

IN THE COURT OF APPEAL OF MANITOBA

Coram: Mr. Justice Christopher J. Mainella
Madam Justice Jennifer A. Pfuetzner
Madam Justice Anne M. E. Turner

BETWEEN:

<i>KELSEY FEHR and KELLY FEHR</i>	)	<i>M. D. Zacharias and</i>
	)	<i>D. R. Gibson</i>
	)	<i>for the Appellants</i>
(Applicants) Appellants	)	
	)	<i>B. T. Jones</i>
- and -	)	<i>for the Respondent</i>
	)	
<i>MANITOBA HEALTH INSURED</i>	)	<i>M. S. Wire</i>
<i>BENEFITS, INSURANCE DIVISION</i>	)	<i>on a watching brief</i>
	)	<i>for Manitoba Health</i>
(Respondent) Respondent	)	<i>Appeal Board</i>
	)	
- and -	)	<i>Appeal heard:</i>
	)	<i>November 3, 2025</i>
<i>MANITOBA HEALTH APPEAL BOARD</i>	)	
	)	<i>Judgment delivered:</i>
(Respondent)	)	<i>June 9, 2026</i>

On appeal from *Fehr et al v Manitoba (Health Insured Benefits, Insurance Division)*
et al, 2024 MBKB 191 [*KB decision*]

MAINELLA JA

Introduction

[1] Medicare, universally provided public health care services, is seen by many Canadians as a cornerstone of their national identity: “The policy of

the *Canada Health Act*, R.S.C. 1985, c. C-6, and its provincial counterparts is to provide health care based on need rather than on wealth or status” (*Chaoulli v Quebec (Attorney General)*, 2005 SCC 35 at para 164 per Binnie and LeBel JJ in dissent but not on this point).

[2] But what happens when the promise of universal health care based on need appears illusionary?

[3] The difficult question in this judicial review appeal involves the reasonableness of an administrative decision refusing provincial health insurance for a medical service not available in Manitoba (the treatment).

[4] To place this case in context, this is not a situation of someone trying to jump a waiting list queue for the treatment or seeking to have the treatment performed elsewhere because of a concern raised about the adequacy of care in Manitoba; the treatment in question is simply not offered in Manitoba because of a choice of those in charge of the Manitoba health care system.

[5] The applicants, Kelsey Fehr (Kelsey) and Kelly Fehr (Kelly) (together, the applicants), suffer from a severe form of a debilitating degenerative disease. Their doctors recommended a type of surgery that, at the relevant time, was not performed in Manitoba or elsewhere in Canada. The applicants requested coverage for out-of-province treatment (the insurance) for the surgery in the United States pursuant to *The Health Services Insurance Act*, CCSM c H35 [the *Act*] and the regulations thereunder.

[6] The respondent, Manitoba Health Insured Benefits, Insurance Division, which is part of the Manitoba Department of Health, Seniors and Long-Term Care (Manitoba Health), initially denied the insurance, then

changed its mind and, after the applicants had one successful surgery in the US, reversed its approval and denied the insurance for subsequent surgeries that were medically necessary.

[7] The applicants unsuccessfully challenged Manitoba Health's decision denying the insurance to the respondent, the Manitoba Health Appeal Board (the board).

[8] The applicants then unsuccessfully sought a judicial review of the board's decision before a judge of the Court of King's Bench (the judge) (see *KB decision*). They now appeal the order to this Court.

[9] For the following reasons, I would allow the appeal. As I will explain, the board unreasonably applied the regulation that Manitoba Health relied upon to deny the insurance. In my respectful view, the judge erred in determining that the board made a reasonable decision that was justified in relation to the governing legal and factual context.

Background

The Applicants Suffer from Severe Lipedema

[10] The applicants are twin sisters, age thirty-eight, who both suffer from a severe form of lipedema which is a genetic, likely hereditary disease, that causes abnormal buildup of dense fibrotic fatty tissue in the extremities of the body (particularly lower abdomen, hips, buttocks and limbs). The hallmarks of the disease are inflammation resulting in tissue fibrosis and pain, progressively decreased mobility, and difficulties in daily living. Untreated

lipedema can result in secondary problems, including osteoarthritis, psychological impairment and lower self-esteem.

[11] Unfortunately, lipedema is often misunderstood and misdiagnosed as general obesity or lymphedema due to increased leg size of sufferers or the appearance of being overweight. Many lipedema sufferers find themselves being blamed for their condition, including self-blame, based on lifestyle choices, due to ignorance.

[12] While lipedema rarely affects men, some estimates suggest as much as eleven per cent of adult women may be affected by lipedema in differing degrees of severity.

The Applicants Sought Medical Treatment in Manitoba for Lipedema

[13] Both applicants are an “insured person” within the meaning of the *Act*, entitling them to receive benefits related to their health care in accordance with the *Act* and the regulations thereunder, including the *Excluded Services Regulation*, Man Reg 46/93 [the *Regulation*].

[14] After being diagnosed with lipedema, the applicants sought medical treatment for the disease in Winnipeg, Manitoba, where they reside.

[15] The conventional medical treatment for lipedema in Manitoba and across Canada consists of wearing compression stockings, the use of a pneumatic compression pump for lymphatic drainage, manual lymphatic drainage, medication, exercise, and a healthy diet (collectively, the conservative modalities).

[16] The conservative modalities were ineffective for the applicants. They lived with chronic pain and worsening impairment to their mobility, making daily living difficult.

[17] Based on discussions with their doctors and their own inquiries, the applicants learned that countries such as the US, the UK, Germany and the Netherlands allow lipedema reduction surgery to treat lipedema (the surgery) that cannot be addressed by the conservative modalities.

[18] The most common forms of the surgery in these countries involve tumescent liposuction or water-assisted liposuction. These forms of the surgery involve debulking, excision, and extraction of tissue overgrowth, which occurs because of the disease.

[19] In a tumescent liposuction, a solution consisting of saline, anesthetics and adrenaline is infused into the subcutaneous tissues to cause the fat cells to swell and the vessels to constrict; the surgeon then makes an incision in the skin and uses blunt micro-cannulas to suction the diseased tissue. In the case of water-assisted liposuction, the surgeon makes an incision in the skin and then uses a pressure spray of tumescent fluid to dislodge the diseased tissue from the connective tissue and suction it out with a specialized cannula.

[20] Because no surgeon in Manitoba, or elsewhere in Canada, was able to provide the surgery, the applicants sought the insurance.

[21] One responsibility of Manitoba Health is to administer claims for the insurance. This process is governed by the *Act* and the regulatory framework thereunder, including the *Regulation*.

[22] For patients that need the treatment, there is a specific approval process created by the *Act* and the regulations thereunder. The individual must receive a referral or recommendation from an appropriate doctor for the treatment and the treatment must not be available in Manitoba. These procedural requirements and conditions are not at issue in this case.

2018 Request for the Insurance

[23] On April 18, 2018, the vascular surgeon of Kelsey, Dr. Asad Junaid (Dr. Junaid), sought approval from Manitoba Health for funding for a consultation with the Lipedema Surgery Center in Roswell, Georgia, US. The consultation would have considered Kelsey's suitability for water-assisted liposuction.

[24] On May 24, 2018, Manitoba Health denied the request for the insurance (the 2018 denial decision) based on section 2(18)(b) of the *Regulation*, which reads:

Exclusions

2 The following services are not insured services:

18. Services that are determined by the minister, after reviewing the available evidence, to be

(b) an emerging treatment or diagnostic procedure for an illness, injury or condition for which the efficacy of the service has not been established[.]

Exclusions

2 Les services suivants ne sont pas des services assurés :

18. Les services qui, de l'avis du ministre et après examen de la preuve existante, sont :

b) des démarches diagnostiques ou des traitements nouveaux dont l'efficacité n'a pas été prouvée à l'égard d'une maladie, d'une blessure ou d'un état de santé[.]

[25] Kelsey appealed the 2018 denial decision to the board (see the *Act*, s 10).

[26] The board dismissed the appeal. It “[a]greed with [Manitoba Health] that the evidence for the efficacy of water-assisted liposuction indicated promise, in the short term, but that it was not sufficiently adequate to give it the status of standard of care at the current time.” The board highlighted that it “had to stay disciplined in focusing its attention purely on the evidence based for water-assisted liposuction”, as opposed to the efficacy of liposuction generally or the procedure of tumescent liposuction.

