Schedule A to the Class Complaint Filed February 25, 2025

IN THE HUMAN RIGHTS TRIBUNAL OF BRITISH COLUMBIA

BETWEEN:

GARTH MULLINS and BRITISH COLUMBIA
ASSOCIATION OF PEOPLE ON OPIATE MAINTENANCE

COMPLAINANTS

AND:

HIS MAJESTY THE KING IN RIGHT OF BRITISH COLUMBIA
(MINISTER OF HEALTH) and MEDICAL SERVICES COMMISSION

RESPONDENTS

NOTICE OF COMPLAINT

Part 1: STATEMENT OF FACTS

The Parties

1. Garth Mullins is a writer, radio producer, musician and social activist residing in Vancouver, British Columbia. He is well known as the principal host of the award-winning podcast "Crackdown". Mr. Mullins is a person receiving opioid maintenance treatment. Mr. Mullins has an address for service at 511-55 East Cordova St., Vancouver, British Columbia, V6A 0A5.

2. The British Columbia Association of People on Opiate Maintenance ("BCAPOM") is a non-profit society that was incorporated in 1999 pursuant to the *Societies Act*, R.S.B.C. 1996, c. 433. The purpose of BCAPOM is to fight for the right to quality health care, to end stigma and discrimination and to change the way that opiate therapies are administered in British Columbia. BCAPOM was originally formed as a group of persons on methadone, but it now advances the interests of people who are treated by means of any opiate substitution medication, including methadone, buprenorphine or suboxone. Opioid

substitution medications are also known as Opiate Agonist Treatment ("OAT"). BCAPOM has an address for service at 511-55 East Cordova Street, Vancouver, British Columbia, V6A 0A5.

3. The membership of BCAPOM consists of people who currently have or previously have had opioid use disorder and are currently receiving or seeking OAT, including methadone. BCAPOM offers assistance and advice to peers in accessing medical treatment and engages in advocacy to overcome barriers to treatment access for their members and stakeholders. BCAPOM also engages in and supports scientific and humanities-based research into the lived experiences of its members and peers, and advocates for better prescribing policies and more effective solutions to the overdose crisis. Mr. Mullins is a member and director of BCAPOM.

4. The Medical Services Commission (the "MSC") is a statutory body created by the *Medicare Protection Act*, RSBC 1996, c. 286 (the "*MPA*"). MSC has the statutory responsibility and duty to administer the *MPA*. The MSC reports to the Minister of Health and manages the Medical Services Plan (the "MSP") on behalf of the provincial government. The MSC has an address for service c/o the Deputy Attorney General at PO Box 9290, Stn Prov Govt, Victoria, British Columbia, V8W 9J7.

5. His Majesty the King in Right of British Columbia, represented by the Minister of Health (the "Minister"), is responsible for health care services in the Province of British Columbia. The Minister has specific statutory powers under the *MPA* and oversees and has effective power to direct the MSC and its administration of MSP and the *MPA*. The Minister has an address for service c/o the Deputy Attorney General at PO Box 9290, Stn Prov Govt, Victoria, British Columbia, V8W 9J7.

Overview of the MPA and MSP

6. The *MPA* creates and sustains the MSC, which has the statutory responsibility

and duty to create and maintain MSP. MSC's statutory duties include creating a schedule of fees payable to medical doctors (defined as "practitioners") for the provision of medical services (defined as "benefits") under MSP. Under s. 5 of the *MPA*, the MSC has the power to administer the *MPA*, determine services that are or are not benefits, monitor and assess effectiveness and efficiency of benefits, enter into arrangements and make payment to the costs and rendering benefits that will be provided on a fee for service or other basis.

7. MSP is intended by the legislature to be universal health care available equally to all beneficiaries. Section 5.4 of the *MPA* provides that "[t]he Plan [MSP] applies to 100% of beneficiaries on uniform terms and conditions." The term "benefit" is broadly defined under s. 1 of the *MPA* and includes "medically required services rendered by a practitioner" unless the services are determined by the MSC to not be a benefit.

8. The *MPA* prohibits doctors enrolled with MSP from imposing surcharges for services covered by MSP. Section 17 expressly prohibits all surcharges or private fees for materials, consultations, procedures, use of an office, clinic or other place or for any other matters that relate to the rendering of a benefit covered by MSP. MSP covered medical services for the testing, assessment and management of Opioid Use Disorder ("OUD") and the provision of OAT.

