CONFORMITY OR CONTRADICTION: INTERNATIONAL HEALTH RIGHTS IN CANADIAN COURTS

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Contents

ABSTRACT

This thesis examines court decisions affecting health interests under the *Canadian Charter of Rights and Freedoms* from the perspective of international health rights law. The conceptual outlook is that human rights are constructed and their interpretation both contested and historically contingent. Article 12 of the *International Covenant on Economic and Social Rights (ICESCR)* provides the most comprehensive analytical framework addressing fundamental attributes of health rights such as accessibility, availability, acceptability, non-discrimination as well as the quality of the healthcare system. Less recognised principles in the Canadian context include the social determinants of health, minimum core obligations, and the nature of the state's obligation. After reviewing the basis for the reception of international human rights law in Canada, and based on an empirical review of five Supreme Court of Canada health related *Charter* challenges between 1997-2011 (*Eldridge, Auton, Gosselin, Chaoulli, Insite*) including the parties' submissions, I conclude that the parties and the courts fail to adequately link international health rights to *Charter* interpretation or address relevant interpretive principles. International jurisprudence concerning access to healthcare, minimum core obligations, adequacy in non healthcare determinants of health are ignored in relation both to section 7 interests of life and security of the person and the principles of fundamental justice. Labour cases provide a sharp contrast with health rights cases. In that domain, the presumption of conformity between international law and domestic rights interpretation is well entrenched and even 'soft law' accorded weight as a 'relevant and persuasive' source. In contrast, despite the articulation of legal principles to the contrary, the courts are resistant to applying international human rights law to the interpretation of Charter rights where health interests are at stake. Instead, the influence of the controversial dichotomy between negative and positive rights continues to dominate judicial decisions, in which only government interference with access to healthcare, through its criminal or regulatory jurisdiction, will be found to violate the *Charter*. Judicial deference at the violation or remedial stage continues to weaken oversight where government inaction or under-inclusive healthcare programs leave Canadians without access to the determinants of health they are guaranteed by international law.

Chapter 1 Introduction

Health has been described as fundamental to the enjoyment of all human rights, starting with the right to life and necessary to the enjoyment of all other human rights. Not coincidentally, health rights have been described as "one of the most extensive and complex human rights in the international lexicon."[1] The argument presented in this paper is that despite Canada's claims to conformity with its international human rights obligations, in fact, Canadian courts often overlook or underestimate the complexities of health rights and fail to apply them correctly. As a result, many judicial outcomes run counter to Canada's international health rights obligations. It is argued that a more rigorous judicial application of international health rights principles is necessary.

While at the level of international law Canada is committed to "the highest attainable standard of health," at a domestic level, in the courts, that obligation is largely ignored or misinterpreted, based in part on government legal representations. Health rights have yet to be fully embraced by Canadian courts, and individual health claims, when presented to the courts, if not rejected, often only find protection in limited civil and political rights approaches. Despite or perhaps because of Canadians' pride in Medicare, a health system based on universal public insurance, a rights-based approach to health protection

[1]United Nations, Human Rights Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, 17 January 2007, UN Doc, A/HRC/4/28.

is seen by some healthcare advocates as at worst, antagonistic to the collective public interest, and at best, controversial in its impacts.[2]

The right to health forms part of social rights protections at the international level; protections that include rights in education, employment, social security and an adequate standard of living, among others (also referred to as "economic and social rights (ESRs)," or socio-economic rights.)[3] While Canada has ratified several international treaties that recognise and protect health rights, it has failed to explicitly incorporate health rights into its constitution, human rights codes or legislation.[4]

In this paper I will examine the conceptual basis for economic and social rights and health rights in particular. The various critiques of social rights as a legal basis for holding government accountable will be examined as a means of exploring what I will later encounter in the Canadian jurisprudence as a resistance to or rejection of the implementation of "positive" rights through the *Charter*.

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[2] Institute for Research in Public Policy, "90% of Canadians support public health care," Press release November 4, 2009, http://www.medicare.ca/wp-content/uploads/2009/11/nanos-poll.pdf; see also Colleen Flood and Aeyal Gross, "Litigating the Right to Health: What Can I Learn from a Comparative Law and Health Care Systems Approach?" (2014) 16 HHRJ 2 at 2 who express the concern as follows: "a high volume of rights litigation can challenge the very sustainability of a public health care system and distort resources away from those most in need."

[3] In this paper, the terms socio-economic rights, economic and social rights (ESRs) and social rights will be used interchangeably.

[4] Given the scope of international health rights and Canada's federal system and the constitutional division of powers, health related obligations can include everything from criminal legislation in relation to public health or safety to municipal by-laws concerning erecting a temporary shelter; see for example *PHS Community Services Society v. Canada (Attorney General) (Insite),* [2011] SCC 44 and *Victoria (City) v Adams* [2008] BCSC 1363, upheld on appeal, [2009] BCCA 563; see also Freeman, Mark and Gibran Van Ert, *International Human Rights Law* (Irwin Law, Toronto, 2004) at 302-307; the authors group health among those standard of living rights not explicitly protected in the Canadian *Charter*.

In this thesis I will be explore the scope and content of international health rights, with a focus on Article 12 of the *International Covenant on Economic, Social and Cultural Rights* (ICESCR).[5] Through the work of the treaty monitoring bodies, the universal periodic review process, and the reports of the Special Rapporteur on the Right to Health, I will examine various aspects related to the interpretation and application of health rights.

While the issue of the Canadian reception of international human rights law extends to all international treaties, it is particularly important in the area of social and economic rights, where explicit constitutional and legislative guarantees are absent. Despite its international engagement and ratification of numerous human rights treaties, which include social and economic rights, Canada has failed to take action to resolve barriers to effective implementation through the direct incorporation of its treaty obligations through domestic legislation. The failure to incorporate Canada's international treaty obligations into domestic law means that international treaties are not directly enforceable. I will examine in more detail the uncertainty surrounding the reception of international human rights treaties and its impact on the implementation of internationally recognised health rights in Canada.

The domestic recognition and incorporation of international treaty obligations in Canadian law rests on the extent to which courts choose to interpret the Constitution or

[5] United Nations, *International Covenant on Economic, Social and Cultural Rights (ICESCR),* 1966, 993 UNTS 3.

legislation in a manner consistent with treaty obligations. The Supreme Court of Canada has sent conflicting messages about how far it is willing to go in seeking conformity between international human rights obligations and domestic laws. Next, I will address how the right to health has fared in Canadian courts, and why this is the case, particularly in the application of the *Charter*. Outside the scope of this paper lies the international jurisprudence with respect to non-discrimination, which applies universally to all the rights protected in the various UN human rights treaties. While the international jurisprudence has relevance to the interpretation of s 15 of the *Canadian Charter,* both in wording and content it is remarkably similar to the evolution of Canadian equality rights jurisprudence. However, because many of the cases examined in the paper include both section 15 and section 7 claims, the equality rights analysis will be addressed in a limited way, restricting the focus to areas in which it differs from the international framework of analysis.

Finally, one of the most significant barriers to securing the right to health in Canada lies in the threshold debate over the justiciability of social rights and the distinction between negative and positive rights, long since rejected at the international level. What do international human rights principles offer with respect to this issue? I will conclude with some observations on the way forward for health rights.

Chapter 2 Conceptual approaches to health as a human right

Economic and social rights, including the right to health, while simple on their face, raise complex questions in their interpretation and application. For some, health rights are not legal rights in the sense of being judicially enforceable, but rather aspirational goals within the health policy setting. The concern is that courts and the adversarial system lack the necessary capacity to determine complex, polycentric issues within health systems. In addition to capacity, there are legitimacy concerns, in a political system where fiscal balance is the responsibility of the democratically elected legislature, not the appointed judiciary. In this section, I will consider the "social interest" theory as a justification for the legality of health rights, as well as some of the weaknesses and challenges to that theory, in order to explore those legitimacy concerns.

2.1 Conceptual basis for human rights

Given the challenges faced by Canadian social rights and anti-poverty advocates in relation to an interpretation of the *Charter* that embraces social rights protection, it appears appropriate to address the conceptual underpinnings and critiques of human rights in general and social and economic rights, including the right to health, in particular.

In approaching the conceptual basis of international human rights, the "social interest" theory that claims human rights norms as constructed, in contrast with natural law theory that holds those rights as "essential or inherent," provides a useful starting point.[6] In the discussion that follows, I will use the recent study by John Tobin in *The Right to Health*

[6] Tobin, John, *The Right to Health in International Law* (Oxford: U Press, Oxford, 2012) at 46.

in International Law, in describing the conceptual basis for the right to "the highest attainable standard of health" in international law. I have chosen this study because it represents the most recent and comprehensive review of health rights and the international jurisprudence and literature to date.

Tobin views "social interest theory" as the best description of the process that has lead to the legal recognition of the international right to health. The theory holds that various interests ground human rights, and that to be recognised as worthy of protection as human rights, recognition of those interests depends upon a social consensus or agreement. Rather than being fixed in universally acknowledged and objective legal norms, the social process leads to a shaky *status quo,* one that is constantly "contested, negotiated, and historically contingent."[7]

At the same time, Tobin appears deeply suspicious of interpretative approaches that, in his view, subvert or "manipulate" human rights:

> In the absence of agreement as to the meaning of the right to health and its underlying values, the right risks becoming invisible to those for whom it is not self-evident. It also remains especially vulnerable to manipulation, whether consciously or unconsciously, by those who wish to use it as a rhetorical device with which to agitate, not for an international right to health, but for their own subjective vision of what such a right should entail.[8]

Despite rejecting "subjective accounts," interpretations of the "highest attainable standard of health" must incorporate various perspectives, according to Tobin. An international consensus on human rights that avoids Western cultural imperialism is possible if one

[7] Tobin, *ibid* at 54; the social rights theory appears to say that rights are rights because state parties, through the treaties they have signed, say so, not unlike the positivist's account.

[8] Tobin, *ibid* at 48.

accepts that international human rights form part of a "cultural system – fluid and contentious – that produces and constructs rather than discovers a particular vision."[9] Thus, interpretations incorporate multiple "objective" accounts of human rights.

In addition to diverse legal and social justifications for human rights, morality has a role to play, according to Tobin. However, again, rather than reflecting a unified or universal understanding, international human rights "must accommodate a 'moral universe that is diverse and pluralistic'."[10]

Tobin appears to reject liberal approaches to the conception of human rights in which "the purpose of law" is limited to "constrain(ing) or justify(ing) the exercise of government power."[11] Social rights obligations often require not "constraint" but action. The scope of state obligation in international human rights law is broader than the liberal concept of respect for individual freedoms, and especially in the context of health rights, it includes obligations to fulfill or take action to provide for human need.

Tobin notes that "the interests that form part of a human right will only be transformed into a right if accepted by the duty bearer," or state party in the case of international human rights.[12] In Tobin's view, human rights "were forged as a tool to regulate the relationship between the governed and the governing within a state – to respond to the

[9] Tobin, *ibid* at 59.

[10] Tobin, *ibid* at 49.

[11] Bix, Brian, *Jurisprudence Theory and Content*, 6th ed (Carolina Academic Press, North Carolina, 2012) at 94.

[12] Tobin, *supra* note 6, at 54

perceived failures and particular approaches to governance and power distribution."[13] The "governed" includes the poor, non-citizens, women, and other disadvantaged groups who may be effectively disenfranchised and politically powerless, while elected governments may appear to operate on behalf of economic and unelected elites.

However, with respect to state obligations, Tobin rejects the requirement of enforceability as necessary for the existence of a right, ultimately finding that only the right to non-discrimination in health requires the state to provide an effective judicial remedy.[14]

Tobin rejects the existence of a comprehensive or "coherent and internally consistent normative theory."[15] Unlike the natural rights approach, based on inherent and universal principles, the social interest theory sees law as both reflecting and influencing social norms. Insofar as it suggests an evolving concept of human rights, it is not unlike the Canadian Supreme Court's 'living tree' analogy applied to the constitution. However, Tobin's approach to the justiciability of health rights at the international level, which he describes as "weak" in order to maintain "constructive engagement" with state parties, creates a hierarchy of health rights based on differences in enforceability, which has been explicitly rejected by UN treaty monitoring bodies, including the UN Committee on

[13] Tobin, *ibid* at 55.

[14] Tobin, *ibid* at 207; where the author notes that "But the need to remain constructively engaged with states in the interpretative process suggests that a weak rather than strong approach is warranted with respect to those other aspects of the right to health which should be rendered justiciable."

[15] Tobin, *ibid* at 46.

Economic, Social and Cultural Rights (CESCR).[16] Social interest theory implies that there is a continual struggle between interest groups over the expression and recognition of rights, and politically the consensus may seesaw from one side of the political spectrum to another.[17] Thus, politics and culture inform and influence the recognition of human rights in the social interest approach to human rights.

2.2 Weaknesses of the social interest theory

Defining the scope of health rights is not without controversy. In what represents a controversial position, and one that is at odds with the Committee on Economic, Social and Cultural Rights (CESCR), the UN treaty monitoring body under the *International Covenant on Economic, Social and Cultural Rights (ICESCR)*, Tobin argues that international health rights do not extend to social and economic factors that directly or indirectly determine health, including the 'social determinants of health.'[18] While Tobin acknowledges that Article 12 of the *ICESCR* is not restricted to health care, he argues that the overlap with the right to an adequate standard of living risks making health rights, too

[16] United Nations, Committee on Economic, Social and Cultural Rights (CESCR), fifth sess, *General Comment 3*, 1991, UN Doc, E/1991/23, at para 1 with respect to similarities in enforcement between the *International Covenant on Civil and Political Rights (ICCPR),* 1966, 999 UNTS 171 and the *International Covenant on Economic, Social and Cultural Rights (ICESCR),* 1966, 993 UNTS 3. In relation to the United Nations treaties, concluding observations and general comments of the treaty monitoring bodies as well as the UN Special Rapporteur on Health, the UN document system style of citation has been used wherever possible.

[17] One has only to observe the politicisation of international negotiations, currently underway in relation to the Sustainable Development Goals, to persuade us of the insight this theory offers; Kate Donald, "Strong Commitments to Human Rights Survive in Final Sustainable Development Goals Text, despite sordid final compromises," (Centre for Economic and Social Rights, New York, 2015) at http://cesr.org/article.php?list=type&type=157 .

[18] Tobin, *supra* note 6, at 54 where Tobin in describing the "social interest theory" as the basis for the acceptance of human rights in international law, acknowledges that international human rights are contested and may change over time.

broad, indeterminate and therefore unrealizable.[19] Tobin bases the exclusion of the social determinants of health, on a need to avoid "indeterminancy" in order to maintain the consent and engagement of state parties. While the interpretation and understanding of human rights may shift over time, settled parameters on the scope of a right is necessary.

At the international level, Tobin may be oversimplifying the development of consensus through the human rights treaty making process. Similarly, at the domestic level, Tobin's deference to state consent may under-estimate the power of domestic adjudication of rights to influence the construction of human rights.[20] Domestic adjudication does not depend on consensus. In addition, both inside and outside state institutions, players such as the executive, legislative and judicial branches of government, as well as influential non-governmental stakeholders, will have competing views on what constitutes a "right." In other words, insofar as the "determinancy" of the right to health rests on "state" consent, the state construction of that consent may also be contingent and contested. The scope of the right may depend on what forum gets to decide.

The state consent approach embraced by Tobin includes weak state accountability mechanisms. It comes dangerously close to the "aspirational" view of social rights, a

[19] Tobin, *ibid* at 108-109; see also *ICESCR*, *supra* note 16, Art 11, the right to an adequate standard of living provides for "adequate food, clothing and housing, and to the continuous improvement of living conditions." Apart from these functional critiques, he also suggests that the inclusion of social and economic factors within the right to health is not supported by the text.

[20] Examples of domestic adjudication that have developed significant health rights jurisprudence in the absence of explicit constitutional protections include India, where the Supreme Court has moved beyond the "directive measures" principles to establish enforceable health rights under the right to life, and more recently Germany, where the right to a "dignified existence" has been interpreted to include social security (necessary for access to affordable health care) for migrants; see Winkler, Inga and Claudia Mahler, "Interpreting the right to a dignified minimum existence; a new era in German socio-economic rights jurisprudence" (2013)13 HRLR 388 at 390.

view that appears to be fading in the face of constitutional incorporation of rights at the domestic level and a growing body of jurisprudence at the international level supporting the enforceability of economic and social rights, including health rights.[21] In his emphasis on state consent in constructing the state obligation, Tobin's theory fails to sufficiently address the contested field within states, between institutional and non-institutional players, and their influence on the international jurisprudence.

In the next section I will examine the various critiques of human rights; critiques based the "legal" status of the right, as well as their impact on inequality.

2.3 Critiques of social and economic rights and the right to health

Tobin responds to several critiques of health rights, in relation to the viability of health as a "right", including its reliability and utility. In defending the legitimacy of health rights, he provides a useful overview of the range of potential objections and responses to the status of health as a right.

Starting with the "libertarian" objection, Tobin responds to claims that the redistribution of resources required by "progressive realisation" of "the highest attainable standard of health" violates individual autonomy. The argument continues with the claim that health rights create a perverse incentive for individuals to relinquish responsibility for their individual health, based on the assumption that the state will provide for them. Tobin responds by noting that health is a prerequisite to civil and political freedoms, including

[21] See Langford, Malcolm, "The Justiciability of Social Rights: From Practice to Theory" in Malcolm Langford ed. *Social Rights Jurisprudence* (Camb Univ Press, NY, 2008).

liberty and individual autonomy, and that there is no empirical evidence to support the perverse incentive theory.[22]

The "status" objection to health rights holds that social and economic rights must be distinguished from their civil and political counterparts. The latter are described as universal, cost neutral, secured by legislation, determinate and enforceable. In contrast, the same theorists hold that ESRs are resource dependent, aspirational, indeterminate, and unenforceable.

In response, Tobin points out that many civil and political rights also bear significant costs to society, such as the cost to the justice system in providing the right to "trial without delay." The contested scope of the prohibition on torture is cited as an example of indeterminacy in the civil and political realm. The relative determinacy of health rights, based on a growing body of international and domestic health rights jurisprudence, also contradict the allegation of "indeterminacy."[23]

Containing aspects similar to the previous "status" objection is the "formulation" objection, which holds that ESRs are meaningless because they are "limitless" and therefore inappropriate for a state guaranteed right.[24] Again, Tobin points out that this is based on a false assumption about the nature of human rights claims and lacks analysis of

[22] Tobin, *supra* note 6, at 60.

[23] Tobin, *ibid* at 66-67.

[24] Tobin, *ibid* at 74.

the actual content of health rights. For instance, contrary to the formulation critique, the international right to health does not mean the "right to be healthy."[25]

The "relativist challenge" suggests that international human rights reflect "Western values" many of which are incompatible with non-Western cultures. Responding to the allegation that health rights are a Western construct, Tobin points out the historical antecedents for the right to health in the Constitutions of Mexico and many Latin American states pre-WW II. More broadly, he points out that health, unlike religion, is not as susceptible to cultural relativism. He concedes, however, the need to accommodate cultural aspects in health rights.[26]

While Tobin omits critical legal theory, its rights critique contains elements similar to the "cultural relativist" challenge. It holds that human rights in fact serve to legitimise elite power structures and cultural hegemony.[27] In one version of this theory, rights serve both to stabilise and destabilise power structures; and are "politically ambivalent" unlike the mainstream view of rights as being in opposition to the established power structures:

> Rights are both political tools for the contestation and alteration of mechanisms of power and simultaneously mechanisms of inscription, both disciplinary and governmental, which work to conduct those who rely upon them. Far from being an unproblematic tool for the protection of the subject's freedom, rights emerge in this account as conflicted and ambivalent mechanisms.[28]

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[25] United Nations, Committee on Economic, Social and Cultural Rights, *General Comment 14 (2000): The right to the highest attainable standard of health (Article 12),* 22nd sess, 2000, UN Doc E/C.12/2000/4, at 8.

[26] Tobin, *supra* note 6, at 68-69.

[27] Golder, Ben, "Foucault, Rights and Freedom," (2013) 26 Int J Semiot Law 5–21.

[28] Golder, *ibid* at 5-6.

The focus of the critical legal theorists is on individual freedoms – and is largely limited to civil and political rights concepts and limits on state intervention. This narrow definition of "rights" does not include an analysis of economic and social rights and the concept of state obligation at the international level, including the positive obligation to fulfill rights. Its application to economic and social rights, to the extent that their fulfillment requires wealth redistribution, would require a different analysis.

In fact, despite Roosevelt's articulation of the four "freedoms," including "freedom from want," incorporated into the preamble of the *Universal Declaration of Human Rights (UDHR)*, economic and social rights are typically associated less with individual freedoms, and more with entitlements or fairness in the (re)distribution of common resources.[29] In terms of health rights, while decision-making regarding consent to treatment engages individual liberty concerns, many other aspects of health rights, including accessibility, affordability and availability require, rather than restrict, state intervention.

Various objections to the feasibility or usefulness of health rights originate in concerns regarding "resource allocation." As noted earlier, those critiques that distinguish civil and political rights from economic and social rights based on resources can be rebutted based on actual impacts on government spending, which may occur in both.[30] The extent to

[29] *Universal Declaration of Human Rights (UDHR), 1948, GA Res 217 A (III), UN Doc. A/810.* The *ICESCR*, *supra* note 16, together with the *ICCPR, supra* note 16, form the *International Bill of Rights*, which are based on the UDHR, a resolution passed by the United Nations General Assembly in 1948. As a resolution, the UDHR does not have the binding force of a treaty, although some of its provisions are now considered to form part of customary international law, see Freeman and Van Ert, *supra* note 4.

[30] A distinction remains in that many civil and political rights may result in direct spending within the justice system whereas the primary focus of economic and social rights is found in public

which government spending is impacted, is an important factor that I will address later in this paper.

The "relative resource scarcity" critique suggests that health rights cannot be universal given the disparity in resources between rich and poor states. Tobin accepts that relative resource scarcity may impact upon the realisation of the right to health, but points out that international jurisprudence includes concepts of "progressive realisation" based on "available resources."[31] In addition, Tobin relies on the requirement of international co-operation, which also operates to mitigate the impact of resource disparities.

