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An (In)conceivable Question: Do Provincial Governments Discriminate Against the Infertile by Not Paying for IVF and ICSI Services?

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AN (IN)CONCEIVABLE QUESTION: DO PROVINCIAL GOVERNMENTS DISCRIMINATE AGAINST THE INFERTILE BY NOT PAYING FOR IVF AND ICSI SERVICES?

A COMMENT ON *CAMERON AND SMITH* v. *NOVA SCOTIA (A.G.), THE MINISTER OF HEALTH, THE DEPARTMENT OF HEALTH AND THE ADMINISTRATOR, INSURED PROFESSIONAL SERVICES*

KATE DEWHIRST†

It has been 20 years since the birth of the world's first "test tube" baby. Since then, new reproductive technologies have helped many people realize their dream of having a child. The path to realizing that dream, however, is not an easy one. In addition to the physical and emotional challenges they pose, the new high-tech procedures that assist infertile people in having children can be very expensive. Services such as *in vitro* fertilization (IVF) and intracytoplasmic sperm injection (ICSI) are not covered under most provincial health insurance plans.[1] The recent case of *Cameron and Smith* v. *Nova Scotia (A.G.), the Minister of Health, the Department of Health and the Administrator, Insured Professional Services* [2] is the latest attempt at finding a legal solution to at least some of the economic barriers infertile people face in seeking treatment.

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[1] Ontario is the only province to provide coverage for IVF. The Ontario Health Insurance Plan (OHIP) pays for IVF treatment, but only for women experiencing bilateral fallopian blockage. ICSI is not included in any provincial health insurance scheme in Canada.

[2] *Cameron and Smith* v. *Nova Scotia (A.G.), the Minister of Health, the Department of Health and the Administrator, Insured Professional Services* (5 February 1999), S.H. 137396 (N.S.S.C.) [hereinafter *Cameron*].

Alex Cameron suffers from severe "male factor infertility" that reduces the count and quality of his sperm. He and his wife, Cheryl Smith, would like to have a child that is genetically related to both of them, but they have been unable to conceive due to Mr. Cameron's infertility. They have tried a number of assisted reproduction procedures, including, most notably, IVF with ICSI. As neither IVF nor ICSI is covered by provincial health insurance, the couple sued the Nova Scotia Minister of Health, the Department of Health, and the Administrator of Insured Professional Services to recover out-of-pocket costs for their treatment. Through this case, they sought a declaration that the refusal of the Nova Scotia Health Care Insurance Program to cover the costs of IVF and ICSI is unlawful.

In his February 1999 decision, the Honourable Chief Justice Joseph Kennedy found in favour of the defendants. Kennedy identified two types of legal argument submitted by the plaintiffs: an administrative law argument and a *Canadian Charter of Rights and Freedoms* [3] argument.[4] It is the *Charter* analysis of the *Cameron* case that will be the focus of this comment. Although it took Kennedy C.J. only a few pages to dispense with the plaintiffs' *Charter* argument, I think the issues identified by Mr. Cameron and Ms. Smith warrant detailed examination. The case raises important legal and ethical questions: Do governments discriminate against the infertile by not insuring IVF and ICSI services? Should people who cannot conceive or impregnate be considered disabled? After a thorough examination of both the section 15(1) and section 1 *Charter* arguments, I will conclude that Kennedy C.J. decided correctly that the Nova Scotia government does not breach the *Charter* by not paying for IVF and ICSI services. I

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[3] Part I of the *Constitution Act, 1982,* being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [hereinafter *Charter*].

[4] The bulk of Chief Justice Kennedy's judgment focused on the administrative argument. The plaintiffs claimed,

> a proper interpretation of the [*Health Services and Insurance Act*]and the applicable regulations (including the M.S.I. Tariff and the Hospital Insurance Regulations) require that I.V.F. and I.C.S.I. be insured services and as residents of the Province of Nova Scotia, they are therefore, entitled to the health care insurance benefits claimed by them and have been unlawfully denied coverage by the defendants. *Cameron, supra* note 2 at 5.

Following a thorough review of the administrative arguments, Kennedy C.J. found in favour of the defendants.

will begin my analysis by providing background information on infertility, IVF, and ICSI.

I. Background Information

1. Infertility

According to the Royal Commission on New Reproductive Technologies, infertility is the "diminished ability to bring about a live birth in spite of repeated attempts."[5] For women, infertility is the diminished ability to conceive and/or carry a viable fetus to term and for men it is the diminished ability to impregnate.[6] In effect, infertility is the diminished ability to produce a genetically related child.

In 1991 and early 1992, the Royal Commission on New Reproductive Technologies conducted a study to assess infertility in Canada. It narrowed the sample to estimate the prevalence of infertility in heterosexual couples, involving women aged eighteen to forty-four, married or cohabiting for at least one year, who did not use contraception. The study determined that 8.5% of those couples experienced infertility at the time of the survey.[7] This number is consistent with estimates based upon the United States population, and has been accepted as stable over time.[8] That percentage translates to approximately 250,000 to 360,000 couples in Canada who fail to become pregnant after one year of unprotected intercourse.

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[5] Royal Commission on New Reproductive Technologies, *Proceed with Care: Final Report of the Royal Commission on New Reproductive Technologies*, vol. 2 (Ottawa: Ministry of Government Services Canada, 1993) at 1161 [hereinafter RCNRT].

[6] Infertility should be considered as diminished ability rather than inability. Infertility may be temporary and may make conception more difficult or take longer but not necessarily impossible. However, for others infertility is a permanent and complete inability to conceive or impregnate.