9. The *MPA* provides the MSC with investigative, coercive and punitive powers to ensure compliance with the *MPA*. In particular, the MSC has a statutory mandate and statutory powers to investigate and enforce compliance with the *MPA*, including audit powers. The MSC may take punitive action when practitioners engage in overbilling contrary to the *MPA*, including:

   a. *MPA* s. 15 empowers the MSC to cancel a practitioner's MSP enrolment or lower a practitioner's MSP fees; and

   b. *MPA* s. 37 establishes a hearing process and provides the MSC with the ability to issue orders including fines, reimbursement and prospective

orders forcing a practitioner to adhere to a certain billing practice.

10. The *MPA* also contains significant information sharing provisions. Section 12 gives the MSC discretion to advise the Minister when they have "reason to believe" that a person may have contravened the *MPA*. Section 16 requires the chair of the MSC to alert the "appropriate disciplinary body", in this case the College of Physicians and Surgeons, when the MSC has reasonable grounds to believe that there has been misconduct or incompetence on the part of a practitioner. Section 37 requires the MSC to advise the College of Physicians and Surgeons when an order has been made under that section.

11. The *MPA* also requires the Commission to prepare and file a report with the Minister each year respecting the work of the MSC and the Minister is required to lay that report before the Legislative Assembly. Section 22 of the *MPA* also gives the Minister broad authority to enter into agreements to pay an amount to offset any costs that relates to the rendering of a benefit.

Class Definition and Representatives

12. Garth Mullins and BCAPOM bring this action together as representative complaints on behalf of the class of all persons who paid out-of-pocket private clinic access fees to one or more of the private methadone clinics listed in Appendix "A" as a condition of receiving medical advice and/or prescriptions for OAT, including methadone, buprenorphine, slow release oral morphine or suboxone, from a medical practitioner enrolled in MSP (the "Class").

13. Garth Mullins and BCAPOM do not have any conflicts of interest with members of the Class, and are ready, willing and able to act in the best interests of members of the Class. The remedies sought in this complaint are consistent with BCAPOM's purposes and goals.

Background of Opioid Use Disorder and Opioid Maintenance Therapy

14. All members of the Class have OUD. OUD is a chronic medical illness which

adversely affects mental, social and physical functioning. OUD is characterized by severe adverse physical and psychological withdrawal symptoms when opioids are not consistently taken at regular intervals. Withdrawal symptoms of OUD include vomiting, distress, dysphoria, severe anxiety and panic, as well as seizures and/or death. OUD is recognized as a disability pursuant to the *Human Rights Code*.

15. OAT is a medication-based treatment that can alleviate the mental and social hardships and suffering that attend OUD and the symptoms of opioid withdrawal. OAT maintains mental and social stability for those with OUD. Apart from the benefits to patients, OAT treatment generates significant public savings in criminal justice expenses and emergency medical services. Approximately 45,000 residents of British Columbia, including Mr. Mullins, have received or currently are receiving OAT.

16. OAT is a medical treatment necessary to treat a medical condition and disability. OAT medications, including methadone, buprenorphine or suboxone, may only be dispensed by a pharmacist who is a registrant of the College of Pharmacists of British Columbia pursuant to a prescription issued by a qualified medical doctor who is a registrant of the College of Physicians and Surgeons of British Columbia. Prescribing OAT is a medical service that meets the statutory definitions of “benefit” under the *MPA*. Payment for OAT prescriptions is made to the medical practitioner under MSP. OAT dispensing fees and payment for pharmaceuticals is made to dispensing pharmacists under Pharmacare Plan Z.

17. The *MPA* requires, as part of the public funding model for health care, that the entire cost of OAT treatment for all patients must be paid pursuant to MSP. Section 17 of the *MPA* expressly prohibits a person from charging a patient additional fees for consultations, procedures, use of an office, clinic or other place or for any other matters that relate to the rendering of a benefit (ie. health care).

The Discriminatory Private Funding Model

18. The Respondents established and maintain a user-pay service delivery and payment model for OAT that directs all patients seeking OAT to private medical clinics that require patients to pay out-of-pocket private clinic fees ("Private Clinic Fees") as a pre-condition of obtaining a prescription for OAT from a medical practitioner registered under MSP (the "Private Funding Model"). The Respondents are subjectively aware that the *MPA* specifically forbids medical practitioners from charging additional fees to access clinics associated with the provision of a service covered by MSP.