One of the difficulties with Tobin's argument is that there is no specific obligation or process for redistribution of wealth based on "international co-operation" through the UN system, thus leaving health needs in poorer countries importantly at the mercy of donor charity. The jurisprudence regarding "international co-operation" or intra state obligations based on international human rights treaty obligations is beyond the scope of this paper but is regarded by many as key to the universal realisation of human rights, including the right to health.[32]

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policy areas outside the justice arena. This is not to deny that specialised adjudicative bodies dealing with labour, health, education and other social rights also form part of the justice system.

[31] See *ICESCR, supra* note 16 at Art 2(1), which provides as follows:

Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the *maximum of its available resources*, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures. [emphasis added]

[32] See Gostin, Lawrence, "West Africa's Ebola Epidemic is out of control, but never had to happen" (O'Neill Institute, Briefing Paper No 9, Wash, 2014) and Salomon, Margot, "Why Should it matter that others have more? Poverty, inequality and the potential of international human rights law" (2011) 37 Rev Int Studies 2137.

In terms of the theory of "distorted resource allocation," whereby a "right" is used to increase the share of scarce state resources at the expense of other interests, Tobin emphasizes the importance of "system coherence" whereby rights are to be interpreted in a manner that is *internally* consistent and balanced.[33] However, he concedes that "the reality is that international law does not provide any explicit formula by which to determine the appropriate level of resources to be allocated to the realization of the right to health relative to other human rights or between individuals."[34] However, the commentaries of the United Nations treaty monitoring bodies provide principles such as minimum core obligations and proportionality that may guide such decisions.[35]

Instead, Tobin suggests that the process for state justification, and the limitation of rights by the state offers a means of resolving any distortions in resource allocation. This assumes that the criteria used for state justification of rights violations are "evidence based, consultative and participatory."[36]

Unfortunately, Tobin's description of the process for state justification, fails to address the lack of resources and procedural safeguards for "participatory processes" involving social rights holders and defenders. In practice, the general nature of the CESCR recommendations to states provides a wide measure of discretion and it is really at the

[33] Tobin, *supra* note 6, at 69-70.

[34] Tobin, *ibid* at 71; This may be too great a concession on Tobin's part, as the concept of minimum core obligation, non-discrimination, and retrogressive measures, offer principles upon which the resolution of conflicting rights may be based.

[35] See part 3.6 on minimum core obligation and 3.8 on the nature of the state's obligation in this thesis.

[36] Tobin, *supra* note 6 at 72; Tobin focuses on the state obligation to respect human rights, while perhaps understating the obligation to fulfill human rights, where state inaction is the problem and where state action is necessary for realisation of the right.

domestic level where resource allocation questions become urgent. In fairness, these are empirical questions beyond the scope of Tobin's work. Nevertheless cost questions may constitute a significant aspect of judicial deference to legislative decisions in Canada, particularly under s. 7 and s. 1 of the *Charter,* based on the view that social rights involve resource allocation and courts have limited institutional capacity to determine government policy and budgets. I will return to the significance of cost, as an underlying but often poorly articulated factor, in the analysis of 'positive rights' under the *Charter* by Canadian courts.[37]

In relation to participatory processes, human rights experts and activists, including the former Special Rapporteur on Health, Paul Hunt, have supported a "human rights based approach" to health as an alternative to litigation, as a means of 'claiming' human rights. In response to the concern that litigation distorts resource allocation in favour of powerful sectors or individuals, at the expense of the public interest or system coherence, the human rights based approach offers a deliberative and consultative process.[38] Rather than relying on litigation to hold governments to account, the "human rights based approach" advocates for a multi stakeholder governance process. [39]

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[37] See Chapter 4, note 307 and accompanying text, *infra*, and Lessard, Hester "Dollars Versus [Equality] Rights": Money and the Limits on Distributive Justice" (2012) 58 SCLR (2d) 299 – 332 at 3.

[38] For a discussion of this methodology in the Canadian context see Klein, Alana "Participation and Accountability: New avenues for human rights engagement with the distribution of health resources in Canada" in Bruce Porter and Martha Jackman eds. *Advancing Social Rights in Canada,* (Irwin, Toronto, 2014) at 309; for a review of alternative modes of human rights accountability outside courts, see McKeever, Grainne and Fionnuala Ni Aolain, "Enforcing Social and Economic Rights at the Domestic Level: A Proposal" in Young, Margot et al eds *Poverty: Rights, Social Citizenship, Legal Activism* (UBC Press, Vancouver, 2007).

[39] Klein, *ibid* at 325.

In the area of health, such an approach would bring together public health stakeholders to develop a process for accountability that is not dependent on litigation or court decisions. It involves benchmarks, monitoring, public participation, transparency (including the impacts on resource allocation), and ongoing review and monitoring.[40] This approach appears particularly relevant to a complex system like health, where the role exercised by the state is mitigated and heavily circumscribed by nodes of power held by multiple stakeholders including government, doctors and the pharmaceutical industry. However, until it receives substantial political support and public resources, the human rights based approach is unlikely to have much of an impact on access to either the social determinants of health or health care. It is here that litigation can play a role in creating greater government accountability in the area of health rights.

In the next section, the international jurisprudence in relation to health will be examined, primarily in relation to the UN treaty based obligations to health found in the *International Covenant on Economic, Social and Cultural Rights (ICESCR*) as well as related non-discrimination provisions of other UN treaties to which Canada is a party.

[40] United Nations, Human Rights Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (health systems),* 7th sess, Ag 3, 2008, UN Doc, A/HRC/7/11, at para 96.

Chapter 3 The human right to health in international law

In this chapter the question "what do we mean by health rights?" will be examined from the perspective of international law. Sometimes described as the "poor relation" within the human rights family internationally, social and economic rights, including the right to health, are beginning to move "from the margins to the mainstream" through the work of various UN bodies including treaty monitoring bodies such as the Committee on Economic and Social Rights (CESCR or "the Committee"), the UN Commission on Human Rights now known as the UN Human Rights Council (HRC), and the UN Special Rapporteur on the Right to Health.[41] In order to assess whether the right to health under international law is being "consistently and coherently applied" in Canadian courts, defining the normative content of the right to health is a vital first step.

In 1948, the UN approved the Universal Declaration of Human Rights (UDHR), which identifies the underlying basis for human rights as equality, non-discrimination and human dignity.[42] The UDHR identifies health as a benchmark in relation to the adequacy of the right to an adequate standard of living: "everyone has a right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services." [43] Beyond these general principles, health rights have been included in multiple human rights treaties at the international and regional level, as well as constitutional protections nationally.

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[41] Hunt, Paul, "The right to health: from the margins to the mainstream" (2002) 360 The Lancet 9348 at 1878.

[42] United Nations, UDHR, *supra* note 29.

[43] United Nations, UDHR, *ibid* at Art 25.

3.1 The right to the "highest attainable standard of physical and mental health"

The *International Covenant on Economic, Social and Cultural Rights* (*ICESCR*), is the central multilateral UN human rights treaty dealing with social and economic rights and provides one of the most "comprehensive and integrated" definitions of health rights. For this reason, it will be the primary focus of this study.[44] The *ICESCR* provides what has been described as "the cornerstone" of international health rights in Article 12:

> Article 12
> 1. The States 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 right shall include those necessary for:
> (a) the provision for the reduction of the stillbirth-rate 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.[45]

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[44] See Riedel, Eibe "The Human Right to Health: Conceptual Foundations" in Andrew Clapham and Mary Robinson eds, *Realising the Right to Health* (ruffer & rub, Zurich, 2009) at 25.

[45] *ICESCR*, *supra* note 16; the *ICESCR* entered into force 23 March 1976, ratified by Canada 19 May 1976 with no reservations or declarations. Canada has ratified seven separate international human rights treaties that contain health related obligations, (see note 55 below) as well as endorsing several health related UN Resolutions in relation to health, such as the right to water and protection for HIV/Aids (United Nations, General Assembly, *The need to ensure a healthy environment for the well-being of individuals*, 1990, UNGAOR, Res 45/94; United Nations, General Assembly, *Declaration of Commitment on HIV/AIDS*, 2002, UNGAOR, 54th Sess, Resolution S-26/2, annex; Political Declaration on HIV/AIDS, 2006, UNGAOR, 87th plenary meeting, Res 60/262.; United Nations, General Assembly, *The human right to water and sanitation,* 2010, 64th sess, ag item 48, UN Doc A/RES/64/292. Canada has failed to ratify the following international health rights treaty: the International Labour Organisation (ILO) Social Security Minimum Standard Convention, 1952 (no 102) Geneva, 35th ILC session (28 Jun 1952) containing earnings related protection for both medical care and sickness benefits.

The articulation of the right to health as a right to the "highest attainable standard" of health, originates from the Constitution of the World Health Organisation.[46] A "standard of health" in the context of the *ICESCR* has been interpreted to include the organization of the various components of a health system.[47] Protecting the right to health has been interpreted to encompass both individual "freedoms" and "entitlements," such as the right to refuse non-consensual medical interventions, as well as the right to an effective system of public health protection that results in the prevention and treatment of disease.[48]

Article 12.2 of the *ICESCR* describes health targets and indicators as well as prioritising certain health objectives. In relation to children's health these include the reduction of the rate of still-births and infant mortality and improvements in child development. In respect of the causes of ill-health, environmental and industrial "hygiene" are highlighted. The *prevention* of disease including "endemic, epidemic, and occupational" disease can be seen as providing people with access to the goods and services that they need to stay healthy.[49] The "treatment and control" of disease as well as the "creation of

[46] World Health Organisation (WHO), Constitution of the World Health Organization, 1946, (New York, 22 July 1946 entered into force 7 April 1948), 14 UNTS 185, Preamble, at para 2.

[47] See Hunt, Paul & Gunilla Backman, "Health Systems and the Right to the Highest Attainable Standard of Health" in Andrew Clapham & Mary Robinson eds. *supra* note 43, at 40. In terms of health rights litigation, they draw an analogy between the reform of the justice system through strengthening the right to a fair trial, and strengthening health systems through health rights protection. For the application of the human rights based approach in Canada see Klein, *supra* at note 38, at 325.

[48] Hunt, Paul, "The UN Special Rapporteur on the Right to Health: Key Objectives, Themes, and Interventions" (2003) 7 Journal of HHR 1 at 3.

[49] United Nations, CESCR, General Comment 14, *supra* note 25, para 4: "…the drafting history and the express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access

conditions" to ensure that everyone has "'medical service and medical attention in the event of sickness" both point towards government responsibility to implement and maintain a healthcare system that is accessible to all.[50] State parties to the *ICESCR* are required to "recognise" the rights contained in the Covenant, and to "take steps" necessary to achieve "the full realization of the right."[51]

Elsewhere in the *ICESCR*, the treaty recognises a right to healthy working conditions, "special protection" for expectant mothers and children, and specifies that children be entitled to "special protection and assistance without discrimination for reasons of parentage or other conditions." [52]

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to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment."

[50] *ICESCR, supra* note 16, Preamble, para 3, Articles 12.2(d), 7(b); Article 12 must be read in conformity with the interpretation of Article 9 with respect to "social security" as noted by the Committee on Economic, Social and Cultural Rights; see United Nations, Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 19: The right to social security (Art. 9 of the Covenant)* 39th sess, 2008, UN Doc, E/C.12/GC/19, para 13 where the Committee noted that: "States parties have an obligation to guarantee that health systems are established to provide adequate access to health services for all. In cases in which the health system foresees private or mixed plans, such plans should be affordable, in conformity with the essential elements enunciated in the present general comment. The Committee notes the particular importance of the right to social security in the context of endemic diseases such as HIV/AIDS, tuberculosis and malaria, and the need to provide access to preventive and curative measures."

[51] *ICESCR*, supra note 16, at Article 2(1) and (2).

[52] *ICESCR*, *ibid* Art 7, 10; in relation to children's health, see also the *Convention on the Rights of the Child (CRC)* 1989, 3 UNTS 1577; G.A. Res. 44/25, Article 24, which is fully dedicated to the right to the health of the child, and articles 3 (3), 17, 23, 25, 32 and 28, as well as United Nations, Committee on the Rights of the Child (CRC), *General Comment 15 (2013) on the right of the child to the highest attainable standard of health,* 2013, UN Doc, CRC/C/GC/15; for a detailed discussion of the child's right to health. In relation to women's health, see also *Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW), 1979, 1249 UNTS 13, Art 11 (1) f, 12 and 14 (2) b, and United Nations, Committee on the Elimination of Discrimination Against Women, *General Comment 24, on Women and Health,* 20th Sess, 1999, UN Doc, A/54/38/rev.1, chap. 1.

The *ICESCR* provides that human rights violations may be subject to "justification" or limitation in a manner similar to section 1 of the *Canadian Charter of Rights and Freedoms.*

The scope for a state justification of a violation of rights is as follows:

> The States Parties to the present Covenant recognize that, in the enjoyment of those rights provided by the State in conformity with the present Covenant, the State may subject such rights only to such limitations as are determined by law only in so far as this may be compatible with the nature of these rights and solely for the purpose of promoting the general welfare in a democratic society.[53]

The Committee has identified that in justifying a state infringement on a right, the burden lies on the state, using a proportionality test, to show that the rights restriction is lawful, that it represents the "least restrictive" measure, and that its purpose is to promote "the general welfare."[54] Protection of public health is also relied upon in various provisions as a justification for a limitation on other rights.[55] With respect to remedies under the *ICESCR*, the nature of the state obligation will be reviewed later in this chapter.

3.2 Sources of health rights jurisprudence

The UN human rights treaties ratified by Canada serve as binding sources of international law.[56] Interpreting the text of those treaty obligations is the work of the UN treaty

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[53] *ICESCR, supra* note 16, at Art 4.

[54] United Nations, CESCR, General Comment 14 (2000), *supra* note 25, at para 28, 29.

[55] Freeman and Van Ert, *supra* note 4, at 302-307.

[56] For the purpose of this paper, the seven major UN human rights treaties include the following: the *Convention on the Elimination of all forms of Racial Discrimination (ICERD), 1970,* 660 UNTS 195*, the International Covenant on Civil and Political Rights (ICCPR),* 1966, 999 UNTS 171*, the International Covenant on Economic, Social and Cultural Rights (ICESCR),* 1966, 993 UNTS *3, the Convention on the Elimination of Discrimination Against Women (CEDAW),* 1979, 1249 UNTS 13, *and the Convention against Torture and Other Cruel, Inhuman or Degrading*

monitoring bodies. Their decisions and opinions with respect to treaty interpretation, however, are considered *non-binding* sources of international law, sometimes referred to as 'soft law'.[57] Despite their non-binding status, the commentaries of the treaty monitoring bodies are highly influential and have been described as "relevant and persuasive" sources of international jurisprudence.[58] Other non-binding sources include declarations and resolutions of the UN General Assembly.[59]

The CESCR is a committee of experts created by the UN Economic and Social Council (ECOSOC) in 1985 with a mandate to monitor the implementation of the *ICESCR*.[60] Neither the creation of the Committee nor the general comments are provided for in the text of the *ICESCR*, but they have been incorporated into the Committee's rules of

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*Treatment or Punishment (CAT),*1984, 1465 UNTS 85, UN Doc A/39/51*, the Convention on the Rights of the Child (CRC)*, 1989, 3 UNTS 1577; G.A. Res. 44/25*, and the Convention on the Rights of Persons with Disabilities (CRPD)* 2006, 2515 UNTS 3, GA Res 61/106, ratified by Canada 11 March 2010.

[57] For a definition of 'soft law' see for example See Langford, Malcolm, "The Justiciability of Social Rights: From Practice to Theory" in Malcolm Langford ed. *Social Rights Jurisprudence*, *supra* note 21 at 5, where it is described as influential but non binding work from bodies who do not possess full judicial status, such as UN treaty monitoring bodies; and includes the concluding observations, general comments and results of individual complaints from those bodies.

[58] See Abella J, in *Saskatchewan Federation of Labour v Saskatchewan*, [2015] SCC 4 at para 159 *[SFL]*; international principles of treaty interpretation are themselves the subject of an international treaty: see *Vienna Convention on the Law of Treaties* (VCLT), 1969, 1155 UNTS 331.

[59] Except insofar as the commitments in such declarations have migrated into the realm of international customary law. For instance, provisions of the *Universal Declaration of Human Rights* are sometimes identified as binding obligations due to their status as customary international law; see Freeman and Van Ert, *supra* note 4.

[60] United Nations, Economic and Social Council, *Resolution: Review of the composition, organization and administrative arrangements of the Sessional Working Group of Governmental Experts on the Implementation of the International Covenant on Economic, Social and Cultural Rights*, *E Res 1985/17.*

procedures, and approved by one of the UN's primary governing bodies, the Economic and Social Council. The CESCR's mandate is three-fold: to conduct regular reviews of state parties' fulfillment of their obligations under the *ICESCR* and make recommendations, known as 'concluding observations'; to address individual and state complaints regarding *ICESCR* compliance; and to provide interpretative guidelines with respect to the *ICESCR,* known as 'general comments.'[61] The CESCR completed its fifth review of Canada's performance with respect to the *ICESCR* in 2006, with the sixth review due in 2016. The results of those reviews, in the form of the 'concluding observations' of the Committee, reflect its views of Canada's compliance with the treaty based on the approved list of issues and submissions presented to the Committee. Due to time and space constraints, it is not feasible for the Committee to review Canada's compliance with the *ICESCR* in its entirety.

In terms of the CESCR mandate to provide treaty interpretation through publication of its 'general comments,' human rights experts agree that they are an authoritative source of international jurisprudence, and that they constitute a non-binding, non-coercive, but instructive and persuasive authority concerning international legal principles.[62] The influence of the General Comments on domestic courts and tribunals is said to vary,

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[61] See Bayefsky Anne, *How to Complain to the UN Human Rights Treaty System*, (Transnational Pub, New York, 2002).

[62] Alston, Philip, "The General Comments of the Committee on Economic Social and Cultural Rights," [2010] 104 Am Soc Int'l L Proc 4; The "general comments" as statements of the treaty monitoring bodies, are considered to have jurisprudential weight, based upon and directed at the treaty monitoring and review process. However, Alston suggests that policy makers, such as the World Health Organisation, also play an unacknowledged role in influencing the CESCR's interpretations of the *ICESCR*. See also *Statute of the International Court of Justice* [ICJ Statute], 7 Can TS 1945 (in force 24 October 1945] at s 38(1)(d) regarding "teachings" as elements of international law.

although they can "exert considerable persuasive force on decision makers in domestic legal systems and national courts."[63] However, the persuasive impact and influence of the CESCR General Comments, including General Comment 14, has been described as a largely unexplored area of research.[64]

In Canada, in its approach to treaty interpretation, the Supreme Court of Canada (SCC) has taken a range of positions concerning the general comments and other commentaries of UN treaty monitoring bodies such as the CESCR. In a very recent decision concerning the right to strike, the Supreme Court of Canada had an opportunity to clarify its approach to international human rights sources, including the commentary of a treaty monitoring body similar to the CESCR. In *SFL,* the Saskatchewan Federation of Labour, consisting of the provincial public sector unions, challenged the government over legislation that restricted their right to strike.[65] The Supreme Court of Canada departed from its own 27 year old precedent in finding that the legislative restrictions on the right to strike violated the union members right to "freedom of association" under section 2(d) of the *Charter*.[66] The majority went on to find that the legislative restrictions, in failing to provide a meaningful alternative dispute resolution mechanism, were not minimally impairing or justified under section 1 of the *Charter*.[67] The Court relied on international jurisprudence both in interpreting the scope of the right under section 2(d), as well as the

[63] Mechlem, Kirsten, "Treaty Bodies and the Interpretation of Human Rights," [2009] 42 VanderbiltJIL 905, at 926.

[64] Alston, *supra* note 62, at 7; see also Mechlem, *ibid* at 926.

[65] *SFL, supra* note 58.

[66] *SFL, ibid* at para 75.

[67] *SFL, ibid* at para 62-70, 86.

scope of the government's justification of the violation under section 1 of the *Charter*.

The Court relied upon the commentary of a Committee of Experts under International Labour Organisation Convention 87 (Freedom of association and protection of the right to organise) in order to interpret Canada's international treaty obligations, indicating that it regarded the Committee's commentary as "relevant and persuasive:"

> Under the *International Covenant on Economic, Social and Cultural Rights* signatory states are not permitted to take "legislative measures which would prejudice, or apply the law in such a manner as would prejudice, the guarantees provided for in [Convention No. 87]": Article 8(3) of the ICESCR. The principles relating to the right to strike were summarized by the Committee on Freedom of Association…
> …….
>
> Though not strictly binding, the decisions of the Committee on Freedom of Association have considerable persuasive weight and have been favourably cited and widely adopted by courts, tribunals and other adjudicative boards around the world, including our Court….The relevant and persuasive nature of the Committee on Freedom of Association jurisprudence has developed over time through custom and practice and, within the ILO, it has been the leading interpreter of the contours of the right to strike…"[68]

In contrast, the dissenting judgment rejected the substantive conclusions drawn from the commentaries, accusing the majority of "cherry pick[ing]" interpretations to support its conclusions. [69] However, while there may still be a question about the consistency of the approach to the commentaries of UN treaty monitoring bodies such as the CESCR, based

[68] *SFL, ibid* at para 68-69; with respect to the General Comments issued by the UN Human Rights Council (HRC) under the *ICCPR, supra* note 16, the Supreme Court of Canada has held that the HRC interpretations of the provisions of the *ICCPR* are admissible and persuasive as a source of international law; see also *Divito v Canada* [2014] SCC 47 at para 26-27 and *Suresh v Canada* [2002] SCC 1 at para 67 where the Court relied upon the Human Rights Council's General Comment in interpreting the *ICCPR* prohibition on torture, to include protection against being expelled to torture elsewhere, and incorporated that interpretation into section 7 of the *Charter*. With respect to the *ICESCR*, and the General Comments of the CESCR, the Court has not yet made a comparable ruling.

[69] *SFL, ibid* at para 69 and 151.

on the majority decision in *SFL,* the prevailing Canadian view is that they are "relevant and persuasive" sources of interpretation of human rights.

