

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: *Yu et al v. The Attorney
General of British Columbia,*
2003 BCSC 1869

Date: 20031212
Docket: L032654
Registry: Vancouver

Between:

**RICARD YU, WAYNE DONN, R. LEE HUTTON,
SAMUEL H. KRIKLER, DAVID F. MCFARLAND,
DOUGLAS MULHOLLAND, JAMES W.M. STEPHEN and
GRANT RODEN**

PETITIONERS

And

THE ATTORNEY GENERAL OF BRITISH COLUMBIA

RESPONDENT

And

BRITISH COLUMBIA MEDICAL ASSOCIATION

RESPONDENT

Before: The Honourable Madam Justice Ross

Reasons for Judgment

Counsel for the Petitioners

W. Stanley Martin

Counsel for the Respondent The
Attorney General Of British
Columbia

Gerald W. Ghikas, Q.C.
Robert J.C. Deane

Counsel for the Respondent
British Columbia Medical
Association

W.S. Berardino, Q.C.
Lauri Ann Fenlon

Date and Place of Hearing:

October 27, 2003
Vancouver, B.C.

INTRODUCTION

[1] On August 27, 2003 Order in Council 830 2003, now gazetted as B.C. Reg. 327/2003 (the "Regulation") was made. The Regulation deemed virtually all pathology services, wherever performed, to be "general hospital services" under the ***Hospital Insurance Act***, R.S.B.C. 1996 c. 204. The practical effect of the Regulation is to remove the compensation of clinical pathologists from the regime established under the ***Medicare Protection Act***, R.S.B.C. 1996, c. 286 to deal with the compensation for services rendered by physicians. The result has been a unilateral reduction in fees paid to clinical pathologists for their services.

[2] The petitioners, who are clinical pathologists dealing with clinical pathology testing in the community, bring this application seeking a declaration that the Regulation is void and of no force and effect in that it is *ultra vires*. They are joined by the Respondent, British Columbia Medical Association ("BCMA"), which has the exclusive right and obligation to represent all doctors in the province in their dealings with the Government in relation to publicly funded health care.

[3] The sole issue is whether the Regulation is *ultra vires*. The Attorney General contends that it is not, both because it is expressly authorized by section 5 of the **Hospital Insurance Act** and by reference to the general regulation making authority conferred upon the Lieutenant Governor in Council by section 29(1) of the **Hospital Insurance Act** which refers to the powers of section 41 of the **Interpretation Act**, R.S.B.C. 1996, c. 238.

[4] The petitioners and BCMA submit that the Regulation is *ultra vires* because it exceeds and is inconsistent with the **Hospital Insurance Act** and because it is inconsistent with the overall legislative framework for health care in the province.

STATUTORY FRAMEWORK

[5] The **Hospital Insurance Act** is a part of an integrated legislative scheme dealing with the medicare system in the province. In order to place the Regulation at issue in context, a useful starting place is the **Canada Health Act** R.S.C 1985, c. C-6.

Canada Health Act

[6] In order to qualify for a full cash contribution from the federal Government under the **Canada Health Act**, a province must satisfy the criteria set out in sections 7-12 of the **Act**.

[7] Provisions of this **Act** relevant to these proceedings include the following. The Preamble to this **Act** provides, in part:

-that it is not the intention of the Government of Canada that any of the powers, rights, privileges or authorities vested in Canada or the provinces under the provisions of the **Constitution Act, 1867**, or any amendments thereto, or otherwise, be by reason of this Act abrogated or derogated from or in any way impaired;

[8] Relevant definitions include:

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

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

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

"hospital services" means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely,

(a) accommodation and meals at the standard or public ward level and preferred accommodation if medically required,

(b) nursing service,

(c) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations,

(d) drugs, biologicals and related preparations when administered in the hospital,

(e) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,

(f) medical and surgical equipment and supplies,

(g) use of radiotherapy facilities,

(h) use of physiotherapy facilities, and

(i) services provided by persons who receive remuneration therefore from the hospital,

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

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

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

"surgical-dental services" means any medically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures;

[9] Pursuant to section 7, five criteria are specified that must be met by the health care insurance plan of a province in order that a province may qualify for full cash contribution towards its insured health services and extended health services from the Federal Government. These are:

- (a) public administration;
- (b) comprehensiveness;
- (c) universality;
- (d) portability; and
- (e) accessibility.

[10] With respect to the criterion of public administration, section 8(1) provides:

(1) In order to satisfy the criterion respecting public administration,

(a) the health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority appointed or designated by the government of the province;

(b) the public authority must be responsible to the provincial government for that administration and operation; and

(c) the public authority must be subject to audit of its accounts and financial transactions by such authority as is charged by law with the audit of the accounts of the province.

[11] Such an authority has been established in this province pursuant to the ***Medicare Protection Act***.

[12] To satisfy the criteria of comprehensiveness, the province's health care insurance plan must insure all medically necessary services provided by hospitals and by medical practitioners (s.9 of the ***Act***).