[7] RCNRT, *supra* note 5 at 195–96.

[8] See J.A. Collins, D. Feeny & J. Gunby "The Cost of Infertility Diagnosis and Treatment in Canada in 1995" (1997) 12 Human Reprod. 951 at 952 [hereinafter Collins]. The article discusses the Royal Commission on New Reproductive Technologies studies on the prevalence of infertility and compares the results with similar studies in the United States. The comparative rates are approximately 8.5% in Canada in 1995 and 7.9% in the U.S. in 1989. The article concludes that rates of infertility have been stable over time.

Given that infertility estimates are often used to bolster or undermine arguments regarding the provision of IVF and ICSI services under provincial health insurance plans, it is worth noting here that not all persons who are infertile wish to access assisted reproduction. One report estimates that 45% of infertile couples seek some form of medical assistance, including IVF, to achieve pregnancy.[9] Some infertile individuals choose not to have children. Others seek alternative methods of having children.[10]

2. IVF and ICSI

IVF is a process of reproductive fertilization outside of the body. In *Cameron*, Chief Justice Kennedy described IVF as,

> a medical procedure whereby ova, surgically removed from the female partner (usually after drug-induced hyper ovulation), are introduced to sperm from the male partner in a laboratory where fertilization is permitted to occur. If this happens, one or more fertilized ova are then re-implanted in the female partner by a surgical procedure.[11]

For pregnancy to occur, the embryo must implant into the uterine wall. It may take a number of IVF cycles to result in a pregnancy and there is no guarantee that a pregnancy will ever be achieved and/or carried to term.

ICSI is a relatively new procedure that has been used as part of IVF treatment. Kennedy C.J. accepted the evidence before the court that ICSI has become "the treatment of choice" for couples with male-factor infertility.[12] It is a procedure that uses only one sperm and injects it into the cytoplasm of the ovum. The procedure makes fertilization possible with sperm cells that lack the physical and biochemical properties to penetrate the ovum or reach the ejaculate.[13]

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[9] Collins, *ibid.*

[10] Other methods of having children include adoption, fertility drug therapy, therapeutic donor insemination (TDI) and surrogate arrangements. Some infertile couples become pregnant over time without medical intervention. See J.A. Collins, E.A. Burrows & A.R. Willan, "The Prognosis For Live Birth Among Untreated Infertile Couples" (1995) 64 Fertility & Sterility 22.

[11] *Cameron*, *supra* note 2 at 2.

[12] *Ibid.*

[13] For more information on ICSI, see Health Council of the Netherlands: Committee on *In vitro* fertilization, *Assisted Fertilization: ICSI* (The Hague: Health Council of the Netherlands, 1996).

3. Cost-Effectiveness

One of the most significant considerations in the debate of whether or not to fund IVF and ICSI is the issue of cost-effectiveness. In evidence produced in the *Cameron* case, it was estimated that if IVF and ICSI were to be covered in Nova Scotia, the government would be required to pay close to two million dollars annually.[14] Estimates for coverage in Ontario range between $40 million and $60 million annually.[15] If the services were to become provincially insured, the current rates of use would likely increase, which would in turn increase the estimated costs.

There are also highly controversial issues respecting the rates of effectiveness for IVF and ICSI treatments. For IVF,

> success rates vary considerably across populations. For example, they are higher in younger women (thirty-five years of age or under) and in women with tubal disease, and lower in older women (over forty years of age), *and for couples with indications of male factor infertility (i.e. low sperm count)*, severe endometriosis, or unexplained infertility. [emphasis added][16]

Some clinics state effectiveness rates per pregnancy as opposed to per live birth, which would significantly inflate the success rate of the treatment. The Canadian statistics for the effectiveness rate of IVF for live births per cycle is 13.5%. The effectiveness rate of ICSI is slightly higher at 14.3%.[17] The costs of IVF and ICSI are extremely high considering that the procedures are not overly effective.

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[14] M. Joyce conducted a study for the Nova Scotia government in response to the Cameron and Smith claim. The study based its results on current rates of use of reproductive services. Joyce concluded that if it were to insure these services, Nova Scotia would have to pay $1.85 million/year for IVF services alone. Adding ICSI services would increase the costs to $1.97 million/year. The cost translates to $21 000/live birth for IVF services alone to $43 000/live birth if IVF, ICSI, drugs and additional complications are insured. The study has been validated by J.A. Collins and is consistent with his published estimates of costs. See Collins, *supra* note 8 at 955.

[15] See *OHIP*, *infra* note 43 at 36.

[16] Cited in P. Neumann, "Should Health Insurance Cover IVF? Issues and Options" (1997) 22 J. Health Pol'y & L. 1215 at 1221, referring to S.L. Tan et al., "Cumulative Conception and Livebirth Rates after In-Vitro Fertilization" (1992) 339 Lancet 1390, and American Fertility Society and the Society for Assisted Reproductive Technology, "Reproductive Technology in the United States and Canada: 1992, Results Generated from the American Fertility Society/ Society for Assisted Reproductive Technology Registry" (1992) 62 Fertility & Sterility 1121.

