

IN THE MATTER OF: The Nova Scotia *Human Rights Act*
- and -

IN THE MATTER OF: Board File No. 51000-30-H14-1909

BETWEEN: **Gordon “Wayne” Skinner**
 (“Complainant”)

- and -

**Board of Trustees of the Canadian Elevator Industry Welfare
Trust Fund**
 (“Respondent”)

- and -

The Nova Scotia Human Rights Commission
 (“Commission”)

For the Complainant: Gordon “Wayne” Skinner, self-represented

For the Respondent: Christopher Perri, counsel

For the Commission: Kendrick Douglas, counsel

Date of Hearing: October 3-4, 2016

Date of Decision: January 30, 2017

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DECISION OF THE BOARD OF INQUIRY

Overview

[1] Employee benefit plans are not required to cover the sun, moon, and the stars. However, where an employee with a disability requests coverage that is consistent with the purpose of a plan and comparable to coverage provided to other beneficiaries, more is required from a plan administrator than simply an assertion that its hands are tied by its policy and forms. In the absence of evidence that extending coverage would unreasonably alter the plan premiums or risk its financial sustainability, non-coverage of a medically-necessary drug may amount to discrimination. For the reasons that follow, I find that the complainant in this case was discriminated against when he was denied coverage for medical marijuana by the trustees responsible for making decisions under his benefit plan.

Background & Factual Findings

Introduction

[2] The complainant, Gordon “Wayne” Skinner, was an elevator mechanic employed by ThyssenKrupp Elevator Canada. On August 13, 2010, he was involved in a motor vehicle accident while working.

[3] As a result of this accident, the complainant developed both a physical and mental disability. Physically, the complainant suffers from chronic pain. Mentally, the complainant has been diagnosed with both anxiety and depressive disorders. Since the accident, he has been unable to work and now qualifies for permanent impairment and extended earnings replacement benefits.

[4] For almost two (2) years following the accident, the complainant’s medical conditions were treated by way of narcotic and non-narcotic pain medication as well as anti-depressants. These more conventional drugs proved ineffective and in or around the summer of 2012, the complainant began consuming medical marijuana after obtaining the appropriate prescription and license. The medical marijuana was a significant improvement on conventional pain medication.

[5] Initially, the complainant’s medical marijuana was covered by his employer’s motor vehicle insurer, Cunningham Lyndsey. By May 2014, the complainant had reached the

maximum limit of \$25,000 of coverage offered under that insurance policy. On May 4, 2014, he approached the respondent's agent in this matter seeking coverage.

[6] The respondent, the Board of Trustees of the Canadian Elevator Industry Welfare Trust Fund (the "Trustees"), is responsible for the management of the Canadian Elevator Industry Welfare Trust Plan (the "Welfare Plan"). The Welfare Plan was established in 1952 and provides health and related benefits for employees and former employees, such as the complainant, working in the unionized sector of the Canadian elevator industry.

[7] In accordance with the trust declaration establishing the Welfare Plan, the Trustees appointed Manion Wilkins & Associates Ltd. ("Manion Wilkins") to administer the day-to-day operations of the Welfare Plan. It is Manion Wilkins who the complainant initially contacted in writing, on May 7, 2014, seeking interim coverage for his medical marijuana pending his appeal to the Workers' Compensation Board, who had initially denied coverage.

[8] Manion Wilkins forwarded the complainant's request to the Trustees for consideration at its upcoming meeting on May 22, 2014. The complainant also wrote the Trustees directly and provided them with an extensive documentation package supporting his request.

[9] On May 22, 2014, the Trustees voted to deny the complainant's request, ostensibly for two reasons. First, medical marijuana has not been approved by Health Canada under the *Food and Drugs Act*, RSC 1985, c F-27 and as such it does not receive a drug identification number ("DIN"); accordingly, the Trustees reasoned, medical marijuana is not an approved drug under the terms of the Welfare Plan. Second, since the complainant's disabilities were the result of a compensable workplace accident, the Trustees determined that any related medical expenses ought to be covered by a provincial medicare plan, and were therefore excluded from coverage under the Welfare Plan. This decision was communicated to the complainant.

[10] On May 27, 2014, the complainant sent the Trustees a second request for coverage along with further documentation. This request was added to the Trustees' June 26, 2014 meeting agenda. In the intervening period, the complainant submitted additional medical information to support his request. On June 26, 2014, the Trustees again voted to deny the complainant's request for coverage of medical marijuana. The reasons for denial were the same.

[11] The following day, June 27, 2014, the complainant wrote the Trustees again seeking reconsideration. The Trustees treated this email communication as a third appeal and added it to their agenda for their August 13, 2014 meeting. On August 13, 2014, the Trustees again voted to deny the complainant's request for coverage, again providing the same reasons for denial.

[12] In August of 2014, the complainant approached the Nova Scotia Human Rights Commission (the "Commission") and on October 30, 2014, he filed a formal complaint under the *Human Rights Act*, RSNS 1989, c 214 (the "Act") alleging discrimination in the provision of services on account of physical and mental disability. The Commission went through its regular process and decided, at its meeting on February 17, 2016, to refer the complaint to a board of inquiry pursuant to s. 32A(1) of the *Act*. By letter dated April 29, 2016, the Commission

informed me of my nomination by the Chief Judge of the Provincial Court as the board of inquiry in this matter.

[13] Case management and scheduling conflicts resulted in the matter not being set down for hearing until October 3-4, 2016. In advance of the hearing, the parties were able to prepare an agreed statement of facts along with an associated exhibit book: Exhibit 1, Agreed Statement of Fact and Exhibit Book. This substantially reduced the amount of hearing time required.

[14] Both the respondent and the Commission submitted pre-hearing briefs. The complainant did not submit a pre-hearing brief. Three (3) days before the hearing was to commence, the complainant attempted to share a large number of documents with the board via an online cloud storage service. The board advised the complainant that a pre-hearing brief was not the place to share new evidence and that these materials would not be considered by the board unless they were introduced at the hearing. Following the hearing, the respondent made post-hearing submissions to the board. Neither the Commission nor the complainant chose to make post-hearing submissions.

Jurisdiction

[15] None of the parties raised any concern about the board's jurisdiction to hear this matter even though it arose in the context of a collective agreement. Nonetheless, some preliminary remarks on jurisdiction are warranted because significant portions of the respondent's argument focused on interpretation, application or violation of the Welfare Plan, which forms part of the respective collective agreements between individual employers and unionized employees in the Canadian elevator industry.

[16] There is a two-step approach for determining whether a labour arbitrator has exclusive jurisdiction to hear a complaint arising from a collective agreement. The first step requires an assessment of the arbitrator's jurisdiction in the context of the relevant legislative framework(s). The second step requires a determination of the nature or essential character of the dispute: *Halifax (Regional Municipality) v Nova Scotia (Human Rights Commission)*, 2008 NSCA 21 at paras 21-23 [*HRM*].

[17] In *HRM*, the Court of Appeal affirmed the Chambers judge's reasoning that the *Trade Union Act*, RSNS 1989, c 475, the *Human Rights Act*, and the applicable collective agreement in that case, when read together, did not grant exclusive jurisdiction to a labour arbitrator. The board has not been provided with the relevant collective agreement nor with any other information that would lead me to a different conclusion than that reached in *HRM*.

[18] In *HRM*, the Court of Appeal also affirmed the Chambers judge's finding that the essential character of the dispute in that case was one of alleged racial discrimination. In this case, the essential character of the dispute is one of alleged discrimination on the basis of physical or mental disability. The issue in dispute does not arise "either explicitly or implicitly from the interpretation, application or violation of the Collective Agreement": *HRM* at para 48. Rather, the question before the board is whether the Welfare Plan is itself discriminatory or

whether the Trustees failure to exercise their discretion was discriminatory. Accordingly, the board has jurisdiction to inquire whether this matter raises a violation of the *Act*.

The Welfare Plan

[19] In order to understand the issue before the board, it is necessary to highlight some details of the Welfare Plan, its benefits coverage and limits, as well as the authority it grants to the Trustees.

[20] Like all benefits plans, the Welfare Plan does not cover everything. No benefits plan can cover the sun, moon, and the stars and expect to also be financially sustainable. The whole purpose of insurance is to allow beneficiaries to contract for a known loss (in the form of insurance premiums) in exchange for coverage in the event of an unknown future loss (e.g. prescription medication costs resulting from an unforeseen illness). In order for any insurance scheme to be efficient, sustainable, and affordable, insurers must be able to specify and limit what future losses are covered. Benefits plans are no different.

[21] Consistent with the foregoing, the purpose of the Welfare Plan is to provide benefits to employees in the most efficient and sustainable manner as determined by the Trustees. Under the Welfare Plan, the Trustees are explicitly empowered to create a benefits regime that includes conditions and rules of eligibility, and to employ third-parties to administer the regime.

[22] The Welfare Plan includes such conditions and rules for the coverage of major medical benefits. Specifically, the Welfare Plan Member Booklet provides:

(e) Major Medical Benefits (Employees and Dependents)

The specified Major Medical expenses are payable provided they are reasonable and customary, needed for medical care and provided they are not covered by your Provincial Medicare Plan up to an Overall Lifetime Maximum of \$25,000 per covered person. When this maximum is reached each covered person will be reimbursed up to a maximum of \$5,000 per year thereafter. *Note: these maximums do not apply to the Prescription Drug or Vision Care benefit.*

(1) Prescription Drug Benefits

- Reasonable and customary charges incurred for **medically necessary drugs and medicines** specified below.
- Such drugs and medicines must be **obtained only by prescription from a person entitled by law to prescribe them and dispensed by a licensed pharmacist, physician or other health care practitioner authorized by provincial legislation to dispense them.**

No benefit shall be payable for any single purchase of drugs which would not reasonably be used within 90 days from the date of purchase.

(a) Eligible Drug Expenses:

- **All generic drugs and life sustaining medications**
- Diabetic supplies such as needles, syringes, test strips, lancets and solutions
- For retired members age 65 years and older, prescription drug costs in excess of that paid by a provincial drug plan, including any required annual premiums
- Smoking cessation products will be reimbursed at 75% up to a maximum of \$500 per calendar year
- Erectile dysfunction drugs up to the maximum of \$1,000 per calendar year
- Oral contraceptives

(b) Generic Drugs

If there is a generic substitute for the drug the covered person has been prescribed, the Welfare Plan will reimburse only up to the cost of the lowest priced generic equivalents regardless of whether the brand name or the generic equivalent is purchased.

If, for any reason, the covered person's health care practitioner insists the covered person receive a certain brand name medication, the words "no substitution" must be included on the prescription. The covered person will be reimbursed based on the cost of the brand name drug upon proof that the covered person's health care practitioner has specified "no substitution."

(c) Ingredient Cost:

For drugs listed in the provincial Drug Benefit Formulary and Limited Use Drugs the ingredient cost will be limited to the current Formulary price plus a mark-up. For all other drugs the ingredient cost will be limited to the pricing followed by the major drug wholesaler in the applicable province, plus a mark-up.

...

