

## Chapter 4

# CHARTER REVIEW OF HEALTH CARE ACCESS

Martha Jackman\*

\* This chapter is a revision and update of the author's earlier article: "Charter Review as a Health Care Accountability Mechanism in Canada" (2010) 18 Health L.J. 1.

### A. INTRODUCTION

There is widespread support in Canada for the idea that those who need health care are entitled to receive it, irrespective of their ability to pay. This fundamental principle is reflected in the program conditions of the *Canada Health Act* and underlies public expectations of the health care system as a whole.<sup>1</sup> In dismissing a constitutional challenge to Alberta's ban on private health insurance in *Allen v. Alberta*,<sup>2</sup> Slatter J. describes the key elements of the Canadian health care system: "Economic Universality. Because basic health care is publicly funded, all Canadians have equal access to it"; and "Risk universality. ... No Canadian is denied coverage, or expected to contribute more to health care costs, based on his or her medical profile."<sup>3</sup> Justice Slatter goes on to suggest that "[t]hese features of the system undoubtedly account, in large measure, for the public support of the system, and the willingness of Canadians to devote the substantial public resources necessary to operate it."<sup>4</sup> As Roy Romanow affirms in the *Final Report* of the Commission on the Future of Health Care in Canada: "Canadians consider equal and timely access to medically necessary health care services on the basis of need as a right of citizenship, not a privilege of status or wealth."<sup>5</sup>

The legislative and other measures taken by Canadian governments to ensure access to health care based on need are consistent not only with Canada's international human rights obligations, including the right "to the enjoyment of

---

<sup>1</sup> R.S.C. 1985, c. C-6, and see, generally, Flood chapter.

<sup>2</sup> [2015] A.J. No. 964, 2015 ABCA 277 (Alta. C.A.) [hereinafter "*Allen*"], affg [2014] A.J. No. 345, 2014 ABQB 184 (Alta. Q.B.), leave to appeal refused [2015] S.C.C.A. No. 461 (S.C.C.). Justice Slatter rejected the plaintiff's argument that *Chaoulli v. Quebec (Attorney General)*, [2005] S.C.J. No. 33, [2005] 1 S.C.R. 791 (S.C.C.) [hereinafter "*Chaoulli* (S.C.C.)"], was sufficient authority for a declaratory order that Alberta's prohibition on private health insurance was unconstitutional.

<sup>3</sup> *Allen*, at para. 16.

<sup>4</sup> *Ibid.*

<sup>5</sup> Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada – Final Report* (Saskatoon: Commission on the Future of Health Care in Canada, 2002) at xvi.

the highest attainable standard of physical and mental health” set out in article 12 of the *International Covenant on Economic, Social and Cultural Rights* (“ICESCR”),<sup>6</sup> but with domestic constitutional guarantees under the *Canadian Charter of Rights and Freedoms*.<sup>7</sup> In a study undertaken for the Romanow Commission in 2002, Donna Greschner attributed the limited number of health care cases during the first two decades of the *Charter* to “the relative universality, accessibility and comprehensiveness of Canada’s existing Medicare system”.<sup>8</sup>

There is, however, growing awareness of the failures of the publicly funded system as it is currently structured, particularly in relation to indigenous people, people living in poverty, those with mental illnesses or addictions, and other groups experiencing significant health-related disadvantage.<sup>9</sup> At the same time, the assumption that access to health care should depend solely on need, rather than ability to pay, is being questioned in light of unmet demands for emerging services and concerns about undue wait times for care, as well as by those arguing for greater privatization as the only possible response to the pressures facing the public system. In the words of Slatter J.A.:

Canada’s system of universal health care is perceived by many as the crowning achievement of Canadian social policy. The majority of Canadians support the public funding of health care and oppose attempts to shrink or compromise the system. At the same time, many Canadians criticize the system; they would like it to be even better than it is.<sup>10</sup>

Along with debates over accessibility, questions persist about how and to whom health care decision-makers are answerable for individual and systemic decisions affecting access to care. Improving accountability to patients and to the public has been a key recommendation in all major health system reviews undertaken at the federal and provincial/territorial levels over the past 20 years.<sup>11</sup> In the case of health care, like other socio-economic rights in Canada however, political or consensus-based approaches to accountability have been preferred over rights-based frameworks, and the core elements of accountability – monitoring, justification and remedies – which are called for under

<sup>6</sup> *International Covenant on Economic, Social and Cultural Rights* (December 16, 1966), 993 U.N.T.S. 3, Can. T.S. 1976 No. 46, art 12(1) (entered into force January 3, 1976); Committee on Economic, Social and Cultural Rights, *General Comment No. 14, The Right to the Highest Attainable Standard of Health*, UNCESCOR, 22d Sess, UN Doc. E/C/12/2000/4 (2000).

<sup>7</sup> *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [hereinafter “*Charter*”].

<sup>8</sup> Donna Greschner, “How Will the Charter of Rights and Freedoms and Evolving Jurisprudence Affect Health Care Costs?” in Tom McIntosh, Pierre-Gerlier Forest & Gregory P. Marchildon, eds., *The Romanow Papers, Volume 3: The Governance of Health Care in Canada* (Toronto: University of Toronto Press, 2004) 83 at 93.

<sup>9</sup> See, generally, Chen chapter; Dennis Raphael, ed., *Social Determinants of Health: Canadian Perspectives*, 3d ed. (Toronto: Canadian Scholars’ Press, 2016).

<sup>10</sup> *Allen*, at para. 14.

<sup>11</sup> See, generally, Martha Jackman, “The Future of Health Care Accountability: A Human Rights Approach” (2016) 47:1 *Ottawa L. Rev.* (forthcoming).

international health and human rights law are weak or non-existent within the Canadian system.<sup>12</sup>

In an environment where the underlying premise of medicare is being tested, and where alternative accountability mechanisms are lacking, the *Charter* has enormous potential as a means of ensuring that health care decision-making is equitable and effective in ensuring access to care for those who need it. The Supreme Court of Canada's 1997 judgment in *Eldridge v. British Columbia (Attorney General)*<sup>13</sup> established that the *Charter* applies not only to governments but to hospitals and other private entities providing publicly funded health care services.<sup>14</sup> Justice LaForest summarized the *Charter* violation in that case: "In order to receive the same quality of care [as hearing persons], deaf persons must bear the burden of paying for the means to communicate with their health care providers, despite the fact that the system is intended to make ability to pay irrelevant."<sup>15</sup>

Chief Justice McLachlin observed, in her 2005 decision in *Chaoulli v. Quebec (Attorney General)*, that the "*Charter* does not confer a freestanding constitutional right to health care".<sup>16</sup> She emphasized, however, that "where the government puts in place a scheme to provide health care, that scheme must comply with the *Charter*."<sup>17</sup> In the absence of an explicit right to health care in the *Charter*, the section 15 guarantee of equal protection and benefit of the law enables the courts to assess health care decision-making in light of substantive equality principles. The process whereby decisions are made can also be reviewed in accordance with the section 7 requirement that any deprivation of life, liberty and security of the person must be in accordance with the principles of fundamental justice. And, in cases where a rights violation has been found, governments have an opportunity to demonstrate that decision-making affecting access to care is reasonable and demonstrably justified, as section 1 of the *Charter* demands.

Notwithstanding the *Charter's* potential as a means of ensuring both accountability and respect for domestic and international human rights within the Canadian health care system, patients pursuing access to health claims and

---

<sup>12</sup> *Ibid.*

<sup>13</sup> [1997] S.C.J. No. 86, [1997] 3 S.C.R. 624 [hereinafter "*Eldridge* (S.C.C.)"].

<sup>14</sup> The Supreme Court's analysis in *Eldridge* suggests that the *Charter* applies to institutional as well as individual health care providers, including physicians, irrespective of the setting in which publicly funded services are provided; see Martha Jackman, "The Application of the Canadian Charter in the Health Care Context" (2000) 9:2 Health L. Rev. 22. See, however, *Rasouli (Litigation Guardian of) v. Sunnybrook Health Sciences Centre*, [2011] O.J. No. 1100, 2011 ONSC 1500 at paras. 90-93 (Ont. S.C.J.), aff'd [2011] O.J. No. 2984, 2011 ONCA 482 (Ont. C.A.), leave to appeal granted (*sub nom. Cuthbertson v. Rasouli*) [2011] S.C.C.A. No. 329 (S.C.C.), where the Ontario Superior Court relied on the common law relationship between hospitals, doctors and patients as a basis for concluding that physicians' health care decisions were not subject to *Charter* review.

