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CITATION: Flora v. Ontario Health Insurance Plan, 2008 ONCA 538
DATE: 20080704
DOCKET: C47182

COURT OF APPEAL FOR ONTARIO

SHARPE, CRONK and GILLESE JJ.A.

BETWEEN:

ADOLFO A. FLORA

Appellant

and

GENERAL MANAGER,
ONTARIO HEALTH INSURANCE PLAN

Respondent

Mark J. Freiman and John A. Dent, for the appellant

Janet E. Minor and Matthew Horner, for the respondent

Heard: January 21. 2008

On appeal from the order of Justices Gloria J. Epstein, Ellen M. Macdonald and Donald R. Cameron of the Superior Court of Justice, sitting as the Divisional Court, dated January 15. 2007, with reasons reported at (2007), 83 O.R. (3d) 721.

CRONK J.A.:

I. INTRODUCTION

[1] The appellant, Adolfo A. Flora, was diagnosed with liver cancer in 1999. After consulting several Ontario doctors, he was told that he was not a suitable candidate for a liver transplant and was given approximately six to eight months to live.

[2] Mr. Flora explored his overseas treatment options. Eventually, at a cost of about $450.000. he underwent chemoembolization to contain the growth and decrease the size

of his existing tumours and a living-related liver transplantation (LRLT), a procedure involving the transfer of part of a living donor's liver to the patient, at a hospital in London, England. Fortunately, these procedures saved Mr. Flora's life.

[3] Mr. Flora applied to the Ontario Health Insurance Plan (OHIP) for reimbursement of his medical expenses. When his reimbursement request was rejected by the respondent, the General Manager of OHIP, Mr. Flora sought a review of OHIP's decision before the Health Services Appeal and Review Board. The majority of the Board upheld OHIP's denial of reimbursement on the basis that the treatment received by Mr. Flora in England was not an "insured service" within the meaning of the *Health Insurance Act*, R.S.O. 1990, c. H.6 (the Act) and s. 28.4(2) of R.R.O. 1990, Reg. 552 (the Regulation). Mr. Flora's subsequent appeal to the Divisional Court was dismissed.

[4] Mr. Flora now appeals to this court. He argues that the Divisional Court erred: (i) by applying the reasonableness standard of review to the Board's decision; (ii) by concluding that the Board's decision was reasonable; and (iii) in the alternative, by failing to declare that s. 28.4(2) of the Regulation violates his rights to life and security of the person under s. 7 of the *Charter of Rights and Freedoms*.

[5] For the reasons that follow, I would dismiss the appeal.

II. RELEVANT LEGISLATIVE PROVISIONS

[6] The following legislative provisions are pertinent:

> *A. The Act:*
>
> 11.2 (1) The following services are insured services for the purposes of the Act:
>
> 1. Prescribed services of hospitals and health facilities rendered under such conditions and limitations as may be prescribed.
>
> 2. Prescribed medically necessary services rendered by physicians under such conditions and limitations as may be prescribed.
>
> 3. Prescribed health care services rendered by prescribed practitioners under such conditions and limitations as may be prescribed.
>
> 12. (1) Every insured person is entitled to payment to himself or herself or on his or her behalf for, or to be otherwise provided with, insured services in the amounts and subject to such conditions and co-payments, if any, as are prescribed.

B. The Regulation:

28.4 (2) Services that are part of a treatment and that are rendered outside Canada at a hospital or health facility are prescribed as insured services if,

(a) the treatment is generally accepted in Ontario as appropriate for a person in the same medical circumstances as the insured person; and

(b) either,

(i) that kind of treatment that is not performed in Ontario by an identical or equivalent procedure, or

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

C. The Canada Health Act, R.S.C. 1985, c. C-6 (the CHA):

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

D. The Charter:

7. 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.

III. FACTS

(1) Diagnosis and Transplant Eligibility

[7] In the early 1970s, Mr. Flora contracted Hepatitis C from tainted blood in a blood transfusion carried out during surgery to remove a benign tumour from his esophagus. Eventually, this led to cirrhosis of the liver and, despite regular monitoring, a diagnosis of liver cancer (hepatocellular carcinoma or "HCC") in 1999. Mr. Flora was then 50 years old. His cancer was advanced and multifocal – he had several tumours or lesions. His prognosis was dire – he was told by Ontario doctors that he had about six to eight months to live.

[8] When Mr. Flora's liver cancer was detected, only cadaveric liver transplants were performed in Ontario. LRLTs were relatively new and adult-to-adult LRLT programs were in their infancy both in Canada and Europe. As a result, an adult-to-adult LRLT had not yet been undertaken in this province, although paediatric LRLTs had been performed.

[9] At that time, adult patient eligibility for cadaveric liver transplants was determined by physicians in Ontario based on medically-established guidelines developed in the mid-1990s, known as the "Milan Criteria". Under these criteria as employed in Ontario, doctors would only undertake a liver transplant if: (i) the patient had one tumour equal to or less than five centimetres in diameter; (ii) alternatively, in the case of multiple tumours, no more than three tumours existed, each equal to or less than three centimetres in diameter; and (iii) there was no evidence of vascular invasion or spread of the cancer outside the liver. These restrictions recognized Ontario's chronic shortages of transplant organs relative to need, and the goal of ensuring that transplant candidates with high survival prospects were approved for transplants in priority to patients with lower chances of good survival outcomes.

[10] Imaging studies conducted on Mr. Flora in Ontario in December 1999 and in England in February 2000 revealed that he had multiple tumours, some of which were quite large and in excess of the Milan Criteria as applied in Ontario.

[11] Faced with his alarming diagnosis and prognosis, Mr. Flora examined the possibility of a liver transplant with Dr. Florence Wong, a specialist in gastroenterology and hepatology at the Toronto General Hospital (the TGH). Dr. Wong, in turn, explored Mr. Flora's treatment options with several other Ontario specialists, including the Medical Director of the Liver Transplant Unit at the TGH. This unit assessed Mr. Flora and concluded that he was ineligible for a cadaveric liver transplant under the Milan Criteria.

[12] As a result, with Dr. Wong's assistance, Mr. Flora consulted a number of experts overseas, including Dr. M.P. Manns, Director of the Department of Gastroenterology and Hepatology at the Hanover Medical School in Germany. Based on an assessment of Mr. Flora conducted in early February 2000, Dr. Manns reported that Mr. Flora's cancer was "amenable neither to resection [surgical removal] nor to liver transplantation due to its multifocal nature".