(e) Prescription Drug Exclusions:

- **Over the counter medications or drugs for which a prescription is not required by law (federal or provincial)**
- Fertility drugs or drugs to promote abortion
- **Drugs which are not considered medically necessary, e.g. cosmetic or weight loss/lifestyle, unless they are approved under the Express Scripts Canada Prescription Drug Plan—Prior Authorization Procedure**
- Vitamins (injectable or oral) unless they legally require a prescription
- Alcohol swabs
- Medication which is provided and administered by a health care practitioner (unless they legally require a prescription)
- Hospital Funded/Administered drugs are not covered by the Welfare Plan
- HIV/AIDS medications

- Contraceptive devices

...

[Underlining emphasis in original; Bolded emphasis added.]

[23] In its pre-hearing brief and during oral argument, the respondent spent much time arguing that medical marijuana was not an eligible expense under the Welfare Plan because it was not a drug. Medical marijuana was not a drug, according to the respondent, because it has not been approved by Health Canada, lacks a drug identification number (DIN), and is not included on the Nova Scotia provincial Formulary.

[24] The appropriate classification of non-approved drugs or medicines has arisen in two recent labour arbitration cases, neither of which were presented to the board by any of the parties. In *Corporation of the City of Hamilton v Hamilton Professional Fire Fighters' Association*, 2016 CanLII 16885 (ON LA) [*City of Hamilton*], the arbitrator denied a grievance resulting from a refusal of coverage, under a benefits plan, for prescribed medical marijuana. The arbitrator reasoned that the collective agreement, reached through negotiation by sophisticated parties, explicitly required drugs to possess a Health Canada DIN in order to be eligible for reimbursement, and since marijuana lacks such a DIN, the benefits plan was correct in refusing reimbursement under the collective agreement.

[25] By contrast, in *University of Western Ontario v University of Western Ontario Faculty Association* (2008), 95 CLAS 145, 2008 CarswellOnt 7554 (ON LA) [*UOWO*], the arbitrator allowed a grievance resulting from a refusal for coverage, under a benefits plan, for a prescribed medication that lacked a Health Canada DIN (though it had been provided with a provincial formulary DIN) and was therefore held not to be a Health Canada-approved drug. The arbitrator reasoned that the benefits plan included coverage for both drugs *and* medications, and though the prescription may reasonably have been viewed as not a “drug” it could appropriately be viewed as a “medication” which made it eligible for reimbursement.

[26] While nothing in this case turns on whether medical marijuana ought to be considered a drug versus a medication, I note there are many aspects of the Welfare Plan that support a strong argument for medical marijuana being an eligible medical expense.

[27] First, unlike in *City of Hamilton*, the Welfare Plan does not expressly limit coverage to drugs possessing a DIN; the Welfare Plan does not define what constitutes a “drug” and does not limit the definition of “drug” to only “Health Canada-approved” drugs or any other express category. The respondent’s contention that its claims form, which has a field where a DIN can be inputted, somehow supersedes the text of the Welfare Plan or provides definitional clarity, is a stretch.

[28] Second, like in *UOWO*, the Welfare Plan includes coverage for both drugs *and* medicines; even if medical marijuana is not a “drug” under the Welfare Plan, the inclusion of coverage for “drugs and medicines” requires some definition to be given to “medicines.” For the

reasons outlined in *UOWO*, an arbitrator could reasonably conclude that medical marijuana is a medicine even if it is not a drug.

[29] Third, the Welfare Plan includes a pricing regime for drugs that are not included in the provincial formulary; this suggests that inclusion on the provincial formulary is *not* the exclusive basis for determining whether a drug or medicine is an eligible expense.

[30] Fourth, the Welfare Plan spells out the types of drugs and medications that are excluded from coverage, expressly stating that “[o]ver the counter medications or drugs for which a prescription is not required by law (federal or provincial)” are excluded; since medical marijuana requires a prescription by law, this suggests that it does not fall within this particular exclusion.

[31] Based on the foregoing and the reasoning in *UOWO*, medical marijuana could very much be considered a drug or medicine eligible for coverage under the Welfare Plan. It bears repeating that the board does *not* have jurisdiction to interpret and apply the Welfare Plan for the purposes of determining whether there was a violation of the applicable collective agreement. The board’s jurisdiction is limited to determinations of whether there was a violation of the *Act*.

[32] In its post-hearing brief, the respondent changed its reasoning on the eligibility of medical marijuana for coverage under the Welfare Plan. Rather than focus on whether medical marijuana was a “drug” or “medicine,” the respondent argued that the complainant had not established medical marijuana as “medically necessary.” Medical necessity is a requirement for coverage under the Welfare Plan.

[33] The respondent reasoned that limiting coverage to “[r]easonable and customary charges incurred for medically necessary drugs and medicines” meant that a drug or medicine had to be “generally accepted by the medical community” in order to be eligible. The respondent further argued that medical marijuana did not meet this definition because it has not been approved by Health Canada and there is not a general consensus within the medical community as to its safety and efficacy.

[34] The problem with the respondent’s argument is that the Welfare Plan uses the terms “reasonable” and “customary” in relation to “charges incurred” and not in relation to whether a particular drug or medicine is reasonable or customary. There are no explicit terms in the Welfare Plan requiring a “general acceptance” of a drug for eligibility and there is at least an arguable case that the use of the words “reasonable” and “customary” do not support the respondent’s position.

[35] The Welfare Plan does restrict coverage to “medically necessary” drugs or medicines, but does not define what medically necessary means. It is not for the board to provide a definition of what “medically necessary” means under the Welfare Plan, as this case does not turn on an interpretation and application of the Welfare Plan, but I note that the Welfare Plan includes an implicit definition of “medically necessary.”

[36] In the list of exclusions from coverage, the Welfare Plan provides “cosmetic or weight loss/lifestyle” drugs as examples of the types of drugs or medicines that are not medically

necessary. This appears to have nothing to do with medical consensus and everything to do with the purpose for which a drug or medicine is prescribed.

[37] Since the medical marijuana in this case was prescribed for pain management, it seems there is *prima facie* support for its medical necessity, owing to the fact that conventional prescription pain management drugs are normally eligible for coverage. For reasons that are expanded on below, I have found that medical marijuana was medically necessary for the complainant, but this conclusion was reached based on the evidence presented to the board and not based on an interpretation of the Welfare Plan.

[38] The final aspect of the Welfare Plan that needs to be highlighted is the discretionary authority it grants the Trustees. The Welfare Plan grants the Trustees a broad authority to construe and change the Welfare Plan as needed in order to meet the purpose of the Welfare Plan. This could be a case-by-case change or it could be a permanent change to the Welfare Plan.

[39] The parties agreed that the Trustees have “full and sole authority to determine all questions of the type, amount and duration of benefits provided by the Welfare Plan. The Board of Trustees also has full authority for determining all questions of eligibility and entitlement to benefits under the Welfare Plan”: Exhibit 1, Agreed Statement of Facts, para 5.

[40] Accordingly, the Trustees had the authority under the Welfare Plan to interpret its terms in a way that would have made medical marijuana an eligible drug, to approve coverage for medical marijuana on a case-by-case basis even though it was not ordinarily covered, or to change the Welfare Plan to make medical marijuana an eligible drug. This authority is constrained only by the limitation that any such changes must be economically sustainable. The following exchanges demonstrate the respondent’s acceptance of this interpretation:

Chair: So the Board [of Trustees] could have covered medical marijuana?

Counsel for the Respondent: Well the Board – the Board could have covered medical marijuana regardless. They have the discretion to change the plan.

...

Counsel for the Respondent: They do have the discretion to define the terms of the Welfare Plan but their discretion is limited by the terms of the Declaration of Trust so they can do so with the caveat that they still have to manage the benefits in an economical and efficient manner. So it’s a limited discretion.

[41] In summary, first, even though there is an argument to be made that a labour arbitrator could reasonably have found the Trustees’ decision to be in non-compliance with the Welfare Plan and associated collective agreement, this board does not have jurisdiction to reach that conclusion; the board has proceeded on the presumption that the Trustees were correct in their interpretation and application of the Welfare Plan, and considered whether that interpretation and application violated the *Act*. Second, the Trustees had discretionary authority to make a case-by-case decision or to modify the Welfare Plan, something they chose not to do; the board does have

jurisdiction to review such decisions and to determine whether they amount to a violation of the *Act*.

Regulatory Framework for Medical Marijuana in Canada

[42] This inquiry into the Welfare Plan and the Trustees' decision-making under the Welfare Plan arises in the context of a legal and regulatory framework for medical marijuana in Canada that is undergoing rapid changes. The complainant spent a great deal of time and effort explaining those changes to the board. Unfortunately, most of these submissions were partially or completely irrelevant to this inquiry.

[43] The question before the board is not whether medical marijuana should be readily available to Canadians nor whether it is adequately available to Canadians at the present moment. The question before the board is whether the exclusion of coverage for medical marijuana under the Welfare Plan and/or the Trustees' refusal to exercise their discretion to alter the Welfare Plan amounted to a violation of the *Act*.

[44] While significant portions of the complaint's submissions were irrelevant, there are aspects of those submissions that are partially relevant; these aspects are summarized in the following paragraphs that focus on the legal and regulatory framework of medical marijuana in Canada.

[45] After a series of court decisions, legislative responses, subsequent court decisions, and subsequent legislative responses, medical marijuana is now legal in Canada: *See, inter alia, R v Parker* (2000), 188 DLR (4th) 385, 146 CCC (3d) 193 (ON CA) [*Parker*]; *Marijuana Medical Access Regulations*, SOR/2001-227; *R v JP* (2003), 231 DLR (4th) 179, 177 CCC (3d) 522 (ON CA); *Medical Marijuana Access Regulations*, SOR 2003/387; *Canada (Attorney General) v Sfetkopoulos*, 2008 FCA 328; *Marijuana for Medical Purposes Regulations*, SOR/2013-119; *R v Smith*, 2014 BCCA 322 [*Smith*]; and *Allard v Canada*, 2016 FC 236.

[46] While the reasoning in these decisions is complex and not immediately transferable to the human rights arena, nor determinative of this inquiry, one trend that emerges is the repeated judicial finding, based on anecdotal and expert evidence, of a significant benefit to some patients from using medical marijuana: *See eg Smith* at paras 107-114. For example, in *Smith* at para 114, the British Columbia Court of Appeal held, in applying the test for engagement of section 7 of the *Charter*: "a 'person of reasonable sensibility' would find the restriction to dried marijuana to have a serious and profound effect on [the accused's] physical and psychological integrity."

[47] Following these constitutional cases and regulatory responses, there have been some administrative and judicial decisions finding that various statutory regimes required coverage for medical marijuana.

[48] In *Nova Scotia (Community Services) v Campbell*, 2014 NSCA 94, the Court of Appeal upheld an application judge's finding that the Minister of Community Services was required to pay for medical marijuana as a special need under the *Employment Support and Income*

Assistance Act, SNS 2000, c 27, but limited that obligation to medical marijuana that was purchased through legal suppliers.

[49] In *20126337 (Re)*, 2012 CanLII 16282 (NB WCAT), an Appeals Panel found that medical marijuana was a compensable drug under the New Brunswick *Workers' Compensation Act*, RSNB 1973, c W-13.

[50] In *TN v Personal Insurance Company of Canada*, FSCO A06-000399 (26 July 2012), an arbitrator found that medical marijuana was a good or service of a medical nature and therefore compensable under the *Statutory Accident Benefits Schedule – Accidents on or After November 1, 1996*, O Reg 403/96 that forms part of the Ontario *Insurance Act*, RSO 1990, c I8. The arbitrator also found, based on expert evidence, that while medical marijuana might be considered experimental in nature, its use for the treatment of the insured's pain, anxiety, insomnia and poor appetite, was not experimental.