<sup>15</sup> *Eldridge*, at para. 71.

<sup>16</sup> *Chaoulli* (S.C.C.), at para. 104.

<sup>17</sup> *Ibid.*

those advocating on their behalf have had limited success in the 20 years since the Supreme Court confirmed in *Eldridge* that *Charter* rights are engaged by government action and inaction in this crucial area of social policy. This chapter will consider the reasons that, outside of the criminal law context, the courts have been resistant to *Charter* access to health care claims, even in cases where individual lives and well-being are at direct and immediate risk. In particular, the chapter will point to undue judicial deference to governments' funding choices and the courts' negative-rights approach to the interpretation and application of the *Charter* as the two principal reasons that *Charter* review has been largely ineffective in addressing either the substantive barriers or the accountability of decision-making affecting access to care. The chapter will conclude by suggesting what is required for this situation to change.

## **B. SUCCESS AND FAILURE OF *CHARTER* ACCESS TO CARE LITIGATION**

### **1. CRIMINAL LAW BARRIERS TO CARE**

Criminal law barriers to care have been found to violate the *Charter* in several recent Supreme Court cases. For example, in *Canada (Attorney General) v. PHS Community Services Society*,<sup>18</sup> the claimants successfully challenged the federal government's refusal to grant the Insite safe injection facility an exemption from the *Controlled Drugs and Substances Act*<sup>18</sup> that was necessary to enable Insite's staff to offer supervised injection services to intravenous drug users in Vancouver's Downtown Eastside.<sup>19</sup> The Supreme Court found that by depriving Insite's clients of "potentially lifesaving medical care ... and health-protecting services", the government had violated the claimants' section 7 rights to life and security of the person.<sup>20</sup> Chief Justice McLachlin affirmed that: "Where a law creates a risk to health by preventing access to health care, a deprivation of the right to security of the person is made out ... . Where the law creates a risk not just to the health but also to the lives of the claimants, the deprivation is even clearer."<sup>21</sup> Given the proven benefits of Insite's safe injection and related health services, for both individual and public health and safety, the Court found that the federal government's decision was arbitrary, and as such in violation of section 7 principles of fundamental justice.<sup>22</sup> The Court concluded that no section 1 justification for the decision could succeed,<sup>23</sup> and it ordered the federal

<sup>18</sup> [2011] S.C.J. No. 44, [2011] 3 S.C.R. 134 (S.C.C.) [hereinafter "*Insite*"].

<sup>18</sup> S.C. 1996, c. 19.

<sup>19</sup> *Insite*. See generally Margot Young, "Sleeping Rough and Shooting Up: Taking British Columbia's Urban Justice Issues to Court" in Martha Jackman & Bruce Porter, eds., *Advancing Social Rights in Canada* (Toronto: Irwin Law, 2014) 413.

<sup>20</sup> *Insite*, at paras. 91-92.

<sup>21</sup> *Ibid.*, at para. 93.

<sup>22</sup> *Ibid.*, at paras. 130-132.

<sup>23</sup> *Ibid.*, at para. 137.

Minister of Health to provide the exemption that Insite needed to continue offering its services.<sup>24</sup>

In *Carter v. Canada (Attorney General)*,<sup>25</sup> the claimants challenged the *Criminal Code*<sup>26</sup> prohibition on assisted suicide that prevented them from obtaining physician assisted death as a form of end of life care. The Supreme Court agreed that by forcing the claimants to end their lives sooner than they might otherwise have done, by interfering with their ability to make decisions concerning their bodily integrity and medical care, and by leaving them to endure intolerable suffering, the denial of a physician's assistance in dying violated the claimants' section 7 rights to life, liberty and security of the person.<sup>27</sup> The Court found that the prohibition on physician assisted dying was overbroad in terms of its objective of protecting the vulnerable, thus violating the principles of fundamental justice,<sup>28</sup> and could not be justified as a minimal impairment of the claimants' rights under section 1.<sup>29</sup> On that basis, the Court held the prohibition on physician-assisted death to be unconstitutional in regard to competent consenting adults with "grievous and irremediable" medical conditions.<sup>30</sup>

Outside the criminal law context, however, the courts have been highly reluctant to seriously engage with the *Charter* as a health care review mechanism. Some *Charter* claimants have won their cases at the trial level, but have seen these favourable rulings reversed on appeal.<sup>31</sup> Others have prevailed, but on non-*Charter* grounds.<sup>32</sup> And while the Supreme Court has been willing to strike down certain criminal law prohibitions on access to care, the scope of governments' obligations to ensure access to the health services that have been decriminalized remains, as the *Jane Doe 1 v. Manitoba* case illustrates, unresolved.<sup>33</sup> The plaintiffs, two women who experienced significant delays in

<sup>24</sup> *Ibid.*, at paras. 150, 156; see also *R. v. Smith*, [2015] S.C.J. No. 34, [2015] 2 S.C.R. 602.

<sup>25</sup> *Carter v. Canada (Attorney General)*, [2015] S.C.J. No. 5, [2015] 1 S.C.R. 331 (S.C.C.) [hereinafter "*Carter*"]. Notably, an application has been filed by Julia Lamb and the British Columbia Civil Liberties Association challenging the constitutionality of the amendments to the *Criminal Code* in response to the Court's decision in *Carter: Lamb v. Canada (Attorney General)* (July 27, 2016), Vancouver S165851 (B.C.S.C.), online: <https://bccla.org/wp-content/uploads/2016/08/2016-07-27-Response-to-Civil-Claim.pdf>.

<sup>26</sup> R.S.C. 1985, c. C-46, ss. 14, 241(1)(b).

<sup>27</sup> *Carter*, at paras. 58, 66.

<sup>28</sup> *Ibid.*, at para. 86.

<sup>29</sup> *Ibid.*, at para. 121.

<sup>30</sup> *Ibid.* at para. 127.

<sup>31</sup> See, for example, *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, [2004] S.C.J. No. 71, [2004] 3 S.C.R. 657 (S.C.C.); *Jane Doe 1 v. Manitoba*, [2005] M.J. No. 335, 2005 MBCA 109 (Man. C.A.), leave to appeal refused [2005] S.C.C.A. No. 513 (S.C.C.).

<sup>32</sup> See, for example, *Association pour l'accès à l'avortement c. Québec (Procureur général)*, [2006] J.Q. no 8654, 2006 QCCS 4694 (Que. S.C.) and *Pictou Landing Band Council v. Canada (Attorney General)*, [2013] F.C.J. No. 367, 2013 FC 342 (F.C.).

<sup>33</sup> [2004] M.J. No. 456, 2004 MBQB 285 (Man. Q.B.) [hereinafter "*Jane Doe* (Q.B.)"], revd [2005] M.J. No. 335, 2005 MBCA 109 (Man. C.A.) [hereinafter "*Jane Doe* (C.A.)"], leave to appeal refused [2005] S.C.C.A. No. 513 (S.C.C.).

accessing abortion services, challenged the exclusion of abortions performed outside public hospitals from Manitoba's health insurance plan. In response to the province's motion to dismiss the claim, the Court of Queen's Bench granted summary judgment in favour of the plaintiffs on the grounds that the Supreme Court's *R. v. Morgentaler* decision was sufficient precedent for recognizing that the harm caused by delays in access to abortion violated the *Charter*.<sup>34</sup> As the trial judge concluded: "there is no reason or logic behind the impugned legislation which prevents women from having access to therapeutic abortions in a timely way."<sup>35</sup> On appeal, however, the Manitoba Court of Appeal agreed with the province that the plaintiffs' affidavit evidence was an insufficient basis for the summary judgment in the case. The Court concluded that a full hearing was required to address the complex issues raised by the plaintiffs' claim and it overturned the trial judge's order.<sup>36</sup>

Almost three decades after the *Morgentaler* decision, it is clear that decriminalization has not guaranteed women's access to reproductive health services. Instead, women seeking abortions continue to face direct and system barriers to publicly funded care in many parts of the country.<sup>37</sup> As the Supreme Court affirmed with reference to its *Charter* ruling in relation to medically assisted death in *Carter*: "The declaration simply renders the criminal prohibition invalid. What follows is in the hands of the physicians' colleges, Parliament, and the provincial legislatures."<sup>38</sup>

A review of the post-*Eldridge* case law suggests that judges, at both the trial and appellate levels, are sidestepping the question of whether decisions affecting access to care comply with the procedural and substantive requirements of the *Charter* in two ways. First, the courts are exercising a high level of deference to the funding choices of governments and their delegates within the health care system in cases where barriers to care are being impugned as *Charter* rights violations. Second, rather than subjecting such decisions to serious scrutiny to determine whether life, security of the person or equality interests have been infringed, judges are relying on a negative rights approach to existing *Charter* guarantees to dismiss claims seeking positive government measures to ensure access to care.

