

The Right to Health Care

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They have needs, and because they live within a welfare state, these needs confer entitlements—rights—to the resources of people like me. Their needs and their entitlements establish a silent relation between us. As we stand together in line at the post office, while they cash their pension cheques, some tiny portion of my income is transferred into their pockets through the numberless capillaries of the state. The mediated quality of our relationship seems necessary to both of us. They are dependent on the state, not upon me, and we are both glad of it . . . My responsibilities towards them are mediated through a vast division of labour When they can't go on, an ambulance will take them to the hospital, and when they die, a nurse will be there to listen to the ebbing of their breath. It is this solidarity among strangers, this transformation through the division of labour of needs into rights and rights into care that gives us whatever fragile basis we have for saying that we live in a moral community.¹

Introduction

In an atmosphere of heightened public concern over the erosion of the public health care system in Canada, establishing a right to health care has taken on an urgent quality for Canadian legal scholars and human rights activists. This contemporary public fervour has pushed Canadians into a philosophical battle over the right to health care that has been waged internationally for quite some time.² The existence of a human right to health care continues to be a topic of heated debate among academics despite the fact that such a right has been recognized in several international instruments, most notably the *International Covenant on Economic, Social and Political Rights*.³ But a human right, even one supported by international law, is not a legal right—it is not justiciable, and thus cannot be used as a tool by Canadian citizens who want to be proactive in improving and maintaining the quality of their public health care. While an overview of the

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¹M. Ignatieff, *The Needs of Strangers: An Essay on Privacy, Solidarity and the Politics of Being Human* (New York: Penguin Books, 1986) at 10.

²Indeed, most coherent 'isms' known in the western world have been vigorously applied to the issue of the existence of a right to health care at one time or another, to varying degrees of success – or failure, depending on the outcome hoped for. See T.J. Bole III & W.B. Bondeson, eds., *Rights to Health Care* (Boston: Kluwer Academic Publishers, 1991).

³16 December 1966, 993 U.N.T.S. 3; Can. T.S. 1976 No. 46 (ratified by Canada on 19 May 1976).

philosophical debate between libertarians and economic theorists on one hand, and egalitarian theorists on the other, is an appropriate starting point for an attempt to locate a legal right to health care in Canada, it is Canadian health law jurisprudence that will ultimately furnish human rights activists with the tools they seek. Under the *Canada Health Act*,⁴ the Canadian Federal Government has undertaken to provide Canadians with universal, free health care. The task for Canadian health care activists is to engage existing constitutional apparatus in the struggle to influence health care resource allocation decisions. Sections 7 and 15 of the *Charter of Rights and Freedoms*⁵ appear to be promising constitutional tools available for use in enforcing positive, socio-economic rights to health care in Canada.

There is No “Right” to Health Care: Libertarian and Economic Theories

An overview of the libertarian approach to health care provides a good framework for understanding the kind of claim socio-economic rights, such as the right to health care, make on society in general and governments in particular. By accepting only “negative” rights as true rights and rejecting claims of “positive” rights, libertarians are able to make quick cognitive work of claims to health care. K. Selick explains the classical liberal understanding of positive and negative rights as follows:

Over the past four centuries, western liberal democracies have viewed rights primarily as protective mechanisms. A right is like an invisible wall keeping us safe from the interference of others. . . . The right to life, for example, simply meant the right not to have one’s life taken away—the right not to be killed—by others. It did not mean the right to require others to give one the means of sustenance.⁶

Rights—that is, negative rights—require only non-interference from other people and the government. To say that positive rights exist implies a corresponding duty to actively support the right claimed. According to the libertarian view, such a claim on the autonomy of other human beings is more properly characterized as a privilege and not a right.

J. Waldron offers an attack on this classic liberal theory of rights by pointing out that in terms of a person’s right to non-interference from the government,

⁴R.S.C. 1985, c. C-6.

⁵Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [hereinafter the *Charter*].

⁶“Rights and Wrongs in the Canadian Charter” in A.A. Peacock, ed., *Rethinking the Constitution: Perspectives on Canadian Constitutional Reform, Interpretation, and Theory* (Don Mills, Ontario: Oxford University Press, 1996) 103 at 104.

[t]he fact that the government itself does not persecute him does not mean his rights are being adequately taken care of. Similarly his freedom from arbitrary arrest and imprisonment is not vindicated if the government restrains only the kidnappers in the ranks of its own officials. . . . So it is not true to say that the traditional liberal rights require from governments nothing more than omissions whereas modern socio-economic rights involve costs. All rights—even rights to liberty—are costly to uphold.⁷

It follows from this that while the libertarian approach separates negative rights (civil and political rights) and positive rights (economic and social rights) into separate camps based on the claims they make on the autonomy of other human beings, this distinction is highly artificial. Be that as it may, the claims of entitlement resulting from recognition of positive rights *necessarily* bring a claiming individual “into conflict with at least one other human being In fact, positive rights effectively give some people the right to violate the rights of others.”⁸ Such a violation of other people’s negative rights could be said to occur when a “right” to basic universal health care coverage means that the government must tax the rich in order to give to the poor.