In 2000, the Committee on Economic, Social and Cultural Rights (CESCR) produced its first General Comment specifically addressing the right to health under Article 12, known as "General Comment 14."[70] While acknowledging its non-binding character, it has been described as "compelling and ground breaking."[71] It represents the most complete UN sponsored analysis of the development of the right to health so far. Although General Comment 14 is the primary interpretative document regarding the right to health, there are other relevant general comments from the CESCR that refer to health rights. These include general comments regarding the nature and scope of the government obligation and domestic implementation with respect to social and economic rights, as well as the right to food, water, and sanitation as part of an adequate standard of living.[72] In

[70] United Nations, CESCR, General Comment 14 (2000), *supra* note 25; In addition to providing interpretative guidelines known as "general comments" on the meaning of the treaty and state obligations, the CESCR's mandate includes the responsibility to monitor treaty compliance of member states as part of a revolving 'periodic review' process. The results of the periodic review of member states are summarized in "Concluding Observations"(CO). In the lead up to the periodic review, the Committee receives reports from the government, or "state parties." Since the mid 1990s, the CESCR also had begun to receive reports from domestic NGOs with special expertise or knowledge of human rights on the ground. Canada is under an obligation to report periodically to the CESCR under Part IV of the *ICESCR*; see for instance Art 16: "The States Parties to the present Covenant undertake to submit in conformity with this part of the Covenant reports on the measures which they have adopted and the progress made in achieving the observance of the rights recognized herein." The CESCR was created in 1987 and consists of 18 members. See also, Langford, Malcolm and Jeff A. King, "The Committee on Economic, Social and Cultural Rights" in Malcolm Langford ed., *Social Rights Jurisprudence*, *supra* note 21.

[71] United Nations, Human Rights Council, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, *supra* note 1.

[72] United Nations, CESCR, *General Comment 3 (State obligation)* 1991, *supra* note 16; *General Comment 9 (Domestic application),* 1998, UN Doc, E/C.12/1998/24, para 10; *General Comment 12 (the right to food under Article 11 "Right to an adequate standard of living")* 1999, UN Doc,

addition, the right to social security as well as the overarching provision regarding non-discrimination have significance for the interpretation of health rights under Article 12.[73]

In respect of other sources of international health rights jurisprudence, the reports from the UN "Special Rapporteur on the highest attainable standard of health" constitute a growing body of non-binding, but "relevant and persuasive" jurisprudence. Established by the UN Commission on Human Rights [since replaced by the UN Council on Human Rights (UNCHR)] in 2002, the Special Rapporteur provides an important source of health rights analysis, on an annual basis, based on directives received from the UNCHR and country visits.[74] Those reports have included topics ranging from access to pharmaceuticals ("essential medicines") including pricing, patents and research and development; trade issues in relation to health obligations to provide "international assistance and development," as well as reports on "neglected diseases."[75] Their stated objective is to make the right to health "specific, accessible, practical and operational."[76] The special rapporteur on the right to the highest attainable standard of health has explored accountability mechanisms in the form of right to health indicators, benchmarks

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E/C.12/1999/5, at para 5 (malnutrition); *General Comment 15 (Water and sanitation)* 2003, *supra* note 52, para 11, 12, 13.

[73] *General Comment 16 (Equal Rights for Men and Women),* 2005, 34th sess, UN Doc, E/C.12/2005/3*,* at para 29, *General Comment 19 (Social security)* 2008, UN Doc, E/C.12/GC/19; and *General Comment 20 (Non-discrimination)* 2009, UN Doc, E/C.12/GC/20, para 33 and 35.

[74] United Nations, Commission on Human Rights (UNCHR), Resolution (Special Rapporteur on the Highest Attainable Standard of Health), 2002, UNORCHR, Res 2002/31.

[75] United Nations, "Special Rapporteur on the highest attainable standard of health," http://www.ohchr.org/EN/Issues/Health/Pages/AnnualReports.aspx

[76] United Nations, Special Rapporteur, *supra* note 1, para 19.

and monitoring.[77]

Other non-binding sources of international health rights jurisprudence include the declarations and guidelines of the UN General Assembly and the World Health Organisation (WHO).[78] In addition, the treaty-based complaint process known as an "optional protocol" provides another non-binding source of decision-making and interpretation in relation to health rights, with respect to an alleged treaty violation, where all domestic remedies have been exhausted.[79] An optional protocol may be contained in the treaty itself, or a separate ancillary treaty. The recently approved optional protocol

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[77] See for example, United Nations, General Assembly, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *Report to the General Assembly (Right to Health Indicators),* 2003, UN Doc, A/58/427, at para 36.

[78] See for example, World Health Organisation, *Report of the International Conference on Primary Health Care*, Article II, Alma-Ata Declaration, Alma-Ata, 6-12 September 1978, in *World Health Organization, "Health for All,"* Series, No. 1, (WHO, Geneva, 1978). The Constitution of the World Health Organisation states: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition," *World Health Organisation Constitution,* 1946, *supra* note 45; see also United Nations, Resolutions of the General Assembly, *The Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care,* 1991, UNGA, Res 46/119; *The need to ensure a healthy environment for the well-being of individuals,* 1990, UNGA, Res 45/94; as well as United Nations, General Assembly Declarations concerning HIV/Aids, *Declaration of Commitment on HIV/AIDS*, UNGAOR, 54th Sess, 2002, Res S-26/2, annex; *Political Declaration on HIV/AIDS*, 2006, UNGAOR, 87th plenary meeting, Res 60/262.

[79] See Bayefsky, *supra* note 61, at 6, referred to as "optional undertakings"; Canada has signed five UN optional protocols, however, these do *not* include the optional protocol in relation to the *ICESCR* and Art 12. The ratified optional protocols include: *Optional Protocol to the International Covenant on Civil and Political Rights (OP-ICCPR)*,1966, 999 UNTS*; Second Optional Protocol to the International Covenant on Civil and Political Rights, Aiming at the Abolition of the Death Penalty* 1989, 1642 UNTS; *Optional Protocol on the Convention on the Elimination of All Forms of Discrimination against Women (OP-CEDAW*), 2002, 2131 UNTS; *Optional Protocol on the Convention on the Rights of the Child on the Sale of Children, Child Prostitution and Child Pornography (OP-SALE)* 2002, 2171 UNTS, GA Res 54/263; *Optional Protocol on the Convention on the Rights of the Child on the Involvement of Children in armed Conflict (OP-AC)* 2000, 2173 UNTS, GA Res 54/263.

pursuant to the *ICESCR* provides rights seekers, who have exhausted all their domestic judicial remedies, access to a complaint process to present their case to the CESCR. The decision of the Committee is considered persuasive but not binding on the state party, and may serve as well as a source of international health rights jurisprudence to the extent that it has relevance to the implementation of Article 12. [80] The optional protocol under the *ICESCR* came into force in 2013, but has yet to be ratified by Canada.[81] However, Canada has ratified both optional protocols to the *ICCPR*: one deals generally with treaty rights violations and the other specifically relates to capital punishment. The complaint process has been described as "an important advocacy tool for vindication and redress."[82]

The interpretive weight of the CESCR commentary and recommendations in relation to complaints under the optional protocol may represent its greatest influence, rather than the outcome of individual complaints. The Ontario Court of Appeal recently determined that the optional protocol under the *ICCPR* is an "unincorporated" treaty, and therefore at the domestic level, government is free to disregard its provisions, as well as the Committee's advice or recommendations pursuant to individual complaints.[83]

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[80] Hogg, Peter, *Constitutional Law in Canada,* 5th ed (Toronto, Thomson Reuters, 2007) at 36.9(c); See also Bayefsky, *supra* note 61, at 54 who notes that while the UN treaty monitoring body's views are authoritative, they are not legally binding and there is no sanction for non implementation.

[81] *Optional Protocol to the International Covenant on Economic, Social and Cultural Rights*, 2008, GA Res 63/117, UNGAOR, 63d Sess, Supp No 49, UN Doc A/RES/63/117, entry into force 5 May 2013; in a similar fashion, Canada has declined to ratify the *Optional Protocol to the Convention on the Rights of Persons with Disabilities*, 2007, UNGAOR, 61st Sess, Annex II, Agenda item 67 (b), UN Doc Doc.A/61/611, GA Res 61/106.

[82] See Bayefsky, *supra* note 61 at 4.

[83] See *Ahani v R* [2002] 431 OJ OCA at para 41 and 48; see also Hogg, *supra* note 80 at 11.4.

In *Ahani v R*, the Ontario Court of Appeal had the opportunity to consider the persuasive value of an interim decision of the UN Human Rights Committee under the first optional protocol to the *ICCPR.*[84] While Canada has ratified both the optional protocol and the *ICCPR,* neither has been expressly implemented by way of legislation. In *Ahani v R,* Mr Ahani's deportation, earlier confirmed by the Supreme Court of Canada in a previous decision, was again at issue.[85] As a result of receiving a complaint that Canada was violating Ahani's rights by deporting him to a country where he would likely be subject to torture, the Human Rights Committee released an 'interim measure' requesting Canada not to do so until it had time to consider his complaint. Based on the Human Rights Committee's recommendation, Mr. Ahani sought an interim injunction from the Ontario courts, to suspend his deportation pending the Human Rights Committee's determination of his complaint. Mr. Ahani presented two arguments in relation to the optional protocol: he argued that to ignore the Committee's request would be to deprive the court of the Committee's process which could have 'persuasive value', and that a rejection of the Committee's request would amount to bad faith and a violation of Canada's obligation under section 26 of the *Vienna Convention on the Law of Treaties.* However, both the Ontario Supreme Court and the Court of Appeal refused the injunction and upheld the government's decision to proceed with the immediate deportation, contrary to the HRC's recommendation. They found that because neither the *ICCPR* nor the optional protocol was directly enforceable, that Canada was free to ignore the Human Rights Committee

[84] *Ahani, ibid* at para 364.

[85] *Ahani, ibid* at para 43-49.

request.[86] As noted by Bayefsky, courts are not bound by decisions or recommendations of the treaty monitoring bodies such as the HRC, arising out of the complaint process.[87]

In what follows, the treaty provisions, the general comments of the CESCR as the primary treaty monitoring body, and the reports of the Special Rapporteur will be used to analyse the nature and scope of international health rights.

3.3 Health rights framework

As part of the framework for the right to health, the CESCR has identified that the enjoyment of the "highest standard of physical and mental health" includes both freedoms and entitlements. Freedom encompasses the right to refuse unwanted medical treatment. In terms of entitlements, the right requires the state party to fulfill the right to ensure that people have access to health facilities, goods and services.[88]

> "…health facilities, goods and services, including the underlying determinants of health, shall be available, accessible, acceptable and of good quality…for example, "accessible" has four dimensions: accessible without discrimination, physically accessible, economically accessible (i.e. affordable), and accessible health-related information.[89]

The highest attainable standard of health includes both a functioning health system as well as the components of that system including the medical and other expertise necessary to the functioning of the health system. In addition, the rights require adequate

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[86] *Ahani, ibid* at para 42 and 49.

[87] Bayefsky, *supra* note 61 at 4.

[88] *ICESCR, supra* note 16, at para 12(b)(ii); United Nations, CECSR General Comment 14, *supra* note 25, at para 12.

[89] United Nations, Special Rapporteur on the right to health, 2003, *supra* note 77 at para 34.

provision of health related facilities, goods and services. "Goods and services" are defined throughout to include the determinants of health, including potable water and adequate sanitation.[90]

3.3.1 Accessibility

'Accessibility' covers a range of factors including the affordability, availability, and acceptability of the health related facility, good or service. Physical accessibility requires a health system that ensures that health goods and services are within safe, physical reach of "vulnerable and marginalised groups" including rural and indigenous populations, older persons, persons with disabilities and HIV/AIDS. Accessibility also includes physical accommodation such as providing a wheelchair ramp.

The CESCR, in its most recent periodic review of Canada's compliance with the Covenant, has identified gaps in health rights that may relate to physical accessibility, particularly for First Nations resident on reserve:

> The Committee is also concerned by the significant disparities still remaining between Aboriginal people and the rest of the population in areas of employment, *access to water, health*, housing and education, and by the failure of the State party to fully acknowledge the barriers faced by African Canadians in the enjoyment of their rights under the Covenant. [emphasis added] [91]

With respect to "economic accessibility," or affordability, the CESCR states "equity demands that poorer households should not be disproportionately burdened with health

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[90] *ICESCR*, *supra* note 16, para 12(b) see also para 4, 10, 11, 36.

[91] United Nations, Committee on Economic Social and Cultural Rights, (CESCR), Concluding Observations (Canada), 2006, E/C.12/CAN/CO/4, E/C.12/CAN/CO/5 at para 15.

expenses as compared to richer households."[92] The concept of 'disproportionate burden' requires some sense of what a reasonable or proportionate burden should be, however, the CESCR does not address this question. At the heart of the debate over the redistributive impacts of health-rights litigation lays the fact that modest health costs for a poor person may be unaffordable, while expensive treatments can be outside the capacity of a middle-income household. While Canadian courts have acknowledged that the burden of health care costs may make private access illusory, economic accessibility has not been accepted as a principle in *Charter* rights litigation involving health.[93]

The right to health includes not just access to medical care, but also access to essential medicines, and the right to a "healthy" home/environment/workplace.[94] Canada's system of publicly insured health care in excluding medicine fails to reflect international health rights norms. In addition, the state obligation to create the conditions necessary for a healthy home environment raises significant questions in relation to First Nations communities on reserve, where there are significant deficiencies in access to housing and safe drinking water.

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[92] United Nations, CESCR, General Comment 14, 2000*, supra* note 25, at 12(b)(iii).

[93] See *Canadian Doctors for Care et al v Canada (AG) and the Minister of Citizenship and Immigration*, [2014] FC 651, application for a stay denied, appeal withdrawn, at para 564 where, in denying the Applicants section 15 claim, the trial judge noted that "I fully recognize that the right of those affected to pay for their own medical treatment will be a largely illusory one, given the fact that most of those affected by the 2012 modifications to the IFHP will be economically disadvantaged individuals." But contrast with the SCC's judgment in *New Brunswick (Minister of Health & Community Services) v. G (J)* [1999] 3 SCR 46, at 100, where the court recognised that unaffordability rendered legal services inaccessible and imposed an obligation on government to provide legal aid where legal representation is essential to a fair hearing and the life, liberty or security of the person is at stake under s 7 of the *Charter*.

[94] United Nations, CESCR, GC 14, *supra* note 25 at para 15.

Finally, the CESCR notes that to be truly accessible, the public requires a right to "information and ideas" concerning health matters.[95] The Committee cross-references the right to information in Article 12 of the *ICESCR* with the right to know in the *ICCPR*.[96] This is particularly emphasized in relation to women and adolescent girls and their access to information concerning their sexual health, for example.[97] The CESCR in its most recent periodic review of Canada's compliance with the *ICESCR* has highlighted the particular risks and vulnerability faced by homeless girls in accessing health services.[98]

3.3.2 Availability, acceptability and quality of health systems

The right to the "highest attainable standard" of health means that there must be a "sufficient quantity" of facilities, goods and services including the social determinants of health.[99] This includes sufficient numbers of health professionals, essential drugs, and other health related facilities.[100] What constitutes "sufficient" is a relative question. It raises significant issues in the Canadian context where the rationing of medical services is a reality, but Canadian courts continue to show considerable deference to government choices regarding the rationing of medical care.[101]

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[95] United Nations, CESCR, GC 14, *ibid* at 11, 12(b)(iv)

[96] United Nations, CESCR, GC 14, *ibid* at 12(b)(iv); see also *ICCPR*, supra note 16, at Art 19.2.

[97] United Nations, CEDAW Committee, General Recommendation 24, *supra* note 51, at 18.

[98] United Nations, CESCR, Concluding Observations, 2006, *supra* note 91, at para 57.

[99] United Nations, CESCR, GC 14 (2000), *supra* note 25, para 12(a).

[100] United Nations, CESCR, GC 14 (2000), *ibid* para 12(a).

[101] See for example, *Flora v Ontario*, [2008] ONCA 538, at para 10, where the government refusal to fund life saving out of country medical care was found to be "reasonable" and upheld on judicial review; the outcome can be contrasted with *Stein v Quebec*, [1999] RJQ 2416 (Sup Ct) where the administrative decision denying payment for out of province medical care was overturned, and the Court approved the award of a special fee.

Within the scope of "acceptability" are those health services, goods and facilities that accommodate diverse cultural needs as well as meeting ethical standards.[102] In Canada, cultural norms in relation to social services remain controversial but appear to be finding acceptance in the human rights realm. In considering Canada's obligations under the *Convention on the Rights of the Child* in relation to child protection services for First Nations children on reserve, the Canadian Human Rights Tribunal relied on international jurisprudence, and the views of the Committee on the Rights of the Child, in finding that 'culturally appropriate' services were part of a child's right to substantive equality.[103] In that case, a First Nations child protection agency challenged the federal government's approach to funding child protection services on reserve, based on a claim that the funding resulted in inferior supports and services. The Canadian Human Rights Tribunal upheld the claim, in a manner that may have significant repercussions for other social services, including health services. Finally, in order to assure adequate quality, health systems must provide, for instance, "skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation."[104] These principles concerning accessibility, adequacy, sufficiency and acceptability are particularly relevant to the health of First Nations people living on

[102] United Nations, CESCR, GC 14 (2000), *supra* note 25, para 12(c).

[103] See *First Nations Child and Family Caring Society of Canada v Canada*,[2016] CHRT 2, at para 449; see generally the discussion of the application of international human rights obligations at para 428-455; In relation to aboriginal people in Canada, the right to 'traditionally appropriate' health treatment for First Nations has been found to be a 'constitutionally protected' right under s 35 of the *Constitution*; see *Hamilton Health Sciences Corp v HD* [2014] ONCJ 603.

[104] United Nations, CESCR, GC 14 (2000), *supra* note 25, para 12(d).

reserve in Canada, whose health is disproportionately affected by inadequate access to medical care, potable water, adequate sanitation and housing.[105]

3.3.3 Social determinants of health

The state party obligation to protect health is not "confined to the right to health care" but includes the determinants of health: [106]

> The right to health is an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health related education and information, including on sexual and reproductive health.[107]

The protection of health related social and economic rights is derived in part from the *Universal Declaration on Human Rights*, (UDHR) that "everyone has a right to a standard of living adequate for the *health* of himself and of his family, *including* food, clothing, housing and medical care and necessary social services."[108]

With respect to social determinants of health, the CESCR notes that:

> …the drafting history and the express wording of article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote

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[105] Canada, Royal Commission on Aboriginal Peoples (RCAP), *Report of the Royal Commission on Aboriginal Peoples: Gathering Strength,* vol 3 (Supply and Services Canada, Ottawa,1996) Chapter 1 at 1: "Aboriginal Peoples in Canada endure ill health, insufficient and unsafe housing, polluted water supplies, inadequate education, poverty and family breakdown at levels usually associated with impoverished developing countries. The persistence of such social conditions in this country — which is judged by many to be the best place in the world to live — constitutes an embarrassment to Canadians, an assault on the self-esteem of Aboriginal people and a challenge to policy makers." In the intervening years since the Royal Commission Report, the disparities in First Nations health have not seen changes: see Romanow, Roy, *Building on Values: the Future of Health Care in Canada* (Commission on the Future of Health care in Canada, Ottawa, 2002) at 211 and Truth and Reconciliation Commission, *Honouring the Truth, Reconciling for the Future* (The Truth and Reconciliation Commission of Canada, Ottawa, 2015) at 190.

[106] United Nations, CESCR, GC 14 (2000), *supra* note 25, para 4.

[107] United Nations, Special Rapporteur on the Right to Health, *supra* note 77.

[108] *Universal Declaration of Human Rights*, 1948, *supra* note 29, Art 25 [emphasis added].

> conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.[109]

Thus, in addition to access to health facilities, goods and services, health rights address social factors. Internationally, water as a determinant of health, is both part of the health rights, as well as an emerging right of its own.[110]

The former Special Rapporteur on the right to health, Paul Hunt, noted in a report to the UN General Assembly that:

> The health of individuals, communities and populations requires more than medical care. For this reason, international human rights law casts the right to the highest attainable standard of physical and mental health as an inclusive right extending to not only timely and appropriate medical care but also the underlying determinants of health, such as access to safe water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, access to health-related education and information, including on sexual and reproductive health, and freedom from discrimination. The social determinants of health, such as gender, poverty and social exclusion, are major preoccupations of the right to the highest attainable standard of health.[111]

This link between health rights and poverty has so far been largely unexplored by courts

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[109] United Nations, CESCR, GC 14 (2000), *supra* note 25, at para 4.

[110] United Nations, CESCR, GC 14 (2000), *ibid* para 4, 11; see also CEDAW Committee, *General Recommendation 24 (Article 12 of the Convention: Women and Health,) supra* note 51, at para 31(c) regarding reproductive health rights; the right to water has been interpreted by the CESCR to form part of the right to health; see Human Rights Council, CESCR, *General Comment No. 15, the right to water (ICESCR Art 11 and 12), supra* note 52. In addition, keeping in mind that resolutions of the UN General Assembly form part of "soft law" given that they are not enforceable, the right to water and sanitation subsequently became the subject of a resolution: UN General Assembly, Resolution: The human right to water and sanitation, 28 July 2010, 64th sess, ag item 48, UNORGA, UN Doc A/RES/64/292.

[111] United Nations, Report of the Special Rapporteur on the right of everyone to the highest attainable standard of physical and mental health, *supra* note 40, para 45.

in health rights litigation in Canada, which has focussed largely on access to medical care.[112] Yet at an international level, social determinants form part of the "minimum core obligations" in relation to health rights, and thus have priority in terms of obligating the state party to take immediate action to realise the right. In preparation for its sixth periodic review under the *ICESCR*, Canada has now filed its report.[113] Under the right to health, Canada identifies federal government initiatives in child nutrition and guidelines for drinking water thus acknowledging access to adequate food and water as forming part of health rights.

Arguments have been raised against interpreting Article 12 to include the social determinants of health, on the basis that this leads to duplication and overlaps between health rights and the right to an adequate standard of living. John Tobin argues that the social determinants are protected elsewhere in the *ICESCR* under Article 11, which protects food, clothing, housing and 'living conditions' as part of the right to an adequate standard of living. Countering this concern, is that the potential for overlapping human

[112] The World Health Organisation (WHO) convened the Commission on Social Determinants of Health in 2005. The Commission is focused on addressing "health equity" to reduce the gap in health outcomes between rich and poor. While it describes equity as an "ethical imperative" it notes that "access to quality housing and shelter and clean water and sanitation are human rights and basic needs for healthy living" and identifies state responsibility for health inequalities and inequities; "poor and unequal living conditions are the consequence of poor social policies and programmes, unfair economic arrangements, and bad politics." World Health Organisation, *Closing the Gap in a Generation: Final Report*, (WHO, Geneva, 2008) at 1, retrieved at: http://whqlibdoc.who.int/hq/2008/WHO_IER_CSDH_08.1_eng.pdf.