## 2. UNDUE DEFERENCE TO GOVERNMENT FUNDING CHOICES

The high level of judicial deference in cases where governments are being challenged to defend funding choices that limit access to care is illustrated in a number of decisions. For example, in *Cameron v. Nova Scotia (Attorney*

<sup>34</sup> [1988] S.C.J. No. 1, [1988] 1 S.C.R. 30 (S.C.C.) [hereinafter "*Morgentaler*"].

<sup>35</sup> *Jane Doe* (Q.B.), at para. 73.

<sup>36</sup> *Jane Doe* (C.A.), at para. 29.

<sup>37</sup> See, generally, Gruben chapter; Jocelyn Downie & Carla Nassar, "Barriers to Access to Abortion through a Legal Lens" (2007) 15 Health L.J. 143; Sanda Rodgers, "Abortion Denied: Bearing the Limits of Law" in Colleen M. Flood, ed., *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006) 107.

<sup>38</sup> *Carter*, at para. 132.

*General*), the claimants – a childless couple – argued that lack of health insurance coverage for Intra Cytoplasmic Sperm Injection (“ICSI”), a form of *in vitro* fertilization treatment, discriminated against the infertile thereby violating section 15 of the *Charter*.<sup>39</sup> The trial court rejected the claim on the grounds that ICSI was not “medically required”.<sup>40</sup> A majority of the Court of Appeal agreed with the appellants that the exclusion of the treatments had a discriminatory impact on the infertile relative to the fertile, for whom “every aspect of having children” was covered by medicare.<sup>41</sup> But the Court went on to find that, given competing health spending priorities, the decision not to fund ICSI was a reasonable limit on the appellants’ rights under section 1 of the *Charter*.<sup>42</sup>

The claimants in *Cameron* argued that both the exclusion of ICSI from Nova Scotia’s health insurance plan, and the province’s failure to maintain an independent administrative process for reviewing such decisions, violated the *Charter*.<sup>43</sup> In 1997, based on an agreement between the organization representing physicians in the province and the provincial Department of Health, intrauterine insemination was one of several procedures removed from the list of provincially insured services in order to achieve projected savings of \$2.5 to \$3 million annually.<sup>44</sup> The Court of Appeal in *Cameron* observed that, while “the primary bench mark [*sic.*] for deinsurance was that it would not adversely affect the general health of the patient”,<sup>45</sup> the delisting occurred without consultation with the two physicians who performed the procedure in Nova Scotia.<sup>46</sup> In terms of the administrative recourse available to challenge such decisions, the Court noted that the responsibilities of the province’s Medical Services Commission were transferred to the provincial Department of Health in 1976 and, as a consequence, the Commission’s independent review procedure was lost.<sup>47</sup>

In response to the appellants’ challenge to the province’s failure to maintain an independent appeal process for disputed claims, the Court concluded that: “While from the perspective of consumers of health care, it would be desirable to have an independent tribunal to review decisions of the Department to fund or not to fund procedures, there is no requirement at law that such an appellate procedure be a part of the scheme.”<sup>48</sup> As for the defunding decision itself, the Court took note of the appellants’ characterization of the process for deciding

---

<sup>39</sup> [1999] N.S.J. No. 33, 172 N.S.R. (2d) 227 (N.S.S.C.) [hereinafter “*Cameron* (S.C.)”], aff’d [1999] N.S.J. No. 297, 204 N.S.R. (2d) 1 (N.S.C.A.) [hereinafter “*Cameron* (C.A.)”], leave to appeal refused [1999] S.C.C.A. No. 531, [2000] 1 S.C.R. viii (S.C.C.); see, generally, Barbara von Tigerstrom, “Equality Rights and the Allocation of Scarce Resources in Health Care: A Comment on *Cameron v. Nova Scotia*” (1999-2001) 11:1 Const. Forum Const. 30.

<sup>40</sup> *Cameron* (S.C.), at paras. 101-102, 154-58.

<sup>41</sup> *Cameron* (C.A.), at para. 122.

<sup>42</sup> *Ibid.*, at para. 236.

<sup>43</sup> *Cameron* (S.C.).

<sup>44</sup> *Cameron* (C.A.), at para. 65.

<sup>45</sup> *Ibid.*

<sup>46</sup> *Ibid.*, at para. 121.

<sup>47</sup> *Ibid.*, at para. 34-36.

<sup>48</sup> *Ibid.*, at para. 104.

what services were eligible for provincial health insurance coverage: “The list, they say, is compiled without reference to principle; it is compiled in the arbitrary discretion of bureaucrats in consultation with the body responsible for representing the economic interests of medical practitioners.”<sup>49</sup> The Court was, however, unwilling to engage in the level of review the appellants were seeking in regard to either the decision-making process or the substance of the funding decision at issue, concluding instead that:

The evidence makes clear the complexity of the health care system and the extremely difficult task confronting those who must allocate the resources among a vast array of competing claims.

...

The 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.

... We must necessarily show considerable deference to the decision makers in this exercise.<sup>50</sup>

In *Shulman v. College of Audiologists and Speech Language Pathologists of Ontario*, a similar decision-making process to the one at issue in *Cameron* resulted in the de-funding of audiologists’ services in Ontario.<sup>51</sup> The applicants, who included hearing impaired individuals and organizations representing the deaf and hard-of-hearing, challenged Ontario’s decision to stop funding hearing-aid evaluations and re-evaluations performed by audiologists operating independently of physicians. The choice to de-list these services was made by a body created by agreement between the Ontario Medical Association, representing doctors in the province, and the Ontario Ministry of Health, that was charged with finding \$50 million/year in savings through changes to the province’s schedule of insured services.<sup>52</sup> As the plaintiffs in *Shulman* described it: “The government and the Ontario Medical Association negotiated these cuts behind closed doors, as part of their process to set fees for the province’s physicians. Not only did the government not consult with any deaf or hard of hearing persons ... they also failed to consult with the ... Specialists ... who treat them.”<sup>53</sup>

The applicants argued that the delisting decision violated section 15 of the *Charter* because of its adverse impact on the deaf and hard-of-hearing, a

<sup>49</sup> *Ibid.*, at para. 98.

<sup>50</sup> *Ibid.*, at paras. 234, 236-37.

<sup>51</sup> [2001] O.J. No. 5057, 155 O.A.C. 171 (Ont. Div. Ct.) [hereinafter “*Shulman*”]; see, generally, Colleen M. Flood & Joanna N. Erdman, “The Boundaries of Medicare: Tensions in the Dual Role of Ontario’s Physician Services Review Committee” (2004) 12 Health L.J. 1 at 13-14.

<sup>52</sup> *Shulman*, at para. 6.

<sup>53</sup> Consumer Coalition for Access to Audiological Services, News Release, “Ear Nose and Throat Specialists Asked to Support Their Patients” (October 9, 2001).



disproportionate number of whom are also poor.<sup>54</sup> The Divisional Court rejected the argument that the de-listing created discriminatory barriers to care and instead concluded that the hearing-impaired were treated no differently than others.<sup>55</sup> In dismissing the plaintiffs' claim, the court warned: "The healthcare system is vast and complex. A court should be cautious about characterizing structural changes to OHIP which do not shut out vulnerable persons as discriminatory, given the institutional impediments to design of a healthcare system by the judiciary."<sup>56</sup>

In *Cilinger c. Quebec (Procureur Général)*, the applicant attempted to launch a class action against the Quebec government, alleging that the failure to ensure that breast cancer patients could obtain radiation treatment within eight weeks of surgery interfered with their physical and psychological integrity and thereby violated their section 7 rights.<sup>57</sup> While the Superior Court held that the applicant could proceed against the 12 publicly funded hospitals providing radiation services in Quebec, it found, and the Court of Appeal agreed, that the class action could not be brought against the government itself.<sup>58</sup> In the court's view, the province's health funding choices were political decisions calling for judicial deference to the point of being non-justiciable:

C'est essentiellement le cadre législatif et réglementaire mis en place pour baliser l'utilisation des ressources et faire échec aux dépassements budgétaires qui est dans la mire de l'appelante. Ces décisions sont à la fois discrétionnaires et souvent le résultat des inévitables arbitrages des agents de l'État entre les différents enjeux sociétaux. Il est donc incontestable ... que le débat se situe dans la sphère politique et est, par conséquent, soustrait à l'action des tribunaux.<sup>59</sup>

### 3. A NEGATIVE RIGHTS APPROACH TO ACCESS TO CARE CLAIMS

The second way in which the courts are avoiding the constitutional issues raised by patients in their access to health care claims is by adopting a narrow, negative-rights based, approach to the *Charter*. While claimants have

<sup>54</sup> *Shulman*, at para. 20.