[51] Other administrative decision-makers have held in the opposite direction. Indeed, the Workers' Compensation Board, in the complainant's own case, held that he was not entitled to medical aid assistance in the form of medical marijuana under the *Workers' Compensation Act*, SNS 1994-95, c 10: Exhibit 1, Agreed Statement of Facts, Exhibit Book, Tab 12. The Workers' Compensation Board based its decision on its own somewhat dated jurisprudence, expert commentary from early 2000 on the efficacy of medical marijuana for pain, and an independent medical opinion.

[52] The problem with the complainant's reliance on these decisions is that they are all cases where the result was predicated upon the specific statutory language involved. While these cases do show the shifting legal response to medical marijuana in Canada, none of the them are directly applicable to this inquiry under the *Act*.

[53] The complainant also presented some evidence that some medical insurers are beginning to cover medical marijuana: Exhibit 6, Isabel Teotonio, "Private insurer covers medical marijuana costs," *Toronto Star* (20 Mar 2015). There is also some evidence that the Canada Revenue Agency considers medical marijuana to be a legitimate medical expense for tax purposes: Exhibit 7, CBC, "Cannabis prescriptions are eligible medical expense, CRA confirms" (11 Sept 2015). However, legitimacy in the eyes of some insurers or some governmental agencies does not help answer the question of whether non-coverage under the Welfare Plan or the Trustees' decision amounts to a violation of the *Act*. I also note that both of these pieces of evidence are dated far after the decisions at issue in this inquiry. Accordingly, these pieces of evidence have been given no weight by the board.

[54] Despite these fairly seismic changes in the legal and regulatory framework for medical marijuana in Canada, it has yet to be approved by Health Canada under the *Food and Drugs Act* and is not listed on the Nova Scotia Formulary or any other provincial formulary. However, the legal status of medical marijuana means that it can be prescribed by physicians, which then allows a patient to purchase, possess, and consume marijuana without threat of criminal sanction. The complainant received one of those prescriptions.

[55] In summary, while there have been major changes in the legal and regulatory framework for medical marijuana, some of which have been based, in part, on the medical benefits that marijuana provides to some persons, these changes are not determinative of the inquiry before the board. Moreover, even though some administrative decision-makers have found an entitlement to medical marijuana, and even though some insurers are starting to cover medical marijuana, all of these decisions are linked to the particular statutory or contractual framework in those cases. This inquiry is focused, not on these major changes, but on the complainant's request for coverage of medical marijuana under the Welfare Plan, the Trustees' response, and the question of whether there has been a violation of the *Act*.

Importance of Medical Marijuana to the Complainant

[56] At both the hearing and in its post-hearing brief, the respondent challenged the medical necessity of medical marijuana for the complainant. While medical necessity has relevance for interpreting the Welfare Plan—something the board has already made clear it lacks the jurisdiction to do—it also has relevance to the human rights analysis in this inquiry. For the reasons that follow, I do not accept the respondent's argument and find as fact that medical marijuana was and remains medically necessary for the complainant.

[57] The respondent's position was somewhat surprising given its consent to the following paragraphs from the Agreed Statement of Facts:

Mr. Skinner's medical conditions, as noted-above, were being treated by way of Hydromorphone and other narcotics and anti-depressants. Beginning in or around the summer of 2012, Mr. Skinner began consuming medical marijuana on the advice of his then treating psychologist, Dr. Dennis Allaby.

Since 2012, Mr. Skinner's use of medical marijuana has significantly improved his ability to manage pain as well as his functionality and mental well-being. In fact, such treatment has been so effective that by May 20, 2014, medical marijuana has replaced all medications including the anti-depressant and narcotic medications that Mr. Skinner has been taking [emphasis added].

[58] There is a small error in the foregoing in that the initial recommendation to consume medical marijuana came from the complainant's treating physician and not his psychologist (who was not legally authorized to prescribe such medications). Beyond this small error, these agreed facts are enough to resolve the question of medical necessity, but the board was also presented with more evidence to support this finding.

[59] The complainant was first prescribed medical marijuana by Dr. David Bond, a certified anesthesia and chronic pain management specialist. That first prescription was made pursuant to the now repealed *Marihuana Medical Access Regulations*, SOR/2001-227. Those regulations required a medical declaration before an authorization to possess dried marihuana for medical purposes would be issued.

[60] Paragraphs 6(1)(e)-(f) of the Regulations specified what was to be included in the medical declaration and read as follows:

The medical declaration under paragraph 4(2)(b) must indicate

...

(e) that conventional treatments for the symptoms have been tried or considered and have been found to be ineffective or medically inappropriate for the treatment of the applicant; and

(f) that the medical practitioner is aware that no notice of compliance has been issued under the *Food and Drug Regulations* concerning the safety and effectiveness of marihuana as a drug.

[61] In short, the Regulations as they stood at the time the complainant was prescribed medical marijuana, required both an attestation of medical necessity *and* an attestation that conventional treatments were ineffective or medically inappropriate. Moreover, the Regulations required that prescriptions for non-end-of-life applications of medical marijuana, such as the complainant's use for chronic pain, be made by a specialist or a generalist who had consulted a specialist: *Marihuana Medical Access Regulations*, SOR/2001-227, s 6(2).

[62] The board was also presented with numerous medical opinions that support the medical necessity of medical marijuana for the complainant, including the medical declarations of the complainant's treating physician and letters from his treating psychologist.

[63] The only contrary opinion before the board is that of an unnamed Medical Advisor, retained by the Workers' Compensation Board in conjunction with the complainant's workers' compensation claim. This Medical Advisor opined that there was not sufficient evidence to support the effectiveness of medical marijuana, noted there were "multiple other medications that the worker has not explored as treatment options" and recommended that he be referred to a chronic pain physician or physiatrist. The Medical Advisor specifically provided Dr. Koshi as an example of such a physician: Exhibit 1, Agreed Statement of Facts, Exhibit Book, Tab 12, p 5.

[64] Interestingly, the complainant was subsequently seen by Dr. Edwin Koshi, a physical medicine and rehabilitation pain medicine specialist. His twenty-one (21) page report was presented to the board. Notably, his ultimate conclusion supported the use of medical marijuana. Dr. Koshi states: "Although I do have reservations, I agree with the use of marijuana on condition that the physicians who started marijuana monitor the risks associated [with] its use": Exhibit 1, Agreed Statement of Facts, Exhibit Book, Tab 7, p 4.

[65] In addition to the Federal requirements for prescribing medical marijuana, provincial regulators have also developed professional standards regarding the authorization of marijuana for medical purposes. The College of Physicians & Surgeons of Nova Scotia guideline instructs:

The College considers the authorization of marijuana for medical purposes to be comparable to prescribing medication. Authorizing a patient's use of marijuana for medical purposes is a clinical decision. The College recommends that any such decision be informed by sound clinical evidence: Exhibit 1, Agreed Statement of Facts, Exhibit Book, Tab 32, p 1.

A version of these guidelines, which was substantively similar, was provided to the Trustees by the complainant: Exhibit 8, Board of Trustees' File.

[66] From the College's guidelines, it can be presumed, unless contrary evidence is provided, that physicians prescribing marijuana are doing so for a medical purpose based on clinical evidence. No such evidence was provided to the board that would displace the opinions provided by the complainant's treating physician and the independent medical opinion provided by Dr. Koshi.

[67] The board also had the benefit of receiving *viva voce* evidence from the complainant's treating physician, Dr. David Bond, a certified anesthesia and chronic pain management specialist, and seeing this evidence tested on cross-examination by the respondent's counsel.

[68] Dr. Bond testified that he considers medical marijuana to be an "end of the line" treatment that he only prescribes or suggests continued use of where conventional treatments have not worked and a patient responds positively to the medical marijuana.

[69] Dr. Bond further testified that his focus is on functionality because it is not possible to measure a patient's subjective experience of pain. When asked whether medical marijuana had improved the complainant's functionality, he responded affirmatively.

[70] In its post-hearing brief, the respondent attempted to make much of Dr. Bond's apparent unwillingness to state that medical marijuana was necessary for the complainant. The respondent's counsel did not question Dr. Bond on the necessity of medical marijuana at the hearing. The only person to ask Dr. Bond for comment on necessity was the complainant, to which Dr. Bond replied:

I think everybody who has pain deserves access to the various drugs that we do have for pain to try to improve their functions, is what we do all the time in pain medicine. So in that respect you could say there was a necessity to try to provide an individual with a pain killer that worked, and by that I mean improved their function.

[71] From Dr. Bond's testimony, I do not take him to be disavowing the medical necessity of medical marijuana. Dr. Bond's professional standards require a medical purpose and clinical evidence for suggesting medical marijuana; the Federal regulations at the time of the complainant's first prescription required a medical declaration attesting to the necessity of medical marijuana and that conventional medications were medically inappropriate or ineffective. No evidence was presented to the board to suggest that Dr. Bond was deviating from these standards and rules when he prescribed medical marijuana to the complainant.

[72] Instead, what I take Dr. Bond to have been saying is that for the medical treatment of pain, the appropriate word to use is not “necessity” but rather “functionality.” On functionality, Dr. Bond was unequivocal: “if your pain is inadequately addressed your function will get worse and worse.” Dr. Bond also accepted that this would have ripple effects on the complainant’s family.

[73] While Dr. Bond may have used the word “functionality” the board finds as fact that his prescription of medical marijuana for the complainant was medically necessary insofar as it was justified based on clinical evidence and consistent with Federal regulations.

[74] The respondent also attempted to suggest that the complainant had not established a linkage between his medical marijuana usage and improved functionality. The respondent based this argument on two points: 1) Dr. Bond’s refusal to confirm such a linkage, and 2) the complainant’s continued usage of medical marijuana, sometimes up to his full prescription amount, during a period when his functionality had diminished.

[75] Dr. Bond did not testify that there was no linkage. What Dr. Bond stated was that he would not be able to comment definitively without looking at his clinical records for each time the complainant came to see him. Dr. Bond also testified that he only prescribed or suggested *continued use* of medical marijuana where conventional treatments had not worked and a patient responded positively to the medical marijuana. Implicit in this statement is the fact that if a patient was not responding positively to medical marijuana, Dr. Bond would not continue to prescribe it to the patient. Under questioning from the board, Dr. Bond expressly stated: “But if I have patients who've tried marijuana and it isn't improving their function then I suggest that we stop.”

[76] The respondent had the opportunity to question Dr. Bond and the following exchanges are the most germane to the question of the effectiveness of medical marijuana for the complainant:

Counsel for the Respondent: So let me just see if I – I have this right then, is it fair to say you – you prescribed medical marijuana to Mr. Skinner after he had tried other conventional painkillers and didn't have success with them?

Dr. Bond: Yes.

Counsel for the Respondent: Okay. And you're not saying he had no success with the other pain killers, you're saying marijuana provide – was more effective?

Dr. Bond: I'm – I'm saying that he had an inadequate improvement in function with the conventional painkillers.

Counsel for the Respondent: And – okay. So to finish that off then – and you said earlier when he's – when Mr. Skinner's using marijuana there is times when he has improved function and other times when he does not have improved function, is that right?