2019 Request for the Insurance

[27] On September 18, 2019, with the support of the applicants’ local plastic surgeon, Dr. Ziesmann, referred by Dr. Junaid, the applicants sought approval from Manitoba Health for the insurance for total body lymph-sparing liposuction at the Stanford University Medical Center in Palo Alto, California, US (Stanford).

[28] On November 19, 2019, Manitoba Health denied the request for the insurance. The denials addressed both water-assisted liposuction and tumescent liposuction (the 2019 denial decision).

[29] As before, Manitoba Health denied the insurance for water-assisted liposuction because it concluded that the surgery was an emerging treatment, the efficacy of which has not been established with respect to lipedema (see the *Regulation*, s 2(18)(b)).

[30] Manitoba Health denied the insurance for tumescent liposuction at Stanford because it concluded that “standard liposuction, including tumescent, is available in Canada, and even available in Winnipeg MB.”

[31] The applicants appealed the 2019 denial decision to the board only in relation to the insurance for tumescent liposuction at Stanford. In support of the applicants, Dr. Ziesmann advised that both water-assisted and tumescent liposuction were recognized treatment options for lipedema. He also explained that he was unaware of any doctor in Winnipeg or Canada who has expertise in the surgery.

[32] The applicants’ appeal to the board did not proceed because Manitoba Health changed its position. At the outset of the appeal, on May 21, 2020, counsel for Manitoba Health announced that Manitoba Health had reversed its decision and that it would “approve the [insurance] in these two cases.” Counsel “apologize[d] for the late notice” and advised that a letter would be sent out explaining what expenses under the *Act* would be approved for the insurance to attend Stanford.

[33] On July 23, 2020, Manitoba Health advised the applicants that it had approved the insurance under the *Act* and its regulations “to attend [Stanford] to receive [the surgery]” (the approval decision). The approval decision stated that “[f]urther treatment or follow-up will require another letter and the prior approval of [Manitoba Health].”

The Surgery at Stanford

[34] The applicants’ travel to Stanford for the surgery was delayed by travel restrictions related to the COVID-19 pandemic.

[35] On August 9, 2021, the applicants attended Stanford for a pre-surgical consultation with Dr. Dung Nguyen (Dr. Nguyen). Dr. Nguyen is a plastic and reconstructive surgeon who is a specialist in lymphedema and lipedema surgery and has treated hundreds of patients with these diseases. Manitoba Health paid the fees related to these pre-surgical consultations.

[36] Dr. Nguyen evaluated Kelly's lipedema. She noted "nodular areas of fibrosis to both upper extremities, abdomen, thighs and calves, and most significantly to the lateral hips", which is common with lipedema patients. Dr. Nguyen observed Kelly's "lower extremities have diffuse fibrotic fatty tissue overgrowth which causes significant disability, secondary to the heavy weight of her limbs."

[37] Dr. Nguyen's diagnosis of Kelsey's lipedema was identical.

[38] The surgery for the applicants was on April 22, 2022. The surgery was to remove the fibrotic fatty tissue within the extremities and lateral hips to debulk the dense weight and to allow for a softening of the underlying skin and tissue (the first surgery). Post-operation compression garments are worn to help skin and tissues contract as much as possible.

[39] Prior to the first surgery, Stanford advised Manitoba Health of the procedures that would be performed and their cost. Manitoba Health was advised that the applicants would need four to five of these surgeries as part of their treatment plans. Manitoba Health advised Stanford that, except for payment for compression garments, it would cover the costs.

[40] The first surgery was directed to the areas causing the most “burden” to them, specifically the bilateral lower extremities and hips, particularly medial, anterior, and lateral thighs.

[41] The first surgery was successful. About twelve to fourteen litres of diseased tissue was removed from each of their thighs. The applicants lost between thirty-five to forty pounds and reported “significant improvement in [their] overall pain in the legs as well as improvement in [their] gait balance and ability to walk with ease due to the volume reduction in [their] medial thighs.”

Manitoba Health Denies the Insurance for Subsequent Surgeries

[42] After the first surgery, the applicants began arrangements for their next surgeries at Stanford, with the assistance of Dr. Ziesmann.

[43] On June 10, 2022, Manitoba Health advised Kelly that it would no longer cover the surgery because a decision had been made among plastic surgeons in Manitoba that the surgery “is no longer a standard of care”.

[44] On June 16, 2022, Dr. Ziesmann recommended to Manitoba Health that the applicants receive the insurance for a second surgery at Stanford.

[45] On June 22, 2022, Dr. Nguyen’s nurse practitioner at Stanford advised Manitoba Health that:

[The surgery] is a well-known option to improve [the applicants’] pain and gait imbalance. . . . [The applicants need] additional liposuction procedures to treat [their] lower extremities below the knees and to the posterior thighs and hips, as well as to [their] upper extremities and abdominal area.

[The surgery] is NOT a cosmetic procedure. The dense, fibrotic fatty tissue causes significant disability and pain for the [applicants] and impedes their normal gait and . . . [the surgery] allow[s] [them] to resume many activities. . . . [A]pproving [the first surgery] (which provided a successful result) and then denying the same service to the [applicants] in the future is unethical and could cause harm to [their] physical and mental health.

[46] Over the course of the summer and fall of 2022, Manitoba Health and Dr. Ziesmann communicated about the applicants' diagnosis and their need for further surgeries. Ultimately, on October 5, 2022, Dr. Ziesmann advised Manitoba Health that it was likely that Dr. Nguyen had already provided his medical opinion regarding the recommended treatment plan.

[47] On October 12, 2022, Manitoba Health requested an itemized list from Stanford as to the medical services to be provided for a second surgery for the applicants.

[48] On November 3, 2022, Stanford provided to Manitoba Health the requested information about the costs of a second surgery. Dr. Nguyen's nurse practitioner highlighted that "the debulking of tissue overgrowth with reconstructive tumescent liposuction/suction assisted lipectomy to address the build-up of fibrotic tissue due to progressive lipedema is the standard of care." Further, the surgery was a "medically necessary" procedure. Finally, it was noted that delays in Manitoba Health's approval process were having a negative impact on the applicants.

[49] On November 23, 2022, Manitoba Health denied the insurance for a second surgery at Stanford based on section 2(18)(b) and (c) of the *Regulation* (the 2022 denial decision). The 2022 denial decision stated that it

has been “determined that liposuction is not considered a standard of care for the treatment of lipedema and benefits would not be payable.”

[50] Manitoba Health also stated that the “excision of excess skin” is “elective plastic surgery” and is excluded from coverage by section 2(15) of the *Regulation* unless it is “medically required, with certain exceptions which are not relevant in this instance.” It is not disputed that this justification provided by Manitoba Health is directly connected to the denial pursuant to section 2(18)(b) of the *Regulation* and is not an independent legal justification to deny the insurance.

Appeal to the Board

[51] On December 14, 2022, the applicants appealed the 2022 denial decision to the board. The two issues the appeal raised were:

- i) Was the 2022 denial decision inconsistent with the approval decision?
- ii) Is the surgery a medical service that is not insured due to section 2(18)(b) and (c) of the *Regulation*?

Factual Context Relating to the Surgery

[52] Evidence was adduced before the board as to whether the surgery is an insurable medical service within the meaning of section 2(18)(b) of the *Regulation*.

[53] According to the record, the 2022 denial decision to treat Grade 3 and 4 lipedema (i.e., the severest forms) was based on a brief two-page

memorandum authored on December 20, 2022, by the Deputy Minister of Health, Karen Herd (Ms. Herd) (the memo).

[54] The memo advises that in 2017, Manitoba Health received a request from a Manitoba doctor for out-of-country coverage for a patient to receive water-assisted liposuction in Germany to treat a painful form of generalized lipedema.

[55] Manitoba Health sought the opinion of Dr. Denis Hosking (Dr. Hosking) as to whether efficacy had been established to determine that water-assisted liposuction for painful lipedema is a standard of care. Dr. Hosking advised that he had “not done any detailed research” on water-assisted liposuction to treat lipedema. In his view, based on the documentation submitted in support of the request, there was not “adequate proof of efficacy to support the request”. Based on this opinion, Manitoba Health denied the insurance pursuant to section 2(18)(b) of the *Regulation*.

