearing and to appear in person before the Commission. Such applicants will be given 21 days to exercise their right to a hearing.

15. Hospitals, universities, institutions and/or communities may seek pre-approval for an exemption to facilitate recruiting.

"DAVID S. KELLY"
David S. Kelly
Chair
Medical Services Commission

APPENDIX "B": THE PERMANENT MEASURES

CONSOLIDATION OF MINUTES OF COMMISSION 96-0015 AND 96-0054

In order to ensure more equitable access to medical services and more equitable distribution of physician resources based on population needs and to assist in the better management of the provincial health care budget, the Medical Services Commission (MSC) hereby adopts the following PHYSICIAN SUPPLY MEASURES, effective October, 1, 1996, in accordance withSections 4(1)(r.1) and 21 of the Medicare Protection Act (*Act*).

1. Effective October 1, 1996, the Interim Physician Supply Measures, pursuant to Minute of the Commission numbers: 1033, 1059, 1080, and 1093 are rescinded and replaced with the measures described herein.

2. In accordance with Section 4(1)(c) the services provided by medical practitioners will not be benefits under section 1 of the *Act* unless the practitioner:

   (a) is assigned to a category eligible for a fee-for-service (FFS) billing number, or;

   (b) works under a contract with an agency which has MSC approved positions under alternate payment arrangements.

   These measures only apply to physicians receiving FFS payments.

3. a) By authority of section 21(1) and 21(4) of the *Act*, the payment schedules specifying the amounts payable to or on behalf of practitioners for rendering benefits under the *Act* will vary by the category of practitioner as outlined below.

   b) If a practitioner makes an election under section 13 (opting out), the category to which he or she is assigned still applies. An opted out practitioner may not bill a beneficiary an amount greater than that which applies to his or her category.

   c) Medical practitioners who entered medical practice in British Columbia on or after February 11, 1994:

   I) will be assigned to the applicable category in accordance with the Physician Supply Plan (PSP) developed under section 7 and will be subject to

the prescribed payment rate for each region and specialty as outlined in Categories 3.1, 3.2 and 3.3.

ii) will earn 20 points plus the community NIA percentage allowance for each full year of active practice and residence in British Columbia. Partial years will be calculated on a pro-rata basis.

iii) once these practitioners have attained 100 points, they are entitled to 100 percent of the payment rate in all regions of the Province as long as they maintain registration and permanent residence in British Columbia;

iv) accumulation of points begins as of February 12, 1994, and is retroactive to that date for those practitioners entering practice since that time;

3.1 Category

Practitioners who have entered into practice in British Columbia on or after February 11, 1994, within a Region where, according to the MSC, a defined need for physician services exists in that practitioner's specialty.

Applicable Payment Schedule

100 percent of MSP FFS Payment Schedule.

Practitioners in Category 3.1 who relocate their practice to a Region as defined by the MSC as either adequately or over-supplied with practitioners in that practitioner's specialty will be reassigned to the respective category 3.2 or 3.3 if the relocation takes place prior to the attainment of 100 points as outlined in Section 3(c).

3.2 Category

Practitioners who have entered into practice in British Columbia on or after February 11, 1994, within a Region where, according to the MSC, the supply of physician services in that practitioner's specialty is adequate to meet need.

Applicable Payment Schedule

75 percent of MSP FFS Payment Schedule.

Practitioners in Category 3.2 who relocate their practice to a Region as defined by the MSC as either under or over-supplied with practitioners in that practitioner's specialty will be reassigned to the respective category 3.1 or 3.3 if the relocation takes place prior to the attainment of 100 points as outlined in Section 3(c).

3.3 Category

Practitioners who have entered into practice in British Columbia on or after February 11, 1994, within a Region where, according to the MSC, the supply of physician services in that practitioner's specialty already exceeds the need.

Applicable Payment Schedule

50 percent of MSP FFS Payment Schedule.