L. Peikoff is a particularly vocal critic of the recognition of a positive right to health care in the United States.⁹ In his view, such a right is not only illegitimate, but immoral for the following reasons:

Observe that all legitimate rights have one thing in common: they are rights to action, not to rewards from other people. The American rights impose no obligations on other people, merely the negative obligation to leave you alone. The system guarantees you the chance to work for what you want – not to be given it without effort by somebody else. The right to life does not mean that your neighbors have to feed and clothe you; it means you have the right to earn your food and clothes yourself. . . . you have no right to the actions or products of others except on terms to which they voluntarily agree. . . nobody has the right to the services of any professional individual or group simply because he wants them and desperately needs them.¹⁰

Simply put, a need does not create a right. M. Faria, Jr. takes this reasoning a step further by emphasizing that “[h]ealth care is not a right, just as there are no rights

⁷“Nonsense Upon Stilts? - a reply” in J. Waldron, ed., *Nonsense Upon Stilts: Bentham, Burke and Marx on the Rights of Man* (Methuen: New York, 1987) 151 at 157.

⁸Selick, *supra* note 6 at 105.

⁹“Health Care is Not a Right” (Town Hall Meeting on the Clinton Health Plan, Costa Mesa, California, 11 December 1993), online: <<http://www.bdt.com/pages/Peikoff.html>> (date accessed: 23 March 2001).

¹⁰*Ibid.*

to shelter (housing), clothing, food, or a paid vacation to Acapulco or Miami Beach. In essence, no individual is entitled to the services or the fruits of another's labor without just compensation. Physicians should be free to offer their services free of government coercion."¹¹ This kind of inflexible and impersonal dismissal of positive or welfare rights has prompted some proponents of positive rights to comment:

The argument that health care is not a right but a service which must be paid for inevitably comes from those in society who are secure in the knowledge that they can afford to pay for this service and who are not troubled by the thought that there are others who are unable to do so. No doubt such persons will also insist that their treatment is conducted according to high standards. But, in supporting their important individual rights as patients, let us not forget those at the poorer end of society whom they are prepared to leave behind.¹²

This criticism is to a certain degree unfair. Libertarianism does not reject the impulse to aid the poor and the destitute of society, it simply argues that voluntary charity, not government-enforced charity, must answer to the moral claims of the needy.

R. A. Epstein, in *Mortal Peril: Our Inalienable Right to Health Care*, offers a somewhat softer libertarian approach to the issue of a right to health care by appealing to economic principles.¹³ In his view, the market—as it consists of voluntary “win/win” transactions in the form of freely entered into contracts between doctors and patients—is the only truly trustworthy foundation upon which to build a health care system.¹⁴ Let the market forces work their magic in order to increase access, quality and affordability of health care for the majority of society, Epstein says, and let voluntary charity account for the “hard cases”:

These all too human emotions do some good in helping the unfortunate, but they misunderstand the connection between charity and justice. Charity has to come from the physician . . . it cannot be compelled by

¹¹“Is There a Right to Health Care?” (1999) 4:4 Medical Sentinel 125 at 126, online: <<http://www.haciendapub.com/article22.html>> (date accessed: 23 March 2001). Dr. Faria is a consultant neurosurgeon and author of *Vandals at the Gates of Medicine* (Macon, Georgia: Hacienda Publishing, 1995) and *Medical Warrior: Fighting Corporate Socialized Medicine* (Macon, Georgia: Hacienda Publishing, 1997). See also L.R. Huntoon, “Health Care and the ‘Distributive Ethic’ -- ‘Natural Rights’ vs. Socialism” (1999) 4:5 Medical Sentinel 177, online: <<http://www.haciendapub.com/huntoon3.html>> (date accessed: 27 November 2001).

¹²J.A. Hayes, “Health Care as a Natural Right” (1992) 11 Med. & L. 405 at 414. See also D. Giesen, “Health Care as Right: Some Practical Implications” (1994) 13 Med. & L. 285.

¹³(Don Mills, Ontario: Addison-Wesley Publishing, 1997).

¹⁴*Ibid.* at 44.

any court conscious of the long-term dislocations its decision might bring. . . . Systems of voluntary compassion are sustainable because the dimensions of the program are limited by the willingness of its supporters to give of their own resources, not those of others. No one should be against compassion. But everyone should be on guard against conscripting others into their compassionate causes.¹⁵

While Epstein's capitalist view is appealing in its simplicity, it does not take into account the reality of market failure or, in other words, the failure of voluntary charity:

Collective charity efforts, like other collective ventures, may founder if contribution is left strictly voluntary. The most familiar difficulty is the free-rider problem. Even if each potential contributor to a good whose production requires a collective effort recognises the importance of producing it, so long as contribution is not enforced, each may elect not to contribute, since contribution is a cost to him, if he believes that either enough others will contribute to achieve the good or they will not, regardless of whether he contributes.¹⁶

Moral free-riding occurs when a society recognizes the societal value or inherent "good" of responding to an apparent need but fails to bear equally the burden of that response. For instance, moral free-riding is inherent in both Epstein's and Faria's recognition that while there is a need for free medical services for the poor, only doctors themselves, on a voluntary basis, should bear the burden of responding to that need.