19. The Private Funding Model requires Class members to bear the additional financial burden of paying Private Clinic Fees to access OAT medical services they need to treat their medical condition and systemically deprives Class members of the protection afforded by the *MPA*. In particular, the Private Funding Model requires Class members to make regular or monthly clinic fee payments to private methadone clinics in exchange for access to OAT.

20. In addition to the financial burden imposed on Class members by the Private Funding Model, the Private Funding Model results in lower adherence rates to the treatment protocol and deters some patients who cannot afford the Private Clinic Fees from obtaining treatment. The Private Funding Model forces Class members into a privatized healthcare subsystem applicable only to persons who suffer OUD.

21. The Respondents are aware of the financial costs unlawfully imposed on Class members by the Private Funding Model, and they are aware of the adverse effects of the Private Funding Model on treatment adherence and treatment access for persons with OUD. The complainants are aware that it is not necessary to prove intention to discriminate in order to establish a breach of the *Human Rights Code*, but intention to discriminate may be relevant to remedy.

22. The creation and ongoing maintenance of the Private Funding Model by the

Respondents is the product of longstanding and deep-rooted discriminatory attitudes against persons with OUD, which is recognized as a disability under the *Human Rights Code*. These longstanding attitudes persist despite the declaration of a public health emergency in 2016 in respect of illicit drug overdose deaths, and despite decriminalization of various OUD-related non-pharmaceutical drugs under the *Controlled Drugs and Substances Act*. Discriminatory attitudes and stereotypes underly the actions and omissions of the respondents that created and sustain the Private Funding Model.

23. The Private Funding Model results in discriminatory adverse effects against Class members who suffer from a recognized disability and who are thus members of a group protected by the *Human Rights Code* from discrimination. The adverse consequences include financial costs, social harm, loss of dignity, psychological harm and harm to health and well-being. The Private Funding Model is both based on and perpetuates negative stigma and stereotypes about Class members, including:

    a. Stereotypes and prejudices that persons who require OAT do not actually require medical treatment but simply lack the morals or strength of character to be abstinent;

    b. Stereotypes and prejudices that persons with OUD do not want treatment for their condition;

    c. Stereotypes and prejudices that Class members are unstable, disorderly and ungovernable and therefore deserving of lesser medical treatment; and

    d. Stereotypes and prejudices that Class members are second-class citizens that do not deserve public benefits and should not be entitled to universal health care because of their condition.

24. The Respondents' creation and maintenance of the Private Funding Model is reinforced by numerous ancillary actions taken by the Respondents to actively

divert persons seeking OAT medications away from family doctors, ordinary walk-in clinics and hospital emergency wards. The Respondents' actions include:

a. Creating policies requiring and/or encouraging practitioners that do not charge private clinic fees (eg. emergency room physicians, family physicians, walk-in clinic physicians and other medical and administrative staff) to refer patients seeking OAT to the private methadone clinics;

b. Directing patients seeking OAT to private clinics using pamphlets, websites and other marketing tools;

c. Creating institutional scarcity of publicly funded OAT clinics;

d. Refusing or failing to use *MPA* investigative and/or enforcement powers to stop practitioners enrolled under MSP from charging Private Clinic Fees; and

e. Refusing or failing to share information about the Private Funding Model to the College of Physicians and Surgeons and Legislative Assembly.

25. There is no *bona fide* and reasonable justification for the Private Funding Model. The Private Funding Model is contrary to the public policy of providing universal health care, is not necessary for provide the services, causes unnecessary suffering to those who cannot afford to pay the Private Clinic Fees and to those for whom it causes a failure of adherence, and creates negative consequences for non-patients who bear additional costs of the criminal justice system and emergency systems.

26. The overall purpose of Canadian healthcare legislation and the *MPA* is "to preserve a publicly managed and fiscally sustainable health care system for British Columbia in which access to necessary medical care is based on need and not an individual's ability to pay." The government of British Columbia has taken steps to mitigate the adverse effects of the Private Funding Model by

paying the Private Clinic Fees for persons receiving income assistance or disability assistance directly to the private clinics and by paying the Private Clinic Fees for some but not all Indigenous patients. Mitigation of some of the adverse effects of the Private Funding Model recognizes the adverse effects of the Private Funding Model and acknowledges the need to fix the problem, and demonstrates the unjustifiability of the Private Funding Model.

27. The Private Funding Model is unreasonable and unjustifiable because it contributes to the opioid crisis. On April 14, 2016, the Provincial Health Officer declared a public health emergency in response to the rapid increase in opioid overdoses and related deaths in British Columbia, and the Premier and Minister of Health have repeatedly stated that their intention is to improve access to drug treatment. The Private Funding Model creates financial barriers to recovery that, to the knowledge of the Respondents, contributes to relapses, contributes to the resumption of use of inexpensive unregulated street drugs including fentanyl and contributes to overdoses, chronic injuries and deaths.