[13] The criterion of accessibility is provided for in section 12 which states:

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

(a) must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons;

(b) must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;

(c) must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and

(d) must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.

2) In respect of any province in which extra-billing is not permitted, paragraph (1) (c) shall be deemed 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.

[14] It is noteworthy that the **Act** contemplates separate regimes relating to health care services provided by medical practitioners and health care services provided by hospitals. It contemplates, as well, that the financial arrangement will be distinct in the two situations with the provincial Government paying reasonable compensation to practitioners, but providing funds to hospitals in respect of the costs of insured health services.

[15] The British Columbia Legislature has enacted two statutes which respond to the requirement of comprehensiveness established in section 9 of the **Canada Health Act**. The **Hospital Insurance Act** provides for funding for health services provided by hospitals. Funding for health services provided by medical practitioners is provided for by the **Medicare Protection Act**. There are two funding sources, and the two **Acts** are complementary and mutually exclusive. A service is insured under either the **Hospital Insurance Act** or the **Medicare Protection Act**, but not under both.

Medicare Protection Act

[16] With respect to the ***Medicare Protection Act***, the Preamble provides:

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.

[17] Thus, the central principles intended to be entrenched by the ***Medicare Protection Act*** as set out in the Preamble reflect the criteria for payment under the ***Canada Health Act***.

[18] The purpose of the ***Medicare Protection Act*** is stated in section 2:

2 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.

[19] The **Medicare Protection Act** defines a diagnostic facility as:

"diagnostic facility" means a facility, place or office principally equipped for

(a) prescribed diagnostic services, studies or procedures, or

(b) the taking or collecting of specimens for purposes of diagnosis, treatment or prevention of illness, injury or disease

and includes any branches of a diagnostic facility;

[20] A key component of the **Medicare Protection Act** is the administration of the Medical Services Plan by an independent Medical Services Commission, the public authority mandated by s.8 of the **Canada Health Act**. Section 3(1) of the **Medicare Protection Act** provides for the make-up of the Commission: three members of the Commission are appointed by the BCMA, three by the Government and three are jointly selected by the BCMA and the Government to represent the public. Each member has one vote and the majority rules (s.3(8) and (9)).

[21] The Medical Services Commission is a tripartite Commission representing the Government, the medical profession and the public. It is continued by section 3. The function of the Commission is described in section 3(3) of the **Medicare Protection Act** as follows:

The Medical Services Plan established under the former Act is continued and the function of the commission is to facilitate, in the manner provided for in this Act, reasonable access, throughout British Columbia, to quality medical care, health care and diagnostic facility services for residents of British Columbia under the Medical Services Plan.

[22] It is clear, therefore, that the Commission was intended by the Legislature to have a central role with respect to diagnostic facility services under the Medical Services Plan.

[23] The responsibilities of the Commission pursuant to section 5 include: to administer the **Medicare Protection Act** on a non-profit basis; to receive premiums that are payable by beneficiaries; to determine whether a service is a benefit or whether any matter is related to the rendering of a benefit. The Commission establishes payment schedules that specify the fee a doctor will receive for rendering a particular health service (section 26(1)(a)). There are provisions requiring the Medical Services Commission to pay for the services provided by doctors and to do so in a manner and within the timeframes mandated by the Regulations (section 27).

[24] It is noteworthy that pursuant to section 5(2), the Commission is not to exercise its powers in a way that does not satisfy the criteria in section 7 of the **Canada Health Act**.

[25] Section 13 of the *Medicare Protection Act* provides in part:

13 (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.

(4) Payments for benefits performed in an approved diagnostic facility must be paid to the practitioner who was responsible for rendering the benefit.

[26] With respect to limits on billing, section 17 provides:

17 (1) Except as specified in this Act or the regulations or by the commission under this Act, a person must not charge a beneficiary

(a) for a benefit, or

(b) for materials, consultations, procedures, use of an office, clinic or other place or for any other matters that relate to the rendering of a benefit.

(2) Subsection (1) does not apply:

(a) if, at the time a service was rendered, the person receiving the service was not enrolled as a beneficiary;

(b) if, at the time the service was rendered, the service was not considered by the Commission to be a benefit;

(c) if the service was rendered by a practitioner who

(i) has made an election under section 14(1),
or

(ii) is subject to an order under section 15(2)(b);

(d) if the service was rendered by a medical practitioner who is not enrolled.

[27] Payment schedules and benefit plans are dealt with pursuant to section 26, as follows:

26 (1) The commission

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

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

(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.

[28] Finally, the powers and responsibilities of the Commission with respect to the approval of a diagnostic facility for the purposes of permitting benefits to be performed in it are detailed in Part 6 of the **Medicare Protection Act**.