[13] Later the same month, Mr. Flora also met with Dr. Roger Williams, a hepatologist and Head of the Liver Unit at the Cromwell Hospital in London, England (the Cromwell), and Dr. Shamsudin Mohamed Rela, a transplant surgeon, of the same hospital (Mr. Flora's U.K. doctors). The Cromwell operates on private funding.

[14] The Cromwell's LRLT program had been initiated only some months earlier, in the fall of 1999, to assist overseas patients who had no priority in cadaver donor organ allocation under England's national health care system. In its program, the Cromwell

used cadaveric transplant eligibility criteria to determine patient-eligibility for a LRLT. However, these criteria were broader than Ontario's Milan Criteria: the Cromwell offered liver transplantation if the prospective patient had three tumours or less, with a maximum diameter of 5 centimetres. As well, the Cromwell's approach to these criteria was flexible. For example, lesions of only a few millimetres in size were accorded little, if any, significance in transplant assessments at the Cromwell.

[15] Mr. Flora underwent immediate chemoembolization at the Cromwell and was found to be eligible for a liver transplant under that hospital's cadaveric transplant selection criteria. Because of the extensive wait lists in England for cadaveric organs, particularly for non-residents, Mr. Flora was approved as a candidate for a LRLT. He was regarded at the Cromwell as an "acceptable", but not the "best", candidate for this procedure. Mr. Flora's brother agreed to serve as the living donor.

[16] Before undertaking the LRLT procedure, Mr. Flora returned to Canada and consulted Dr. William Wall, the Director of the Multi-Organ Transplant Program at the London Health Sciences Centre in London, Ontario (the LHSC), the only other hospital in Ontario that performed liver transplants apart from the TGH. The LHSC was then in the process of selecting its first candidate for an adult-to-adult LRLT. The first adult-to-adult LRLT in Ontario was performed at the LHSC on April 4, 2000, 35 days after Mr. Flora was assessed by that hospital's transplant team.

[17] Because no LRLT-specific patient candidacy criteria existed, Mr. Flora's eligibility for a LRLT at the LHSC was evaluated under the Milan Criteria. The LHSC transplant team determined that Mr. Flora was not an acceptable candidate for either a cadaveric transplantation or a LRLT due to the apparent number and size of his lesions.

[18] At both the Cromwell and the LHSC, the animating rationale for restricting eligibility for LRLTs was an ethical one: given the serious and significant physical and other risks to the donor of donating a portion of his or her liver, only those patients with high survival prospects would be selected for the procedure. The health and safety of the living donor was a dominant concern.

(2) OHIP Application

[19] On February 22, 2000, Dr. Wong completed an application to OHIP for payment of Mr. Flora's medical expenses in England by signing a form called a "Prior Approval Application for Full Payment of Insured Out-of-Country Health Services" (the OHIP Application). In respect of the question, "Is the treatment generally accepted in Ontario as appropriate for a person in these medical circumstances?", Dr. Wong checked "yes" in a box on the form. In response to the question, "Is this treatment performed in Ontario by an identical or equivalent procedure?", Dr. Wong indicated in a handwritten note: "The treatment can be performed in Ontario, but Mr. Flora is deemed an unsuitable candidate."

[20] On February 24, 2000, Mr. Flora's OHIP Application was denied. Nevertheless,

he elected to proceed with a LRLT at the Cromwell. The surgery was performed on March 26. 2000. Happily, it appears to have been completely successful.

(3) Expert Evidence

[21] The Board received documentary evidence from several Ontario doctors who were involved in Mr. Flora's care, including Dr. Wall. As well, Dr. Wall testified before the Board. He indicated that, at the LHSC, liver transplantation would not be recommended for a patient who had more than three tumours due to the high risk of cancer recurrence. Dr. Wall also said that if Mr. Flora's condition had met the Milan Criteria, he would have been put on the wait lists in Ontario for a cadaveric liver. Because Mr. Flora's cancer was malignant. he would have had priority on the wait lists and, if listed in early January 2000. likely would have received a cadaveric organ in about 50 days. He would also have been considered for a LRLT at the LHSC.

[22] It was also Dr. Wall's opinion that:

> From a medical point of view, the decision regarding [Mr. Flora's] ineligibility was straightforward and not difficult. The cancers were too numerous (the various imaging tests suggested 5 cancers, I thought there might have been as many as six) and taken together, they were too large on the imaging tests.

[23] The Board was also provided with expert evidence from Mr. Flora's U.K. doctors, by telephone. They testified that Mr. Flora fell within the accepted criteria at the Cromwell for the performance of a LRLT and expressed the opinions that, with a LRLT, Mr. Flora had an estimated five-year survival rate of 70-75% (Dr. Williams) or 60-80% (Dr. Rela).

[24] There was no dispute among the experts that, without a liver transplant, Mr. Flora would have died.

(4) Decisions Below

[25] The issue before the Board was whether the treatment received by Mr. Flora at the Cromwell was an "insured service" under s. 28.4(2) of the Regulation and, therefore, under the Act. The parties agreed that the treatment in question consisted of both Mr. Flora's chemoembolization procedure and his LRLT.

[26] Pursuant to s. 12(1) of the Act, an insured person is entitled to receive payment from OHIP for "insured services" in such amounts and subject to such conditions and co-payments. if any. as are prescribed. Section 28.4(2) of the Regulation establishes a two-part test for the determination of whether an out-of-country medical treatment constitutes an "insured service". Under the first branch of the test, the treatment in question must be "generally accepted in Ontario as appropriate for a person in the same medical circumstances as the [reimbursement claimant]" (s. 28.4(2)(a)). The second branch of the

test requires that the treatment be one that is not performed in Ontario by an identical or equivalent procedure or, if performed in Ontario, that it is necessary for the claimant to travel out of Canada to avoid a delay "that would result in death or medically significant irreversible tissue damage" (s. 28.4(2)(b)).

[27] The majority of the Board[1] held that while the second branch of the test – s. 28.4(2)(b) – was satisfied in Mr. Flora's case, the first branch – s. 28.4(2)(a) – was not because his medical treatment in England was not "generally accepted in Ontario as appropriate for a person in [his] medical circumstances". Accordingly, Mr. Flora had not satisfied the test under s. 28.4(2) of the Regulation for an "insured service" and no reimbursement of his medical expenses at the Cromwell was available under s. 12(1) of the Act. The Board, therefore, upheld the denial of Mr. Flora's OHIP Application.