Practitioners in Category 3.3 who relocate their practice to a Region defined by the MSC as either adequately or under-supplied with practitioners in that practitioner's specialty will be reassigned to the respective category 3.1 or 3.2 if the relocation takes place prior to the attainment of 100 points as outlined in Section 3(c).

Exemptions

3.4 Category

Practitioners who have attained 100 points through the physician supply point system as outlined in 3(c).

Applicable Payment Schedule

100 percent of MSP FFS Payment Schedule.

3.5 Category

Practitioners who, with the approval of the MSC, are recruited to the following positions in the University of British Columbia (UBC) Faculty of Medicine: Dean, Head of Department, Head of Division, Full Professor.

Applicable Payment Schedule

100 percent of MSP FFS Payment for as long as they remain in the position to which they were recruited.

Practitioners in category 3.5 will attain points as outlined in Section 3(c).

3.6 Category

Medical practitioners practising as a bona fide locum. The practitioner must have entered into a written agreement with the original physician that is being replaced, and that agreement must state the reason for the locum and a specified period of time, with a minimum of 48 hours and a maximum of one year in length or for the term of an approved leave as outlined in Section 3.8, during which the practitioner will be engaged as a locum. During the time that the locum is entitled to an exemption, the original physician must be absent and must not bill the Medical Services Plan (MSP). The locum must bill MSP using his/her personal billing number and the original physician's payment number.

Applicable Payment Schedule

The locum will be paid at the same rate at which the original physician would have been paid, had the original physician been the one performing the services to which the billings relate. If the locum does not bill the MSP using the original physician's payment number, than the applicable payment rate as outlined in sections 3.1, 3.2, 3.3, and 3.4 of this Minute will apply. Once the agreement expires, the practitioner's claims are subject to the applicable rate for that region as outlined in sections 3.1, 3.2, 3.3, and 3.4. An exemption will not be granted where, in the opinion of the Commission, the locum agreement expands the original physician's regular practice. Practitioners in Category 3.6 will attain points as outlined in Section 3(c).

3.7 Category

Practitioners who enter into practice in British Columbia in pre-approved positions or who are otherwise able to demonstrate to the satisfaction of the Commission that there is a medical need for their services in a particular community.

The Commission, acting on the advice of the Physician Supply Advisory Committee (PSAC), may grant specific approval for certain position vacancies to be created under this category to meet specific needs within a region, provincial program, or agency, notwithstanding that the region may, overall, be designated as an oversupplied or adequately supplied area with respect to physician services.

Application to establish a position in category 3.7 must be made by a Regional Health Board (RHB), a hospital, or other agency prior to the position being advertised. The RHB must be informed of all applications and offered opportunity for input within a reasonable time frame.

The application to create a position is to be reviewed by the PSAC which will make its recommendation to the MSC. After a position has been approved in category 3.7, the agency, hospital, RHB, or program which sponsored the position will advertise, process applications, and select a candidate from among the qualified applicants. Where the position is being added to a multi-practitioner group, clinic, agency, program or the like, the practitioners in the existing group must be consulted prior to a final decision being made.

In cases where several qualified applicants apply for a position which carries with it an exemption from payment proration, and where the position has funding through an alternate payment arrangement currently financed through the Alternate Payments Branch (APB) of MSP, the responsibility and authority for the selection of the successful candidate will rest with the agency which holds the APB contract.