<sup>55</sup> *Ibid.*, at paras. 28, 31.

<sup>56</sup> *Ibid.*, at para. 43.

<sup>57</sup> [2004] J.Q. No. 11627, [2004] R.J.Q. 2943 (Que. C.A.) [hereinafter "*Cilinger (C.A.)*"], affg (*sub nom. Cilinger c. Centre hospitalier de Chicoutimi*) [2004] J.Q. No. 2058, [2004] R.J.Q. 3083 (Que. S.C.) [hereinafter "*Cilinger (S.C.)*"], leave to appeal refused [2004] C.S.C.R. no 582 (S.C.C.); see, generally, Lorian Hardcastle, "Case Comment: *Cilinger c. Centre Hospitalier de Chicoutimi*" (2006) 14:3 Health Law Review 44.

<sup>58</sup> *Cilinger (C.A.)*, at para. 17.

<sup>59</sup> *Ibid.* at para. 16. "It is essentially the legislative and regulatory framework set up to balance resources and to prevent budgetary overruns that is the appellant's focus. These decisions are both discretionary and often the result of the inevitable balancing of competing social interests. It is therefore indisputable ... that the debate belongs within the political sphere and is, consequently, removed from the purview of the courts." [translated by author]

successfully challenged criminal law prohibitions in *Carter* and other recent cases, the courts' negative rights approach to the *Charter* has been highly problematic where access to care is dependent on positive government measures, rather than government inaction. For example, in *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*,<sup>60</sup> the parents of four autistic children relied on the *Eldridge* decision to challenge the province's refusal to fund their children's intensive behavioural autism treatment. The result, they argued, was a discriminatory failure to meet the particular health needs of children with autism. While the petitioners were successful at trial and on appeal, a unanimous Supreme Court rejected their claim.<sup>61</sup>

In her judgment for the Supreme Court of Canada, McLachlin C.J.C. found that, because autism services were a "recent and emergent"<sup>62</sup> therapy that was not included among the "core" physician services funded under B.C.'s health insurance legislation, the petitioners were not deprived of a benefit "provided for by the law" within the meaning of section 15 of the *Charter*.<sup>63</sup> As she declared: "This Court has repeatedly held that the legislature is under no obligation to create a particular benefit. It is free to target the social programs it wishes to fund as a matter of public policy, provided the benefit itself is not conferred in a discriminatory manner."<sup>64</sup> The failure of B.C.'s health insurance regime to fund anything other than "core" therapies delivered by physicians was not discriminatory, in McLachlin C.J.C.'s view, because it was "an anticipated feature of the legislative scheme".<sup>65</sup>

This negative-rights based conception of the right to health care is even clearer in the Supreme Court's judgment in *Chaoulli*.<sup>66</sup> The plaintiffs, a physician and an elderly patient who had experienced delays obtaining two hip replacements, argued that Quebec's prohibition on private health insurance resulted in undue wait times that put patients' section 7 rights to life and to security of the person at risk, and should therefore be struck down. Their claim was rejected at trial<sup>67</sup> and by the Court of Appeal,<sup>68</sup> but was granted by a majority of the Supreme Court. Justice Deschamps held that the ban violated the right to life and to personal inviolability under article 1 of the Quebec *Charter of*

<sup>60</sup> [2004] S.C.J. No. 71, [2004] 3 S.C.R. 657 (S.C.C.) [hereinafter "*Auton* (S.C.C.)"]; see, generally, Martha Jackman, "Health Care and Equality: Is there a Cure?" (2007) 15 Health L.J. 87 at 113.

<sup>61</sup> *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, [2000] B.C.J. No. 1547, 2000 BCSC 1142 (B.C.S.C.), affd [2002] B.C.J. No. 2258, 2002 BCCA 538 (B.C.C.A.).

<sup>62</sup> *Auton* (S.C.C.), at para. 56.

<sup>63</sup> *Ibid.*, at para. 35.

<sup>64</sup> *Ibid.*, at para. 41.

<sup>65</sup> *Ibid.*, at para. 43.

<sup>66</sup> See, generally, Marie-Claude Prémont, "L'affaire Chaoulli et le système de santé du Québec: cherchez l'erreur, cherchez la raison" (2006) 51 McGill Law J. 167; 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 of Toronto Press, 2005).

<sup>67</sup> *Chaoulli c. Quebec (Procureur général)*, [2000] J.Q. No. 479, [2000] R.J.Q. 786 (Que. S.C.) [hereinafter "*Chaoulli* (S.C.)"].

<sup>68</sup> *Chaoulli c. Quebec (Procureur général)*, [2002] J.Q. No. 759, [2002] R.J.Q. 1205 (Que. C.A.).

*Human Rights and Freedoms*.<sup>69</sup> In their concurring judgment, McLachlin, C.J.C., Bastarache and Major JJ. found that, given delays in accessing care within the public system, the limits on private insurance also infringed section 7 of the Canadian *Charter*.<sup>70</sup> In their dissent, Binnie, Lebel and Fish JJ. disagreed with the majority's conclusion that the prohibition was arbitrary,<sup>71</sup> referring to evidence accepted by the trial judge that the ban was necessary to protect the publicly funded system, upon which everyone relies.<sup>72</sup>

After opining at the very outset of her judgment that “the choice of waiting lists as a management tool falls within the authority of the state and not of the courts”,<sup>73</sup> Deschamps J. summarized what she considered to be the key issue before the Court in *Chaoulli* (S.C.C.): “In essence, the question is whether Quebeckers who are prepared to spend money to get access to health care that is, in practice, not accessible in the public sector because of waiting lists may be validly prevented from doing so by the state.”<sup>74</sup> For her part, McLachlin C.J.C. affirmed that, while the *Charter* “does not confer a freestanding constitutional right to health care”,<sup>75</sup> Quebec's ban on private insurance was objectionable because it prevented “ordinary” Quebec residents from securing private insurance that would enable them to obtain private health care in order to avoid delays in the public system.<sup>76</sup> In the majority's view, rather than requiring the government to deal with the problem of waiting lists within the public system, or to take any affirmative measures to protect universal access, section 7 of the *Charter* demanded state inaction: the appellants must be free to buy their own health care without government interference.

Where the appellants succeeded in having their right to private care affirmed in *Chaoulli*, reliance on the Supreme Court's negative interpretation of the *Charter* doomed the claim to access publicly funded care in *Flora v. Ontario (Health Insurance Plan, General Manager)*.<sup>77</sup> The plaintiff in that case was diagnosed with liver cancer and, after consulting several Ontario specialists, was told that he was not a suitable candidate for a liver transplant and that he had six months to live. He subsequently underwent a “living-related” liver transplant at a private hospital in England. He sought reimbursement of the \$450,000 cost of the treatment from the Ontario Health Insurance Plan (“OHIP”), which turned down his request.<sup>78</sup> He then applied to the provincial Health Services Appeal and Review Board, which confirmed the treatment did not meet the regulatory requirement that it be “generally accepted” in Ontario as appropriate for a

<sup>69</sup> CQLR, c. C-12, ss. 1, 9.1; *Chaoulli* (S.C.C.), at para. 100.

<sup>70</sup> *Chaoulli* (S.C.C.), at para. 124.

<sup>71</sup> *Ibid.*, at paras. 168, 255.

<sup>72</sup> *Ibid.*, at paras. 240-241.

<sup>73</sup> *Ibid.*, at para. 2.

<sup>74</sup> *Ibid.*, at para. 4.

<sup>75</sup> *Ibid.*, at para. 104.

<sup>76</sup> *Ibid.*, at paras. 111, 124.

<sup>77</sup> [2008] O.J. No. 2627, 2008 ONCA 538 (Ont. C.A.) [hereinafter “*Flora* (C.A.)”], affg [2007] O.J. No. 91, 83 O.R. (3d) 721 (Ont. Div. Ct.) [hereinafter “*Flora* (Div. Ct.)”].