Hospital Act

[29] The next relevant statute is the **Hospital Act** R.S.B.C. 1996 c. 200. Section 1 of the **Act** defines "hospital" as:

"hospital", except in Parts 2 and 2.1, means a nonprofit institution that has been designated as a hospital by the minister and is operated primarily for the reception and treatment of persons

(a) suffering from the acute phase of illness or disability,

(b) convalescing from or being rehabilitated after acute illness or injury, or

(c) requiring extended care at a higher level than that generally provided in a private hospital licensed under Part 2;

[30] Section 4(1) provides that a hospital must not refuse to admit a person on account of the person's indigent circumstances.

[31] The *Hospital Act* imposes certain general requirements on acute care hospitals (Part 1) and provides a detailed regime with respect to private hospitals (Part 2). It empowers the Minister to withhold payments to a hospital if it does not comply with a statute or if it is not administered in a manner satisfactory to the Minister (section 47).

[32] For purposes of this application, the most noteworthy aspect is that the statutory regime applicable to hospitals is quite distinct from the regime which applies to medical practitioners or diagnostic facilities under the *Medicare Protection Act*.

Hospital Insurance Act

[33] The final statutory component in this integrated scheme is the ***Hospital Insurance Act***. This **Act** provides the scheme under which hospitals are funded for the hospital services they provide to residents of the province.

[34] Relevant definitions under the ***Hospital Insurance Act*** include:

"benefits" means the general hospital services authorized under this Act;

"hospital" means, except in sections 24 and 29 (2) (a),

(a) a hospital as defined by section 1 of the *Hospital Act* that has been designated under this Act by the Lieutenant Governor in Council as a hospital required to provide the general hospital services provided under this Act,

(b) a private hospital as defined by section 5 of the *Hospital Act* with which the government has entered into an agreement requiring the hospital to provide the general hospital services provided under this Act,

(c) a hospital owned and operated by Canada that has been designated under this Act a "federal hospital",

(d) an agency or establishment that

(i) provides a service to hospitals or a health service and

(ii) has been designated as a hospital facility by the Lieutenant Governor in Council, or

(e) an establishment in which out patient services are available that has been designated a diagnostic and treatment centre by the Lieutenant Governor in Council for providing out patient benefits to

beneficiaries in accordance with this Act and the regulations;

[35] The general hospital services provided under the ***Hospital Insurance Act*** are defined in section 5 as follows:

5 (1) Except as provided in subsection (2), the general hospital services provided under this Act are the following:

a) for qualified persons requiring treatment for acute illness or injury, the public ward accommodation, necessary operating and case room facilities, diagnostic or therapeutic X-ray and laboratory procedures, anesthetics, prescriptions, drugs, dressings, cast materials and other services prescribed by regulation;

(b) for qualified persons requiring active treatment for chronic illness or disability, the public ward accommodation, physiotherapy and occupational therapy, minor operating room and diagnostic X-ray and laboratory services, prescriptions, drugs, dressings, cast materials and other services prescribed by regulation;

(c) for qualified persons requiring treatment or diagnostic services as out patients, the out patient treatment or diagnostic services prescribed by regulation.

(2) General hospital services under this Act do not include the following:

(a) transportation to or from hospital;

(b) services or treatment that the minister, or a person designated by the minister, determines, on a review of the medical evidence, the qualified person does not require;

(c) services or treatment for an illness or condition excluded by regulation of the Lieutenant Governor in Council.

[36] By virtue of section 8 hospitals must provide services to Beneficiaries.

8 Every hospital must provide for beneficiaries those public ward facilities, including necessary operating and case room facilities, X-ray and laboratory diagnostic and therapeutic procedures, anesthetics, and other services, dressings and drugs the Lieutenant Governor in Council requires or provides for under regulations.

[37] Beneficiaries pay no or limited charges for hospital services. The **Medicare Protection Act** provides in section 9 that the hospitals are paid annually an amount determined by the Minister to reimburse the hospital for all or part of the cost of providing hospital services to beneficiaries.

[38] The Minister of Health Services has the powers and duties under the statute. Under the **Hospital Insurance Act** there is no body equivalent to the Medical Services Commission under the **Medicare Protection Act**.

[39] Finally, the power to make regulations is found in section 29 which provides in part:

29 (1) The Lieutenant Governor in Council may make regulations referred to in section 41 of the *Interpretation Act*.

(2) Without limiting this section, the Lieutenant Governor in Council may make regulations for the following:

...

(b) the facilities and services that hospitals in British Columbia as a group or individually must provide for beneficiaries under this Act in order to qualify them for payment by the government, and the amount of the payment to hospitals;

...

(f) the hospital treatment and services referred to in section 5 for which payment must be included in the amounts paid to hospitals;

[40] That final provision has now been amended in the **Health Services Statutes Amendment Act**, Bill 33, to provide "the treatment and services referred to in section 5".