[28] One member of the Board dissented. She preferred the evidence of Mr. Flora's U.K. doctors over that of Dr. Wall regarding Mr. Flora's suitability for a LRLT and concluded that both branches of the s. 28.4(2) test for an "insured service" were satisfied. Consequently, she would have reversed OHIP's denial of reimbursement.

[29] Mr. Flora appealed to the Divisional Court. He advanced three principal arguments: (i) the standard of review applicable to the Board's decision was correctness; (ii) the Board erred in law in its interpretation and application of s. 28.4(2)(a) of the Regulation: and (iii) in the alternative, s. 28.4(2) of the Regulation violated s. 7 of the *Charter*.

[30] The Divisional Court unanimously rejected these arguments. It held that the standard of reasonableness, rather than correctness, applied to a review of the Board's decision and that the Board's decision was reasonable. It also rejected Mr. Flora's *Charter* s. 7 challenge.

IV. ISSUES

[31] There are three issues:

(1) Did the Divisional Court err by applying the reasonableness standard of review to the Board's decision?

(2) Did the Divisional Court err by holding that the Board's decision was reasonable?

(3) Did the Divisional Court err by failing to hold that s. 28.4(2) of the Regulation offends s. 7 of the *Charter*?

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[1] Throughout the balance of these reasons, I refer to the majority's decision as the decision of the Board.

V. ANALYSIS

(1) Standard of Review

[32] Mr. Flora argues that the issue before the Board was "a pure question of law" concerning the meaning of the phrase "generally accepted in Ontario as appropriate" under s. 28.4(2)(a) of the Regulation. He submits that because the Board has no specialized expertise relative to the courts to determine such a legal question, no deference is owed to the Board and the correctness standard of review applies.

[33] I disagree. In my opinion, reasonableness is the appropriate standard of review in this case. I say this for the following reasons.

[34] At the time of the appeal to the Divisional Court, an evaluation of the four factors comprising the pragmatic and functional approach to judicial review was required to determine the proper level of deference owed to the Board's decision. See for example, *Pushpanathan v. Canada (Minister of Citizenship and Immigration)*, [1998] 1 S.C.R. 982: and *Monsanto Canada Inc. v. Ontario (Superintendent of Financial Services)*, [2004] 3 S.C.R. 152. The Divisional Court undertook this analysis and concluded that, overall. the application of the requisite factors in this case favoured the deferential standard of reasonableness.

[35] Since the Divisional Court's decision. the Supreme Court of Canada rendered its decision in *Dunsmuir v. New Brunswick*, 2008 SCC 9. *Dunsmuir* now governs the standard of review analysis applicable to administrative decisions. Under *Dunsmuir*, the reasonableness *simpliciter* and patent unreasonableness standards of review have been collapsed into a single standard of reasonableness. However, I do not understand *Dunsmuir* to have entirely jettisoned the factors relevant under the pragmatic and functional analysis. To the contrary, *Dunsmuir* confirms that the factors considered by the Divisional Court continue to be relevant to the determination of the appropriate standard of review applicable to the decision of an administrative tribunal.

[36] The majority of the Supreme Court in *Dunsmuir* explained the standard of review analysis in these terms (at para. 62):

> In summary, the process of judicial review involves two steps. First, courts ascertain whether the jurisprudence has already determined in a satisfactory manner the degree of deference to be accorded with regard to a particular category of question. Second, where the first inquiry proves unfruitful, courts must proceed to an analysis of the factors making it possible to identify the proper standard of review.

As the majority in *Dunsmuir* indicated at para. 64, the "factors" referenced in this passage include those that applied under the pragmatic and functional approach.

[37] In my view, the Divisional Court properly applied these factors in this case. The

Divisional Court accepted that two factors support the application of the least deferential standard of review – correctness. First, the legislature did not enact a privative clause to insulate the Board's decision from judicial review. Instead, s. 24(1) of the Act affords a broad right of appeal to the Divisional Court. I agree with the Divisional Court that this factor suggests that less deference is to be afforded to the Board on judicial review. *Dunsmuir* at para. 52.

[38] The Board's task was to determine whether the medical treatment received by Mr. Flora in England constituted an "insured service" within the meaning of the Act and s. 28.4(2) of the Regulation. This determination did not require the Board to engage in an evaluation of broad policy-laden choices that involved "the balancing of multiple sets of interests of competing constituencies": see *Monsanto* at para. 15. The Divisional Court concluded that this factor also suggests less deference to the Board's decision. Again, I agree.

[39] That said, *Dunsmuir* reiterates that deference is owed by reviewing courts where – as here – the challenged tribunal decision involves a question in which the legal and factual issues are interwoven and cannot be readily separated. The question at issue before the Board was fact-driven and case specific. As the Divisional Court observed, the express language of s. 28.4(2)(a) links the funding test to Mr. Flora's medical circumstances. *Dunsmuir* recognizes that the requirement for this type of fact-driven inquiry is a strong indicator for the application of the reasonableness standard of review (at paras. 51 and 53).

[40] The relative expertise of the Board also militates in favour of the reasonableness standard. The Divisional Court properly emphasized that the Board was required "to consider the specifics of Mr. Flora's case, clinical considerations, and professional and ethical standards" and that this analysis involved "an understanding of medicine, an area where the courts cannot claim to have greater expertise than the Board members ..."

[41] Moreover, in reaching its decision, the Board was engaged in interpreting the Act and s. 28.4(2) of the Regulation, in respect of which it must be taken as having considerable familiarity. The review of OHIP reimbursement decisions concerning out-of-country medical services is a common undertaking of the Board. The Supreme Court of Canada has repeatedly held, and *Dunsmuir* confirms, that even in respect of a pure question of law, the decision of an expert tribunal regarding the interpretation and application of its 'home' statute, or of statutes closely connected to its function, with which the tribunal will have particular familiarity, may attract deference (at paras. 54-56).

[42] The interpretation and application of s. 28.4(2) was a matter well within the domain of the Board's experience. To use the language of the majority in *Dunsmuir*, the Board's inquiry did not involve an issue of general law "that is both of central importance to the legal system as a whole and outside [its] specialized area of expertise" so as to attract the correctness standard of review. *Dunsmuir* at para. 60. Nor does Mr. Flora's

Charter s. 7 challenge convert the nature of the question at issue before the Board into one of broad legal complexity and significance. Section 6(3) of the *Ministry of Health Appeal and Review Boards Act, 1998*, S.O. 1998, c. 18, Sch. H, precludes the Board from undertaking *Charter*-based inquiries. Mr. Flora's *Charter* s. 7 challenge, therefore, was first addressed by the Divisional Court.