[56] The memo goes on to state that recently, Manitoba Health had consulted with Dr. Jennifer Guiffre (Dr. Guiffre), the lead for plastic surgery in Manitoba. The memo states that the opinion of Dr. Guiffre is that:

[T]he medical evidence is not strong enough at this time to consider this medical service to be [the] standard of care for this high-grade condition. There is no new evidence available to support the use of liposuction in high-grade lipedema patients. [Dr. Guiffre] opined that it does not meet [the] standard of care. In addition, there is no good evidence to show that any particular type of liposuction is superior, whether it is liposuction, water-assisted liposuction, laser, ultrasound, water-jet, or tumescent.

[57] Accordingly, the view of Ms. Herd was that the insurance for “any type” of liposuction surgery for Grade 3 and 4 lipedema, including excision

of excess skin, should be denied under section 2(18)(b) and (c) of the *Regulation*.

[58] The board was provided with materials from the applicants and Manitoba Health, including the historical documents relating to the applicants' medical treatments and the memo. Additionally, the applicants each provided a letter from Dr. Tim McCarthy (Dr. McCarthy), Director, Rheumatology Research Unit, at the Manitoba Clinic.

[59] Dr. McCarthy has been treating the applicants for lupus and polychondritis overlap condition.

[60] Dr. McCarthy advised that, according to US guidelines, the surgery should only occur after treatment had been attempted using the conservative modalities and the surgery "should be performed by a surgeon trained in methods that preserve the lymphatic vasculature."

[61] According to Dr. McCarthy, there is a "scarcity of surgeons with this training and this is the reason why this had to be done in the United States."

[62] Dr. McCarthy referred to research done in 2019 and 2022 by the Canadian Agency for Drugs and Technologies in Health (CADTH) as to the clinical effectiveness of the surgery (see Canadian Agency for Drugs and Technologies in Health, *Liposuction for the Treatment of Lipedema: A Review of Clinical Effectiveness and Guidelines*, by Kwakye Peprah & Danielle MacDougall (Ottawa: CADTH, 7 June 2019), online: <ncbi.nlm.nih.gov>; Khai Tran & Jennifer Horton, "Liposuction for Lipedema: 2022 Update",

(2022) 2:8 Can J Health Tech, online: <cda-amc.ca> [2022 CADTH report] [together, the CADTH reports].

[63] CADTH, now known as Canada’s Drug Agency (CDA), is a health organization that was created in 1989 and is funded by the federal, provincial and territorial governments (with the exception of Quebec). CADTH described its role to be that of “a pan-Canadian health organization, created and funded by Canada’s federal, provincial, and territorial governments” and stated that it “provide[s] Canada’s health system leaders with independent evidence and advice so they can make informed drug, health technology, and health system decisions, and [its] collaborate with national and international partners to enhance [its] collective impact.”

[64] Dr. McCarthy said that, while the quality of the evidence is “limited”, according to the CADTH reports, the surgery “resulted in significant improvement of pain, sensitivity to pressure, edema, bruising, fluid retention and quality of life.”

[65] Finally, Dr. McCarthy observed that the symptoms of the applicants improved after the first surgery.

[66] The CADTH reports referenced by Dr. McCarthy form part of the record before the board and were commented on by the parties in their submissions at the hearing on March 23, 2023.

[67] The applicants also filed an affidavit from E.C., who is a resident of Manitoba and has severe lipedema. In 2022, E.C. applied to Manitoba Health for the insurance for the surgery at a medical clinic in Beverly Hills,

California. Manitoba Health paid for three of the surgeries for E.C. (January, March and May 2022).

[68] The three surgeries improved E.C.'s lipedema symptoms.

[69] On September 23, 2022, Manitoba Health advised E.C. that no further surgeries would be approved as the surgery was considered to be an emerging treatment, the efficacy of which has not been established with respect to the treatment of lipedema.

[70] At the outset of the appeal, the board explained that it is “not a branch” of Manitoba Health. Rather, it is “an independent body that has been created to assess whether [Manitoba Health]’s decisions have been made in accordance with the applicable Acts or regulation. The [b]oard’s mandate is also stated in the legislation, and [it] cannot sway from this mandate.”

[71] Manitoba Health’s submission to the board was that “the key issue” in this appeal “is whether [the surgery] is an emerging treatment or not.” Manitoba Health argued that “the evidence has not demonstrated at this point that [the surgery] has emerged as a standard of care for treatment of lipedema.” During the course of the appeal, the board was advised by Manitoba Health that the only way its decision could be overturned, and benefits could be paid under the *Act*, was if the board determined that “[the surgery] has emerged as a standard of care.”

[72] Manitoba Health said that it changed its position about the insurance because, after consulting with local experts, an administrative decision was made to exclude the surgery under the *Regulation* until such time that the

evidence shows that the surgery has emerged by way of it becoming the standard of care for lipedema for which the effectiveness has been established.

[73] Manitoba Health highlighted that the memo, what it called the “exclusion memo,” was an administrative decision that excludes the surgery from the insurance under the *Regulation* for everyone. The board was told that it needs “to be cautious about interfering or overriding” this policy decision. Manitoba Health went on to argue that, while there was medical expertise on the board, it is “not constituted as a medical expert panel to determine these types of matters specifically.”

[74] Manitoba Health, in response to a question from the board, said that section 2(18)(b) of the *Regulation* is to be interpreted such that “[i]f the effectiveness of the treatment hasn’t been established, then it’s an emerging treatment”.

[75] Manitoba Health, also in response to a question from the board, submitted that the efficacy of the treatment is established by scientific evidence that proves “the [surgery] is effective for treatment of a particular condition.” In this case, Manitoba Health relied on local plastic surgeons who said the surgery is not the standard of care in Canada. Manitoba Health stated that the CADTH reports confirm scientific research in this area lacks the “gold-standard” of a randomized clinical study demonstrating that the surgery is a safe, effective treatment. Manitoba Health argued that there is “lack of evidence that this has emerged as a safe and effective treatment” and thus it cannot be said that the surgery has emerged as a standard of care.

Decision of the Board

[76] On May 10, 2023, the board released its reasons dismissing the applicants' appeal on the basis that the surgery was not an insured service by virtue of section 2(18)(b) of the *Regulation* (the appeal decision).

[77] On the first issue, the board accepted the argument of Manitoba Health that there was no inconsistency between the 2022 denial decision and the approval decision because the language of the approval decision was conditional. The appeal decision states:

[40] The [b]oard considered the conditions set out by [the approval decision] to provide benefits for the initial treatment with the condition that any further treatment(s) will require a new letter and prior approval of Manitoba Health.

[78] In terms of the second issue, the board also accepted the submission of Manitoba Health. It stated:

[41] The [b]oard agrees with [Manitoba Health] that [the surgery] is currently not the standard of care and that [the surgery] is an emerg[ing] treatment and thus is an excluded service according to regulations enacted under [the *Act*].

[42] The mandate of the [b]oard is to determine if [Manitoba Health] correctly followed the Legislation and its regulations in making [its] decision.

[43] The [b]oard concludes that [Manitoba Health] followed the Legislation and its regulations in making its decision and the appeal is dismissed.

Liposuction Treatment in Germany

[79] The applicants could not afford to pay for further surgeries at Stanford.

[80] Instead, in September 2023, the applicants arranged to have a further surgery, at their own expense, at the Ernst von Bergmann Hospital in Bad Belszig, Brandenburg, Germany.

[81] As was the case after the first surgery, the applicants experienced similar improvement in terms of less pain and increased mobility.

[82] The applicants have been advised by their doctors at Stanford and Germany that they will likely require five further surgeries to address the areas of their body where there is a buildup of diseased tissue due to their severe form of lipedema.

Judicial Review of the Appeal Decision

[83] On June 13, 2023, the applicants filed a notice of application for a judicial review of the appeal decision in the Court of King's Bench. The judge framed the issues on the judicial review this way (*KB decision* at para 12):

The applicants say [the appeal decision] is unreasonable in several respects, which I summarize as follows:

- [The appeal decision] is not transparent, intelligible or justified, nor is it justifiable considering the relevant legal and factual matrix;
- In July 2020, when Manitoba Health approved [the insurance] for [the surgery] to be performed at [Stanford], Manitoba Health was aware that a series of procedures would be performed over time. Having made the decision

to fund [the surgery], it was not open to Manitoba Health to deny the second surgeries; and

- The [b]oard answered the wrong question when it concluded that [the surgery] is not the standard of care for lipedema. It did not consider, as it should have, the efficacy of the treatment option.