[41] This amendment is part of a wider program of reorganization instituted by the Government. Until relatively recently most health care services, including hospitals, were managed by an array of boards, councils and societies. In late 2001, these bodies were amalgamated into five regional health authorities: the Northern Health Authority, the Interior Health Authority, the Vancouver Island Health Authority, the Vancouver Coastal Health Authority and the Fraser Health Authority. Each regional health authority is responsible for planning, coordinating and delivering health care services, including hospital services, within its respective region. The Provincial Health Services Authority is responsible for governing and administering provincial programs and highly specialized services.

[42] Section 15.2 of the *Health Authorities Act*, R.S.B.C. 1996, c.180 provided that all of the property, rights, debts and obligations of the existing hospital boards, such as hospitals themselves, passed to and vested in the new health authority boards. Where the province owned a hospital or health care facility, s. 17 of the *Health Authorities Act* entitled it to transfer that facility to the board of the relevant regional health authority.

[43] Therefore, for the purposes of ownership, funding and management, hospitals are no longer discrete physical premises held by individual hospital boards or societies. They are now owned, administered, managed and funded by the boards of the health authorities.

[44] To reflect this change in responsibilities and funding, the *Hospital Insurance Act* was amended by the *Health Services Statutes Amendment Act*, 2003, S.B.C. 2003, c.33. Section 5 of the *Health Services Statutes Amendment Act*, 2003 repeals s. 9 of the *Hospital Insurance Act* which provides for an amount to be paid to "every hospital" and replaces it with a provision requiring payments to be made to each of the regional health boards, the Nisga's Nation, and the Provincial Health Services Authority. Consequential amendments were also made to ss. 1, 5, 10(2), 12, and 29(2) of the *Hospital Insurance Act*.

FACTUAL BACKGROUND

[45] The petitioners are pathologists who practice in a variety of community and hospital lab settings in the province. There were approximately 200 pathologists practising in British Columbia in the 2001-2002 fiscal year. These pathologists, exemplified by the petitioners, have various types of working arrangements:

- (a) some of these pathologists work exclusively within hospitals and receive salaries (or compensation through contractual arrangements) from the respective regional health authorities;
- (b) other pathologists are partners in, or employees of, organizations such as Metro McNair Laboratories Ltd., Valley Medical, Dr. C.J. Coady & Associates (whose 50 partners also own and operate B.C. Biomedical Laboratories Ltd.), or other pathologist associations; and
- (c) some pathologists both work in hospitals on salary or contract from the respective regional health authorities while at the same time being a partner in, or employee of, one of the private laboratory testing services or pathologist associations.

[46] Clinical pathology testing covers various diagnostic procedures and tests which are performed on both hospital in-patients and ambulatory patients. The general categories are haematology (blood tests), microbiology and chemistry. Some pathology testing is essentially performed only in hospitals, for example, anatomical pathology and transfusion medicine.

[47] Pathology testing does not include other diagnostic medical procedures, such as diagnostic radiology, nuclear medicine, diagnostic ultrasound, CAT, MRI and PET scans and electro-diagnosis.

[48] Clinical pathology testing can be performed on ambulatory patients in the community; hospital outpatients, hospital in-patients; and patients who attend at a hospital emergency department.

[49] In hospitals and small community laboratories, it is common for the collection of specimens and the conduct of some of the analytical procedures to take place in the same facility. In the case of the larger private labs, specimen collection takes place in a facility which is approved for this purpose only (a "collection centre" or "bleeding station") and analytical procedures are conducted at a central facility which is not approved for specimen collection.

[50] At present, each community lab facility or specimen collection facility, is an approved diagnostic facility under the **Medicare Protection Act** and is also accredited by the Diagnostic Accreditation Program of B.C.

[51] A patient referred by a physician in the community for pathology testing may attend at a hospital lab as an out-patient or may attend at a community lab.

[52] Hospital labs see patients who fall into three categories: hospital in-patients, hospital outpatients, and emergency department patients. The hospital out-patients are referred by a physician in the community.

[53] Most clinical pathology testing procedures fall within fee items in the Medical Services Plan payment schedule and are included in the BCMA Guide to Fees. This guide sets out both the Medical Services Plan fees and the BCMA recommended fees for procedures which fall outside the Medical Services Plan schedule. The BCMA Guide also divides fees between a technical component which represents the laboratory overheads and a professional component, which is deemed payable to the responsible laboratory physician.

[54] Clinical pathology testing for patients seen at community labs or as out-patients at hospital labs has historically been covered under the Medical Services Plan.

[55] In respect of procedures which are covered under the Medical Services Plan, a billing is submitted to the Medical Services Plan under the billing number of the relevant pathologist. Where the billing is in respect of an out patient at a hospital laboratory, the typical but not invariable arrangement is for the hospital to receive the technical component and the pathologist to receive the professional component of the fee.

[56] Clinical pathology testing for hospital in-patients, surgery patients and emergency room patients has been funded by the Government to the hospital under the ***Hospital Insurance Act***.

[57] In November, 2002 the Ministry of Health announced a comprehensive review of the province's laboratory services. As part of that process, Lillian Bayne, a consultant for the province, delivered a report entitled *B.C. Laboratory Services Review Report* in July, 2003.