<sup>78</sup> *Flora* (Div. Ct.), at paras. 2-6.

person in the “same medical circumstances” as the plaintiff.<sup>79</sup> The plaintiff appealed the Board’s decision to the Ontario Divisional Court, which concluded that his section 7 rights had not been infringed since he remained free to seek the care he wanted outside the province.<sup>80</sup>

The court distinguished the *Chaoulli* decision on the grounds that “in the case at bar, the government has not prohibited anything ... the Regulation does not in any way restrict an individual from securing his or her own health care or in arranging his or her own treatment.”<sup>81</sup> The court found that while the government’s decision whether or not to fund a particular treatment “may certainly impact a person’s s. 7 interests, such an effect is not the type of infringement contemplated by s. 7. If it were, it would seem that the burden on the government would be limitless.”<sup>82</sup> The Court of Appeal upheld the trial court’s conclusion that lack of OHIP funding was constitutionally unobjectionable.<sup>83</sup> In the court’s view: “the reach of s. 7 does not extend to the imposition of a positive constitutional obligation on the Ontario government to fund out-of-country medical treatments even where the treatment in question proves to be life-saving in nature.”<sup>84</sup>

The Federal Court decision in *Canadian Doctors for Refugee Care v. Canada (Attorney General)*<sup>85</sup> adopts a similarly narrow approach to governments’ health care obligations under section 7 of the *Charter*. The applicants challenged the federal government’s decision to exclude certain classes of migrants, including failed refugee claimants and refugee claimants from designated countries of origin, from receiving publicly funded services under the Interim Federal Health Benefit Program (“IFHP”). After reviewing the impact of the cuts, Mactavish J. found that the denial of access to care constituted “cruel and unusual treatment or punishment” under section 12 and was discriminatory based on national or ethnic origin under section 15.<sup>86</sup> However, she dismissed the argument that the IFHP cuts violated the applicants’ rights to life and to security of the person under section 7 of the *Charter*.<sup>87</sup>

In coming to this conclusion, Mactavish J. pointed to the fact that, unlike the IFHP claimants, the applicants in *Chaoulli* were not asking the court to order the government to pay for, but rather were challenging limits on their ability to

---

<sup>79</sup> *Ibid.*, at para. 40, 43.

<sup>80</sup> *Ibid.*, at para. 168.

<sup>81</sup> *Ibid.*, at para. 174.

<sup>82</sup> *Ibid.*, at para. 204.

<sup>83</sup> *Flora* (C.A.), at para. 102.

<sup>84</sup> *Ibid.*, at para. 108. See also *C.C.-W. (Litigation guardian of) v. Ontario (Health Insurance Plan, General Manager)*, [2009] O.J. No. 140, 95 O.R. (3d) 48 (Ont. Div. Ct.); *Graham v. Ontario Health Insurance Plan (General Manager of)*, [2014] O.J. No. 1185, 2014 ONSC 1623 (Ont. Div. Ct.).

<sup>85</sup> *Canadian Doctors for Refugee Care v. Canada (Attorney General)*, [2014] F.C.J. No. 679, 2014 FC 651 (F.C.) [hereinafter “*Refugee Care*”].

<sup>86</sup> *Ibid.*, at paras. 11-14.

<sup>87</sup> *Ibid.*, at para. 571.

obtain, their own private care.<sup>88</sup> Although the safe injection program at issue in the *Insite* case was publicly funded, Mactavish J. also distinguished that decision, arguing that “[t]here is ... a world of difference between requiring the state to grant an exemption that would allow a health care provider to provide medical services funded by others and requiring the state itself to fund medical care.”<sup>89</sup> Referring to the concerns of the dissenting justices in *Chaoulli*, Mactavish J. affirmed:

... basing a positive right to health care on section 7 of the Charter would require the Courts to weigh in and determine the appropriate scope of health services and the acceptable length of wait times reasonably required under the Charter. This would be a very uncomfortable role for the Courts, as it has long been recognized that decisions as to the setting of priorities and the allocation of scarce resources are matters not for the Courts, but for governments.<sup>90</sup>

Rather than examining the deleterious impact of the denial of IFHP coverage on the lives and security of the person of the claimants, Mactavish J. simply rejected their section 7 claim on the grounds that “the Charter’s guarantees of life, liberty and security of the person do not include the positive right to state funding for health care”.<sup>91</sup> This was, in her view, “a right that not even Canadian citizens possess”.<sup>92</sup>

### C. THE WAY FORWARD

By adopting an excessive degree of deference to government spending choices and a negative conception of the *Charter* rights to life, security of the person and equality in the health care context, Canadian courts have avoided squarely addressing access to health care as a *Charter* issue. In cases like *Auton* and *Shulman*, courts have resisted dealing with the question of whether decision-making that limits access to care, either by excluding particular services or patient groups from public health insurance coverage or the *de facto* operation of waiting lists, is consistent with *Charter* equality values at a substantive level, as required by section 15. In cases like *Cameron*, *Flora* and *Refugee Care*, the courts have also failed to address the important issue of whether decision-making processes affecting access to health care services are principled and just, in accordance with the procedural and substantive requirements of section 7 of the *Charter*. And, since few section 7 or 15 health claims have been granted, governments have rarely, if ever, been called upon to show that barriers to care constitute reasonable and justifiable limits within the meaning of section 1 of the *Charter*. Justice Slatter’s statement, in *Allen*, captures the prevailing judicial view: “The Canadian governments could abolish the universal health care system at any time. They can remove services from the system, or add new

---

<sup>88</sup> *Ibid.*, at paras. 533-534.

<sup>89</sup> *Ibid.*, at para. 538.

<sup>90</sup> *Ibid.*, at para. 535.

<sup>91</sup> *Ibid.*, at para. 571.

<sup>92</sup> *Ibid.*, at para. 740.

services. These social policy choices do not engage the constitution; neither the *Charter* nor the judiciary have much to contribute to the debate.”<sup>93</sup>

The courts’ reluctance to subject individual and systemic decisions affecting access to care to *Charter* scrutiny is regrettable, not only because effective alternatives are lacking within the publicly funded system, but also because the *Charter* has enormous potential as an accountability mechanism in this context. The *Charter* provides a valuable framework for assessing whether decisions limiting access to health care comply with basic constitutional values. Through the process of *Charter* review, health care decision-makers can be called upon to explain: the reasons that access to care is denied; the manner in which rationing decisions are made; and whether decisions limiting access to health care are reasonable and justifiable not only in terms of their stated objectives, cost-savings or otherwise, but also in terms of their actual effects at both an individual and a broader societal level.

In particular, section 15 of the *Charter* enables courts to examine health care decision-making in light of substantive equality principles. Direct and systemic barriers to care, such as the refusal to fund interpretation services in *Eldridge*, the termination of funding for audiologists’ services in *Shulman* and the limits on abortion funding in *Jane Doe*, can be reviewed for their discriminatory impact on people with disabilities, women, immigrants and other disadvantaged groups. For its part, section 7 of the *Charter* provides a basis for assessing the process whereby access to care decisions are made within the publicly funded system, such as: the decision not to fund the out of province service being sought in *Flora*; decisions as to the level of funding provided for radiation services in the *Cilinger*; or the choice to de-list particular treatments or patient groups, such as in the *Cameron* or *Shulman* cases. In considering whether there has been full compliance with the principles of fundamental justice under section 7, courts can question whether decision-making is transparent, participatory and informed, or instead whether it is arbitrary or driven by private rather than public interests.

Finally, in cases like *Jane Doe* or *Cameron* where section 7 or section 15 rights violations have been found, governments have an opportunity to demonstrate that decision-making affecting access to care, including decisions not to fund, or to terminate funding for particular health services, complies with the requirements of section 1 of the *Charter*. In light of the evidence presented by the parties, courts can verify a governments’ claims that cost savings decisions are rational and evidence-based as opposed to merely reactive, speculative, or the product of stereotypes and systemic patterns of neglect in relation to the health interests and needs of disadvantaged groups. Conversely, where a claimant is seeking access to care for which there is little or no evidence of clinical effectiveness, or where the benefits of a particular treatment are clearly outweighed by its risks and costs, the decision to ration or to deny access can be upheld as a reasonable and justifiable limit on *Charter* rights.

---

<sup>93</sup> *Allen*, at para. 35.

