Curtailing Income Tax Relief for Cosmetic Medical Expenses

Ling Chu, Alan Macnaughton, and Nicole Verlinden*

PRÉCIS

Le présent article propose un examen approfondi sur les plans juridique et politique d’une modification instaurée dans le budget du gouvernement fédéral du Canada de 2010 en vue d’exclure du crédit d’impôt pour frais médicaux les frais médicaux engagés à des fins esthétiques. L’analyse s’appuie sur les connaissances rattachées à ces types de frais et qui relèvent de la médecine et des sciences sociales.

La modification apportée dans le budget est présentée comme une mesure tout à fait légitime sur le plan fiscal, en dépit de la plus grande complexité qui en découle.

L’expérience acquise par l’instauration de règles similaires aux États-Unis, en Australie et au Québec indique que peu de différends avec les contribuables sont à prévoir si ces mesures sont mises à exécution avec la même rigueur que dans ces administrations.

Le libellé que l’on trouve dans la loi (nouveau paragraphe 118.2(2.1)) propose aux contribuables deux approches pour éviter l’exclusion des frais médicaux engagés à des fins esthétiques : 1) le service pour lequel les frais ont été engagés est « exigé à des fins médicales ou restauratrices », ou 2) elles ne sont pas encourues « à des fins purement esthétiques ». Ces deux motifs d’exception peuvent être interprétés de façon extensive par les contribuables.

L’exception des fins médicales ou restauratrices est susceptible d’être souvent invoquée par les contribuables qui font l’objet d’un traitement médical de nature esthétique en vue de soulager une détresse psychologique liée à leur aspect physique. Étant donné l’insuffisance de preuves scientifiques montrant que les interventions esthétiques de ce genre ont un effet thérapeutique pour ce type de problème, il pourrait être souhaitable d’imposer par la voie législative que cette exception soit limitée à la détresse liée au trouble de l’identité sexuelle.

* Ling Chu is of the School of Business and Economics, Wilfrid Laurier University, Waterloo, Ontario (e-mail: lchu@wlu.ca). Alan Macnaughton is of the School of Accounting and Finance, University of Waterloo (e-mail: amacnaug@uwaterloo.ca). Nicole Verlinden is of Deloitte & Touche LLP, Toronto (e-mail: nverlinden@deloitte.ca). Thanks for helpful comments are due to Mei Chen, Ting Chen, David Duff, Andrew Jones, Olivia Kwan, Glenda Rutledge, Jocelyn Schaffenburg, Paula Yin, and Michael Ziesmann, as well as two anonymous reviewers, and to attendees at the Tax Expenditures and Public Policy in Comparative Perspective conference, held in Toronto in September 2009, and the Tax Policy Research Symposium sponsored by the Deloitte Centre for Tax Education and Research at the University of Waterloo and held in Toronto in June 2010.
La deuxième exclusion pourrait sans doute s’appliquer à presque tous les frais engagés pour des soins d’esthétique dentaire (qui représentent actuellement environ un cinquième de tous les frais médicaux engagés à des fins esthétiques). Les autres administrations ont connu le même problème sur cette question. Il n’est pas facile de combler cette lacune dans les règles, et il faudrait alors se passer de l’adverbe « purement » dans le libellé des frais médicaux qui ne sont pas couverts. L’Agence du revenu du Canada devrait également fournir des indications précises sur cette question.

**ABSTRACT**

This article is a comprehensive legal and policy review of an amendment introduced in the 2010 Canadian federal budget to exclude cosmetic medical expenses from the medical expense tax credit. The analysis is guided by knowledge relevant to these expenses from the fields of medicine and the social sciences.

The budget amendment is shown to be well justified in tax policy terms, despite the increased complexity it brings. A review of experience with similar rules in the United States, Australia, and Quebec suggests that few disputes with taxpayers should be expected if the enforcement level is similar to that in those jurisdictions.

The wording of the legislation (new subsection 118.2(2.1)) provides taxpayers with two separate avenues for avoiding the exclusion of cosmetic medical expenses: (1) the service for which the expense is paid is “necessary for medical or reconstructive purposes,” or (2) it is not “purely for cosmetic purposes.” Both of these exceptions may be subject to expansive interpretation by taxpayers.

The medical necessity exception is likely to be used extensively by taxpayers who obtain cosmetic medical treatment in order to alleviate appearance-related psychological distress. In light of the limited scientific evidence that cosmetic procedures are therapeutic for this problem, it might be desirable to legislate that this exception will be limited to distress related to gender identity disorder.

The second exception could potentially apply to almost any expenditure for cosmetic dentistry (which currently represents about one-fifth of all cosmetic medical expenses). Other jurisdictions have had a similar problem in this area. Filling this gap in the rules is difficult and would likely require removing the requirement that expenses be “purely” cosmetic to be caught. Detailed guidance from the Canada Revenue Agency would also be required.

**KEYWORDS:** TAX CREDIT ■ MEDICAL ■ EXPENSES ■ AMENDMENTS

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INTRODUCTION

The Canadian federal budget of March 4, 2010, as implemented by Bill C-9, has redefined medical expenses for tax purposes to eliminate the tax relief provided by the medical expense tax credit for purely cosmetic medical and dental expenses. The consequent reduction in the annual cost of the credit for the federal government is

1 Canada, Department of Finance, 2010 Budget, Budget Plan, March 4, 2010.
estimated at $40 million, or about 4 percent, plus provincial savings.\(^3\) This change in policy follows similar initiatives in Quebec, the United States, and Australia.

Although one might think that this is just another amendment to the medical expense rules necessitated by the constant progress of medical research, the history is otherwise. Income tax relief for medical expenses in Canada dates back only to 1942, while cosmetic surgery has its origins in World War I:

> If soldiers whose faces had been torn away by bursting shells on the battlefield could come back into an almost normal life with new faces created by the wizardry of the new science of plastic surgery, why couldn’t women whose faces had been ravaged by nothing more than the hand of the years find again the firm clear contours of youth.\(^4\)

Given this history, one might ask why a carve-out for cosmetic expenses was not part of the original medical expense deduction in 1942, and why it has not been added in the many decades since. Is there debate over the proper tax treatment of such expenses? Are cosmetic medical expenses capable of being defined in the objective way needed for tax administration? Can the budget amendment be improved? Has the budget estimated the additional tax revenue correctly? The purpose of this article is to address these questions, and more, by providing a comprehensive legal and policy review of the tax treatment of cosmetic medical expenses, drawing on the experience in other jurisdictions with similar rules and the extensive non-tax medical and social science literature on cosmetic medical and dental services. No previous tax research in Canada or elsewhere has been devoted to this general topic, although the questions of whether fertility treatments\(^5\) and gender reassignment surgery\(^6\) should be considered cosmetic have been addressed in the US context. Related statutory changes to the goods and services tax/harmonized sales tax (GST/HST) are not discussed in detail in this article, although the definition that governs the application of this tax to cosmetic medical services is similar.

Our analysis results in five main conclusions:

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3 The $40 million figure is from the Budget Plan, supra note 1, annex 5, table A5.1, at 338. The revenue cost of the medical expense tax credit is estimated to be $955 million for 2009: Canada, Department of Finance, *Tax Expenditures and Evaluations 2009* (Ottawa: Department of Finance, 2009), 17.


1. There is little support in the literature for income tax relief for cosmetic medical expenses, and therefore the 2010 budget amendment is well justified.
2. The wording of the amendment provides significant room for taxpayers to argue that they are not caught by the exclusion of such expenses, particularly on the ground that the treatment or procedure is medically necessary to alleviate psychological distress.
3. International experience teaches us that rules restricting tax relief for cosmetic medical expenses attract little controversy, perhaps because they are not interpreted and enforced strictly.
4. Depending on the administrative position of the Canada Revenue Agency (CRA) in the area of cosmetic dentistry, more than one-fifth of cosmetic medical expenses may not be covered by the budget amendment, but extending coverage may be problematic.
5. Finally, the budget amendment could be improved by legislating that psychological motivation (except in the case of gender identity disorder) does not make an expense non-cosmetic.

We begin with a discussion of the framework for tax relief for medical expenses under Canada’s health-care and tax systems. We then review the tax law prior to the budget amendment and analyze the amending legislation in some detail. Next, we discuss the broad policy considerations relating to the question of tax relief for cosmetic medical expenses. After reviewing the market for cosmetic medicine and dentistry, we describe the experience in three other jurisdictions—the United States, Australia, and Quebec—that exclude cosmetic medical expenses from tax relief. We also address the problem of drawing a clear dividing line between cosmetic and non-cosmetic expenses. Finally, we review various methods for estimating the revenue effects of implementing the budget amendment. A concluding section summarizes the main points of the article.

**THE FRAMEWORK FOR TAX RELIEF FOR MEDICAL EXPENSES**

**Public Versus Private Expenditures**

Although Canada’s medicare system provides for a large role for government in paying for health-related goods and services, 30 percent of all health-care expenditures in Canada are financed privately. Subject to certain restrictions, these private expenditures are eligible for income tax relief under federal and provincial law, as discussed below.

The broad framework of Canadian medicare is that public funds pay for hospital costs and the fees of physicians and related medical practitioners, while private funds

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7 Canadian Institute for Health Information, *National Health Expenditure Trends, 1975-2008* (Ottawa: CIHI, 2008), xiii. The cost of tax relief for medical expenses is not included in these data.
pay for dental services and most drugs administered outside a hospital or clinic.\(^8\)
Cosmetic medical services are generally also part of privately borne costs.

The legal basis for excluding cosmetic medical expenses from direct government subsidy starts with the Canada Health Act, which provides that the federal government will make a full cash contribution to a province for a health-care insurance plan if, among other things, the plan insures all “medically necessary” hospital services and “medically required” physician services.\(^9\) This mandate is interpreted differently from province to province, but the official Ontario rules for physician services are typical.\(^10\) Notable procedures covered that are to a degree cosmetic include repair of significant and unsightly trauma scars to the neck or face, including port wine stains; repair procedures for post-traumatic deformities, including bone revision and prosthesis implantation; and post-mastectomy breast reconstruction. Items with a cosmetic aspect that are generally not covered include surgery to alter changes in appearance caused by aging; excision or destruction of tattoos; removal of hair; treatment of hair loss that is not post-traumatic; removal of warts; destruction or repair of chronic acne scars; breast augmentation; cosmetic liposuction; and excision of redundant skin for removal of wrinkles. Patients cannot claim psychological distress relating to body image to obtain coverage of these items. However, exceptions are made where a procedure is recommended by a mental health facility, or performed on a person under the age of 18 and in an area of the body that is normally unclothed.

These rules are not simple to administer. In Ontario, just the general statement of the rules takes up seven pages in the schedule of benefits,\(^11\) and case-by-case government approval of specific patient situations in advance of treatment is often required.

**Forms of Tax Relief**

As noted above, federal and provincial tax legislation provides some relief for privately financed medical expenses. The form of this relief depends on how the expense is paid for.

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\(^8\) Catastrophic levels of drug costs are also government-paid in most provinces, but the definition of this varies considerably. For details, see Canadian Cancer Society, *Cancer Drug Access for Canadians* (Toronto: Canadian Cancer Society, September 2009).

\(^9\) Canada Health Act, RSC 1985, c. 6, sections 7(b) and 9, and the definitions of “insured health services,” “hospital services,” and “physician services” in section 2.

\(^10\) Ontario, Ministry of Health and Long Term Care, *Schedule of Benefits: Physician Services Under the Health Insurance Act* (Toronto: Ministry of Health and Long Term Care, October 1, 2009), appendix D. Section 37.1(1) of regulation 552 of the Health Insurance Act, RSO 1990, c. H-6, provides for the issuance of the schedule. The specific services not covered are listed throughout the schedule and in section 24 of that regulation. For background on how the schedule is established, see Colleen M. Flood and Joanna Erdman, *The Boundaries of Medicare: The Role of Ontario’s Physician Services Review Committee* (Montreal: Institute for Research on Public Policy, 2004).

\(^11\) Ontario, Ministry of Health and Long Term Care, supra note 10.
Medical Expense Tax Credit

For federal income tax purposes, individuals may claim a 15 percent (in 2010) non-refundable tax credit for personally paid allowable medical expenses. Under section 118.2 of the Income Tax Act, allowable medical expenses are the excess of medical expenses (as defined below) above a specified threshold, which is the lesser of 3 percent of the individual’s net income and a dollar amount ($2,024 in 2010). The credit has been in place since 1988, at which time it replaced a deduction introduced in 1942. If the medical costs are paid for by private insurance, the cost of this insurance paid by the individual qualifies as a medical expense.

For provincial income tax purposes in all provinces but Quebec, the same items qualify as medical expenses for provincial medical tax credits, but the dollar amount in the threshold and the credit rates vary. The combined federal and provincial-territorial credit rate on allowable medical expenses in 2010 varies from 19 percent (in Nunavut) to 26 percent (in Saskatchewan).

A supplementary federal credit (the refundable medical expense supplement) increases this credit rate by a further 25 percentage points (that is, to 44-51 percent in 2010, depending on the province or territory). However, because of the current income and dollar-limit restrictions, the supplementary credit is unlikely to apply to many cosmetic expenses.

Employer-Sponsored Health Plans

Under subparagraph 6(1)(a)(i) of the Act, employer contributions to a PHSP (a private health services plan) do not result in a taxable benefit to employees.