[43] Thus, the Board's expertise in medical matters and in respect of a legislative scheme with which it is frequently engaged, strongly supports the application of the reasonableness standard.

[44] Finally, and importantly, existing jurisprudence suggests that the reasonableness standard applies to a review of the Board's decision. Ontario courts have previously held that a Board decision under the Regulation regarding payment of out-of-country medical expenses is reviewable on the reasonableness standard. See for example, *Ruggiero Estate v. Ontario (Health Insurance Plan, General Manager)* (2005), 78 O.R. (3d) 28 (Div. Ct.) at paras. 9-13.

[45] I conclude that the reasonableness standard of review applies to the Board's decision. I therefore pass to the next issue, whether the Board's decision meets that standard.

(2) Reasonableness of the Board's Decision

[46] Mr. Flora argues that the Board made a series of errors in its s. 28.4(2)(a) analysis that render the Board's decision both unreasonable and incorrect. He submits that the Board erred: (i) by relying on the evidence of cadaveric transplant eligibility criteria; (ii) by relying on Dr. Wall's evidence concerning the appropriateness of a LRLT for Mr. Flora in the face of contradictory evidence from experienced international medical experts; (iii) by conflating the availability of LRLTs in Ontario with the issue whether Mr. Flora's LRLT was medically appropriate; and (iv) by adopting an interpretation of "appropriate" under s. 28.4(2)(a) that is contrary to the purpose of the Act and the CHA. Mr. Flora further contends that the Divisional Court fatally erred by incorporating many of these Board errors into its own reasoning, leading to the flawed conclusion that the Board's decision was reasonable. I will consider these submissions in turn.

Meaning of Reasonableness

[47] I begin with consideration of the meaning of 'reasonableness'. In *Dunsmuir*, the majority of the Supreme Court of Canada explained this standard in the judicial review context in these terms (at para. 47):

> [C]ertain questions that come before administrative tribunals do not lend themselves to one specific, particular result. Instead, they may give rise to a number of possible, reasonable conclusions. Tribunals have a margin of appreciation within the range of acceptable and rational solutions. ... In

> judicial review, reasonableness is concerned mostly with the existence of justification, transparency and intelligibility within the decision-making process. But it is also concerned with whether the decision falls within a range of possible, acceptable outcomes which are defensible in respect of the facts and law.

It is against this standard that the Board's decision must be measured.

Evidence Relied on by the Board

[48] I do not accept Mr. Flora's submission that the Board erred by relying on the expert evidence of cadaveric transplant eligibility criteria in determining whether a LRLT was generally accepted in Ontario as appropriate for a person in Mr. Flora's medical circumstances.

[49] Both Mr. Flora's U.K. doctors and Dr. Wall testified that the transplant eligibility criteria at their hospitals are the same for cadaveric transplants and LRLTs. The transplant team at the LHSC used Ontario's Milan Criteria, which were originally designed to evaluate patient eligibility for cadaveric liver transplants, to assess Mr. Flora's eligibility for a cadaveric transplant and a LRLT. Mr. Flora's U.K. doctors employed the Cromwell's cadaveric transplant eligibility criteria to evaluate Mr. Flora's eligibility for both types of transplant. In both jurisdictions, therefore, cadaveric transplant eligibility criteria were considered appropriate for LRLT candidacy assessments and were utilized in Mr. Flora's case.

[50] The real difference between the approach of the specialists in the two jurisdictions lies in the *content* of the selection criteria employed in their respective hospitals for *both* types of liver transplants. The criteria utilized at the Cromwell were broader and more "relaxed" than Ontario's Milan Criteria, allowing for a higher risk of tumour recurrence. The application of the two sets of cadaveric transplant eligibility criteria resulted in different LRLT eligibility determinations.

[51] Dr. Williams confirmed that Mr. Flora was assessed at the Cromwell for both a cadaveric transplant and a LRLT utilizing that institution's cadaveric transplant selection criteria. He said that the use of these criteria for the evaluation of LRLT eligibility is recognized by international experts, although some experts also urge the adoption of less stringent criteria to determine LRLT eligibility. Dr. Williams, however, expressly refrained from offering any opinion on the latter proposal.

[52] Moreover, according to Dr. Williams, Mr. Flora received a LRLT at the Cromwell because the delay on the cadaveric liver transplant wait lists in England would have been too long (six to eighteen months) and, as a non-resident, Mr. Flora would not have received a cadaveric organ in time. In contrast, it was Dr. Wall's uncontested evidence that if Mr. Flora had satisfied the Milan Criteria he would have received a cadaveric

transplant in Ontario in about 50 days and he would have been considered for a LRLT at the LHSC.

[53] Mr. Flora attacks those of the Divisional Court's findings that suggest that the evidence of several Ontario doctors supported the appropriateness of the use of the Milan Criteria to assess a patient's suitability for a LRLT. He argues that Dr. Wall was the only Ontario doctor who provided this evidence and, as a result, there was no evidence before the Board of a medical "consensus" in Ontario on this issue.

[54] In my view, this complaint is of no import. The critical question is whether the Board understood the nature of the expert evidence regarding the criteria used in Ontario and England to assess the appropriateness of a LRLT for Mr. Flora.

[55] The Board's reasons reflect no misapprehension of the evidence on this issue. It was Dr. Wall's uncontradicted evidence before the Board that Ontario's Milan Criteria "are generally accepted criteria in all of the liver transplant programs in Canada". Mr. Flora's eligibility for a LRLT was assessed both in England and Ontario utilizing cadaveric transplant eligibility criteria. The Board's reasons reveal that it had a firm grasp of the available expert evidence about the disparate transplant eligibility criteria used in Ontario and England and the differing treatment decisions arrived at for Mr. Flora on the application of those criteria in both jurisdictions.

[56] Mr. Flora also argues that the Board erred, and its decision was rendered unreasonable, by "its incorporation of the shortage of cadaveric organs into its interpretation of whether a LRLT was generally accepted in Ontario as appropriate treatment for persons in Mr. Flora's medical circumstances". I cannot accede to this argument.

[57] The Board noted the necessity of allocating scarce resources in various parts of its reasons. These comments refer to the supply of cadaveric organs, a factor irrelevant to patient selection for a LRLT. However, read in their entirety, the Board's reasons demonstrate that it understood that the issue of cadaveric organ supply was relevant to the purposes behind the original development of the Milan Criteria, that selection criteria specific to LRLT patient candidacy had not been developed in Europe or Canada, and that the 'supply issue' pertinent to LRLTs concerned the availability of living organ donors rather than the availability of cadaveric organs.