[17] J.A. Collins, *An Overview of Medical Care and Public Health Issues Concerning In Vitro Fertilization Techniques, With Emphasis on Male Infertility* (Faculty of Health Sciences,

II. Section 15 Analysis—the Equality Provision

> *Every individual is equal before and under the law and has the right to equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.*
>
> - Section 15(1) *Canadian Charter of Rights and Freedoms*

Mr. Cameron and Ms. Smith sought a declaration that the *Health Services and Insurance Act* [18] offends section 15(1) of the *Charter* because the government does not provide IVF and ICSI services under Nova Scotia's health insurance scheme. In this section, I will argue that the plaintiffs' case is suspect at both stages of a section 15(1) analysis and runs contrary to a broad purposive analysis of the equality provision.

The framework for a section 15(1) analysis was set out in *Andrews* v. *Law Society of British Columbia.*[19] It is a two-step process with the burden of the analysis on the party alleging the violation. In *Miron* v. *Trudel,* McLachlin J. described the *Andrews* test:

> First the claimant must show a denial of "equal protection" or "equal benefit" of the law, as compared with some other person. Second, the claimant must show that the denial constitutes discrimination. At this second stage, in order for discrimination to be made out, the claimant must show that the denial rests on one of the grounds enumerated in s. 15(1) or an analogous ground and that the unequal treatment is based on the stereotypical application of presumed group or personal characteristics.[20]

For Mr. Cameron and Ms. Smith to be successful, they had to convince the Court that the health insurance policy creates a distinction and that the distinction constitutes discrimination. They were unable to do so.

McMaster University) [unpublished] at 8 based on the published study J. de Mouzon & P. Lancaster, "World Collaborative Report on In Vitro Fertilization Preliminary Data for 1995" (1997) 14 J. Assisted Reprod. & Genetics 251S.

[18] R.S.N.S. 1989, c. 197.

[19] [1989] 1 S.C.R. 143 [hereinafter *Andrews*].

[20] [1995] 2 S.C.R. 418 at 485.

1. The Distinction

The Court agreed with Cameron and Smith that the government policy under the *Health Services and Insurance Act* does create a distinction. However, Kennedy C.J. did not agree with the scope or the nature of the distinction as described by the plaintiffs. Mr. Cameron and Ms. Smith claimed they, and infertile persons, are denied equal benefits under the law. They argued that the Nova Scotia government denies infertile people medically necessary services (IVF and ICSI), thereby preventing couples with male-factor infertility from producing children. They further asserted that fertile people receive all medically necessary reproductive services and infertile people do not. For example, abortion, prenatal, and postnatal services for the fertile are covered while IVF and ICSI services for the infertile are not.

Kennedy C.J. limited the distinction to "the denial of funding for specific medical treatment" and did not allow the characterization to be broadened to include the denial of the opportunity to have children. The Court reached its description of the scope and nature of the distinction through the responses to three questions: Is a medically necessary service denied? Do fertile persons get all medically necessary services? Who is the appropriate comparative group?

i. Is a medically necessary service denied?

"Medically necessary" and "medially required" are concepts associated with the *Canada Health Act* [21] and the provincial health insurance statutes. Unfortunately, neither "medically necessary" nor "medically required" have been defined by legislation. Neither has any court defined these terms beyond the facts specific to the case being considered.[22]

Medical necessity is the criteria by which provincial governments are required to provide insured medical services. Medically necessary services should be included in provincial health insurance schemes as insured services.[23] The *Canada Health Act* reads, "the health insurance

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[21] R.S.C. 1985, c. C–6.

[22] *Cameron, supra* note 2 at 28.

[23] The determination of what is and what should be an insured service is a complicated process. For a detailed discussion of this issue, see T.A. Caulfield, "Wishful Thinking: Defining 'Medically Necessary' in Canada" (1996) 4 Health L.J. 63.

plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists."[24] The provinces are not expected to insure *all* physician-provided services as not all services provided by physicians are considered medically required. The provinces *may* insure non-medically necessary services at their discretion, but are not obliged to do so.

The Canadian Medical Association (CMA) defines "medically necessary services as those that a qualified physician determines are *required* to assess, prevent, treat, rehabilitate or palliate a given health concern or problem."[25] Some medical services are easily identified as necessary, such as cardiac surgery. Other services, such as IVF and ICSI, challenge governments to define what is "medically necessary" or at least provide a clearer framework with which to decide what will be insured.

In the *Cameron* case, the Court was not convinced that IVF and ICSI are medically required or medically necessary procedures. Although they may be indicated as options for the medical treatment of infertility, Kennedy C.J. concluded that it is difficult to argue that infertile people *require* IVF and ICSI services. One problem with the argument that IVF and ICSI are medically necessary is that there are other viable options available to people with infertility. IVF and ICSI are neither the only options nor necessarily the most successful options available to infertile persons. Infertile people may remain childless, adopt, take fertility drugs, or have other medical procedures such as varicocelectomy, myomectomy,[26] and therapeutic donor insemination. Many infertile people do not choose to have any medical intervention because infertility can go untreated without causing physical harm.[27] The fact that there are many other options open to infertile people weakens the strength of the assertion that IVF and ICSI are medically required.

Furthermore, IVF and ICSI would not likely meet the CMA definition of medically necessary. IVF and ICSI are not required to

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[24] *Canada Health Act*, R.S.C. 1985, c. C–6, s. 9.

[25] Canadian Medical Association, "Core and Comprehensive Health Care Services" (1995) 152 Can. Med. Assoc J. 740A [emphasis added].

[26] Varicocelectomy and myomectomy are discussed at *infra* notes 54 and 55.