When the Commission assesses whether there is a demonstrated medical need for a medical practitioner's services in a particular community, the Commission will consider such factors as the following:

a) demographic factors, including the number of general practitioners and specialists in the community, skill mix of existing medical practitioners in the community, distance from major medical community, road distance from major population centre, size of community, and exceptional circumstances.

b) whether the medical practitioner has been granted admitting and treatment privileges within a hospital, and;

c) whether the medical practitioner will be serving a unique patient population need;

Medical need for an applicant's services in a particular community will not be established to the Commission's satisfaction if the only information the applicant relies on is the fact that the applicant intends to replace a physician or to purchase an existing practice;

An exemption under this category may be granted subject to conditions set by the Commission. A medical practitioner who has obtained such a conditional exemption is only entitled to 100 percent of the relevant payment schedule during the time that he/she fully complies with all of those conditions upon which the exemption was granted;

A practitioner applying for a billing number in a community that receives a Northern Isolation Allowance payment and with written confirmation of community support will automatically qualify for a 100 percent billing number under this category, as long as he/she continues to practise in that community, or earns 100 points as outlined in Section 3(c).

Applicable Payment Schedule

100 percent of MSP FFS Payment Schedule.

Practitioners in category 3.7 will attain points as outlined in Section 3(c). Practitioners in Category 3.7 who relocate their practice prior to the attainment of 100 points, are subject to the payment rates outlined in sections 3.1, 3.2 and 3.3.

3.8 Category

Practitioners who have previously been issued a full (i.e. 100 percent) billing number by MSP but who are absent from the Province for a period of 24 months or less for educational, sabbatical or humanitarian purposes and who have maintained registration with the College of Physicians and Surgeons of British Columbia during their absence. The period of 24 months may be extended at the discretion of the MSC.

Practitioners who have previously been issued a full (i.e. 100 percent) billing number by MSP but who are absent from the province to provide services to the Canadian military and who have maintained registration with the College of Physicians and Surgeons of British Columbia are exempt conditional to their return to the province within 6 months following their discharge from military service.

Applicable Payment Schedule

100 percent of MSP FFS Payment Schedule.

Grandfathering

3.9 Category

Medical practitioners engaged in specialty residency programs in British Columbia as of June 30, 1995, and who are qualified, or who become qualified, as general practitioners during their speciality residency programs.

Applicable Payment Schedule

100 percent of MSP FFS Payment Schedule.

This exemption is limited to practice as a general practitioner and will be effective only for the duration of the specialty residency.

3.10 Category

Physicians in active practice in British Columbia as of February 11, 1994.

Applicable Payment Schedule

100 percent of MSP FFS Payment Schedule.

3.11 Category

Practitioners in post-graduate training in British Columbia as of June 30, 1995, including those who were, as of June 30, 1995, accepted into training programs that commenced subsequent to that date, and who apply for a British Columbia billing number within one year of completing their training.

Applicable Payment Schedule

100 percent of MSP FFS Payment Schedule.

3.12 Category

UBC medical graduates in post-graduate training either inside or outside British Columbia as of June 30, 1995, including those who were, as of June 30, 1995, accepted into training programs that commenced subsequent to that date, and who apply for a British Columbia billing number within one year of completing their training.

Applicable Payment Schedule

100 percent of MSP FFS Payment Schedule.

3.13 Category

Persons in UBC medical school up to and including the 1995/96 entry class, who apply for a British Columbia billing number within one year of completion of their training.

Applicable Payment Schedule

100 percent of MSP FFS Payment Schedule.

4. Visa Graduates of Foreign Medical Schools wishing to enroll in the MSP of British Columbia may do so only with the approval of MSC contingent upon:

   a) having been recruited to a region that is designated, by the MSC, to be underserviced;

   b) having been selected by that particular community from among available candidates;

c) the practitioner's signed undertaking to reside and practice in that community for a minimum of three years;

d) upon completion of the obligations set out above, Visa Graduates of Foreign Medical Schools will be subject to the applicable payment schedule as outlined in Sections 3.1, 3.2, 3.3 and 3.4. These practitioners will earn points as outlined in Section 3(c).

e) a physician who enters practice in British Columbia under the provisions of this article, who fails to fulfill the three year service obligation, must apply to the MSC for assignment to another category. The MSC is under no obligation, under such circumstances, to assign the practitioner to any new category. In that case, pursuant to section 12(6) of the *Act*, the practitioner is not entitled to be paid.