There are two common designs for a PHSP. The first design, known as a traditional PHSP or a group plan, does not have dollar limits for most categories of expenses. These plans control costs by limiting the type of expenses covered, and hence they generally do not cover cosmetic medical expenses. The plan might directly exclude all such services, or it might indirectly exclude the majority of them by not covering any physician service that is not part of medicare. However, some health plans for executives in the United States have no limits on procedures covered, and presumably such plans exist in Canada also.

The second design is called a flexible spending account or a health-care spending account. These plans normally set dollar caps for all categories of expenses. Since

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12 RSC 1985, c. 1 (5th Supp.), as amended (herein referred to as “the Act”). Unless otherwise stated, statutory references in this article are to the Act.


14 Section 122.51.


the dollar caps provide the required cost control, the coverage can be broader, and cosmetic medical expenses are often included.

**Deduction for the Self-Employed**

PHSPs may also be purchased by self-employed individuals, such as sole proprietors or partners of an unincorporated business. A deduction for premiums paid is available under section 20.01. Since the expenses covered can be chosen by the business owner, these plans can be a way to obtain tax relief for cosmetic medical expenses. However, the deductible premium is limited (to $1,500 per year per adult covered and $750 per child) unless the business has a sufficient number of arm’s-length employees covered under the plan with coverage equivalent to that of the business owner and his or her family.

**THE TAX TREATMENT OF COSMETIC MEDICAL EXPENSES**

**Defining Medical Expenses: Subsection 118.2(2)**

The foundation of the provision of income tax relief for privately borne medical expenses is the definition of medical expenses under subsection 118.2(2). For our purposes, the key provisions of the definition are paragraphs (a) and (n). Paragraph (a) provides that medical expenses include amounts paid to a medical practitioner, dentist, nurse, or hospital in respect of medical or dental services. Paragraph (n) provides that prescription drugs are an eligible expense.

The CRA views a medical or dental service as any service performed by a medical practitioner acting within the scope of his or her professional training. Accordingly, the CRA’s position prior to the budget amendment was that fees for cosmetic medical services paid to medical practitioners such as physicians, surgeons, and dentists qualified as medical expenses.¹⁷

One limited basis for the CRA to challenge cosmetic medical or dental expenses under the prior law was provided by paragraph 118.4(2)(a), which requires that the medical practitioner must be authorized to practise as such pursuant to the laws of the jurisdiction in which the service is rendered. Thus, a payment to a spa for laser hair removal treatments provided by a person who was not a doctor or a nurse might have been challenged on this basis.¹⁸

**The Budget Amendment: New Subsection 118.2(2.1)**

The new cosmetic expense rule is found in subsection 118.2(2.1). The provision reads in its entirety as follows:

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¹⁸ The meaning of the term “medical practitioner” is discussed in *Couture v. The Queen*, 2008 DTC 3357 (TCC).
(2.1) The medical expenses referred to in subsection (2) do not include amounts paid for medical or dental services, nor any related expenses, provided purely for cosmetic purposes, unless necessary for medical or reconstructive purposes.19

The new rule applies to expenses incurred after March 4, 2010.

The direct effect of this provision is to limit eligibility for the medical expense tax credit to non-cosmetic expenses. This restriction has implications for insured services under private health plans. The CRA’s longstanding practice is to limit the types of expenses that PHSPs can cover to those eligible for the medical expense tax credit,20 and the CRA has confirmed orally that the budget amendment is intended to apply to PHSPs as well. If the CRA’s position is correct, plans covering purely cosmetic expenses will no longer qualify as a non-taxable benefit for the employee under subparagraph 6(1)(a)(i) and sponsors deducting premiums for these plans under section 20.01 will no longer be able to do so.21

A dictionary definition of “cosmetic” is “intended to adorn or beautify the body” and “aimed at improving, restoring or modifying the appearance.”22 Further, cosmetic surgery has been defined as follows: “Operations and other procedures that revise or change the appearance, colour, texture, structure, or position of bodily features, which most would consider otherwise to be within the broad range of ‘normal’ for that person.”23 Within the goal of improving appearance, there are two subgoals: making the person look younger, or enhancing the person’s appearance from the “normal” level toward some aesthetic ideal.

Cosmetic surgery, as that term is most commonly used, does not include reconstructive surgery, such as performing skin grafts after major burns, or creating prostheses or natural replacements for parts of a person’s body that were missing at birth, removed or damaged by surgery (such as a mastectomy for breast cancer), or damaged in accidents or military combat. Therefore, the exclusion for reconstructive surgery in the legislation appears to be included for greater certainty. The term generally used for the combination of cosmetic surgery and reconstructive surgery is plastic surgery.24 However, some types of cosmetic surgery may be considered to draw from specialized areas of medical practice, notably dermatology, otolaryngology, and ophthalmology.

19  SC 2010, c. 12, section 13(1).
21  For further discussion, see Alan Macnaughton, “Cosmetic Medical Services and PHSPs” (2010) vol. 18, no. 5 Canadian Tax Highlights 9-10.
22  Canadian Oxford Dictionary, 2d ed.
The budget gives the following examples of purely cosmetic expenses: liposuction, hair replacement procedures, Botox25 injections, and tooth whitening.26 No examples are given in the explanatory notes relating to the income tax amendment, although the examples cited in the budget are repeated in the explanatory notes for the related Excise Tax Act amendments.27 On May 3, 2010, the CRA posted on its Web site a page entitled “Medical Expense Tax Credit (METC)—Cosmetic Procedures.”28 The page listed 16 items that are generally considered ineligible (that is, cosmetic) expenses, and 7 items that continue to be eligible for the medical credit. On the same day, the CRA also changed the Web page “Which Medical Expenses Are Eligible?” to highlight the budget amendment at the top of the page and to add a note about the amendment under the entry for cosmetic surgery.29 We will discuss the expenses covered, in both their technical and tax policy aspects, in a later section of the article.

The inclusion of “related expenses” in new subsection 118.2(2.1) appears to be intended to exclude from medical expenses various items directly connected to the delivery of the cosmetic service, such as the cost of drugs used (for example, anaesthetics, Botox, and chemicals for facial peels), laboratory tests, the cost of an attendant, nursing services, facility fees, and transportation. However, it is our understanding that the CRA intends to apply a lower standard of nexus between the services and the expenses, so that cosmetic prescription drugs administered orally at home by a patient could be considered to be related to cosmetic services (consultation with a physician about a cosmetic problem and the dispensing of the drug by a pharmacist). Whether this is the correct interpretation of the amendment is unclear.

Exceptions

The wording of the legislation provides taxpayers with two separate avenues for avoiding the exclusion of cosmetic medical expenses: (1) the service is “necessary for medical or reconstructive purposes”; or (2) it is not “purely for cosmetic purposes.”30 Both of these exceptions may be subject to expansive interpretation by taxpayers.

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25 Botulinum toxin, which is sold in Canada under the trade names Botox and Dysport.
26 Budget Plan, supra note 1, at 341.
27 Canada, Department of Finance, Explanatory Notes Relating to the Income Tax Act, the Excise Act, 2001, the Excise Tax Act, the Air Travellers Security Charge Act and Related Acts and Regulations (Ottawa: Department of Finance, April 2010), 8 and 158.
30 The wording of the provision seems to suggest that a service could be simultaneously “necessary for medical or reconstructive purposes” and “purely cosmetic.” This is hard to imagine. Perhaps a better drafting approach would have been to simply exclude “purely cosmetic” services from the credit, and then define such services as those that are not necessary for medical or reconstructive purposes.
Medical Necessity

Reconstructive medical and dental services can probably be clearly defined: some trauma, injury, or disease must have caused a problem, and the reconstructive procedure attempts to fix it. However, the words “necessary for medical . . . purposes” are surprisingly vague. Although there is extensive jurisprudence on the meaning of medical necessity in connection with medicare and private health insurance, this is a new concept for the Act.

One could take a very narrow view of this exception. As noted above, medical necessity is officially the ground on which decisions are made as to which procedures receive government funding under medicare. Thus, the fact that in order to qualify for the medical credit the services must not have been paid for under medicare may be considered to resolve the question; no cosmetic services can be medically necessary. However, the Department of Finance must have had some reason to insert this phrase in the statute.\(^{31}\) Also, the context and purpose of the Canada Health Act and the Income Tax Act are very different, and hence the phrase should not be given the same meaning for both purposes. While the medicare definition determines what medical costs have priority to be publicly subsidized, the tax credit definition is attempting to refine tax liability to reflect ability to pay.

The Department of Finance’s explanatory notes to subsection 118.2(2.1) provide the following comment:

Examples of procedures that would generally be considered to have a medical or reconstructive purpose include those that would ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or a disfiguring disease.\(^{32}\)

Notably absent from this list is the alleviation of psychological distress relating to body image. However, since the explanatory notes are not part of the law (and in any event the word “includes” suggests an incomplete list), the courts will have to decide whether the exception applies in such cases.

Psychological considerations have had a major role in defining medical necessity for the purposes of direct government payment (that is, medicare). In the United Kingdom, a survey of decision guidelines of health authorities found that three-quarters of the guidelines include psychological distress as grounds for cosmetic surgery.\(^{33}\)


\(^{32}\) Supra note 27, at 8. The same wording is used in the current US legislation, which is discussed below (see infra note 123 and the related text).

further UK study shows that over two-thirds of patients referred by their physician to the National Health Service (NHS) for elective cosmetic surgery (ECS) have no physical reason for the surgery. Although the study did not report the proportion of these patients who actually received the surgery, it appears that a substantial proportion of them did. According to the authors of the study,

[w]ithin the NHS, ECS is provided for two purposes. First, it is provided on restorative, symptomatic or functional grounds. . . . Secondly, where such physical indications are absent, surgery is provided to ameliorate psychosocial dysfunction and distress caused by self-consciousness about a bodily abnormality.

The scientific literature does not support the idea that psychological distress can necessitate medical intervention to alter physical appearance. Research shows that patients are satisfied with cosmetic surgery, but this may not be qualitatively any different from the satisfaction that people obtain from any consumption expenditure. To argue medical necessity, one would want evidence of long-lasting gains in psychosocial functioning, and that is not available. This is not to say that there is negative evidence; rather, the methodological shortcomings of the existing studies are such that the most prudent inference is simply “not supported by evidence.”

Still, patient circumstances differ considerably, and a medical practitioner’s assessment of a particular patient may have considerable weight with the CRA and in court—even if the scientific basis for that assessment is not strong. Some patients may even choose a medical practitioner to perform the service on the basis that the practitioner views the service as medically necessary and therefore non-cosmetic. If the service qualifies as such, the patient will not only obtain an income tax benefit, but also save the GST/HST that would otherwise apply.

Purely Cosmetic Purposes

The second exception to the exclusion rule hinges on the wording “services . . . provided purely for cosmetic purposes.” “Purely” is a strong word, and it is not used anywhere else in the current Act. It is somewhat analogous to the common expression


35 “[A] study of a typical NHS clinic showed that almost half of the requests for nose jobs were treated, along with a quarter for tummy tucks, half for breast reduction and a fifth of those who wanted breast enhancements”. Janice Turner, “Should We Fight for Our Right to a Facelift?” The Times (London), December 19, 2009, 19.

36 Cook et al., supra note 34, at 55.

“all or substantially all,” except that in this case there is no qualifier. The effect of the use of “purely” in the new provision can be illustrated by noting the following situations in which the purpose of a medical or dental procedure or treatment could be considered not purely cosmetic (assuming for present purposes that the alternative to “purely cosmetic” is “functional” in a medical sense):

1. the procedure has a medical purpose but also results in an incidental cosmetic benefit, such as removing a cancerous mole from the face;
2. the procedure has a dual purpose, such as an operation on the nose that corrects airway obstruction while also improving appearance, or a breast reconstruction following a mastectomy that involves breast enlargement relative to the pre-cancer situation; and
3. the procedure is sought for the purpose of improving appearance but may also have an incidental non-cosmetic benefit, such as tooth contouring and reshaping (one of the 16 items listed as an ineligible expense by the CRA), which may also make teeth easier to clean.

The third situation could be particularly problematic for the CRA; the courts will have to decide how strictly the word “purely” will be interpreted.

Furthermore, the reasons why the purpose of a service might not be purely cosmetic might not be limited to medical function. Psychological considerations could be another reason. Thus, instead of introducing psychological grounds under the medical necessity exception as discussed above, one could argue that where expenses are incurred at least partly for psychological reasons, they are not “purely” cosmetic. A lower standard of proof might be required for this argument to be sustained. Similarly, the purpose of a medical service might not be purely cosmetic if the expense is incurred at least partly for an income-earning purpose (as discussed below). It is possible that psychological motivations that do not rise to the level of medical necessity or income-earning motivations that are insufficient to generate a deduction as a business or employment expense might still be enough to make the expense excepted under the purely cosmetic requirement. Of the two exceptions under the new cosmetic expense rule, “purely cosmetic” might be the more expansive one.