[113] Canada, Sixth periodic report to the United Nations Committee on Economic, Social and Cultural Rights (CESCR); Consideration of reports submitted by States parties under articles 16 and 17 of the International Covenant on Economic, Social and Cultural Rights, (23 April 2013), received: 17 October 2012, UN Doc E/C12/CAN/6; Canada also identifies a range of improvements in health care services, and particularly the federal/provincial funding formula, reduction in wait times, growth in medical school enrolment, and improved health information technology.

rights protection does not appear to undermine the enforcement of those rights. On the other hand, the exclusion of the social determinants of health from Article 12, would significantly weaken the health rights protections afforded to poor and disadvantaged communities whose health depends to a larger extent on those determinants. Tobin fails to address the negative impact of the exclusion of the social determinants on the health rights of disadvantaged communities. Tobin also fails to address other social determinants that currently do not find treaty protection such as water and sanitation, neither of which is explicitly protected in the *ICESCR* or any other UN human rights treaty.[114] The CESCR has interpreted access to potable water and sanitation as forming part of the right to health under Article 12 and one of the core obligations in relation to health.[115] Water as a determinant of health has received extensive attention from both the World Health Organisation, which identifies access to potable water a health priority, and from the UN Special Rapporteur on the right to health.[116] In conclusion, it appears that there is no strong reason to reject the CESCR's interpretation of Article 12 to include the social determinants of health.

Access to potable water and adequate sanitation are clearly among the "conditions" necessary to physical health. Interpreting health rights to include water and sanitation

[114] While not protected under any UN human rights treaty, the right to water has been the subject of numerous international meetings, WHO declarations and reports, and a Declaration of the UN General Assembly.

[115] United Nations, CESCR, General Comment 14, *supra* note 25 at para 4, 11, 12, 15, 43(c).

[116] Access to water is necessary to life and access to improved water sources and sanitation were identified as part of the Millennium Development Goals, under environmental sustainability, and monitored by the World Health Organisation; see also United Nations, Report to the UN General Assembly (Water, Sanitation, and the right to the highest attainable standard of health) 2007, *supra* note 70.

addresses health inequalities.[117] Tobin's exclusion of the social determinants of health from the category of health rights ignores the focus on "prevention" contained in Article 12 and runs counter to the view of human rights as "indivisible, interdependent and interrelated." [118]

The significance of the social determinants of health in Canada has been extensively documented; where poor health outcomes have been directly linked to poverty, especially with respect to First Nations reserve communities and low-income households.[119] In this context, based on international jurisprudence, these conditions have clear human rights significance, not merely social and public health policy implications.

3.3.4 Minimum core obligations

At an early stage of its development, the CESCR interpreted the *ICESCR* as containing certain "minimum core obligations."[120] The significance of the minimum core obligation is that the state party is obligated to take *immediate* steps to protect "minimal essential

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[117] United Nations, Committee on Economic, Social and Cultural Rights (CESCR), Statement on Poverty and the International Covenant on Economic, Social and Cultural Rights, (10 May 2001), UNESCOR, 25th sess, Agenda item 5, UN Doc E/C.12/2001/10 at para 17.

[118] United Nations, World Conference on Human Rights, *Vienna Declaration and Programme of Action*, 12 July 1993, A/CONF.157/23, available at: http://www.refworld.org/docid/3ae6b39ec.html [accessed 8 February 2016] at I.5.

[119] See Martha Jackman, "Law as a Tool for Addressing the Social Determinants of Health," in Timothy Caulfield et al ed*, Public Health Law and Policy in Canada*, 3rd Ed, (Toronto, LexisNexis, 2013) at 98-101; see also Office of the Auditor General of Canada (OAG), "Access to Health Services for Remote First Nations Communities: Report 4," (Ottawa, Min of Public Works, 2015) at 2 and 26; see also Dennis Raphael, *Poverty in Canada: Implications for Health and Quality of Life*, 2nd ed, (Toronto, Cdn Scholars Press, 2011) at 223.

[120] United Nations, CESCR, General Comment 3: The nature of the state parties' obligation, (1 January 1990) *supra* note 16, at 10, for the CESCR's first expression of "minimum obligation" "to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party." While the "minimum core obligations" are subject to immediate effect, other rights under the *ICESCR* are subject to the more gradual remedy of "progressive realization." See also Riedel *supra* note 44, at 32.

levels of each of the rights in the Covenant, including essential primary health care."[121] While there is no reference to "minimum core obligations" in the text of the *ICESCR*, the CESCR described these obligations as the "raison d'etre" of the *ICESCR* and imposed significant evidentiary burdens on state parties that disregard these obligations.[122] The minimum core obligations represent a prioritisation of certain social and economic rights over others, who are subject to the more gradual obligation of "progressive realisation."

With respect to health, the text of Article 12 is not easily interpreted to embody a minimum core. Rather than a minimum, it refers to the "highest attainable" standard, unlike other provisions of the *ICESCR* that reference adequacy.[123] The reference to health, rather than health care, makes it more difficult to relate health to a "minimum core" of goods and services.

Article 12.2 serves as the main textual source for the components of the minimum core. In addition to a minimum essential level of primary healthcare, the CESCR has identified essential drugs, access to food, basic shelter, sanitation, and potable water among the minimum core obligations which State parties have an immediate duty to provide.[124]

> …the Committee is of the view that a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party. Thus, for example, a State party in which any

[121] United Nations, CESCR, GC 14 (2000), *supra* note 25, at 43-45.

[122] United Nations, CESCR, General Comment 3: The nature of the state parties' obligation, *supra* note 16, at 9.

[123] *ICESCR, supra* note 16, at Article 11: "adequate standard of living…including adequate food, clothing and housing…"

[124] United Nations, CESCR, GC 14 (2000), supra note 25, at 43-45; see also United Nations, CESCR, General Comment 3: The nature of the state parties' obligation, *supra* note 16, at 10.

> significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education is, prima facie, failing to discharge its obligations under the Covenant.[125]

Finally, the minimum core includes an immediate right to a national health plan and strategy. The state has an *immediate* obligation to "take steps" which has been interpreted as adopting and implementing a national public health strategy and plan of action, including a participatory review and monitoring process, and the setting of health indicators and benchmarks.[126] A human rights based approach to health policy has been identified both as an important means of realising the right to health, and achieving accountability in Canada's health system.[127] Canada currently lacks a national health plan and strategy.

The concept of "minimum core" is a direct response by the CESCR to the issue of the implementation of economic and social rights. Through minimum core obligations, the CESCR attempts to place certain economic and social rights on the same footing as civil and political rights, in focussing on immediate, rather than progressively realised entitlements.

The concept of a "minimum core" is not without controversy and has been the subject of criticism for its focus on minimum standards for two reasons.[128] First, in developed

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[125] United, Nations, CESCR, General Comment 3: The nature of the state parties' obligation, *ibid* at para 10.

[126] CESCR, GC 14 (2000), *supra* note 25, at para 43(f), 52, 56-58.

[127] See Klein, *supra* note 38 at 325. See also; Hunt and Backman, *supra* note 47, at 42-46.

[128] See Salomon, *supra* note 32, at 2140.

countries, the concern is that the minimum core obligation could become the ceiling rather than the floor, based on marginally tolerable rates of assistance that keep people in poverty. Second, the minimum core ignores more recent epidemiological evidence that it is the gap between the rich and poor, and not absolute incomes at the bottom that undermine health.[129] The approach to poverty alleviation embedded in the concept of minimum core, which focuses upon the poorest of the poor, can be viewed as running counter to the emphasis on "everyone" in the attainment of the 'highest attainable" standard of health.

In conclusion, the state party's minimum core obligation consists of essential levels of primary health care and the social determinants of health, as well as non-discrimination, and a national health plan and strategy. The concept is not without controversy, and may run counter to evidence-based approaches to public health issues in terms of reducing the gap between high and low income earners, rather than limiting the focus to poverty alleviation.

Another contentious area with respect to the minimum core obligations lies in the test for justification by state parties. The CESCR has determined that minimum core obligations take immediate effect, unlike other rights and obligations that are subject to "progressive realisation."[130] In the words of Paul Hunt, the former UN special rapporteur on health:

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[129] See Salomon, *ibid* at 2141; see also Wilkinson, Richard and Kate Pickett, *The Spirit Level: Why Equality is Better for Everyone* (Penguin, London, 2010), for the epidemiological studies suggesting the income inequality is a primary indicator of population health.

[130] See *ICESCR, supra* note 16 at Art 2(1). With the exception of the minimum core obligation, the *ICESCR* rights are subject to the more gradual process of "progressive realisation" where the

> While many elements of the right to the highest attainable standard of health are subject to progressive realization and resource availability, the right also gives rise to some obligations of immediate effect that are subject to neither.[131]

In the context of health rights, the CESCR has described the minimum core obligation as '"non derogable," meaning that violations are not subject to justification by the state on any grounds.[132] However, elsewhere the CESCR has suggested that a state party may claim justification of a violation of minimum core obligations based on resource constraints, although there is a heightened burden of proof.[133]

This inconsistency has served to highlight the difficulties in interpreting the state obligation with respect to health rights. Non-derogable rights are generally associated with *jus cogens,* the "peremptory norms" of customary international law, which are considered to include a number of rights with health implications such as the right to be free from torture or cruel and unusual treatment, murder or forced disappearances, prolonged arbitrary detention, and "a consistent pattern of gross violations of internationally recognised human rights."[134] In Canadian courts, at the level of theory if

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state party is required to take steps based on "the maximum of its available resources" to achieve complete protection of the right.

[131] United Nations, Report of the Special Rapporteur, *supra* note 40, at para 63.

[132] United Nations, CESCR, GC 14 (2000), *supra* note 25.

[133] United Nations, CESCR, General Comment 3: The nature of the state parties' obligation, *supra* note 16 at 9-10; there is some question whether GC 3 has been revised by subsequent General Comments on this point such that the better view is that such rights are now non-derogable.

[134] United Nations, Human Rights Committee, General Comment 24, UN Doc CCPR/C/21/Rev 1/ Add 6 (1994) a 8; see also *Restatement (Third) of Foreign Relations of the US* (1987) § 702 at d-i, § 102 at k (1987); the Restatement is generally recognised as a codification of *jus cogens* norms; see EJ Criddle and Evan Fox-Decent, "A Fiduciary Theory of Jus Cogens Norms" (2009) 34 Yale JIL 331.

not practice, this law may be applied "without the need for an express legislative act, unless there is a clear conflict with statute or common law" although like treaty law, the recognition and enforcement of customary international law is not explicitly addressed or incorporated in the text of the Canadian *Charter*.[135]

With respect to health rights, the identification of certain minimum core obligations as 'non derogable' may be tied to their proximity to these *jus cogens* norms, particularly those with health implications. This connection is not made explicit, however, in the general comments of the CESCR. Nevertheless, the CESCR is clear that minimum core obligations are capable of immediate effect, even if there is some uncertainty regarding whether they are "non derogable" or capable of some level of state justification for non-performance.[136]

In respect to children's right to health, as contained the in *Convention on the Rights of the Child,* the treaty monitoring body, 'the Committee on the Rights of the Child' has identified the following minimum core obligations:

> The core obligations, under children's right to health, include:
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> (a) Reviewing the national and subnational legal and policy environment and, where necessary, amending laws and policies;

[135] See Schabas, William, *International Human Rights Law and the Canadian Charter*, 2nd ed (Carswell, Toronto, 1996) at 16 and 20; however, the experience with the enforcement of *jus cogens* norms in Canada has been very uneven, particularly in relation to protection against torture; see *Suresh v Canada supra* note 68.

[136] See also Mechlem, *supra* note 63, at 940-941 for a discussion of the impact of such inconsistencies.

> (b) Ensuring universal coverage of quality primary health services, including prevention, health promotion, care and treatment services, and essential drugs;
>
> (c) Providing an adequate response to the underlying determinants of children's health; and
>
> (d) Developing, implementing, monitoring and evaluating policies and budgeted plans of actions that constitute a human rights-based approach to fulfilling children's right to health.[137]

In addition to imposing obligations of 'immediate effect', under a human rights approach, the minimum core obligation is also significant as a means of targeting and prioritising health resources to the needs of the most disadvantaged:

> Thus, the core obligations of economic, social and cultural rights have a crucial role to play in national and international developmental policies, including anti-poverty strategies.[138]

While elevating the minimum core obligation to the highest priority within the right to health, at a policy level this designation provides little guidance for resource allocation in relation to other government responsibilities. In terms of Canada's minimum core obligations regarding health, the CESCR in its most recent concluding observations on Canada in 2006 highlighted reductions in government support for social assistance and social services. Given the typology of health rights, this reduction undermines the minimum core obligations with respect to the social determinants of health including adequate food and housing.[139] Given that the CESCR's concluding observations are in

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[137] United Nations, Committee on the Rights of the Child, General Comment 15 on the right of the child to the enjoyment of the highest attainable standard of health (art. 24), *supra* note 51, at para 73.

[138] United Nations, CESCR, Statement on Poverty, *supra* note 115, para 17.

[139] United Nations, CESCR, Concluding Observations of the Committee on Economic, Social and Cultural Rights (CO), Canada, *supra* note 91 at para 20; the CESCR also notes an increase in healthcare spending during the same period.

the nature of recommendations, their impact can largely seen at the political level both nationally and within the UN.

While there are few examples of Canadian courts addressing the concept of a "minimum core obligation" when interpreting and applying the Canadian *Charter*, it has clear ramifications for human rights in Canada.[140] A violation of the 'minimum core' of the right to health would have primary relevance under a section 1 analysis where, under the proportionality test, the state would bear a heavy burden to show a "minimal impairment" of the right.[141] The concept of minimum core thus represents an important doctrine that could be applied in the Canadian legal system. In addition, a key component of the minimum core obligation in relation to health is the right to non-discrimination, to which I will return in the next section.

3.3.5 Non-discrimination

The approach to non-discrimination under the UN human rights treaties is very similar to the approach to equality rights in Canada under section 15 of the *Charter*.[142] While the *ICESCR* treaty provisions pre-date the *Charter*, the CESCR general comment interpreting

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[140] See for example the judgement of L'Heureux-Dube J in *Gosselin v Quebec, infra* note 346 at 146 where she uses the concept of "minimum core" to interpret the principles of fundamental justice to include a requirement of adequacy in obtaining the basic necessities of life in relation to social assistance.

[141] See for example, *Samity v Bengal* [1996] SCJ 25, p. 29 a case dealing with the Indian Constitution, where the Indian Supreme Court rejected the state party's justification based on insufficient resources, in a case where a critically injured patient was unable to access timely and adequate emergency care; as cited in United Nations, Special Rapporteur on the Right to Health, *supra* note 1, para 64-66; see also *Canadian Charter of Rights and Freedoms*, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), 1982, c 11.

[142] It is for this reason, that the Canadian equality rights jurisprudence has generally not looked to international UN human rights treaties or jurisprudence in interpreting s 15.

non-discrimination dates from 2009 and references earlier international and Canadian caselaw.[143] Unlike social and economic rights, where there exist no comparable Canadian constitutional or legislative provisions, the international law on non-discrimination provides few new insights for the development of Canadian jurisprudence in relation to equality rights. It is for that reason that the international non-discrimination jurisprudence will not be explored in depth, except to the extent that it differs from equality rights in Canada, specifically with respect to the prohibited grounds of discrimination.

Non-discrimination is a cardinal feature of the rights in the Covenant, including health rights. Article 2.2 of the *ICESCR* provides as follows:

> The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.[144]

In General Comment 14, the CESCR indicates that non-discrimination is a key aspect of health rights. It includes non-discrimination in access to health care, as well as the social determinants of health and the "means and entitlement" for their procurement.[145] "Inappropriate health resource allocation" is identified as a potential source of discrimination within the health system, where expensive curative health services are

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[143] The United Nations Committee on Economic, Social and Cultural Rights (CESCR) released General Comment 20, *supra* note 73, concerning non-discrimination under the *ICESCR*, in 2009, 20 years after the Supreme Court of Canada rendered its first decision under s 15 in *Andrews v Law Society of BC* [1989] 1 SCR 143.

[144] *ICESCR*, supra note 16, Art 2.2; see also Art 3 regarding discrimination between men and women.

[145] United Nations, CESCR, GC 14, *supra* note 25, para 18.

chosen over primary and preventive types of health services that may benefit the majority.[146] The state obligation to non-discrimination under Article 2.2 is of "immediate effect," in contrast with the more gradual state obligation of "progressive realisation." [147] The CESCR has provided detailed analysis of the application of Article 2.2 in its general comments.[148]

The CESCR has determined that there should be no differential treatment in accessing existing healthcare resources based on protected grounds – what is commonly referred to as "direct discrimination." In addition, the state party has an obligation to take into account the needs of disadvantaged or protected groups – for instance, to accommodate the reproductive needs of women or the rehabilitative needs of persons with disabilities. This is often referred to as indirect or 'substantive' discrimination.[149] A State's failure to take action to address under inclusive health programs, may constitute a violation where government is under a positive obligation to provide health related goods and services, rather than simply ensuring the non-discriminatory distribution of existing programs.

One of the most important features of the right to non-discrimination in the enjoyment of the highest attainable standard of mental and physical health is that it is considered to be

[146] United Nations, CESCR, GC 14, *ibid* para 19.

[147] See for instance, United Nations, CESCR, *supra* note 89, para 50.

[148] See United Nations, CESCR, General Comment 20: Non-discrimination in economic, social and cultural rights, *supra* note 73.

[149] United Nations, CESCR, GC 20, *ibid* para 10.

of "immediate effect."[150] Unlike other aspects of the right to health, which are subject to the principle of "progressive realisation," states have an immediate obligation to implement and protect the right to non-discrimination.[151] This can be distinguished from Canadian jurisprudence under the *Charter,* where section 1 of the *Charter* allows for government justification of violations of section 15.

One of the principle areas in which the international non-discrimination jurisprudence differs from Canadian jurisprudence in relation to section 15 and non-discrimination is in the scope of the prohibited grounds. Similar to section 15 of the Canadian *Charter*, the prohibited grounds of discrimination under the *ICESCR* are considered to be inclusive, not exclusive. In addition to the express grounds, "other status" in Article 2.2 of the *ICESCR* has been interpreted to include "health status," such as being HIV positive.[152] In the Canadian context, "health status" would generally be subsumed under the ground of "disability."[153] However, the Committee's interpretation of 'other status' provides a wide scope for new grounds:

> Other possible prohibited grounds could include the denial of a person's legal capacity because he or she is in prison, or is involuntarily interned in a psychiatric institution, or the intersection of two prohibited grounds of discrimination, e.g. where access to a social service is denied on the basis of sex and disability.[154]

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[150] United Nations, CESCR, GC 20, *ibid* at para 7; see also CESCR, GC 14 (2000), *supra* note 25 , para 12(b), 18, 19, 30.

[151] United Nations, CESCR, GC 20, *supra* note 140.

[152] United Nations, CESCR, GC 20, *supra* note 140, para 33; In addition, "other status" has been interpreted to include grounds related to age, nationality, marital and family status, sexual orientation and gender identity, as well as economic and social situation, among others.

[153] At the international level, "disability" as a prohibited ground of discrimination is addressed specifically in the *Convention on the Rights of Persons with Disabilities*, *supra* note 58.

[154] United Nations, CESCR, GC 20, *supra* note 140 at para 27.

However, more controversially the prohibited grounds in the *ICESCR* have also been interpreted by the CESCR as including 'analogous' grounds related to poverty, as well as economic and social inequality:

> Economic and social situation
> 35. Individuals and groups of individuals must not be arbitrarily treated on account of belonging to a certain economic or social group or strata within society. A person's social and economic situation when living in poverty or being homeless may result in pervasive discrimination, stigmatization and negative stereotyping which can lead to the refusal of, or *unequal access to, the same quality of education and health care* as others, as well as the denial of or unequal access to public places.[155]

States have an obligation to the poor who cannot afford health care or health insurance.[156] It is significant to note that social and economic inequalities are tied to unequal access to health care in the international jurisprudence. In its 2006 review of Canada, the CESCR noted generally that:

> The Committee recommends that federal, provincial and territorial legislation be brought in line with the State party's obligations under the Covenant, and that such legislation should protect poor people in all jurisdictions from discrimination because of their social or economic status.[157]

The recommendations of the CESCR to incorporate protection against discrimination based on social or economic status has not been implemented at either the federal or provincial level.[158] Within Canada, similar recommendations with respect to

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[155] United Nations, CESCR, GC 20, *supra* note 140, para 35 [emphasis added].

[156] United Nations, CESCR, GC 14, *supra* note 25, para 19.

[157] United Nations, CESCR, Concluding Observations, 2006, supra note 91 at 39; although not directly linked with health rights, the CESCR also identified Canada's failure in protecting First Nations and aboriginal women's groups from discrimination in their enjoyment of social and economic rights.

[158] It should be noted that some provincial jurisdictions have included protections related to income; see for instance the prohibited grounds of discrimination contained in the Nova Scotia *Human Rights Act*, RSNS 1989, c 214, at s 5(1)(t) "source of income."

incorporating poverty related grounds under the heading of "social condition" have also been ignored in relation to the *Canadian Human Rights Act.*[159] While politically unpopular in Canada, according to the CESCR, poverty as a ground of discrimination is protected under the *ICESCR,* and forms part of Canada's international obligations relation to health rights.

Non-citizenship also finds wide protection as a prohibited ground under international jurisprudence. The CESCR has stated that:

> The ground of nationality should not bar access to Covenant rights, e.g. all *children within a State, including those with an undocumented status,* have a right to receive education and *access to adequate food and affordable health care.* The Covenant rights apply to everyone including non-nationals, such as refugees, asylum-seekers, stateless persons, migrant workers and victims of international trafficking, regardless of legal status and documentation.[160]

While the Supreme Court of Canada has yet to rule on this aspect of non-discrimination in relation to undocumented migrants, the opinion of the CESCR stands in contrast to determinations of lower courts, where the grounds have been restricted to exclude migrant works and undocumented migrants.[161] The Court's ruling cannot be reconciled with Canada's international obligations towards the children of refugees and undocumented migrants.