[27] Although the underlying cause of the infertility, such as a sexually transmitted disease, might be physically harmful if untreated.

diagnose, assess or prevent infertility, nor are they rehabilitative or palliative services. Nor has IVF been recognized as medically necessary in the United States. The procedure is not covered by most health plans in the U.S. Although IVF is accepted as, "a medical procedure for a medical problem"—infertility—most health plans exclude it from coverage on the basis that it is not medically necessary.[28]

ii. Do fertile persons get all medically necessary services?

Mr. Cameron and Ms. Smith asserted that fertile people are insured for all their medically necessary services, such as abortions and prenatal and postnatal care. There are at least two problems with this assertion. First, it is simply untrue with regard to services provided to Nova Scotians in other provinces. For example, under the Medical Services Insurance (MSI) regulations article 9.01(3) "Excluded Services," therapeutic abortion is listed as an exclusion under the "Interprovincial Billing Agreement." The article reads, "a Nova Scotian may be insured for one of these services but it can not be billed through the Interprovincial Reciprocal Billing Process." Indeed, there are many medically necessary services denied to all residents, both fertile and infertile, under the interprovincial billing arrangements.

Secondly, even for services provided within Nova Scotia, the government does not insure all medically necessary services. For example, electrolysis, which is used for hirsutism, is not an insured service in Nova Scotia.[29] Along with IVF, there are other services explicitly excluded from health insurance coverage in Nova Scotia.

The Court rejected the plaintiffs' claim with regard to medically necessary. It found the generalization that fertile people receive all medically necessary services while infertile people do not to be problematic. Kennedy C.J. held, "[i]n fact, there are numerous individual services denied the fertile as well as the infertile (e.g. electrolysis) and many medical services funded for the infertile such as diagnostic procedures."[30]

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[28] Neumann, *supra* note 16 at 1215.

[29] See Nova Scotia's "Physicians Manual" at 10 where electrolysis is listed as an excluded service. Electrolysis is required for women with hirsutism, who, without it, may suffer considerable psychological harm.

[30] *Cameron, supra* note 2 at 45.

iii. Who is the appropriate comparative group?

The plaintiffs submitted that the policy under the *Health Services Insurance Act* distinguishes between the fertile and the infertile. However, the Court concluded the distinction "contrasts those people who wish to access funded services and those who wish to access unfunded services."[31] The plaintiffs' categorization of the comparative groups is also inaccurate based on their false assumption that only infertile persons desire access to IVF and ICSI. There are many fertile people who will also want access to IVF and/or ICSI techniques. Same-sex couples, single people without sexual partners, people who want to avoid passing on genetic problems, as well as people, like Ms. Smith, who are themselves fertile and in relationships with infertile partners, may need to access IVF and/or ICSI to have a genetically related child. The provincial funding for these services is denied to fertile and infertile persons.

2. Does the Distinction Constitute Discrimination?

Not every law that creates a distinction between groups is considered discriminatory. The second stage of the section 15(1) analysis requires that the distinction be shown to be discriminatory based on an enumerated or analogous ground. Discrimination was not proven in the *Cameron* case. The Court in *Cameron* declined to determine whether the infertile should be classified as physically disabled or an analogous group or neither. Kennedy C.J. held that "the non-funding of IVF and therefore ICSI, is based on the nature of the treatment being sought, rather than the personal characteristics of those persons seeking the funding, the infertile."[32]

In his discussion of the administrative law argument, Kennedy C.J. found that the non-funding for IVF and ICSI is based "on the failure of these medical treatments to come within criteria necessary before a medical procedure is funded."[33] The exclusion of the services from the provincial scheme, the Court concluded, has nothing to do with the personal characteristic of being infertile, but instead is due to the fact

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[31] *Ibid.*
[32] *Ibid.* at 47.
[33] *Ibid.* at 48.

that the medical community has not brought them forward through the usual process, to be considered for inclusion.

The *Charter* analysis is terminated at this point in the *Cameron* case. I submit that had the rest of the *Charter* analysis been applied, the same finding would have been reached: there was no discrimination against the plaintiffs specifically, nor against the infertile generally. To demonstrate, I will continue the analysis.

i. Does infertility fall within an enumerated ground?

Mr. Cameron asserted that his infertility should be considered a physical disability. This categorization is legally significant. If infertility had been characterized as a physical disability, Mr. Cameron might have been able to advance his argument of discrimination based on an enumerated ground of section 15(1). The *Charter* does not define physical disability. It is therefore, necessary to look to other sources to establish what a legal definition of disability might include. A review of Canadian human rights legislation and common law cases suggests that the courts could broadly interpret disability, but may choose not to do so. A purposive approach to section 15 suggests that the courts ought not to do so on these facts.

a. Human rights legislation

Human rights legislation in Canada has very broad and inclusive definitions of physical disability. The *Canadian Human Rights Act* does not define disability per se but claims to protect against discrimination based on disability which includes "any previous or existing mental or physical disability and includes disfigurement and previous or existing dependence on alcohol or a drug."[34]

The *Nova Scotia Human Rights Act*[35] has a broad definition of disability. It reads:

> s. 3(l) physical disability or mental disability means an actual or perceived:
>
> i) loss or abnormality of psychological, physiological or anatomical structure or function,

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[34] R.S.C. 1985, c. H–6, s. 25.

[35] R.S.N.S. 1989, c. 214, as am. by S.N.S. 1991, c.12.

ii) restriction or lack of ability to perform an activity,

iii) physical disability, infirmity, malformation or disfigurement, including, but not limited to, epilepsy and any degree of paralysis, amputation, lack of physical coordination, deafness, hardness of hearing or hearing impediment, blindness or visual impediment, speech impediment or reliance on a hearing-ear dog, a guide dog, a wheelchair or a remedial appliance or device,

iv) learning disability or dysfunction in one or more of the processes involved in understanding or using symbols or spoken language,

v) condition of being mentally handicapped or impaired,

vi) mental disorder, or

vii) previous dependency on drugs or alcohol.