The *Eldridge* (S.C.C.) case itself provides a compelling illustration of the value of *Charter* review in this regard.<sup>94</sup> A central issue in *Eldridge* was whether B.C.'s failure to fund sign language interpretation services was a reasonable or justifiable limit on the equality rights of the Deaf. At trial, the plaintiffs filed evidence that the provincial Ministry of Health had earlier turned down two requests by the Western Institute for the Deaf for funding that would have allowed that non-profit organization to continue providing medical interpretation services to deaf patients in the Lower Mainland, free of charge. The Institute's first request for funding was rejected out of hand. The Institute's second request was reviewed by a health ministry official who recommended that \$150,000 in annual funding be granted. The trial judge cited an internal memorandum from the ministry's Executive Committee – the body that ultimately turned down the Institute's funding request – explaining its negative decision as follows: "... it was felt to fund this particular request would set a precedent that might be followed up by further requests from the ethnic communities where the language barrier might also be a factor."<sup>95</sup>

In coming to the conclusion that B.C.'s failure to provide publicly funded interpretation services for the deaf violated the *Charter*, the Supreme Court was not persuaded by the government's argument that "recognition of the appellants' claim will have a ripple effect throughout the health care field, forcing governments to spend precious health care dollars accommodating the needs of myriad disadvantaged persons."<sup>96</sup> The Court characterized the government's evidence as "conjectural"<sup>97</sup> and held that the refusal to fund interpretation services, at an estimated annual cost of 0.0025 per cent of the provincial health care budget, could not be justified under section 1 of the *Charter*.<sup>98</sup> In LaForest J.'s words:

... I am of the view that the failure to fund sign language interpretation is not a "minimal impairment" of the s. 15(1) rights of deaf persons ... . The evidence clearly demonstrates that, as a class, deaf persons receive medical services that are inferior to those received by the hearing population. ... The government has simply not demonstrated that this unpropitious state of affairs must be tolerated in order to achieve the objective of limiting health care expenditures.<sup>99</sup>

In terms of the specific health service at issue in *Eldridge*, the provincial government's refusal to provide medical interpretation for the deaf and the justification advanced by health ministry officials for this decision were in no way evidence-based. The government did not undertake any assessment of the

<sup>94</sup> See, generally, Dianne Pothier, "*Eldridge v. British Columbia (A.G.): How the Deaf Were Heard in the Supreme Court of Canada*" (1998) 9:2 N.J.C.L. 263.

<sup>95</sup> *Eldridge v. British Columbia (Attorney General)*, [1992] B.C.J. No. 2229, 75 B.C.L.R. (2d) 68 at 75 (B.C.S.C.) [hereinafter "*Eldridge* (B.C.S.C.)"].

<sup>96</sup> *Eldridge* (S.C.C.), at para. 91.

<sup>97</sup> *Ibid.*, at para. 92.

<sup>98</sup> *Ibid.*, at para. 87.

<sup>99</sup> *Ibid.*, at para. 94.

actual health and financial costs versus benefits before making its decision. As the Charter Committee on Poverty Issues argued in its intervention in *Eldridge*:

As the evidence presented at trial makes clear, the cost of providing interpretation services represents a modest expenditure relative to total provincial health care spending. Moreover, without interpretation services, persons who are deaf are at heightened risk of having their medical conditions misdiagnosed, of requiring more frequent and lengthy physician and hospital visits, of receiving inadequate preventive care, and of receiving care which is inappropriate or delayed. Providing interpretation services may well reduce rather than increase provincial health care expenditures. Under section 1, government bears the onus of proof, and in this case, the province has failed to establish that public funds were actually saved.<sup>100</sup>

The particular funding decision that was challenged in *Eldridge* is symptomatic of a broader problem of inequality of access to health care services for people with disabilities in Canada – one that has been well documented.<sup>101</sup> The decision to refuse funding for interpretation services reflected and perpetuated a discriminatory lack of attention to the core health care needs of the deaf at all levels of the system, from the Ministry of Health through to individual hospitals and health providers. The decision-making process at issue was arbitrary, opaque and discriminatory. The underlying reasons for the decision: a concern that other minority language groups would make similar demands, as well as its purported cost-savings justification, were equally suspect. Absent pursuing a *Charter*-based claim before the courts, the plaintiffs in *Eldridge* had no effective means of holding health care decision-makers accountable for their funding choice. The availability of *Charter* review enabled them: to challenge the discriminatory intent and effects of the government's decision; to expose the inadequacies and inequities of the decision-making process that was employed to make it; and to demand that the government demonstrate, rather than merely assert, that its decision was rational as a matter of health policy and spending, quite apart from its deleterious impact at the level of fundamental rights.

The situation in *Eldridge* is akin to the one at issue in *Toussaint v. Canada (Attorney General)*,<sup>102</sup> now the subject of a petition to the United Nations Human Rights Committee.<sup>103</sup> After working in Canada for a number of years as an undocumented migrant the applicant, Nell Toussaint, developed several life-

<sup>100</sup> *Ibid.* (Factum of the Intervener Charter Committee on Poverty Issues at para. 44) (the author represented the Charter Committee on Poverty Issues in the case).

<sup>101</sup> See, generally, Canadian Human Rights Commission, *Report on Equality Rights of People with Disabilities* (Ottawa: Minister of Public Works and Government Services, 2012) at 80-98.

<sup>102</sup> [2010] F.C.J. No. 987, 2010 FC 810 (F.C.) [hereinafter "*Toussaint* (F.C.)"], aff'd [2011] F.C.J. No. 984, 2011 FCA 213 (F.C.A.) [hereinafter "*Toussaint* (F.C.A.)"], leave to appeal refused [2011] S.C.C.A. No. 412 (S.C.C.).

<sup>103</sup> After the Supreme Court denied her leave to appeal, Ms. Toussaint filed a petition to the UN Human Rights Commission under the *Optional Protocol to the International Covenant on Civil and Political Rights* (December 16, 1966), 999 U.N.T.S. 171 (entered into force March 23, 1976); that proceeding is ongoing, see Social Rights in Canada, *Nell Toussaint v. Canada* HRC No. 2348-2014, online: <http://www.socialrightscura.ca/eng/legal-strategies-right-to-healthcare.html>.



threatening medical conditions related to untreated diabetes and hypertension.<sup>104</sup> Her application under the IFHP was denied, on the grounds that she did not fall within the four classes of immigrants eligible for coverage.<sup>105</sup> On judicial review, the Federal Court found that her exclusion from the IFHP violated the applicant's rights to life and to security of the person.<sup>106</sup> However, the court held that denying health care benefits to the applicant and others who entered or remained in Canada illegally was not arbitrary, since it was consistent with the government's objective of preventing Canada from becoming a "health-care safe-haven".<sup>107</sup> The Federal Court of Appeal accepted that "the appellant was exposed to a ... risk significant enough to trigger a violation of her rights to life and security of the person."<sup>108</sup> However, it concluded that the appellant's own conduct was the "operative cause" of any injury to her section 7 rights,<sup>109</sup> and that her exclusion from the IFHP did not violate section 7 principles of fundamental justice.<sup>110</sup>

In applying for coverage under the IFHP in May 2009, Ms. Toussaint explained that she was unable to pay for the medical care she required and that, given the severity of the health problems she faced, accessing the IFHP was a matter of life and death.<sup>111</sup> In July 2009 she received, as Zinn J. described it, a "short" decision from an official within the Health Management Branch of Citizenship and Immigration Canada stating that, because the applicant was not a refugee claimant, a resettled refugee, a person detained under the *Immigration and Refugee Protection Act*<sup>112</sup> or a Victim of Trafficking in Persons, her request for IFHP coverage could not be approved.<sup>113</sup> In her *Charter* claim, Ms. Toussaint described the decision-making process that resulted in her being refused access to health coverage – a decision Zinn J. found "exposed her to a risk to her life as well as to long-term, and potentially irreversible, negative health consequences"<sup>114</sup>:

[No] consideration appears to have been given of alternative means of obtaining necessary healthcare. There is no transparency, predictability, rationality or accountability to the decision to disqualify the Applicant from access to healthcare. The Applicant was not given any reasons for her disqualification from the benefit which she could address or respond in a

---

<sup>104</sup> *Toussaint* (F.C.), at para. 8.

<sup>105</sup> *Ibid.*, at para. 19.

<sup>106</sup> *Ibid.*, at para. 91.

<sup>107</sup> *Ibid.*, at para. 94.

<sup>108</sup> *Toussaint* (F.C.A.), at para. 61.

<sup>109</sup> *Ibid.*, at paras. 72-73.