28. The Respondents, without a *bona fide* and reasonable justification, have adversely impacted Class members by implementing and sustaining the Private Funding Model knowing that it harms and discriminates against Class members by denying them publicly funded health care, or, alternatively, denying them the protection afforded by s.17 of the *MPA*, both of which are an accommodation or service customarily available to the public. The Respondents' acts and omissions have directly or indirectly discriminated against Class members based on a physical and/or mental disability contrary to s. 8 of the *Code*.

Representing the Class

29. BCAPOM and Mr. Mullins are ready, willing and able to represent Class members, and are committed to making decisions in the best interests of the Class members. BCAPOM and Mr. Mullins have no conflicts of interest with any Class members, and BCAPOM's goals and objectives support and are entirely consistent with the advancement of the interests of Class members in this

proceeding. BCAPOM and Mr. Mullins are informed of and aware of the issues and are generally familiar with the framework of the *Human Rights Code* and the purpose of the *Code* in redressing and eliminating discrimination in British Columbia.

30. The Complainants' interests are aligned with the Class. Garth Mullins is a methadone patient adversely affected by the Private Funding Model. Mr. Mullins has personally made payments of approximately $10,000 in Private Clinic Fees over a period of ten years as a pre-condition of access to OAT medical services. BCAPOM's members are persons living with OUD, many of whom are out-of-pocket for payment of Private Clinic Fees to access OAT medical services under the Private Funding Model.

31. The Complainants seek to make this complaint on behalf of all Class members. The Class is defined in terms of the adverse financial effects exacted on members of the class by the Private Funding Model created and maintained by the Respondents. The Complainants assert that the Private Funding Model causes or contributes to additional harms to persons seeking OAT (i.e. barriers to accessing OAT, reduced treatment retention for existing patients and perpetuation of stereotypes).

32. The Complainants have no reason to believe that any Class members do not want the Complainants to bring this complaint on their behalf.

33. The Complainants propose to provide notice to Class members of this complaint through the Complainants' social media channels, by means of the Crackdown podcast (of which Mr. Mullins is the principal host), by means of press releases disseminated on the BCAPOM website, social media and mailing list, and by means of notices posted to the Complainants' lawyer's website.

34. The Complainants are outspoken advocates and in regular communication with many Class members in the community, are well placed to disseminate news of this complaint by word of mouth. Communication with Class members will

include distribution of information about opt-out options for individuals who do not wish to participate as Class members.

Part 2: RELIEF SOUGHT

35. The Class seeks the following relief:

    a. A declaration that the Private Funding Model discriminates against Class members based on their disability;

    b. An order that the Respondents cease their implementation of the Private Funding Model by making direct payment to private clinics pursuant to MSP or another funding mechanism of amounts equal to similar to the Private Clinic Fees, and/or cease the ancillary activities that divert OAT patients away from medical practitioners who do not charge private clinic fees or user fees to patients;

    c. An order that the Respondents reimburse or compensate class members for the private clinic fees each of them paid out-of-pocket as a pre-condition of obtaining OAT-related medical services from practitioners enrolled with MSP;

    d. An order for damages to Class members adversely impacted by the Private Funding Model as compensation for injury to dignity, feelings and self-respect; and

    e. Such further and other orders as the Tribunal may find just and equitable.

Part 3: LEGAL BASIS

1. For the reasons set out above, the Private Funding Model discriminates against Class members without *bona fide* and reasonable justification contrary to the *Human Rights Code*. OAT is a necessary medical treatment and benefit that, by ordinary operation of the *MPA*, should be covered by MSP. The Private Funding Model discriminates against Class members by forcing Class members

to pay for medical services that are required by law to be paid for within MSP, resulting in financial costs, social harm, loss of dignity, psychological harm and harm to health and well-being. The Private Funding Model is both based on and perpetuates negative stigma and stereotypes about Class members.