[84] The judge decided that the circumstances of the surgery in Germany, which post-dated the appeal decision, did not properly form part of the record on the judicial review. Accordingly, the judge did not consider this part of the relevant context in her reasonableness review of the appeal decision. The applicants did not raise a concern in this Court with this part of the *KB decision*. This concession was appropriate (see *Manitoba Metis Federation Inc v Brian Pallister et al*, 2019 MBQB 118 at para 66).

[85] The judge had little difficulty in concluding that the board did not err in deciding that the approval decision did not commit it to funding a series of treatments. She stated (*KB decision* at paras 24-25):

[The appeal decision] pointed to [the approval decision] that stated further, or follow-up treatment, would require another letter from their specialist and prior approval of Manitoba Health.

[The appeal decision] properly posed the question, gave its answer and explained why it decided this way. I find no deficiency, large or small, with this aspect of [the appeal decision]. To decide the matter differently as the applicants ask, would be to substitute my decision for the [b]oard's.

[86] The judge agreed with the applicants that there were “shortcomings” as to why the board agreed with Manitoba Health that the surgery was an emerging treatment and therefore excluded by the *Regulation* (*KB decision* at para 21).

[87] The judge noted that the appeal decision fails to “provide any analysis. Put simply, the [b]oard did not answer the critical question of why it agrees with Manitoba Health” (*ibid*). She said that this is contrary to the requirement of an administrative tribunal explaining or justifying their decision as discussed in *Canada (Minister of Citizenship and Immigration) v Vavilov*, 2019 SCC 65 at para 79 [*Vavilov*].

[88] However, she said that when she reads “[the appeal decision] as a whole, in light of the record, including the parties’ submissions, [she found] an internally coherent and rational chain of analysis that is justified by the facts and law involved” (*KB decision* at para 23).

[89] In reaching this conclusion, the judge noted that “the [b]oard had two competing positions before it” as to whether the surgery was an emerging treatment or was the standard of care for lipedema (*ibid* at para 26).

[90] The judge summarized the evidence each of the parties relied upon for the issue in dispute. She explained that appeals under the *Act* are “to be conducted on an informal basis” such that “the [b]oard is not bound by the rules of evidence” as to the information put before it and which it can rely upon (*ibid* at para 34). She highlighted that the transcript of the appeal confirmed that the board received detailed written and oral submissions from the parties and that members of the board asked questions. Ultimately, she stated (*ibid* at para 32):

In the end, the [b]oard was presented with two distinct and opposing views. [The appeal decision] does not explain why it agreed with Manitoba Health, but given the evidence and submissions, by saying it did so, the chain of reasoning becomes

transparent and intelligible given the facts and in light of the *Act* and the *Regulation*.

[91] It should be noted that the judge made a minor factual error in her recitation of the facts in the *KB decision*. She said that Manitoba Health told the board that its decision to change its approval and deny the insurance for the surgery was “based” on the CADTH reports (*ibid* at para 27). This is not accurate.

[92] It is difficult to tell exactly what information was relied upon in the 2022 denial decision because the memo was created only after the applicants filed their appeal to the board. However, what can be said is that, while the memo refers to some scientific sources that Manitoba Health relied upon to make its decision, such as the historic report of Dr. Hosking and recent discussions with Dr. Guiffre, no mention is made in the memo of any reliance on the CADTH reports.

[93] According to the transcript of the appeal before the board, Manitoba Health advised the board that the evidence relied upon to deny the insurance was “simply what’s in the memo. We haven’t presented to you anything else.”

[94] While there is no difficulty in Manitoba Health relying upon the CADTH reports to defend its denial of the insurance in the appeal before the board, it is not accurate to say the CADTH reports formed part of the initial administrative decision to deny the insurance for the surgery. The record does not support the judge’s finding.

[95] However, given the circumstances, nothing turns on this factual error. In my view, it is not material.

Discussion

Standard of Review

[96] The standard of review on an appeal from a decision dismissing an application for judicial review is directed at two questions. The appellate court must decide whether the court below identified the appropriate standard of review of the administrative decision and then decide whether it applied that standard correctly (see *Agraira v Canada (Public Safety and Emergency Preparedness)*, 2013 SCC 36 at para 45 [*Agraira*]).

[97] As was explained in *Northern Regional Health Authority v Horrocks*, 2021 SCC 42 [*Horrocks*] on the judicial review appeal: “A reviewing judge’s selection and application of the standard of review is reviewable for correctness” (at para 10; see also *Ontario (Attorney General) v Ontario (Information and Privacy Commissioner)*, 2024 SCC 4 at para 15; *Mason v Canada (Citizenship and Immigration)*, 2023 SCC 21 at para 36).

[98] Made clear in *Horrocks* and *Agraira* is that this Court owes no deference to the decision of the reviewing judge. Rather, we are to perform a *de novo* review of an administrative decision (see *Horrocks* at para 10, quoting *Agraira* at para 45). This analysis requires this Court to ““step into the shoes’ of the lower court” and focus on the administrative decision under review (i.e., the appeal decision) (*Agraira* at para 46, citing *Merck Frosst Canada Ltd v Canada (Health)*, 2012 SCC 3 at para 247).

Positions of the Parties

[99] The parties agree that the judge identified the correct standard of review; the standard of reasonableness (see *KB decision* at para 13). The relevant principles the judge had to consider in a reasonableness review of the appeal decision are set out in *Vavilov* and have been summarized by this Court in *Smith v The Appeal Commission*, 2023 MBCA 23 at para 75.

[100] The other non-controversial aspect of this case is that the appeal decision satisfies the first requirement of *Vavilov*, in that it “is based on an internally coherent and rational chain of analysis” (at para 85). I agree with the judge that the analysis of the appeal decision is rational and logical; whether it is justifiable given the controlling legal and factual context is a separate question.

[101] Consistent with the approach outlined in *Newfoundland and Labrador Nurses’ Union v Newfoundland and Labrador (Treasury Board)*, 2011 SCC 62, the judge assessed the reasonableness of the appeal decision by looking at its reasons in the complete context of the record.

[102] As the judge explained, the board adopted the position of Manitoba Health as to why the applicants should be denied the insurance under the *Act* and the *Regulation*. Specifically, the surgery is not an insured medical service because it is an emerging treatment, the efficacy of which has not been established (see the *Regulation*, s 2(18)(b)).

[103] This is a situation of an administrative board adopting the reasoning of an administrative decision maker as its own. I see no difficulty with the board doing this; administrative justice is not judicial justice (see *Vavilov* at

paras 91-98). That said, it is not uncommon in the judicial system for a court to adopt the reasons of a lower court or decision maker as its own so long as the court independently arrives at the same decision and expresses its adoption in a transparent way that is intelligible for the purposes of appellate review. That is the situation here. Moreover, the *Act* expressly makes clear that the board may “confirm” the decision of Manitoba Health to deny the insurance under the *Act* or the regulations thereunder (see the *Act*, s 10(5)(a)).

[104] The true dispute in this appeal is the second type of fundamental flaw discussed in *Vavilov*, as to whether the appeal decision is “untenable in light of the relevant factual and legal constraints that bear on it” (at para 101).

[105] The positions of the parties can be summarized this way.

[106] The applicants argue that the appeal decision was unreasonable because it applied the wrong legal test under section 2(18)(b) of the *Regulation*. Instead of assessing whether the surgery is an emerging treatment with unproven efficacy, the board mistakenly focused on whether the surgery is the standard of care in Manitoba.

[107] The applicants also contend that the board ignored or failed to explain why it rejected significant medical evidence. This includes evidence from Stanford and the applicants’ doctors indicating that the surgery was medically necessary and had already shown successful results. They further argue that the board selectively relied upon the CADTH reports, disregarding portions acknowledging substantial patient-reported improvements in pain, mobility, quality of life, and long-term outcomes following the surgery.

[108] Manitoba Health submits that the judge correctly applied the *Vavilov* reasonableness standard in upholding the appeal decision. Manitoba Health acknowledges the appeal decision was not perfect but maintains it was adequate and supported by the evidence.

