

Putting Health To Rights: A Canadian View on Global Trends in Litigating Health Care Rights

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The majority of the world's constitutions now include mention of a right to health or health care. Will the courts be effective at championing the health rights of vulnerable populations? Courts recognize that health systems embody complex tradeoffs, and have struggled to draw a principled line of deference to government decision-making. Worldwide, one finds courts drawing this line in various ways, depending, among other things, on their country's constitutional aspirations, the maturity and internal accountability of its health system, and broader currents of social mobilization. For their part, Canadian courts have been very restrained, conceptualizing health rights largely in negative terms – overturning restrictions on access to abortion, medical marijuana, and so on – while refusing to recognize any positive duty on the part of government to provide particular health services. Could Canadian courts do more, without tumbling into overreach? The paper ends by sketching options for a more robust and progressive approach to adjudicating health rights claims.

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I. Introduction

The majority of the world's constitutions now include mention of a right to health or health care.¹ Though in some countries health rights are purely symbolic or aspirational, it is often assumed that courts will play a role in holding governments accountable under these rights.² Proponents of a rights-based approach believe (or hope) that "[r]ights remove discretion from development and provide a framework of accountability. Rights ensure services for the most marginalised and vulnerable populations, making it hard to claim progress by reference to

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1. Office of the UN High Commission for Human Rights, *The Right to Health: Fact Sheet No. 31* (Geneva: UN High Commission for Human Rights, 2008).
 2. A recent study finds that approximately 70% of constitutions worldwide contain health-related guarantees, while the right is justiciable in approximately 40%. See Courtney Jung, Ran Hirschl & Evan Rosevear, "Economic and Social Rights in National Constitutions," *Am J Comp L* [forthcoming] at 6-9, online: Social Science Research Network <http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2349680>.

numerical aggregates.”³ Will health rights live up to this promise?⁴

Answering this question is difficult as a thorough comparative analysis is complicated, perhaps insurmountably, by various confounding factors. Still, we can marshal what empirical evidence there is and rely on insights from experts in health law and policy across different countries witnessing the litigation of health care rights. In what follows, we explore the contextual factors that shape the impact of health care rights, moving from global trends to the specifics of the Canadian context. As a starting point, in Part I (below) we provide an overview of the basic dilemma facing courts as they venture into the adjudication of health care rights, namely, the challenge of staking out a legitimate institutional role and avoiding overreach into areas that are the purview of elected or executive bodies. This dilemma does not arise in a vacuum, however, and Part II explores some of the contextual factors that shape courts’ approaches to the adjudication of health rights, including national aspirations and constitutional traditions, the maturity of existing health systems, their mix of public/private financing and administration and broader currents of social mobilization. As explained, these contextual factors may partly explain Canadian courts’ general conservatism vis-à-vis health rights, as compared to the bolder approach taken by courts in other countries.

Of course, context does not wholly determine the path of health rights. Canadian courts have made pivotal interpretive choices, which have seriously limited the effectiveness of rights as an accountability mechanism in health care for marginalized groups. Part III explores Canadian jurisprudence in this arena, focusing on the Supreme Court’s largely ‘negative’ conception of the rights to life and security of the person, and its very restrained reading of the section 15 equality guarantee as it applies to health. To date, these rights have done little

3. Michel Sidibe & Kent Buse, “Global Health Governance After 2015 – Authors’ Reply” *The Lancet* (21 September 2013) 382:9897, online: [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(13\)61967-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(13)61967-4/fulltext).
4. Our discussion focuses largely on rights to *health care*, as this has been the primary focus of litigation in Canada and abroad. For ease of expression we will occasionally use the terms ‘health rights’ or ‘right to health,’ though strictly speaking this encompasses a broader range of interests (*e.g.* rights to public health prevention and equitable health outcomes).

to ensure accountability to vulnerable populations, and indeed the negative interpretation favoured by the Court is being used to challenge the legal foundations of universal health care.⁵ Even taking into account the contextual factors that recommend judicial restraint in the Canadian context, the results have been disappointing. As will be explained, courts in similarly-situated countries, such as the UK, have had success in pressing for greater accountability in health care decision-making, while heeding the concern about overreach.

II. The Central Dilemma in Adjudicating Health Rights

Though jurisdictions vary considerably in their approach to conceptualizing and enforcing health care rights, a basic concern arises irrespective of context – over the legitimacy of having courts oversee the allocation of health care resources. Decisions about the allocation of health care resources are ‘polycentric’ by nature, requiring robust evidence of complex tradeoffs at a systems level,⁶ while the courts’ institutional competence lies, it is claimed, in adjudicating discrete conflicts between two parties. As Christopher P. Manfredi and Antonia Maioni argue,

The strength of the adversarial system is its capacity to sort through the historical facts about past events that transpired between disputing parties in order to implement retrospective remedies that will restore each party to the status it enjoyed prior to the dispute. By contrast, general policy formation requires the analysis of complex social facts about the relationship between ongoing phenomena in order to regulate those relationships prospectively.⁷

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5. *Chaoulli v Quebec (Attorney General)*, 2005 SCC 35 [*Chaoulli*]; *Canadian Independent Medical Clinics Association v Medical Services Commission of British Columbia* (28 January 2009), Vancouver S-090663 (BCSC) (Writ of Summons of Plaintiffs) online: Medicare.ca <<http://medicare.ca/wp-content/uploads/2009/05/cimcawrit.pdf>>.
 6. Lon Fuller & Kenneth Winston, “The Forms and Limits of Adjudication” (1978) 92:2 Harv L Rev 353.
 7. Christopher P Manfredi & Antonia Maioni, “Judicializing Health Policy: Unexpected Lessons and an Inconvenient Truth” in James B Kelly & Christopher P Manfredi, eds, *Contested Constitutionalism* (Vancouver: UBC Press, 2009) 129 at 137. See also Kent Roach, “The Courts and Medicare: Too Much or Too Little Judicial Activism” in Colleen M Flood, Kent Roach & Lorne Sossin, eds, *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto: University

The dilemma is especially vivid in lower income countries, where scarce resources often mean that one life can be saved at the expense of another. South Africa's Constitutional Court acknowledged this reality in its often-cited *Soobramoney* ruling, as it declined to intervene on behalf of an elderly patient seeking access to dialysis, underscoring "the danger of making any order that the resources be used for a particular patient, which might have the effect of denying those resources to other patients to whom they might be more advantageously be devoted."⁸ Institutional competence aside, there are also separation of powers arguments against having courts second-guess decision-making by the legislative and executive branches. Elected bodies are democratically entrusted to reconcile the diverse interests at play with these polycentric tradeoffs, it is argued, making judicial forays into this area democratically illegitimate.

There are, of course, replies to these concerns that must be taken seriously. On the issue of resource allocation and polycentrism, courts have long interfered in defense of civil and political rights, though this too has significant resource implications.⁹ Moreover, outside of the rights context, courts adjudicate a host of other polycentric issues in law (*e.g.* competition law, anti-trust law and division of powers questions).¹⁰ Regarding concerns about the courts' ability to regulate relationships prospectively, some have pointed to novel remedies available to courts, including suspended or delayed declarations of invalidity.¹¹ On the issue of democratic legitimacy, some have argued that judicial review can in

of Toronto Press, 2005) 184 at 186-88 (arguing against public interest standing on grounds that it allows abstract claims to proceed, lacking facts 'that add flesh and bone to the case').