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[159] Canadian Human Rights Review Panel, Report, at 106 (Canada, Ottawa, 2000).

[160] United Nations, CESCR, General Comment 20, *supra* note 73, at 30, where discrimination based on 'nationality' is broadly interpreted.

[161] See for instance the judgment of Stratas, J in *Toussaint v Canada* [2011] FCA 215, para 99 where 'immigration status' was rejected as an analogous ground under s 15, in a case where an undocumented migrant was deprived of access to healthcare.

The open-ended ground of discrimination includes "other status." This may include the concept of "intersectionality" in a human rights violation. This reflects the interaction with other protected rights, such as poverty (right to an adequate standard of living and social security), violence against women (discrimination against women), and migration (health rights of non-citizens).[162] Such intersecting grounds are "commonly recognized when they reflect the experience of social groups that are vulnerable and have suffered and continue to suffer marginalization."[163]

Intersectionality in discrimination claims has been recognised by the Supreme Court of Canada in *Law v Canada*.[164] In a case I will return to, Stratas J of the Federal Court of Appeal, while acknowledging the importance of intersectionality to the equality analysis under the *Charter*, ruled that there was insufficient evidence linking gender to the equality rights violations in a case involving an undocumented woman migrant worker, to justify the Women's Legal Education and Action Fund's application for intervener status.[165]

In addition to Article 2.2 of the *ICESCR*, Article 26 of the *ICCPR* provides explicit protection against discrimination:

> All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion,

[162] United Nations, CESCR, General Comment 20, *supra* note 73 para 33.

[163] United Nations, CESCR, GC 20, *ibid* para 27.

[164] [1999] 1 SCR 497 at para 93; see also *Withler v Canada* [2011] SCC 12 at para 63.

[165] *Canada (Attorney General) v. Canadian Doctors for Refugee Care* [2015] FCA 34 at 25, 26

> political or other opinion, national or social origin, property, birth or other status.[166]

The right to equality and non-discrimination under the *ICCPR* is broad, and could include discrimination in relation to health. The rights in the *ICCPR* are also of "immediate effect." In addition, as a result of Canada's ratification of the First Optional Protocol - an international complaint process - under the *ICCPR*, there are additional treaty based remedies for equality rights violations under the *ICCPR*. Canada has not yet ratified the Optional Protocol under the *ICESCR*. In addition to the *ICESCR* and the *ICCPR*, the principle of non-discrimination in access to health related goods and services is reinforced and further defined in a number of other international human rights treaties, with respect to race, women, children, and persons with disabilities.[167]

3.3.6 The nature of the state's obligation

Central to the realisation of international human rights is the concept of 'state obligation.' In human rights terms, it means that a government can be held responsible not simply for its actions, but for inaction as well. In relation to economic and social rights, as previously discussed, this has been a huge area of contention. The starting principle for a state's obligation for those who advocate that health rights must be more than a "slogan" is that they are not merely aspirational, but binding in the same manner as civil and

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[166] *ICCPR*, *supra* note 16, at Art 26; see also Article 24, which protects children against discrimination on protected grounds in special measures due to age.

[167] See *CEDAW*, at Art 12 and 14 (rural women) *supra* note 56; CEDAW Committee, *General Recommendation 24 (Article 12 of the Convention: Women and Health),* at Art 25; CRC, *supra* note 52, at Art 24; CRC Committee, *General comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health* (art. 24), *supra* note 56 at Art 5(e)(iv). Both the *Universal Declaration of Human Rights* (UDHR, supra note 29) as well as the *International Covenant on Civil and Political Rights [ICCPR], supra* note 16, protect against non-discrimination and are considered to be subject to immediate enforcement.

political rights.[168]

In General Comment 14, the Committee begins by stating that the right to health is "fundamental" and "indispensable for the exercise of other human rights."[169] All treaty obligations to which a state is a party are considered to be legally binding on government.[170] This statement reiterates previous General Comments concerning the binding nature and justiciability of economic and social rights.[171]

> "The right to health imposes some immediate obligations: Although subject to progressive realization and resource constraints, the right to health imposes various obligations of immediate effect." [172]

The right to health imposes a corresponding duty on government to take steps towards the realisation of the right by "all appropriate means." Article 2.1 of the *ICESCR* states:

> Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.[173]

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[168] See United Nations, Special Rapporteur on the Right to Health, *supra* note 77, para 8, 9, where he argues that health rights should be more than a "slogan" based on "the fundamental principle that international human rights law, including the right to health, should be consistently and coherently applied across all relevant national and international policy-making processes."

[169] United Nations, CESCR, GC 14 (2000), *supra* note 25 at 1; on the civil and political side, the right to life, to non-discrimination, and to be free from cruel and unusual treatment have been applied to protect health interests.

[170] *ICESCR*, Optional Protocol, *supra* note 79, Preamble para 4; see also World Conference on Human Rights, Declaration and Programme of Action, 25 June 1993, *supra* note 116, at I.5.

[171] See for example, United Nations, CESCR, General Comment 9: The domestic application of the convenant, *supra* note 72, at 10, concerning justiciability.

[172] Hunt, Paul, *supra* note 48, at 3.

[173] *ICESCR*, *supra* note 16 at Art 2(1); like the *ICESCR*, health rights protections contained in *CEDAW, CRC, ICERD,* and *CRPD* adopt a similar approach to obligations of "immediate effect" and those subject to "progressive realisation."

Described as "progressive realisation," the state obligation under the *ICESCR* recognises that the capacity of states to address health rights is relative to their level of development.

Across all UN human rights treaties, the consensus among UN human rights treaty monitoring bodies, including the CESCR, is that the state obligation consists of the duty to "respect, protect and fulfill" the rights contained in the treaty.[174] This typology of the state obligation has no direct textual basis.[175] The unanimous opinion of expert UN bodies provides the most influential basis for understanding the obligation. The duty to respect "requires the State to refrain from denying or limiting equal access for all persons, including prisoners, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services."[176] It is the concept of state obligation that sits most comfortably with Canadian courts. It prohibits government from interfering or impeding access to therapeutic treatment, health facilities, goods and services. It includes direct forms of discrimination, such as restricting access to health related goods or services based on prohibited grounds.

There are numerous examples of cases that fall into this category in Canada. The criminalisation of therapeutic health services, such as occurred in *Morgentaler,* represents a failure to respect the right to health.[177] Another example of a state restriction on health

[174] United Nations, CESCR, GC 12 *supra* note 71, para 30.

[175] United Nations, CESCR, GC 12, ibid at para 33; See also Tobin, *supra* note 6 at 185.

[176] United Nations, CESCR, GC 14 (2000), *supra* note 25, at 34; See also United Nations, Human Rights Council, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, *supra* note 1.

[177] United Nations, CESCR, GC 14 (2000), *ibid* at 8; see also *R. v. Morgentaler*, [1988] 1 SCR 30.

can be found in the criminalisation of the use of marijuana for medical purposes, also recognised as a rights violation in Canada.[178] It can also be found in state sanctioned approval of non-consensual medical treatment, in the absence of proper procedural safeguards.[179] These rights are often classified as "negative rights" because they require the state to remove restrictions or *not* to interfere with the enjoyment of a right.[180] Examples of state restrictions could include by-laws that bar access to the health service or good, or restrict individual autonomy or decision making with respect to healthcare.

While the Supreme Court of Canada has not explicitly addressed the concept of Canada's obligation as it exists in the international human rights jurisprudence, the Court's approach to legislative restrictions is clearly consistent with this interpretation of Canada's state obligations. Although not cited as such, a number of health-related cases provide examples of this type of obligation. In a recent decision, the Supreme Court of Canada was faced with a claim that federal government restrictions on access to a provincially funded health facility constituted a violation of life and security of the

[178] See *R v Parker* [2000] OJ 2787 at para 148; where the Ontario Court of Appeal references Article 12.1 and 12.2(d) of the ICESCR, the right to the highest attainable standard of health, and the right to conditions for medical service, in finding that the complete prohibition on the consumption and cultivation of marijuana was a violation of the appellant's right to liberty and security of the person, not in accordance with the principles of fundamental justice under s 7 of the *Charter*.

[179] United Nations, CESCR, General Comment 14, *supra* note 25, para 8.

[180] The theoretical antecedents for the distinction between negative and positive rights has been traced to the work of the philosopher Irving Berlin in a discussion that distinguishes between human rights that create "restraints' on government action, as opposed to prescriptive remedies, that require government to act: see Langford, Malcolm, "The Justiciability of Social Rights: From Practice to Theory" in Langford, Malcolm ed *Social Rights Jurisprudence*, *supra* note 21, at 8.

person under section 7 of the *Charter*.[181] In commenting on the legislative barrier to access to the supervised injection facility the Court noted that:

> The trial judge made crucial findings of fact that support the conclusion that denial of access to the health services provided at Insite violates its clients' section 7 rights to life, liberty and security of the person. He found that many of the health risks of injection drug use are caused by unsanitary practices and equipment, and not by the drugs themselves. He also found that "[t]he risk of morbidity and mortality associated with addiction and injection is ameliorated by injection in the presence of qualified health professionals": *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.[182]

In the controversial case of *Chaoulli,* the Quebec *Charter* was interpreted to prohibit government from erecting statutory barriers to the right to private healthcare insurance in conditions where reasonable access to services was found to be unavailable through the publicly funded health care system.[183] Thus, when the government erects a fence by legislation or policy that prevents access to existing heath care services or programs, Canadian courts have struck down the legislation or policy on grounds that are broadly consistent with the state party's 'obligation to respect' in international law.

The next aspect of the state obligation is found in the 'duty to protect.' This aspect of the obligation engages government as a regulator of non-government activities to prevent third parties from undermining the right to health. Under the international rubric,

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[181] *PHS Community Services Society v. Canada (Attorney General) (Insite) supra* note 4; however, McLachlin J found the violation was caused by the Minister's refusal to issue an exemption to the operation of s 4 of the CDSA, rather than striking down the legislative provision of trafficking, based on a finding that clients and staff were not liable to prosecution.

[182] *PHS Community Services Society v. Canada (Attorney General) (Insite), ibid* [emphasis added].

[183] See *Chaoulli v Quebec (AG)* [2005] 1 SCR 791.

governments have a duty to *protect* health rights by preventing third parties from denying access, to ensure that the private health care sector does not threaten the accessibility of health facilities, goods and services. For example, this aspect of the government obligation requires effective regulation of health professionals to ensure that they meet appropriate educational and ethical standards.[184] There are few examples under the *Charter* addressing the government obligation to protect against rights infringements by third parties. One such example, is found in *Jane Doe v Toronto* where the Court found that the police failure to warn women of a recidivist rapist in their neighbourhood was a violation of their right to security of the person under section 7, and based on discriminatory stereotypes under section 15.[185] Thus the Court held the government responsible for the harm caused by a third party, the serial rapist, based on the negligent and discriminatory actions of the police force.

The former special rapporteur on the right to health, Paul Hunt, has identified the deportation of an individual to a country where he would be denied medical treatment, as an example of "inhuman treatment" under the *ICCPR*, and contrary to the duty to protect the right to health.[186] However, this argument was explicitly rejected in a recent Canadian case where a father of three from Mexico, following the rejection of his refugee claim, argued that Canadian immigration legislation should be interpreted in light of the duty to protect his right to health, so as to bar his deportation. He suffered from a life threatening

[184] United Nations, CESCR, GC 14 (2000), *supra* note 25, at 35; see also United Nations, Report of the Special Rapporteur, *supra* note 40, at 82-84; examples include environmental regulation to protect public health.

[185] *Doe v Toronto*, [1998] 39 OR (3d) 487 On HC.

[186] United Nations, Human Rights Committee, *Report of the Special Rapporteur*, *supra* note 77, para 79.

health condition and could not afford to pay the cost of medical treatment. Despite the fact that Mexico did not provide such treatment in the public system, the Court ruled that his removal would not violate his rights.[187] Despite the broad language of the *Charter* guarantees and their application to 'everyone,' the Courts have a very poor track record in social rights protections for non-citizens in Canada. The duty to protect against rights violations by private actors, found its strongest statement in the context of the right to work, particularly in *Dunmore* where the Supreme Court of Canada found that the government had a duty to include collective bargaining protections to agricultural workers.[188]

The duty to *fulfill* health rights has been further defined to require government to "facilitate, provide and promote" the conditions necessary for health.[189] It requires governments "to adopt appropriate legislative, administrative, budgetary, judicial, promotional, and other measures towards the full realization of the right to health."[190] Government obligations include taking positive measures to address gaps in health protection. While it does not specify what type of health system is desirable (public, private or mixed) the Committee has identified that resources should be equitably allocated, and services made "affordable for all."[191]

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[187] See *Covarrubias v. Canada (Minister of Citizenship and Immigration),* 2006 FCA 365, at 41.

[188] *Dunmore, supra* note 503.

[189] United Nations, CESCR, GC 14 (2000), *supra* note 25, at 33.

[190] United Nations, CESCR, *ibid* para 33.

[191] United Nations, CESCR, *ibid* para 36.

In describing the state obligation to fulfill health rights, the CESCR states that everyone is entitled to "a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health."[192] These types of entitlements are often conceptualised as "positive rights" in Canada, or the duty to "fulfill" the right, because they require the government to put in place measures to rectify what would otherwise constitute a violation. The Committee defines this obligation to include the right to "appropriate and timely" medical care, as well as other determinants of the health.

Health rights are among what are sometimes referred to as "second generation" rights, after the first generation of civil and political rights, although this hierarchy is highly contested. The distinction relies primarily on the concept of negative obligations (typically associated with civil and political rights) as opposed to positive obligations (social and economic rights) on government.[193] While the distinction itself has been described as "artificial and ideologically oriented," it is possible to argue that similar distinctions have served as the basis of legal reasoning in Canada that has rejected a "freestanding constitutional right to healthcare."[194]

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[192] United Nations, CESCR, *ibid.*

[193] See Currie, John H. *Public International Law*, (Irwin Law, Toronto, 2008) at 419-421.

[194] See Marie-Ève Sylvestre "The Redistributive Potential of Section 7 of the *Charter*: Incorporating Socio-Economic Context in Criminal Law and in the Adjudication of Rights" (2011-2012) 42 Ottawa L. Rev. 389 at 407; see also McLachlin, CJ in *Chaoulli, supra* note 183, at para 104 regarding "freestanding" rights; in *Chaoulli* the Court made no reference to Canada's international health rights obligations.

3.4 Other related treaty rights; the "right to life"

As noted previously the rights protected in the UN Bill of Rights (consisting of both the *ICESCR* and the *ICCPR*) are often described as "indivisible, interdependent and interrelated."[195] This approach is supported in the preamble to the *ICCPR*:

> Recognizing that, in accordance with the Universal Declaration of Human Rights, 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…[196]

However, while the *ICCPR* and the *ICESCR* are equally binding in the Canadian legal system, they differ in two important respects. Unlike the *ICESCR* Optional Protocol, Canada has ratified the *ICCPR* Optional Protocol, with the consequence that violations under the *ICCPR* are subject to the complaint process under that treaty.[197] In addition, the state is obligated under the *ICCPR* to take immediate action to remedy harm, unlike the *ICESCR*, which imposes a restricted obligation of immediate response tempered by "progressive realisation."

Article 6(1) of the ICCPR protects the "right to life" as follows:

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[195] *Vienna Convention on the Law of Treaties* [VCLT], 1969, *supra* note 58.

[196] *International Covenant on Civil and Political Rights*, *supra* note 16, preamble.

[197] See *Optional Protocol to the International Covenant on Civil and Political Rights*, adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966 entry into force 23 March 1976, in accordance with Article 9; ratified by Canada in 1976, *supra* note 77. A second optional protocol under the *ICCPR* deals exclusively with complaints in relation to abolition of the death penalty; see Second Optional Protocol to the International Covenant on Civil and Political Rights, aiming at the abolition of the death penalty Adopted and proclaimed by General Assembly resolution 44/128 of 15 December, 1989; ratified by Canada November 25, 2005, *supra* note 79.

> Every human being has the inherent right to life. This right shall be protected by law. No one shall be arbitrarily deprived of his life.[198]

The remainder of Article 6 addresses the death penalty and the crime of genocide. The Human Rights Committee (HRC), as the treaty body responsible for monitoring implementation of the *ICCPR* and for investigating and reporting on complaints filed in relation to the optional protocol, has produced two general comments, interpreting Article 6, where it has cautioned against a narrow interpretation of the right to life:

> Moreover, the Committee has noted that the right to life has been too often narrowly interpreted. The expression "inherent right to life" cannot properly be understood in a restrictive manner, and *the protection of this right requires that States adopt positive measures.* In this connection, the Committee considers that it would be desirable for States parties to *take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics.*[199] [emphasis added]

Infant mortality, increasing life expectancy and addressing malnutrition and epidemics involve protecting health, and represent overlapping jurisdiction in the area of health between Article 6 of the *ICCPR* and Article 12 of the *ICESCR*.

During the HRC's most recent review of Canada's record of implementation under the *ICCPR,* it heard evidence concerning the "right to life" and "freedom from ill treatment" in relation to healthcare for refugees and undocumented migrants. Its Concluding Observations appear to recognise healthcare within its mandate:

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[198] *Optional Protocol ICCPR, first, ibid* at Article 6.

[199] United Nations, Human Rights Committee (HRC), *General Comment No 6: Article 6 (Right to life),* 16th session, 1982, UN Doc, GEC 6630 E(1), at para 5.

> The State party should ensure that all refugee claimants and irregular migrants have access to essential health-care services, irrespective of their status.[200]

In terms of health interests, in the context of complaints filed under the Optional Protocol, the HRC has accepted as a matter of principle that a state-imposed exposure to health risk, such as exposing prison inmates to persons suffering from serious communicable disease like tuberculosis constitute a violation of the "right to life."[201]

In the next section the place of health in the Canadian constitutional framework will be examined followed by an overview of the Canadian health system. Treaty implementation in international law will be contrasted with the system for reception of international law, followed by the specific treatment of human rights treaties related to health in Canada.

[200]United Nations, Human Rights Committee*, List of Issues for the 6th Periodic Report of Canada*, 2014, CCPR/C/CAN/Q/6, at para 14; Human Rights Committee, Concluding Observations (Canada) 2015, CCPR/C/CAN/CO/6 at para 12; in its reply to the list of issues, Canada submitted that the changes to the refugee healthcare program was designed to ensure that refugees did not receive benefits "more generous" than Canadian taxpayers see Canada, Reply to List of Issues, 2015, CCPR/C/CAN/Q/6/Add.1.

[201] United Nations, Human Rights Committee, *Cabal and Pasini v Australia*, 2003, Communication 1020/2001, UN Doc, CCPR/C/78/D/1020/2001at para 7.7.

Chapter 4 Health and Canada's international treaty obligations

4.1 Health in the Canadian Constitution – Division of powers

Having reviewed health from the perspective of Canada's international human rights obligations, in this next part I will review how these obligations are shared and safeguarded under the Canadian Constitution. Then I will discuss how those constitutional structures influence the scope of the publicly insured Canadian health care systems in relation to international requirements.

As a federal state, the *Constitution Act,1867* provides for the distribution of powers between the federal and the provincial/territorial governments in Canada. As with many social programs, the *Constitution Act* is silent when it comes to modern day health systems and services.[202] As a result, health is an area of concurrent and overlapping jurisdiction between the federal and provincial governments, in which each level of government has some power to legislate.[203] For its part, the provincial constitutional authority over health matters is based on its jurisdiction over hospitals, and "property and civil rights," as well as "matters of a merely local or private matter."[204] The provinces carry the bulk of the responsibility for providing health care services and the insurance and regulation of the health care professions, based on their jurisdiction over "property

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[202] See *Constitution Act*, 1867, (UK), 30 & 31 Vict., c 3, reprinted RSC 1985, App II, No 5; see also, Jackman, Martha "Constitutional Jurisdiction over Health in Canada" (2000) 8 Health LJ at 95.

[203] *RJR-Macdonald Inc. v Canada* [1995] 3 SCR 199 (SCC) at para 32; *Schneider v British Columbia* [1982] 2 SCR 112 (SCC) at 142.

[204] *Constitution Act,* 1867, *supra* note 202 at 92(7), (13), (16). See also Hogg, *Constitutional Law in Canada, supra* note 80, at 32.1.

and civil rights."[205] Mental health and addiction services are generally considered part of the provincial responsibility for 'local or private matters.' Pursuant to its constitutional mandate to regulate municipal bodies, the provinces also play a role in community health. The 'invisibility' of healthcare in Canada's Constitution has been interpreted as a reflection of underlying social values in 1867 that regarded health as a matter of 'private arrangements' to be dealt with through 'the family and the market.' The Constitution is a reflection of early 'market economy models' of health, which served to reinforce social inequalities.[206] Current Canadian trends towards 'passive privatisation' are reminiscent of this early history.[207]

For its part, the federal government derives much of its power over health from its spending power:

> The federal spending power, or Parliament's power to spend money raised through taxation and otherwise dispose of public property, inferred from sections 91(lA), 91(3) and 106 of the Constitution Act, 1867, provides the basis for considerable federal activity in the field of health, including for the most significant piece of federal health legislation - the Canada Health Act.[208]

Parliament has exerted an important influence on provincial health care policy through the exercise of its spending power, in providing financial support through health care

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[205] Jackman, "Constitutional Jurisdiction," *supra* note 202, at 111; see *Constitution Act*, 1867, supra note 202, at s 92(13) and s 92(16).

[206] See Lessard, Hester, "The Construction of Health Care and the Ideology of the Private in Canadian Constitutional Law" 1993, 2 Annals Health L. 121 at 124, 128.

[207] See Flood, "Just Medicare: The Role of Canadian Courts in Determining Health Care Rights and Access," [Winter 2005] J Law Med Eth 669, at 670.