Process

5. The following procedures will be used by the Commission in enrolling medical practitioners:

a) medical practitioners will be enrolled pursuant to Section 12 of the *Act*;

b) all medical practitioners being enrolled will be assigned to the applicable category 3.1, 3.2 or 3.3 unless they apply for and receive an exemption based on the criteria outlined above;

c) the applications will be processed in the normal way and a notice will be sent to the applicant informing him or her of the category to which he or she has been assigned and identifying the applicable payment schedule.

d) where a medical practitioner has been granted an exemption for a locum, the original physician must confirm in writing to the Commission that a bona fide locum agreement is in existence and provide the Commission with sufficient information to enable it to monitor the conditions set out above.

e) the Physician Supply Advisory Committee to the Commission (PSAC) is continued. The composition and terms of reference of PSAC are set out in Minute #96-0016.

f) medical practitioners seeking an exemption on the basis of medical need will be asked to provide pertinent information for consideration of the Physician Supply Advisory Committee. The burden of proof will lie with the applicant.

g) the Physician Supply Advisory Committee will examine the requests submitted to it and make recommendations to the Commission.

h) before the Commission makes a decision, the Commission will notify the applicant in writing of the Physician Supply Advisory Committee's recommendations within 90 days of receiving the complete application. Applicants who wish to make submissions with respect to the PSAC's recommendation or otherwise wish to appeal the Commission's decision assigning them to a particular category set out in this Minute, have the right to appear in person before the Commission. Such applicants will be given 21 days to exercise their right to a hearing.

i) all practitioners applying for and receiving new British Columbia billing numbers must complete a registration form declaring their community of current practice, and from that point onward are obligated to inform the Commission of any change. Failure to notify the Commission will result in the loss of points earned for that year or the removal of the practitioner's billing number.

6. Effective January 1, 1997, a practitioner's enrollment or entitlement to receive payment from the MSP either through fee-for-service or alternate payment arrangements will be rescinded at the end of the calendar year in which the practitioner passes his or her 75th birthday. Practitioners who wish to remain enrolled or continue to receive payments from the MSP may make special application to the Commission. In such cases, the Commission shall request the PSAC for a recommendation. The PSAC shall, in making its recommendation, consider the needs of the community, applying the criteria outlined in section 3.7.

7. A Physician Supply Plan (PSP), including a supply template will be produced semi-annually by the MSC, acting on the advice of the Physician Supply Advisory Committee. Reporting to the MSC, the PSAC's PSP will determine whether each Region is under, adequately, or oversupplied with physicians in each specialty. It will do so on the basis of the population demographics, population

to physician ratios, local needs, and the physician resource needs of approved programs. This report will quantify the numbers and specialty types of physicians needed by each region, or surplus extent in each region. The report will explicitly set out the criteria upon which its conclusions are based.

Upon approval of the MSC, the first Physician Supply Plan together with the template, will be published by October 1, 1996.

Definitions

practising medicine - Engaged in any occupation that requires licensure by the College of Physicians and Surgeons of British Columbia as a qualification, including but not limited to: health service administration, public administration, occupational medicine, academic or research activities, and clinical medicine whether privately or publicly funded. (See Minute of the Commission 96-0063.) For sessional, contract or other alternative payment arrangements, active denotes full-time practice. Practice arrangements of lesser duration will be considered on a pro-rata basis. For fee-for-service, full-time active practice is defined as receiving not less than the 40th percentile of the annual income for general practice.

permanent residence - at least 8 full months of every year spent at a BC address. Permanent residence is not invalidated by an absence for educational, sabbatical or humanitarian purposes outside of BC for a period of 24 months provided the practitioner maintains full registration with the College of Physicians and Surgeons of BC during the period of absence. The period of 24 months may be extended at the discretion of the MSC.

region - means the regions as defined within the physician supply template.