[109] Manitoba Health says it was reasonable for the board to base its decision on whether scientific research shows the surgery is effective enough to be part of the Canadian standard of care for lipedema. Manitoba Health stresses that a treatment becomes part of the standard of care only when sufficient evidence has established its effectiveness.

[110] Manitoba Health accepts that the treatment can be considered standard of care in Manitoba even if not offered here, potentially allowing the insurance. However, it submits that because the surgery is not recognized as part of the standard of care, it is properly treated as an emerging treatment under the *Regulation*.

[111] Manitoba Health further argues that foreign acceptance of the surgery does not mean it has emerged in Canada. Manitoba Health says the board appropriately relied upon the lack of clear scientific evidence, findings from the CADTH reports indicating no clinical proof of effectiveness and prior board decisions on similar procedures. It also says the applicants' personal improvement from the first surgery does not amount to scientific evidence of efficacy.

[112] The parties also made brief submissions on Manitoba Health's change of position to reject the request for the insurance, then approve the surgery and then deny follow up surgeries after the first surgery. As I will explain, this issue ultimately does not bear on my assessment of whether the

appeal decision was reasonable. I will refer to this issue later in my discussion of the appropriate remedy for the board's unreasonable decision.

Reasonableness Review: General Principles

[113] Legislative intent is the “‘polar star’ of judicial review” (*Vavilov* at para 33). The board was thus required to be alive to and adhere to the essential aspects of the legal standard created by section 2(18)(b) of the *Regulation* (see *Vavilov* at paras 120-22). An administrative decision that is outside of the factual and legal constraints of the board is unreasonable (see *Vavilov* at paras 85, 101).

[114] As this Court explained in *Manitoba Government and General Employees’ Union v The Minister of Finance for the Government of Manitoba, The Honourable Scott Fielding*, 2021 MBCA 36 [*MGEU*], *Vavilov* requires that “decisions relating to statutory interpretation must accord with the text, context and purpose of the provision and statutory scheme, and other statutory or common law” (*MGEU* at para 59).

[115] While *Vavilov* states that evaluation of the appeal decision be “robust” (at para 12), the review cannot be a disguised form of correctness where this Court substitutes its own view on the merits (see para 83).

[116] Given my view that Manitoba Health, the board and the judge misinterpreted the relevant statutory framework in a material way, in particular section 2(18)(b) of the *Regulation*, it is appropriate to begin my analysis with this issue.

Statutory Interpretation: General Principles

[117] In *Rizzo & Rizzo Shoes Ltd (Re)*, 1998 CanLII 837 (SCC), the Supreme Court of Canada explained that statutory interpretation cannot be based on statutory language alone. The legislative words must be read in their entire context, not only in their grammatical and ordinary sense, but harmoniously with the scheme of the legislation, the object of the legislation, and the intention of the Legislature.

[118] Also germane to statutory interpretation is section 6 of *The Interpretation Act*, CCSM c I80, which provides:

Rule of liberal interpretation

6 Every Act and regulation must be interpreted as being remedial and must be given the fair, large and liberal interpretation that best ensures the attainment of its objects.

Solution de droit

6 Les lois et les règlements sont censés apporter une solution de droit et s'interprètent de la manière la plus équitable et la plus large qui soit, compatible avec la réalisation de leur objet.

[119] I would highlight that the *Act* (and the *Regulation*) is remedial social welfare legislation designed to protect the health of eligible insured persons in Manitoba by providing them with insured medical services. Accordingly, a liberal interpretation of the *Act* and the *Regulation* is required as to entitlement to insured medical services; any doubt in legislative language should be resolved in favour of the claimant seeking benefits (see *Alpha Laboratories Inc v Ontario*, 1999 CarswellOnt 537 at para 10, [1999] OJ No 552 (ON Div Ct), leave to appeal to ONCA refused (27 April 1999), leave to appeal to SCC refused, 27419 (20 April 2000); *Abrahams v Attorney General of Canada*, 1983 CanLII 17 at 10 (SCC)).

Regulation of the Content of Medical Services in Manitoba

[120] Under section 2(1) of the *Act*, the definition of medical services is as follows:

“medical services” means all services rendered by a medical practitioner that are medically required but does not include those services excepted by the regulations; (« soins médicaux »)	« soins médicaux » Tous les soins administrés par un médecin et qui sont médicalement nécessaires, sauf les soins exclus par les règlements. (“medical services”)
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[121] This definition is consistent with the language of the *Canada Health Act*, RSC 1985, c C-6, s 2.

[122] As was explained in *Cameron v Nova Scotia (Attorney General)*, 1999 NSCA 14, leave to appeal to SCC refused, 27584 (29 June 2000), the content of medical services in the various provincial health care systems is a policy decision. The discretion to fund a medical service is a question not only of medicine but of the availability of funds to finance the service (see *ibid* at paras 78-79). This exercise of discretion is not the responsibility of the courts, rather the judicial role is limited to ensuring that those that “administer the policy follow their own rules – in particular, [the governing statutory framework]” (*ibid* at para 101).

[123] The comments of Abella JA (as she then was) in *Agricultural Research Institute of Ontario v Campbell-High*, 2002 CanLII 10432 at para 29 (ONCA), albeit in a different context, are important to remember:

The government occupies a unique -- and uniquely powerful -- role in its relationship with the public. This power imbalance, in

turn, creates a duty on the government to act in a way that enhances public confidence in reliable fairness from the government.

Section 113(1) of the Act

[124] The *Act* sets out a process where a specific medical service can be designated as either insurable or not insurable by way of a regulation under the *Act*:

Regulations by LG in C 113(1) The Lieutenant Governor in Council may make regulations

...

(i) designating and describing medical services in respect of which benefits are payable when they are rendered to an insured person elsewhere than in Manitoba;

...

(k) prescribing the services, or respecting the manner of determining the services, in respect of which an insured person is not entitled to receive benefits[.]

Règlements du lieutenant-gouverneur en conseil

113(1) Le lieutenant-gouverneur en conseil peut, par règlement :

...

i) désigner les soins médicaux à l'égard desquels des prestations sont payables lorsqu'ils sont fournis à un assuré ailleurs qu'au Manitoba;

...

k) indiquer les soins à l'égard desquels un assuré n'a pas le droit de recevoir des prestations ou régir la façon de les déterminer[.]

[125] In *Appellant v Manitoba Health, Seniors and Active Living, Insured Benefits, Insurance Division*, 2020 CanLII 45525 (MBHAB) [*facial feminization case*], the board recognized that rather than enacting regulations pursuant to section 113(1) of the *Act* as to which medical services are insured services, Manitoba Health often operates by “internal policies” as to coverage (at para 37). This practice of decision making about the funding of medical

services being done quietly and inside government bureaucracy is not unique to Manitoba (see Jocelyn Downie, Timothy Caulfield & Colleen M Flood, *Canadian Health Law and Policy*, 2nd ed (Markham: Butterworths, 2002) at 23).

[126] There is no regulation pursuant to either section 113(1)(i) or (k) of the *Act* that specifically address whether the surgery is an insured medical service or not. Accordingly, the correct procedure to answer that question was the analysis required by section 2(18)(b) of the *Regulation*. As was the situation in the *facial feminization case*, Manitoba Health relied on an internal policy, as opposed to a regulation under section 113(1) of the *Act*. The history of the *Regulation* is important to understand, particularly given the importance of transparency in administrative decision making that *Vavilov* demands.

History of the Regulation

[127] In 1992, the health care system of Manitoba was altered by the integration of the independent Health Services Commission into the government department, Manitoba Health (see *The Health Services Insurance Amendment and Consequential Amendments Act*, SM 1992, c 35). The Minister of Health became responsible for all powers previously exercised by the Commission, including funding for insured medical services.

[128] The controversy of funding an out-of-province medical service that is not available in Manitoba is not a new one, nor is a problem unique to Manitoba.

[129] The former version of the *Regulation* provided a different procedure for resolving this type of issue. It read as follows:

Exclusions

2. The following services are not insured services:

18. Services that are determined by the minister, after consultation with the College of Physicians & Surgeons of Manitoba, to be

(a) experimental or provided as applied research; and

(b) any other services, whenever provided, that are in any way provided in conjunction with or in relation to the services referred to in clause (a).