38 One US plastic surgeon and otolaryngologist suggests that in nasal surgery (rhinoplasty), “the most common scenario is the patient seeking both functional and cosmetic improvement. After all, a misshapen nose is often associated with corresponding functional abnormalities”: Richard E. Davis, “Functional Rhinoplasty” at http://www.davisrhinoplasty.com/functional-rhinoplasty.html. On the other hand, according to the Canadian Society of Otolaryngology, “the majority of [operations] are performed for cosmetic reasons to enhance the aesthetic appearance of the nose”: Canadian Society of Otolaryngology, “Rhinoplasty and Septoplasty” at http://www.entcanada.org/public2/patient16.asp. The CRA appears inclined to the latter view, since rhinoplasty is one of the 16 items that it identifies as generally cosmetic (CRA, supra note 28).

Non-Standard Tax Relief for Cosmetic Expenses

The budget amendment affects the definition of medical expenses for the purposes of the medical expense tax credit and, according to the CRA’s administrative practice, tax provisions regarding PHSPs. However, tax relief for cosmetic medical expenses could be provided under other provisions of the Act for employment expense deductions, business expense deductions, and non-taxable fringe benefits in rare circumstances. The personal benefit would have to be established to be non-existent or small, given the provisions denying tax relief for personal expenses in paragraph 18(1)(h) and elsewhere. This would be difficult, since the benefit of cosmetic medical expenses is not limited to business hours. In the absence of Canadian court cases or CRA opinion on this issue, the possible circumstances are best illustrated by examining experience in other countries.

In the United States, an exotic dancer persuaded the court that she derived no personal benefit from her extreme breast augmentation surgery, and thus she was allowed a deduction from business income rather than the more limited medical expense deduction. The judge’s description of the taxpayer’s situation suggests that this was an unusual case:

The implants under consideration here are not those usual breast implants that women seek to enhance their personal appearance. Rather, petitioner, in pursuit of additional income, had inserted implants that augmented her breasts to such an extent that they made her appear “freakish.” They were so large [bra size 56FF] that they ruined her personal appearance, her health, and imposed severe stress on her personal and family relationships.40

However, the absence of other cases, Internal Revenue Service (IRS) opinions, and practitioner commentary supporting similar deductions suggests that a deduction is available in the United States only in such unusual situations where the personal benefit is absent or extremely small.41

The practice in the United Kingdom appears to be different. In Parsons v. Revenue & Customs,42 a self-employed stuntman established to the court’s satisfaction that costs for a knee operation and for chiropractic and massage services were “wholly and exclusively” for the purposes of his business activities, although expenditures for fitness training and boxing classes were not. The court’s reasoning, that the allowed expenses were a bona fide job requirement and would not have been incurred by the particular taxpayer if not for the demands of his business, seems to be applicable to some cosmetic expenses as well. This is shown by the statement by counsel

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41 In another case, an actor was permitted a deduction for the cost of replacement dental work:
for the Crown that Her Majesty’s Revenue and Customs (HMRC) would accept a television presenter’s having a mole removed from his or her face as deductible under the general provisions for the deduction of business expenses.\textsuperscript{43} Also, HMRC’s guidance manual for audit staff considers the possibility of a deduction for cosmetic expenses for “a person in the public eye” and concludes that in “exceptional circumstances” the presumption of private motive can be overcome.\textsuperscript{44}

Possibly a business expense deduction could be available in Canada in fields in which beauty and/or a youthful appearance are highly valued. This might apply, for example, to performing artists and on-camera television people, in circumstances where it can be demonstrated that the expense provides an income-earning advantage.\textsuperscript{45} There could be an immediate deduction, or alternatively the expense could be considered to be on account of capital and deductible over time. In the latter case, a capital cost allowance deduction might be available under class 8, since this class includes any tangible capital property not included in another class.

\section*{Comparison with Other Countries}

Two-thirds of member countries in the Organisation for Economic Co-operation and Development (OECD) provide a deduction, credit, or allowance under the personal income tax for medical expenses, but less than one-fifth of non-OECD countries do so.\textsuperscript{46} OECD countries that do not provide such relief include the United Kingdom, France, New Zealand, Spain, and Sweden.

It is common practice for countries to restrict the coverage of cosmetic medical expenses under publicly funded health-care programs. For example, the US medical-cost subsidy program for seniors (Medicare) has the following policy:

\begin{quote}
Medicare generally doesn’t cover cosmetic surgery unless it’s needed because of accidental injury or to improve the function of a malformed body part. Medicare covers breast reconstruction if you had a mastectomy because of breast cancer.\textsuperscript{47}
\end{quote}

The general exclusion of cosmetic expenses from tax relief (in those countries that otherwise provide such relief for medical expenses) has been much less common. In 1991, the United States became the first country with such a rule, and

\textsuperscript{43} Ibid., at paragraph 28.


\textsuperscript{45} For example, perhaps a professional singer could argue that rhinoplasty would enable him or her to attain a certain pitch.


\textsuperscript{47} Centers for Medicare and Medicaid Services, \textit{Your Medicare Benefits} (Baltimore: US Department of Health and Human Services, 2008), 12. The same policy applies to the Medicaid program for the poor.
Australia followed in 2005. Canada becomes the third such country with the 2010 budget amendment (although Quebec has excluded cosmetic medical expenses from its provincial medical tax credit since April 1, 2005). Keyword searches using the database of the International Bureau of Fiscal Documentation indicate that the other 17 OECD countries with medical expense tax relief have no such exclusion. Among non-OECD members covered by the database, the only exclusion found is in the Ukraine, for the cost of cosmetic surgery.

Korea has moved in the other direction, adding the costs of cosmetic surgery to the list of expenses eligible for the medical expense deduction in 2006. According to Minister of Finance and Economy and Deputy Prime Minister Kwon Oh-Kyu,

> [p]eople undergoing plastic surgery should be just as eligible for tax breaks as any other patient going under the knife, given that obesity and physical deformity have now come to be recognized as an illness.

However, the government also noted that a main motivation for the change was to increase the ability of the Korean tax authority to measure the taxable income of cosmetic surgery clinics. This income is otherwise difficult to identify because these clinics are not covered by national health insurance plans.

**BROAD TAX POLICY CONSIDERATIONS**

We will now consider the tax policy arguments that have been raised in relation to income tax relief for medical expenses in general and cosmetic medical expenses in particular. Policy issues concerning the definition of cosmetic medical expenses are discussed in a later section of the article.

**Horizontal Equity**

*The Involuntariness Argument*

In the 1970s two US scholars, William Andrews and Mark Kelman, addressed the issue of whether there should be a tax deduction for personal expenses, including

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48 International Bureau of Fiscal Documentation, *IBFD Tax Research Platform* (Amsterdam: IBFD) (online database). The United Kingdom is not in this category (notwithstanding a comment to the contrary in the Budget Plan, supra note 1, at 341), since the United Kingdom provides no tax relief for medical expenses.

49 Deloitte Anjin LLC, “Proposed Revisions to Tax Laws” (September 18, 2006) *Korean Tax Newsletter* 1-7. The deduction was originally available for two years beginning December 1, 2006, but the provision was later extended for another year. It has now expired, but there is a possibility that the Korean government will introduce a further extension by the year-end.


51 E-mails to the authors from Seung Woong Choi, Deloitte Anjin LLC, April 5 and 7, 2010.
medical expenses. A summary of the controversy, focusing on the application to cosmetic medical expenses, is provided below. Although the discussion concerns a tax deduction, rather than the tax credit used in Canada since 1988, the fundamental issue is the same in either case—whether there should be income tax relief for medical expenses.

The arguments raised by Andrews and Kelman are based primarily on horizontal equity, which is the principle that two people with the same ability to pay should bear the same tax liability. Andrews uses this principle to argue that such expenses are not consumption, and thus should be deductible under either an income tax or a consumption tax, while Kelman takes the opposite position.

The essential argument put forward by Andrews is that medical expenses are different from other personal expenses:

What distinguishes medical expenses from other personal expenses at bottom is a sense that large differences in their magnitude between people in otherwise similar circumstances are apt to reflect differences in need rather than choices among gratifications.

This may be referred to as “the involuntariness argument” for tax relief for medical expenses. Note that “involuntary” is not used here in the ordinary sense of “absence of will” or “unintentional”; rather, it means that the taxpayer had no choice but to incur the expenditure, because the consequences otherwise would be dire.

Kelman’s response to Andrews’s argument is that most medical expenses are not unavoidable and fixed in amount (such as the cost of an emergency-room visit to stop arterial bleeding). Many examples of more or less discretionary spending can be cited. Annual influenza vaccinations are one; the long-term health of most

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53 The discussion of the Andrews-Kelman debate is brief because, as shown below, the two authors arrive at the same conclusion on cosmetic medical expenses. Thus, the more significant issues are those that legal scholars would refer to as consequentialist: impacts on efficiency, gender equality, vertical equity, and simplicity. For in-depth discussions that set the debate within the context of other personal expenses (such as charitable donations) and also discuss the different concepts of income employed by Andrews and Kelman, see Pratt (2004), supra note 5, and Tim Edgar, “The Concept of Taxable Consumption and the Deductibility of Expenses Under an Ideal Personal Income Tax Base,” in Richard Krever, ed., Tax Conversations: A Guide to the Key Issues in the Tax Reform Debate (London: Kluwer Law International, 1997), 293-363.

54 While this definition is adequate for the purposes of this discussion, the broader view—that people in similar circumstances should bear the same tax liability—applies in other contexts (for example, benefit taxes).

55 Consumption forms part of income because, according to the Haig-Simons concept of income, income is defined as consumption plus the change in net wealth over the period.

56 Andrews, supra note 52, at 336.

57 Kelman, supra note 52, at 866.
people is unaffected by whether they get seasonal influenza. Similarly, the itch and skin disturbance from poison ivy will eventually get better on its own without the sufferer incurring costs for drugs. Any surgery that is not urgently required because of a medical emergency (“elective surgery”), such as cataract surgery, is also partially subject to choice.

Kelman also restates the issue in economic terms: for Andrews’s view of the world to be correct, medical-care expenditures would have to vary only according to illnesses experienced, and would be price- and income-inelastic (that is, unresponsive to changes in price or income).  

Tim Edgar has encapsulated the difference in view between Andrews and Kelman in describing two sets of hypothetical taxpayers under an income tax. Andrews’s argument, he says, compares taxpayer A, who has a salary of $50,000, with taxpayer B, who has a salary of $60,000 and expenses for medical needs of $10,000. If one accepts Andrews’s view that medical expenses reflect needs and are not a form of consumption, both taxpayers have the same ability to pay and hence should pay the same amount of tax. To achieve horizontal equity, taxpayer B should be given a tax deduction for his medical expenses of $10,000, so that both taxpayers end up with the same taxable income of $50,000.

On the other hand, Edgar says, Kelman is comparing taxpayers C and D, both of whom have salaries of $80,000 and are in the same reduced state of health. Taxpayer C incurs medical expenses of $10,000 to improve his health, while taxpayer D chooses to forgo medical care and spends $10,000 on a vacation. Kelman’s argument is essentially that taxpayers C and D have the same $80,000 to spend for all discretionary purposes and hence should pay the same amount of tax. Under this scenario, horizontal equity requires that no medical expense deduction be provided; otherwise, individuals could deduct a significant amount of personal gratification in the form of medical care.

The viewpoints of Andrews and Kelman seem to be quite distinct. However, for two extreme (polar) cases of types of medical expenses, their views coincide.

Consider first the case of medical expenses necessary to sustain life. Assuming that these are involuntary and fixed in amount, horizontal equity analysis suggests that this is an appropriate refinement of ability to pay, and hence a deduction for this type of medical expense is justified. Thus, Kelman accepts that a medical expense deduction is justified on horizontal equity grounds for the treatment of any ailment “for which all taxpayers would always seek treatment.”

58 Ibid., at 865.
59 Edgar, supra note 53, at 348.
60 Kelman, supra note 52, at 861. However, in Canada there might be few, if any, medical expenses necessary to sustain life that would be borne privately and hence would be eligible for tax relief. Medicare covers most hospital costs, and even for prescription drugs, provinces may cover the cost if it is a significant fraction of income and is not covered by a company health plan. For example, the Ontario government’s Trillium drug program covers drug costs if they are in excess of 4 percent of income.
The second case is purely discretionary medical expenses. Both Andrews and Kelman note that some types of medical expenses reflect personal gratification. The policy implication is that legislators should define a category of purely discretionary medical expenses and deny tax relief for those expenses.

Where do cosmetic medical expenses fit in this continuum? Andrews comments that

particular medical expenses may reflect a considerable component of voluntary personal gratification. It is difficult to find any difference in principle, for example, between expenditures for elective plastic surgery and for cosmetics.\(^{61}\)

Kelman notes this comment with approval.\(^{62}\) Thus, Andrews and Kelman agree that expenditures for cosmetic surgery, and presumably cosmetic medical expenses in general, are purely discretionary expenses that do not merit tax relief.