8. *Soobramoney v Minister of Health, KwaZulu-Natal* [1998] 1 SA 765 at 776 (S Afr Const Ct) [*Soobramoney*].
9. Kent Roach, "The Challenges of Crafting Remedies for Violations of Socio-economic Rights" in Malcolm Langford, ed, *Social Rights Jurisprudence: Emerging Trends in International and Comparative Law* (Cambridge: Cambridge University Press, 2009) 46 at 49 [Roach, "Crafting Remedies"]; Stephen Homes & Cass Sunstein, *The Cost of Rights: Why Liberty Depends on Taxes* (New York: WW Norton & Co, 1999).
10. Jeff King, *Judging Social Rights* (Cambridge: Cambridge University Press, 2012) at 198-99.
11. Roach, "Crafting Remedies", *supra* note 9.

fact be democracy-enhancing – *e.g.* by targeting judicial scrutiny on government actions undertaken without robust and inclusive democratic deliberation.¹² Together these replies offer a preliminary defense of judicial involvement in the protection of social rights, including rights to health care. The thornier challenge is to strike a proper institutional balance – delivering improved accountability in a manner that plays to the courts’ institutional strengths, while avoiding overreach into areas where the courts have little or no expertise to add, such as the determination of what new drugs and technologies should be funded.

Courts themselves are often keen to avoid overreach, or even the perception of overreach, and this fundamentally shapes jurisprudence in the area of health care rights. An example commonly cited here is *R v Cambridge Health Authority*,¹³ a UK decision concerning a 10-year-old girl, diagnosed with terminal leukemia, whose family launched an administrative law challenge in the hope of securing a further round of chemotherapy and a second bone marrow transplant – therapies the Cambridge Health Authority had refused on grounds of high cost and poor prognosis. In rejecting the family’s claim, the Court of Appeal explained that,

[d]ifficult and agonising judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment which the court can make. In my judgment, it is not something that a health authority ... can be fairly criticised for not advancing before the court.¹⁴

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12. Alana Klein, “Section 7 of the Charter and the Principled Assignment of Legislative Jurisdiction” (2012) 57 Sup Ct L Rev 59; Martha Jackman, “Protecting Rights and Promoting Democracy: Judicial Review under s.1 of the Charter” (1996) 34:4 Osgoode Hall LJ 661. See also *Vriend et al v Alberta*, [1998] 1 SCR 493 (per Iacobucci J: “where the interests of a minority have been denied consideration, especially where that group has historically been the target of prejudice and discrimination, I believe that judicial intervention is warranted to correct a democratic process that has acted improperly” at para 176).
 13. *R v Cambridge Health Authority, ex parte B* (1995), 25 BMLR 5 (QB) [*Cambridge Health Authority QB*], rev’d [1995] 2 All ER 129 (CA) [*Cambridge Health Authority CA*].
 14. *Cambridge Health Authority CA, ibid* at 137. In the Canadian context, see *e.g. Chaoulli*, *supra* note 5 at para 161 *et seq* (Binnie and Lebel JJ dissenting). In the South African context, see *Soobramoney*, *supra* note 8 at

This approach of categorical deference to the resource allocation decisions of health authorities lies at one extreme of judicial attitudes towards health care rights. There is justifiable concern that it offers insufficient accountability, allowing health authorities to simply “toll the bell of tight resources,” as the lower court put it in *Cambridge Health Authority*.¹⁵ At the opposite extreme lies the approach taken in Brazil and other Latin American countries, where rights to health care have at times been interpreted as ‘trumps,’ with the judiciary showing little or no deference to overall resource allocations when ruling on individual claims.¹⁶ This approach has its own pitfalls, foremost the risk of scarce health care resources being redistributed under the regressive principle of ‘to each according to their ability to litigate.’ In the end, one hopes that courts will chart a path between deference and activism that advances the goals that inspire the right to health – namely ameliorating the stark inequalities that often exist in health care.

But as discussed in the next section, this path must be charted amidst various context-specific factors, which include the specific wording and method of enactments of health care rights (*e.g.* whether by ordinary statute or as part of a grand vision of transformative constitutionalism), the design and in-built accountability of a country’s health care system and the broader currents of social mobilization that inevitably influence the interpretation and enforcement of health care rights. As we will go on to argue, in Canada we have the luxury of a robust public health care system and thus we are not in the same need as Columbia, South Africa or India of challenging massive historical inequities.¹⁷ Thus in the Canadian context a reasonable solution may lie in the courts offering a measure of accountability, particularly for vulnerable and marginalized

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15. *Cambridge Health Authority* QB, *supra* note 13 at 17.
16. Octavio Luiz Motta Ferraz, “The Right to Health in the Courts of Brazil: Worsening Inequities?” (2009) 11:2 Health & Hum Rts 33; Octavio Luiz Motta Ferraz, “Harming the Poor Through Social Rights Litigation: Lessons from Brazil” (2011) 89:7 Tex L Rev 1643 [Ferraz, “Lessons from Brazil”].
17. There are of course serious and systemic health inequities in Canada, including gaping disparities in health outcomes among the country’s Aboriginal population.

populations, while also showing deference both to elected bodies and the expertise of health authorities.

III. Health Care Rights in Context

Much of the research to date on the impact of health rights litigation adopts a comparative lens, contrasting the experiences of diverse countries in search of emerging patterns and workable typologies.¹⁸ Comparative analysis of case law is an important component of this research, but when cases are taken out of context, they offer limited and potentially misleading guidance. For example, Canadian courts have been very conservative – at times arguably regressive – in *Charter* cases concerning access to health care (more on this below). But to what extent is this driven by non-doctrinal factors, such as the design of Canada’s health system, its mix of public and private financing, its administrative processes for rationing and so on? An understanding of these broader factors is essential to sound comparative analyses.¹⁹

Three contextual factors are discussed below: national aspirations underlying rights guarantees, the design and maturity of existing health systems, and levels of social mobilization around vital issues of health equity. These factors are highlighted in part because they are germane to Canada’s experience with health care litigation. A host of other contextual factors – such as extreme resource limitations, bribery and corruption

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18. This paper, particularly in Parts I and IV, draws upon findings of Colleen Flood & Aeyal Gross, eds, *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge: Cambridge University Press, 2014). Other recent comparative studies on health rights litigation include: Alicia Ely Yamin & Siri Gloppen, eds, *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Cambridge, Mass: Harvard University Press, 2011); Varun Gauri & Daniel M Brinks, eds, *Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developed World* (Cambridge: Cambridge University Press, 2008); Jung, Hirschl & Rosevear, *supra* note 2; Katharine G Young & Julieta Lemaitre, “The Comparative Fortunes of the Right to Health: Two Tales of Justiciability in Colombia and South Africa” (2013) 26:1 Harv Hum Rts J 179.
19. Ted Marmor, Richard Freeman & Kieke Okma, “Comparative Perspectives and Policy Learning in the World of Health Care” (2005) 7:4 *Journal of Comparative Policy Analysis* 331.

within health systems and lack of judicial independence – shape the impact of health litigation in other countries, but have less relevance in comparison to Canada.²⁰