Dated: February 25, 2025

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Signature of Lawyer for the Complainants
Jason Gratl
Gratl & Company
Barristers and Solicitors
511-55 East Cordova Street
Vancouver, BC V6A 0A5

Appendix A to BCAPOM/Mullins Human Rights Complaint

Abbotsford Health Centre	33634 Busby Rd, Abbotsford, British Columbia, V2S 1V2
Alliance Clinic	10085 Whalley Blvd, Surrey, British Columbia V3T 4G1
Alouette Addictions Services	22477 Lougheed Hwy, Suite 201, Maple Ridge, British Columbia, V2X 2T8
AVI Health Centre	55 Victoria Road, Suite 216, Nanaimo, British Columbia, V9R 5N9
Bio-Scan Methadone Maintenance	750 West Broadway, Suite 410, Vancouver, British Columbia, V5Z 1H3
Bio-Scan Methadone Maintenance	11950 80th Avenue, Suite 100, Delta, BC V4C 1Y2
Bridgeview Medical	8556 120 St #110, Surrey, British Columbia, V3W 3N5
Cedarview Clinic	9380 College St, Chilliwack, British Columbia, V2P 4L6
Columbia Coast Addiction Services	1371B Cedar Street, Campbell River, British Columbia, V9W 2W6
Commercial Health Centre	2703 Commercial Drive, Vancouver, British Columbia, V5N 4C5
Corner Stone Chemical Dependency Clinic	4 South Ave, Williams Lake, BC, V2C 1J8
Doc-Side Medical Clinic	#100, 678 East Hastings Street, Vancouver, British Columbia, V6A 1R1
Food for the Soul Project Society	#1, 22335 Lougheed Highway, Maple Ridge, British Columbia, V2X 2T3
Hub Medical Centre	108A-32883 South Fraser Way, Abbotsford, British Columbia, V2S 2A6
Interior Chemical Dependency Clinic	3 – 517 Tranquille Rd. Kamloops, British Columbia, V2B 3H3
Lower Mainland Drug Freedom	25 Blackwood Street, New Westminster, British Columbia, V3L 1A7
Marine Gateway Medical Clinic	9172 120 St #103, Surrey, British Columbia, V3V 4B5

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McCallum Health Centre	2481 McCallum Rd #105, Abbotsford, British Columbia, V2S 3P8
Midtown Health Centre	#101, 2359 Clearbrook Road, Abbotsford, British Columbia, V2T 2X6
Nanaimo Pain Clinic	#A, 495 Dunsmuir Street, Nanaimo, British Columbia, V9R 6B9
New Beginnings	10690 135A Street, Surrey, British Columbia, V3T 4E2
North Island Medical Clinic	1405 Spruce Street, Campbell River, British Columbia, V9W 7K1
Oak Grove Clinic	1872 Kingsway, Vancouver, British Columbia, V5N 2S7
OAT Clinic (Abbotsford)	2777 Gladwin Rd #108, Abbotsford, British Columbia, V2T 4V1
OAT Clinic (Vancouver)	633 E Hastings St., Vancouver, British Columbia, V6A 1R2
Outreach Services Clinic	603 Gorge Road East, Victoria, British Columbia, V8T 2W7
Pacific Oak Clinic	523 Main St, Vancouver, British Columbia, V6A 2V1
Park City Medical Center	10216 128th Street, Suite 103, Surrey, British Columbia, V3T 2Z3
Phoenix Transformations Clinic	#4, 1400 Cowichan Bay Road, Cobble Hill, British Columbia, V8H 0K9
Royal Oak Clinic	#103, 1638 E Broadway, Vancouver, British Columbia, V5N 1W1
Scott Town Medical Clinic	9556 120th Street, Surrey, British Columbia, V3V 4C1
Sigma Health Centre	#102, 46198 Yale Road, Chilliwack, British Columbia, V2P 2P1
Spring Medical Clinic	4453 Lougheed Hwy, Burnaby, British Columbia, V5C 0E4
Sunshine Coast Treatment Services	4739 Joyce Avenue, Powell River, British Columbia, V8A 3B5

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Surrey Metro Clinic	10517 King George Boulevard, Surrey, British Columbia, V3T 2X1
Trew Beginnings	#216, 55 Victoria Road, Nanaimo, British Columbia, V9R 4N9
True Care Clinic	22470 Dewdney Trunk Rd #105, Maple Ridge, British Columbia V2X 5Z6
Valley Oak Clinic	#D, 9666 King George Highway, Surrey, British Columbia, V3T 2V4
Victoria Road Clinic	200-55 Victoria Road, Suite 216, Nanaimo, British Columbia, V9R 5N9
Westminster Medical Clinic	7636 6th Street, Burnaby, British Columbia, V3N 3M5
Yale Medical Centre	1280 Granville Street, Vancouver, British Columbia, V6Z 3B2