Exclusions

2 Les services suivants ne sont pas des services assurés :

18. Les services qui, de l'avis du ministre et après consultation avec le Collège des médecins et chirurgiens du Manitoba, sont:

a) des services expérimentaux ou des services rendus dans le cadre de la recherche appliquée;

b) d'autres services, quelque que soit le moment où ils sont rendus, fournis conjointement avec les services visés à l'alinéa a) ou fournis relativement à ceux-ci.

[130] In 2005, the *Regulation* was changed to its current form (see *Excluded Services Regulation, amendment*, Man Reg 170/2005). The procedure of consultation with the College of Physicians & Surgeons was removed. As well, while the language of section 2(18)(a) was retained with slight modification, a new section 2(18)(b) was added (thus drawing the distinction between experimental and emerging medical services):

Exclusions

2. The following services are not insured services:

Exclusions

2. Les services suivants ne sont pas des services assurés :

18. Services that are determined by the minister, after reviewing the available evidence, to be

- (a) experimental or provided as part of a clinical trial or an applied research study;
- (b) an emerging treatment or diagnostic procedure for an illness, injury or condition for which the efficacy of the service has not been established; or
- (c) any other services that are provided in conjunction with or in relation to services referred to in clause (a) or (b).

18. Les services qui, de l'avis du ministre et après examen de la preuve existante, sont :

- a) des services expérimentaux ou des services rendus dans le cadre d'essais cliniques ou d'études dans le domaine de la recherche appliquée;
- b) des démarches diagnostiques ou des traitements nouveaux dont l'efficacité n'a pas été prouvée à l'égard d'une maladie, d'une blessure ou d'un état de santé;
- c) d'autres services fournis conjointement avec les services visés à l'alinéa a) ou b) ou relativement à ceux-ci.

The Meaning of Section 2(18)(b) of the Regulation

[131] Unfortunately, in my respectful view, Manitoba Health, the board and the judge misinterpreted the plain language of section 2(18)(b) of the *Regulation* when it is read in the context of the entire legislative scheme.

[132] As stated before, the appeal decision was that because, in the board's view, the surgery was an emerging treatment for lipedema, it is "thus" an excluded service according to section 2(18)(b) of the *Regulation*. The board

stated that Manitoba Health had “correctly followed” the *Act* and the *Regulation*.

[133] In my respectful view, the reasoning of the board is a “sufficiently serious shortcoming” (*Vavilov* at para 100) because the interpretation of the board as to the meaning of section 2(18)(b) was central to the appeal decision. The board’s interpretation of the legislation ignores its true meaning; whether or not the surgery is emerging is not determinative as to whether the surgery is uninsurable given the language of section 2(18)(b) of the *Regulation*.

[134] I agree with the submission of Manitoba Health that the meaning of section 2(18)(b) of the *Regulation* must be ascertained by looking at the legislative scheme as a whole. There are regulatory provisions under the *Act* that allow for benefits for medical services performed outside of Canada where there is a specialist referral and the medical service is not adequately available in Manitoba or in Canada (see *Medical Services Insurance Regulation*, Man Reg 49/93, s 7(2)(b); *Hospital Services Insurance and Administration Regulation*, Man Reg 48/93, ss 16(2), 18(2)).

[135] The meaning of section 2(18)(b) of the *Regulation* is therefore something quite different than the situation that provision of the medical service in Manitoba or Canada is inadequate. In my view, the language used in section 2(18)(b) requires an assessment of two separate questions.

[136] The first question, in applying section 2(18)(b) of the *Regulation*, is to decide whether a treatment or diagnostic procedure (the procedure) is emerging or not. This question is separate and apart from the efficacy of the procedure, a topic I will turn to in a moment.

[137] In answering this initial question, the decision maker must be mindful that the *Regulation* distinguishes between a procedure that is emerging and one that is experimental or provided in the course of applied research (see the *Regulation*, s 2(18)(a)).

[138] Additionally, in approaching the interpretation of bilingual legislation, the court should, as far as possible, attempt to ascertain legislative intent through a determination of the shared or common meaning of the two versions if there is no discordance (see *R v Daoust*, 2004 SCC 6 at paras 26-30).

[139] The language of the English and French versions of section 2(18)(b) of the *Regulation* is consistent with each other. In particular, the French version of section 2(18)(b) of the *Regulation* highlights that the procedure is emerging when it is “nouveaux” (new) as opposed to established.

[140] Therefore, if the facts of a situation lead to the conclusion that the procedure has emerged, the procedure is insurable under the *Act* and the *Regulation* (save a legal reason in the scheme to the contrary). This is consistent with a liberal interpretation of remedial social welfare legislation as explained previously.

[141] However, if the administrative decision maker concludes that the procedure is emerging, the analysis is not over. This is the material *Vavilov* error of the board in terms of not adhering to the governing statutory framework. Section 2(18)(b) of the *Regulation* is clear that it is only where the efficacy of the procedure has not been established that insurance must be denied. There are two parts to the analysis for the decision maker under section 2(18)(b), not one.

[142] Regrettably, the record is full of instances of the terms “efficacy” and “effective or effectiveness” being used interchangeably. It is important to highlight that the language used in section 2(18)(b) of the *Regulation* is “efficacy,” not “effective”.

[143] The definition of “efficacy” is “the ability to produce a desired or intended result”, whereas “effective” is defined as “successful in producing a desired or intended result” (Angus Stevenson, Judy Pearsall & Patrick Hanks, eds, *Oxford Dictionary of English*, (Oxford: Oxford University Press, 2010) sub verbo “efficacy”, “effective”).

[144] The subtle, but important, distinction in the language in the context of medical treatment is explained this way in Agency for Healthcare Research and Quality, *Criteria for Distinguishing Effectiveness From Efficacy Trials in Systematic Reviews*, by Gerald Gartlehner et al, AHRQ Report No 06-0046 (Rockville, Md: AHRQ, April 2006) at 3, online: <ncbi.nlm.nih.gov>:

Clinicians and policymakers often distinguish between the *efficacy* and the *effectiveness* of an intervention. Efficacy trials (explanatory trials) determine whether an intervention produces the expected result under ideal circumstances. Effectiveness trials (pragmatic trials) measure the degree of beneficial effect under “real world” clinical settings. Hence, hypotheses and study designs of an effectiveness trial are formulated based on conditions of routine clinical practice and on outcomes essential for clinical decisions.

[emphasis in original, footnote omitted]

See also Per Nilsen et al “Tempering implementation optimism: distinguishing between efficacy and effectiveness in implementation

research” (2025) 6:90 Implementation Science Communications, online: <link.springer.com>.

[145] Courts have recognized that the standards of efficacy and effective are different in terms of the required degree of certainty (see *R v Goodchild*, 2018 ONSC 4291 at para 24; *Simpson v Chiropractors’ Association of Saskatchewan*, 1999 SKQB 89 at para 227, rev’d in part 2001 SKCA 22).

[146] It is an error to use the concepts of efficacy and effective or effectiveness interchangeably. They are two distinctly different standards of certainty. For example, much was made about the relevance of the CADTH reports. On close reading, they speak primarily, but not exclusively, about the effectiveness of the surgery. The relevant analysis here was the efficacy of the surgery, not the effectiveness of the surgery.

[147] Interestingly, a survey of the laws in Manitoba highlights that the terminology of efficacy is used in only two statutes and six regulations, all of the regulations relate to health care. In contrast, the standard of effectiveness is used in 165 statutes and 200 regulations.

[148] When dealing with statutory interpretation, there is a presumption in favour of the ordinary, non-technical meaning of words (see Ruth Sullivan, *The Construction of Statutes*, 7th ed (Toronto: LexisNexis, 2022) at 54-63; *TransCanada Pipelines Ltd v Manitoba*, 2013 MBCA 88 at para 54).

[149] Viewed from an ordinary, non-technical standard, the language in the *Regulation* of efficacy should be interpreted in much the same way as the dictionary defines it, does it produce the intended result or effect, or simply, “does it work” under ideal conditions.

[150] At the end of the day, in applying a legislative standard, fidelity must be shown to the choices of the legislator. Here, it was decided that the legal standard as to whether the surgery would be insured would be efficacy (can it work in ideal circumstances) as opposed to effective (does it work in the real world).

[151] To summarize, provided the surgery is not excluded from the insurance by a specific regulation under the *Act*, the insurability for it is to be determined in accordance with the *Regulation*.