Infertility could possibly be included under subsection (i) as the loss or abnormality of physiological function of reproduction (either conceiving or impregnating). Both the *Ontario Human Rights Code* [36] and the *Manitoba Human Rights Act* [37] provide similarly broad definitions.

b. Case law

The case law provides an expansive conception of disability. There is a diverse range of conditions that have been legally recognized as disabilities. Courts have included AIDS,[38] deafness,[39] obesity,[40] hypertension,[41] and asthma[42] under the rubric of disability.

However, in a recent Ontario Health Services Appeal Board case, the Board concluded that infertility does not fit the definition of physical

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[36] R.S.O. 1990, c. H. 19.

[37] R.S.M. 1987, c. H. 175.

[38] *Brown* v. *British Columbia (Minister of Health)* (1990), 66 D.L.R. (4th) 444 (B.C.S.C.) at 458. The plaintiffs submitted that HIV infection is a physical disability. Counsel for the defendants conceded.

[39] *Eldridge* v. *British Columbia (Attorney General)* [1997] 3 S.C.R. 624 [hereinafter *Eldridge*].

[40] *Davison* v. *St. Paul Lutheran Home of Melville, Saskatchewan* (1991), 91 C.L.L.C. 17, 017 (Sask. Bd. Of Inquiry).

[41] *Horton* v. *Niagara (Regional Municipality)* (1987), 19 C.C.E.L. 259, 88 C.L.L.C. 17,004, 9 C.H.R.R. D/4611 (Ont. Bd. Of Inquiry).

[42] *DeJager* v. *Canada (Department of National Defence)* (1986), 7 C.H.R.R. D/3513, 86 C.L.L.C. 17,017 (Can. Human Rights Tribunal).

disability within the meaning of section 15(1) of the *Charter*.[43] The case involved five couples with male-factor infertility who appealed individual decisions by the General Manager of the Ontario Health Insurance Plan (OHIP). As in Nova Scotia, Ontario does not insure IVF with ICSI, although it does fund IVF for women with fallopian tube blockage. The couples claimed a section 15 violation of the *Charter* based on the enumerated grounds of sex and physical disability. The appellate court did find a section 15(1) *Charter* violation and that the *Health Insurance Act* did infringe the appellants' right to equal benefit of the law without discrimination based on *sex*, but dismissed the submission that infertility is a physical disability.

The Board accepted the description of physical disability offered by La Forest J. in *Eldridge*. That description is:

> It is an unfortunate truth that the history of disabled persons in Canada is largely one of exclusion and marginalization. Persons with disabilities have too often been excluded from the labour force, denied access to opportunities for social interaction and advancement, subjected to invidious stereotyping and relegated to institutions . . . . This historical disadvantage has to a great extent been shaped and perpetuated by the notion that disability is an abnormality or flaw. As a result, disabled persons have not generally been afforded the "equal concern, respect and consideration" that s. 15(1) of the *Charter* demands. Instead, they have been subjected to paternalistic attitudes of pity and charity, and their entrance into the social mainstream has been conditional upon their emulation of able-bodied norms . . . . One consequence of these attitudes is the persistent social and economic disadvantage faced by the disabled. Statistics indicate that persons with disabilities, in comparison to non-disabled persons, have less education, are more likely to be outside the labour force, face much higher unemployment rates and are concentrated at the lower end of the pay scale when employed.[44]

The Board concluded that La Forest J.'s description provides insight into the type of disability that should be given constitutional protection under section 15(1). On the facts, the Board was not convinced that infertility meets that understanding of disability.

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[43] *D.R. and L.R., B.C. and L.A.C., B.L. and R.F., L.E. and M.E., J.H. and K.H.* v. *the General Manager, The Ontario Health Insurance Plan and Ontario (A.G.)* (29 January 1999) No. 5472, 5491, 5932, 5937, 5948 et al. (Health Services Appeal Bd) [hereinafter *OHIP*].

[44] *Eldridge*, *supra* note 39 at 668.

Under the *Americans with Disabilities Act*,[45] a disability is defined as "a physical or mental impairment that substantially limits one or more of the major life activities." Recent American court decisions have come to opposite conclusions regarding infertility as a disability and whether excluding treatment of infertility from health insurance coverage is a violation of the *Americans with Disabilities Act*.[46] Thus, American jurisprudence may be found to both support and refute the position that infertility should be considered a disability.

c. Experiential support

It may be relevant to future courts that people experiencing infertility describe their infertility as a reproductive disability. Jamie Cameron, a law professor at Osgoode Law School in Toronto wrote of her own experience,

> both pragmatically and as a matter of compassion, we have to get out of the Dark Ages and recognize infertility for what it is: a physical disability, pure and simple . . . . Reproduction is a biological function, and a bodily function at that. Like other parts of the body, parts of that system can break down. When one of the parts of the system is not functioning properly, it should be fixed, just as we fix problems with kidneys, eyes, ears, livers and so on.[47]

The broad definitions of the human rights legislation and the testimonies of infertile people who identify themselves as disabled may be compelling support that infertility should be considered a physical disability. However, the *OHIP* decision runs counter to such a conclusion. At this point, what can be concluded is that it is an open question as to whether it is discrimination. What remains to be considered, therefore, is whether it *ought* to be considered discrimination.