<sup>110</sup> *Ibid.*, at para. 82.

<sup>111</sup> *Toussaint* (F.C.), (Memorandum of Argument, at para. 11).

<sup>112</sup> S.C. 2001, c. 27.

<sup>113</sup> *Toussaint* (F.C.), at para. 18-19.

<sup>114</sup> *Ibid.*, at para. 91.

meaningful way. She was simply told she was ineligible because she did not belong to one of a list of groups who are provided the benefit ...<sup>115</sup>

Dr. Manuel Carballo, a Professor of Clinical Public Health at Columbia University and an expert called in *Toussaint*, described the irrationality of the federal government's refusal to extend health care coverage to undocumented migrants:

To deny this vulnerable group's access to health care is both contrary to the principles of universal access and human rights and short-sighted in terms of public health and sustained socio-economic development. This is being increasingly recognized and the number of countries committed to providing health care to undocumented migrants is growing. They are doing so not only out of a spirit of humanitarianism, but also on the basis of the evidence that undocumented migrants do not abuse health care services, do not arrive looking for health care, and are eager to work and "fit in". Further, they recognize that prevention, early diagnosis and treatment of illness in this vulnerable population will provide savings in the longer term ...<sup>116</sup>

The Ontario government cuts to provincial health coverage for various classes of migrants that eventually led to the *Toussaint* and *Refugee Care* claims at the federal level, were themselves subject to *Charter* review in *Irshad (Litigation guardian of) v. Ontario (Minister of Health)*.<sup>117</sup> The appellants in *Irshad*, including a disabled child deemed to be medically inadmissible to Canada but living with his family in Ontario by virtue of a federal Minister's permit, challenged the residency requirements and three-month waiting period for OHIP coverage.<sup>118</sup> The Ontario Court of Appeal found that the provincial residency requirements, imposed among other major cost-cutting changes to the health care system following reductions in federal health transfers in 1994,<sup>119</sup> were based on immigration status which was not, in the Court's view, an analogous ground of discrimination under section 15.<sup>120</sup> The court also rejected the argument that the three-month waiting period discriminated against new immigrants relative to those moving to Ontario from another province.<sup>121</sup> In coming to its decision, the court described the origins of the 1993-94 Ontario cuts to migrant health coverage:

The annual increases in health care costs, coupled with large reductions in the federal transfer payments relied on to fund health care, made the fiscal crisis

<sup>115</sup> *Ibid.* (Memorandum of Argument at para. 39).

<sup>116</sup> *Ibid.* (Affidavit of Manuel Carballo at paras 45-46).

<sup>117</sup> [2001] O.J. No. 648, 55 O.R. (3d) 43 (Ont. C.A.) [hereinafter "*Irshad*"], affg [1999] O.J. No. 301, 60 C.R.R. (2d) 231 (Ont. Gen. Div.); see also *Clarken v. Ontario (Health Insurance Plan)*, [1998] O.J. No. 1933, 109 O.A.C. 363 (Ont. Div. Ct.); *T. (A.) (Litigation Guardian of) v. Ontario (Health Insurance Plan, General Manager)*, [2010] O.J. No. 2044, 2010 ONSC 2398 (Ont. Div. Ct.).

<sup>118</sup> *Irshad*, at paras. 71-74.

<sup>119</sup> *Ibid.*, at paras. 24-34.

<sup>120</sup> *Ibid.*, at para. 140.

<sup>121</sup> *Ibid.*, at paras. 144-150.

faced by the province particularly acute within the health care field. The Ministry had to make deep cuts in its budget ... and it was announced that services that had previously been covered by OHIP would no longer be covered.<sup>122</sup>

As the Court of Appeal explained, prior to 1994, immigration status was irrelevant for purposes of access to health care in Ontario and, consistent with the definition of a “resident” in the *Canada Health Act*, anyone lawfully in Canada living in the province was eligible for OHIP coverage.<sup>123</sup> In 1994, in addition to introducing a three-month waiting period and excluding temporary residents, including foreign workers, foreign students and applicants for landed immigrant status awaiting a medical exam, the province also called on the federal government to assume the health care costs of refugees living in Ontario.<sup>124</sup>

The denial of access to care in *Toussaint*, like the IFHP cuts challenged in the *Refugee Care* case, and the OHIP exclusions at issue in *Irshad*, targeted a group that has experienced historic and ongoing disadvantage within Canadian society: immigrants, including undocumented migrants, refugees and new immigrants in particular.<sup>125</sup> Nevertheless, in contrast to *Eldridge*, rather than exposing the discriminatory intent and effects of the government’s choices around inclusion and exclusion from the publicly funded system, the Federal Court and Federal Court of Appeal in *Toussaint* relied upon and reinforced stereotypes about migrants and the interaction between immigrant status and access to health care. At the trial level in *Toussaint*, Zinn J. affirmed that to provide publicly funded care to undocumented migrants such as Ms. Toussaint “would make Canada a health-care safe-haven for all who required health care and health care services”.<sup>126</sup> At the Court of Appeal, Stratas J.A. agreed that: “If the appellant were to prevail in this case and receive medical coverage ... without complying with Canada’s immigration laws, others could be expected to come to Canada and do the same. Soon, as the Federal Court warned, Canada could become a health care safe haven, its immigration laws undermined.”<sup>127</sup>

As Ms. Toussaint submitted in her petition to the United Nations Human Rights Commission, rather than simply accepting the government’s submissions in the *Insite* case, the Supreme Court “took note of reliable evidence showing that, contrary to prevalent myths, provision of safe injection facilities did not, in

---

<sup>122</sup> *Ibid.*, at para. 27.

<sup>123</sup> *Ibid.*, at paras. 18-20

<sup>124</sup> *Ibid.*, at paras. 20, 29-30.

<sup>125</sup> See, generally, Chen chapter; Y.Y. Brandon Chen, “The Future of Precarious-Status Migrants’ Right to Health Care in Canada” (2017) 54 *Alta. L. Rev.* (forthcoming); Constance MacIntosh, “Wealth Meets Health: Disabled Immigrants and Calculations of ‘Excessive Demand’” in Jocelyn Downie & Elaine Gibson, eds., *Health Law at the Supreme Court of Canada* (Toronto: Irwin Law, 2007) at 293.

<sup>126</sup> *Toussaint* (F.C.), at para. 94.

<sup>127</sup> *Toussaint* (C.A.), at para. 113.

fact, lead to increased illegal drug use”.<sup>128</sup> In contrast, at the Federal Court and Court of Appeal in *Toussaint*, “common demeaning stereotypes suggesting that undocumented migrants are simply out to take advantage of free services in their destination countries were relied upon by the respondent government and largely accepted by the courts without being tested against reliable evidence.”<sup>129</sup> Ms. Toussaint points out that, instead, “[t]hese courts could have recognized the disproportionality between any purported benefits from such deterrence and the deprivation of the right to life through the denial of health care as did the Supreme Court of Canada in the *Insite* case.”<sup>130</sup>

Canadian courts have a vital role to play in ensuring that access to health care decisions, such as the ones at issue in *Eldridge* and in *Toussaint*, are subject to open and rigorous *Charter* scrutiny. In some cases this will result in decisions being overturned. In other cases, where limits on access to care are fair and evidence-based, government choices are likely to be upheld. The role of *Charter* review in this context is not simply to provide an adjudicative recourse of last resort for decisions that adversely affect access to care, or to guarantee any patient or group of patients a specific outcome. Rather, *Charter* review can ensure that health care decision-making is both evidence-based and properly informed by constitutional values of fundamental justice and substantive equality. The entitlement to a rights-informed framework for health care decision-making is particularly important where barriers to access to care raise systemic concerns in relation to vulnerable groups: situations like in *Eldridge*, *Toussaint* or the ongoing *Grant v. Winnipeg Regional Health Authority case*, where effective safeguards are lacking within the health care system itself.<sup>131</sup>

## D. CONCLUSION

In the absence of effective alternatives, the *Charter* has enormous potential as a health care accountability mechanism. As described above, section 15 of the *Charter* enables courts to assess health care decision-making in light of substantive equality principles. The process whereby decisions are made within the publicly funded system can also be reviewed under section 7. And, in cases where a rights violation has been found, governments have an opportunity to demonstrate that decision-making affecting access to care is reasonable and justified in accordance with the requirements of section 1. For the *Charter* to operate as an effective accountability mechanism in this way, however, health

---

<sup>128</sup> Social Rights in Canada, *Nell Toussaint v Canada*, HRC No. 2348-2014, at para. 173, online: <http://www.socialrightscura.ca/eng/legal-strategies-right-to-healthcare.html>.