[152] Application of section 2(18)(b) of the *Regulation* requires analysis by the administrative decision maker of two questions:

- 1) Is the procedure emerging for the illness, injury or condition?

If the answer is no, the analysis is over and the procedure is insurable, provided the claim meets all other legal requirements.

- 2) If the procedure is emerging, has the efficacy of it been established for the illness, injury or condition?

The relevant analysis is that of efficacy, can the procedure work under ideal conditions. The standards of efficacy versus effectiveness should not be conflated. The language chosen by the legislator must be respected.

[153] The legal onus is on the claimant to establish on the balance of probabilities both requirements of section 2(18)(b) of the *Regulation*. Ultimately, in accordance with *Vavilov*, the administrative decision maker

must provide a coherent and rational chain of analysis that is justified in relation to the controlling legal and factual context.

[154] The appeal decision could be quashed on the basis that the board decided the applicants' statutory appeal outside the constraints imposed by the governing legislation. However, merely remitting the case back to the board with a direction to apply the correct legal standard would not properly address other aspects of the appeal decision where it failed to adhere to factual constraints that were placed on it by the record.

Factual Constraints Placed on the Board by the Record

Is the Surgery Emerging?

[155] The evidence before the board was that the surgery has been used around the world for decades to successfully treat lipedema and medical professionals have developed newer and better techniques such as water-assisted liposuction to improve patient results and decrease recovery times. In past practice, the board has recognized the reality that many Western nations permit and publicly fund the surgery to treat severe lipedema cases (see *Appellant v Manitoba Health, Seniors and Active Living, Fee-For-Service/Insured Benefits*, 2018 CanLII 103421 (MBHAB)). It stretches credulity to say the surgery is something new and thus can be said to be emerging as opposed to emerged. This is particularly so because Manitoba Health recognizes the surgery does occur in Manitoba already but not for lipedema.

[156] The board accepted Manitoba Health's position that the surgery is an emerging treatment because it is not the standard of care in Manitoba to

treat lipedema. While I accept that evidence as to the standard of care for the procedure is a relevant consideration in applying section 2(18)(b) of the *Regulation*, care must be exercised as to reliance on such evidence.

[157] The law has long recognized that the standard of care for medical treatment can vary between localities. As Professor Klar explains (Lewis N Klar, *Tort Law*, 5th ed (Toronto: Carswell, 2012) at 403):

[T]he locality rule is merely illustrative of the well-accepted proposition that the conduct of a defendant must be judged on the basis exhibited by a reasonable person “in like circumstances,” and that accordingly, the location of the service *might* be one of these relevant circumstances. If, for example, the service was performed in an area which had limited access to facilities, equipment, and specialists, the defendant can only be asked to do what the reasonable person so limited would have done. It may very well be, however, that the location did not limit the quality of the service’s performance, and if so, it is not a relevant consideration.

[emphasis in original, footnote omitted]

[158] While this commentary is directed to the standard of care in a claim for medical negligence, the analysis is sound that the relevant standard of care is a question of fact, the significance of which turns on the circumstances, particularly different localities.

[159] In my view, the locality rule was a live issue in this case that had to be addressed by proper fact-finding by the board.

[160] Appropriately, before the board, Manitoba Health conceded that the fact that the surgery does not exist in Canada, but does exist in foreign jurisdictions, is not determinative as to insurability for the medical service

(see *Stein c Québec (Tribunal administratif)*, 1999 CanLII 11195 (QCCS) [*Stein*]).

[161] The problem here is that the board had to assess the evidence about the standard of care in relation to the surgery and provide reasons for its analysis. Several parts of the factual context are relevant.

[162] The board had conflicting expert evidence from reliable sources as to whether there is a standard of care for the surgery. In fairness to the board, I would not read the appeal decision as a broad statement that it is disagreeing with eminent medical professionals in other jurisdictions and disputing that the surgery is a safe and efficacious treatment from a purely medical perspective. The language used in the 2022 denial decision “that liposuction is not considered a standard of care for the treatment of lipedema” was imprecise. That statement is impossible to reconcile with the information Manitoba Health had from Stanford and other foreign sources that say the exact opposite. For example, the applicants provided the board with a 2021 expert panel report on the standard of care for lipedema in the US (see Karen L Herbst et al, “Standard of care for lipedema in the United States” (2021) 36:10 Sage Journals, online: <journals.sagepub.com>) [the American report].

[163] I take the 2022 denial decision to be a localized characterization of the standard of care; the surgery is not considered a standard of care in Manitoba.

[164] According to the 2019 denial decision, the surgery is a medical service performed in Manitoba, however not for the treatment of lipedema. This begs the question, why?

[165] According to the uncontradicted statements of Dr. Ziesmann and Dr. McCarthy, the problem in Manitoba (and broadly in Canada) is the lack of plastic surgeons trained in the correct procedure as opposed to the availability of equipment. As Dr. McCarthy explained, a professionally trained surgeon is necessary to preserve lymphatic vasculature. Dr. McCarthy's opinion is supported by the American report at 788, which states:

4.15. [The surgery] should be performed by surgeons experienced in the care of people with lipedema, with expert knowledge of the anatomy and function of lymphatic collection systems, using meticulous care to avoid lymphatic injury.

[166] For example, in the record before the board was the training of Dr. Nguyen. Before she began practicing at Stanford, she completed a fellowship in microsurgery, specializing in lymphedema/lipedema surgical treatments, at one of the largest reconstructive surgery centers in the world, located in Taiwan. It is easy to understand why Dr. McCarthy said surgeons with this sort of training are in short supply, particularly in Canada.

[167] The applicants provided sufficient evidence that the surgery is a standard of care in multiple jurisdictions around the world. The position articulated by Stanford and in the American report was unequivocal on this point. The evidence adduced by the applicants was sufficient to establish that, because the surgery is a standard of care, it has emerged for the purposes of section 2(18)(b) of the *Regulation*.

[168] Manitoba Health accepted this reality because it changed its original position, denying the insurance for the surgery for each of the applicants at Stanford.

[169] To be consistent with *Stein* and the concession that Manitoba Health made before the board, the board needed to explain why it was nevertheless reasonable to conclude that the surgery was an emerging treatment. This would require an intelligible and factual reasoning based on the record that is absent here.

If the Surgery is Emerging, Has the Efficacy of it Been Established?

[170] It is obvious from the appeal decision that the board simply decided the applicants' administrative appeal on the basis that because there is no standard of care for the surgery in Manitoba, the surgery is excluded from the insurance pursuant to section 2(18)(b) of the *Regulation*. As stated before, this failure to follow the correct legal standard is reason alone to quash the appeal decision.

[171] In fairness to Manitoba Health, it did raise submissions before the board and during the judicial review process that the efficacy of the surgery has not been established. Those arguments need to be addressed.

[172] The argument advanced is there is an absence of the necessary gold standard of a randomized and controlled clinical study as to the surgery, and thus the requirements of section 2(18)(b) of the *Regulation* cannot be satisfied by the applicants.

[173] There are two problems with this submission.

[174] First, the relevant legal context is that the plain language of the *Regulation* is that clinical trials or applied research are only mentioned as germane for section 2(18)(a) of the *Regulation*, not section 2(18)(b). The

correct analysis under section 2(18)(b) is directed to the questions of emerging and efficacy, as I have explained. There is merit to the applicants' position that randomized, controlled trials are not the only way to prove the efficacy of the surgery; regard may be had to expert opinion, clinical judgment, and outcomes. All of these are facts on which reasonable inferences can be drawn.

[175] Second, Manitoba Health is attempting to view the evidence through the lens of effectiveness as opposed to efficacy, which, as previously stated, is an error. The factual context here was that there was significant evidence before the board that the surgery works, in the absence of controlled clinical studies, in ideal circumstances.

[176] There is no question that the CADTH reports note that the American report (and similar guidelines in the other jurisdictions) is based on what the CADTH calls low-quality evidence in the form of mainly retrospective studies with methodological limitations. The 2022 CADTH report states that, “[g]iven the inadequate clinical and safety data on liposuction, and the limitations of the identified guidelines, it is still unclear if this technique should be implemented as an option among the standard procedures for treating people with lipedema in Canada.”