**More Recent Views**

Almost all post-Kelman contributions to the horizontal equity argument for tax relief for medical expenses support such relief,\(^{63}\) but they note, without going into detail on types of expenses, that some medical expenses should qualify while others should not. Turnier says that it is appropriate to allow a deduction for “involuntary expenditures . . . that are necessary for survival and basic well-being,” and he cites “basic expenditures for . . . medical care” as meeting that test.\(^{64}\) Geier calls for a deduction for “nondiscretionary” consumption, including medical expenses, particularly those “necessary for life to continue,” such as open-heart surgery.\(^{65}\) Zelenak says that ability to pay should be measured in terms of “‘clear income’—the amount of income a person has in excess of subsistence needs,” which would properly include a deduction for the costs of “basic medical care.”\(^{66}\)

Only two of these authors refer explicitly to cosmetic medical expenses. Turnier suggests that it is necessary to distinguish between “those expenditures necessary for maintaining good health and those, such as cosmetic surgery, that constitute medical forms of consumption.”\(^{67}\) Pratt notes that “[m]edical care falls on a continuum, with

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61 Andrews, supra note 52, at 337.
62 Kelman, supra note 52, at 861.
63 The exceptions are the two Pratt articles, supra note 5.
64 William J. Turnier, “Evaluating Personal Deductions in an Income Tax—The Ideal” (1981) vol. 66, no. 2 *Cornell Law Review* 262-96, at 280. Although the coverage is described as “basic,” it would still vary by a person’s health, and thus separate tax relief over and above the basic personal tax credit (or, in the United States, the personal exemption) would be required.
67 Turnier, supra note 64, at 280.
emergency, life-saving treatment on one end, and cosmetic surgery on the other end,” but does not express a clear preference as to where the line for tax relief should be drawn.68

The principal advocate of income tax relief for cosmetic medical expenses on horizontal equity grounds is Michael Ruel. In an article opposing New Jersey’s sales tax on cosmetic surgery, Ruel argues that societal pressure makes cosmetic surgery less than voluntary:

Presenting the choice [to undergo cosmetic surgery] as an unnecessary, discretionary expense is far from reality. Women can either feel inferior, enjoy a lower quality of life, and be rejected by mainstream society, or else suffer the pain and toil of cosmetic surgery.69

Further, even if cosmetic surgery is not absolutely involuntary, it is as involuntary as other qualifying medical expenses:

[M]ost “traditional” medical services, such as vaccinations and physicals, do not rise to the level of necessity.70

Hence, if we accept certain expenses as deserving of tax relief because they improve physical well-being, we should do the same for expenses, such as cosmetic expenses, that improve psychological well-being.71 Support for this broader definition of health is provided by the World Health Organization:

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.72


69 Michael D. Ruel, “‘Vanity Tax’: How New Jersey Has Opened Pandora’s Box by Elevating Its Moral Judgment About Cosmetic Surgery Without Consideration of Fair Health Care Policy” (2007) vol. 28, no. 1 Journal of Legal Medicine 119-34, at 133. See also J. Carolina Chavez, “An Exploration of ‘Vanity Taxes’ as a Method of Increasing State Revenue” (July 28, 2008) State Tax Notes 255-61. A selective excise tax on cosmetic medical expenses is much less defensible than removing income tax relief for such expenses. As both articles note, why should this type of service be taxed while other services are not? Furthermore, such a tax may be said to unfairly target women. Thus, even the National Organization of Women, which strongly opposes the glorification of cosmetic surgery as harmful to women, opposed the fall 2009 “Botax” proposal to include a special tax on cosmetic medical expenses in the American health-care reform legislation: National Organization of Women, “NOW Statement on Proposed Cosmetic Surgery Tax,” news release, December 16, 2009.

70 Ruel, supra note 69, at 130.

71 Ibid., at 133.

Ruel’s social pressure argument is subject to the weakness that there is similar social pressure for cars, clothing, and other lifestyle choices. Also, although a much greater proportion of females than males incur cosmetic medical expenses, the percentages are still far below what would be required to demonstrate that cosmetic medical expenses “must” be incurred. The percentages of prime-age females in the United States who have cosmetic surgery and cosmetic dentistry procedures in any given year are 1.3 percent and 1.7 percent respectively. As discussed later, the proportion of individuals who have had cosmetic surgery in their lifetime is not substantially higher.

Although Ruel does not address this point, his argument for cosmetic medical expenses as a psychological necessity seems to apply best to people who meet the criteria for diagnosis of body dysmorphic disorder (BDD). BDD is an anxiety disorder listed since 1987 in the American Psychiatric Association’s Diagnostic and Statistical Manual for Mental Disorders (“the DSM”). People with BDD are excessively preoccupied with body image and perceived defects in their physical features, even though most people would find these features to be normal. The psychological discomfort felt by people with BDD is often so high that they are unable to interact with others or function normally in society.

It is estimated that two-thirds of people with BDD receive cosmetic treatments, and the majority receive more than one. Others seek cosmetic treatments but are turned down. One study reports that BDD is present in 9 percent of people seeking cosmetic surgery.

People with BDD generally do not benefit from cosmetic treatments; even if one presumed defect is modified to the person’s satisfaction, he or she is likely to come

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73 The calculations are 1.204/103.1 and 1.8/103.1 respectively, where the components of the calculation are as follows: US female population aged 15 to 64 in 2009, 103.1 million (US Census Bureau); 1.204 million cosmetic surgery procedures in 2009 on females aged 18-64 (American Society for Aesthetic Plastic Surgery, 2010 Report of the 2009 Statistics (Arlington Heights, IL: ASAPS, 2010), 9-10); and 1.8 million female cosmetic dentistry patients of any age in 2007 (American Academy of Cosmetic Dentistry, “Cosmetic Dentistry Continues To Surge—Market Estimated at $2.75 Billion,” press release, December 13, 2007). No similar meaningful figures can be calculated for non-surgical procedures since it is normal for one patient to have several such treatments in a year.

74 According to recent research, this could be the result of differences in activity in the visual processing area of the brains of people with BDD (reported in Jane E. Brody, “When Your Looks Take Over Your Life,” New York Times, March 23, 2010, 7).


76 Many feel that a BDD sufferer cannot give informed consent to the surgery, and in these circumstances, it is ethically inappropriate for the surgeon to operate: Theresamarie Mantese, Christine Pfeiffer, and Jacquelyn McClinton, “Cosmetic Surgery and Informed Consent: Legal and Ethical Considerations” (2006) vol. 85, no. 1 Michigan Bar Journal 26-29, at 28. Surgeons may also refuse to operate because dissatisfied patients with BDD are likely to sue.

77 Phillips, supra note 75, at 234. See also Cook et al., supra note 34, at 63.
up with another and then another, seeking further treatments and risking real disfigurement. One study reports that 81 percent of cosmetic treatments undergone by BDD sufferers resulted in no change in overall BDD severity.\textsuperscript{78} Thus, even though incurring cosmetic expenses may be involuntary for BDD sufferers, tax relief would be inappropriate since it would create an incentive for ineffective treatments.

\textbf{Income-Earning Expenses}

It is well known that there is a “beauty premium”; studies show that, on average, more attractive people earn more.\textsuperscript{79} Even good teeth bring economic returns.\textsuperscript{80} If cosmetic medical expenses do indeed raise income, this provides an alternative horizontal equity justification for tax relief, although only for the portion of such expenses that is incurred for an income-earning purpose. Revenue authorities and courts in the United States and the United Kingdom have accepted this argument in narrow circumstances (as discussed above), and no great harm seems to have resulted. However, as a justification for broad-based tax relief, it fails to persuade.

In part, this is because it is not proven that expenditures on cosmetic medical services can produce this beauty premium. To date, all empirical studies of the beauty premium are based on comparing people who have experienced different levels of natural attractiveness over their whole lives. If the increase in earnings occurs through increased self-confidence and the pre-adult years are most important in developing that confidence, cosmetic medical expenses (which are usually incurred in the adult years) may not produce the same increase in earnings. Future studies of people who do or do not incur cosmetic medical expenses may be able to resolve this question.

The empirical studies also suggest that the increased earnings vary by occupation and may not occur in all places of work, even for the same occupation. Evidence for this is that lawyers in the private sector have been found to be more attractive than those in the public sector.\textsuperscript{81}

Most importantly, disentangling the personal benefit from the business benefit and allowing tax relief only for the latter is possible in theory\textsuperscript{82} but probably impossible.

\textsuperscript{78} Phillips, supra note 75, at 236.


\textsuperscript{81} Jeff E. Biddle and Daniel S. Hamermesh, “Beauty, Productivity, and Discrimination: Lawyers’ Looks and Lucre” (1998) vol. 16, no. 1 \textit{Journal of Labor Economics} 172-201, at 172. The argument is that the more attractive lawyers should gravitate to the area of practice where the return to attractiveness is highest, namely, the private sector.

\textsuperscript{82} From a theoretical perspective, it is incorrect to allow a deduction only where there is no personal benefit (as seems to have been the case in the United States and the United Kingdom); the business-related portion of the expense should be deductible in all circumstances. For a formal model showing in principle how one could calculate the business portion of an employment-related expense, see Alan Macnaughton, “Fringe Benefits and Employee Expenses: Tax Planning and Neutral Tax Policy” (1992) vol. 9, no. 1 \textit{Contemporary Accounting Research} 113-37, at 123.
in practice. The problems of ill-defined tax relief provisions are shown by Australia’s deduction for work-related expenses; since it is difficult to audit all claims, such deductions are growing at three times the rate of growth of the economy.\(^\text{83}\) Also, if cosmetic medical expenses were granted tax relief on the basis of enhanced earning potential, why wouldn’t the government allow a portion of the cost of an expensive wardrobe, haircut, manicure, personal trainer, makeup, or any other image-making expense?

**Neutrality**

Although Andrews advocates a deduction for medical expenses on equity grounds, he recognizes that there is a neutrality (also called an allocation or economic efficiency) issue. The point is that a deduction (or tax credit) for the cost of medical care reduces the after-tax price of medical care relative to other goods and services to be purchased out of private, after-tax funds,\(^\text{84}\) and taxpayers change their expenditure on medical care in response. Thus, the tax system is non-neutral and causes the amount consumed to be higher than in a hypothetical world without taxes. Smart and Stabile estimate that there is such an effect, but only a small one; the price elasticity for medical expenses is in the range of \(-0.2\) to \(-0.5\), implying that a 10 percent reduction in the after-tax cost of medical services increases the amount consumed by 2 to 5 percent.\(^\text{85}\) This overconsumption could be expected to apply to cosmetic medical services as well, although whether the effect is larger or smaller than for other medical services is unknown. In any event, for the change in the tax system to have an effect on the consumption of cosmetic medical services, people have to know about it. When Quebec removed cosmetic expenses from its medical credit in 2005, one cosmetic surgeon commented that the effect on demand should be small because most patients had been unaware of the tax benefit.\(^\text{86}\)

Most people would probably say that the tax system should be neutral toward cosmetic medical expenses; that is, one consumption good should not be favoured over another.\(^\text{87}\) This argument leads to the conclusion that tax relief for cosmetic medical expenses is a bad thing.\(^\text{88}\)


\(^{84}\) Andrews, supra note 52, at 342.

\(^{85}\) Michael Smart and Mark Stabile, “Tax Credits, Insurance and the Use of Medical Care” (2005) vol. 38, no. 2 *Canadian Journal of Economics* 345-65. For most consumer goods and services, the price elasticity of demand is between \(-0.5\) and \(-1.5\).


\(^{87}\) Theories of optimal taxation could lead to different conclusions—for example, that goods that are inelastic, complementary to leisure, or consumed more by the rich should bear a higher tax burden. However, uniform taxation lowers administrative costs and limits the lobbying by interest groups: Bernard Salanié, *The Economics of Taxation* (Cambridge, MA: MIT Press, 2003), 72-73.

\(^{88}\) An additional neutrality argument against tax relief for medical expenses is that such relief inevitably distorts the decision as to whether to purchase medical insurance: Louis Kaplow,
Gender Equity

Advocates of gender-based analysis contend that the different impacts of tax policy changes on gender groups should be considered in the tax policy process. Applying this concept to the present issue, one might inquire into the effects of removing tax relief for cosmetic medical expenses as prescribed by the budget amendment.

The first step is to consider the distributional effects of the policy change. Since women represent the vast majority of consumers of cosmetic medical expenses, the tax increase probably applies mainly to them (although some people would be claiming the expense on their spouse’s tax return). However, most analysts contend that, while such distributional effects should be noted, they do not constitute an argument for or against a policy.

The second step in gender-based analysis is to examine the effect on society of the reduced spending on cosmetic medical expenses induced by the budget amendment. Feminist scholars generally argue that women who incur cosmetic expenses increase the pressure on other women to improve their body image, causing them to suffer a decline in self-concept to the extent that they are unable to do so; accordingly, discouraging the incurring of such expenses would be seen as a positive step. Other scholars view the impact of cosmetic medical expenses as more neutral, arguing that women can incur cosmetic expenses as a demonstration of autonomous decision making. Thus, gender-based analysis suggests that the incentive effect of eliminating tax relief for cosmetic medical expenses should be socially positive or neutral. In any case, the effect of the change on expenditures should be expected to be small since the elasticity estimate reported above suggests that expenditures on medical services are relatively unresponsive to price.

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“Income Tax Deductions for Losses as Insurance” (1992) vol. 82, no. 4 American Economic Review 1013-17, at 1014. However, this argument is inapplicable here since private health insurance policies usually do not cover cosmetic expenses.