[58] On July 9, 2003, the Government announced that it planned to reform laboratory services. The Government plans, outlined

in various documents released on that date, included a reduction in fees for laboratory tests on September 1, 2003 by 8% and on April 1, 2004 by a further 12%. The Government also announced a plan to consolidate funding for laboratory services. The Government announcement did not set out any legal route by which the Government would achieve fee reductions or consolidation of funding.

[59] Then, on August 27, 2003, the Regulation at issue in this proceeding, Order in Council No. 830/2003 was made. The provision reads:

On the recommendation of the undersigned, the Administrator, by and with the advice and consent of the Executive Council, orders that effective September 1, 2003, the Hospital Insurance Act Regulations, B.C. Reg. 25/61, is amended by adding the following section:

- 5.24 (1) In this section, "pathology services" means, subject to subsection (3), the laboratory analysis of any blood, tissue, or body fluid by any process method and includes, but is not limited to, the following:
- (a) analytical, immunological, or molecular biological assays;
 - (b) haematology, clinical chemistry, transfusion medicine, cytogenetics, gross and histological (microscopic) anatomic pathology, and microbiology and virology tests.
- (2) If pathology services are ordered for a qualified person by a medical

practitioner, dentist, podiatrist, or midwife for the purpose of diagnosis, clinical management, or early detection or prevention of congenital or acquired disease, these services are general hospital services.

- (3) Pathology services do not include the laboratory procedures listed in Schedule B if they are performed by a physician for or on his or her own patients without a referral. - C. HANSEN, *Presiding Member of the Executive Council*.

SCHEDULE B

Candida Culture
E.C.G. tracing, without interpretation
Examination for pinworm ova
Fern Test
Fungus, direct examination, KOH preparation
Glucose - semiquantitative (dipstick analysed visually or by reflectance meter)
Haemoglobin - cyanmethaemoglobin method, and/or haematocrit
Haemoglobin - other methods
Occult blood - faeces
Pregnancy test, immunologic - urine
Secretion smear for eosinophils
Sedimentation rate
Sperm, seminal examination for presence or absence
Stained smear
Trichomonas and/or Candida, direct examination
Urinalysis - Chemical or any part of (screening)
Urinalysis - Microscopic examination of centrifuged deposit
Urinalysis - Complete diagnostic, semi-quant and micro
White cell count only

[60] The effect of the Regulation is to deem virtually all pathology services, wherever performed, to be "general

hospital services" under the *Hospital Insurance Act*. The Government's announced position is that the effect of OIC 830/2003 is to move designated laboratory services, previously covered by the *Medicare Protection Act*, under the *Hospital Insurance Act*.

[61] Pathologists have continued to submit billings under their billing numbers to the Medical Services Plan for services provided after September 1, 2003, but payments received from the Government have been reduced by 8%. On the figures announced by the Government, this represents an aggregate reduction in payments of about \$2 million per month from the amount paid by the Medical Services Plan prior to September 1, 2003. The Government's announced plan is to reduce aggregate payments for such services by approximately \$5 million a month starting April 1, 2004 from the pre-September 1, 2003 level.

[62] The significance of this must be viewed in the context of the existing arrangements for payment of doctor's services under the *Medical Protection Act*. The BCMA, which the Government has appointed as the sole and exclusive bargaining agent for physicians, is a signatory, along with the Government and the Medical Services Commission, to a number of

agreements which govern the delivery of medical services under the **Medicare Protection Act**.

[63] One of the key agreements is called the Second Master Agreement. This Agreement deals with fundamental aspects of medicare. It tracks the **Medicare Protection Act** and provides that the Medical Services Commission will have nine members, three appointed by the BCMA, three by the Government, and three joint appointments to represent the public (Article 7.2). The Agreement says that the Government will give a sum of money called the "available amount", to the Medical Services Commission to pay for doctor's services (Article 8). The Agreement also sets up a process for setting the fee to be paid to a doctor for each service and states that the fees cannot be changed except in accordance with the process set out in the Agreement (Articles 16 and 17). The Agreement also says that these items cannot be removed from the fee schedule without agreement of the BCMA, the Government, and the Medical Services Commission (Article 17.2).

[64] After a lengthy bargaining process, the Government and the BCMA entered into a Memorandum of Agreement. Article 14(b) of the Memorandum of Agreement provides for fee increases to the fee schedule for physicians under the Medical Services Plan in accordance with the process set out in the

Second Master Agreement. The laboratory pathologists were allocated a fee increase of 9.8% effective April 1, 2002. This allocation was presented to the Ministry of Health Services and approved by the Medical Services Commission.