[208] Jackman, "Constitutional Jurisdiction," *supra* note 202, at 97.

funding formulas and agreements with the provinces.[209] The *Canada Health Act* represents a "classic" example of this approach, whereby the voluntary nature of the conditions imposed upon the provinces in exchange for health care funding has been described as "constitutionally unobjectionable."[210]

Based on its criminal law jurisdiction, the federal government has the power to regulate activities which control "activities that put human health at risk" in order to regulate in the interests of public health.[211] Such regulatory authority ranges from control of pharmaceuticals, environmental protection, prohibitions on the possession, sale and production of narcotics, access to abortion services and assisted suicide.[212] As the Supreme Court of Canada noted in *PHS Community Services Society v. Canada (Attorney General) (Insite):*

> Parliament has power to legislate with respect to federal matters, notably criminal law, that touch on health. For instance, it has historic jurisdiction to prohibit medical treatments that are dangerous, or that it perceives as "socially undesirable" behaviour…..[213]

Thus, the federal power to regulate through its criminal law powers, when it enters the public health field, can result in certain kinds of restrictions on the provincial jurisdiction over health and health care programs.

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[209] See Hogg, *supra* note 80, at 32.2 and 6.8

[210] See Jackman, "Constitutional Jurisdiction," *supra* at note 202, at 98.

[211] Jackman, "Constitutional Jurisdiction," *ibid* at 102; the criminal law power has been found to support federal regulation over the tobacco industry (*RJR MacDonald v Canada* [1995] 3 SCR 99) as well as environmental assessment and protection (*R v Hydro Quebec* [1997] 3 SCR 213).

[212] *PHS*, *supra* note 4 at para 97-99; see *Constitution Act,* s. 91(27); while the ban on abortion in the *Criminal Code* was found to be intra vires, the offence was found to be unconstitutional as a violation of the right to security of the person under s 7 of the *Charter*; see *R v. Morgentaler,* [1988] *supra* note 177.

[213] *PHS, ibid*, McLachlin CJ, at para 68.

While the provinces carry the bulk of the responsibility for the provision of healthcare goods and services, the federal government has responsibility for these services for certain groups including immigrants, refugees (under its jurisdiction over "naturalisation and aliens"), First Nations, and veterans.[214] In addition, the residual power over "peace, order and good government" in the preamble to section 91 of the *Constitution Act* 1867, has been held to impose a responsibility for matters of "national concern" including health emergencies, such as epidemics.[215]

In cases of conflict between federal and provincial laws with respect to health, the Supreme Court of Canada has supported the concept of shared and concurrent responsibilities between governments:

> The federal role in the domain of health makes it impossible to precisely define what falls in or out of the proposed provincial "core". Overlapping federal jurisdiction and the sheer size and diversity of provincial health power render daunting the task of drawing a bright line around a protected provincial core of health where federal legislation may not tread.[216]

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[214] *Constitution Act*, 1867, *supra* note 202, s 91(24), (25), (7). See also Flood, Colleen "Litigating Health Rights in Canada: White Knight for Equity?" in Colleen Flood and Aeyal Gross eds *The Right to Healthcare at the Public Private Divide* (Cambridge U Press; New York, 2014) at 106, 109. Other matters under exclusive federal government jurisdiction include national defence and the military, quarantine, and penitentiaries.

[215] See Hogg, *supra* note 80, at 32.2; Jackman, "Constitutional Jurisdiction," *supra* note 202, at 103; citing *R. v Schneider* [1982] 2 SCR 112.

[216] *Carter v R*, 2015 SCC 5 at para 51, 66; where the Court rejected the argument that BC could avoid the Criminal Code restrictions on physician assisted dying based on the doctrine of extra-jurisdictional immunity in relation to health. The Court ultimately ruled that the federal Criminal Code restrictions on physician assisted dying constituted an interference with liberty and security of the person, by limiting decisionmaking with respect to an individual's bodily integrity and medical care as well as prolonging their suffering; see also *PHS*, *supra* note 4, at para 68.

Thus given the shared jurisdiction over health, the federal government may legislate in a manner that limits access to provincial health care services.

In *Carter v Canada,* the provinces argued in favour of an exclusive provincial jurisdiction over health in terms of the power to "deliver necessary medical treatment for which there is no alternative."[217] In rejecting this argument and the application of the interjurisdictional immunity doctrine, the Court stated that:

> In our view, the appellants have not established that the prohibition on physician-assisted dying impairs the core of the provincial jurisdiction. Health is an area of concurrent jurisdiction; both Parliament and the provinces may validly legislate on the topic…This suggests that aspects of physician-assisted dying may be the subject of valid legislation by both levels of government, depending on the circumstances and focus of the legislation.

Thus the argument that the provincial jurisdiction over physician assisted dying was exclusive to the provinces was also rejected.

In cases like *Insite* where the province and the federal government implemented opposing policies, it has fallen to the Supreme Court of Canada to define the limits of their constitutional jurisdiction. In *Insite,* the Court issued a mandamus order against a federal government Minister, which had the effect of aligning the federal jurisdiction over narcotics with provincial jurisdiction over the treatment of addiction. In contrast, in *Carter,* in finding that the Criminal Code provisions violated the claimants right to life, liberty and security of the person, contrary to the principles of fundamental justice, in a manner that could not be justified under section 1, the Court noted that:

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[217] *Carter*, *ibid* para 52.

> It is for Parliament and the provincial legislatures to respond, should they so choose, by enacting legislation consistent with the constitutional parameters set out in these reasons.

The Court granted a declaration rendering the criminal prohibition on doctor-assisted dying invalid, but suspended its operation for a period of 12 months, which was subsequently extended by a further four months.[218]

In its reports to the UN treaty bodies' review committees, Canada has summarised the constitutional division of powers and responsibility for health in the following terms:

> Health care
> All Canadian residents have reasonable access to insured hospital and physician services on a prepaid basis, and on uniform terms and conditions. Provincial and territorial governments are responsible for the delivery of health care services to their residents. The Government of Canada assists in the financing of these services through fiscal transfers, primarily through the Canada Health Transfer. It also provides health care benefits and/or services to certain groups such as the First Nations and Inuit, veterans, Canadian Forces, incarcerated individuals in federal institutions, and refugees. The health care system in Canada is predominantly publicly financed with a mix of public and private delivery. It is composed of 13 interlocking provincial and territorial health insurance plans that share the principles of universality, accessibility, comprehensiveness, portability and public administration. [219]

4.2 Section 36(1) of the Constitution and "essential public services"

The Canadian Constitution commits both federal and provincial governments to providing "essential public services" of "reasonable quality" to all Canadians:

> 36 (1) Without altering the legislative authority of Parliament or of the provincial legislatures, or the rights of any of them with respect to the exercise of their legislative authority, Parliament and the legislatures, together with the

[218] *Canada v Canada* [2016] SCC 4.

[219] Canada, *Core Document*, 2013, UN Doc HRI/CORE/CAN/ 2013 for similar wording at 171.

> government of Canada and the provincial governments, are committed to
>
> (a) promoting equal opportunities for the well-being of Canadians;
>
> (b) furthering economic development to reduce disparity in opportunities; and
>
> (c) providing essential public services of reasonable quality to all Canadians.[220]

"Essential services" under section 36(1) have been interpreted to include health services.[221]

The Canadian government has relied upon section 36(1) in its reports to the UN treaty monitoring bodies, including its "Core Report," in connecting this constitutional requirement to its social rights obligations, including health:

> Section 36 of Part III of the Constitution Act, 1982….commits federal and provincial governments to promoting equal opportunities for the well-being of Canadians, furthering economic development to reduce disparity in opportunities and providing essential public services of reasonable quality to all Canadians….These provisions are particularly relevant in regard to Canada's international obligations for the protection of economic, social and cultural rights.[222]

Section 36(1) has also been relied upon by Canadian courts, as forming the basis for shared cost government programs in relation to public services. In *Winterhaven v Canada,* in addition to the spending power, the Court pointed to section 36(1) of the Constitution Act, 1982, as the basis for the *Canada Health Act* in fulfilling Canada's

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[220] Constitution Act, 1982, *supra* note 141.

[221] *Winterhaven v Canada* (1988), 53 D.L.R. (4th) 413 (Alta. C.A.), leave to appeal to S.C.C. refused 55 D.L.R. (4th) viii at 21-23; see also *Eldridge v BC* [1997] 3 SCR 624*,* at para 25.

[222] See Canada, *Core Document*, 1998, forming part of the reports of state parties (Canada) UN Doc HRI/CORE/1/Add. 91, at 127; see also Canada, *Core Document*, 2013, *supra* note 219, for similar wording at 169.

obligation to provide "essential public services of reasonable quality to all Canadians."[223]

4.3 Development of the Canadian health system and national standards

Federal government promotion and protection of universal publicly insured health care services in Canada began to take shape in the 1950s through legislation in relation to hospital services (including doctor's services provided in hospitals) and primary care in doctor's offices.[224] The effect of the legislation was to create a publicly insured single payer health care system for "medically necessary" doctor and hospital services, based on federal government cost sharing of provincial government health care programs.

The spending power has formed the basis for Parliament's creation of national standards, as found in the *Canada Health Act (CHA),* which provide that publicly insured health care programs in Canada must reflect national standards of public administration, comprehensiveness, universality, portability and accessibility.[225]

Canada's Medicare program provides a voluntary national health care plan through federal cost sharing for matters within provincial health jurisdiction.[226] As noted previously, the court has upheld the *CHA* as a valid exercise of federal powers in a challenge to the federal government's jurisdiction to impose national standards in

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[223] *Constitution Act*, 1982, *supra* note 141 at 36(1).

[224] See *Hospital Insurance and Diagnostic Services Act*, SC 1957, c 28, proclaimed (Royal Assent) May 1, in force July 1, 1958; *Medical Care Act,* SC 1966-67, c. 64; both statutes were replaced by the *Canada Health Act*, RSC 1985, c C-6 in 1985.

[225] Hogg, *supra* note 80 at 32.2; see also Canada, *Core Document*, 2013, *supra* note 219, at 97; *Canada Health Act* [CHA] *supra* note 224, at s 7; see also Flood "Litigating Health Rights in Canada White Knight for Equity?" in Colleen Flood and Aeyal Gross eds *The Right to Health care at the Public Private Divide*, *supra* at note 214 at 84.

[226] *CHA*, *supra* note 216, s 15; see also Hogg, *ibid.*

healthcare.[227]

The *CHA* is restricted to "insured health services" defined as hospitals, physician services, and certain surgical dental procedures, although there is no clear definition of what constitutes a "medically necessary" service.[228] The exact scope of health care services is left to provincial discretion and the provinces can also opt out of the *CHA* arrangements.[229] The *CHA* imposes a condition of provincial information sharing in order to monitor compliance, but which also serves to meet Canada's international reporting obligations with respect to health.[230]

Other health care services, not included in Medicare, include significant areas of health such as dental care, pharmaceuticals and non-physician related health care by professionals outside of hospital. The *CHA* has no bearing on these health care services and the provinces are free to fund health care services outside of Medicare on their own terms. In most provinces this includes financial eligibility requirements that restrict such programs to a low-income threshold. In Canada, it has been observed that this health care system has resulted in "profound inequalities, with vulnerable populations denied access

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[227] *Winterhaven Stables Ltd v Canada (AG)*, *supra* note 213: "the federal contributions are now made in such a way that they do not control or regulate provincial use of them. As well there are opting out arrangements that are available to those provinces who choose not to participate in certain shared-cost programs"; see also Constitution Act, 1982, *supra* note 141.

[228] See Flood, "White Knight," *supra* note 214, at 80.

[229] Flood, *ibid* at 79; in practice, the list of insured services is the subject of negotiations between the provincial departments of health and the provincial medical associations. The CHA also prohibits extra billing and user fees, in conformity with its emphasis on a universal health care system, *supra* note 217; see also *Chaoulli*, *supra* note 183 where Dechamps J relies on the lack of uniformity between provinces to ground her conclusion that the legislative restriction on private health insurance was not minimally intrusive; at para 74.

[230] *CHA*, *supra* note 216, at s 13.

or receiving substandard care." [231] For instance, this division or responsibility for healthcare between the federal and provincial governments has seen the exclusion of some non-citizens from publicly insured healthcare programs.

Among the core obligations imposed on state parties in relation to the right to health, the CESCR has identified the implementation of a "national public health strategy and plan of action," including a review and monitoring process, with indicators and benchmarks. While the national standards contained in the CHA form the basis of Medicare they clearly do not constitute a comprehensive public health strategy and plan of action. The accountability mechanisms in terms of a participatory review process in setting health indicators, benchmarks, monitoring and evaluation are absent from the CHA. To the extent that health indicators have been identified, they are the result of multi-lateral federal-provincial health agreements but do not reflect a participatory review process outside of government.

While the Canadian Medicare system provides access to hospitals and doctors, there is no universal national pharmacare program, and large gaps remain in the area of access to essential medicines, dental care, as well as an estimated 30% of health costs that are not publicly insured.[232]

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[231] See *Canada Health Act* (CHA), *supra* note 224, see, at s 2, definition of "insured person" as a "resident"; see also Flood, *supra* note 207, at 81 and *Toussaint v Canada* [2011] FCA 213 Stratas J, upholding, 2010 FC 810, [2011] 4 F.C.R. 367, leave to appeal dismissed, [2011] SCCA 412.

[232] See Flood, Colleen, "Just Medicare: The Role of Canadian Courts in Determining Health Care Rights and Access," [Winter 2005] J Law Med Eth 669, see note and accompanying text at 668; the authors claim that the gaps in uninsured health services is growing in a process described as "passive privatisation."

While the Canadian single payer system of public insurance known as "Medicare" claims universality as one of its features, it continues to exclude certain groups, including refugees, undocumented or irregular migrants and their children. Responsibility for health in the case of First Nations is a matter of considerable disagreement while disproportionately poor health outcomes for First Nations, especially those living on reserve, have earned Canada international censure.[233]

Thus, accessibility in terms of affordability of uninsured health services remains a significant feature of the Canadian health care system, despite Medicare. Flood notes that the current system creates significant inequities where the free market essentially determines who gets access. In terms of health care quality provincial government regulation of privately financed health care outcomes is limited.[234] The gaps in the healthcare system in Canada adversely affect the poor's access to essential medicine, dental care and community mental health and homecare.[235] Thus in Canada, the publicly

[233] Jackman, "Constitutional Jurisdiction", *supra* note 202, at 106-109 where she notes that the provincial government now provides access to healthcare services to all First Nations living on and off reserve while Health Canada continues to deliver directly public health services such as "health promotion, immunization, dental health, and drug and alcohol prevention and treatment programs"; The public health role played by the federal government on reserve and its dismal record in relation to clean drinking water represents have been described as "third world conditions" and represent significant inequality in the Canadian system; See Status report of the Auditor General of Canada http://www.oagbvg.gc.ca/internet/English/parl_oag_201106_04_e_35372.html (June, 2011); http://www.cbc.ca/news/canada/manitoba/bad-water-third-world-conditions-on-first-nations-in-canada-1.3269500; see also McIntosh, Constance, "Envisioning the future of aboriginal health under the health transfer process." (2008) Special Ed. Health L.J. 67.

[234] See Hogg, *supra* note 80 at 32.5; see also Colleen Flood "Litigating Health Rights in Canada: White Knight for Equity?" *supra* note 214, at 79.

[235] Flood, *ibid* at 81.

insured healthcare system is "far from comprehensive in any ordinary sense of the word" and poverty is strongly linked with poor health outcomes.[236]

In summary, in terms of health rights, while section 36(1) commits governments to the provision of "essential public services," including health related services, the obligations with respect to "reasonable quality" have yet to be tested in court. The *Charter* contains no explicit health protections. While federal cost sharing of provincial health plans is conditional upon compliance with certain national standards, comprising the national system of Medicare, those standards lack effective and participatory monitoring processes and mechanisms consistent with Canada's international obligations with respect to health rights. In addition, despite a system of publicly insured hospital and doctor services, there remain significant gaps and inequities in the Canadian healthcare system, that raise serious questions about Canada's compliance with its international obligation to provide the "highest attainable standard" of health.

4.4 Treaty implementation in international law: the Vienna Convention

The international rules with respect to ratification, interpretation and implementation of treaties are found in the *Vienna Convention on the Law of Treaties*, 1969 (*VCLT*).[237] The starting point for implementation is *pacta sunt servanda*, meaning that the state party

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[236] Flood, *ibid* at 81, 82; see also Raphael, *Poverty in Canada*, *supra* note 117, at 223 where it is stated: "The poverty and poor-health relationship is one of the most robust associations known to the health and social sciences."

[237] *Vienna Convention on the Law of Treaties* [VCLT] 1969, *supra* note 58; The sources of international law are set out in the *Statute of the International Court of Justice*, 1945 (ICJ Statute) and consist of four parts: multilateral treaties, custom, general principles and judicial decisions *supra* note 61, at s 38(1). In this section I will focus on the role of multilateral treaties ratified by Canada.

must carry out its legal undertakings in good faith.[238] The second principle is that under international law, states cannot rely on existing domestic law, including the constitutional division of powers as exist within federal states such as Canada, as a justification for violating international obligations.[239]

In *Ahani v R* the Ontario Court of Appeal considered the argument that Canada was acting in bad faith under the *Vienna Convention on the Law of Treaties* by failing to abide by the Human Rights Committee's interim measure under the *ICCPR* optional protocol, recommending that Canada suspend deportation proceedings against Mr Ahani.[240] As a result of Canada's ratification of both the *ICCPR* and the optional protocol, both the treaty and the optional protocol are considered 'binding' in international law. However, because Canada has failed to implement those international obligations through explicit legislation, the Court found that Canada was free to disregard the Committee's recommendation, and that such action did not amount to 'bad faith' under the *Vienna Convention.*

In international law, while the use of legislative means ("laws or other measures as may be necessary to give effect to the rights recognised in the Covenant") is recommended to give effect to binding treaty obligations, the question of what exact measures must be

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[238] *VCLT, ibid* s 26.

[239] *VCLT, ibid* s 27; see also CESCR, General Comment 9, supra note 19, at para 3 where the CESCR goes on to note that: "In other words, States should modify the domestic legal order as necessary in order to give effect to their treaty obligations."

[240] See *Ahani v R supra* note 83.

used to incorporate a treaty in domestic law is left up to the discretion of the state party, as long as it is according to democratic processes.[241] [242]

In terms of treaty interpretation, the *VCLT* provides that: "A treaty shall be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in the light of its object and purpose." [243] Context includes related agreements, state practice, and any other "relevant rules of international law."[244]

4.5 Reception of international human rights treaty obligations in Canada

The general principles of Canadian law with respect to the reception of international law are well established, although not without some controversy.[245] In Canada, international treaties ratified by Canada are not self-executing meaning that they do not become enforceable within Canada automatically upon ratification.[246] Unlike some states, whose constitutions speak to the incorporation of treaties, Canada's constitution is silent on this point.[247]

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[241] For example, see *ICESCR supra* note 16, Art 2.1; CESCR, General Comment 9, *supra* note 72, at para 5; see also *ICESCR, ibid* Art 1.1; which imposes an obligation of self determination.

[242] *ICCPR, supra* note 16, at Art 3.2(a) and (b); see also ICESCR, *ibid* at Art 1.

[243] *VCLT supra* note 57, at Art 31.

[244] *VCLT, ibid* at Art 31 and 32.

[245] Freeman and Van Ert, *supra* note 4, at 153-158; for a discussion of the weaknesses and inconsistencies in the Canadian approach see also Van Ert, Gibran *Using international law in Canadian courts (*The Hague: Klwer, 2002) at 5-6 for a summary of the critiques.

[246] See Hogg, *supra* note 80, at 11.4.

[247] For an example of a Constitution that incorporates international treaty law, see Constitution of Kenya 2010, (Const 2010), at 2(6),which provides that: "Any treaty or convention ratified by Kenya shall form part of the law of Kenya under this Constitution."

As a result of judicial interpretation, in the absence of explicit constitutional provisions, the state power to enter into treaties in Canada lies exclusively with the federal executive power. Treaty making is considered a unilateral "prerogative of the Crown." [248] Based on Canada's unwritten Westminster tradition, treaty making is considered part of the executive's residual power over 'foreign affairs.'[249]

Treaty implementation can also be viewed as the product of a political system where the executive branch of the federal government has exclusive jurisdiction to ratify or withdraw from a treaty, however, those ratified treaties are not directly enforceable within Canada unless they are expressly implemented by legislation.[250] This has been described as a "dualist" system of treaty implementation in which both executive and legislative action are required for a treaty to be directly enforceable in domestic courts.[251] The requirement of implementing legislation is based on the principle that the executive branch of government, through the ratification of a treaty, cannot be permitted to indirectly change the law, as that would undermine the supremacy of Parliament or the legislatures to make laws through an elected body. In order for a treaty to be directly

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[248] Van Ert, *Using international law*, *supra* note 245 at 66.

[249] Van Ert, *ibid* at 66. As the author notes, the category of 'foreign affairs' seems ill matched with human rights treaties whose focus is primarily on individual protections within states, rather than state to state affairs.

[250] *Baker v. Canada (Minister of Citizenship and Immigration),* [1999] 2 SCR 817 at 69; For a discussion of this constitutional power see generally, Hogg, *supra* note 80, at 11.2, 11.3 (b) and 11.4. where he notes that in a constitutional democracy, the received view is that the power to enact laws is reserved for the institutions of responsible government and elected representatives.

[251] Hogg, *ibid* at 11.3(b). See also *Turp v R* [2012] FC 893, challenging Canada's withdrawal from the Kyoto Protocol, where the FCA found that the resolution by Parliament to ratify the Protocol was not binding, and that the power to conclude or withdraw from the treaty remained with the executive branch; as cited by the dissent in *SFL v Saskatchewan*, *supra* note 58: "Judicial review and the use of international law as an interpretive aid should not become a euphemism for this Court interfering in the government's prerogative over foreign affairs."

enforceable in Canada, the legislature must enact legislation, and such legislation must be expressly designed to incorporate the treaty obligations.

In terms of Canada's federal system of government, based on a 1935 decision of the Privy Council, the accepted view is that while the federal executive has exclusive power to ratify international treaties, in the case of health, formal implementation of health rights will depend upon both legislative and other measures initiated by both the federal and provincial governments, respectively.[252] This may include concurrent jurisdiction to implement Canada's treaty obligations by way of legislation.[253] At the same time, under international law and particularly the *VCLT* as previously noted, governments at all levels - federal, provincial, and municipal - are bound by international treaties that are ratified by Canada, whether or not they are incorporated into domestic law by enacting legislation.