Vertical Equity
Provided that one accepts the argument that cosmetic medical expenses are not a valid reduction of ability to pay, tax relief for cosmetic medical expenses could also be a problem of vertical equity (appropriate taxation of people with less versus more ability to pay). Although with a tax credit each person claiming the credit receives the same tax saving, vertical equity problems arise in other ways. Affluent taxpayers are more likely to have luxury-style expenses such as cosmetic medical expenses, and people who incur cosmetic medical expenses may be more likely to have medical expenses that exceed the threshold for claiming the credit.\footnote{Zelenak, supra note 66, at 115; and Kelman, supra note 52, at 860. The trend in recent years is for cosmetic medical expenses to be much more of a middle-class phenomenon, although data are scarce. The threshold issue is discussed further in a later section of the article in connection with revenue estimation.}

Simplicity
If tax relief is provided for medical expenses in general, simplicity is reduced by carving out cosmetic expenses from such relief. The degree to which this is a problem depends on how difficult it is to define such expenses. Chavez argues that this is very difficult, and she questions whether a workable definition of cosmetic medical expenses can be developed.\footnote{Chavez, supra note 69, at 260.} This issue is discussed below. The main conclusion is that although there are many areas of potential controversy, the experience of other jurisdictions is that there have been few disputes in practice, possibly because little audit pressure has been exerted in the more difficult areas of the definition.

Tax Compliance
Any measure that increases the perceived fairness of the tax system is believed to increase people’s willingness to comply with tax law. Thus, removing income tax relief for cosmetic medical expenses might have a small positive effect on compliance, particularly since expenses have a high public profile.

Employer-Paid Medical Expenses
The analysis above concerns the rationale for providing or denying tax relief for personally incurred medical expenses; however, there is a direct connection to the treatment of employer-paid health costs as a taxable or a non-taxable benefit: all of the same arguments apply. Thus, the availability of relief for cosmetic medical expenses should be the same regardless of the source of the expenditure. As noted above, the intention of the CRA is that the budget amendment should apply equally in both circumstances.
Summary
Because cosmetic medical expenses are almost unanimously viewed as purely discretionary, tax policy goals of horizontal and vertical equity suggest that income tax relief for such expenses should be eliminated. The neutrality goal—the desire to eliminate the shifting of consumption away from other consumption goods and toward cosmetic medical expenses—reinforces this result. Furthermore, eliminating tax relief for cosmetic medical expenses is beneficial, or at worst neutral, for gender equity. The only negative effect of this tax change is increased complexity.

These arguments support the position that personally paid cosmetic expenses should not qualify for the medical tax credit and cosmetic expenses paid by an employer through an employer-sponsored health plan should be a taxable benefit to the employee. The only exception is that tax relief could perhaps be provided for the rare taxpayer who can establish that the cosmetic expense is for an income-earning purpose.

Despite agreement on the general policy of denying tax relief for cosmetic medical expenses, a myriad of problems arise with developing a definition of the types of expenses that should be excluded. This issue is addressed in the discussion that follows.

THE COSMETIC MEDICINE AND DENTISTRY MARKET
Types of Expenses
Cosmetic medical expenses fall into four categories: cosmetic surgery; cosmetic non-surgical medical procedures; cosmetic dentistry; and cosmetic prescription drugs. As discussed above, these expenses are not usually covered under medicare or employer-sponsored health insurance plans.

These four categories have generally accepted industry definitions, although the concept of cosmetic prescription drugs is newer and hence not as well defined as the others. For the purposes of this discussion, we will use the industry definitions and the related industry data. The difference between what is covered under these four categories and what is covered under the 2010 budget amendment is a policy question to which we will return in a later section of the article.

Cosmetic surgery generally has permanent or long-lasting effects. In contrast, many cosmetic non-surgical procedures produce only temporary results; for example, Botox treatments must be repeated every four to six months.

Non-surgical treatments are perceived as being more “natural,” shorter in recovery time, less risky in terms of outcome (because they are generally non-permanent), and less likely to be immediately noticed by others (because they may be done in several steps). Many non-surgical treatments are particularly related to the anti-aging goal.

94 Over-the-counter cosmetic preparations (such as tooth whitening kits, skin creams, and other cosmetics) are not included because they do not qualify for tax relief.

Cosmetic dentistry is the branch of dentistry dealing with the appearance of the teeth. Typical procedures to “improve your smile” are bonding (the application of tooth-coloured materials to the tooth surface); the application of veneers (thin porcelain covers applied to the front of the teeth); and tooth whitening, or dental bleaching (which corrects discoloration from coffee, tobacco, age, or the use of certain antibiotics). As performed by a dentist, tooth whitening is achieved through bleaching agents or laser treatments.⁹⁶ Home treatments for tooth whitening do not qualify for tax relief.

Cosmetic prescription drugs are currently rare. The principal ones are Proppecia (chemical name finasteride), prescribed for male pattern baldness, and Latisse (chemical name bimatoprost), for making eyelashes longer, fuller, and darker.⁹⁷ Both are effective only for as long as the drugs are taken; that is, they must be taken continuously (as maintenance drugs) rather than for an acute-symptoms period. Latisse has not yet been approved by Health Canada. A third drug is tretinoin, which in topical form is sold under the trade names Retin-A, Retisol-A, and Renova. It is used as a cosmetic drug to treat fine wrinkles, dark spots, or rough skin on the face (and also for the non-cosmetic treatment of acne).

Prescription drugs are currently under development for skin whitening, liver spots, and obesity, but it is very difficult to predict which drugs will be approved for public release and succeed in the market.⁹⁸

Market Characteristics

The only source of Canadian data on the market for cosmetic procedures is Medicard Finance, and the validity of some aspects of those data has been questioned.⁹⁹ Therefore, the discussion in this section relies primarily on US data. Annual surveys of the market for cosmetic medical procedures (surgical and non-surgical) are conducted by the American Society for Aesthetic Plastic Surgery (ASAPS).¹⁰⁰ These

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⁹⁷ A study of 280 volunteers showed that eyelashes typically grew 25 percent longer, 106 percent thicker, and 18 percent darker (reported in Natasha Singer, “Love the Long Eyelashes. Who’s Your Doctor?” New York Times, January 14, 2009, A1). Although Latisse seems to be used primarily for cosmetic purposes, it may have a therapeutic effect for people who suffer from hypotrichosis (reduced amount of hair from birth onward) of the eyelashes.
⁹⁸ Meridia and Xenical are two anti-obesity drugs that are currently on the market, and both have cosmetic and non-cosmetic uses. See Andrew Pollack, “Medicine’s Elusive Goal: A Safe Weight-Loss Drug,” New York Times, October 17, 2009, B1.
⁹⁹ Polonijo and Carpiano, supra note 91. However, Medicard Finance is one of several data sources used in the section on revenue estimates below.
¹⁰⁰ A competing annual survey has been produced by the American Academy of Cosmetic Surgery (AACS). The AACS survey does not report numbers for total fees, and so is not used here. We note, however, that this survey reports considerably higher numbers of procedures than those reported by the ASAPS—for example, 3.7 million “invasive” (that is, surgical) procedures in the AACS survey for 2009 versus 1.5 million in the ASAPS survey. Average fees for procedures also seem to be higher than in the ASAPS survey. See American Academy of Cosmetic Surgery, 2009 Procedural Census (Chicago: AACS, February 2010), 7 and 9.
surveys are considered to be of sufficient reliability to be included in the US government’s Statistical Abstract of the United States. A survey of cosmetic dentistry has been released by the American Academy of Cosmetic Dentistry (AACD). No such survey is available for the market for cosmetic drugs.

Cosmetic medical procedures and cosmetic dental procedures appeal to similar age groups. Dental patients are slightly older in median age (45 versus 43); in the 25th and 75th percentiles, the two groups are identical (age 35 and age 54 respectively).

Females account for 92 percent of all cosmetic medical procedures (surgical and non-surgical). Cosmetic dental procedures are also a female-dominated market, but to a lesser degree—only 67 percent of patients are female. Cosmetic prescription drugs are mostly used by males, since the leading drug (Propecia) is for male-pattern baldness.

For females in all age groups combined, the three most common cosmetic surgeries are breast augmentation, liposuction (fat removal), and eyelid surgery. These three surgeries are also respectively the most common surgeries for the 19-34, 35-50, and 51-64 female age groups. For males, the top three surgeries are liposuction, rhinoplasty, and eyelid surgery.

The top three non-surgical (or “minimally invasive”) medical procedures are Botox injections (which are used to temporarily reduce lines, wrinkles, and crow’s feet from the face and neck); hyaluronic acid applications (which are used to reduce wrinkles, plump up thin lips, or enhance shallow face contours); and laser hair removal. This ranking of the commonest procedures is true for both males and females and does not differ much by age.

**Market Size and Growth**

US data in table 1 show that the market for cosmetic medical procedures has been increasing rapidly. Much of this growth occurred between 1997 (the first year of data) and 2003; in this period, surgical procedures increased by 80 percent and non-surgical procedures increased more than fivefold. Since then (to 2009), the number of surgical procedures has not increased at all, while the number of non-surgical procedures has grown by almost one-third—more slowly than before, but still substantially.

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102 Calculated from grouped data reported by the American Society for Aesthetic Plastic Surgery, “Liposuction No Longer the Most Popular Surgical Procedure According to the New Statistics,” news release (New York: ASAPS, March 16, 2009) and the AACD, supra note 73.

103 ASAPS, supra note 102.

104 AACD, supra note 73.

105 ASAPS, supra note 73.

106 Ibid.

TABLE 1 Cosmetic Medical Procedures and Dental Patients in the United States, 1997-2009 (Selected Years)

<table>
<thead>
<tr>
<th></th>
<th>1997</th>
<th>2003</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical procedures</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical</td>
<td>1.0</td>
<td>1.8</td>
<td>2.1</td>
<td>1.9</td>
<td>2.1</td>
<td>1.8</td>
<td>1.5</td>
</tr>
<tr>
<td>Non-surgical</td>
<td>1.1</td>
<td>6.4</td>
<td>9.3</td>
<td>9.5</td>
<td>9.6</td>
<td>8.5</td>
<td>8.5</td>
</tr>
<tr>
<td>Total</td>
<td>2.1</td>
<td>8.3</td>
<td>11.4</td>
<td>11.5</td>
<td>11.7</td>
<td>10.3</td>
<td>10.0</td>
</tr>
<tr>
<td>Dental patients</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2.35</td>
<td>2.69</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: Totals may not add because of rounding.


Table 2 shows total physician/surgeon fees for cosmetic medical procedures in the United States for various years. The figure for 2009 is US$10.5 billion, which is down 18 percent from the peak in 2005.\textsuperscript{108} Both the surgical and non-surgical figures for the last two years are probably affected by the recession, and should be expected to pick up again as economic growth resumes.\textsuperscript{109}

Table 2 also shows similar data for cosmetic dentistry. The AADC estimates that in 2006 the amount paid to its members for cosmetic procedures in the United States was US$2.75 billion, up 15 percent from 2005.\textsuperscript{110} This growth is noteworthy, since physicians’ and surgeons’ fees during the same period declined by 1.6 percent.

Sales for the leading cosmetic prescription drugs are estimated at US$514 million annually, comprising US$440 million for Propecia\textsuperscript{111} and US$74 million for Latisse.\textsuperscript{112}

Adding together the three estimates—US$10.5 billion for medical procedures, US$2.75 billion for dental procedures, and US$514 million for pharmaceuticals—total cosmetic medical expenditures for the most recent reported year were

\textsuperscript{108} Ibid.
\textsuperscript{110} AADC, supra note 73.
\textsuperscript{112} Allergan, Inc., Form 10-K: Annual Report (Irvine, CA: Allergan, February 27, 2010), 65. The company’s projection for 2010 is US$140 million: Allergan Inc., Allergan Reports Fourth Quarter 2009 Operating Results (Irvine, CA: Allergan, February 2010). The US$314 million total does not include tretinoin because (as noted above) the product has both cosmetic and non-cosmetic uses, and it is sold under the same trade names for both uses.
US$13.8 billion. As shown in table 2, the percentage shares for the different types of expenditure are 43 percent for surgery, 33 percent for non-surgical medical procedures, 20 percent for dental procedures, and 4 percent for drugs.

The revenue figures are subject to a number of caveats. The cosmetic medical procedures figure does not include charges for the facility, anaesthesia, medical tests, etc. Work performed by board-certified plastic surgeons is included, but not work performed by general practitioners (who especially do non-surgical procedures). The figure for cosmetic dentistry is the full amount charged to patients, but it reflects only procedures performed by members of the AACD. The figure for cosmetic prescription drugs is too high in that it represents worldwide revenues rather than just US revenues, but it is also too low in that it reflects the price at which the pharmaceutical companies sell the drug rather than the retail price paid by taxpayers. Overall, it is likely that the US$13.8 billion estimate is too low, but by an unknown amount.

**Competitive Rates of Cosmetic Surgery**

A large-scale international survey (involving 11,950 respondents) conducted in 2006 showed significant international differences regarding cosmetic surgery.\footnote{AXA Canada, *Retirement Scope 2007: Canadian Results with International Comparison* (Montreal: AXA Canada, 2007).} Canada

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**TABLE 2  Cosmetic Medical Expenditures in the United States, 2003-2009 (Selected Years)**

<table>
<thead>
<tr>
<th></th>
<th>2003</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>Most recent year</th>
<th>Most recent year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>$ billions</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical . . . . .</td>
<td>6.5</td>
<td>8.2</td>
<td>7.6</td>
<td>8.4</td>
<td>7.2</td>
<td>6.0</td>
<td>6.0</td>
<td>43</td>
</tr>
<tr>
<td>Non-surgical . .</td>
<td>2.9</td>
<td>4.2</td>
<td>4.5</td>
<td>4.8</td>
<td>4.6</td>
<td>4.5</td>
<td>4.5</td>
<td>33</td>
</tr>
<tr>
<td>Subtotal . . . .</td>
<td>9.4</td>
<td>12.4</td>
<td>12.2</td>
<td>13.2</td>
<td>11.8</td>
<td>10.5</td>
<td>10.5</td>
<td>76</td>
</tr>
<tr>
<td>Dental fees . .</td>
<td>2.4</td>
<td>2.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmaceuticals(a) .</td>
<td>0.5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.5</td>
<td>4</td>
</tr>
<tr>
<td>Total . . . . . .</td>
<td>13.8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>100</td>
</tr>
</tbody>
</table>

Note: Dollar amounts are in US currency and are not adjusted for inflation (which was 12 percent over the period 2003-2009). Totals may not add because of rounding.