[177] However, the evidence before the board was far more than the anecdotal impressions of the applicants and their doctors. The evidence from Stanford, a world-renowned scientific institution and leader in the field, that the lives of thousands of patients have been improved by the surgery is impossible to disregard. According to the criteria set out in the American report, it is readily understandable why Dr. Nguyen would have recommended the surgery for the applicants: they were young and in good health; the

conservative modalities had been attempted and had failed; and while the surgery does have risks associated with it, it was being performed at Stanford by a surgeon, with the necessary expertise.

[178] The board completely ignored whether this evidence meets the relevant legislative standard, efficacy. Moreover, the record is undisputed that this is not a situation where Stanford is unique. Comparable results have been achieved elsewhere in the US and in countries with public health care systems such as Germany, the UK and the Netherlands, according to the CADTH reports.

[179] Appropriately, Manitoba Health conceded at the hearing of the judicial review appeal that the cost of the surgery is not a relevant consideration as to its efficacy being established. While this Court is sensitive to the reality that health care budgets are not infinite, nor are courts accountable for public finances in the same way that Manitoba Health is, if travel-related costs are removed from the analysis, the surgery is approximately \$10,000, with variations between foreign jurisdictions. This is a rough estimate, as the record is imprecise.

[180] The bottom line is what was before the board was not a request that dramatically affects health care finances in Manitoba to the detriment of the greater good.

[181] Finally, I am not persuaded by Manitoba Health's argument that the board was entitled to consider its past practice in the 2018 denial decision and other cases in terms of water-assisted liposuction.

[182] The difficulty with this submission is that, while it was appropriate for Manitoba Health to argue that the scientific literature in the judicial review appeal was similar to the 2018 denial decision, according to the transcript of the appeal before the board, Manitoba Health conceded that the issue in the 2018 denial decision was different, as it was about water-assisted liposuction, not tumescent liposuction.

[183] Moreover, the board in the 2018 denial decision took great pains to say that it was only deciding the issue before it, as opposed to the insurance for the surgery generally or tumescent liposuction. The prior decisions of the board about water-assisted liposuction have little precedential value to the judicial review appeal, save that it can safely be said in all of these liposuction cases there is no evidence of a randomized and controlled clinical study stating that the surgery was an effective treatment. That said, the relevant legislative standard is efficacy, which is an entirely different standard.

Conclusion

[184] I am satisfied that the board applied the wrong legal standard when it dismissed the applicants' statutory appeal. It relied upon Manitoba Health's misreading of section 2(18)(b) of the *Regulation*. The board leapt to the conclusion that the surgery was an uninsured medical service simply because there is no standard of care for the surgery in Manitoba. This conclusion ignored the evidentiary record that the surgery is a standard of care in multiple foreign jurisdictions, and there is an obvious reason why the surgery is not offered in Manitoba, due to a shortage of trained surgeons.

[185] Even if one assumes that the surgery is an emerging treatment, which is a dubious proposition on this record, I am of the view that, had the

board properly turned its mind to the question of efficacy, the evidence before it provided only one reasonable conclusion: that the efficacy of the treatment was established.

[186] I wish to make clear that the appeal decision in this case does not mean that just because the surgery is successful for some patients that everyone is entitled to the service as an insured benefit; health care decisions must be made based on a case-by-case basis by Manitoba Health based on the evidence (see *Appellant v Manitoba Health, Insurance Division, Insured Benefits*, 2022 CanLII 101431 (MBHAB); *facial feminization case*).

[187] In summary, while I am prepared to accept that the appeal decision is reasonably transparent and intelligible, it is not justified based on a reasonableness review given the controlling legal and factual context.

Remedy

[188] The normal remedy on a reasonableness review is to remit the matter back to the administrative tribunal for reconsideration. However, when it is clear that there is only one reasonable interpretation, the reviewing court should make a pronouncement on that interpretation (see *Pepa v Canada (Citizenship and Immigration)*, 2025 SCC 21 at para 121, citing *Vavilov* at para 141).

[189] As the *KB decision* noted, there are events that occurred after the appeal decision as to the second surgery in Germany. I agree with the judge that is a matter that Manitoba Health can now address in light of this Court's decision that it was unreasonable to determine that a second surgery for the

applicants was an excluded insured medical service pursuant to section 2(18)(b) and (c) of the *Regulation*.

[190] I would however reject the applicants' submission that Manitoba Health's change of position as to the insurance was arbitrary, and it is barred from denying the insurance for the surgery going forward. I agree entirely with the judge's analysis on this issue. I am satisfied that the approval decision did not write a blank cheque to fund all surgeries for the applicants. That is contrary to the case-by-case analysis for funding approval that the *Act* and regulations thereunder required, and the unambiguous conditional language Manitoba Health used in the approval decision. I see no error in the judge's reasonableness review of this aspect of the appeal decision.

[191] The implication of this in terms of remedy is that the applicants do not have the right to have the surgery performed at Stanford if there are other reasonable alternatives. This Court is not privy to the pertinent information and would not speculate on the level of care, or its costs, in Germany versus Stanford (or elsewhere). That is a matter for Manitoba Health to consider in light of the information shared with it by the applicants and their doctors.

[192] If Manitoba Health makes a decision that the applicants do not agree with as to the insurance for the second surgery or medically necessary subsequent ones, the matter can be raised with a differently constituted panel of the board based on the reasons provided by Manitoba Health for its decision and this Court's views.

One Final Comment

[193] In a free society, no one is above the law. While simple, that idea is important and timeless. Lord Bingham captured what is meant by the idea of the “the rule of law” this way (Tom Bingham, *The Rule of Law* (England: Penguin Books, 2011) at 8):

The core of the existing principle is, I suggest, that all persons and authorities within the state, whether public or private, should be bound by and entitled to the benefit of laws publicly made, taking effect (generally) in the future and publicly administered in the courts.

[194] Such comments are important to remember given the reality that the administrative state continues to grow more powerful in the daily lives of Canadians. The rule of law demands that important decisions, like those that affect the health of all participants in the universal public health care system, be transparent, intelligible, and justified. All Canadians have, as they should, the expectation that their health care system will be operated fairly and within the boundaries of the law by its administrators (see *Reference re Secession of Quebec*, 1998 CanLII 793 at para 70 (SCC)).

[195] According to the debate about the reform of the health care system of Manitoba in 1992, concern was raised about the independence of the board and whether it would be a “meaningful” check on Manitoba Health as to decision making in relation to the health care of Manitobans (Manitoba, Legislative Assembly, *Debates and Proceedings (Hansard)*, 35-3, vol 41, No 85 (12 June 1992) at 4593 (Hon Gulzar Cheema) online: <gov.mb.ca/legislature/hansard/hansard.html>).

[196] The practice at Manitoba Health of excluding medical services across the board, as opposed to a case-by-case assessment, by way of the memo, as opposed to following the procedure laid out in the *Act*, is contrary to the rule of law. If the policy makers in charge of the Manitoba health care system wish to create a legally permissible restriction as to the general parameters of the content of health insurance, it must be done openly by regulation and not by opaque bureaucratic decision making. This is what the rule of law requires.

[197] When one reads the memo in this case, it purports to direct an across-the-board decision on funding a medical service for all Manitobans, a power that, according to the law, must be exercised by regulation, not by a bureaucrat pen. The board should have rejected this approach by Manitoba Health as it clearly offended the statutory scheme. At the end of the day, the board is not, nor should be perceived to be, a rubber stamp of the decisions made by Manitoba Health. That is not consistent with the mandate of being an independent decision maker that the Legislature gave to the board in the *Act*.

[198] Additionally, the board should have refused Manitoba Health efforts to apply a different legal standard to the applicants' appeal than what is set out in the plain language of section 2(18)(b) of the *Regulation* when read in the context of the overall scheme. The facts here, when applied to the correct legal standard, make clear that there is only one reasonable outcome, which favoured the position of the applicants.

[199] While the courts are not in the business of making individual health care decisions with broad implications as to the expenditure of limited public

funds, they will hold the decision makers in the health care system and the board responsible for failure to follow the law, as what occurred in this case.

Disposition

[200] In the result, I would allow the appeal.

[201] I would set aside the order of the judge and quash the appeal decision denying the insurance under the *Act* and its regulations for a second surgery out of province.

[202] I would remit this matter to a differently constituted panel of the board for re-determination in accordance with these reasons, if necessary.

[203] Finally, I would order that the applicants have one set of costs, on a tariff basis, in this Court and the Court below.

_____ JA

I agree: _____ JA

I agree: _____ JA