[58] In the end, the Board properly focused on the critical evidence in this case, namely: (i) the unanimous expert evidence that cadaveric liver transplant eligibility criteria were used both in Ontario and England to determine Mr. Flora's eligibility for a LRLT; (ii) the expert evidence from a leading Ontario liver transplant specialist – Dr. Wall – that Mr. Flora did not satisfy the medical criteria for a LRLT in this jurisdiction; and (iii) the unanimous opinion evidence of Mr. Flora's Ontario specialists that he was also ineligible for a cadaveric liver transplant.

[59] In all these circumstances, the Board's reliance on the evidence of cadaveric

transplant eligibility criteria was clearly reasonable.

[60] I also do not accept Mr. Flora's contention that the Board erred by relying on Dr. Wall's evidence regarding Mr. Flora's candidacy for a LRLT in Ontario. The Board stated at p. 17 of its reasons: "[I]t is the opinion of Ontario physicians [to] which the Board must give the greatest weight in this appeal."

[61] This Ontario-centric focus to the Board's inquiry was mandated by the language of s. 28.4(2)(a) itself. Under that provision, the treatment in respect of which OHIP reimbursement is sought must be generally accepted as appropriate "in Ontario" for a person in the same medical circumstances as the reimbursement claimant. Section 28.4(2)(b) contains language to the same effect. As the Divisional Court stressed, the focus of s. 28.4(2)(a) is "on accepted treatment standards in Ontario". I agree with the Divisional Court that the intention of the legislature with respect to s. 28.4(2) is clear:

> [I]t is intended to limit reimbursement to those procedures and treatments that would have been considered appropriate for an equivalent individual in equivalent circumstances in Ontario ... It is obvious that the legislature intended to emphasize the local nature of the provision. [Emphasis in original.]

[62] The Board recognized that s. 28.4(2)(a) of the Regulation is concerned with the medical practices and standards applicable in Ontario. The Board put it this way (at p. 17): "The issue before the Board, however, is whether the treatment is generally accepted *in Ontario* as appropriate for a person in the same medical circumstances." [Emphasis in original.]

[63] The evidence of Mr. Flora's U.K. doctors was principally concerned with the applicable transplant eligibility criteria in the United Kingdom and Europe. Mr. Flora's U.K. doctors, although eminent in their fields, did not profess any expertise in Ontario's medical practices and standards, or in the application of Ontario's liver transplant eligibility criteria.

[64] In contrast, the record reveals that Dr. Wall, also an eminently qualified liver transplant specialist, was well-versed in Ontario's liver transplant medical standards and practices. The record indicates that at the time of Mr. Flora's assessment, Dr. Wall was the most experienced liver transplant surgeon in Canada.

[65] At the time of Mr. Flora's liver cancer diagnosis, the TGH and the LHSC were the only two Ontario hospitals performing liver transplants of any kind. It was Dr. Wall's evidence that although no Canadian transplant facility had done an adult-to-adult LRLT by February 2000, the LHSC had the expertise and ability to do one and had embarked on its own adult-to-adult LRLT program. Dr. Wall testified that Mr. Flora was found to be ineligible for *any* liver transplant because his cancer was too extensive and was outside

the criteria recognized in Ontario for liver transplant selection.

[66] By deciding to accord greater weight to Dr. Wall's evidence than to that of Mr. Flora's U.K. doctors, the Board simply determined that Dr. Wall was better positioned than Mr. Flora's U.K. doctors to provide opinion evidence of generally accepted medical practices and standards in Ontario. This conclusion was open to the Board on the evidence.

[67] Mr. Flora relies on the contents of the OHIP Application as completed by Dr. Wong, which I have earlier described, to argue that there was conflicting evidence before the Board from Mr. Flora's Ontario specialists on the core issue of whether a LRLT treatment was "generally accepted in Ontario as appropriate" for a person in his medical circumstances. I disagree.

[68] Dr. Wong did not testify before the Board. Nor did Mr. Flora seek to have any written materials from Dr. Wong admitted by the Board to explain her entries on the OHIP Application. Perhaps more importantly, Dr. Wong is not a liver transplant specialist. She did not personally evaluate the appropriateness of a liver transplant – cadaveric or otherwise – for Mr. Flora. She referred Mr. Flora to Dr. Les Lilly at the TGH for that purpose and the TGH Liver Transplant Unit evaluated Mr. Flora's suitability for a cadaveric liver transplant. Dr. Wall, at the LHSC, assessed Mr. Flora's eligibility for both a cadaveric transplant and a LRLT. The fact that Dr. Wong checked a box on the OHIP Application indicating that a LRLT for Mr. Flora was "generally accepted in Ontario as appropriate" must be viewed in that context.

[69] It is also significant that Mr. Flora's OHIP Application pre-dated his assessment at the LHSC. In the OHIP Application, Dr. Wong was addressing a "possible" LRLT at the Cromwell. There was no evidence before the Board or the Divisional Court that Dr. Wong disagreed with the LRLT eligibility decision made by the LHSC transplant team in respect of Mr. Flora or that she challenged the transplant selection criteria utilized for that purpose.

[70] Moreover, the Board was alert to the statements made by Dr. Wong on the OHIP Application. After recognizing the statements made by her on which Mr. Flora relied, the Board noted that Dr. Wong had also indicated on the OHIP Application that, "Physicians in Ontario will not give Mr. Flora chemoembolization or [a LRLT]" (at p. 10). The Board then indicated:

> [T]he Board understands the form to indicate that while in Dr. Wong's opinion liver transplantation is generally accepted as appropriate for a person suffering from [Mr. Flora's] condition, [Mr. Flora's] condition did not satisfy guidelines established within the province.

In the absence of contrary evidence from Dr. Wong before the Board, I cannot conclude

that this interpretation of her statements on the OHIP Application was unreasonable.

[71] Accordingly. I see no error in the Board's reliance on the evidence impugned by Mr. Flora.

Interpretation of Section 28.4(2)(a)

[72] Mr. Flora advances two arguments in support of his contention that the Board and the Divisional Court erred by misinterpreting s. 28.4(2)(a) of the Regulation. He submits first. that the Board "conflated" the issue of the availability of the LRLT procedure in Ontario with the issue of its appropriateness for Mr. Flora. Next, he maintains that the Divisional Court erred by accepting an interpretation of s. 28.4(2)(a) that is inconsistent with the purpose and objectives of the Act and the CHA. I would reject these arguments.