\(a\) Worldwide sales of Propecia and Latisse.

seems to rank around the middle for the rate of cosmetic surgery—in a 3-way tie for 8th out of 15 countries—with 3 percent of people in the labour force aged 25 or older reporting that they have had such surgery at least once in their lifetime. On the other hand, Canada ranks 2nd out of the 15 countries in the rate of surgery for retired people up to age 75 (6 percent).\textsuperscript{114} Perhaps this means that cosmetic surgery is more common later in life in Canada than in other countries.

Within Canada, the limited data available suggest that there is much more interest in cosmetic surgery in Quebec than in Ontario: 40 percent of respondents in Quebec reported that cosmetic surgery allowed them to “get younger,” while only 14 percent in Ontario reported this view.\textsuperscript{115}

Canada and the United States are similar in cosmetic surgery rates\textsuperscript{116} and in the proportion of such people who plan to have such surgery in the future to look younger.\textsuperscript{117} However, far fewer Canadians than Americans plan to have cosmetic surgery in the future to change something about their body that they do not like.\textsuperscript{118} This might suggest that the market for cosmetic surgery has less opportunity for growth in Canada.

The highest rates of cosmetic surgery in the countries surveyed are for Australia, Belgium, and France (9 percent, 8 percent, and 6 percent respectively).\textsuperscript{119} However, there is some indication that South Korea (which is not included in this survey) might have a higher rate. A different survey reported that 47 percent of South Korean women over age 18 have had either surgical or non-surgical cosmetic medical treatments.\textsuperscript{120}

\textbf{THE EXCLUSION OF COSMETIC MEDICAL EXPENSES IN OTHER JURISDICTIONS}

Even if the desirability of denying tax relief for cosmetic expenses is accepted, the wisdom of attempting to do so may be challenged on the basis that it creates “a tax that is almost impossible to enforce fairly.”\textsuperscript{121} In this regard, the experiences of the

\begin{itemize}
\item \textsuperscript{114} Ibid., at 80, giving the rate for 11 countries. For the remaining 4 countries, the rates were obtained from similar AXA publications for Portugal, Singapore, and Australia. See http://www.retirement-scope.axa.com.
\item \textsuperscript{115} AXA Canada, supra note 113, at 83. The high positive rates on this question appear not to equate with actual intentions to undergo the surgery, however.
\item \textsuperscript{116} Ibid., at 82. The rates are 3 percent versus 4 percent for the working group, and 6 percent versus 4 percent for the retired group, respectively.
\item \textsuperscript{117} Ibid. The rates are 7 percent versus 8 percent for the working group, and 4 percent versus 8 percent for the retired group, respectively.
\item \textsuperscript{118} Ibid. (11 percent versus 24 percent respectively). These figures are for the non-retired; the difference was also large among retired people (8 percent versus 21 percent respectively).
\item \textsuperscript{119} Ibid., at 80.
\item \textsuperscript{120} The data are from the PhD thesis of Um Hyun-shin of Kyung Hee University, “Survey Shows 77% of Korean Women Favour Cosmetic Surgery,” cited in The New Light of Myanmar, February 24, 2007, 11.
\item \textsuperscript{121} Chavez, supra note 69, at 258.
\end{itemize}
United States, Australia, and Quebec are instructive in predicting the success of the 2010 budget initiative in Canada.

In all three jurisdictions, there are very few court cases interpreting the cosmetic expense rules. Therefore, the discussion below is based largely on an inspection of the rules and a review of the opinions given by the respective tax authorities.

The United States

Section 213(a) of the Internal Revenue Code allows a deduction for expenses paid for medical care of the taxpayer or the taxpayer’s spouse or dependant, to the extent that the expenses exceed 7.5 percent of adjusted gross income. As a result of the Revenue Reconciliation Act of 1990, cosmetic medical expenses are excluded by the following:

213(d)(9) Cosmetic Surgery.

(A) The term “medical care” does not include cosmetic surgery or other similar procedures, unless the surgery or procedure is necessary to ameliorate a deformity arising from, or directly related to, a congenital abnormality, a personal injury resulting from an accident or trauma, or disfiguring disease.

(B) For purposes of this paragraph, the term “cosmetic surgery” means any procedure which is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.

This two-part test is rather wordy and confusing; section 213(d)(9)(A) has been described by a court as “not a model of clarity,” and section 213(d)(9)(B) has been the subject of a judge’s application of De Morgan’s laws of formal logic in an attempt to interpret it. It appears that the taxpayer seeking a deduction can argue either that the expenses do not relate to cosmetic surgery or a similar procedure, or that the “surgery is necessary to ameliorate” a specified condition. Further, an appearance-improving procedure is not cosmetic surgery if it promotes proper bodily function or prevents or treats illness or disease. In the 20 years since the provision was enacted, only two cases have addressed its interpretation.

122 Internal Revenue Code of 1986, as amended (herein referred to as “IRC”).
124 William Magdalin, 96 TCM 491 (2008).
126 O’Donnabhbain, supra note 125, at 29.
127 This is the interpretation of the majority in O’Donnabhbain.
128 A third case, Magdalin, supra note 124, relates to infertility and does not address the type of expenses discussed in this article. On this case, and the interpretation of the provision in general, see Pratt (forthcoming), supra note 5.
In *Al-Murshidi v. Comm'r*, Al-Murshidi suffered from morbid obesity and lost more than 100 pounds. As a result of the weight loss, she developed a mass of loose hanging skin. This mass prevented her from comfortably performing her duties at work and was prone to infection and sores. She had three procedures to remove excess fat, skin, and fluid. The court found that because morbid obesity is recognized by the medical community as a serious disease and the procedures meaningfully promoted the proper function of her body and treated her disease, her surgeries were not cosmetic surgeries as defined in section 213(d)(9)(B). Furthermore, even if they were cosmetic surgeries, the skin mass was a deformity stemming from a diagnosed disease, and therefore she met the exception provided in section 213(d)(9)(A).

In *O'Donnabhain*, the court examined the situation of Rhiannon O'Donnabhain, who was born physically male but suffered from severe gender identity disorder. After receiving the diagnosis, O'Donnabhain lived as a female and underwent feminizing hormone replacement therapy, gender reassignment surgery, and breast augmentation surgery. The court ruled that the first two expenses were non-cosmetic and tax-deductible because gender identity disorder qualified as a disease and these expenses were effective treatments of that disease. However, the breast augmentation surgery was considered to be cosmetic because the hormone treatments had already induced in the taxpayer breast size and appearance commensurate with the female gender.

The IRS has indicated that it will accept a medical expense deduction for laser eye surgery to correct myopia and for breast reconstruction surgery following a mastectomy that is part of cancer treatment, but it will not allow a deduction for tooth whitening to correct age-based discoloration. Presumably the argument for disallowing tooth whitening is that the words “any procedure which is directed at improving the patient’s appearance” appear to be sufficiently general as to include these expenses.

**Australia**

The Australian net medical expenses tax offset provides a 20 percent rebate (tax credit) on medical expenses over a threshold of A$1,500. Medical expenses are defined to include payments “to a legally qualified medical practitioner, nurse or chemist [pharmacist], or a public or private hospital, in respect of an illness or operation” and payments “for therapeutic treatment administered by direction of a

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129 No. 4230-00S, 2001 WL 1922698 (TC, December 13, 2001). The case does not have precedential value because it was decided under IRC section 7463, which governs disputes involving amounts of US$50,000 or less.

130 Supra note 125. At the time of writing, it is not yet clear whether the IRS will appeal the decision. See also Jeremiah Coder, Amy S. Elliott, and Sam Young, “Tax Court Finds Controversial Surgery Mostly Deductible” (2010) vol. 126, no. 6 *Tax Notes* 715-17.


132 Ibid.
legally qualified medical practitioner.” However, effective July 1, 2005, medical expenses do not include ineligible expenses. These are defined as payments

(a) to a legally qualified medical practitioner, nurse or chemist, or a public or private hospital, in respect of a cosmetic operation that is not a professional service for which a medicare benefit is payable under Part II of the *Health Insurance Act 1973*; or

(b) to a legally qualified dentist for:

(i) dental services; or

(ii) treatment;

that is solely cosmetic.

Although the term “operation” above seems to imply surgery, the explanatory memorandum circulated by authority of the Treasurer in connection with the cosmetic expense amendments says that the term “operation” is synonymous with “procedure.” Thus, a particular medical procedure is an ineligible expense if it meets two tests: (1) it is “cosmetic” under the normal meaning of that term; and (2) Australian medicare (the public expenditure program for health) does not provide a partial subsidy. (Unlike medicare in Canada, Australian medicare pays only for part of the cost for the non-poor.)

The Australian Treasury has listed as examples of ineligible expenses Botox injections, rhinoplasty, tooth bleaching, and implantation of a jewel in a tooth. In addition, the Australian Taxation Office (ATO) has issued an interpretive decision stating that an operation to change a taxpayer’s voice in consequence of the treatment of gender identity disorder would be ineligible. In issuing this decision, the ATO cited a dictionary definition of cosmetic, which offered as one meaning “designed to effect superficial alteration while keeping the basis unchanged.” On the other hand, the Australian Treasury considers laser vision correction surgery, breast reconstructive surgery following cancer, dental braces, and dentures to be eligible expenses.

**Quebec**

The medical expense tax credit offered under Quebec’s personal income tax law allows taxpayers a non-refundable tax credit of 20 percent of eligible medical expenses.

133 Income Tax Assessment Act 1936, section 159P(4), paragraphs (a) and (d) of the definition of “medical expenses.”

134 Ibid., the definition of “ineligible medical expenses.”


136 Ibid.


138 Australia, Treasury Department, supra note 135.
less 3 percent of family income. Unlike Canada’s federal medical expense tax credit, there is no dollar threshold.

In 2005, the provincial government restricted the eligibility of certain medical expenses that were purely cosmetic in nature. The reason cited for the amendment was that certain medical expenses were being incurred more as a matter of a personal choice rather than to remedy a health condition.\textsuperscript{139}

Section 752.0.11.1.3 of the Quebec Taxation Act\textsuperscript{140} states in part:

The medical expenses referred to in section 752.0.11.1 do not include . . .

(b) the expenses paid for medical, paramedical or dental services provided for purely cosmetic purposes; and

(c) the transportation, travel or lodging expenses paid for medical, paramedical or dental services provided for purely cosmetic purposes.

The 2005-6 Quebec budget stated that “purely cosmetic” means

where treatment is deemed not medically necessary. . . . Such expenses are primarily those paid for

—breast augmentation or lift,
—liposuction,
—tummy tuck,
—facelift,
—eyelift (upper and lower),
—rhinoplasty,
—laser resurfacing,
—botox injections,
—orthodontics work (for cosmetic purposes),
—teeth whitening.\textsuperscript{141}

No court cases have been decided relating to Quebec’s provision, and no clarification of the law has been issued by Revenu Québec.\textsuperscript{142}

\textbf{DRAWING THE DIVIDING LINE}

\textbf{General Issues}

As noted above, Canada’s new cosmetic medical expense rule redefines medical expenses to exclude “amounts paid for medical or dental services, [and] any related expenses, provided purely for cosmetic purposes, unless necessary for medical or

\textsuperscript{139} Finances Québec, 2005-2006 Budget, Budget Plan, April 21, 2005, 24.
\textsuperscript{140} RSQ, c. I-3.
\textsuperscript{141} Finances Québec, supra note 139, at 24.
\textsuperscript{142} Revenu Québec, “Medical Expenses,” IN-130-V (Montreal: Revenu Québec, 2008) refers to the non-deductibility of cosmetic expenses but does not provide any examples.
reconstructive purposes.” However, the wording of the provision is open to interpretation. In this section, we will review the new rule in light of the experience of the three jurisdictions noted above and the information presented on the market for cosmetic medicine and dentistry. We will then consider how the line might be drawn for cosmetic expenses in the four categories identified earlier.

**Link to Medicare**

The existence of the Canadian medicare system makes the problem of restricting tax relief to cosmetic expenses much simpler than it would otherwise be. Medicare will pay for correcting serious medical problems affecting a person’s appearance, and thus the problem of tax relief for private expenses does not arise in those cases. For example, medicare in Ontario (and probably other provinces as well) will cover post-mastectomy breast reconstruction, the destruction of a port wine stain on the face or neck, or less physically significant skin blemishes and birth defects that are nevertheless emotionally traumatic because the patient is a child. Thus, in such situations, only incidental expenses such as the cost of transportation or a private room will need to be included in medical expenses for tax purposes. (However, these costs could be significant in particular situations.)