Dr. Bond: Yes.

[77] Following this exchange, counsel for the Commission had the following exchange with Dr. Bond:

Counsel for the Commission: I have a question. Dr. Bond, is it not true chronic pain, that it's episodal?

Dr. Bond: Yes. It – it can vary from week to week, yes.

Counsel for the Commission: Day to day, hour to hour. Thank you very much.

[78] While the respondent had an opportunity, it did not question Dr. Bond on whether periods of decreased functionality, while taking a particular medication, were indicative of that medication's ineffectiveness. Dr. Bond was not asked whether the complainant's continued usage of some amount of medical marijuana, occasionally up to his maximum prescription amount, during a time when his functionality deteriorated, was indicative of medical ineffectiveness. Dr. Bond was not asked how an average patient would respond to less than full access to prescribed pain medication. Dr. Bond was not asked how the effectiveness of medication can or should be assessed where the illness or symptom it is responding to is episodic.

[79] Instead, the respondent has made a bare assertion after that fact. The board has not been provided with any evidence to support this assertion. While the board can follow the respondent's reasoning, the board prefers Dr. Bond's sworn testimony that he only suggests continued use of medical marijuana where it is having a positive impact for the patient's functionality.

[80] Moreover, the complainant's testimony, unchallenged on cross-examination, was that medical marijuana has had a positive impact on his functionality. He further testified that he could not afford to consume the amount that he felt he needed to achieve his desired functionality. When asked whether more marijuana always improved his functionality, the complainant responded that the dose that he needed to manage his pain varied and depended on other factors such as his level of anxiety.

[81] Based on the foregoing, the board finds as fact, on a balance of probabilities, that medical marijuana was the most effective medication for treating the complainant's chronic pain. The board further finds that conventional medications were not effective because they had too many undesired side effects. The board agrees with the respondent's submission that the complainant has not established that conventional medications were ineffective or contraindicated with any other condition or illness he has, such as Hepatitis C. Conventional pain medications were ruled out by the complainant's treating physician because they did not improve his functionality and caused undesirable side effects.

[82] The complainant testified at length about the side effects he experienced when on conventional pain medication. What follows is only a very brief summary of this testimony.

[83] The complainant testified that the dose of conventional pain medication that he needed to take in order to obtain pain relief was so high that it left him often close to unconsciousness. He testified that this medication left him incontinent and that on multiple occasions he soiled his bed and couch, furniture that his family could not afford to replace. He testified that conventional medication altered his mood, making him irritable and angry, often towards his family members. He testified that it affected his libido and ability to be sexually intimate with his wife.

[84] The complainant further testified at length about what it was like to live in under-managed pain when he did not have adequate access to medical marijuana. Again, the board is only providing a very brief summary of this testimony.

[85] The complainant testified that the pain left him unable to work, resulting in the need to go on social assistance, an experience he found embarrassing and degrading. The complainant testified that the pain altered his mood to the point that he was a “horrible person.” The complainant testified about the anxiety he experienced from sudden and sharp pain episodes. He testified how these episodes could occur at the most inopportune times. He testified that waking up in pain screaming was so disruptive that he relocated to sleeping in the family’s shed so that his pain would have a lesser impact on their lives. Despite these efforts, the complainant also testified that his changed behavior had profound effects on his family. He testified how the pain left him disheveled and unable to socialize. He testified about having suicidal ideation in response to the pain.

[86] The complainant’s testimony on the impact of pain on his life was supported by letters from his psychologist, Dennis Allaby. Mr. Allaby, who passed away at some point between the filing of this complainant and the hearing before the board, writes:

Wayne has attended therapy for the past two years for chronic pain management and clinical depression which is linked directly to his experience of chronic pain. From my observations, when he has been on narcotic medications he has been folded over in pain, and even shaking with spasms on different occasions. He has experienced migraines and been so mentally distraught that antidepressants were necessary. The ineffectiveness and side effects from the narcotic medication were damaging to his physical health and to his family relationships. More specifically, he struggled to interact with his family due to not being fully coherent and this caused a great deal of strain on his marriage and on the quality of the relationships with his children: Exhibit 1, Agreed Statement of Facts, Exhibit Book, Tab 6.

[87] In summary, the under-management of the complainant’s chronic pain had a severely negative impact on him and his family. Medical marijuana was initially prescribed to the complainant because conventional pain medications were ineffective and caused too many undesirable side effects. Medical marijuana was found to be effective at improving the complainant’s functionality. This had a significant improvement on the complainant’s mental well-being and life. However, none of this is determinative, in and of itself, of the issue that is before the board and the question of whether there has been a violation of the *Act*.

Issue

[88] Whether the Welfare Plan's exclusion of coverage for medical marijuana and/or the Trustees' refusal to exercise their discretion to extend coverage for medical marijuana amounts to a violation of the *Act*?

Analysis

Test for Discrimination

[89] The legal approach for resolving human rights complaints is two-fold. First, the complainant must establish, on a balance of probabilities, a *prima facie* case of discrimination. Second, and only if a *prima facie* case is proven, the respondent must establish, on a balance of probabilities, either 1) that a statutory exemption under human rights legislation applies, or 2) a non-discriminatory justification for its policy or practice *and* evidence that it took reasonable steps to accommodate the complainant up to the point of undue hardship: *Ontario Human Rights Commission v Simpson-Sears Ltd.*, [1985] 2 SCR 536 at 558-559; *British Columbia (Public Service Employee Relations Commission) v British Columbia Government Service Employees' Union*, [1999] 3 SCR 3 at 32-33; *Moore v British Columbia (Education)*, [2012] 3 SCR 360 at para 33.

[90] While human rights legislation is quasi-constitutional and must be construed in accordance with *Charter* values, the resolution of human rights complaints is a statutory exercise and the starting point is the relevant legislation: *International Association of Fire Fighters, Local 268 v Adekayode*, 2016 NSCA 6 at paras 59-60 [*Adekayode*].

[91] Accordingly, section 4 of the *Act* provides the following meaning of discrimination:

For the purpose of this Act, a person discriminates where the person makes a distinction, whether intentional or not, based on a characteristic, or perceived characteristic, referred to in clauses (h) to (v) of subsection (1) of Section 5 that has the effect of imposing burdens, obligations or disadvantages on an individual or a class of individuals not imposed upon others or which withholds or limits access to opportunities, benefits and advantages available to other individuals or classes of individuals in society.

[92] Based on this definition, there is a three-part legal test for establishing a *prima facie* case of discrimination in Nova Scotia. A complainant must prove: 1) a distinction (intentional or non-intentional), 2) based on a characteristic outlined in the *Act*, and 3) that imposed a burden, obligation or disadvantage on the complainant or a class of individuals that was not imposed on others (or the corollary of denying a benefit to the complainant or class that was afforded to others).

Human Rights Review of Benefits Plans

[93] Applying the test for *prima facie* discrimination to benefits plans is not a simple task. Unlike other jurisdictions that broadly exempt bona fide retirement, pension or employee benefits plans from the ambit of human rights legislation, the *Act* only excludes aged-based distinctions in such plans from the prohibition against discrimination.

[94] Paragraph 6(1)(g) of the *Act* states that the prohibition against discrimination does not apply: “to prevent, **on account of age**, the operation of a bona fide pension plan or the terms or conditions of a bona fide group or employee insurance plan” [emphasis added].

[95] Accordingly, in Nova Scotia, where a pension or employee insurance plan is developed for a sound and accepted business purpose, age-based distinctions will not amount to discrimination under the *Act*: *Tri-County Regional School Board v Nova Scotia (Human Rights Board of Inquiry)*, 2015 NSCA 2. In this case, the distinctions at issue are not age-based, therefore, the exemption in paragraph 6(1)(g) of the *Act* does not apply.

[96] The *Act* also exempts benefits plans from the prohibition against discrimination where the objective or reason for differential treatment under a benefits plan is “the amelioration of conditions of disadvantaged individuals or classes of individuals...”: *Act*, s 6(i). It was such an objective that led the Court of Appeal in *Adekeyode* to conclude that giving more benefits to a particular class of persons was not discriminatory under the *Act*. In this case, there is no objective of amelioration of conditions of disadvantaged individuals or classes of individuals, therefore, the exemption in paragraph 6(1)(i) of the *Act* does not apply.

[97] The final aspect of the *Act* that could potentially exempt an employee benefits plan from scrutiny is paragraph 6(1)(f), which reads:

where a denial, refusal or other form of alleged discrimination is

(i) based upon a *bona fide* qualification,

(ia) based upon a *bona fide* occupational requirement; or

(ii) **a reasonable limit prescribed by law as can be demonstrably justified in a free and democratic society** [emphasis added];

[98] The thrust of paragraph 6(1)(f) addresses bona fide job qualifications or occupational requirements and the vast majority of case law citing this paragraph has the same focus. However, subparagraph 6(1)(f)(ii) exempts denials, refusals, or other forms of allegedly discriminatory treatment from the *Act* where the limitation is prescribed by law *and* can be demonstrably justified in a free and democratic society.

[99] In *Gilliard v Pictou (Town)* (2005), 53 CHRR D/211, 2005 CarswellNS 650 (NS BOI), the board considered whether the Town of Pictou’s by-law exempted or justified its denial of the complainant’s request for access to a public performance facility, but the board did not discuss subparagraph 6(1)(f)(ii) of the *Act* at length. Beyond this case, there has been no extensive treatment of this subparagraph.

[100] Subparagraph 6(1)(f)(ii) of the *Act* has two components. First, any denial, refusal or other allegedly discriminatory treatment must be “prescribed by law.” Second, it must be “demonstrably justified in a free and democratic society.” The wording is essentially identical to the substantive portion of section 1 of the *Charter*; therefore, it should be interpreted to have the same meaning.

[101] In the context of the *Act*, “prescribed by law” means a denial, refusal or other allegedly discriminatory treatment that is “expressly provided for by statute or regulation, or results by necessary implication from the terms of a statute or regulation or from its operating requirements ... [or] from the application of a common law rule”: *R v Therens*, [1985] 1 SCR 613 at 645.

[102] The Welfare Plan was created as part of a private law interaction. None of the parties have suggested that the Welfare Plan or the Trustees’ decisions are “prescribed by law.” Accordingly, subparagraph 6(1)(f)(ii) of the *Act* does not apply and it is unnecessary to discuss the meaning of “demonstrably justified” in the context of the *Act*. However, the board notes that this subparagraph could theoretically apply to an aspect of a *public* benefits plan that was created by statute, regulation or extension of a common law rule.

[103] Even though retirement, pension or employee benefits plans are not exempt from scrutiny under the *Act* (except as discussed above), in enquiring whether a particular part of a benefits plan is discriminatory or whether discretionary decisions made under a plan are discriminatory, the board must be cognizant of its impact on freedom of contract and private law bargaining.

[104] In a well-functioning and efficient market, the insurance premiums paid for a benefits plan will have been carefully matched to the scope of coverage for unknown future losses. If that scope of coverage is expanded, there is a possibility that the premiums will no longer reflect the private law bargain that was struck. This does not mean, however, that economic efficiency or private law bargaining arguments will displace scrutiny under the *Act*.

[105] The Legislature has made clear its intention *not* to broadly exempt benefits plans from such scrutiny in Nova Scotia. The Supreme Court of Canada has made clear that private parties cannot contract out of human rights legislation within a collective agreement and that any such clauses are void *pro tanto*: *Craton v Winnipeg School Division No 1*, [1985] 2 SCR 150.