4.6 Implementing international treaty obligations through legislation

Thus, there are two types of treaty obligations in Canada; those where binding treaties have been directly implemented through legislation, and those where there is no express implementing legislation. Courts in Canada have determined that parliamentary

[252] For the exclusive power of the executive branch of the federal government to execute an international treaty see: *AG Canada v AG Ontario "Labour Conventions Case* [1937] AC 326 at para 13, 20: "While the ship of state now sails on larger ventures and into foreign waters she still retains the water-tight compartments which are an essential part of her original structure. Within the British Empire there is a well-established rule that the making of a treaty is an executive act, while the performance of its obligations, if they entail alteration of the existing domestic law, requires legislative action. Unlike some other countries the stipulations of a treaty duly ratified do not within the Empire, by virtue of the treaty alone, have the force of law." See also Hogg, *supra* note 80.

[253] See Hogg, *ibid* at 11.3(b).

resolutions, preambles to statutes, and similarities in wording are insufficient to constitute 'implementing' legislation.[254] For instance, in *Quebec v Canada,* the Quebec government sought a ruling from the Quebec Court of Appeal that the federal *Youth Criminal Justice Act* was contrary to Quebec's international human rights obligations under the *Convention on the Rights of the Child* and the *ICCPR.*[255] The Quebec government had previously passed an Order in Council (OIC) indicating its adoption of the *Convention on the Rights of the Child* (*CRC*) and the *ICCPR*. The Quebec Court of Appeal considered the OIC in relation to submissions that the *CRC* was an incorporated treaty in Quebec and thus directly enforceable. As well, the Court considered the preamble of the federal *Youth Criminal Justice Act,* which reads as follows: "WHEREAS Canada is a party to the United Nations Convention on the Rights of the Child and recognizes that young persons have rights and freedoms…" However, in both instances, the Court determined that neither Quebec's Order in Council, nor the preamble to the *YCJA* referencing the *CRC*, was sufficient to implement the *CRC* in domestic law.[256] As a result, the *CRC* continues to be considered as one of the many 'unimplemented' human rights treaties in Canada.

The imposition of strict legislative requirements to implement international human rights treaties in Canada has been strongly criticised.[257] The critique points to examples of

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[254] See *MacDonald v. Vapor Canada Ltd.,* [1977] 2 S.C.R. 134 at 171.

[255] *Quebec v Canada* [2003] R.J.Q. 1118, 175 C.C.C. (3d) 321, QCA at 87

[256] *Quebec v Canada, ibid* at 91.

[257] See Hogg, *supra* note 80, at 11.4 who disagrees with the Privy Council's interpretation of s 132 of the Constitution in restricting the federal power to legislate with respect to its treaty obligations in favour of allowing federal implementation of treaty obligation regardless of the division of powers; for an alternative approach see Kindred, Hugh, "The use and abuse of

analogous non-legislative law making that has received judicial recognition as binding on government, including policy making by the executive council or Cabinet,[258] the common law, and *jus cogens* principles of international customary law.[259] In contrast, courts have so far failed to give international human rights treaties similar recognition as binding instruments.

Unlike other international treaties, in the case of international *human rights* treaties, courts have rarely found that they have been directly implemented by statute. One notable exception is the *Immigration Act*, which the Supreme Court of Canada held implements the 1953 Convention on Refugees:

> Since the purpose of the [Immigration] Act incorporating Article 1F(c) is to implement the underlying Convention, the Court must adopt an interpretation consistent with Canada's obligations under the Convention. The wording of the

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international legal sources by Canadian courts: searching for a principled approach" in Fitzgerald, Oonagh E, ed *The Globalised Rule of Law* (Irwin Law, Toronto, 2006) at 5 where the author argues that the concerns regarding the non-legislative character of international treaty obligations is misplaced, and that in a manner similar to other binding legal principles, such as the common law, there is no reason why international human rights treaty obligations could not be directly enforceable in Canada.

[258] This type of program can be seen in the health field, at the federal level, in the Interim Federal Health Program (IFHP) for non-residents, as well as at the provincial level in Nova Scotia, in what is currently known as the 'Disability Supports Program,' based solely on financial approval through a provision of the *Appropriations Act*.

[259] *Jus cogens* norms form part of international customary law, and are described as " norms … considered peremptory in the sense that they are mandatory, do not admit derogation, and can be modified only by general international norms of equivalent authority." In terms of human rights they include prohibitions against genocide; slavery or slave trade; murder or disappearance of individuals; torture or other cruel, inhuman, or degrading treatment or punishment; prolonged arbitrary detention; systematic racial discrimination; See Criddle, Evan and Evan Fox-Decent " A fiduciary theory of jus cogens" *supra* note 134; See also Van Ert, Using *International Law in Canadian Courts*, *supra* note 245, at 165; as Van Ert points out, however, the Supreme Court of Canada has not clearly applied this principle is cases where it would appear to be relevant, such as *Suresh, supra* note 68 where they have preferred to apply treaty based analysis rather than customary law analysis, in relation to the international human rights prohibition against torture.

> Convention and the rules of treaty interpretation will therefore be applied to determine the meaning of Article 1F(c) in domestic law.[260]

Despite this exception, however, most of Canada's international human rights treaty obligations have not been directly implemented through legislation, despite the close proximity in wording and drafting history of Canadian human rights statutes to their international cousins.[261] In the case of health, while the provincial human rights statutes protect non-discrimination in the provision services, including health related services, they do not provide explicit protection for health rights comparable to Article 12.

4.7 Canada's reporting on its international human rights obligations

Canada's approach to the implementation of its international human rights treaty obligations is set out in numerous government reports to the UN treaty monitoring bodies. In its most recent *Core Document*, Canada reiterates that it is not its practice to directly implement a human rights treaty through a single piece of legislation. Rather, in collaboration with the provinces, prior to the ratification of a treaty, it examines all existing laws for compliance with the treaty and amends them as far as is necessary to bring them into compliance with its new treaty obligations, without explicitly referring to the treaty.[262] The basis for this approach is said to lie in the jurisdictional division of power between provincial, territorial and federal levels of government.[263] The implementation of Canada's international treaty obligations through legislation is thus said to be "indirect" in the sense that in the absence of explicit incorporation of the treaty

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[260] *Pushpanathan v Canada* [1998] 1 S.C.R. 982 at para 51.

[261] Freeman and Van Ert, *supra* note 4, at 189.

[262] Canada, *Core Document*, 2013, *supra* note 219, para 121.

[263] Canada, *Core Document*, 2013, *ibid* para 122.

obligations they cannot be directly enforced. A Canadian law that is seen to violate international human rights treaty obligations can therefore only be challenged indirectly within Canada, through the application of interpretive principles to the legislation in issue, or to the *Charter* as the supreme law in Canada.

In contrast, the CESCR has recommended the use of legislation and all "appropriate means" to implement binding international human rights obligations.[264] Those means are generally considered to include judicial remedies for rights violations. The CESCR sets out three principles for implementation of *ICESCR* obligations within the domestic legal order: first, the measures taken must be adequate to ensure the "fulfillment" (i.e. the justiciability of positive obligations) of the treaty obligations. Second, the CESCR recommends that the means must be the most effective, and if they differ from the means taken to implement other human rights treaties, there must be compelling justification for the difference. In Canada, based on the wording of the *Charter of Rights and Freedoms,* there are clear differences in the means taken to recognise human rights, as civil and political rights such as freedom of association, religion, and speech, have been explicitly incorporated in the *Charter*. However, as referenced previously, the *Charter* is silent with respect to social and economic rights, including 'the right to the highest attainable standard of health." Finally, formal adoption or incorporation of the Covenant into domestic law is "strongly encouraged."[265] Again, Canada has deliberately opted for a system of treaty implementation that does not directly incorporate international treaty

[264] CESCR, *General Comment 9: the domestic application of the Covenant, supra* note 72, at para 1, 10 and 14; see also CESCR, *General Comment 3: The nature of the state parties' obligation, supra* note 16, at para 3, 4, 5, 7, 8.

[265] CESCR, *General Comment 9: the domestic application of the Covenant, ibid* at para 7, 8.

rights constitutionally or legislatively. In its latest *Core Document*, the Canadian government reiterates that international treaties are not directly enforceable, and that it is not its practice to enact a single piece of legislation to incorporate treaty obligations.

> It is not the practice in Canada for one single piece of legislation to be enacted incorporating an entire convention on human rights into domestic law, primarily due to the division of jurisdiction between federal and provincial/territorial levels. Rather, many different federal, provincial and territorial laws and policies together serve to implement Canada's international human rights obligations.[266]

In terms of legislative implementation of health rights, Canada has specifically referenced the *Canada Health Act,* together with the conditions of public administration, comprehensiveness, universality, portability and accessibility, as a source of national standards. But with respect to access to health care, Canada has so far remained silent in responding to critiques concerning the gaps in the Medicare system. In its most recent *Core Document*, *reasonable* access to health care was addressed as follows:

> All Canadian residents have reasonable access to insured hospital and physician services on a prepaid basis, and on uniform terms and conditions. …It is composed of 13 interlocking provincial and territorial health insurance plans that share the principles of universality, accessibility, comprehensiveness, portability and public administration.[267]

Canada's report does not specifically identify the social determinants of health as a health rights goal, but it does give consideration to programs that address housing and vulnerable persons including homeless persons, children, women, persons with disabilities and aboriginal people.[268] Canada's report to the CESCR also contains general references to the "many laws and policies" adopted by all levels of government in Canada

[266] Canada, *Core Document*, 2013, *supra* note 219, at para 120-122; in contrast see Human Rights Council, *Report on the Universal Periodic Review*, 2009, General Assembly, 11th sess, ag item 6, A/HRC/11/17.

[267] Canada, *Core Document*, 2013, *ibid* at 171.

[268] Canada, *Core Document*, 2013, *ibid* at 174 -184.

that "assist in the implementation" of the rights contained in the Covenant[269] but it fails to identify the legislation upon which it bases this claim.

Following its most recent periodic review of Canada's compliance with the *ICESCR*, the CESCR criticised Canada for its approach to treaty implementation, specifically its failure to enact legislation to implement treaty rights, to strengthen modes of redress for rights violations, and to strengthen domestic enforcement of international rights.[270] While admitting that the *ICESCR* is not directly enforceable through legislation, in its reply Canada relies upon constitutional mechanisms of judicial interpretation: "courts will interpret ordinary legislation as though the legislature intended to comply with Canada's treaty obligations, absent a clear intention to the contrary."[271] Thus, in the interpretation of domestic legislation, while Canada reports that courts will take international treaty obligations into consideration, it reserves the right to derogate from those obligations. According to Canada's *Core Document* international treaties are "relevant" to the interpretation of the *Charter*.[272] Canada has noted that "through their relevance to the interpretation of the Canadian *Charter* of Rights and Freedoms, international human

[269] Canada, *Core Document*, 1998, *supra* note 222.

[270] United Nations, CESCR, *Concluding Observations (CO) (Canada)* 2006, *supra* note 91; the Committee's observations appear to apply generally to the ICESCR obligations, including education, health, social security, an adequate standard of living and employment rights, and do not single out any particular Article, or health rights specifically.

[271] Canada, *Core Document*, 1998, *supra* note 222 para 128-130; *Core Document*, 2013, *supra* note 219, para 130.

[272] *Core Document*, 2013, *ibid* at para 128.

rights treaties have a role to play in determining whether legislation is valid or invalid under the Constitution of Canada."[273]

Canada also referenced statements from the Supreme Court of Canada to the effect that the rights in the *Charter* should be interpreted to provide at least as much protection as "similar" treaty provisions.[274] The difficulty with respect to health rights is that neither the *Charter* nor domestic legislation contain "similar" wording to that contained in international human rights treaties. However, contrary to Canada's earlier statements to the United Nations, the Supreme Court of Canada recently appears to have abandoned the requirement of "similarity" in interpreting section 2(d) of the *Charter* (freedom of association) in a manner consistent with international human rights protection of the right to strike contained in Article 8 of the *ICESCR*.[275] This will be discussed at further length in the next chapter.

Despite the views of the CESCR with respect to the desirability of implementation through legislative means, international human rights treaties ratified by Canada continue to be excluded from direct enforcement in Canadian law. Unimplemented international human rights treaties thus depend for their 'incorporation' upon judicial practices of *Charter* and statutory interpretation.

4.8 Statutory interpretation and international human rights treaties

[273] Canada, *Core Document*, 1998, *supra* note 222, para 147; this passage does not appear in Canada's most recent *Core Document*, 2013, *supra* note 219.

[274] Canada, *Core Document*, 1998, *ibid* para 143-4.

[275] *SFL v Saskatchewan*, supra note 58.

In the case of unincorporated international human rights treaties, such as the *ICESCR* and Article 12 concerning health rights, courts in Canada have relied upon legal principles that seek to interpret legislation, regulations, and policy such that they conform with international law.[276] This approach depends upon a judicial presumption that domestic law conforms to international law. The presumption is, however, rebuttable. As a rebuttable presumption, courts have had difficulty agreeing on the correct application of this principle of interpretation, including the test for rebuttal, and it has not been applied consistently in Canadian courts.[277] In addition, it has been remarked that the Supreme Court of Canada has identified an approach that lies outside the framework of the presumption of conformity in relation to statutory interpretation. That approach treats the values underlying Canada's international human rights obligations as forming part of the context in which the courts interpret domestic statutes. [278]

The principles at play with respect to the interpretive use of international human rights law are similar but not identical to the general approach taken by the courts to other non-human rights treaties.[279] There is a presumption that domestic law is in conformity with

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[276] Freeman and Van Ert, *supra* at note 4 at 153, Sullivan, Ruth, *Construction of Statutes*, 5th ed (LexisNexis, Toronto, 2008) at 421-39; for examples of its application to government policy, see *Insite, supra* note 175, and *Canadian Doctors for Refugee Care*, *supra* note 93.

[277] Van Ert, Gibran, "What is reception law" *supra* note 245 at 85; For a discussion of the inconsistencies in approach see Weiser, Irit, "Undressing The Window: Treating International Human Rights Law Meaningfully in the Canadian Commonwealth System" (2004) 37 UBC L Rev 113 – 155 at 75-76; see also most recently, the contrasting views of the majority and dissent in *SFL v Saskatchewan*, *supra* note 58.

[278] Van Ert, *Using International Law,* supra note 245 at 347; citing L'Heureux-Dube in *Baker supra* note 250 at 70 "the values reflected in international human rights law may help inform the contextual approach to statutory interpretation and judicial review."

[279] Non-human rights treaties seek primarily reciprocity in resolving state to state conflicts, in areas such as trade, fishing, and other cross border state activities. The judicial approach

international treaty obligations, although in the case of human rights law, there is no requirement that there be a statutory ambiguity. It is now accepted that the legislation being interpreted does not require explicit 'ambiguity' in order for the presumption to apply.[280] It is sufficient if the ambiguity is 'latent,' such as an inconsistency between the grammatical meaning of the text and the legislative intent. Legislative intent can be "evidenced by the existence of a treaty which the legislature is presumed not to intend to violate."[281]

The presumption is rebuttable insofar as "nothing in the Canadian Constitution prevents Parliament or provincial legislatures from enacting laws that violate international law."[282] Under the domestic legal system all levels of government in Canada can continue to rely on legislation that contravenes the *ICESCR,* in the absence of any direct incorporation of its various human rights guarantees, until the courts rule otherwise.[283] This can be contrasted with international law and the interpretative principle contained in Article 27 of the *VCLT*, which provide that domestic law cannot be relied upon as a justification for

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predates the arrival of the Universal Declaration of Human Rights, and the UN human rights treaties that followed post WW II. It can be argued that the underlying rationale for the approach is poorly suited to the human rights context, where the responsibilities are towards citizens and individuals, not state to state agreements. International human rights violations involve state actions or inactions that have a direct impact on citizens and individuals, rather than the other state parties to the treaties.

[280] *National Corngrowers Assn v Canada* [1990] [1990] 2 S.C.R. 1324 at para 44-46; where the Court found that it was sufficient if a "latent" ambiguity could be found.

[281] Van Ert, *Using international law, supra* note 245 at 124.

[282] Freeman and Van Ert, *supra* note 4 at 158.

[283] See Irit Weiser, *supra* note 277; See also Hogg *supra* note 80 at 11.4; See *VCLT*, supra note 57, at Art 27.

violating international obligations.[284] In terms of procedure, unlike foreign law, which requires evidentiary proof, courts may take judicial notice of international law, including treaty obligations, as it is considered to be "part of the legal context in which legislation is enacted and read."[285]

The divergent judicial approaches to the application of these interpretive presumptions is demonstrated by the majority and dissenting judgments from the Supreme Court of Canada, where they were faced with a challenge to the constitutionality of a Criminal Code provision, allowing for the defence of "reasonable correction" of a child contained in section 43 of the Criminal Code.[286] In *Canadian Foundation for Children Youth and the Law v Canada* the provision was attacked as a violation of children's rights to security of the person in a manner contrary to the principles of fundamental justice under section 7 of the *Charter*. In a majority decision, Chief Justice McLachlin noted that "statutes should be construed to comply with Canada's international obligations."[287] In selecting a narrow interpretation of section 43 of the *Criminal Code,* the Chief Justice relied upon international legal sources, including the *Convention on the Rights of the Child*, the *International Covenant on Civil and Political Rights* and a report of the Human Rights Committee regarding punishment of children in schools, to support her conclusion. These binding and non-binding sources of international human rights law

[284] *VCLT, ibid* at Article 26. Every treaty in force is binding upon the parties to it and must be performed by them in good faith. Article 27. A party may not invoke the provisions of its internal law as justification for its failure to perform a treaty. This rule is without prejudice to article 46.

[285] Sullivan, *Construction of Statutes*, *supra* note 276 at 422.

[286] *Canadian Foundation for Children Youth and the Law v Canada* [2004] SCC 4, para 31-33.

[287] *Canadian Foundation, ibid* at 31; citing *Ordon Estate v. Grail* [1998] 3 SCR 437, para 137.

were then used to interpret the phrase 'reasonable in the circumstances' contained in section 43 of the *Criminal Code.* While accepting that the statutory defence could violate the child's right to 'security of the person,' she rejected the argument that the Criminal Code provision violated the principles of fundamental justice for vagueness or overbreadth. In order to achieve this result, she limited the interpretation of the permissible zone for physical correction of children by reading down the statutory defence to make it consistent with international law and Canadian jurisprudence. Specifically she concluded that section 43 *as properly interpreted* does not offend the principles of fundamental justice under section 7 of the *Charter*.

The dissenting judgment of Arbour J, reached a different conclusion in finding that section 43 was contrary to section 7 of the *Charter*. She used international human rights jurisprudence to "inform" her interpretation of the *Charter,* as opposed to the more narrow approach of Justice McLachlin which focused on statutory interpretation:

> Canada's international obligations with respect to the rights of the child must also inform the degree of protection that children are entitled to under section 7 of the *Charter*.[288]

In addition to the binding and non-binding international sources cited by McLachlin CJ, Arbour J included an additional source: the concluding observations concerning Canada of the Committee on the Rights of the Child.[289] Those observations include a recommendation that Canada "remove the existing authorisation of the use of reasonable force" based on the 'imprecision' of the legal test, that may 'pave the way' for 'arbitrary'

[288] *Canadian Foundation, ibid* at para 186.

[289] *Canadian Foundation, ibid* at para 187.

reliance on the defence.[290] Arbour's judgment concluded that the phrase 'reasonable under the circumstances' as contained in section 43 of the Criminal Code concerning the use of force against children was contrary to the international jurisprudence, and thus the "principles of fundamental justice" under section 7 of the *Charter*.

The radical difference in result between the majority and dissenting judgments reflects the uncertainty embedded in the implementation of international human rights law in Canada. The majority saved the statutory provision from unconstitutionality through a 'narrowing' reliance on statutory interpretation, using international human rights law as a reference. In contrast, the dissent found that the statutory provision on its face violates section 7 of the *Charter*, using the presumption that the *Charter* must conform with international human rights law. Adding to the uncertainty in the result, they disagreed on the applicable provisions of international human rights jurisprudence. While the importance of international law to the Court's reasoning is worthy of note, the failure to provide a clear framework of interpretation leads to blurred lines and future uncertainty for prospective rights holders and rights bearers.

4.9 Application of international jurisprudence to administrative discretion

Any discussion of the reception of international law in Canada would be remiss without reference to the Supreme Court of Canada's 1999 decision in *Baker v Canada* where it applied the international law of child rights to *Immigration Act* policy and the exercise of administrative discretion.[291] In determining the proper scope of administrative discretion

[290] *Canadian Foundation, ibid* at para 188.

[291] *Baker*, *supra* note 250.

the Supreme Court of Canada ruled that it should be guided by the "principles and values" contained in ratified (and thus binding) international human rights treaties.[292] In *Baker* the Supreme Court of Canada determined that the proper exercise of discretion by immigration officials includes the principle of the "best interests of the child" as expressed in the *Convention on the Rights of the Child*:

> "... the legislature is presumed to respect the values and principles enshrined in international law, both customary and conventional. In so far as possible, therefore, interpretations that reflect these values and principles are preferred.[293]

This presumptive approach is similar to that used for statutory interpretation. Including the phrase "in so far as possible" leaves open the possibility of rebuttal, where a court concludes that no treaty compliant interpretation is possible. However, the criteria for what constitutes an adequate rebuttal remains unexplained, leaving government considerable 'wiggle room' in justifying any alleged departures from international law.

4.10 International human rights law and Charter interpretation

The Canadian jurisprudence with respect to the framework for the application of international human rights law to the *Charter* has been described as "opaque" and "one

[292] See *Baker, ibid* at para 70; for further discussion of the application of international human rights to administrative action see also in Ruth Sullivan, Driedger on the Construction of Statutes, 3d ed, *supra* note 276, at 330; Hill and Sossin, "Social Rights and Administrative Justice" in Martha Jackman and Bruce Porter in *Advancing Social Rights in Canada supra* note 38, where they suggest that in *Baker* the SCC has created a situation where unincorporated international human rights norms are a "binding constraint on administrative discretion" at 361.

[293] See *Baker*, *ibid* LHeureux-Dube at 70, quoting Sullivan, in *Construction of Statutes*, *supra* note 276; see also see also *Canadian for Children, Youth and the Law v Canada*, where the interpretation of s 43 CC was found to be in conformity with *CRC*, *supra* note 52, para 31-32.

area of continued uncertainty."[294] More than a decade ago the same commentator noted that:

> The Supreme Court of Canada has so far failed to elaborate a satisfactory and consistently applied approach for the use of international human rights in *Charter* interpretation[295]

In this section, the question of whether the Supreme Court of Canada's approach to the use of international human rights treaties has become any more transparent will be examined.