A. Health Rights and Broader Constitutional Aspirations

Though fundamental rights are often conceived as ‘universal,’ the purpose and aspirations underlying rights guarantees vary considerably, reflecting a country’s history, its experiences with colonialism, racial or ethnic divisions, its stage of economic development and so on. Courts may be emboldened or inhibited by these factors in their defense of health rights. Thus, for example, South Africa’s post-Apartheid constitution recognizes a right to health care, along with other ‘second generation’ rights, under a general theory of ‘transformative constitutionalism,’ which aims at rectifying deep and longstanding injustices through a process guided by the rule of law.²¹ These transformative aspirations are reflected in the unequivocal language of South Africa’s constitutional guarantees regarding health, which states that “[e]veryone has the right to have access to ... health care services, including reproductive health care,” and mandates that “[t]he state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realization of these rights.”²² Emboldened by this language, the Constitutional Court of South Africa addressed the legitimacy of judicial

20. On judicial independence and health rights, see Oscar Cabrera & Fanny Gomez, “Litigating the Right to Health in Venezuela: A Non-Justiciable Right in the Context of a Deficient Health Care System” in Flood & Gross, *supra* note 18 at 394; on the impact of bribery and corruption, see Eva Foldes, “Addressing Equity in Health Care at The Public-Private Intersection: The Role of Health Rights Enforcement in Hungary” in Flood & Gross, *supra* note 18 at 208; on health rights under extreme resource scarcity, see Remigius N Nwabueze, “The Legal Protection and Enforcement of Health Rights in Nigeria” in Flood & Gross, *supra* note 18 at 371.

21. Karl Klare, “Legal Culture and Transformative Constitutionalism” (1998) 14:1 SAJHR 146; Eric Christiansen, “Transformative Constitutionalism in South Africa: Creative Uses of Constitutional Court Authority to Advance Substantive Justice” (2010) 13:3 J Gender Race & Just 575.

22. *Constitution of the Republic of South Africa, 1996*, No 108 of 1996, s 27.

review unequivocally in its *Treatment Action Campaign* ruling: “[i]n so far as [the adjudication of health care rights] constitutes an intrusion into the domain of the Executive, that is an intrusion mandated by the Constitution itself.”²³

By contrast, inasmuch as Canadian courts have recognized health-related rights, these have been derived from the *Charter’s* open-ended guarantees, notably the section 7 protections against unjust infringements of “life, liberty and security of the person” and the section 15 “right to the equal protection and equal benefit of the law without discrimination ...”²⁴ There is debate, even among progressive legal scholars, as to how far Canadian courts should venture in the direction of recognizing social rights, under this ambiguous constitutional mandate. Some encourage a more rigorous judicial review on questions of access to health care,²⁵ while others caution that “attempts to leverage a *comprehensive* protection of social rights out of an instrument that is chiefly aimed at protecting a class of civil and political rights is not only undesirable, but irresponsible and undemocratic.”²⁶ Perhaps this ambiguous constitutional mandate partly explains the courts’ restrained approach to date: a 2008 comparative study by the International Commission of Jurists, looking at cross-country variations in the adjudication of economic, social, and cultural rights, reveals that Canadian courts have been exceptionally conservative in their approach²⁷ – recognizing positive rights to health care in only one

23. *Minister of Health and Others v Treatment Action Campaign and Others*, [2002] ZACC 15 at para 99 [TAC].

24. Some have long maintained that s 7 is meant only to govern the individual’s “interaction with the justice system and its administration.” See *New Brunswick (Minister of Health and Community Services) v G (J)*, [1999] 3 SCR 46 at para 65.

25. Martha Jackman, “Charter Review as a Health Care Accountability Mechanism in Canada” (2010) 18 Health LJ 1 [Jackman, “Charter Review”]; Bruce Porter, “A Right to Health Care in Canada: Only If You Can Pay For It” (2005) 6:4 ESR Review: Economic and Social Rights in South Africa 8.

26. King, *supra* note 10 at 200 [emphasis in the original].

27. International Commission of Jurists, *Courts and the Legal Enforcement of Economic, Social and Cultural Rights: Comparative experiences of justiciability* (Geneva: ICJ, 2008).

notable ruling.²⁸

This is not to suggest that a broader recognition of health care rights would run contrary to Canada's constitutional values or its aspirations as a nation. Certainly the plain wording of the *Charter* does not bind Canadian courts to a conservative interpretation of health care rights. The wording of article 21 of India's Constitution²⁹ is nearly identical to section 7 of the *Charter*, and yet the Indian Supreme Court has been more active in championing health rights (and economic, cultural and social rights generally).³⁰ Moreover, Canada long ago ratified the *International Covenant on Economic, Social and Cultural Rights*, which includes a "right of everyone to the enjoyment of the highest attainable standard of physical and mental health."³¹ Courts in other countries, such as Israel and the Netherlands, have been swayed in their reading of domestic health rights by their countries' ratification of the right to health under international law.³² In interpreting this right, international law has roundly rejected the negative/positive rights distinction to which, as explained below, Canadian courts continue to cling.³³

On the one hand, lower and middle income countries have led the world in embracing these rights – which is understandable, given there is often an urgent and widespread need for improved access to basic care in these countries and to correct an often appalling imbalance of resources devoted to the private as opposed to public system. Yet the very scale of

28. *Eldridge v British Columbia (Attorney General)*, [1997] 3 SCR 624 [Eldridge].

29. "No person shall be deprived of his life or personal liberty except according to procedure established by law." *The Constitution of India*, 1949, as amended by *The Constitution (One Hundred and Twentieth Amendment) Bill*, 2013, art 21.

30. Jung, Hirschl & Rosevear, *supra* note 2.

31. *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 UNTS 3. Canada ratified the ECSR in 1976.

32. Aeyal Gross, "The Right to Health in Israel between Solidarity and Neoliberalism" in Flood & Gross, *supra* note 18 at 159; Andre den Exter, "Health Access in the Netherlands" in Flood & Gross, *supra* note 18 at 188.

33. UN Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 9: The domestic application of the Covenant*, 3 December 1998, E/C 12/1998/24.

unmet needs in these countries may present a problem that is beyond the power of courts to address. Thus, in making the case that health care litigation in Brazil has led to siphoning of resources by wealthier Brazilians, health law scholar Octavio Ferraz rejects the proposition that *more litigation by the poor* offers a solution:

[E]ven if poor people had effective access to the courts and started to litigate en masse ... and even if courts were as receptive to their claims as they are to those of middle class right-to-health litigants ... their mandatory injunctions would soon face a brick wall due to lack of political will and normative consensus on radical egalitarian measures. No court, however willing, would have the power to overcome that obstacle.³⁴

As we write, however, Columbian courts are charting a very bold course and aim to directly impact health policy through a series of recent rulings that are issuing directions to the government on how to reform health care policy. Arguably these kind of court-induced systemic reforms will benefit all Columbians, including the poor. In the Canadian context, such reforms would challenge entrenched concepts of parliamentary sovereignty and conceptions of judicial deference and, in our view, are unlikely to occur in the foreseeable future.