The failure of libertarianism and economic theory to deal with the issues of market failure and the inadequacy of voluntary charity can be overlooked only if a person feels in no way responsible for answering to the needs of other human beings. Indeed, "[t]he conservative counter-attack on the welfare state is above all an attack on the idea that . . . needs make rights; an attack on this idea puts into question the very notion of a society as a moral community."¹⁷ W. K. Mariner points out that the economic, libertarian account "depends upon two controversial assumptions: (1) everyone morally deserves the talents, intelligence, health status, and wealth he or she begins with, so that all voluntary trades are fair and just by definition; and (2) health care is no more important than ordinary commercial goods."¹⁸ The idea of society as a moral community; the concept of "moral luck";

¹⁵*Ibid.* at xiii.

¹⁶A.E. Buchanan, "The Importance of Health Care" in Bole & Bondeson, *supra* note 2, 169 at 177.

¹⁷Ignatieff, *supra* note 1 at 13.

¹⁸"Book Review: Mortal Peril: Our Inalienable Right to Health Care?" (1998) 279:4 JAMA at para. 3, online: JAMA <<http://www.jama.ama-assn.org/issues/v279n4/ffull/jbk0128-4.html>> (date accessed: 27 November 2001).

and the special, distinguishing quality of health care that arguably makes it a human right, will be dealt with in the next section.

Articulating the Right to Health Care: The Egalitarian Approach

As Waldron points out,

Where a claim about human rights is contested—as many of the socio-economic ones are, for example—there is nothing to do but to work one’s way back toward the deeper values and commitments that lie behind it, in the hope of finding premises not too far removed from those that one’s opponent wants to use to justify her convictions.¹⁹

What deeper values and commitments can we rely on in the “moral community” of Canada to justify a human right to health care? In the broadest of terms, the commitment shown by Canadians to democratic values of equality and justice may help to anchor arguments regarding a human right to health care.

In terms of justice, the idea of “moral luck” emphasizes the reality that not all human beings are born onto a level playing field. When considering health care, the “need for medical services can be plausibly considered to be a result of a natural lottery which applies to every one of us.”²⁰ Therefore, those of us who are wealthy and healthy enough to engage in the pursuit of happiness have not necessarily *earned* our place on the playing field, rather, we were *lucky* enough to have landed there. Such luck cannot serve as a solid basis for a libertarian or economic claim that we are logically or morally entitled to ignore the needs of the unlucky. It follows that equality does not mean treating everyone the same regardless of their situation, but rather, requires that additional steps—positive steps, if you will—be taken in order to provide everyone with access to the same opportunities. If we recognize the fact that “basic health is requisite for competing for social opportunities” we can go on to say that “a right to health care is implied by a fundamental notion of fairness; it ‘makes sense’ or is rational for society to provide such a service.”²¹

Of course, this analysis presumes that people in general want to do more for their community than simply participate in a complex network of social contracts. Not everyone feels that the egalitarian pursuit of a moral community is a convincing justification for a right to health care, as is clearly indicated in the works of Epstein and Peikoff. With such irreconcilable world views at issue, why pursue an articulation of the need for health care as a right at all? Why not simply deal with

¹⁹*Supra* note 7 at 165.

²⁰G.E. Jones, “The Right to Health Care and the State” (1983) 33:132 *Philosophical Q.* 279 at 279.

²¹*Ibid.* at 280.

it as a shared moral obligation or duty to other people – in other words, why not promote health care as an entitlement rather than a right? According to A.E. Buchanan, “[t]he public good argument for enforcing obligations to collective aid does not depend upon any assumption that individuals have a *right* to the good in question.”²² Brody points out that underlying the quest for a right to health care in the United States is the need to develop policies for providing to those who cannot afford to pay for them some, but unfortunately not all, of those things that would improve their health and increase their life expectancy.” Brody argues, however, that “[t]he appeal to the right to health care . . . is in no position to help us think about these issues.”²³

While this is an insightful statement, Buchanan’s “public good” approach lacks the punch inherent in a human rights claim. It fails to recognize the power that democratic nations afford to rights. According to V. Leary:

treating health care as a human right means regarding the dignity of the individual and social justice as primary concerns. The rights-based approach also considers health care as a public good because of its importance for life and dignity of the individual and not simply as a commodity to be allocated solely by market forces. This view also stresses the importance of non-discrimination in the allocation of health care and confers on the individual an entitlement to the right in question which should be protected through legislation or administrative measures. The concept of an entitlement, in short, is derived from the concept of a right. Finally, recognizing a right to health care focuses special attention on the needs of vulnerable groups: the poor, minorities, and children.²⁴

Leary goes on to invoke the theories of R. Dworkin, who defines rights as “‘trumps’ which generally, but not unfailingly, will prevail over other societal considerations. They create a presumption of special protection.”²⁵ The special protection afforded rights in a democratic society enables the public to exert some kind of influence, beyond just voting in a new government, over how the current government responds to those rights, or takes them seriously. It is not enough to classify health care as a common good.