[106] But the Supreme Court of Canada has also held that a collective agreement may be the best evidence of the reasonable accommodation balance that was struck to the mutual benefit of the employer and employees: *Syndicat des employés de l’Hôpital général de Montréal v Sexton*, 2007 SCC 4, paras 18-19 [*Sexton*]. Accordingly, the board must be careful in its application of the *Act* to benefits plans, like the Welfare Plan, that form part of a collective agreement, and cognizant of the other important legal values and goals at stake.

Public or Employee Benefits Plan Case Law

[107] The respondent provided the board with two cases and four human rights tribunal decisions where the question was whether a benefits plan discriminated against the complainant:

Battlefords and District Co-op v. Gibbs, [1996] 3 SCR 566 [Gibbs]; *Adekayode, supra*; *Ball v Ontario (Community and Social Services)*, 2010 HRTO 360 [Ball]; *El Jamal v Minister of Long-Term Care*, 2011 HRTO 1952 [El Jamal]; *Kueber v Ontario (Attorney General)*, 2014 HRTO 769 [Kueber]; *Marshall v Ontario (Health and Long-Term Care)*, 2014 HRTO 1580 [Marshall]. Neither the Commission nor the complainant provided the board with any relevant cases that applied human rights law to an allegation of a discriminatory benefits plan.

Appellate Court Jurisprudence

[108] In *Gibbs*, Sopinka J writing for the majority, held that it is necessary to employ a purposive analysis of a benefits plan when analyzing whether a particular clause was discriminatory under human rights legislation. The starting point is thus a determination of the purpose of a plan. This is followed by a comparison of the benefits allocated to employees for the same purpose, as opposed to comparing benefit provision for disparate purposes, which would obviously be different.

[109] Under a purposive analysis, the majority stated at 582:

it is not a justification for the employer to point out that the plan treated all employees equally prior to the materialization of the risk of disability. A contract that explicitly provides for distinctions on prohibited grounds, albeit distinctions that only potentially occur in the future, is contrary to the objects of human rights legislation.

[110] The majority further held the appropriate distinction to compare was between people who were unable to work because of mental disability and people who were unable to work because of physical disability, and reasoned that since these two groups were explicitly treated differently under the benefits plan, discrimination had been established.

[111] In *Gibbs*, McLachlin J (as she then was) wrote a concurring opinion that is relevant to this inquiry. McLachlin J cautioned that a purposive focus on the class of person being compensated under a benefits plan, rather than the need being provided for, could open the door to benefits plans that are narrowly constructed so as to permit *de facto* discrimination against persons who fall outside a particular construction. According to McLachlin J, the appropriate response is for the Legislature to provide exemptions from human rights legislation that would allow benefits plans to justify the unequal provision of benefits in certain circumstances.

[112] It is important to note that this framework continues to be consistent with the Supreme Court of Canada's more recent *Charter* jurisprudence addressing allegations of discriminatory government benefit programs: *See Auton (Guardian ad litem of) v British Columbia (Attorney General)*, 2004 SCC 78 at para 42 [Auton]; *Hodge v Canada (Minister of Human Resources Development)*, 2004 SCC 65 at paras 24-26; *Nova Scotia (Workers' Compensation Board) v Martin*, 2003 SCC 54 at para 94 [Martin]. This jurisprudence has tended to blend formal and substantive comparisons and repeatedly clarified that discrimination analysis, under the *Charter*, should not be formulaic: "The central and sustained thrust of the Court's s. 15(1) jurisprudence has been the need for a substantive contextual approach and a corresponding repudiation of a formalistic 'treat likes alike' approach": *Withler v Canada (Attorney General)*, 2011 SCC 12 at

para 32; *See also R v Kapp*, 2008 SCC 41; *Andrews v Law Society of British Columbia*, [1989] 1 SCR 143; *Quebec (Attorney General) v A*, [2013] 1 SCR 61; *Kahkewistahaw First Nation v Taypotat*, [2015] 2 SCR 548.

[113] In many respects, this blended approach of looking at both the formal class of persons being covered and the substantive need being addressed, under a benefits plan, can be seen in the Nova Scotia case of *Adekayode*. There, one class of employees received parental leave top-ups that another class of employees did not. While the board initially held that the distinction amounted to a violation of the *Act*, this was overturned on appeal by the Court of Appeal. The Court found that the *Act* permitted the unequal provision of benefits in circumstances where they were justified on an ameliorative basis, and concluded that the sub-class of persons who received extra benefits were generally in a more challenging position that justified those differential benefits.

[114] Neither *Gibbs* nor *Adekayode* are directly analogous to this case. In both of those cases, the benefits plan at issue made explicit distinctions between beneficiaries based on an enumerated ground. In *Gibbs*, employees who became disabled because of a mental disorder were entitled to a shorter period of sick leave benefits than employees who became disabled for other reasons. In *Adekayode*, the collective agreement topped up the federal Employment Insurance benefits for adoptive parents on leave, but did not provide the same benefit to birth parents.

[115] In this case, there is no direct or formal distinction being made between beneficiaries; the Welfare Plan does not cover medical marijuana for any person. If the Welfare Plan discriminates it does so in a non-direct or adverse fashion in the sense that an apparently neutral eligibility rule adversely affects the complainant.

[116] The *Act* prohibits both direct and adverse distinctions when they are made based on an enumerated ground and result in unequal imposition of disadvantage. Therefore, the test for *prima facie* discrimination and any case law expanding on this test must be construed in a way that allows for the possibility of adverse effects discrimination.

[117] In *British Columbia (Public Service Employee Relations Commission) v British Columbia Government Service Employees' Union*, [1999] 3 SCR 3 [*Meiorin*], the Supreme Court of Canada addressed the distinction between direct and adverse effect discrimination. This took place in the context of the appropriate test for assessing bona fide occupational requirements and not in the context of the appropriate test for *prima facie* discrimination. McLachlin J (as she then was), writing for a unanimous Court, provided lengthy reasons why direct and adverse effect discrimination should be treated the same under human rights law.

[118] Most importantly, for the purposes of this inquiry, McLachlin J noted how distinctions between direct and adverse discrimination could have pernicious results including the legitimization of systemic discrimination. In particular, McLachlin J cited with approval at 25, the following passage from an academic article:

The difficulty with [treating direct and adverse discrimination differently for the purposes of bona fide occupational requirement assessments] is that it does not challenge the imbalances of power, or the discourses of dominance, such as racism, ablebodyism and sexism, which result in a society being designed well for some and not for others. It allows those who consider themselves ‘normal’ to continue to construct institutions and relations in their image, as long as others, when they challenge this construction are ‘accommodated’: Shelagh Day & Gwen Brodsky, “The Duty to Accommodate: Who Will Benefit?” (1996), 75 Can Bar Rev 433 at 462 [parenthetical additions not in original].

[119] In agreeing with this passage, McLachlin J held at 26: “Interpreting human rights legislation primarily in terms of formal equality undermines its promise of substantive equality and prevents consideration of the effects of systemic discrimination....”

[120] The meaning of *substantive equality*, for the purposes of human rights law, was recently discussed by the Court of Appeal in *Adekayode*. There, the Court explained: “Substantive equality aims to capture the discriminatory effects of a facially neutral law or a formally well-meaning program. It is about substance over form.” The Court went on to cite a lengthy passage from Peter W Hogg, *Constitutional Law of Canada* (Toronto: Carswell, 2007), looseleaf 5th ed supplemented, vol 2, which discusses how a law or policy can be discriminatory on its face, in its effect, or in its application.

[121] The board has not been presented with any binding precedent that supports the proposition that non-direct or adverse effects discrimination cannot take place in the context of employee benefits plans. On the contrary, the Supreme Court of Canada’s jurisprudence, in both *Charter* and human rights cases, suggests that promises of equality and prohibitions against discrimination should be broadly interpreted, including in benefits plan cases, to address both direct and adverse forms of discrimination.

[122] To summarize, the starting point, for answering whether a benefits plan is discriminatory under the *Act*, is a determination of the purpose of the plan in all of the circumstances. The next step is a comparison of how the benefits are allocated to beneficiaries under the plan. The relevant analytical point of comparison is the benefits being received for the same purpose *not* the benefits being received for different purposes. This comparison should not be formulaic and should take into consideration substantive equality. In other words, the comparison should employ a broad and purposive interpretation of the *Act* that incorporates the possibility of both direct and adverse effects discrimination.

Human Rights Tribunal Jurisprudence

[123] The human rights tribunal cases provided by the respondent are all decisions of the Human Rights Tribunal of Ontario. Accordingly, they are not technically binding on this board. More importantly, they are also not directly analogous to this case and in some instances suffer from erroneous reasoning that is inconsistent with binding appellate precedent.

[124] The human rights tribunal cases cited are distinguishable for two reasons. First, the Ontario *Human Rights Code*, RSO 1990, c H.19 (the “*Code*”) uses different language to prohibit discrimination. The *Code* is framed in terms of granting a right to every person to “equal treatment with respect to services” and the right to receive those services without discrimination based on enumerated grounds. This invites a focus on whether a complainant was treated equally. The *Code* also does not expressly include direct and non-direct unequal treatment in its prohibition. By contrast, the *Act* focuses on whether a direct or indirect distinction was discriminatory. With this said, the human rights jurisprudence that has emerged in Ontario and Nova Scotia is quite similar, despite this different statutory language; therefore, the difference in language is not a sufficient reason, in and of itself, to not be persuaded by Ontario tribunal decisions (even if it may explain why some tribunal decisions reached a different result).

[125] Second, in each of the cases provided, the allegation of discrimination was against a public benefits plan, the Ontario Drug Benefit Program. In this inquiry, the allegation of discrimination is against a private employee benefits plan. There are important distinctions between private and public benefits plans.

[126] The purpose of public benefit programs can be different than private benefits plans. Unlike some employee benefits plans, like the Welfare Plan in this inquiry, the purpose of public benefit programs is not to maximize benefits but to provide a sufficient level of benefits. Governments are responsible for providing programming in a variety of areas and must balance the level of service provision and funding in one area against the level of service provision and funding in other areas. Human rights tribunals and reviewing courts are thus cognizant of the polycentric nature of government decision-making when service levels are set, and careful not to permit public law to inappropriately infringe on Legislative powers. This can be observed in *Ball*, where the Ontario Human Rights Tribunal stated at para 2:

At the heart of this case [which dealt with special diet allowances under the Ontario Disability Support Program] is a significant tension inherent in the design of large-scale benefit programs for people with disabilities. On one hand, an important value of human rights law is responsiveness to individual characteristics and needs that stem from disability. On the other, the effective, fair, and consistent administration of benefit programs that promote equality for persons with disabilities may be better done through the use of categories. This Decision requires balancing of these sometimes conflicting values in determining whether and how the special diet program violates the *Code*.

[127] By contrast, the purpose of the Welfare Plan in this inquiry is to provide the maximum level of benefits to employees that is possible while maintaining economic efficiency and sustainability.

[128] These two distinctions, different statutory language and public/private framework, are sufficient to reduce the persuasive value of the human rights tribunal decisions provided. But the persuasive value of some of the decisions is further reduced because of the erroneous reasoning employed.