(a) <u>The "conflation" argument</u>

[73] Mr. Flora's claim that the Board erred by conflating the availability of a LRLT in Ontario with its appropriateness for Mr. Flora is predicated on the proposition that the "appropriateness" of a medical treatment is to be measured solely by its medical efficacy. In other words, if the proposed treatment would potentially benefit the patient, in the absence of any contraindications for the treatment it must be regarded as medically necessary and appropriate under s. 28.4(2)(a) of the Regulation.

[74] There are at least four difficulties with this proposition. First, as the Divisional Court held. it ignores the reality of medical care and the process of decision-making by physicians in Ontario. A variety of considerations inform the medical decision whether to offer a liver transplant to a specific patient. These include issues regarding donor organ supplies, patient survival prospects and, in the case of LRLTs, ethical considerations concerning risk factors for prospective organ donors.

[75] In particular, there was evidence before the Divisional Court from Dr. Peter Singer. an Ontario professor of medicine, a bio-ethicist and the Director of the University of Toronto Joint Centre for Bioethics, that the appropriateness of a proposed medical treatment for a particular patient is "not purely a medical concept". To the contrary, "[A] physician's determination about whether treatment is appropriate includes not only medical facts like the projected chance of success but also ethical considerations." Thus, with LRLTs. "[T]he potential risk to the donor, in relation to the benefit to the recipient, play[s] a significant role in the decision whether to offer a transplant." In their evidence before the Board, Mr. Flora's U.K. doctors and Dr. Wall also confirmed that ethical considerations form an essential part of medical decision-making concerning patient selection for a LRLT.

[76] Thus. the thesis that the appropriateness of a LRLT turns solely on its medical efficacy brushes aside the centrality of ethical considerations in transplant decision-making.

[77] Second. the medical efficacy approach to the interpretation of "appropriateness" is

inconsistent with the plain language of s. 28.4(2)(a). If the interpretation of "appropriateness" advanced by Mr. Flora were to govern, any potentially life-saving out-of-country medical treatment would qualify for public funding under the Act, regardless of a patient's particular medical circumstances, simply because it would be of potential benefit to the patient. This would ignore the requirement under s. 28.4(2)(a) that the "appropriateness" of a treatment be determined with reference to a person "in the same medical circumstances" as the reimbursement claimant.

[78] Section 28.4(2) of the Regulation embodies a clear conceptual distinction between the "appropriateness" and the "availability" of a medical treatment. Section 28.4(2)(a) is concerned with the former, while s. 28.4(2)(b) focuses on the latter. On the plain language of s. 28.4(2), the legislature has indicated that a treatment may be generally accepted in Ontario as appropriate (s. 28.4(2)(a)), although it is not performed in Ontario (s. 28.4(2)(b)). In accordance with well-established principles of statutory interpretation, meaning must be accorded to each branch of the s. 28.4(2) funding test. There is nothing in s. 28.4(2)(a) to suggest that the "appropriateness" of a medical treatment is to be determined exclusively on the basis of its potential medical efficacy.

[79] Third, the interpretation of "appropriateness" posited by Mr. Flora is also inconsistent with the legislative purpose of s. 28.4(2). I agree with the Divisional Court that the purpose of s. 28.4(2) is to allow Ontario residents "to receive funding for the same level of health care services abroad that they are entitled to receive in Ontario". If the medical efficacy interpretation of "appropriateness" was accepted, it would mean that Ontario residents would be entitled to bypass the requirements of s. 28.4(2)(a) and receive publicly-funded medical treatments that are offered solely on the basis of foreign medical assessments concerning the potential benefit of the treatments at issue. This, too, would 'read-out' the requirement in s. 28.4(2)(a) that the appropriateness of a medical treatment be determined with reference to general medical practices and standards "in Ontario" and the claimant's own medical circumstances.

[80] Finally, the interpretation urged by Mr. Flora reflects an overly broad approach to publicly-funded health care that has been rejected by the courts. See for example, *Auton (Guardian Ad Litem of) v. British Columbia (Attorney General)*, [2004] 3 S.C.R. 657 at 672-73: and *Cameron v. Nova Scotia (Attorney General)* (1999), 177 D.L.R. (4th) 611 (N.S.C.A.) at paras. 235-39. Neither the Act nor the Regulation promise that insured Ontarians will receive public funding for all medically beneficial treatments.

(b) <u>The purpose and objectives of the legislation</u>

[81] Mr. Flora submits that both the Divisional Court and the Board misinterpreted the phrase "accepted as appropriate" under s. 28.4(2)(a) of the Regulation by failing to accept the views of internationally renowned experts – Mr. Flora's U.K. doctors – concerning the appropriateness of a LRLT for Mr. Flora. The core of his complaint was succinctly set out at para. 51 of his factum:

> To deny an Ontarian coverage for a life-saving operation advocated by internationally renowned specialists is inconsistent with the principle of access to health care according to need not according to means. The need in such a case is irrefutable. Also irrefutable is that for most Ontarians, denial of coverage means denial of access to medical treatment.

[82] I would reject this complaint. I am persuaded that the interpretive approach to s. 28.4(2)(a) urged by Mr. Flora is inconsistent with the overall purpose of the Act and the express language of s. 28.4(2)(a).

[83] The Divisional Court described the purpose of the CHA and the Act this way: "[T]he overall purpose of the [CHA] and the [Act] is to provide access to health care on the basis of medical need, not ability to pay." Later in its reasons, the Divisional Court elaborated on the legislative scheme embodied in the Act, indicating that it was designed "to provide insurance coverage against the cost of insured services on a non-profit basis on uniform terms and conditions available to all residents of Ontario". Under this scheme, "Health professionals determine which medical services are appropriate in the treatment of their patients." I do not understand Mr. Flora to challenge these statements.

[84] Mr. Flora also accepts the Divisional Court's characterization of the purpose of s. 28.4(2) of the Regulation:

> [Section 28.4(2)] ensures that funding of out-of-country medical treatments is provided fairly and equally in a manner that upholds Ontario's medical and ethical standards, while protecting vulnerable Ontario patients in a responsible, cost-effective manner.
>
> ....
>
> Limiting the funding of out-of-country medical treatments to those that are "generally accepted in Ontario" ensures that public funds are not spent on treatments that are inconsistent with the ethics and values of the Ontario medical profession and the Ontario public. This safeguards the integrity of the health care system.

[85] Several features of this legislative regime must be emphasized. The funding provided by the Act does not extend to all medical treatments or procedures. Only those medical services that the legislature has determined should be included as "insured services" qualify under the Act for reimbursement by OHIP.