²²*Supra* note 16 at 180.

²³B.A. Brody, “Policy Debates and the Right to Health Care” in Bole & Bondeson, *supra* note 2, 113 at 126.

²⁴“Defining the Right to Health Care” in A.R. Chapman, ed., *Health Care Reform: A Human Rights Approach* (Washington D.C.: Georgetown University Press, 1994) 87 at 97.

²⁵*Ibid.* at 99.

Recognizing the Right to Health Care

If the egalitarian case for health care as a human right is convincing, it makes sense to make that right a justiciable one. Of course,

the existence of human rights does not depend on prior legal recognition in any particular jurisdiction. Quite to the contrary, one central function of human rights, like moral rights generally, is to criticize the law at any particular time and place, and they could not play this role if their existence depended on prior legal recognition.²⁶

We cannot, and should not, rely on the law to tell us whether a human right to health care exists. The law merely tells us what our *enforceable* rights are.

In the United States, legal recognition of a right to health care would be the first step in requiring the government to provide universal, basic health care that is not dependent on the user's ability to pay. Canada has already recognized this governmental obligation—or common good—under the *Canada Health Act*.²⁷ Legal recognition of a right to health care in Canada would give citizens constitutional tools to use in battling infringement on the existing medicare system and in holding the government accountable for allocation decisions.

While cost must be a concern for governments that have undertaken to provide their citizens with universal health care coverage, economics as a basis for allocation decisions is considered to be “deficient in its failure to emphasize and protect the dignity of individuals and minorities. Some social policies should be adopted because they are morally right and cannot be solely judged on the basis of cost-benefit analysis, particularly those conducive to greater respect for the individual person.”²⁸ For Canadians, a legal right to health care could mean that allocation decisions must adhere to the “principles of fundamental justice” as per section 7 of the *Charter*, and furthermore, must respect the equality rights guaranteed under section 15 of the *Charter*.²⁹ Such an approach can be described as egalitarian because it relies on independent principles of justice to “specify a pattern of distribution that is morally right even if it conflicts with autonomy or with the maximizing of the aggregate good.”³⁰ Presuming there is a human right to health care generally, is this right justiciable in Canada?

²⁶D. W. Brock “The President’s Commission on the Right to Health Care” in Chapman, *supra* note 24, 65 at 75.

²⁷*Supra* note 4.

²⁸Leary, *supra* note 24 at 96.

²⁹*Supra* note 5.

³⁰R.M. Veatch, “Egalitarian Justice and the Right to Health Care” in Chapman, *supra* note 24, 106 at 108 [emphasis in original].

Does the *Charter* Support a Legal Right to Health Care in Canada?

Canadians are generally quite proud of Canada's universal health care system, though most people agree that the system leaves a great deal of room for improvement. The fact that there is even a question as to whether a legally entrenched right to health care exists in Canadian law would undoubtedly come as a shock to most Canadians. The truth of the matter is that while the *Canada Health Act* provides a loose framework of principles for the provision of universal health care, it is not constitutionally entrenched. Thus, the right to health care remains vulnerable to legislative erosion. This vulnerability is presumably why legal scholars have set out to prove that health care, along with other socio-economic rights, is a fundamental right under section 7 of the *Charter*. For, "if a right to basic and medically necessary health care and services is recognised as an aspect of the right to 'Life, liberty and security of the person', it follows that any government denial of such care must respect the requirements of procedural due process or, in the language of section 7, must accord with 'principles of fundamental justice.'"³¹ What this means is that:

any decision to deny access to basic and medically necessary care without advising the person affected that a decision was being made and on what grounds, and without affording him or her an opportunity to participate in the decision-making process or to otherwise respond to the decision, would be open to section 7 scrutiny ... In sum, section 7 would require full and meaningful participation by patients in decisions regarding their care.³²

Put another way, "[t]he ambiguity of section 7 of the *Charter* provides a golden opportunity for positive-rights activists to implement their agenda."³³

Section 7 reads:

Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

Selick, a harsh critic of socio-economic rights, points out that

³¹M. Jackman, "The Requirements of Procedural Due Process with Respect to Health Resource Allocation" in Canadian Bar Association, *Background Papers for "What's Law Got to Do With It?": Health Care Reform in Canada* (Ottawa: Canadian Bar Association, 1994) 1 [hereinafter "Procedural Due Process"] at 7.

³²*Ibid.* at 8-9.