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[45] 42 U.S.C. 120101–122213 (1988 & Supp. IV 1992).

[46] See: *Pacourek* v. *Inland Steel Co.* 858 F. Supp. 1393 (N.D. Ill. 1994) [permitting coverage under the ADA] and *Zatarain* v. *WDSU-Television, Inc.* 881 F. Supp. 240 (E.D. La. 1995) [denying coverage under the ADA].

[47] B.J. Cameron, "Fighting Infertility: Please Respect My Choice" *The Globe and Mail* (5 Nov. 1990).

ii. Purposive approach to section 15

The purpose of section 15 of the *Charter* is to ensure equality and to protect Canadians from discrimination. Beyond the *Andrews* framework, there may be other equality arguments that the courts should take into consideration. These should be considered in a discussion of the inclusion of infertility under the rubric of disability.

iii. The message of prioritizing genetically related children

If a court were to accept the assertion that infertility is a disability, it might be seen to be prioritizing genetically related children. Let us examine the Cameron and Smith situation as an example. The reason for participating in IVF and ICSI is to have a genetically related child. Mr. Cameron and Ms. Smith probably have the option to use therapeutic donor insemination (sperm donation from another man) to have a child. The child would be genetically related to Ms. Smith, but not to Mr. Cameron. Would the courts be sending a message that it is preferable for Mr. Cameron and Ms. Smith to have a child, genetically related to both of them, than to have a child that is not genetically related to Mr. Cameron? Adoption is probably available to Mr. Cameron and Ms. Smith. Do the courts have a preference for genetically related children over adopted children?

The government is not prohibiting Mr. Cameron and Ms. Smith from raising children, rather it is not paying for their preferred method of becoming parents. If the courts were to accept that Mr. Cameron is disabled by reason of his infertility, that is, he is disabled because he cannot produce a genetically related child, it may send a message that genetically related children are preferable to other children. This would be a damaging message to send and one that clearly runs counter to public policy.

iv. Message to the disability community

Courts should also consider the message they would send to the disability community by defining infertility as a disability. Many members of the disability community do not agree that infertile persons should be considered disabled. Traditional definitions discuss disability in terms of medical conditions and treatments. The position of the

disability community has generally been to reject a medical model of disability. Judith Mosoff writes,

> The life experience of disability is characterized by discrimination and presentation of false choices . . . . Women with disabilities reject a medical model of disability and tend to be skeptical of medicine and science because of the role these have played in their own lives. *For these reasons the disability community rejects reproductive technology at this time because it is likely to further disadvantage people with disabilities.* [emphasis added][48]

There may be a feeling that infertile people are misappropriating disability discourse by advancing the claim of entitlement to reproductive services based on reproductive disability. Mosoff discusses at length the irony of the use of disability discourse by the infertile and a reliance on a medical definition of what it is to be disabled,

> Ironically . . . the "medicalization" of reproductive technology may serve the interests of women who claim a reproductive disability. But medicalization does not serve women with disabilities well. *In short, women with fertility problems have adopted disability rights language to further their claims to entitlements and have adopted medical discourse in argument despite the fact that the disability rights movement has concluded that such a discourse is inconsistent with its interests.*[emphasis added][49]

The legal definition of disability has been dependent on a medical model. By defining infertility as a medical condition that requires medical treatment and categorizing it as a disability, the courts would be promoting the message that disability is a medical issue. Including the infertile under physical disability may serve to further marginalize members of the existing disability community.

In *Cameron*, Kennedy C.J. concluded that Mr. Cameron and Ms. Smith were not able to prove that the *Health Services and Insurance Act* offends section 15(1) of the *Charter*. The plaintiffs' arguments failed due to their inability to prove that the decision not to fund IVF and ICSI services was based on the personal characteristics of those seeking the funding (the infertile) and was therefore discriminatory. Future courts

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[48] J. Mosoff, "Reproductive Technology and Disability: Searching for the "Rights" and Wrongs in Explanation" (1993) 16 Dal. L.J. 98 at 99.

[49] Mosoff, *ibid.* at 119.

may come to a different conclusion and wish to examine the potential classification of the infertile within an enumerated or analogous ground. I have discussed some of the issues that might arise in such an examination and I conclude that there are compelling reasons not to include infertility in the definition of physical disability within its meaning under section 15(1) of the *Charter*.

III. Section 1 Analysis—Governmental Justification

> *The* Canadian Charter of Rights and Freedoms *guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.*
>
> - Section 1 *Canadian Charter of Rights and Freedoms*

The decision in *Cameron* does not include a section 1 *Charter* analysis as there was no *Charter* breach found. However, I will examine the possible section 1 arguments as they may present themselves on appeal and in future cases concerning this issue. If a court were to determine that not funding IVF and ICSI services constitutes discrimination based on an enumerated ground and a breach of the section 15(1) equality guarantee, a government would be required to justify the violation under section 1 of the *Charter*. I will argue that a government policy that does not fund IVF and ICSI services may be legally justified.

The generally accepted framework for a section 1 analysis comes from *R.* v. *Oakes*.[50] The *Oakes* test has two steps:

1. Is the objective of the legislation important enough to override a *Charter* right or freedom?
2. Are the means chosen proportional?
   a) Is there a rational connection to the objective?
   b) Is there minimal impairment of the right or freedom in order to achieve the objective?
   c) Is the effect proportional to the objective?

I will go through each component of the *Oakes* test and then examine the role of judicial deference to the legislature, as it would apply on the facts.