[129] In *Ball*, the issue was whether the special diet component of Ontario’s social assistance programs discriminated against certain persons with disabilities, either because the special diet they required was not funded or because it was funded at a lower proportion of the actual expense of the diet as compared to other individuals with disabilities.

[130] After providing a helpful review of human rights case law as it applies to benefits programs, the tribunal turned its attention to the purpose of the special diet component. The tribunal held this determination was a legal question, not a factual one, that was to be “based upon the legislation and regulations and appropriate extrinsic evidence”: *Ball* at para 77.

[131] Relying on the fact that the special diet component was one of four components of the social assistance program, and citing the Supreme Court of Canada’s acceptance in *Martin* of the need for large-scale compensation systems to employ categories or classes, the tribunal stated:

It is evident, in my view, that the purpose of the program is to provide funding for diets where this is generally medically recognized as a treatment for the disability experienced by the individual. The program is not intended to fund scientifically unrecognized, experimental, or ‘fad’ diets. It is not intended to fund an individually developed diet tailored to all of a person’s characteristics and circumstances, prescribed by a dietician or other health practitioner. **It is designed to fund diets in circumstances where, as a result of the individual’s disability or disabilities, the need for a special diet is generally recognized in the Ontario medical community:** *Ball* at para 94 [emphasis added].

[132] The respondent argues that *Ball* stands for the proposition that the Welfare Plan was only obligated to pay for drugs or medicines that are generally recognized by the medical community. The problem with this argument (as will be elaborated on below) is that the purpose of Ontario’s special diet program is not the same as the Welfare Plan, and the statutory framework in which both arise is different. *Ball* supports the proposition that a “generally recognized by the medical community” standard applies for Ontario’s special diet component, but this does not mean that such a standard will apply automatically to any other public or private benefits program or plan.

[133] In *El Jamal*, the issue was whether the Ontario Drug Benefit Program’s failure to fund a particular drug amounted to a violation of the *Code*. The drug in question was medically necessary for the complainant’s disability and had been prescribed, but was not included in the program’s formulary and the complainant’s request for case-by-case approval had been denied. Unfortunately, the tribunal’s decision does not discuss the extent of the complainant’s disability, the medical use of the drug (Phosphate Novartis), nor the extent of the negative impacts of non-use on the complainant, except to say that “the respondent’s denial of funding was frustrating for the applicant and that it lead to unfortunate health-related difficulties for him”: *El Jamal* at para 15.

[134] The tribunal concluded that there had been no *Code*-related violation. It based this conclusion on five grounds. First, the applicant’s argument would require the tribunal to adjudicate the appropriate scope of a benefit plan, an inquiry that was beyond the purpose of the *Code*. Second, differential treatment was a prerequisite for a *Code*-related violation and such

treatment could not arise in the context of non-inclusion of coverage, only from under-inclusion of coverage. Third, the complainant's argument would require coverage for all drug products for eligible disabled people. Fourth, the complainant had not put forward any evidence or expected evidence to show that non-coverage "detrimentally affects persons with particular disabilities differently [than] it does individuals who do not have these disabilities": *El Jamal* at para 23. Fifth, the complainant had not argued his disability was factor in the negative case-by-case decision, and the tribunal did not have the power to consider whether he was treated fairly or appropriately.

[135] In *Kueber*, the issue was again whether the Ontario Drug Benefit Program's failure to fund a particular drug, in this case medical marijuana, amounted to a violation of the *Code*. Unlike in *El Jamal*, which was decided using a summary hearing, *Kueber* proceeded to a full hearing. The tribunal heard evidence from the complainant, who was self-represented, and from the Director of Drug Program Services within the relevant ministry. Relying on the framework developed in *Gibbs* and applying *El Jamal*, the tribunal determined that it was not a violation of the *Code* to deny coverage for medical marijuana under the program.

[136] The tribunal noted that the program was limited to drugs that had been approved by Health Canada and reviewed by an expert medical panel within the relevant provincial ministry. The tribunal further noted that of 10,000 to 15,000 drugs approved by Health Canada, only 3,800 had been approved for inclusion on the program's formulary.

[137] In applying *Gibbs*, the tribunal concluded that the purpose of the program was "to provide cost-effective drug product coverage based on the best clinical and economic evidence available ... [and] not to provide funding for every drug or treatment that may provide a therapeutic benefit to an eligible person": *Kueber* at para 25.

[138] The tribunal assumed that marijuana was effective for treating the complainant's pain, but nonetheless concluded that exclusion of the drug under the program did not arise as a result of a *Code*-related reason. The tribunal explained at paras 28-29:

There is no evidence before the Tribunal of such a *Code*-related reason. The purpose of the Program is to provide a cost-effective drug plan to eligible persons. By definition, the plan cannot include every treatment that may have a therapeutic benefit. There is no question that the applicant, as a person with a disability, is denied something that would help her pain, but that cannot be the test. To apply that test would mean the Ministry discriminates against eligible persons when they are denied any disability-related therapy. This is contrary to the very purpose of the Program. It would also defeat the purposes of the *Code* to apply such a broad definition to discrimination. As the Tribunal stated in *El Jamal* at paragraph 19, 'the purpose of the *Code* is not to define the appropriate scope of a benefit plan without regard to the underlying purpose of the plan or to require that benefits be made available to individuals simply because they identify with a *Code*-related factor.'

Unlike in *Gibbs* and *Brooks* where employees were denied employment benefits for discriminatory reasons, there is no *Code*-related reason in this case. Medical marijuana

is not covered because it is not a drug approved by Health Canada and because the government disputes its efficacy and safety. The evidence before me suggests, at the very least, that there is a dispute regarding its efficacy and safety notwithstanding the applicant's own experience. There may also be public policy reasons as to why marihuana is not paid for by the government. Despite the multitude of reasons that may exist for excluding medical marihuana from coverage, there is no evidence that any of them are *Code*-related. It is for this reason that the Application is dismissed.

[139] The tribunal did not consider whether case-by-case denial amounted to a violation of the *Code* because the complainant had not requested case-by-case coverage.

[140] In *Marshall*, the issue was again non-coverage of a drug under the Ontario Drug Benefit Program. The drug had previously been covered when it was manufactured and sold in Canada, but was removed from the formulary when the manufacturer began limiting its production and sale to the United States. The complainant sought coverage for the costs associated with filling a prescription for the drug in the United States, but was denied by the program. After citing the reasoning in *El Jamal* at length and noting the decision in *Kueber*, the tribunal concluded that no *Code*-related violation had occurred.

[141] In *El Jamal*, *Kueber*, and *Marshall*, the result was predicated on a particular articulation of the purpose of the Ontario Drug Benefit Program. The board takes no issue with this articulation, but notes that it is not transferable to the Welfare Plan. What the board does take issue with is the human rights reasoning employed.

[142] While the board accepts that benefits plans cannot cover the sun, moon, and the stars, consideration of whether non-coverage of a particular drug, for a particular person, amounts to discrimination, does *not* mean that a benefits plan will immediately be required to cover all drugs prescribed to a person with a disability. Such reasoning is simplistic and ignores the complexity of human rights jurisprudence.

[143] The *prima facie* discrimination test is tripartite and requires a distinction, based on an enumerated ground, that imposes disadvantage(s) not imposed on others. It goes without saying that not all distinctions will automatically establish *prima facie* discrimination. Even where *prima facie* discrimination is established, human rights law permits justifications for why a particular policy or action was necessary or why it would be unreasonable to require a respondent to alter its policy or action. In other words, a finding that non-coverage of a particular drug, in particular circumstances, constitutes *prima facie* discrimination, does not necessarily mean that non-coverage amounts to a violation of human rights legislation for that drug, let alone other drugs or other circumstances.

[144] Appellate courts have been clear that human rights legislation is to be given a broad and purposive interpretation that incorporates notions of substantive equality into the analysis. Instead, the tribunal in *El Jamal*, *Kueber*, and *Marshall* has taken an overly formulaic approach, one that asks whether all eligible persons were formally treated the same, not whether the effects of an apparently neutral rule were borne adversely or unequally.

[145] In each case, the tribunal appears to have presumed that adverse effects discrimination cannot occur in the context of public benefits programs. While the leading cases are examples of direct discrimination, no precedents have been provided to support the proposition that there cannot be adverse effects discrimination in the context of a benefits plan.

[146] On the contrary, in its section 15 *Charter* jurisprudence, the Supreme Court of Canada has made clear that public benefits programs can discriminate indirectly or by effect:

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

[147] To the extent that the tribunal, in *El Jamal*, *Kueber*, and *Marshall*, concluded that the exclusion resulting from non-coverage was consistent with the overall purpose of the program, the reasoning employed may be correct and consistent with the Supreme Court of Canada's directions. But what is problematic is that the tribunal's conclusion in each case, regarding consistency, was reached on a formal basis with only minimal substantive analysis of the individual complainant's circumstances.

[148] The tribunal in each case provided almost no analysis of an individual complainant's disability nor the negative medical or personal effects of non-coverage of a drug. Instead the tribunal characterized the impact of non-coverage as frustrating or resulting in undescribed "health-related difficulties": *El Jamal* at para 16. It may be that functional outcomes were properly not part of the purpose of the program in those cases—though the inclusion of coverage on a case-by-case basis or in rare and immediately threatening circumstances would suggest otherwise—but this does not mean that functional outcomes or an individual's substantive experience are irrelevant to other benefits programs.

[149] In summary, *stare decisis* does not require the board to follow decisions of the Human Rights Tribunal of Ontario. The persuasive value of the tribunal decisions provided is minimal because the purpose of the program under review in each of those cases is substantially different from the purpose of the Welfare Plan in this inquiry. The board is required to give the *Act* a broad and purposive interpretation when assessing whether a benefits plan is discriminatory and must apply the test for *prima facie* discrimination in a manner that includes direct, indirect, and

adverse effects discrimination. The substantive impact of non-coverage on a complainant may be relevant in the inquiry where part of the purpose of a plan is to ensure that certain needs are met.

Prima Facie Discrimination

[150] The board must apply the foregoing to the issue in this inquiry: Whether the Welfare Plan's exclusion of coverage for medical marijuana and/or the Trustees' refusal to exercise their discretion to extend coverage for medical marijuana amounts to a violation of the *Act*?

[151] Following the process described in *Gibbs*, the first step is a determination of the purpose of the Welfare Plan. The second step is a comparison of the benefits allocated to employees for the same purpose.

Step 1 – Determination of the Purpose of the Welfare Plan

[152] The Welfare Plan includes a purpose statement that reads:

The Trustees agree to receive, hold and administer the Trust Fund **for the purpose of providing Benefits for Employees** and their beneficiaries in accordance with the Welfare Plan adopted from time to time by the Trustees and to pay the costs of administration of the Welfare Fund and Plan incurred by the Trustees pursuant to the provisions of this Agreement: Agreed Statement of Facts, Exhibit Book, Tab 1.

[153] The Welfare Plan grants the Trustees various powers necessary to operate a pension and benefits scheme, but for gleaning the overall purpose of the Welfare Plan, Article 4, Section 3(m) is most helpful:

The Trustees are hereby empowered, in addition to such other powers as are set forth herein or conferred by law:

...

(m) generally to do all acts, whether or not expressly authorized herein, which the Trustees may deem necessary to accomplish the general objective of enabling the Employees to obtain Benefits in the most efficient and economical manner.