B. Health Rights, Judicial Deference, and the Public/Private Divide

The trajectory of health care rights litigation is also shaped, in fundamental ways, by the basic design of a country's health system – notably its reliance on private versus public financing and administration. For example, in countries that have adopted a managed competition model whereby universal access is achieved through heavy regulation of private for-profit health insurers, such as Colombia, there is a greater potential for litigation on the part of patients against such insurers. Under a managed competition scheme, laws and regulations stipulate a basic basket of coverage; but where insurers fail to meet these requirements, this results in conflicts with patients that may ultimately be litigated under the right to health. In Colombia, this basic dynamic has in the past contributed to a tsunami of health rights litigation, thanks in part to a low-cost and expeditious

34. Ferraz, "Lessons from Brazil", *supra* note 16 at 1667.

system of adjudication (so-called *tutela* hearings).³⁵

This expanded role for private for-profit insurers changes the basic complexion of health rights litigation, particularly vis-à-vis the worries about polycentrism and democratic legitimacy discussed above. In the Colombian context, courts may reason that the refusal of treatments by private insurers is motivated by profit, and less a reflection of polycentric tradeoff between the interests of all patients. Likewise, there is obviously little concern over the democratic legitimacy of judicial review of rationing decisions by private insurers. In some instances, Colombian courts have scrutinized the government-mandated basket of services, which has predictably been far more controversial, inviting accusations of ‘government by judges.’³⁶

Contrast this with Canada, where the *Canada Health Act*³⁷ stipulates that the financing of medically necessary care must be publicly administered. Given the driving concern about overreach, it is perhaps to be expected that Canadian courts would take a deferential approach under these circumstances, and indeed a degree of reticence is seen across other industrialized countries with (relatively) well-functioning tax-financed health systems.³⁸ In theory at least, when a Canadian patient is denied needed care, a government or a governmental agency has made the decision with a public interest mandate vision. As well, a far more expansive range of tradeoffs are at play as courts second guess resource allocation within a tax-financed system; resources redirected to health care may have to be drawn from a pool that supplies funding for many other vital government services. Finally, whereas Colombia’s *tutela* rulings typically impacted only the parties involved (although the sheer volume of claims ultimately had a systemic effect), judicial precedents related to publicly administered health systems will in theory have a broad and lasting impact – given that “[t]he nature of modern government means that justice for an individual will often require systemic measures that

35. Everaldo Lamprea, “Colombia’s Right-to-health Litigation in a Context of Health Care Reform” in Flood & Gross, *supra* note 18 at 131; Young & Lemaitre, *supra* note 18.

36. Young & Lemaitre, *ibid* at 189.

37. RSC 1985, c C-6 [CHA]

38. See generally Flood & Gross, *supra* note 18.

will deliver justice to much larger groups.”³⁹

Such contextual factors may partly explain Canadian courts’ reluctant and conservative approach to the recognition of health care rights, particularly by comparison to the hyper-individualized approach taken in some Latin American countries. Surface appearances can be somewhat misleading though: under tax-financed universal health systems, judicial approaches which on their face seem cautious and deferential – *e.g.* courts recognizing only negative rights in health care – can potentially have very disruptive effects. The Supreme Court of Canada’s much-criticized *Chaoulli* decision, discussed later, is a case in point.

C. Health Rights and Social Mobilization

It is widely recognized that broader social movements are often instrumental in the success or failure of health rights at every stage, from the launching of claims, through the litigation process, and in pressuring governments to honour their obligations in the wake of a successful court challenge.⁴⁰ Civil society groups can shape the outcome of health rights litigation in various ways, whether by promoting public awareness around an issue, lobbying governments to finance treatments or close access barriers, funding test litigation, participating in litigation as third party interveners and, in the event of a courtroom success, monitoring and reporting on government compliance with court orders.

The importance of social mobilization to success in the litigation of health rights is commonly illustrated with the example of HIV/AIDS activism, and the South African Constitutional Court’s (CCSA) decision in *Treatment Action Campaign*⁴¹ – arguably one of the world’s most discussed and celebrated health rights decisions to date.⁴² In *TAC*,

39. Roach, “Crafting Remedies”, *supra* note 9 at 49. But note discussion below of the less-than-systematic implementation of the Supreme Court of Canada’s *Charter* ruling requiring provision of interpretive services for deaf patients as they seek medically necessary care.

40. Siri Gloppen, “Litigation as a Strategy to Hold Governments Accountable for Implementing the Right to Health” (2008) 10:2 Health & Hum Rts 21.

41. *TAC*, *supra* note 23.

42. Lisa Forman & Jerome Amir Singh, “The Role of Rights and Litigation in Assuring More Equitable Access to Health Care in South Africa” in Flood

the CCSA interpreted the right to health care as requiring the South African government to expand access to a drug (nevirapine) used in preventing mother-to-child transmission of HIV. Prior to the litigation, activists had successfully lobbied the manufacturer to provide the drug free of charge, but the South African government nevertheless restricted its availability to certain test sites, citing *inter alia* safety concerns and the cost of complementary services (*e.g.* counseling services, formula milk). In rejecting these government justifications, the CCSA cited evidence that political pressures had already led to expanded provision of nevirapine in some regions, demonstrating that “provided the requisite political will is present, the supply of nevirapine at public health institutions can be rapidly expanded ...”⁴³ Moreover, the Court explained, the government’s recent infusion of nearly a billion rand in new funding for HIV treatment indicated that, “budgetary constraints ... are no longer an impediment.”⁴⁴

Social mobilization was instrumental to the *TAC*’s success story within the courtroom and beyond. Thus, for example, by building treatment literacy and pressuring drug makers to provide nevirapine at no cost, activists undermined government’s argument from resource constraints; by lobbying successfully for expanded delivery programs in some regions, activists demonstrated that the barriers to national rollout were political, and not resource-related; and social mobilization triggered the government’s decision to pre-emptively expand budgets for HIV treatments while the case was before the courts, further undermining the argument from resource constraints.

A comparison between *TAC* and *Grootboom and Others v Oostenberg and Others*⁴⁵ – another famous South African case related to housing rights – reveals how courtroom victories may ring hollow on the ground,

& Gross, *supra* note 18 at 288; Young & Lemaitre, *supra* note 18 at 215; Mark Heywood, “South Africa’s Treatment Action Campaign: Combining Law and Social Mobilization to Realize the Right to Health” (2000) 1:1 *Journal of Human Rights Practice* 14; Leslie London, “What is a Human-Rights Based Approach to Health and Does it Matter?” (2008) 10:1 *Health & Hum Rts* 65.

43. *TAC*, *supra* note 23 at para 119.

44. *Ibid* at para 120.

45. [2000] ZACC 19 [*Grootboom*].

absent effective and persistent social mobilization.⁴⁶ Eight years after her precedent-setting victory under the South African Constitution's right to housing, Irene Grootboom died in middle age, homeless and destitute.⁴⁷ Summing up the decision's ultimate impact, one commentator explains that, "no major shifts in housing policy have followed this test case, largely because of the lack of civil society pressure or a social movement in the area of housing."⁴⁸

Much the same difficulty has arisen where Canadian courts have recognized positive rights with respect to health care. In *Eldridge*,⁴⁹ the Supreme Court of Canada ruled that government's failure to provide interpretive services for deaf patients was an infringement of equality rights under section 15 of the *Charter*. Though disability activists greeted the decision as a major victory, implementation has been disappointing: to date British Columbia and Ontario have been the only provinces to comply with the ruling. Even in these provinces, medical interpretive services have been plagued by problems of underfunding and interpreter shortages.⁵⁰

Often, when this connection is drawn between social mobilization and the realization of health rights, a tactical lesson is drawn: activists seeking access to a given therapy through court challenges are advised to take a multi-pronged approach, building sustainable political momentum around their cause. Stepping back from that tactical advice, a bigger

46. Forman & Singh, *supra* note 42.

47. *Grootboom*, *supra* note 45; Pearlie Joubert "Grootboom dies homeless and penniless", *Mail & Guardian* (28 August 2008), online: Mail and Guardian <<http://www.mg.co.za/article/2008-08-08-grootboom-dies-homeless-and-penniless>>.