[65] Part of the laboratory reform initiative implemented under Order in Council 83/2003 is a reduction of the fees paid to laboratory pathologists by 8% as of September 1, 2003, and by a further 12% as of April 1, 2004. In other words, although the Government agreed to increase fees paid to laboratory pathologists by 9.8% in the spring of 2002, using Order in Council 830/2003 it has unilaterally taken back that increase and has imposed a further 10.2% reduction by April 1, 2004.

[66] The question of whether that conduct amounts to a breach of the Memorandum of Agreement is presently the subject of arbitration pursuant to the provisions of the Agreement.

LEGAL PRINCIPLES

[67] Regulations, as delegated legislation, may only be validly enacted if they are strictly in accordance with the regulation-making power and within the spirit of the enabling statute. Regulations may neither exceed nor be inconsistent with the statutory provisions under which they are made; see *R. v. National Fish Co. Ltd.*, [1931] Ex.C.R. 73 at 81-82.

[68] The application of this principle of conformity was addressed in *Waddell v. Schreyer* (1983), 5 D.L.R. (4th) 254 (B.C.S.C.). In that decision Mr. Justice Lysyk stated at 271 and 272:

In determining the scope of a power or discretion delegated by Parliament it may be necessary to look beyond the literal terms of the particular delegating provision of the enactment to ascertain limitations on that power or discretion which must have been intended by Parliament.

...

...In determining whether impugned subordinate legislation has been enacted in conformity with the terms of the parent statutory provision, it is essential to ascertain the scope of the mandate conferred by Parliament, having regard to the purpose(s) or objects(s) of the enactment as a whole. The test of conformity with the Act is not satisfied merely by showing that the delegate stayed within the literal (and often broad) terminology of the enabling provision when making subordinate legislation. The power-conferring language must be taken to be qualified by the overriding requirement that the subordinate legislation accord with the purposes and objects of the parent enactment read as a whole.

[69] Just as subordinate legislation cannot conflict with its parent legislation, it cannot conflict with another Act unless a statute so authorizes, see *Friends of the Oldman River Society v. Canada (Minister of Transport)*, [1992] 1 S.C.R. 3 at 38 per La Forest J.

[70] There is a presumption of validity, see *Re Heppner and Minister of the Environment for Alberta* (1977), 80 D.L.R. (3d)

112 at 118 per Lieberman J.A. for the Court (Alta. S.C. (A.D.)). As a matter of construction, where possible, an interpretation that permits reconciliation will be preferred, see *Friends of the Oldman*, supra, at 38.

[71] Extrinsic evidence may be considered in relation to the question of the purpose of the statute, see *Re Heppner*, supra, at 119.

[72] It is not for the court to second guess the Government with respect to the wisdom of its policy decisions, as Chief Justice McEachern, as he then was, stated in *British Columbia Civil Liberties Association v. British Columbia (Attorney General)* (1988), 24 B.C.L.R. (2d) 189 at 191 (B.C.S.C.):

It must not be assumed that this Court has a free hand to second-guess either the legislature or the Cabinet. All courts are bound by the pronouncement of the Supreme Court of Canada in *Thorne's Hardware Ltd. et al v. The Queen*, [1983] 1 S.C.R. 106, 143 D.L.R. (3d) 577 at 580-81, (S.C.C.) 46 N.R. 91 [Fed.] where Dickson, J., (as he then was), speaking for the Court, said:

"The mere fact that a statutory power is vested in the Governor in Council does not mean that it is beyond judicial review: *Attorney General of Canada v. Inuit Tapirisat of Canada*, [1980] 2 S.C.R. 735 at p. 748. I have no doubt as to the right of the courts to act in the event that statutorily prescribed conditions have not been met and where there is therefore fatal jurisdictional defect. Law and jurisdiction are within the ambit of judicial control and the courts are entitled to see that statutory procedures have been properly complied with: *The King v. The National Fish*

Co., [1931] Ex. C.R. 75; *Minister of Health v. The King* (Ex p. Yaffe), [1931] A.C. 494 at p. 533.

Decisions made by the Governor in Council in matters of public convenience and general policy are final and not reviewable in legal proceedings. Although, as I have indicated, the possibility of striking down an order in council on jurisdictional or other compelling grounds remains open, it would take an egregious case to warrant such action. This is not such a case."

ANALYSIS

[73] The first issue to be considered is whether the Regulation is expressly authorized as falling within the scope of section 5(1)(c) of the *Hospital Insurance Act*, the provision of diagnostic services for out-patients:

5 (1) Except as provided in subsection (2), the general hospital services provided under this Act are the following:

...

(c) for qualified persons requiring treatment or diagnostic services as out patients, the out patient treatment or diagnostic services prescribed by regulation.

[74] The Respondent Attorney General submits that the term out-patient as used in the section refers to everyone who is not an in-patient, in other words, for purposes of that section everyone who is not a patient in a hospital is an out-patient.

[75] If that is so, then the Regulation is indeed within the express language of the *Hospital Insurance Act*. It would, however, also mean that all treatment and diagnostic services for persons not in hospital are in fact "general hospital services" within the scope of the section.