[154] The Welfare Plan Member Booklet further explains:

The Welfare Plan was designed to provide you and your eligible dependents with health and welfare protection. You, as the member, will be reimbursed for specific medical, health and dental costs which you have incurred. In addition, the Plan provides you with life, accidental death and dismemberment, and disability insurance: Agreed Statement of Facts, Exhibit Book, Tab 2, p 7.

[155] The letter from the Trustees that prefaces the Member Booklet states:

The Welfare Plan was established in 1952 and the Pension Plan was established on October 1, 1962. **Since then due to the sound financial condition of the Trust Funds the Trustees have been able to extend and improve the benefits under both Plans from time to time:** Agreed Statement of Facts, Exhibit Book, Tab 2, p 1.

[156] Based on this framework, I find that the legal purpose of the Welfare Plan is to provide benefits to beneficiaries, but to do so in a way that is efficient, economical, and sustainable. This means that the purpose of the Welfare Plan is not to cover everything, but where the financial condition of the Trust Funds permits, the purpose of the Welfare Plan is to increase the pension and welfare benefits available to beneficiaries, subject to the caveat of sustainability and maintenance of appropriate reserves. In this sense, the purpose of the Welfare Plan is to maximize the pension and welfare benefits available to beneficiaries without compromising the financial viability of the Trust Funds.

Step 2 – Comparison of the Benefits Allocated to Beneficiaries

[157] The respondent argues that the complainant was not treated any differently than any other beneficiary under the Welfare Plan. Medical marijuana was not covered for anyone; therefore, the complainant was not subjected to differential treatment. This argument would only be correct if human rights law was limited to formal distinctions. Instead, the board must analyze the substantive treatment of beneficiaries under the Welfare Plan. The analytical point of comparison is the drug coverage available to beneficiaries and not some other benefit.

[158] In addition to maximizing benefits of beneficiaries, the Welfare Plan is also designed to take the special medical needs of beneficiaries into account. While the Welfare Plan normally only covers generic drugs, it includes a process for covering name brand medication where the prescribing physician states on the prescription that “no substitution” is permitted: Exhibit 1, Agreed Statement of Facts, Exhibit Book, Tab 2, p 28. Where this occurs, the Welfare Plan covers the full cost for the brand name medication. This suggests that some beneficiaries get special coverage, based on their medical needs, when recommended by their physician.

[159] The Welfare Plan’s exclusion of medical marijuana was not designed to treat certain beneficiaries differently than others, but this exclusion had the substantive result or effect of treating the complainant differently. Whereas some beneficiaries receive coverage for their medically-necessary, prescription drugs, by special request, the complainant’s special request for a medically-necessary, prescription drug, is excluded by the plan because the drug in question has not been formally approved by Health Canada even though it can be legally prescribed. This is a distinction within the meaning of section 4 of the *Act*.

[160] The exclusion of coverage resulted in a burden or disadvantage for the complainant. Unlike other beneficiaries, he was denied coverage of the drug his physician had prescribed, a drug, which on the facts of this case, was only prescribed *after* all conventional pain medication had been tried without success.

[161] In its post-hearing brief, the respondent argued that medical marijuana was not medically necessary for the complainant even though it may have been beneficial. The respondent cites

King v Ontario (Community and Social Services), 2015 HRTO 307 [*King*] for the proposition that evidence of a medical benefit is not the same as evidence of medical necessity.

[162] *King* is another Ontario Human Rights Tribunal decision where the question was whether the coverage being requested was one that was “generally recognized by the medical community.” I have already explained that this is a standard that is unique to the public benefits programs at issue in the cases cited by the respondent. The Welfare Plan, by contrast, only requires a finding of medical necessity.

[163] In any case, the test for *prima facie* discrimination requires proof of a “disadvantage” not proof that a complainant was denied something that is “medically necessary.” Limiting coverage to medically necessary drugs may be a relevant factor at the justification stage of the human rights analysis, but it is not, in my view, the appropriate standard at the *prima facie* stage of the analysis.

[164] The Legislature chose not to qualify the word “disadvantage” in section 4 of the *Act*. It did not, for example, use the words “substantial disadvantage” or “significant disadvantage” or “serious disadvantage.” At the same time, it is also clear that there is a *de minimis* component to “disadvantage.” Human rights law is not supposed to be engaged by mere trifles.

[165] In my view, the meaning of “disadvantage” in section 4 of the *Act* is flexible. What disadvantage means will depend on the circumstances of a given case in conjunction with an assessment of the other factors of the test for *prima facie* discrimination. This is consistent with appellate instruction that the test should not be applied formulaically.

[166] Denial of coverage of a drug that has been prescribed by a physician is sufficient to meet the standard of “disadvantage.”

[167] The board has already reviewed at length (above) the beneficial impact of medical marijuana for the complainant. The board reiterates its finding that medical marijuana was effective at improving the complainant’s functionality and resulted in a significant improvement in the complainant’s mental well-being and life. Non-coverage threatened these benefits and produced numerous externalities beyond the complainant’s own personal experience, such as a family member being called in to acquire marijuana on behalf of the complainant through informal avenues. The cumulative effects of non-coverage resulted in a substantial disadvantage for the complainant and his family.

[168] If I am wrong and the meaning of disadvantage in the *Act*, in these circumstances, requires a finding that coverage of a given drug was medically necessary, I reiterate that I have already determined medical marijuana was medically necessary for the complainant. As the board explained in greater detail above, the regulatory regime in place, at the time the complainant was prescribed medical marijuana, required a finding of medical necessity. A finding of medical necessity is also supported by the testimony of the complainant’s treating physician. The respondent has not led any evidence to counter the medical necessity of marijuana for the complainant. The respondent’s submissions on this point amount to a parsing of the evidence and are rejected.

[169] “Distinction” and “disadvantage,” alone, are insufficient to meet the test for *prima facie* discrimination. As Abella J explained, in concurring reasons, in *Sexton* at para 49:

[T]here is a difference between discrimination and a distinction. Not every distinction is discriminatory. It is not enough to impugn an employer’s conduct on the basis that what was done had a negative impact on an individual in a protected group. Such membership alone does not, without more, guarantee access to a human rights remedy. It is the link between that group membership and the arbitrariness of the disadvantaging criterion or conduct, either on its face or in its impact, that triggers the possibility of a remedy. And it is the claimant who bears this threshold burden.

[170] The *Act* ensures this linkage by requiring that any impugned distinction be “based on” an enumerated ground. The respondent argues the exclusion of medical marijuana in the Welfare Plan was based on sound, non-arbitrary policy choices, namely the non-approval of medical marijuana by Health Canada, and not based on the applicant’s disability. The complainant argues the Trustees denied him coverage because of stigma associated with some of his disabilities. The Commission contends the Trustees’ decision was “based on” the complainant’s disability because the complainant made an explicit accommodation request to the Trustees.

[171] The meaning of “based on” in the *Act* and comparable language in other human rights legislation in Canada has received recent appellate consideration. Both the Supreme Court of Canada and the Court of Appeal have made clear that “based on” should not be interpreted as creating a causal relationship requirement between the differential treatment and the complainant’s enumerated characteristic; instead, courts have preferred to use the terms “factor” or “connection” while recognizing that this does not change the legal onus that is on the complainant: *Quebec (Commission des droits de la personne et des droits de la jeunesse) v Bombardier Inc (Bombardier Aerospace Training Center)*, 2015 SCC 39 at paras 49-52; *Nova Scotia Liquor Corporation v Nova Scotia (Board of Inquiry)*, 2016 NSCA 28 at paras 46-47.

[172] Applying the terms “factor” or “connection” is more difficult in cases, like this one, where the differential treatment resulted from non-direct or adverse effects. The concern in adverse effects cases is not that a person’s enumerated ground was factored into a given decision, but that their particular needs were not factored in at all or at least not adequately enough.

[173] The problem of ablebodyism is not that the able-bodied in society will be actively looking to treat persons with disabilities differently—though such direct discrimination does occur—the problem with ablebodyism is that it leads the able-bodied to construct the basic institutions of our society and to make related policy choices as though the relevant needs to be met are those of the able-bodied.

[174] Similarly, in *Meiorin*, there was no allegation that the employer’s aerobic fitness standard for forest firefighters was designed to discriminate against women. The standard developed was in response to a Coroner’s Inquest Report, and both men and women were included in the study groups that led to the standard. A follow-up study recommended that the employer “initiate another study to examine the impact of the Tests on women” but this appears not to have been

acted upon: *Meiorin* at paras 6-8. Thus, the allegation in *Meiorin*, like in this case, was one of non-consideration or under-consideration of the impact of a policy on an enumerated group.

[175] In *Meiorin*, the Court held there was one test for justifying a *prima facie* case of either direct or adverse effects discrimination on the grounds of bona fide occupational standards. The Court did not discuss an application of the *prima facie* discrimination test in any detail, but implicitly accepted that it had been satisfied by the complainant.

[176] It is not clear, from the Court's reasons, whether *prima facie* discrimination was established at the time the policy was developed, at the time the follow-up study researchers recommended further sex-based analysis, or at the time when the complainant brought the differential impact, based on sex, to her employer's attention. What is clear is that at some point in this chain, the Court was of the view that sex was a sufficient factor in, or sufficiently connected to, the employer's decision, such that the test for *prima facie* discrimination was satisfied.

[177] In an ideal world, employers will consider the differential impact of their policies on their employees at the earliest time possible, with a mind to whether any differential impact adversely affects an employee, based on an enumerated characteristic, in a way that is arbitrary or cannot be justified. But this ideal standard will not always be achieved. Success likely depends on the capacity of an employer, the circumstances of an employee, the degree of differential impact, and the extent to which this impact was readily apparent to an employer.

[178] The test for *prima facie* discrimination is to be applied flexibly, and the "based on" component is no different. In some cases, it may be that *prima facie* discrimination is established at the point a policy is developed while in other cases it may not be established until the differential impact is brought to the attention of the employer.

[179] In this case, it is not necessary to resolve this issue. It may be that the Trustees should have realized the differential impact, of excluding coverage for medical marijuana from the Welfare Plan, on beneficiaries such as the complainant. But it is certainly the case that the Trustees became aware of the differential impact when it was brought to their attention by the complainant.

[180] The complainant presented the Trustees with an extensive document package that described his disability and outlined the negative impact of not having coverage for medical marijuana. This package included materials from the complainant's psychologist, his treating physician, and an independent medical assessment, as well as submissions from the complainant: Exhibit 8, Board of Trustees' File.

[181] Having received this documentation from the complainant and treating his requests for coverage as an appeal, it is clear that the complainant's disability was a factor in or connected to the Trustees' decision. In fact, the complainant's chronic pain and request for drug coverage appears to have been the central issue being considered by the Trustees.

[182] The complainant has not established that the Trustees made their decision based on any stigma associated with his disabilities, but that is not the test. The test for *prima facie* discrimination only requires that a complainant's disability be a factor in, or connected to, a policy or decision. In my view, this arguably occurred at the time the Welfare Plan was created or at the time that the complainant applied for coverage of medical marijuana, but it definitely occurred at the time he appealed the denial of coverage and requested accommodation from the Trustees.