48. London, *supra* note 42 at 67.

49. *Eldridge*, *supra* note 28.

50. Colleen M Flood & YY Brandon Chen, "Charter of Rights & Health Care Funding: A Typology of Canadian Health Rights Litigation" (2010) 19:3 *Annals Health L* 479 at 489-94 and 509-18. The interplay between litigation and social mobilization is a two-way street. In some instances, headline-making cases draw public attention to an issue, potentially shifting public opinion and spurring change through political channels. This dynamic has been observed in Canada as well, as the Supreme Court's rulings on physician assisted suicide, IVF funding, and access to autism therapies have coincided with changing public attitudes on these issues.

picture question is whether – given its dependence on social mobilization – a rights-based approach to health care will tend to advance equity overall.

Effectiveness at social mobilization is, after all, partly a function of a constituency’s resources and political influence, raising the concern that health rights, insofar as their exercise requires societal backing, may tend to benefit comparatively advantaged groups.⁵¹ Some prominent critics of health rights have argued, for example, that groundbreaking progress around HIV/AIDS was due partly to that disease’s impact on middle and upper classes. They point to the fact that global spending on HIV/AIDS has vastly eclipsed spending on other diseases that more narrowly target the poor, killing in comparable numbers, such as malaria and tuberculosis.⁵²

Of course, concerns about health care resources flowing on the basis of ‘ability to mobilize’ can arise even without the courts’ involvement. For example, in New Zealand’s drawn-out debate over public funding for the breast cancer drug Herceptin, the courts sided with the country’s Pharmaceutical Management Agency (PHARMAC), ruling that the latter’s decision to limit funding for the drug to a nine-week regimen was reasonable, and rejecting the claimant’s demand for a twelve-month regimen.⁵³ Following that ruling, however, a new government came to power, and delivered on its election promise to extend funding for Herceptin to twelve months, overriding PHARMAC’s decision that this could not be justified under the country’s guidelines for rationing.⁵⁴

A related concern is that public attention and social mobilization is often stirred by a ‘rescue imperative’ – focusing on discrete health issues for which effective therapies are available. With the development of effective

51. *Ibid* at 71.

52. Roger England, “The Dangers of Disease Specific Programmes for Developing Countries” (2007) 335:7619 *Brit Med J* 565; William Easterly, “Human Rights are the Wrong Basis for Health Care”, *Wall Street Journal* (12 October 2009). See generally Julia H Smith & Alan Whiteside, “The History of AIDS Exceptionalism” (2010) 13:47 *Journal of the International AIDS Society* 1.

53. *Walsh v Pharmaceutical Management Agency*, [2008] NZHC 44.

54. Joanna Manning, “Litigating a Right to Health Care in New Zealand” in Flood & Gross, *supra* note 18 at 19.

anti-retroviral medicines, the HIV/AIDS epidemic came to fit this description and became a candidate for effective social mobilization and judicial intervention in the South African context. It is not clear that the most pressing health inequities in the Canadian context fit this framing. For example, the appalling disparity in health outcomes experienced by Canada's Aboriginal population, or the country's growing epidemic of non-communicable diseases, will not be addressed by expanding access to particular pharmaceuticals. Will the public rally around a rights-based framing of these complex multi-factorial challenges? Are the courts in any position to devise and enforce effective remedies?

IV. Health Care Rights in the Canadian Context

To this point we have seen the central dilemma facing courts in adjudicating health rights (*i.e.* a concern about overreach), and discussed various contextual factors that further shape the prospects for health rights litigation – including factors that partly explain Canadian courts' deferential approach to date. Of course, deference can take many forms, and so a further question is whether Canadian courts, in addressing claims concerning the right to health care, have drawn lines of deference in the right places. To explore that question, we provide an overview of health litigation under the *Charter*, specifically under sections 7 and 15.⁵⁵ It will be argued that in drawing these lines, Canadian courts have favoured formalism over substantive fairness: broadly speaking, a hard line has been drawn, interpreting the section 7 right to life and security of the person as a 'negative' right, while the section 15 equality right has been read as guaranteeing only 'access to the basket' of care committed to statutorily by provincial insurers. One can acknowledge that the Canadian context calls for a degree of judicial deference while questioning the wisdom of this path. Courts in other similarly situated countries, such as the UK, have had success at holding governments

55. Canadians have other options for litigating issues of access to health care (*e.g.* administrative law review). For a brief overview of the options available to patients refused care in Ontario, see Colleen M Flood, Carolyn Tuohy & Mark Stabile, "What Is In and Out of Medicare? Who Decides?" in Colleen M Flood, ed, *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006) 15 at 17-30.

accountable for reasonable decision-making in health care.

A. Focus on ‘Negative’ Rights

In the Canadian context, judicial oversight of health care resource allocation has been avoided in part by construing the *Charter’s* section 7 guarantee of ‘life, liberty and security of the person’ as protecting only negative rights. In most cases where Canadian claimants have secured health care related victories through litigation, the prize has been a negative right – for example, overturning restrictions on access to abortion services, safe injection sites and medical marijuana.⁵⁶ This approach can perhaps be defended as a plain reading of the Canadian *Charter*, which as explained, differs from other modern bills of rights in its focus on standard civil and political rights to the exclusion of explicit social and economic rights. At times the Supreme Court of Canada has stated explicitly that the *Charter* grants no positive right to health care, as in this passage from its unanimous 2004 ruling, *Auton v British Columbia*: “[t]his Court has repeatedly held that the legislature is under no obligation to create a particular benefit.”⁵⁷

As many commentators have noted, recognition of a negative right to a particular therapy does little to advance equitable access. Evidence suggests, for example, that access issues worsened in the years following the *Morgentaler* decision, as the number of hospitals offering abortion

56. *R v Morgentaler* [1988] 1 SCR 30 (access to abortion) [*Morgentaler*]; *Canada (Attorney General) v PHS Community Services Society*, 2011 SCC 44 (safe injection sites) [*PHS*]; *R v Parker* (2000), 49 OR (3d) 481 (CA) (medical marijuana). See Flood & Chen, *supra* note 50 at 494.

There have also been a handful of *Charter* challenges to criminal laws impacting health rights, but which do not implicate access to health care *per se*: *Canada (Attorney General) v Bedford*, 2013 SCC 72 (challenging prostitution laws as an infringement of security of the person); *R v Mabior*, 2012 SCC 47 (challenging criminal law provisions requiring disclosure of HIV status).

57. *Auton (Guardian ad litem of) v British Columbia (Attorney General)*, 2004 SCC 78 at para 41 [*Auton*]. See also Chief Justice McLachlin’s comment in *Chaoulli*, *supra* note 5 at para 104 that the *Charter* “does not confer a free standing constitutional right to health care.” In other contexts, the Court has expressed an openness in principle to recognizing positive rights under s 7. See *Gosselin v Quebec (Attorney General)*, 2002 SCC 84.

services declined, forcing many women to incur out-of-pocket expenses traveling to receive the service out of province, or in private clinics.⁵⁸ In countries such as Canada, where citizens rely largely on the state for the financing and governance of health systems, overturning state-imposed obstacles can at best be a first step towards ensuring equitable access.