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[50] [1986] 1 S.C.R. 103, 26 D.L.R. (4th) 200 [hereinafter *Oakes* cited to D.L.R.].

1. Pressing and Substantial Objectives to the Legislation

The objective of a health insurance act, such as the *Health Services and Insurance Act,* is to provide comprehensive health insurance to residents. The statute determines the resource allocation for all health services in the province. In *OHIP*, the Health Services Appeal Board found, "[i]t is difficult to imagine a more pressing and substantial objective for a provincial government than allocating scarce resources to medically necessary health care services."[51] Undoubtedly, future courts would agree that this constitutes a pressing and substantial objective.

2. Proportional Means

i. Rational connection

A government would have to prove a rational connection between the decision not to fund IVF and ICSI treatments and the objectives of the legislation. In Nova Scotia, the objective of the *Health Services Insurance Act* is to allocate resources to the most appropriate health services. The exclusion of IVF and ICSI could be seen as a discretionary decision by a provincial government to appropriately allocate public resources. The Nova Scotia government has not determined IVF and ICSI to be either medically necessary or priority medical services and therefore has not included those services in the health insurance scheme. I submit that the government would meet the rational connection test. This conclusion can be supported by the decision in *OHIP*. The Board categorized the aim of the applicable regulation as "to fund only medically necessary treatments." Since the Board concluded that ICSI is not medically necessary, excluding ICSI from funding was rationally connected to the objective of the legislation.

ii. Minimal impairment

The burden would be on a government to demonstrate that they complied with the minimal impairment requirement. A provincial government has the discretion to decide whether to fund procedures that are not medically necessary but does not have a duty to do so. Because

[51] *OHIP, supra* note 43 at 27.

of the complete denial of insurance coverage for IVF and ICSI, it *could* be argued that the Nova Scotia government has not made sufficient efforts to minimize the harmful impacts of the statute. However, at least four responses can be made to this argument.

First, supporters for IVF and ICSI funding might argue that the Nova Scotia government could offer partial funding for IVF cycles. The Royal Commission on New Reproductive Technologies supported partial government funding for IVF. In its report, the Commission recommended that governments only fund IVF services for women with bilateral fallopian tube blockage.[52] The courts may be persuaded that the government should be responsible to insure IVF for that purpose. However, Mr. Cameron and Ms. Smith, and other couples with male-factor infertility or female-factor infertility other than bilateral fallopian tube blockage, would not be assisted by such an inclusion.

Second, courts have concluded that governments do not have to make exemplary provisions to meet the minimal impairment test. They must, however, make satisfactory provisions.[53] The Nova Scotia government has not refused to insure all procedures to treat infertility. For male-factor infertility, the province pays for varicocelectomies. Varicocelectomy has been proclaimed as an effective treatment for male-factor infertility.[54] Mr. Cameron admitted that he had this procedure, which was paid for by the government. Ms. Smith underwent a procedure known as myomectomy to remove the fibroids in her uterus.[55] The Nova Scotia government paid for this procedure. These medical procedures are deemed to enhance an infertile person's chance of impregnating or conceiving, respectively. These procedures may more directly treat the infertility than either IVF or ICSI. The funding

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[52] See RCNRT, *supra* note 5 at 564 for Articles 128 and 129.

[53] See Eldridge, *supra* note 39.

[54] One cause of male-factor infertility is a varicocele, a collection of swollen veins in the scrotum that brings excess blood and heat to the testicle, reducing semen volume and quality. A varicocelectomy, which removes dilated veins in the spermatic cord in an attempt to cool the conditions for optimal sperm formation, can successfully correct the condition. See R. Amelar, "Male Infertility Being Overcome By New Techniques" *The Associated Press* (6 December 1993) (CP 93 QL). The report discusses studies that showed improved semen quality in 70% to 80% of men who had a varicocelectomy and their wives and their wives had triple the pregnancy rate of other couples.

[55] A myomectomy is the surgical removal of muscular benign tumours from the uterus.

for varicocelectomy and myomectomy procedures may be sufficient to prove that the government does provide for the medical treatment of infertility.

Third, it is noteworthy that neither IVF nor ICSI services are prohibited in Nova Scotia. Such services are still available when paid for privately. There may be objections that the cost of such procedures are prohibitive for many individuals. However, it is significant that the government has not legally prohibited people from receiving the services.

Fourth, there are also other options available to infertile people who wish to have children. Adoption is a possibility. Therapeutic donor insemination would also be an alternative for couples experiencing male-factor infertility. These alternatives would not provide wholly genetically related children, but do serve as methods for infertile people to have children. The government is therefore not denying infertile people access to having and raising children.

iii. Effects

In *Dagenais* v. *Canadian Broadcasting Corp.*, Lamer C.J. described the effects analysis portion of the *Oakes* test:

> there must be a proportionality between the deleterious effects of the measures which are responsible for limiting the rights or freedoms in question and the objective, *and there must be a proportionality between the deleterious and the salutary effects of the measures.* [emphasis in original][56]

The harmful effects of the measures that infringe a *Charter* right must not outweigh the benefits of the measures. There are a number of issues that should be considered in this analysis, including the socio-economic gap, the cost-effectiveness, and the risks of ICSI.

a. Socio-economic gap

If IVF and ICSI are not publicly paid for, those who cannot afford the high costs will simply not have access to the services. Unfortunately, that problem is not unlike the lack of access to many other health goods and services that are not insured including electrolysis, prescription

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[56] [1994] 3 S.C.R. 835 at 889, 120 D.L.R. (4th) 12 at 46.

drugs outside of the hospital for people under the age of sixty-five, and most dental care.