³³Selick, *supra* note 6 at 110.

this section is ambiguous. Why is the right not to be deprived of life, liberty, and security of the person contained in a separate phrase from the main rights themselves? Is the right to life something different from the right *not to be deprived of life*? Could this section have been drafted with the deliberate intention of leaving open the interpretation that the rights to life, liberty and security of the person actually encompass the positive right to be given the material means of sustaining one's life or achieving financial security, as well as the traditional negative right not to be killed?³⁴

There is no definitive statement from the Supreme Court of Canada regarding socio-economic rights under section 7 of the *Charter*, however several cases attempting to argue that the government has a legal duty to provide social assistance have been unsuccessful.³⁵ That said, as Jackman points out, in the Supreme Court's 1989 decision in *Irwin Toy Ltd. v. Quebec (A.G.)*,³⁶ "the Court expressly left open the possibility that 'economic rights fundamental to human life or survival' (as distinct from economic rights of a corporate/commercial nature), would be protected under section 7."³⁷ Surely health care, as it contributes to a person's ability to participate in society and the marketplace, is fundamental to human life or survival?

Jackman, an outspoken proponent of socio-economic rights under the *Charter*, thinks that a "credible claim can be made that section 7 of the *Charter* guarantees a constitutional right to health care. In practical terms, a right to life and to security of the person is meaningless without access to health care, both in a preventative sense, and in the event of acute illness."³⁸ In support of her general argument that "[a]n interpretation of the section 7 right to 'life, liberty and security of the person' that includes a right to health care reflects the broader social context in which the *Charter* was adopted—the background against which the Court has argued that the *Charter* must be understood,"³⁹ Jackman cites Wilson J. from *Stoffman v. Vancouver General Hospital*: "government has recognized for some time that access to basic health care is something no sophisticated society can legitimately deny to any of its members."⁴⁰

³⁴*Ibid.* at 109.

³⁵See e.g. *Fernandes v. Manitoba (Director of Social services (Winnipeg Central))* (1992), 93 D.L.R. (4th) 402 at 414 (Man. C.A.); *Conrad v. Halifax (County)* (1993), 124 N.S.R. 251 at 270-72 (N.S.S.C); *Clark v. Peterborough Utilities Commission* (1998), 40 O.R. (3d) 409 at 29 (C.A.); and *Masse v. Ontario (Com. & Social Services)* (1996), 134 D.L.R. (4th) 20 at 40 (Ont. Dist. Ct.).

³⁶ [1989] 1 S.C.R. 927 at 1003-4.

³⁷"Procedural Due Process," *supra* note 31 at 3-4.

³⁸"The Regulation of Private Health Care Under the Canada Health Act and the Canadian Charter" (1995) 6 Constitutional Forum 54 at 56.

³⁹"Procedural Due Process," *supra* note 31 at 56.

⁴⁰[1990] 3 S.C.R. 483 at 544.

Similarly, G. Shea supports an approach to interpretation of *Charter* guarantees that takes into account broad “social, political, economic and cultural values ... shared by the Canadian community” which means considering “the importance that individual Canadians attach to the provision of universal, free health coverage.”⁴¹ The entitlement – not the right – to this universal, free health coverage in Canada is found in the *Canada Health Act*:⁴²

3. It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.

4. The purpose of this Act is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution may be made.

The criteria or principles referred to in section 4 are outlined in section 7 of the *Act*: public administration, comprehensiveness, universality, portability, and accessibility.⁴³

When considering whether section 7 of the *Charter* provides a foundation for a legal right to health care, a court may also consider the international human rights instruments to which Canada is a signatory, though the court itself is not directly bound by them.⁴⁴ These instruments provide an important background for *Charter* interpretation because “they reflect a serious commitment by the government to the specific rights, obligations and principles in them ... All of the rights in issue, including the right to medical care, are consistent with Canadian values and aspirations.”⁴⁵ Compared to many other signatory nations, the Canadian government has been fairly successful in fulfilling its obligations under the following international human rights instruments.

The *International Covenant on Economic, Social and Political Rights* explicitly delineates the human right to health care in international law.⁴⁶ Article 12 states:

⁴¹“Is There a Charter Right to Health Care in Canada?” in Canadian Bar Association, *supra* note 31, 1 at 18.

⁴²*Supra* note 4.

⁴³*Ibid.*

⁴⁴*Slaight Communications v. Davidson*, [1989] 1 S.C.R. 1038 at 1056-57. See also *Baker v. Canada (Minister of Citizenship and Immigration)*, [1992] 2 S.C.R. 817 at para. 70.

⁴⁵Shea, *supra* note 41 at 13-14.

⁴⁶*Supra* note 3.