A deeper concern relates to the insidious effect that negative rights may have when used to challenge laws that promote overall equity. The Supreme Court long ago acknowledged this risk, with Chief Justice Dickson famously writing in an early *Charter* ruling that, “[i]n interpreting and applying the *Charter* ... the courts must be cautious to ensure that it does not simply become an instrument of better situated individuals to roll back legislation which has as its object the improvement of the condition of less advantaged persons.”⁵⁹ Yet this cautionary note was seemingly thrown to the wind with the 2005 decision, *Chaoulli v Quebec*.⁶⁰ There, the co-plaintiffs alleged that, given wait times in the public system, Quebec’s ban on private insurance breached patients’ rights to life and security of the person, under both section 1 of Quebec’s *Charter of Human Rights and Freedoms*⁶¹ and section 7 of the Canadian *Charter*. In a 4-3 decision, the Supreme Court agreed with the petitioners and repudiated the prohibition of private insurance on the basis of the Quebec *Charter*. In their reasoning, the majority relied upon on a crude international comparison of health systems to conclude that the allowance of a parallel private sector would not necessarily undermine the quality of the public health care regime.⁶² Three of the four majority judges in *Chaoulli* also found the legislative prohibition in question to have infringed section 7 of the *Charter*.

Many were surprised at the Court’s willingness to wade into the complex policy issues raised in *Chaoulli*, particularly in light of the

58. See Flood & Chen, *supra* note 50; Sanda Rodgers, “Abortion Denied: Bearing the Limits of Law” in Flood, *supra* note 55 at 107.

59. *R v Edwards Books and Art Ltd*, [1986] 2 SCR 713 at para 136.

60. *Chaoulli*, *supra* note 5.

61. RSQ c C-12, (“[e]very human being has a right to life, and to personal security, inviolability and freedom,” s 1).

62. See Colleen M Flood, “Chaoulli: Political Undertows and Judicial Riptides” (2008) Health LJ at 211 (for a thorough discussion on the flaws of the Supreme Court’s international comparative exercise).

deference shown in earlier rulings in this area.⁶³ Kent Roach has suggested that what distinguished the *Chaoulli* claim, from the Court's perspective, was precisely the negative remedy sought:

The simplicity of the remedy requested by the Charter applicants made their substantive claims attractive to the majority ... The applicants in this case asked for a simple, traditional and easy to enforce remedy. They did not ask the courts to declare that governments had to provide new health care services ... let alone retain jurisdiction to ensure systemic compliance with the Charter ...⁶⁴

This brings us back, in essence, to the basic dilemma concerning the courts' institutional competence, discussed in Part I above. It is easier for courts to strike down law and policy than to oversee its implementation, which does not bode well for the prospects of health rights litigation addressing the needs of disadvantaged groups who depend on government services.

As it happens, *Chaoulli* was the first battle in a larger war to create opportunities for more private financing of medically necessary care and similar litigation is now occurring across Canada. In Alberta, claimant William Murray is currently pursuing a class action against the province for damages he allegedly sustained from the denial of access to a hip replacement procedure under the public health insurance plan. He argues that the denial of public coverage, in conjunction with sections of the *Alberta Health Care Insurance Act*⁶⁵ that prevent treatment access outside of the government-run regime, violates his rights under section 7 of the *Charter*.⁶⁶ An ongoing case initiated by claimants Lindsay McCreith and Ms. Shona Holmes points to wait time problems in Ontario, and calls into question the constitutionality of provincial regulations designed to suppress the expansion of the private health care sector.⁶⁷ A private for-profit clinic, Cambie Surgeries Corporation (Cambie), is contesting the constitutionality of similar provisions under British Columbia's *Medicare*

63. Sujit Choudhry, "Worse than *Lochner*?" in Flood, Roach & Sossin, *supra* note 7 at 76.

64. Roach, *supra* note 7 at 184.

65. RSA 2000, c A-20.

66. *Murray v Alberta (Minister of Health)*, 2007 ABQB 231 at paras 21-22.

67. *McCreith v Ontario (Attorney General)* (5 September 2007), No 07-CU-339454PD3 (Ont Sup Ct) Statement of Claim.

Protection Act.⁶⁸ Cambie is represented by Dr. Brian Day, a past president of the Canadian Medical Association (CMA).⁶⁹

Of late, some more hopeful prospects have emerged in section 7 jurisprudence. In the recent case *Canada v PHS Community Services*,⁷⁰ the issue was whether section 7 was engaged by the federal Minister of Health's withdrawal of an exemption, which had previously allowed the Insite safe injection facility to operate without fear of criminal prosecution under the *Controlled Drugs and Substances Act*.⁷¹ There the majority found that rights to life, liberty and security of the person were engaged by the Minister's decision – forcing as it would the clinic's clientele to dangerous back-alley injection practices.⁷² Continuing with its section 7 analysis, the Court then explored whether the Ministerial decision had been made “in accordance with principles of fundamental justice,” citing evidence of the clinic's success in saving lives to conclude that withdrawal of the exemption was arbitrary and grossly disproportionate.⁷³ Strictly speaking, the claimants in *PHS* secured a negative right, but the decision signals a new willingness on the part of the Court to probe the evidence supporting government decisions to *withdraw* access to health services. Might this precedent carry over to cases where governments attempt to withdraw *funding* for health care programs?

The question may receive an answer in litigation currently underway at the Federal Court, challenging the federal government's recent decision

68. RSBC 1996, c 286.

69. *Cambie Surgeries Corp v British Columbia (Medical Services Commission)*, 2010 BCCA 396. This case is part of an early round of this constitutional battle concerning the ability of the Medical Service Commission to audit Dr. Day's clinic. The audit sampled 468 services provided by two private clinics (Cambie and Specialist Referral Clinic) and found that almost half were illegally billed. See Ministry of Health, Audit & Investigations Branch, *Specialist Referral Clinic (Vancouver) Inc and Cambie Surgeries Corporation Audit Report* (Vancouver: Ministry of Health, Audit and Investigations Branch, 2012), online: BC Ministry of Health <<http://www.health.gov.bc.ca/msp/legislation/pdf/srcsc-audit-report-2012.pdf>>.

70. *PHS*, *supra* note 56.

71. SC 1996, c 19.

72. *PHS*, *supra* note 56 at para 93.

73. *Ibid* at paras 129-33.

to claw back the long-standing *Interim Federal Health Plan*.⁷⁴ Under the new rules, health care coverage for certain categories of refugee claimants is limited to ‘urgent and essential’ care, while others will receive coverage only if their health status poses a threat to public health. The claimants argue, *inter alia*, that the withdrawal of coverage endangers the affected refugees’ section 7 interests – most cannot afford private insurance, and so run the risk of being denied life-saving treatment. The claimants acknowledge that the *Charter* does not confer a positive right to health care, but cite *PHS* to argue that government decisions withdrawing access to care must accord with principles of fundamental justice (*i.e.* avoid arbitrariness and gross disproportionality).⁷⁵

B. Equality of ‘Access to the Basket’

Claimants have used the *Charter*’s section 15 guarantee of “equal benefit of the law without discrimination” to press for access to health goods and services denied under provincial insurance plans. Section 15 does not aim to prevent unequal benefits *per se*, as governments inevitably draw distinctions in the provision of services.⁷⁶ The equality guarantee bars only wrongful forms of discrimination, which deprive individuals of the benefits of the law on the basis of “race, national or ethnic origin, colour, religion, sex, age or mental and physical disability,” along with analogous grounds such as sexual orientation. Canadian courts have disavowed a formalistic approach to the equality guarantee, instead requiring governments to “take into account the underlying differences between individuals in society,”⁷⁷ adjusting laws to achieve substantive equality.