The link in the Australian cosmetic expense rule to operations that are partially subsidized by medicare raises the possibility that the Canadian government could have depended on the medicare rules even more explicitly, and simply stated that surgeries and non-surgical medical procedures denied payment by medicare would also not be considered to be medical expenses for tax purposes. However, many items that are not covered by medicare are non-cosmetic and medically worthwhile, but simply do not meet the cost-benefit criterion of a cash-strapped government (for example, physiotherapy in Ontario).

A variation of this alternative that could have a greater chance of success would be to exclude from the medical expense definition any medical procedure that is not covered by medicare because it is considered cosmetic (as opposed to any other reason for denying payment—for example, because the medical benefit of the treatment is unproven). For this to work, provincial and territorial governments would have to provide the reason for denying payment. Also, this would raise the question of different standards applying in different parts of Canada. For example, it is known informally among surgeons that different provinces use different criteria to decide whether a breast reduction will qualify for payment under medicare; in Ontario, the weight of tissue removed must be 500 grams, whereas 300 grams is sufficient in Manitoba. To make matters even more complicated, if a patient from Ontario goes to Manitoba for the service, the rules of Manitoba are used to decide whether Ontario

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143  Ontario, Ministry of Health and Long Term Care, supra note 10.

144  This approach could not be used to identify includible cosmetic dental procedures or cosmetic prescription drugs since none of these expenses are covered by medicare.
will reimburse Manitoba for the costs. Thus, it is perhaps understandable why this approach was not adopted in the new legislation.

Compliance

The CRA has indicated that on audit a taxpayer may be asked to provide a statement from the medical practitioner supporting an expense claim. This information may also be relevant in court (as it was in the US case of Al-Murshidi).

The 2010 federal budget clarifies that cosmetic medical expenses are taxable under the GST/HST, and the definition is generally the same as that proposed for the Income Tax Act. Thus, GST/HST will be charged on expenses that the practitioner believes to be cosmetic. However, this may not completely eliminate the need for a statement from the medical practitioner because there might be types of medical expenses that qualify for the medical expense tax credit and yet are subject to GST/HST.

Complicating this issue is that for the 58 percent of tax returns that are electronically filed, the CRA receives only the total amount of medical claims and not the details of expenses claimed. Thus, in order to find any cosmetic amounts on an e-filed return, the CRA would have to first ask for the breakdown of the claims.

Surprisingly, none of the other jurisdictions surveyed, nor Canada with respect to the new rule, requires a “purely cosmetic”/otherwise check box on a medical receipt to indicate the status of a particular claim. Providing check box information would likely increase voluntary compliance. It would also make audits easier for the CRA, particularly if the taxpayer’s social insurance number was shown on the receipt and a copy was sent to the CRA. It is well known that compliance is much higher where there is third-party reporting. On the other hand, there is a tradeoff between increase in compliance cost and increase in compliance. Thus, one could justify not requiring third-party reporting in this circumstance until it is known that overclaiming of such expenses is a significant problem. Also, reporting this information

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145 Supra note 28. Perhaps the CRA might create a questionnaire to be completed by the medical practitioner, or even a different questionnaire for each of the more problematic types of cosmetic medical expense. The precedent is the impairment tax credit, for which the CRA has developed separate questionnaires for various types of disability.

146 Supra note 129. However, note that in Al-Murshidi the practitioner identified the operation as cosmetic, even though the court later decided otherwise.

147 See Budget Plan, supra note 1, at 378.


149 This would require an amendment to part II of the Income Tax Regulations. It is our understanding that the CRA does not plan to make such an amendment.

150 In all other respects (putting aside the possibility of misreporting by medical practitioners), the cosmetic expense exclusion meets all of the criteria defining situations where information reporting is appropriate: Leandra Lederman, “Reducing Information Gaps To Reduce the Tax Gap: When Is Information Reporting Warranted?” (2010) vol. 78, no. 4 Fordham Law Review 1733-59, at 1739-41.
would be a wasted effort in the case of taxpayers who do not have enough medical expenses to exceed the threshold required to make a claim. The fact that there is currently no CRA-prescribed form for medical expenses would complicate the problem.

**Cultural Factors**

The Canadian budget amendment is very short and relies on the courts and the CRA to interpret the word “cosmetic,” just as Quebec and Australia have chosen to do in their own jurisdiction. In contrast, the United States has attempted to provide a definition of this term. So far, this difference has had little practical effect, since the items that the various tax authorities describe as being affected by the rules are very similar.151

Despite this similarity of treatment across jurisdictions, there is evidence that the definition of “cosmetic” in society is culture-specific and could change over time, and hence the tax rules may be implicitly culture-specific as well. This is most clearly illustrated by reconstructive procedures and by drugs for the regulation of height.

Consider reconstructive procedures. Breast reconstructions after mastectomy were chosen by no more than 27 percent of females in any age group in Nova Scotia between 1991 and 2001, and 4 percent of females of all ages combined.152 However, rates seem to vary strongly by jurisdiction; for example, the overall rate in Connecticut is estimated to be four times that in Nova Scotia (16 percent versus 4 percent), even though the medical technology and, of course, the human biology are the same.153 The differing choices of individual patients may simply reflect the view that any non-cosmetic benefits could be outweighed by the risks,154 but one could also infer that many of those who did not undertake the surgery viewed it as merely cosmetic and not of interest.

The use of drugs for the regulation of child growth and height illustrates the principle of cultural specificity in a different way. Some doctors are currently prescribing synthetic human growth hormone for children who have no known medical problem (namely, growth hormone deficiency) but are simply in the shortest 1 percent of their age group.155 This might seem to be perfectly reasonable where, according

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151 The one exception is the *Magdalin* case, supra note 124, in which the specific wording of the US statute may have been significant.


to current social values, being markedly shorter than one’s peers is perceived to be a medical problem. However, that perception could change, as we have seen in the case of tallness among girls. In the 1960s, some girls were medically treated using estrogen, to prevent them from growing taller than the accepted norm. This practice has since been abandoned, at least partly because tallness among girls is no longer considered a problem, and may even be desirable (as shown, for example, by the preference for tall models).  

How are these two situations dealt with by the tax rules? Reconstructive procedures remain eligible medical expenses in all four jurisdictions, because of either an explicit exception from the cosmetic expense rule (Canada and the United States) or an implicit one (Quebec and Australia). Synthetic growth hormone is not specifically addressed in the legislation but would no doubt be considered a non-cosmetic expense, reflecting current cultural norms.

Tax policy makers need to be aware that the rules defining cosmetic procedures reflect current societal views and thus should change over time as those views change. In addition, the cultural link suggests that tax policy makers should be alert to the possibility of bias in creating and applying the tax definition of cosmetic procedures. As discussed below, there is a good case that this is exactly what has occurred in connection with gender reassignment surgery in the United States and Australia.

**Psychological Distress**

As discussed above in our review of the Canadian budget amendment, psychological distress is likely to be a favourite argument of taxpayers in claiming that a particular medical service is non-cosmetic. They might argue that the presence of a psychological motivation makes the expense not “purely” cosmetic, or alternatively that the psychological motivation makes the service medically necessary.  

Similar arguments may be made under the Quebec, US, and Australian legislation.

The policy basis for providing tax relief for otherwise excluded cosmetic procedures on grounds of psychological distress is questionable. As noted above, scientific evidence of long-term psychosocial benefits simply does not exist—not merely for BDD sufferers but for all persons undergoing cosmetic surgery for psychological reasons. Yet the CRA may lose in court because the science is not settled, and because it will be possible to find medical practitioners who believe that a particular patient’s unique circumstances make the cosmetic procedure or treatment medically necessary on psychological grounds.

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156 Ibid., at 9. Medical factors were also at work—the estrogen treatments were also shown to have serious side effects.

157 One factor that would deter taxpayers from making this argument is the cost of obtaining the expert opinion on the psychological distress. In this regard, medicare covers only psychiatrists, and there is currently a scarcity of psychiatrists in all but the largest metropolitan areas in Canada. In these circumstances, psychiatrists may be reluctant to devote their scarce time to assessments needed for tax reasons.
There is one area in which a good case can be made for psychological distress as a necessary medical reason for cosmetic treatment: gender identity disorder is listed as a mental disorder in the DSM, and gender reassignment surgery is accepted as an effective treatment for that disorder.\textsuperscript{158} Nevertheless, both the United States and Australia have chosen to challenge this surgery as cosmetic and ineligible for tax relief. Although one can understand the legalistic view that the taxpayer’s body in these situations does not appear to be defective or misshapen to objective observers, and hence any operation to change it must be cosmetic,\textsuperscript{159} the therapeutic evidence is compelling.

The revenue at stake with respect to gender reassignment surgery is very small. Ontario medicare pays for this and so there would be no Ontario cases, but in many other provinces either such surgery is not covered or the number of patients covered in a year is capped. Relatively few individuals seem to be attracted to undergo the surgeries and medical treatments involved. Medical practitioners also usually require the individual seeking surgery to present in public as the other gender for a year before surgery will be performed.

The conclusion of this analysis is that perhaps the new Canadian rule should be amended to clarify that psychological arguments \textit{other than those for gender identity disorder} cannot be used to claim tax relief for an otherwise excluded cosmetic medical expense. This would follow the position of medicare in Ontario and many other provinces. Also, without waiting for legislative change, the CRA could indicate that it will not consider gender reassignment surgery to be a cosmetic medical expense. The CRA list of May 3, 2010 contained no information on this point.\textsuperscript{160}

\section*{Specific Expenses}
Several policy and legal issues arise with respect to specific medical expenses. Where any of these items are listed as either ineligible (cosmetic) or eligible (non-cosmetic) by the CRA (on the Web page posted on May 3, 2010), this is noted. However, the list is not particularly helpful since it does not address the key areas of controversy, and even for those that it does address, there is not enough detail.\textsuperscript{161}

\section*{Cosmetic Surgical and Non-Surgical Medical Procedures}
Generally, there are few borderline problems in surgical and non-surgical medical procedures. The few that one can envisage are very specific.

\begin{footnotes}
\item[158] O'Donnabhain, supra note 125.
\item[159] Infanti, supra note 6, at 19-21.
\item[160] CRA, supra note 28.
\item[161] Ibid.
\end{footnotes}
- **Repair operations** to correct problems resulting from previous cosmetic surgery. Although it appears harsh to exclude medical costs that are non-cosmetic, the balance might shift if the repair expense could have been anticipated and the patient was warned of this. An example is an operation to correct impaired breathing resulting from cosmetic rhinoplasty.\(^{162}\)

- **Bariatric surgery** (*gastric restriction for weight loss*) if performed for cosmetic purposes. Although Canadian medical practice offers this surgery only to people who have serious obesity-related health problems, expenses incurred outside Canada also qualify for the medical expense tax credit. The CRA list includes “gastic bypass surgery or gastric stapling” as an eligible (non-cosmetic) expense.\(^{163}\)

- **Male circumcision** for non-religious purposes. Taxpayers may challenge this exclusion, citing recent research that appears to support a non-cosmetic purpose: circumcision may reduce the risk of getting the AIDS virus and contracting other sexually transmitted diseases.\(^{164}\)

- **Breast augmentation** for asymmetry. Female breasts often are not perfectly symmetric. For some patients, this procedure may be considered sufficiently cosmetic to be excluded from payment under medicare, yet many physicians would still consider it to be medically necessary. The CRA list identifies breast “shaping, contouring or lifts” as ineligible expenses, without any qualifying details.\(^{165}\)

- **Breast augmentation as part of reconstruction.** The reconstruction after cancer may be such that the taxpayer has effectively had an augmentation relative to the pre-cancer situation.

- **Breast reduction.** Although there is no doubt that this is a significant health problem for many women and can even affect respiratory function,\(^{166}\) the comment above about breast asymmetry applies. There is considerable controversy over where to draw the line between functional and cosmetic surgery in this area.\(^{167}\) The CRA list states that “breast reduction to reduce back and shoulder pain” remains an eligible medical expense.\(^{168}\)

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163 CRA, supra note 28.


165 CRA, supra note 28.


168 CRA, supra note 28.
Cosmetic Dentistry

A major difficulty in defining cosmetic dentistry\(^{169}\) is that one may need to know the reasons for a procedure in the particular patient situation in order to determine whether it is cosmetic. This may be simple if the reasons are objective characteristics of the mouth. For example, applying tooth-coloured materials to the tooth surface (bonding) is a functional repair for teeth that are chipped, broken, or cracked, but it is a cosmetic procedure when used for lightening stains, closing minor gaps, or correcting crooked teeth.\(^{170}\) The same can be said about applying a veneer (a thin porcelain cover) to the front of the tooth—a procedure that is more permanent than bonding but more costly.\(^{171}\) Veneers can also be justified for strengthening purposes—for example, if there is a large filling in the tooth.

The line-drawing problem is even more difficult if the patient’s personal reasons are the significant factor in the choice of procedure. For example, a patient needing a filling who chooses tooth-coloured (composite) fillings rather than silver-coloured (amalgam) fillings may be doing so for reasons of appearance, but some people avoid amalgam fillings for non-cosmetic reasons, such as concerns about mercury content.\(^{172}\) Similarly, the desire for straight, uncrowded teeth is the motivation for orthodontic treatment for most patients, even though, from the dentist’s point of view, the goal may be to realign the teeth for correct occlusion (bite) and disease prevention.\(^{173}\)

The key problem in defining cosmetic services in dentistry is that there is almost always some non-cosmetic benefit for any dental procedure, however minor, and therefore the service is not “purely cosmetic.” As noted above, even tooth contouring and reshaping (one of two ineligible dental items on the CRA list) may make teeth easier to clean.