1. The State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this rights shall include those necessary for:
 - (a) The provision for the reduction of the stillbirthrate and of infant mortality and for the healthy development of the child
 - (b) The improvement of all aspects of environmental and industrial hygiene;
 - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.⁴⁷

Under Article 2(1), a State Party must “take steps ... to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant.”⁴⁸ B. Toebes in *The Right to Health as a Human Right in International Law* deals with the question: “[w]hat precisely do individuals have a right to on the basis of the right to health under international law and what are the resulting obligations on the part of States?”⁴⁹ She concludes that the

core content of the right can be derived from the Primary Health Care strategy of the WHO. Irrespective of their available resources, States have to provide access to maternal and child health care, including family planning; immunisation against the major infectious diseases; appropriate treatment of common diseases and injuries; essential drugs; and adequate supply of safe water and basic sanitation.⁵⁰

It appears that Canada has fulfilled the core content of its international obligations. Is there anything else these international instruments can contribute to the argument for “life, liberty and security of the person” as representing a right to health care under s.7 of the *Charter*? The answer may be found in the concept of “security.”

The preamble to the *Constitution of the World Health Organization* states that health is a principle “basic to the happiness, harmonious relations and *security* of

⁴⁷*Ibid.*

⁴⁸*Ibid.*

⁴⁹(Oxford: Intersentia, 1999) at 4.

⁵⁰*Ibid.* at 347 [emphasis in original].

all peoples.”⁵¹ Article 25(1) of the *Universal Declaration of Human Rights*⁵² states that

Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing *and medical care* and necessary social services, and *the right to security* in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

In the preamble to the *International Covenant on Civil and Political Rights*, State Parties recognize that “the ideal of free human beings enjoying civil and political freedom and freedom from fear and want can only be achieved *if conditions are created* whereby everyone may enjoy his civil and political rights, *as well as his economic, social and cultural rights*.”⁵³ Not only do these instruments consider health to be fundamental to the security of the person, they espouse positive obligations on the part of signatories to provide guarantees for socio-economic rights. Recognizing a right to health care under section 7 of the *Charter* would certainly go a long way in fulfilling Canada’s obligations under these instruments.⁵⁴

Despite the apparent strength of the case for recognition of a right to health care under section 7 of the *Charter*, there is strong case law indicating that a socio-economic right of this nature will not be recognized by the Supreme Court of Canada. Shea points out that in *Brown v. British Columbia (Minister of Health)*,⁵⁵ where the government’s decision not to fully subsidize the cost of drugs used to treat AIDS patients was challenged under sections 7 and 15 of the *Charter*, “[t]he court rejected the plaintiff’s s.7 claim, arguing that the section did not protect against economic deprivations, or guarantee benefits which might enhance life, liberty, or security of the person.”⁵⁶ Furthermore, in *Reference re section 193 and 195.1(1)(c) of the Criminal Code (Canada)*, Lamer J., as he then was, expressed a rather narrow view of the application of section 7 when he held that “the restrictions . . . that section 7 is concerned with are those that occur as a result of the individuals’ interaction with the justice system and its administration.”⁵⁷ The refusal of various courts to recognize positive socio-economic rights under the *Charter*,

⁵¹Signed on 22 July 1946, came into force 7 April 1948, 14 U.N.T.S. 186 [emphasis added].

⁵²G.A. Res. 217(III), U.N. Doc. A/810 (1948) [emphasis added].

⁵³16 December 1966, 999 U.N.T.S. 171, Can. T.S. 1976 No. 47, ratified by Canada on 19 May 1976 [emphasis added].

⁵⁴For an overview of how several other Western countries have dealt with conflict between the right to health under domestic and international law, and the economic reality of imposing cost containment measures, see A.D. Exter & B. Hermans, “Constitutional Rights to Health Care: The Consequences of Placing Limits on the Right to Health Care in Several Western and Eastern European Countries” (1998) 5 Eur. J. Health L. 261.

⁵⁵(1990), 66 D.L.R. (4th) 444 (B.C.S.C.).

⁵⁶*Supra* note 41 at 25.

⁵⁷[1990] 1 S.C.R. 1123 at 1172.

combined with the Supreme Court's finding in *Reference re section 193 and 195.1(1)(c) of the Criminal Code* that section 7 is applicable mainly to the justice system, leads Shea to conclude that "section 7 is incapable of creating an independent right to health care."⁵⁸ B. Windwick, having undertaken an analysis of case law similar to that undertaken by Shea, also finds that "[t]o the extent prediction is possible, the prognosis for s. 7 protection of a right to health-care is not optimistic."⁵⁹

While finding a legal right to health care under section 7 appears unlikely, it may be the case that "positive-rights activists" can "implement their agenda" through other means.⁶⁰ Shea cites G. Pickett in pointing out that "while the government may not have an independently enforceable obligation to provide universal medical care, 'once it has undertaken to do so, it may be constitutionally constrained in how it treats the interests so created.'"⁶¹ The constitutional constraints Pickett refers to are found under section 15 of the *Charter*, rather than under section 7.