74. *Canadian Doctors for Refugee Care v Attorney General or Canada (Minister of Citizenship and Immigration)* (30 October 2013), T-356-13 (FC) (Memorandum of Fact and Law of the Applicants) online: Justice for Children and Youth <http://www.jfcy.org/PDFs/IFHP_Memo_CDRC_CARL.pdf>.

75. Rather than breaking new ground under s 7, the court may opt to decide this case under s 15, as the new regime discriminates against refugees on the basis of their country of origin.

76. “It must be recognized ... that every difference in treatment between individuals under the law will not necessarily result in inequality ...”: *Andrews v Law Society of British Columbia*, [1989] 1 SCR 143 at 164.

77. *Law v Canada (Minister of Employment and Immigration)*, [1999] 1 SCR

While the equality guarantee does not ground a positive right to health care, it may oblige governments to take positive steps to ensure that citizens enjoy equal benefit of established health systems. The singular instance where Canadian courts have recognized a positive obligation on the part of governments to provide health-related services arose under the rubric of equality rights. In *Eldridge v British Columbia*, the Supreme Court ruled that the government's non-funding of sign language interpretation services at public hospitals violated the equality rights of the province's deaf population.⁷⁸ At the time, many had hoped that the Court's unanimous ruling in *Eldridge* might open the door to increased judicial scrutiny of issues of health care accessibility. In the years that followed, claimants drew on the precedent to argue that non-funding of autism therapies⁷⁹ and *in vitro* fertilization⁸⁰ also infringed the right to equality.

From the outcome of these later decisions, though, it appears that the *Eldridge* precedent applies narrowly, guaranteeing only equal 'access to the basket' of health care services deemed 'medically necessary' by government decision-makers. Nola Ries explains the limiting principle at play here: "the *Eldridge* claim is like a wheelchair user asking a library to build a ramp so she may gain access to the books in the library that are available to patrons who can walk up the stairs. In contrast, *Eldridge* is not like the disabled patron asking the library to purchase new books to put on the shelves."⁸¹

The access to the basket principle was deployed in *Auton*, as the Supreme Court ruled unanimously that non-funding of ABA/IBI autism therapies did not infringe the petitioner's section 15 equality rights.

497 at para 25.

78. *Supra* note 28. See also *Moore v British Columbia (Education)*, 2012 SCC 61 (drawing on the *Eldridge* precedent to find that the closure of a Diagnostic Centre for students with learning disabilities created a discriminatory barrier to public schooling, under the BC *Human Rights Code*).

79. *Auton*, *supra* note 57.

80. *Cameron v Nova Scotia (Attorney General)* (1999), 204 NSR (2d) 1.

81. Nola M Ries, "Charter Challenges" in Jocelyn Downie, Timothy Caulfield & Colleen M Flood, eds, *Canadian Health Law and Policy* (Markham: LexisNexis Canada, 2011) 615 at 628-29.

There, the Court explained that neither the *Canada Health Act*,⁸² nor the relevant British Columbia legislation,⁸³ promised funding for ‘non-core’ services. Legislation instead left it to the discretion of the province’s Medical Services Commission to designate particular practitioners and procedures for non-core funding, and ABA/IBI therapy had not been so designated. Thus Chief Justice McLachlin differentiated *Auton* from *Eldridge* by noting that, “*Eldridge* ... was concerned with unequal access to a benefit that the law conferred and with *applying* a benefit granting law in a non-discriminatory fashion. By contrast, [*Auton*] is concerned with access to a benefit that the law has not conferred.”⁸⁴

In effect, the ‘access to the basket’ principle does for section 15 what the ‘negative rights’ reading does for section 7, carving down the right’s scope to align with the basic premise that “... the legislature is under no obligation to create a particular benefit.”⁸⁵ Ultimately, of course, this traces back to the concern about overreach; as Sujit Choudhry puts it,

[t]his reasoning is so difficult to defend that the only way to read *Auton* [is] as having created a political questions doctrine around the scope of the Medicare envelope. The clear message from the Court was that the Court did not wish judges to be drawn into adjudicating upon the design of Medicare on a case-by-case basis, a task for which they are poorly qualified.⁸⁶

A basic concern here is that the ‘access to the basket’ principle offers questionable guidance for achieving substantive equality. Consider even the conclusion reached in the library analogy, namely, that equality is achieved provided that disabled people have physical access to the collection. Surely, though, a commitment to substantive equality must have some bearing on a library’s basket of offerings – *e.g.* the availability of

82. *Supra* note 36.

83. *Medicare Protection Act*, RSBC 1996, c 286.

84. *Auton*, *supra* note 57 at para 38 [emphasis in the original].

85. *Ibid* at para 41. There are other elements to s 15, including the requirement that claimants articulate an appropriate comparator group, and show harm to dignity. We sidestep these issues for two reasons: (1) The ‘access to the basket’ principle arises at an earlier stage in the court’s analysis, meaning that these other criteria will seldom be determinative in s 15 claims involving Medicare rationing; (2) These later stages of s 15 analysis have been overhauled in recent decisions. See *R v Kapp*, 2008 SCC 41 and *Withler v Canada (Attorney General)*, 2011 SCC 12.

86. Choudhry, *supra* note 63 at 93.

books written in braille. The reality is that many of the gravest threats to equity in Canadian health care stem precisely from decisions about what to include in the basket. Canada currently has roughly a 70:30 mix of public to private funding for health care, behind most comparable OECD countries.⁸⁷ That outsized component of privatized care covers many indispensable elements of modern health care, including prescription drugs, dental care, and long-term care.⁸⁸ Their exclusion from the public basket does not necessarily reflect careful and transparent deliberation over relevant tradeoffs. For example, the omission of prescription drug and long-term care coverage is largely a vestige of Canadian Medicare's 1960s origins – a time when drugs accounted for a much smaller portion of health care spending, and health care was largely provided by physicians and/or in hospitals. Technological advancements and an aging population have meant that those excluded components have grown as a percentage of overall health spending, resulting in passive privatization. Meanwhile, year-to-year decisions over what physician services are included under provincial plans appear to be largely the byproduct of annual fee negotiations between provinces and their respective provincial medical associations – a process biased towards preserving the *status quo*, and liable to be influenced by non-medical considerations.⁸⁹ In short, the 'access to the basket' principle arguably insulates serious and systemic inequalities from rights scrutiny, in formalistic deference to legislative decision-making, which appears variously complacent, opaque and non-evidence-based.

87. William Lahey, "Medicare and the Law: Contours of an Evolving Relationship" in Downie, Caulfield & Flood, *supra* note 81 at 6.