[86] The legislative regime is a funding scheme. The Act specifies only those health services that will be financed – in whole or in part – from public funds. The Regulation, in turn, sets out those services that are covered under the funding scheme. It remains the

task of health care professionals to determine the nature of the medical services to be provided to a particular patient.

[87] In this context, s. 28.4(2)(a) of the Regulation entitles residents of Ontario to public funding for the same medical services received outside Ontario as those received within the province that are eligible for reimbursement from OHIP.

[88] However. s. 28.4(2)(a) contains an important limitation on access to public funds for medical services. Funding is provided only where the medical treatment is "generally accepted in Ontario as appropriate for a person in the same medical circumstances [as the reimbursement claimant]". As I have attempted to underscore earlier in these reasons, the incorporation of an "in Ontario" standard into s. 28.4(2)(a) ensures that funding is provided only to the extent that the treatment in question is regarded as appropriate, having regard to the patient's medical circumstances and the medical standards, practices and ethics recognized in this province. I agree with the Divisional Court that:

> This limitation seeks to balance the overall objective of access to health care on the basis of medical need with the goal of ensuring that funding for out-of-country treatments is only provided to the extent that Ontarians would be entitled to receive funding within Ontario, if the treatment were available here.

[89] The Board also recognized this regulatory purpose when it stressed in its reasons that the funding test under s. 28.4(2)(a) is "whether the treatment is generally accepted *in Ontario* as appropriate". [Emphasis in original.]

[90] There is simply nothing in the Act or s. 28.4(2) of the Regulation to suggest that the funding criteria established by s. 28.4(2) are different in kind, or are to be applied any differently, where the appropriateness of the treatment in question is supported by international rather than local medical opinion, or where the nature of the treatment is potentially life-saving. To import such notions into the interpretation of s. 28.4(2) would defeat the equality of access to funded health care envisaged by the Act and the Regulation.

[91] Thus. the interpretative approach urged by Mr. Flora ignores the Ontario-specific standard reflected in s. 28.4(2), as well as the documentary and oral evidence before the Board from Mr. Flora's own Ontario doctors regarding his eligibility for both types of liver transplants.

Conclusion Regarding Reasonableness

[92] I end my analysis of the reasonableness of the Board's decision where I began. Under the formulation of the reasonableness standard articulated in *Dunsmuir*, deference is owed to the Board's decision if it falls within a range of acceptable outcomes that are defensible on the facts and the law and if the justification for the decision is sound,

transparent and intelligible. I have no hesitation in concluding that the Board's decision satisfies these requirements. I turn next to Mr. Flora's *Charter* s. 7 claim.

(3) *Charter* Section 7 Claim

[93] Before this court, Mr. Flora renews his claim that s. 28.4(2) of the Regulation offends s. 7 of the *Charter*. He argues that: (i) the denial of his OHIP Application deprived him of access to a life-saving medical treatment, thereby violating his s. 7 rights to life and security of the person; (ii) the state also deprived him of his s. 7 rights by amending, in 1992, a predecessor version of the Regulation that would have provided funding for his LRLT on the basis of medical necessity; (iii) in any event, s. 7 imposes a positive obligation on the state to provide life-saving medical treatments, thus obviating the need for a finding of state action amounting to deprivation; and (iv) finally, s. 28.4(2) does not comport with the principles of fundamental justice. For the reasons that follow, I conclude that Mr. Flora's *Charter* s. 7 claim fails.

[94] In *R. v. Beare*, [1988] 2 S.C.R. 387 at 401, the Supreme Court of Canada described the requirements for the invocation of s. 7 of the *Charter* in these terms:

> To trigger its operation there must first be a finding that there has been a deprivation of the right to 'life, liberty and security of the person' and secondly, that that deprivation is contrary to the principles of fundamental justice.

See also *Blencoe v. British Columbia (Human Rights Commission)*, [2000] 2 S.C.R. 307 at para. 47; *Winnipeg Child and Family Services v. K.L.W.*, [2000] 2 S.C.R. 519 at para. 70; and *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791, *per* McLachlin C.J. and Major J. (Bastarache J. concurring) at para. 109.

[95] The Divisional Court concluded that Mr. Flora had failed to demonstrate that the Regulation constituted a deprivation by the state of his rights to life or security of the person and that this deficiency was fatal to his *Charter* s. 7 claim. I agree.

[96] In *Chaoulli, supra* the Supreme Court was concerned with a Quebec health care-related statute that limited access to private health services by removing the ability to contract for private health insurance in respect of those services covered by provincial public insurance. Chief Justice McLachlin and Major J. held at para. 104: "The *Charter* does not confer a freestanding constitutional right to health care. However, where the government puts in place a scheme to provide health care, that scheme must comply with the *Charter*."

[97] Chief Justice McLachlin and Major J. also held that the potential denial of timely health care for a condition that is clinically significant to a patient's current or future health engages security of the person under s. 7 of the *Charter* (at paras. 111 and 112). Moreover, "[W]here lack of timely health care can result in death, s. 7 protection of life itself is engaged" (at para. 123). See also the reasons of Binnie and LeBel JJ. at para. 200

and Deschamps J. at paras. 38-40.

[98] In *Chaoulli*, the pivotal consideration was the fact that the impugned prohibition on private health insurance "conspired" with excessive costs in Quebec's public health care system to force Quebeckers onto the wait lists that pervaded the public system. It was this connection between the statutory prohibition on private health insurance and the delays in the public system that anchored the *Chaoulli* holding that the wait lists constituted a deprivation of rights protected under s. 7. In other words, the statutory prohibition in issue was directly linked to the harm suffered by Quebeckers who were compelled by the prohibition to rely on the public health care system and to endure the consequences of significant wait lists.

[99] A similar link between state action and delays in accessing health care grounds the Supreme Court of Canada's decision in *R. v. Morgentaler*, [1988] 1 S.C.R. 30. In that case, the Supreme Court concluded that the s. 7 right to security of the person for women was jeopardized by the mandatory therapeutic abortion committee system established by the *Criminal Code*, which forced women who sought abortions to suffer significant delays in treatment with attendant physical risk and psychological suffering. *Morgentaler* at p. 59 *per* Dickson C.J. and at pp. 105-6 *per* Beetz J., Estey J. concurring.

[100] To similar effect is the Supreme Court's decision in *Rodriguez v. British Columbia* (1993), 107 D.L.R. (4th) 342, which holds that governmental interference with a citizen's bodily integrity – such as a criminal law prohibition on assisted suicide – constitutes a deprivation of security of the person under s. 7.