Section 15: Enforcing the Right to Health Care Without Constitutionally Entrenching It

Two recent decisions, made at opposite ends of the country, have indicated the willingness of the courts to adopt a section 15 analysis in order to address health care activists and concerns about health care policy decisions. *Cameron v. Nova Scotia (Attorney General)*,⁶² decided in 1999, and the more recent decision of *Auton (Guardian ad litem of) v. British Columbia (Minister of Health)*⁶³ both deal with *Charter* claims against the government regarding health care policy. The plaintiffs in *Cameron* and *Auton* both attempted to use section 7 and section 15 to argue against government health care resource allocation decisions. In both cases, the section 7 arguments were ignored by the Court, while the section 15 arguments met with success. Unfortunately, the claim in *Cameron* ultimately failed as a result of the Court's application of s.1 of the *Charter*. Before looking at these two cases, it will be helpful to review *Eldridge v. British Columbia*, the leading Canadian case

⁵⁸*Supra* note 41 at 27.

⁵⁹"Health-Care and Section 7 of the Canadian Charter of Rights and Freedoms" (1994) 3:1 Health L. Rev. 20 at para. 24.

⁶⁰Selick, *supra* note 6 at 110.

⁶¹*Supra* note 41 at 33, citing G. Pickett from a speech entitled "A Right to Health Care? Rationing, Allocation and the Charter of Rights and Freedoms," presented to The Canadian Bar Association--National Law Section, February 1993.

⁶²(1999), 177 D.L.R. (4th) 611 (N.S.C.A) [hereinafter *Cameron*]. An application for leave to appeal to the Supreme Court of Canada was dismissed without reasons on 29 June 2000: [1999] S.C.C.A. No. 531.

⁶³(2000), 78 B.C.L.R. (3d) 55 (B.C.S.C.) [hereinafter *Auton*].

dealing with section 15 of the *Charter* as it applies to allocation of health resources.⁶⁴

In *Eldridge*, the plaintiffs successfully argued that the Government of British Columbia violated section 15 by failing to provide funding for sign language interpreters when required by deaf people attending at hospitals.⁶⁵ In response to the Government's argument that the *Charter* does not "oblige the state to take positive actions, such as to provide services to ameliorate the symptoms of systemic or general inequality" the Court found that "once the state does provide a benefit, it is obliged to do so in a non-discriminatory manner ... In many circumstances, this will require governments to take positive action, for example by extending the scope of a benefit to a previously excluded class of persons."⁶⁶ While this statement appeared promising to health care reform activists, s.1 of the *Charter* still enables governments to justify s.15 infringements on an economic basis. As the Court stated in *Eldridge* "[g]overnments must demonstrate that their actions infringe the rights in question no more than is reasonably necessary to achieve their goals."⁶⁷ In interpreting the Court's decision in *Eldridge*, B. von Tigerstrom observes that in its application of s.1, "[t]he Supreme Court ... left the door open for a justification of discriminatory treatment in health care or other social services based solely on reasons of financial constraints, subject to rational connection, minimal impairment and proportionality tests."⁶⁸

The decision in *Cameron*, while it expanded the use of section 15 to contest health care allocation decisions, did little to shut down the economic escape route available to governments under s.1 of the *Charter*. In *Cameron*, a childless couple used section 15 of the *Charter* to challenge a government funding decision to exclude in vitro fertilization and some other (though not all) fertility treatments from the provincial insurance plan. The Court found that while "[n]ot every person denied a procedure can successfully mount a Charter challenge ... denial of these procedures, on the ground that they are not medically necessary, creates a distinction based on the characteristic of infertility" and that distinction was found to be a discriminatory one.⁶⁹ Having found that s.15 had been violated, the Court then went on to apply a section 1 analysis as per *Andrews v. Law Society of British Columbia*⁷⁰ to determine whether the violation was "demonstrably justified in a free and democratic society."⁷¹ In analysing, under section 1, the government's decision to deny funding to the particular procedure in question, the Court decided that:

⁶⁴(1997), 151 D.L.R. (4th) 577 (S.C.C.) [hereinafter *Eldridge*].

⁶⁵*Ibid.*

⁶⁶*Ibid.* at para. 73.

⁶⁷*Ibid.* at para. 86.

⁶⁸"Equality Rights and the Allocation of Scarce Resources in Health Care: A Comment on *Cameron v. Nova Scotia*" (1999) 11:1 Constitutional Forum at 30.

⁶⁹*Supra* note 62 at 169-70.

⁷⁰(1989), 56 D.L.R. (4th) 1 (S.C.C.).

⁷¹*Charter, supra* note 5, s. 1.