88. Although not required to do so under the *Canada Health Act*, provinces do provide coverage for prescription drugs, home care, etc. however coverage varies significantly from province to province. See Virginie Demers et al, "Comparison of provincial prescription drug plans and the impact on patients' annual drug expenditures" (2008) 178:4 *Can Med Assoc J* 405; Vishnu Kapur & Kosalaya Basu, "Drug coverage in Canada: who is at risk" (2005) 71:2 *Health Policy* 181.

89. Flood, Tuohy & Stabile, *supra* note 55.

V. A Middle Road of Reasonableness Review?

Perhaps it is time that Canadian courts change tack and play a more active role in holding governments accountable for decisions about what to include in the Medicare basket. As Jackman notes, “every major health system review undertaken in Canada over the past decade has concluded with a call for improved health care accountability,”⁹⁰ yet it remains unclear from whence this accountability will originate. At a macro level, the federal government is ostensibly charged with ensuring that provinces comply with principles of comprehensiveness, universality and so on, backed by the threat of financial penalties as authorized by the *Canada Health Act*. Yet the only enforcement action taken by the federal government to date has been with respect to user fees and extra-billing, and even on this score, there has been growing passivity.⁹¹ A key problem here is that the only available enforcement mechanism under the *CHA* – withholding of federal transfers – is likely to exacerbate problems associated with wait times and rationing.

Rather than start from the premise that the Constitution does not confer a free standing constitutional right to health care, courts might begin with a basic recognition that comprehensive and universal public health care are in fact the embodiment of *Charter* values. This might entail opening the door further to positive health rights claims, placing the onus on government to justify denials of care and, where necessary, applying deference at a later stage of analysis. In this way, courts could assist with developing precedents and guidelines that support reasonable, accountable decision-making across the system as a whole, rather than through a blinkered focus on negative rights and ‘access to the basket.’

A potential advantage of such a shift is that it would provide a much-needed counter-balance against regressive *Chaoulli*-style claims. As the issue of access to private insurance for medically necessary care was framed under the existing doctrinal paradigm, the claimant’s section 7 rights were balanced against ‘mere’ policy objectives (*i.e.* maintaining Medicare’s universality) with predictable results: given the complex

90. Jackman, “Charter Review”, *supra* note 25 at 29.

91. Lahey, *supra* note 87 at 48-50.

and uncertain causal dynamics within health systems, governments faced a formidable challenge in *proving* that a ban on private insurance was necessary for the protection of the public tier. Yet surely it is more consonant with *Charter* values, and Canadian public opinion, to frame this as a question of ‘reconciling’ the negative rights of those demanding privately financed care against the positive rights of those dependent on Medicare. In concrete terms, reframing this as an issue of reconciling rights would increase the evidentiary burden on those asserting negative health care rights in a way that threatens principles of universality and solidarity. As Justice Iacobucci has explained,

Under s. 1, the state must justify a violation of an individual’s Charter rights. When reconciling competing Charter rights, on the other hand, a court seeks to reconcile the constitutionally guaranteed rights of one individual with those of another. Consequently, the onus of proof in each of these cases plays out somewhat differently. Under section 1, the party challenging the impugned law must establish a *prima facie* encroachment of a Charter right. The state then bears the serious onus of defending or justifying the violation ... In the reconciling context, there is no rule about onus *per se*.⁹²

The concern of course will be that recognition of positive rights in this context opens a Pandora’s box, leading to the courts micromanaging Medicare. Really though, the question is not *whether* courts should be deferential in adjudicating rights to health care, but *how* that line of deference should be drawn. Experience from similarly situated countries suggests that courts can play an important oversight role without micromanaging health care policy. Short of ordering funding for particular therapies, courts can scrutinize the *process* by which rationing decisions are made, and through evolving jurisprudence, develop guidelines, tests and criteria to ensure ongoing accountability in this regard.⁹³ For example, the ‘Hard Look’ judicial review approach, which has emerged over the past decade in UK administrative law jurisprudence, focuses on ensuring that decision-making processes adhere to principles of procedural fairness, and considers all relevant factors while excluding

92. Justice Frank Iacobucci, “Reconciling Rights’: The Supreme Court of Canada’s Approach to Competing Charter Rights” (2003) 20 Sup Ct L Rev (2d) 137 at 141-42.

93. Lorne Sossin, “Towards a Two-Tier Constitution? The Poverty of Health Rights” in Flood, Roach & Sossin, *supra* note 7 at 172.

irrelevant ones.⁹⁴ Reviewing individual claims, courts look to ensure that the decision-making process has attended to the nature and seriousness of the illness; the cogency of the evidence that the treatment works; the extent and likelihood that it will work in *this* patient; the extent of improvement it might be expected to provide; and the absolute cost of the treatment.⁹⁵ Chris Newdick explains that judicial prodding, focusing on these factors, has incrementally driven improved accountability across the National Health Service (NHS) as a whole – culminating in the codification of guidelines in an NHS Constitution:

The number of cases was limited and, at least at first, their impact on the NHS as a whole was small. However ... as the cases accumulated, they exercised greater influence collectively. As the consistency of the courts' response made the giving of legal advice to health authorities more straightforward (and legal case became increasingly newsworthy), the government responded by publishing the NHS Constitution ... which reduces the cases to a single code of good practice and cements patients' rights.⁹⁶

VI. Conclusion

The aspiration of health care rights is to improve the health of all but particularly to improve upon the health of the most vulnerable. Recognizing health care rights in developing and middle-income countries may be a galvanizing force for progressive changes, supporting and nurturing a radical shift in how resources are allocated to ensure better access for the most vulnerable. But this is not a linear task, and assuming that litigation of health care rights can achieve this goal underestimates the complexity of dealing with issues such as access to justice, the prospect that litigation can distort the socially fair allocation of public resources, the appropriate respective role for courts and governments in health care decision-making and the need for public and policy support for any particular judgment to be implemented on the ground.

In the Canadian context, courts have taken a very conservative approach to the question of health care rights and in only one section 15

94. Chris Newdick, “Promoting Access and Equity in Health: Assessing the National Health Service in England” in Flood & Gross, *supra* note 18 at 118-19 [forthcoming].

95. *Ibid.*

96. *Ibid* at 122.

case has the Supreme Court found that a government should publicly fund a treatment. In all other relevant cases, the Court has only found a “negative” right in the sense of requiring that government laws or policies acting as barriers to the consumption of health care be removed. This conservative approach has now even gone so far as to uphold a challenge to provincial laws banning private health insurance, passed in order to ensure equity and universality in Canadian Medicare. We think the Court has now passed beyond the boundary of showing deference to governmental decision-making in not interpreting section 7 positive rights and crossed the void into attacking values that we see at the core of the *Charter* – equality, access and universality in public Medicare. We recommend that Canadian courts consider, in future *Charter* challenges to public Medicare, that the issue is one of competing rights; any right a petitioner may have to access private care must be weighed against the rights of other Canadians to enjoy a universal, access and equitable public health care system. This would at least attenuate to some degree the extent to which governments are tasked with the near-impossible task of adducing empirical evidence to show that there are no lesser means by which goals of equity, universality and access can be achieved in the Canadian context. Further, we would support that most health care cases be reviewed first through administrative law on grounds that this approach – requiring fair and transparent processes in government decision-making and overall reasonableness of the final decision – is by far the best way for courts to play a role in realizing Canadians’ rights in health care.