<sup>129</sup> *Ibid.*, at para. 170.

<sup>130</sup> *Ibid.*, at para. 174.

<sup>131</sup> [2015] M.J. No. 116, 2015 MBCA 44 (Man. C.A.), revg [2013] M.J. No. 266, 2013 MBQB 194 (Man. Q.B.) and affg [2012] M.J. No. 92, 2012 MBQB 88 (Man. Q.B.), where the plaintiff launched a *Charter* action on her own behalf and on behalf of her brother, Brian Sinclair, a 45-year old disabled Aboriginal man with cognitive impairment who died of a bladder infection after waiting for 34 hours in the emergency room of the Winnipeg Health Centre without receiving any medical attention.

care must be understood by Canadian courts, as it is by Canadians themselves, as a fundamental right.

It is evident that judicial recognition of a constitutional right to publicly funded health care based on need, rather than on ability to pay, does not yet exist in Canada. While courts in other constitutional democracies have shown increasing willingness to impose positive obligations on governments to ensure access to health care, social security, housing and other socio-economic rights, the Canadian judiciary stands out in its conservatism in this regard.<sup>132</sup> Since the inception of the *Charter* judges in Canada have, with rare exceptions, adopted a deferential, negative rights based approach to the *Charter* in socio-economic rights cases, including in cases where access to health care directly engages life, security of the person and equality. In clear contradiction of Canada's obligations under the ICESCR, Canadian judges have frequently held that governments have no affirmative duty to ensure that individuals, particularly those who are members of socially or economically disadvantaged groups, are in fact accorded the equal protection and benefit of *Charter* rights to life, security of the person or equality.<sup>133</sup>

The defects of this “thin and impoverished” vision of the *Charter*, as LaForest J. characterized it in *Eldridge*,<sup>134</sup> are especially glaring in the health care context. In *Chaoulli*, McLachlin C.J.C. approved the remedy being sought by the appellants, which she described as follows:

The appellants do not seek an order that the government spend more money on health care, nor do they seek an order that waiting times for treatment under the public health care scheme be reduced. They only seek a ruling that because delays in the public system place their health and security at risk, they should be allowed to take out insurance to permit them to access private services.<sup>135</sup>

This approach has been taken up in several post-*Chaoulli* cases,<sup>136</sup> most recently in the *Cambie Surgeries Corp. v. British Columbia (Medical Services Commission)*<sup>137</sup> challenge to the ban on private insurance, extra-billing and other limits on private care found by the trial judge in *Chaoulli* to be necessary to

<sup>132</sup> International Commission of Jurists, *Courts and the Legal Enforcement of Economic, Social and Cultural Rights: Comparative Experiences of Justiciability* (Geneva: International Commission of Jurists, 2008).

<sup>133</sup> See, generally, Martha Jackman & Bruce Porter, eds., *Advancing Social Rights in Canada* (Toronto: Irwin Law Inc., 2014).

<sup>134</sup> *Eldridge* (S.C.C.), at para. 73.

<sup>135</sup> *Chaoulli* (S.C.C.), at para. 103.

<sup>136</sup> *Murray v. Alberta (Minister of Health)*, [2007] A.J. No. 428, 2007 ABQB 231 (Alta. Q.B.); *McCreith v. Ontario (A.G.)* (statement of claim filed September 5, 2007), Toronto 07-CU-339454PD3 (Ont. S.C.J.); *Allen*.

<sup>137</sup> *Canadian Independent Medical Clinics Assn. v. British Columbia (Medical Services Commission)*, [2010] B.C.J. No. 1323, 2010 BCSC 927 (B.C.S.C.); *Cambie Surgeries Corp. v. British Columbia (Medical Services Commission)*, [2010] B.C.J. No.1766, 2010 BCCA 396 (B.C.C.A.); [2013] B.C.J. No. 2497, 2013 BCSC 2066 (B.C.S.C.); [2014] B.C.J. No. 390, 2014 BCSC 361 (B.C.S.C.); [2014] B.C.J. No. 1148, 2014 BCSC 1028 (B.C.S.C.) [hereinafter “*Cambie Surgeries*”].

protect the single-payer system.<sup>138</sup> The plaintiffs, including a private clinic co-owned by former Canadian Medical Association President Brian Day, argue that these restrictions violate the section 7 rights of those who have the means but are precluded from jumping the public queue.<sup>139</sup> Rather than imposing a constitutional obligation on governments to improve the public system, the plaintiffs contend that the *Charter* obligates the courts to strike it down.<sup>140</sup>

The argument, adopted by the majority in *Chaoulli* and relied upon by the claimants in the *Cambie Surgeries* case, that the *Charter* does not guarantee the right to receive health care based on need, but only the right to buy it free from government constraint, is not only offensive from a moral point of view, but unconvincing in terms of the language and interpretive context of the *Charter*.<sup>141</sup> Ms. Toussaint has described the implications of such a reading of the *Charter* for her and others in her situation:

Unlike the patients considered in *Chaoulli*, who had the financial resources to purchase private healthcare insurance, the Applicant in the present case lives in poverty and is unable to pay for either private health care or for private insurance. The remedy sought by more affluent applicants in *Chaoulli* would be entirely ineffective in vindicating the present Applicant's rights under s. 7.<sup>142</sup>

Equally objectionable, in light Canada's domestic and international health and human rights commitments, is the call by the dissenting justices in *Chaoulli* for deference to government health policy choices, to the point of suggesting that nothing in the Canadian constitution would preclude the adoption of a U.S. style health care system.<sup>143</sup> As Binnie and LeBel JJ. themselves conclude: "... the impugned provisions were part of a system which is mindful and protective of the interests of all, not only of some."<sup>144</sup>

Public opinion surveys consistently show that an overwhelming majority of Canadians across all demographic groups support the public health care system and public solutions for strengthening it, over expanding private services.<sup>145</sup>

<sup>138</sup> *Chaoulli* (S.C.), at para. 263. In Piché J.'s words: "Il ne faut pas jouer à l'autruche. L'établissement d'un système de santé parallèle privé aurait pour effet de menacer l'intégrité, le bon fonctionnement ainsi que la viabilité du système public."

<sup>139</sup> *Cambie Surgeries, Further Amended Notice of Civil Claim*, Vancouver Registry No. S090663, at paras. 98-100.

<sup>140</sup> *Cambie Surgeries, Opening Statement of the Plaintiffs* (September 6, 2016), Vancouver Registry No. S090663, at para. 1.

<sup>141</sup> See, generally, Bruce Porter, "A Right to Health Care in Canada: Only If You Can Pay For It" (2005) 6:4 ESR Review 8; Lorne Sossin, "Towards a Two-Tier Constitution? The Poverty of Health Rights" 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 of Toronto Press, 2005) 161.

<sup>142</sup> *Toussaint* (F.C.), (Memorandum of Argument, at para. 27.)

<sup>143</sup> *Chaoulli* (S.C.C.), at para. 176.

<sup>144</sup> *Ibid.*, at para. 278.

<sup>145</sup> See, generally, Canadian Health Coalition, *Polls* (Ottawa: Canadian Health Coalition), online: <http://web.archive.org/web/20160314095227/http://healthcoalition.ca/main/polls/>; Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in*

Excessive judicial deference to government funding choices, and the courts' unwillingness to rigorously review either the substance or the process of health care decision-making in light of *Charter* principles, is out of touch with Canadians' understanding of the social significance of the medicare system and their conception of health care as a fundamental right. Until Canadian courts understand health care decision-making as engaging substantive rights to security of the person and equality, *Charter* review of health care access does, as the critics have warned, pose a real danger.<sup>146</sup> As the *Chaoulli* decision illustrates, the prevailing approach risks further undermining the publicly funded system and the right to health of every person in Canada, rather than reinforcing accountability and human rights in this crucial area of social policy.

---

*Canada – Final Report* (Saskatoon: Commission on the Future of Health Care in Canada, 2002) at xvi.

<sup>146</sup> See, for example, Antonia Maioni, "Citizenship and Healthcare in Canada" (2010) 42 *Int'l J. Can. Stud.* 225 at 240; Vandna Bhatia, "Social Rights, Civil Rights and Health Reform in Canada" (2010) 23:1 *Governance: An International Journal of Policy, Administration, and Institutions* 37 at 50; 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 of Toronto Press, 2005).