[76] In support of this construction, the Attorney General relies upon extrinsic evidence demonstrating usage consistent with this interpretation of the definition of out-patient. The petitioners respond that the ordinary definition of the term is not consistent with that usage. The petitioners note that the ordinary dictionary definition of "out-patient" is:

- (a) "A person who receives treatment at a hospital without being hospitalized."

The Canadian Oxford Dictionary (1998)

- (b) "A patient who attends a hospital without staying there overnight. Opp. *In-patient*."

New Shorter Oxford English Dictionary (1993)

- (c) "A person who is received in a hospital for examination or treatment or both, but who is not admitted as a patient."

D.A. Dukelow, *Pocket Dictionary of Canadian Law (3rd Ed)*, (Toronto: Thomson Canada Ltd, 2002)

[77] Since both definitions of the term are apparently possible, it is necessary to consider the term in the context

of the **Hospital Insurance Act** in order to ascertain the scope of the mandate conferred by the Legislature.

[78] In that regard, the Attorney General emphasizes that the scheme created by the statutes is not a place based system and that the Regulation must be understood in the context of the reforms that have taken place with the institution of funding through Regional Health Authorities.

[79] In **Brown v. British Columbia (Attorney General)** (1997), 41 B.C.L.R. (3d) 265 (S.C.) at 280, Mr. Justice Hunter concluded that the purpose of the **Hospital Insurance Act** is "to provide the means with which the Government must create a hospital insurance plan for its residents".

[80] The petitioners submit that it is no part of the **Hospital Insurance Act's** purpose to provide for medical services required by residents outside the hospital context. That purpose is the function of the **Medicare Protection Act**. The **Hospital Insurance Act** is only designed to fund hospitals and not to be the vehicle for compensation to medical practitioners who have billing numbers under the **Medicare Protection Act**. Moreover, the petitioners submit this distinction between the two regimes for health coverage is fully consistent with section 12 of the **Canada Health Act**.

[81] They submit further that first, "hospital" is carefully defined by section 1 of the *Hospital Insurance Act*. Community labs, while they are approved as diagnostic facilities under the *Medicare Protection Act*, are not hospitals for the purpose of this definition or for the purpose of any other definition in the provincial statutes relating to hospitals. Further, they are not hospitals in the ordinary meaning of that term.

[82] Second, the *Hospital Insurance Act* defines the obligation of hospitals to provide services for beneficiaries. This is the function of section 8. Those services include public ward facilities, necessary operating and case room facilities, x-ray and laboratory diagnostic and therapeutic procedures and anesthetics. The concern of this statute with respect to diagnostic facilities is only with the situation where hospitals are required to provide them.

[83] Third, the purpose of defining "general hospital services" under section 5(1) of the *Hospital Insurance Act* is to identify "benefits". The "benefits" are what the beneficiaries receive under this "insurance" scheme, and which they cannot be charged for with certain exceptions by the hospital or any other person. All of this is consistent with the intent of the *Act* being limited to hospital insurance.

[84] Fourth, the term "general hospital services" in section 5(1) and elsewhere in the statute is completely consistent with this reading. The **Hospital Insurance Act** is only concerned with *hospital* services.

[85] Fifth, the particular services referred to in section 5(1)(a), (b) and (c) all appropriately describe services which may be provided by a hospital. There is nothing in section 5(1) to suggest any intent that non-hospital services be included.

[86] Accordingly, the petitioners submit both as an ordinary matter of language, and in the context of the statute, the term should be given its natural meaning. **The Hospital Insurance Act** does not authorize a regulation which deems services to be hospital services which may have no connection whatsoever with a hospital.

[87] The petitioner submits further that this usage is consistent with the usage of "out-patient" and "in-patient" in the other provisions which fall in Division 5, "Benefits", of the **Hospital Insurance Act Regulations**. In a number of instances these provisions contrast these terms in ways which make it clear that the assumption is that the out-patients are receiving hospital treatment or examination. Thus:

(a) Section 5.1 refers to the services which are available or in through the hospital to which the person is admitted as an in-patient, "provided that no qualified person shall be entitled to received, as an in-patient benefit, any treatment or diagnostic service not connected with an illness or condition which necessitates the person's being treated as an in-patient and which could normally be rendered to such person as an out-patient".

(b) Pursuant to s.5.10, "Out-patient cancer therapy" is available to beneficiaries in facilities operated by the Cancer Control Agency which have been designated in writing by the Minister. This presumably reflects the designation of a facility under the definition of "hospital" in the *Hospital Insurance Act*.

[88] The petitioners submit further that, even as amended by Bill 33, the mechanism and nature of payments made under the *Hospital Insurance Act* is a powerful indication that the only services which can be prescribed as "general hospital services" are those provided by the hospitals themselves. The *Hospital Insurance Act* cannot be used as an alternate statutory basis for fee for service medicare.