Neither the Canadian budget amendment nor the laws of the other three jurisdictions provide direct guidance as to what dental procedures might be considered cosmetic. Governments have given a few interpretations of these laws: both the Canadian budget document and the CRA list specifically refer to tooth whitening.\(^{174}\)

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\(^{169}\) From a regulatory perspective, cosmetic dentistry is not a recognized specialty; it is part of the general practice of most dentists. The closest recognized specialty is prosthodontics. See Donald F. Mulcahy, “Cosmetic Dentistry: Is It Really Health Care?” (2000) vol. 66, no. 2 Journal of the Canadian Dental Association 86-87, at 86.

\(^{170}\) See, for example, the American Dental Association, “Cosmetic Dentistry” (http://www.ada.org); About Cosmetic Dentistry, “Tooth Bonding” (http://www.aboutcosmeticdentistry.com); and Toronto’s Studio for Aesthetic Dentistry (http://www.cosmeticdentistryto.com/).

\(^{171}\) US prices cited in 2006 were $1,000-$3,000 per tooth for veneers and $500-$750 per tooth for bonding: Susan Yara, “The Price of a Perfect Smile,” Forbes, February 6, 2006.

\(^{172}\) American Dental Association, “Amalgam (Dental Filling Options)” (http://www.ada.org).


\(^{174}\) Budget Plan, supra note 1, at 341; and CRA, supra note 28.
as do all three of the other jurisdictions; Australia says that implanting a jewel in a tooth is cosmetic; and Quebec mentions cosmetic orthodontics in the budget, although not in interpretations from Revenu Québec.

The whitening effect may be achieved by methods that also have non-cosmetic uses, such as dental bonding and porcelain veneers. It appears that while patients often request whitening, they may be steered by the dentist to these other procedures. Some US evidence for this is that while tooth whitening is reported to be the most commonly requested procedure by patients of cosmetic dentists (29 percent), it represents only 6.5 percent of procedures performed.175

According to industry data,176 tooth whitening accounts for just 5 percent of the US cosmetic dentistry market (US$138 million of US$2.75 billion). Cosmetic orthodontics (an excluded expense in Quebec) accounts for 2 percent of the US market. Tooth contouring and reshaping appears to be too small an item to be listed in the statistics. The biggest items are crown and bridge work (38 percent), bonding (22 percent), and veneers (13 percent), none of which are mentioned by the tax authorities in Quebec, Australia, and the United States as being caught under current rules. The CRA list states that “dental veneers to correct decayed or misaligned teeth” and “dental braces, if required to correct a misaligned bite” are eligible (non-cosmetic) expenses, but it is silent on the treatment of these expenses when incurred for other (that is, cosmetic) purposes.177

If there is a desire to cover areas of cosmetic dentistry beyond the simplest ones—tooth whitening and tooth contouring and reshaping—in the application of Canada’s new cosmetic expense provision, detailed rules defining the situations in which the expenses are to be considered cosmetic will be needed.

**Cosmetic Prescription Drugs**

As noted above, it is our understanding that the CRA intends to interpret the words “related expenses” in the budget amendment to catch cosmetic drugs administered orally at home by a patient.178 The argument is that the drug is related to the cosmetic service of the physician consultation that led to the prescription.

There is a consensus in the industry as to which drugs are considered cosmetic, and therefore the CRA could issue such a list. Because identical drugs may be used for both cosmetic and non-cosmetic purposes, using the chemical name on the list

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176 AACD, supra note 73.
177 Supra note 28. The CRA has also said that dental crowns are non-cosmetic (that is, eligible expenses): CRA document no. 2010-0362981M4, April 13, 2010.
178 See the discussion in the text following note 29, supra.
would not be appropriate; instead, the list should be based on trade names.\(^{179}\) However, there are some minor problems that would need to be overcome. A physician could prescribe a drug intended for a cosmetic use under the trade name of its non-cosmetic use (for example, prescribe the drug finasteride under the name Proscar rather than Propecia).\(^{180}\) Also, for at least one drug, the topical form of tretinoin, the same trade names (Retin-A, Retisol-A, and Renova) are used for both cosmetic and non-cosmetic purposes.

**Overall Assessment**

The discussion above suggests that there are a number of interpretive issues. However, the relatively small number of interpretive opinions and court cases in the three jurisdictions that have had cosmetic expense rules for some time suggests that perhaps the interpretation and enforcement of those rules has not been strict. If the CRA chooses to adopt a similar approach, it is possible that few disputes will arise over Canada’s legislation as well.

If there is significant enforcement effort, it is likely that a chief taxpayer defence will be psychological motivation. Perhaps the legislation should be changed to remove this defence except in the case of gender reassignment surgery.

Cosmetic dentistry has some potential for controversy, but this will occur only if the CRA breaks from the practice in other jurisdictions and makes a serious attempt to identify additional cosmetic expenses in this area. Fairly elaborate legislative and administrative guidance would be required to achieve that result.

**REVENUE ESTIMATION**

In the 2010 budget, the Department of Finance estimated the federal revenue impact of its proposal to be $40 million annually. Following tradition, no explanation was given as to how this estimate was derived. However, it is likely that it was derived almost exclusively from publicly available sources, since the department’s principal private data source, personal income tax returns, contains no information on this subject.\(^{181}\) Given that private data are not required, it is possible to check the reasonableness of the estimate.

In the discussion of relevant Canadian tax law above, it is noted that in the past almost all income tax relief for cosmetic medical expenses has been provided through the medical expense tax credit. Thus, the increased federal and provincial revenue from deleting cosmetic expenses from the list of eligible medical expenses can be calculated as the product of three amounts:

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\(^{179}\) Both Latisse and Propecia, currently the major cosmetic prescription drugs in the United States, were originally developed for non-cosmetic purposes and are also sold under different trade names for cosmetic and non-cosmetic uses. See Singer, supra note 97.

\(^{180}\) A pharmacist could not make this substitution on his or her own, since professional rules would require that the change be approved by the prescribing physician.

\(^{181}\) Only an examination of the receipts submitted by taxpayers claiming medical expenses would provide this information, and as discussed above, even this is not possible for e-filed returns.
1. the estimated amount of cosmetic expenses;
2. the proportion of these expenses that would actually get the tax relief, absent the budget amendment—that is, the amount that would be claimed for the credit and would be above the threshold; and
3. the medical expense tax credit rate for 2010, which is 15 percent.

Estimates of amount 1 can be calculated in three different ways, as set out below. In each case, the difference between Canadian and US dollars is ignored since the two currencies are almost equal in value at the time of writing.

- Use the US total expense figure of $10.6 billion for the items that are included in the budget proposal ($10.5 billion in total physician/surgeon fees + $138 million in tooth whitening expenses) and assume that cosmetic medical expenses are just as common and just as costly in Canada as in the United States. This implies multiplying $10.6 billion by the ratio of the population of Canada to the population of the United States (34 million/308 million = 11 percent). This generates an estimated annual expenditure of $1.17 billion on cosmetic medical procedures in Canada.

- Use the US total but modify that amount by taking into account the admittedly limited Canadian data that suggest that cosmetic medical expenses are less common and/or less costly in Canada. Medicard Finance estimates that the total amount spent in Canada on cosmetic medical procedures in 2005 was $666 million, which is 5.4 percent of the $12.4 billion US figure for that year shown in table 2. Multiplying the lower ratio of 5.4 percent by the $10.6 billion US total produces an estimate of $569 million for annual Canadian expenditures.

- Extrapolate from the revenue raised by New Jersey’s sales tax on cosmetic medical procedures. The revenue raised from this tax from July 2008 to June 2009 was $11.3 million. Dividing by the tax’s 6 percent rate and multiplying by the population ratio of Canada to New Jersey (34 million/8.7 million) gives an estimate of $736 million in annual Canadian cosmetic medical expenditures.

Since there is no clear basis on which to choose between the estimates, amount 1 may be thought of as lying somewhere within the range of $569 million to $1.17 billion.

To calculate amount 2, note that total allowable medical expenses claimed in Canada on 2006 personal income tax returns amounted to $7.4 billion. Out-of-pocket health expenditures of individuals, both reported on returns and not, totalled

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182 Canada News Wire, “Survey Shows Canadians Choosing Non-Surgical Options in Cosmetic Enhancement,” July 13, 2006. The figure is of uncertain reliability since it is no longer shown on the Medicard Finance Web site.
183 Telephone conversation on October 29, 2009 with the Division of Taxation, Department of the Treasury, State of New Jersey.
$22.1 billion in that year.\textsuperscript{185} Thus, 33 percent of individuals’ out-of-pocket medical expenditures were claimed and were eligible for the credit. This roughly accords with published data suggesting that 21 percent of households with incomes over $50,000 qualify for the credit but only 6 percent of filers actually claim it.\textsuperscript{186} Of course, this calculation assumes that the takeup of the credit for cosmetic expenses is the same as for other medical expenses.

It is possible that the 33 percent figure is too low, because cosmetic expenses tend to be lumpy (either zero or high) and hence would exceed the threshold more often than other medical expenses. For example, physician/surgeon fees for breast augmentation, the most common procedure in the United States, average US$3,713.\textsuperscript{187} Similarly, the mean amount spent by a cosmetic dentistry patient is US$5,640.\textsuperscript{188} On the other hand, the average cost of Botox injections is only US$397.\textsuperscript{189} In the absence of more solid information, it seems preferable to make no adjustment for this factor.

Taking the product of amount 1, amount 2, and 15 percent, the revenue estimate for the budget change is $28 million to $58 million per year (for example, $569 million \times 33\% \times 15\% = $28 million). Thus, the Department of Finance estimate seems quite reasonable.

CONCLUSION

The 2010 budget amendment excluding “purely cosmetic” medical expenses from eligibility for the medical expense tax credit should not be controversial in terms of tax policy. Because such expenses seem to be entirely discretionary and consumption-oriented, the rationale offered for the other expenses qualifying for the credit does not apply in this case.

The vast majority of the expenses that will no longer receive tax relief are incurred for the treatment of female patients. The figure is 92 percent in the biggest category, cosmetic surgery.

Reliable Canadian data on the market for cosmetic medical procedures and drugs are not available. However, according to US industry data, the US market breaks down as follows: cosmetic surgery, 43 percent; non-surgical cosmetic medical procedures, 33 percent; cosmetic dentistry, 20 percent; and cosmetic prescription drugs, 4 percent.

In the field of cosmetic dentistry, it appears that because Canada’s new rule applies only to expenses that are purely cosmetic, only tooth whitening and tooth contouring and reshaping (about 5 percent of cosmetic dental procedures) will be

\textsuperscript{185} Canadian Institute for Health Information, supra note 7, at 19.
\textsuperscript{186} Smart and Stabile, supra note 85, at 363.
\textsuperscript{187} Calculated from ASAPS, supra note 73, at 11.
\textsuperscript{188} AACD, supra note 73.
\textsuperscript{189} Calculated from ASAPS, supra note 73, at 11.
ineligible for the tax credit. On this assumption, the rule will reach only 81 percent of the medical expenses that industry groups consider to be cosmetic. Filling this gap in the rules is difficult and will likely require both legislative amendments and detailed guidance from the CRA.

Apart from this gap in coverage, the review of the US, Australian, and Quebec rules excluding cosmetic medical expenses from tax relief shows that the rules seem to be working well, as judged by the absence of controversy in the courts and comments provided by the respective tax authorities. Therefore, the Canadian budget amendment may similarly encounter few problems.

To reduce the scope for disputes with taxpayers, it might be desirable to legislate that expenses will not be excluded from being treated as cosmetic on the ground of a taxpayer's psychological distress over his or her appearance except in the case of gender reassignment surgery.

The budget amendment raises the question of whether there are any other categories of medical expenses that should be excluded from income tax relief because they too are purely discretionary. Expenses that are higher than required to cover the underlying medical condition could be said to be cosmetic. For example, Quebec denies eligibility for its medical expense tax credit for the excess of the cost of eye-glass frames over $200,\(^{190}\) and a similar limit could be put on amounts spent on other ways of correcting near- or far-sightedness (such as corrective laser surgery).\(^{191}\)

Another category of medical expenses that may warrant review is performance enhancement procedures and treatments. For example, mouthpieces may be custom-fitted by dentists to reposition the jaw in order to improve performance while cycling, running, or weight training.\(^{192}\) Some athletes are attracted to anabolic steroids and “blood doping,” to cite two examples in current use; “gene doping” is also on the horizon, having been proven successful in animal experiments.\(^{193}\) In addition, “brain-boosting” drugs such as methylphenidate are being used to improve concentration, focus, and memory.\(^{194}\) These developments suggest that the issue of defining the types of medical expenses that should qualify for tax relief will remain a challenge for tax authorities in the years ahead.

\(^{190}\) Quebec Taxation Act, section 752.0.11.4.

\(^{191}\) In the few occupations in which such corrective surgery is needed for work purposes, employers may choose to pay for it themselves. One such case is Canada’s Armed Forces: Tom Blackwell, “Soldiers in Line for Laser Eye Surgery,”\(^{190}\) National Post, January 20, 2009, A1.