[183] The Trustees had the authority to consider the complainant's request and to respond to it on a case-by-case basis or by changing the Welfare Plan. In denying the complainant's request, the complainant's disability was a factor in the Trustees' decision. This is sufficient to meet the "based on" criteria in section 4 of the *Act*.

[184] In summary, the complainant has established, on a balance of probabilities, that the denial of coverage for medical marijuana amounts to *prima facie* discrimination. Unlike other beneficiaries under the Welfare Plan, the complainant's request for special coverage of a medically-necessary drug, prescribed by his physician, was rejected. This non-coverage had a severely negative impact on the complainant and his family, which amounts to a disadvantage. While the initial non-coverage was only arguably "based on" the complainant's disability, the Trustees' subsequent denial of the complainant's accommodation request, and decision to deny coverage on a case-by-case basis or to amend the Welfare Plan, was "based on" the complainant's disability.

Justification and Reasonable Accommodation

[185] Once the complainant has established a *prima facie* case of discrimination, the legal onus shifts to the respondent to provide a non-discriminatory justification for their policy or decision and to demonstrate that they accommodated the complainant up to the point of undue hardship: *Simpson-Sears Ltd* at 558-559; *Meiorin* at 32-33; *Moore* at para 33.

[186] The respondent did not raise any statutory exemption that would justify its exclusion of coverage for the complainant and thereby nullify a finding of *prima facie* discrimination.

[187] Before turning to the respondent's arguments on undue hardship, I wish to comment briefly on the respondent's other explanation for non-coverage. The respondent argued it was not required to cover the complainant's medical marijuana because such coverage properly fell within the purview of the workers' compensation scheme.

[188] The record discloses that the complainant was *not* receiving coverage for medical marijuana via the workers' compensation scheme at the time of the hearing. On the contrary, the evidence shows the complainant had been denied coverage and was in the process of appealing that denial. The respondent did not present the board with any evidence to suggest that the complainant's appeal would be successful or that coverage of medical marijuana under the workers' compensation scheme was standard or guaranteed.

[189] In any event, employee benefits plans normally only provide secondary coverage that kicks in once primary coverage has been exhausted. The Welfare Plan is no different. This can be seen in the Welfare Plan's Member Booklet, which explains that major medical benefits are covered "provided they are not covered by your Provincial Medicare Plan": Exhibit 1, Agreed Statement of Facts, Exhibit Book, Tab 2, p 27.

[190] Secondary insurance status is not a non-discriminatory justification for non-coverage. The fact that coverage is provided by a primary insurer or public benefits program may be relevant for an assessment of damages resulting from non-coverage, but it is not an explanation for excluding coverage based on an enumerated characteristic.

[191] At the hearing, counsel for the respondent accepted that if the board made a finding of *prima facie* discrimination, it had to find in favour of the complainant unless undue hardship was established. Counsel admitted that the board was not presented with any specific evidence of undue hardship, such as increased costs, resulting from providing coverage for medical marijuana for the complainant. Instead, counsel submitted that undue hardship could be presumed from an application of case law to the circumstances of this case.

[192] In *Peel Law Association v Pieters*, 2013 ONCA 396 at para 72 [*Peel*], the Ontario Court of Appeal explained that respondents in human rights cases "are uniquely positioned to know why they..." adopted a policy or made the decision that they did. As a result:

The respondents' evidence is often essential to accurately determining what happened and what the reasons for a decision or action were.

In discrimination cases ..., the law, while maintaining the burden of proof on the applicant, provides respondents with good reason to call evidence. Relatively 'little affirmative evidence' is required before the inference of discrimination is permitted. And the standard of proof requires only that the inference be more probable than not. Once there is evidence to support a *prima facie* case, the respondent faces the tactical choice: explain or risk losing: *Peel* at paras 72-73.

[193] In this case, hearing dates were set to permit someone from the respondent to testify. Indeed, someone from the respondent was present for day two of the hearing. The respondent did rely on evidence explaining why Health Canada has not approved medical marijuana. However, for reasons that are unclear, the respondent chose not to lead or call any specific evidence to explain or defend its decision. Instead, the respondent relied on the bare assertion that undue hardship could be presumed from the case law and circumstances of the case. I reject this assertion.

[194] In *Sexton* at paras 18-20, the Supreme Court of Canada held a collective agreement may be the best evidence of the reasonable accommodation balance that was struck to the mutual benefit of the employer and employees. However, the clause at issue in that case concerned the maximum amount of time an employee could be absent from work. The Court held this period was not "a monetary benefit included in the remuneration of employees in the same way as health insurance or disability benefits": *Sexton* at para 19. The Court concluded that the time

period within the clause was one factor to be assessed in the analysis of reasonable accommodation, albeit a non-determinative factor. In the result, the Court sided with the employer because the employee had not produced any evidence upon which an arbitrator could have made a finding of *prima facie* discrimination.

[195] In *Adekayode*, extensive evidence was led, by the union *and* the employer, to support the claim that differential parental leave benefits within the Collective Agreement, had an ameliorative purpose. This included testimony by two clinical psychologists with expertise in family therapy and children's development respectively. It was on the basis of this evidence that the Court of Appeal concluded the differential treatment was linked to an ameliorative objective.

[196] By contrast, in this inquiry, a *prima facie* case of discrimination has been established. The respondent has provided almost no evidence to justify its actions.

[197] The record discloses that the respondent estimated the cost of extending coverage for medical marijuana to the complainant at \$60 per day. But no information was provided to the board to put this \$60 in context. For example, the board was not informed whether this amount was comparable, less or more than the per day costs of drug coverage for other persons with chronic ailments.

[198] The board was provided with no information whatsoever to understand how extension of coverage, on a case-by-case basis or as an amendment to the Welfare Plan, would impact either the premiums that beneficiaries were required to pay or the financial sustainability of the plan. There was no evidence provided to suggest that covering medical marijuana would upset the reasonable accommodation balance struck by the Welfare Plan.

[199] In short, the paucity of evidence provided by the respondent was insufficient to discharge its legal onus of responding to the *prima facie* case of discrimination established by the complainant. Accordingly, I find that the respondent has contravened the *Act* by denying coverage for medical marijuana to the complainant in the circumstances of this case.

[200] This does not mean that all private or public employee benefits plans are required to cover medical marijuana or any other drug for that matter. Not all distinctions will be discriminatory. The forgoing analysis was dependent on the circumstances of this case, including the purpose of the Welfare Plan, and the specific circumstances of the complainant.

[201] There may also be statutory or other justifications that are relevant in other cases. It is well accepted that the duty to accommodate varies based on the capacity of the employer. Employers with less capacity or benefits plans with less resources may be able to establish that merely being required to make case-by-case assessments amounts to undue hardship. Others may be able to show that extension of coverage upsets the balance struck within collective agreements, or between insurers and beneficiaries, in a way that cannot be justified or that amounts to undue hardship. Consideration of these issues is best left for other cases with other circumstances.

Conclusion

[202] In this case, the complainant has proven, on a balance of probabilities, that the Trustees' denial, of his request for coverage of medical marijuana under the Welfare Plan, amounts to a *prima facie* case of discrimination. The discrimination was non-direct and unintentional.

[203] Nonetheless, the exclusion of coverage of medical marijuana for the complainant was inconsistent with the purpose of the Welfare and had the adverse effect of depriving him of the medically-necessary drug prescribed by his physician, even though the Welfare Plan covered other special requests for medically-necessary drugs prescribed by physicians for other beneficiaries.

[204] As a result of the respondent's denial of coverage, the complainant's chronic pain has gone under-managed. Having exhausted conventional pain medication and finally finding a drug that provided some relief and improved functionality, even if not always consistently, the complainant lost what he understandably viewed as a lifeline. This had profoundly negative effects on the complainant and his family.

[205] The respondent's justification for non-coverage is wholly inadequate. The respondent led no evidence to establish that coverage of medical marijuana, on a case-by-case basis or as an amendment to the Welfare Plan, would result in undue hardship. There was no evidence presented to suggest that premiums would have to be increased or that the financial viability of the plan would be threatened.

[206] Reliance on the possibility of coverage by a public entity, such as the workers' compensation regime, is not an adequate justification in the circumstances of this case. First, there was no evidence provided to suggest that coverage would be provided by a public benefits program. Second, even if some coverage is ultimately provided by a public benefits program, this only reduces the quantum the Welfare Plan is required to cover. It does not alter the respondent's obligation of coverage and non-discrimination towards the complainant.

[207] Finally, reliance on Health Canada's non-approval of medical marijuana under the *Food and Drugs Act* is not a sufficient justification in the face of numerous appellate decisions that have found, based on anecdotal and expert evidence, a significant benefit to *some* patients from using medical marijuana. The expert evidence tendered in this case supports the conclusion that medical marijuana was medically-necessary and beneficial for treating *this* complainant's chronic pain.

[208] On this basis, I find that the respondent contravened the *Act* when it denied coverage for medical marijuana to the complainant.

[209] At the hearing, the parties requested that the board bifurcate its inquiry into this matter. I accepted this request and explained that if a contravention of the *Act* was established, I would render an interim decision and remain seized of the inquiry. The parties would then be given an opportunity to negotiate a remedy, and in the absence of a settlement, an opportunity to make submissions and tender evidence to the board to support it rendering a final decision on remedy.

This is the approach that will be followed. However, to facilitate a speedy and fair resolution of this case, it is necessary to provide an interim remedy.

[210] During the hearing, it became readily apparent to the board that the complainant's disabilities, chronic pain and anxiety, were significant barriers to his full and effective participation in the hearing. The board observed the complainant in obvious pain at numerous points in the proceedings. The board also observed the complainant in mental distress at various points in the proceedings, sometimes resulting in the complainant breaking down in tears. The complainant's statement to the board, at the start of the second day of hearing, was but one example of these observations.

[211] The inquiry into this matter was started because the complainant was denied coverage for the medically-necessary drug needed to manage his chronic pain. This denial, as the board has already found, resulted in under-management of the complainant's disability. It is unreasonable to expect the complainant, who is self-represented, to engage in extensive and detailed negotiations, regarding a settlement that may have lifelong impacts, while he is suffering from chronic pain, a suffering that is, in part, the result of the respondent's contravention of the *Act*.

[212] Subsection 34(8) of the *Act* grants the board a broad remedial power to rectify contraventions of the *Act*. While in most cases, the board will not provide an interim remedy and will leave remedy negotiations in the hands of the parties, in this case, for the reasons explained, an interim remedy is warranted.

[213] The respondent shall forthwith begin providing coverage of medical marijuana for the complainant, up to and including the full amount of his most recent prescription. This coverage will continue until such time as: 1) the parties are able to reach an agreement regarding remedy that has been finalized by the board, 2) the board issues a final decision on remedy, or 3) an appropriate court has ordered otherwise.

[214] For greater clarity, reimbursement will only be required where: 1) medical marijuana was purchased from a producer licensed by Health Canada or a person legally authorized to produce for the complainant under the *Access to Cannabis for Medical Purposes Regulations*, SOR/2016-230, and 2) the request is supported by an official receipt from the producer or person.

[215] The board remains seized of this inquiry per the parties' request. The board reserves jurisdiction to continue the inquiry to ensure that an appropriate remedy is provided, under subsection 34(8) of the *Act*, in response to the contravention of the *Act* that has been established.

Dated at Halifax, Nova Scotia, this 30th day of January, 2017.

“Benjamin Perryman”

Board of Inquiry Chair