[101] These cases are clearly distinguishable from the case at bar. In contrast to the legislative provisions at issue in *Chaoulli*, *Morgentaler* and *Rodriguez*, s. 28.4(2) of the Regulation does not prohibit or impede anyone from seeking medical treatment. Section 28.4(2) neither prescribes nor limits the types of medical services available to Ontarians. Nor does it represent governmental interference with an existing right or other coercive state action. Quite the opposite. Section 28.4(2) provides a defined benefit for out-of-country medical treatment that is not otherwise available to Ontarians – the right to obtain public funding for certain specific out-of-country medical treatments. By not providing funding for *all* out-of-country medical treatments, it does not deprive an individual of the rights protected by s. 7 of the *Charter*.

[102] This conclusion is supported by the recent decision of this court in *Wynberg v. Ontario* (2006), 82 O.R. (3d) 561. In that case, the claimants asserted a violation of s. 7 in the context of the Ontario government's failure to fund intensive behavioural intervention for autistic children over a certain age. Central to the court's rejection of the s. 7 claim in *Wynberg* was its conclusion that the impugned legislation did not create a mandatory requirement that school-age children attend public school; nor did it otherwise compel such attendance. As a result, the claimants were free to pursue intensive behavioural therapy in the private sector and their s. 7 rights were not violated. Similar

defects apply here in respect of Mr. Flora's s. 7 claim.

Effect of Regulatory Amendment

[103] I would also reject Mr. Flora's claim that the legislature's decision to amend the former version of the Regulation, so as to alter the test for OHIP funding for out-of-country medical services, constitutes a deprivation of rights within the meaning of s. 7.

[104] It seems to me that the decision of this count in *Ferrel v. Ontario (Attorney General)* (1998), 42 O.R. (3d) 97 is a full answer to this claim. In *Ferrel*, Morden A.C.J.O., writing for the court, confirmed that a *Charter* violation cannot be grounded on a mere change in the law. He said (at p. 110): "If there is no constitutional obligation to enact [the legislation at issue] in the first place, I think that it is implicit, as far as the requirements of the constitution are concerned, that the legislature is free to return the state of the statute book to what it was before [the impugned legislation]." Subsequently, in *Lalonde v. Ontario* (2001), 56 O.R. (3d) 505 at para. 94, this court reiterated this principle, stating: "[I]n the absence of a constitutional right that requires the government to act in the first place, there can be no constitutional right to the continuation of measures voluntarily taken, even where those measures accord with or enhance *Charter* values." See also *Baier v. Alberta*, [2007] 2 S.C.R. 673 at paras. 35-36. I therefore turn next to Mr. Flora's assertion that s. 7 imposes a positive obligation on the state to provide, and therefore to fund, life-saving medical treatments.

Claim of Positive State Obligation

[105] The Supreme Court of Canada has expressly left open the question of whether a *positive* right to a minimum level of health care exists under s. 7. In *Gosselin v. Quebec (Attorney General)*, [2002] 4 S.C.R. 429 at paras. 81-83, the court indicated that s. 7 may one day be interpreted to include positive obligations in special circumstances where, at a minimum, the evidentiary record discloses actual hardship.

[106] But, to date, the protection afforded by s. 7 of the *Charter* has not been extended to cases – like this one – involving solely economic rights. As this court stated in *Wynberg, supra* at para. 220, s. 7 of the *Charter* has been interpreted "only as restricting the state's ability to *deprive* individuals of life, liberty or security of the person". [Emphasis in original.] See also *Melanson v. New Brunswick (Attorney General)* (2007), 280 D.L.R. (4th) 69 (N.B.C.A.).

[107] Nor does *Chaoulli* support Mr. Flora's contention that s. 7 imposes positive obligations on the state. Consider again the unequivocal statement by McLachlin C.J. and Major J. at para. 104 of *Chaoulli*: "The *Charter* does not confer a freestanding constitutional right to health care." Moreover, as this court observed in *Wynberg* at para. 222, in *Chaoulli* the claimants did not seek an order requiring the government to fund their private health care or to spend more money on health care: "[O]n the contrary, they sought the right to spend their own money to obtain insurance to pay for private health

care services." On the facts here, there was no law restricting Mr. Flora's ability to spend his own money to obtain a LRLT at a private hospital in England. Indeed, that is precisely what he chose to do.

[108] In my view, on the current state of s. 7 constitutional jurisprudence, where – as here – the government elects to provide a financial benefit that is not otherwise required by law, legislative limitations on the scope of the financial benefit provided do not violate s. 7. On the law at present, the reach of s. 7 does not extend to the imposition of a positive constitutional obligation on the Ontario government to fund out-of-country medical treatments even where the treatment in question proves to be life-saving in nature.

[109] In summary, I agree with the Divisional Court that Mr. Flora failed to establish a deprivation of his rights to life or security of the person under s. 7 of the *Charter*. Moreover, the existing jurisprudence does not permit me to interpret s. 7 as imposing a constitutional obligation on the respondent to fund out-of-country medical treatments beyond those that satisfy the test set out in s. 28.4(2) of the Regulation. In view of these conclusions, it is unnecessary to address Mr. Flora's remaining arguments regarding the conformity of s. 28.4(2) of the Regulation with the principles of fundamental justice.

VI. DISPOSITION

[110] Like the Board and the Divisional Court, I am sympathetic to the difficult circumstances and choices that confronted Mr. Flora when his liver cancer was detected. But as compelling as his situation undoubtedly was, the heart of this appeal concerns the reasonableness of the Board's decision that public funds were not available under the Act to finance Mr. Flora's medical treatment in England. For the reasons given, I see no basis on which to interfere with the Board's decision to affirm the denial of OHIP funding in this case.

[111] I would dismiss the appeal.

[112] The issues raised on this appeal were novel, at least to some extent. Certainly they had implications for the public funding of health care services in Ontario beyond the interests of the involved litigants. These factors tend to support a decision to award no costs of the appeal. However, the parties requested an opportunity to make costs submissions, depending on the disposition of this appeal. Accordingly, if they are unable to agree on costs, and costs are sought by the respondent, the respondent may deliver his brief written costs submissions to the Registrar of this court within fourteen days from the date of these reasons. Mr. Flora shall deliver his brief responding costs submissions to the Registrar within fourteen days thereafter.

RELEASED:

"RJS"
"JUL -4 2008"

"E.A. Cronk J.A."
"I agree E.E. Gillese J.A."
"I agree Robert Sharpe J.A."

23p