[89] Finally it is submitted by both the petitioners and the BCMA that the Regulation is inconsistent with the scheme of provincial health care legislation and in particular with the **Medical Protection Act** and the **Canada Health Act**.

[90] The Attorney General has noted in submissions that legislation with respect to the provision of health care is within the legislative sphere of the province and that accordingly, the province is free to pass legislation that is inconsistent with the **Canada Health Act**. I agree that both those propositions are correct. However, the **Medicare Protection Act** is provincial legislation, and is part of the integrated scheme for the provision of health care in the province. Moreover, that **Act** in section 5(2) contemplates that the Commission will act in a manner that satisfies the criteria of the **Canada Health Act**.

[91] Therefore, in my view, it is appropriate to consider whether the Regulation is inconsistent with the scheme of provincial health care legislation of which the **Medicare Protection Act** is a crucial part. In that respect it is submitted that it is clear that the Regulation is fundamentally inconsistent with that scheme. Indeed the BCMA took the position that the Regulation mocks the integrated scheme in that it ignores and defies the central elements of

that scheme as they relate to the payment of physicians for their services.

[92] In particular, there is under the Regulation no provision for negotiation for compensation between the province and the provincial organization that represents medical practitioners as required by section 12(2) of the **Canada Health Act** and as is manifest in the arrangements made pursuant to the **Medicare Protection Act**. There is no provision for the settlement of disputes relating to compensation through conciliation or binding arbitration under the Regulation as required by section 12(2) of the **Canada Health Act** and as manifest in the arrangements made pursuant to the **Medicare Protection Act**.

[93] I have concluded that the term "out-patient" as used in section 5 of the **Hospital Insurance Act** was not intended by the legislature to have the extended meaning proposed by the Attorney General, but was intended to be limited to services provided by hospitals. This meaning is consistent with the purpose of the **Hospital Insurance Act** and with the usage of the term in that **Act**. Accordingly, the Regulation is not expressly authorized by section 5 of that **Act**.

[94] In addition I have concluded, for the reasons outlined above from the submissions of the petitioner and the BCMA, that that Regulation is inconsistent with the **Hospital**

Insurance Act and with the overall legislative framework for health care in the province. The legislature intended the **Hospital Insurance Act** to deal with hospital services. It exceeds and is inconsistent with that purpose to deem services that are not hospital services and that have no connection with a hospital services to be hospital services. The legislature did not intend the whole framework for compensation of physicians to be circumvented in such a fashion.

[95] The Attorney General submits that the Regulation is authorized pursuant to section 41(1)(a) of the **Interpretation Act** which provides:

41 (1) If an enactment provides that the Lieutenant Governor in Council or any other person may make regulations, the enactment must be construed as empowering the Lieutenant Governor in Council or that other person, for the purpose of carrying out the enactment according to its intent, to

(a) make regulations as are considered necessary and advisable, are ancillary to it, and are not inconsistent with it.

[96] The Attorney General submits that the Regulation is part of a plan to improve delivery of laboratory services.

Services within hospitals, which clearly fall within the scope of section 5 of the **Hospital Insurance Act**, will be improved as part of the overall improvement.

[97] The Attorney General submits further that it is not for this Court to second guess the wisdom of the policy. I agree that that is not the role of the Court. However, the power to pass regulations pursuant to section 41(1)(a) of the **Interpretation Act** is limited by the requirement that the Regulation cannot be inconsistent with the Act. In **Bay Travel Centre Ltd. v. Registrar of Travel Services**, [1981] B.C.J. No. 1033, McLachlin Co.Ct.J, as she then was, stated at paragraph 24:

It is well-established that regulations may neither exceed nor be inconsistent with the statutory provisions under which they are made. If they do, they constitute attempts to legislate by adding to or amending the statute, and will be held to be *ultra vires*: **Belanger v. The King**, (1916) 34 D.L.R. 221; 54 S.C.R. 265. The delegated authority must be exercised strictly and in accordance with the enabling statute; regulations may neither enlarge nor abridge the scope or substance of the delegated power: **King v. National Fish Co. Ltd.** (1931) Ex. C.R. 75. The proper method of construction is to read the enabling statute together with the regulations, so that any excess of power assumed by the body entrusted with the duty of making the regulations is revealed: **King v. National Fish Co. Ltd.** (1931) Ex. C.R. 75.

[98] In this case I have found that the Regulation exceeds and is inconsistent with the **Hospital Insurance Act** and related legislation. Accordingly, the Regulation, as subordinate legislation, however wise a policy it may reflect, cannot be authorized pursuant to section 41 of the **Interpretation Act**.

CONCLUSION

[99] For the reasons given I have concluded that the Regulation is *ultra vires* and accordingly grant a declaration that Order in Council 830 made August 27, 2003 which amends the ***Hospital Insurance Act Regulations***, B.C. Reg. 25/61, effective September 1, 2003 by adding section 5.24 is void and of no force and effect in that it is *ultra vires*.

"Ross J."

The Honourable Madam Justice C. Ross