The Board in *OHIP* acknowledged that the effect of the Ontario regulation is "to very likely deny [some people] the fundamental opportunity to choose, with a willing partner, to conceive and raise a biologically related child, and to enjoy the kind of family life that they desire for themselves."[57] However, this deleterious effect was determined by the Board to be outweighed by the salutary effects of the legislation.

iv. Cost-effectiveness

The Supreme Court of Canada has been clear that budgetary considerations alone will not satisfy a section 1 override of a *Charter* violation.[58] The fiscal reality in Canada is that not all health care services can be insured. In order to provide comprehensive, accessible, safe and universal health care, provincial governments must determine what they will and will not insure. Although not a sufficient argument, evidence of significant economic hardship will be accepted under a section 1 analysis.

There is support that the high cost of IVF and ICSI is a barrier to their inclusion in health insurance schemes. As aforementioned, including IVF and ICSI in the provincial health insurance scheme in Nova Scotia would have significant economic consequences.[59]

The costs are further emphasized by the relatively low effectiveness rates of IVF and ICSI. In the *Cameron* case, the court accepted the testimony of Dr. John Collins that the success rate of IVF is only in the range of 15%–20%.[60] Also, the Royal Commission on New Reproductive Technologies concluded that IVF should be offered as a treatment only in situations in which it has been proven effective. The Commission concluded that the only category of infertility that could be effectively treated by IVF was bilateral fallopian tube blockage.[61]

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[57] *Supra* note 43.

[58] See *Schachter* v. *Canada*, [1992] 2 S.C.R. 679, 93 D.L.R. (4th) 1; Eldridge, *supra* note 39.

[59] *Supra* note 14.

[60] *Cameron*, *supra* note 2 at 30.

[61] RCNRT, *supra* note 5 at 564.

v. Risks of ICSI

Both the Nova Scotia Supreme Court and the Health Services Appeal Board in Ontario accepted evidence that there are potential risks in using ICSI. Some of the common risks are outlined below.[62]

- Scientists are uncertain about the implications of fertilizing ova with immature sperm.
- Studies are inconclusive regarding ICSI offspring and the potential developmental problems, congenital defects, the risk of sex chromosome problems, and DNA fragmentation.
- Ovarian hyper stimulation syndrome is a potential risk (occurring in approximately 5% of IVF cycles) that causes the ovaries to enlarge and fluid to accumulate in the abdomen. Hospitalization may result.
- Multiple gestation pregnancy is a possibility that increases complications.

In both cases, the risks associated with IVF and ICSI were found to raise valid concerns for public funding of these services. These risks combined with the high costs and low effectiveness rates of IVF and ICSI explain the Nova Scotia government's exclusion of these services from the health insurance scheme.

vi. Deference to the legislature

It is also relevant to the section 1 analysis that the Supreme Court of Canada has demonstrated restraint in using the *Charter* to affect governmental budgetary allocations.[63] Provinces clearly have the constitutional authority to make decisions about the administration of health care within the province.

In *Morgentaler* v. *PEI (Ministry of Health and Social Services)*, Jenkins J. wrote,

> The content of publicly funded medical care is the purview of the legislature. Its enacted policies are, in turn, subject to scrutiny by the

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[62] See *Cameron*, *supra* note 2 at 31–33 and *OHIP*, *supra* note 43 at 29–30.

[63] See D. Pothier, "M'Aider, Mayday: Section 15 of the *Charter* in Distress" (1996) 6 N.J.C.L. 295, wherein the author discusses *Schachter* v. *Canada*, *supra* note 58, *Miron* v. *Trudel*, *supra* note 20, *Egan* v. *Canada*, [1995] 2 S.C.R. 513, *Thibaudeau* v. *R.*, [1995] 2 S.C.R. 627; *Eldridge*, *supra* note 39.

> courts upon challenge by citizens for validity based on administrative law, constitutional, *Charter*, and human rights considerations; and by accountability before those by whom the legislature is elected.[64]

In the *Cameron* case, Kennedy C.J. held "[c]ourts should take care before interfering with an elected government's allocation of limited public funds for social programs or the medical profession's determination of health priorities."[65] There would have been a significant economic cost attached to a decision to force the province to fund IVF and ICSI. Any significant changes to existing laws would likely require extensive consultation with the medical community and the population at large.

A government policy that does not fund IVF and ICSI services may be legally justified if the section 1 *Charter* analysis, as set out in *Oakes,* is applied. That conclusion is further supported by the courts' general practice to defer to the legislature in matters involving significant resource allocations.

IV. Conclusion

The Nova Scotia Supreme Court has decided in *Cameron* that provincial governments do not discriminate against the infertile by not insuring IVF and ICSI. Mr. Cameron and Ms. Smith have a dream of having a genetically related child. The problem is that they want the government to pay for their dream. There are thousands of infertile couples in the same position in Canada; couples who want children and look to IVF (with or without ICSI) as their answer. To date, the province of Nova Scotia has not included IVF and ICSI as insured health services. As a result, the costs of high-tech assistance have been too high for some infertile people. Nova Scotia could decide in the future to insure these services. In the meantime, infertile individuals, and couples such as Mr. Cameron and Ms. Smith, will have to look elsewhere to find a solution to the economic barriers they face in accessing these services.

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[64] [1995] 122 D.L.R. (4th) 728 (P.E.I.S.C.) at 734.

[65] *Cameron*, *supra* note 2 at 52.