[t]he policy makers require latitude in balancing competing interests in the constrained financial environment. We are simply not equipped to sort out the priorities. We should not second guess them, except in clear cases of failure on their part to properly balance the Charter rights of individuals against the overall pressing objective of the scheme under the Act To use the words of Sopinka, J. . . . “it would be unrealistic” for this Court to assume that there are unlimited funds to address the needs of all. We must necessarily show considerable deference to the decision makers in this exercise.⁷²

The Court distinguished *Cameron* from *Eldridge* by finding that the accessibility of alternative treatments in *Cameron* meant that section 15 was only minimally impaired.⁷³

In her case comment on *Cameron*, von Tigerstrom notes that while in some cases, denials of funding may be discriminatory,

[i]t cannot be the case, however, that whenever funding is denied for a treatment or procedure that is specifically relevant to or required by persons with a particular medical condition or disability, the mere fact of the denial will be sufficient for a finding of discrimination. There may be grounds for a claim that the provincial government is in violation of its obligations under the *Canada Health Act* to provide comprehensive services.⁷⁴

Where does this leave health care activists who wish to use constitutional tools to attack such denials of funding? In *Auton (Guardian ad litem of) v. British Columbia (Minister of Health)*, the failure of the government of British Columbia to provide effective treatment for autistic children was found to violate section 15 of the *Charter*.⁷⁵ The Court found that the B.C. government’s failure to accommodate the children was discriminatory under section 15, and furthermore, that the government’s failure to provide appropriate treatment to the children undermined “the primary objective of the medicare legislation, which is to provide universal health care.”⁷⁶ Such a failure could not be justified under section 1 on the basis of policy decisions regarding the “‘judicious use’ of limited health care resources.”⁷⁷ *Auton*, in its inherent support of a positive duty attributed to the government to provide therapeutic services to autistic children, may represent a turning point in the debate surrounding the existence of an enforceable positive right to health care in Canada. This right, however, is not articulated as an all-encompassing human right

⁷²*Supra*, note 62 at paras. 236-37.

⁷³*Ibid.* at para. 244.

⁷⁴*Supra* note 68 at 38.

⁷⁵*Supra* note 63.

⁷⁶*Ibid.* at paras. 151-52.

⁷⁷*Ibid.*

under section 7, but rather, is a right to enjoy “non-discriminatory,” as distinct from “equal” access to the benefits of a universal medicare system.⁷⁸

Having created a universal medicare system of health benefits, the government is prohibited from conferring those benefits in a discriminatory manner. In the case of children with autism, their primary health care need is, where indicated, early intensive behavioural intervention. In failing to make appropriate accommodation for their health care needs, the Crown has discriminated against them. It is not the medicare legislation that is discriminatory or defective but the Crown’s overly narrow interpretation of it.⁷⁹

In *Auton*, the Government took the position that the lack of funding for autistic children was a policy decision to which the Court should show judicial deference, arguing that “the effect of funding treatment for autistic children would [be to] direct resources away from other children with special needs.”⁸⁰ This cost-benefit argument was rejected by the Court, which found that such an argument could not be used to “justify a violation of the petitioners’ section 15 rights.”⁸¹

What does *Auton* represent for advocates of a right to health care? While the Court in *Auton* found it unnecessary to deal with section 7 arguments,⁸² it indicated judicial support for of section 15 as a tool to be used in attacking government health care allocation decisions. *Auton* tells us that economic principles alone cannot support decisions for denial of health care funding. This is in keeping with the observation that in Canada, the right to health care means ensuring that “allocation and rationing choices [are] compatible with the egalitarian ideals of our health care system.”⁸³

Conclusion: Choose Your Battles

Does a human right to health care exist? Like all questions engaging world views, the answer to this question depends on who you are asking. What is certain is that for people who believe in its existence, the right to health care does not depend on legal recognition. It may be argued that in Canada, at least, the intellectual battle over the existence of a right to health care less important than the legal battle to influence health care resource allocation decisions. The right to health care, while it may be a human right recognized in international documents, has not been recognized, and most likely will not be recognized, as a justiciable

⁷⁸*Auton*, *supra* note 63 at paras. 126-33.

⁷⁹*Ibid.* at para. 126.

⁸⁰*Ibid.* at para. 147.

⁸¹*Ibid.* at para. 151. This argument was also rejected in *Schacter v. Canada* (1992), 93 D.L.R. (4th) 1 (SCC).

⁸²*Ibid.* at para. 111.

⁸³Shea, *supra* note 41 at 3.

right enshrined in the *Charter*. However, if the goal of locating such a right to health care in Canadian law is to enable public enforcement of egalitarian principles using constitutional tools, then s.15 can be used to achieve this goal. *Auton* tells us that the *Charter* can be used to enforce positive obligations on the government to provide adequate health care to all of its citizens. Defining exactly what “adequate” health care means in Canada, a process that has been ongoing since the advent of the *Canada Health Act*, is the next important battle to be waged by health care activists.⁸⁴

⁸⁴For a discussion of just how difficult it may be to formulate these principles beyond cost-benefit analysis, see T.A. Caulfield “Wishful Thinking: Defining “Medically Necessary” in Canada” (1996) 4 Health L. J. 63 at 85, “[a]s a concept, medically necessary should be one goal of a ‘decision-making framework’ used to make informed health care policy choices on a variety of levels (micro, meso and macro). Further research is required on both formulation of the ‘decision-making framework’ and on the inputs (e.g., outcomes research, cost-effectiveness research, legal and ethical considerations, community values, etc.) required for this process.”