There is no requirement in international law that binding international human rights treaty obligations be "constitutionalised" or incorporated into domestic constitutional documents or even legislation, although incorporation, through targeted domestic legislation, is clearly preferred.[296] The view that the *Charter* should be seen as incorporating Canada's international human rights obligations is not one that has been embraced by either the government or the courts. Instead, most courts appear to agree with the Canadian government, which has maintained that the *Charter* is "one of the main ways in which Canada's international human rights obligations are implemented, *through judicial interpretation* [emphasis added].[297] What this means for social and economic rights, is that it is open to the courts to interpret the *Charter* so as to exclude such rights from constitutional protection. The justification for this omission is generally couched in terms of judicial deference to legislative authority. Nevertheless, in the

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[294] Freeman and Van Ert, *International Human Rights Law*, *supra* note 4.

[295] Freeman and Van Ert, *ibid* at 189.

[296] United Nations, CESCR, *General Comment 9*, *supra* note 72, at para 7 and 8.

[297] See for instance Canada, *Report to the CESCR*, 2004, at 16.

absence of legislative implementation of international human rights treaty obligations, *Charter* interpretation is the principle means by which international human rights obligations have received legal recognition in Canada, and through which individuals can demand accountability from government. The uncertainty concerning the theoretical basis for the reception of international human rights treaties is said to stem from four factors: the sheer multitude of human rights norms, the jurisdictional division in Canadian human rights law between legislation and the *Charter,* the uncertainties concerning the concept of treaty implementation, and the perceived adequacy of domestic law to resolve human rights disputes without recourse to international standards.[298] These concerns serve as a backdrop to in the following discussion of the case law.

In terms of a framework for analysis, in the *Reference re the Public Service Employee Relations Act* (*PSERA*), one of the earliest Supreme Court of Canada decisions invoking Canada's international human rights obligations under the *Charter*, the Court found that the right to strike was not protected under freedom of association, in section 2 (d) of the *Charter*. In that case, the Court was faced with the question whether legislative provisions prohibiting lockouts and strikes in the public service and imposing compulsory arbitration were inconsistent with section 2(d) of the *Charter*. While the majority found no *Charter* violation and upheld the legislative provisions, Dickson J, in dissent, found both that the provision was a violation of section 2 (d) and could not be justified under section 1. In relation to the interpretation of Canada's international treaty

[298] Van Ert, *Using International Law*, *supra* note 245, at 324-332.

obligations with respect to the right to strike, while the majority was silent, however Dickson J noted in his dissenting reasons that:

> I believe that the *Charter* should generally be presumed to provide protection at least as great as that afforded by similar provisions in international human rights documents, which Canada has ratified.
>
> [i]n short, though I do not believe the judiciary is bound by the norms of international law in interpreting the *Charter*, these norms provide a relevant and persuasive source for interpretation of the provisions of the *Charter*, especially when they arise out of Canada's international obligations under human rights conventions[299]

As subsequent commentators have noted, there are actually two separate tests contained in Dickson's judgment, the "presumption of conformity" and, what is viewed as the weaker approach, based on the "relevant and persuasive" test.[300] Unfortunately, no criteria were provided to guide the application of the two tests. Subsequently, in *Slaight Communications Inc. v Davidson,* in addressing the relevance of international human rights norms to the interpretation of section 1 of the *Charter,* the majority adopted Dickson's dissenting judgment in *PSERA* where the Court restated the principle that the *Charter* is *presumed* to accord with *similar* provisions contained in international human rights treaties ratified by Canada.[301] In that case the Court was faced with the question whether the remedy chosen by a labour arbitrator, in restricting the content of an employer's letter of reference of an employee who had been unjustly dismissed, violated the employer's freedom of speech under section 2 (b) of the *Charter.* The Court found that while the employer's right was violated, the infringement was justified, as it

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[299] See *Reference re Public Service Employee Relations Act (Alberta)[*1987] 1 SCR 313, para 64; see discussion of international sources at para 61 -76.

[300] See Van Ert, *Using international law, supra* at note 245.

[301] *Slaight Communications Inc. v. Davidson* [1989] 1 SCR.1038 at para 23.

prevented the employer from lying about the employee in seeking new employment. In applying section 1, the Court chose an approach that recognised Canada's international treaty obligation to the "right to work" in Article 8 of the *ICESCR,* in balancing the interests at stake. *Slaight's* strong endorsement of international law in interpreting the *Charter* represents a major step forward:

> The fact that Canada has undertaken certain international obligations, and that it has done so according to its good faith belief that Canadian law satisfies those obligations is the driving force behind the *Slaight* presumption, and the presumption of conformity in general.[302]

Thus, international law is seen as a necessary step in *Charter* interpretation, as well as presumptively congruent with *Charter* protections. Again in *Slaight*, while implementation of international human rights through *Charter* interpretation is said to rely on a presumption, the Court fails to set out the test for rebuttal.

In 2015, the Supreme Court of Canada revisited the issue whether section 2(d) (freedom of association) of the *Charter* protected the right to strike. This time the Court held that the right to strike was constitutionally protected, overturning its previous decision. In *Saskatchewan Federation of Labour v Saskatchewan* (*SFL*) in what is seen as a major turning point in labour law, the majority reversed its previous position in determining that the Saskatchewan legislation, which removed the right to strike for certain classes of public sector employees, violated section 2(d) of the *Charter*.[303] In both the reasons of the majority and the dissenting judgments, the interpretation of "freedom of association" in international human rights jurisprudence served as the battleground for *Charter*

[302] Freeman and Van Ert, *International Human Rights Law*, *supra* note 4 at 198.

[303] *SFL, supra* note 58.

interpretation.[304] Both agreed with the principle of interpretation that the *Charter* should be interpreted to provide protection at least as great as that contained in Canada's international human rights treaty obligations. However, the majority and the dissent reach opposite conclusions based on conflicting interpretations of the *substance* of the international human rights doctrine with respecting the right to strike.

Madam Justice Abella, speaking for the majority notes that:

> LeBel J. confirmed in *R. v. Hape*, [2007] 2 S.C.R. 292 (S.C.C.), that in interpreting the *Charter*, the Court "has sought to ensure consistency between its interpretation of the *Charter*, on the one hand, and Canada's international obligations and the relevant principles of international law, on the other": para. 55. And this Court reaffirmed in *Divito v. Canada (Minister of Public Safety and Emergency Preparedness),* [2013] 3 S.C.R. 157 *(*S.C.C.), at para. 23, "the *Charter* should be presumed to provide at least as great a level of protection as is found in the international human rights documents that Canada has ratified".[305]

Thus, Abella J equates the arguably softer terminology of *Hape* of seeking "to ensure consistency," to the stronger articulation of a presumption of minimum protection, "at least as great a level of protection" in interpreting the *Charter* in relation to Article 8 of the *ICESCR.* In *SFL,* the language of the presumption becomes even stronger when Abella states "Canada's human rights obligations mandate protecting the right to strike."[306] A presumption that 'mandates' certain action is stronger than one that 'seeks

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[304] *SFL, ibid* para 65; among those public sector employees were a number of health care workers; protection of 'the highest attainable standard of health' under Art 12 of the ICESCR as a justification for limiting the right to strike, is not referred to in the SFL decision, even by the dissent.

[305] *SFL ibid* para 64.

[306] *SFL, ibid* para 62.

to ensure consistency.' This decision marks a resurgence in the Supreme Court's use of international law in interpreting the *Charter*.

Among the binding sources of international law cited by Abella J is Article 8 of the *ICESCR, which* is described as the 'right to work.' The textual differences between the *ICESCR* provision and section 2(d) of the *Charter* are remarkable. Unlike earlier iterations of Dickson's presumption, which ostensibly included a requirement of similarity between the international and *Charter* rights protections, in *SFL* the presumption is applied to interpretations between texts that are dissimilar. This development is particularly important in the context of health rights, which are not explicitly protected in the *Charter*, and which contains no similar wording to Article 12 of the *ICESCR* with respect to the protection of the "highest attainable standard of health."

The international sources cited by Abella include both binding and non-binding jurisprudence. Abella reserves the less intrusive 'relevant and persuasive" approach for non binding sources of international jurisprudence, also known as 'soft law.'

> The relevant and persuasive nature of the Committee on Freedom of Association jurisprudence has developed over time through custom and practice and, within the ILO, it has been the leading interpreter of the contours of the right to strike…[307]

[307] *SFL,ibid* para 69.

This arguably provides the beginning of a framework of analysis for the complex task of applying international human rights jurisprudence.

In *SFL,* the majority reasons clarify and resolve areas of uncertainty in the use of international jurisprudence in interpreting the *Charter*. First, in relation to the requirement of 'similarity,' the Court appears to have no difficulty reading into 'freedom of association' the much more explicit protections of the right to strike in Art 8(3) of the *ICESCR.* Thus, 'similarity' in the sense of literal similarities in wording appears no longer to be a requirement. With respect to the two distinct approaches outlined by Dickson in the *PSERA* dissenting judgement, including both the 'relevant and persuasive' approach and the presumption of conformity, *SFL* provides much needed criteria for their application. The principle of conformity is reserved for binding treaty obligations, sometimes known as 'hard law' while the persuasive standard is reserved for non-binding international norms and opinions.

While the dissent differs in their interpretation of the international jurisprudence, what is remarkable is their clear view that international law is relevant and must be addressed in order to interpret the *Charter.* In a dissenting judgment, Rothstein and Moldaver adopt a deferential approach to *Charter* review, holding that international law should not be permitted to interfere with the federal government's "prerogative" over foreign affairs:

> …Judicial review and the use of international law as an interpretive aid should not become a euphemism for this Court interfering in the government's prerogative over foreign affairs …Moreover, their invocation of international law is

> particularly problematic given the unique historic context in which labour relations have developed within different countries.[308]

While the dissent's analysis accords "little weight" to what it describes as "non binding" sources of international law (conveniently overlooking the binding nature of Article 8 of the *ICESCR*), it disregards the majority's nuances in treatment of hard and soft international law sources.[309] Their sweeping conclusion that: "international law provides no guidance to this Court in determining whether the right to strike is encompassed within section 2(d) of the *Charter* for at least one key reason: the current state of international law on the right to strike is unclear" sidesteps the binding obligations in Article 8. They grant an exception to the Saskatchewan legislation without providing persuasive reasons for this conclusion. [310] While the dissenting judgment does not directly take issue with the presumption that the *Charter* should be interpreted to provide at least as great a level of protection as Canada's binding treaty obligations enunciated by the majority, following *Hape* and *Divito*, they part ways on the proper interpretation of those international treaty obligations.

The dissent's approach in *SFL* is reminiscent of Iacobucci J's judgment in *Baker,* where speaking for the minority, he characterised the concern in the following terms:

> Instead, the result will be that the appellant is able to achieve indirectly what cannot be achieved directly, namely, to give force and effect within the domestic legal system to international obligations undertaken by the executive alone that have yet to be subject to the democratic will of Parliament.[311]

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[308] *SFL, ibid* para 159-160.

[309] *SFL, ibid* para 157 and 159.

[310] *SFL, ibid* para 150.

[311] *Baker, supra* note 250, para 80.

Judicial deference to 'legislative choices' by definition weakens the court's oversight role in protecting the rights of the politically powerless and marginalised in society.

Before concluding that the Supreme Court of Canada has delivered its definitive position regarding the framework for analysis of international human rights jurisprudence, the reasoning in *SFL* must be contrasted with another of its decisions in 2015. In *Henry v British Columbia,* the Court was faced with interpreting the remedial provision in section 24(1) of the *Charter*, pursuant to a claim for damages as a remedy for a Crown violation of constitutional disclosure requirements.[312] Ivan Henry, brought a claim for damages for injuries suffered as a result of his wrongful conviction for several sexual offences and the nearly 27 years in prison that he had unjustly served. Compliance with Canada's international treaty obligations was at issue because Article 14(6) of the *ICCPR* provides that:

> When a person has by a final decision been convicted of a criminal offence and when subsequently his conviction has been reversed or he has been pardoned on the ground that a new or newly discovered fact shows conclusively that there has been a miscarriage of justice, the person who has suffered punishment as a result of such conviction shall be compensated according to law, unless it is proved that the non-disclosure of the unknown fact in time is wholly or partly attributable to him.

Canada has ratified the *ICCPR* and the obligations contained in that treaty are considered to be of "immediate effect" in international law. Despite the clear wording of the treaty provision, and the strong enforcement mechanism in international law, the majority decision, written by Moldaver J, completely ignored this international treaty obligation in

[312] *Henry v British Columbia* [2015] SCC 24.

interpreting section 24(1) of the *Charter* to exclude a remedy of damages against the government for negligent government action in the form of wrongful imprisonment.

The dissenting judgement, written by McLachlin CJ, relied upon international human rights jurisprudence as the basis for her conclusion that damages against the government were available for wrongful imprisonment:

> This result also upholds Canada's international obligations. Canada has committed itself internationally to compensating those who have been wrongfully convicted. Canada has ratified the International Covenant on Civil and Political Rights, 999 U.N.T.S. 171 ("ICCPR"), which provides, at art. 14(6)….
>
> Parliament has not passed legislation to implement this obligation domestically. The obligation expressed in the ICCPR is therefore not directly enforceable in Canadian courts. However, our Court has stated many times that the *Charter* should be interpreted consistently with Canada's international obligations. This was reaffirmed most recently in SFL v. Saskatchewan, 2015 SCC 4 (S.C.C.), at para. 64….
>
> Canada has committed itself to providing compensation to those who have been wrongfully convicted, as expressed in art. 14(6) of the ICCPR. Mr. Henry alleges that he was wrongfully convicted following a trial that was rendered unfair through violation of his right to disclosure. Section 24(1) authorizes the courts to award damages to compensate Mr. Henry for the harm suffered as a result of this *Charter* breach. It would be inconsistent with the international obligation undertaken by Canada through art. 14(6) of the ICCPR to predicate an award of damages under section 24(1) on Mr. Henry's ability to establish an intentional violation of his *Charter* rights. To require proof of intention would be to lower *Charter* protection below the level of protection found in an international human rights instrument that Canada has ratified. The commitment embodied in art. 14(6) thus further supports our conclusion that Mr. Henry need not establish fault to justify an award of damages under section 24(1).[313]

From *Henry,* it is apparent that despite the principles and framework enunciated by the Court in *SFL*, there remains a high degree of uncertainty concerning when international

[313] *Henry, ibid* para 135- 137.

jurisprudence will be used by the Court in interpreting the *Charter*. International human rights appear to be regarded by some judges as optional, rather than mandatory or binding sources of legal interpretation, despite statements to the contrary.

Even where international human rights jurisprudence is cited, the outcomes do not match the rhetoric of rights enunciated by the Court. For instance in *Divito,* a case following *Hape,* in a rousing eulogy on rights, the majority speaks of citizenship as the "right to have rights" and states that international jurisprudence provides a "minimum level of protection in interpreting the *Charter*."[314] Nevertheless, the Court found that a right to citizenship did not impose a duty on the Canadian government to allow a Canadian to transfer to a Canadian prison from a foreign jail. The minority found that even though the *Charter* had been violated (relying on international jurisprudence) the violation was justified and proportionate, based on security objectives.[315]

The difference in the cases appears to lie, in part, upon whether there is legislation purporting to limit the *Charter* right. In *SFL,* legislative restrictions, amounting to an absolute ban on the right to strike, were found to be unconstitutional. In *Henry,* where there was no legislation restricting the right, the *Charter* interpretation was based on doctrine originating in the common law. The majority of the Court appears hesitant to impose obligations on government in the absence of an explicit legislative restriction.

[314] *Divito*, *supra* note 68, para 21 and 25.

[315] *Divito, ibid* at para 72.

In *SFL,* the Court's decision essentially invalidates legislative restrictions imposed by government on the freedom to strike. While it does not impose a positive obligation on government to improve working conditions directly, it prevents government from interfering with workers' freedom to associate and to take strike action to that end. In contrast, in deferring to government in *Henry,* the Supreme Court of Canada adopts a weaker interpretive approach. Given the lack of legislative restraint, this weaker approach cannot be explained through the usual rationale of 'deference to legislative choices' by the Court, or a reflection of its unwillingness to undermine government decision making. However, it might still be explained by judicial discomfort with taking too much responsibility in areas that are seen to lie within an exclusively legislative realm. Another possibility is that the majority's failure to address international obligations stems from a reluctance to impose a positive obligation on government in exposing it to direct financial cost– in *Henry*, to expand *Charter* remedies by providing financial compensation for negligent acts. The irony, of course, is that a decision like *SFL,* dealing with the right to strike as part of the larger bargaining rights of thousands of public sector employees, might have far greater, albeit more indirect, consequences on the public purse. Another aspect of the *SFL* decision is its impact on social and economic rights. The government's claim was based on the purported goal of protecting essential government services, including importantly health services, from the disruption of work stoppages. Neither the majority nor the dissent makes any reference to the other, potentially countervailing, right to the highest attainable standard of health in the course of considering the justification for the legislation under section 1. However, in cases like *Henry,* where there are direct costs to government, and no explicit legislative restrictions,

the majority judgment reflects the ongoing gap between Canada's international obligations and its domestic implementation of those obligations through *Charter* interpretation.[316]

Returning to the original question posed in this section, whether the Supreme Court of Canada's jurisprudence with respect to the framework for analysis of international human rights law through the *Charter* interpretation has become more homogeneous and consistent in the last 10 years in the wake of *Hape, Divito,* and *SFL,* it is fair to say that the Court continues to take divergent approaches. Relevant international human rights treaty obligations are not treated with the same rigour as domestic legal obligations and on occasion continue to be ignored. When they are addressed there appears to be agreement concerning the proper test for implementation. Ambiguity is not required, nor is "similar" wording between the international text and the *Charter* provision. Rather than looking for similarities in wording, the Supreme Court of Canada appears to be satisfied with intent, in analysing whether the purpose of the international treaty provision is congruent with the *Charter* provision. Statutes are subject to a presumption of conformity with binding treaty obligations. Non-binding sources of international human rights law now are more clearly treated as "relevant and persuasive" sources of interpretation of the *Charter*, when no presumption appears to apply. While this approach will not satisfy some who say that human rights are sufficiently universal to

[316] As elaborated on further in the next chapter, one can speculate on whether "dollars trumped rights," see Lessard, Hester, "Dollars Versus [Equality] Rights": Money and the Limits on Distributive Justice" *supra* note 37 at 299 – 332, quoting the words of Justice Binnie in *NAPE v Nfld* [2004] 3 S.C.R. 381, at para. 65.

presume that Canadian law must conform with both binding and non-binding sources, it does mark an improvement.

Where the Supreme Court of Canada continues to baffle and bewilder at times, is whether it will address international human rights sources at all, or simply ignore their existence, as the majority did in *Henry*. In addition, even where the same test is used, as can be seen in *SFL,* opposite conclusions can be reached based on the same international human rights jurisprudence. Thus, quite apart from the proper interpretive principles to be used, considerable uncertainty remains as to whether and when the judiciary will refer and rely upon international human rights treaty obligations and non-binding sources in their interpretation of the *Charter*.

In the next section I will examine how the Canadian jurisprudence with respect to the use of international law in *Charter* interpretation has been applied specifically in relation to section 7 of the *Charter.* Section 7 is most closely related to the protection of economic and social rights in the *Charter.* In relation to the use of international jurisprudence in the interpretation of section 7 of the *Charter*, in *Irwin Toy,* one of the earliest cases to consider the scope of "security of the person" the court referenced the definition of various socio-economic rights (not including health) as contained in the *ICESCR* in declining to rule that all interests with an economic aspect should be excluded from the definition of "security of the person:"

> The intentional exclusion of property from section 7, and the substitution therefor of "security of the person" has, in our estimation, a dual effect. First, it leads to a general inference that economic rights as generally encompassed by the term "property" are not within the perimeters of the section 7 guarantee. This is not to

> declare, however, that no right with an economic component can fall within "security of the person". Lower courts have found that the rubric of "economic rights" embraces a broad spectrum of interests, ranging from such rights, included in various international covenants, as rights to social security, equal pay for equal work, adequate food, clothing and shelter, to traditional property — contract rights. To exclude all of these at this early moment in the history of *Charter* interpretation seems to use to be precipitous. We do not, at this moment, choose to pronounce upon whether those economic rights fundamental to human life or survival are to be treated as though they are of the same ilk as corporate-commercial economic rights. In so stating, we find the second effect of the inclusion of "security of the person" to be that a corporation's economic rights find no constitutional protection in that section.[317]

While the initial promise of this passage has not been realised, in recognising socio-economic rights as protected under section7, the Supreme Court of Canada has not excluded such protections. With respect to health interests, on the other hand, the Court has been clear that such interests may be protected with the right to security of the person, including a delay caused by government in receiving access to health care (*Chaoulli),* and laws that create a risk to health through preventing access to health care (*Insite*), although international jurisprudence did not play a role in the Court's reasoning in either case.[318]

Subsequently, international jurisprudence has primarily been used to assess the content of the "principles of fundamental justice" as opposed to the rights protected in "life, liberty and security of the person." Whereas Article 3 of the Universal Declaration of Human Rights protects "life, liberty and security of the person" none of the UN human rights treaties Canada has ratified contain wording similar to "the principles of fundamental justice." In the application of international jurisprudence, the approach, therefore, has

[317] *Irwin Toy v Quebec* [1989] 1 SCR 927, para 96.

[318] *Chaoulli, supra* note 183; *PHS, supra* note 175.

been to determine whether particular aspects of international human rights law, meet the Canadian test of "principles of fundamental justice." In a very early reference, without adopting any particular interpretive approach, Lamer J of the Supreme Court noted that the principles have "found expression in the international conventions on human rights."[319] In *Suresh* the Supreme Court of Canada described the principles of fundamental justice under section 7 as the "basic tenets of the legal system" and interpreted it to include both procedural and substantive elements, thus requiring courts to examine both the objectives and means used by government. [320] In *Suresh* the Court was faced with the question whether a deportation where there was a substantial risk of torture, was contrary to the principles of fundamental justice under section 7. A unanimous Court concluded that:

> International treaty norms are not, strictly speaking, binding in Canada unless they have been incorporated into Canadian law by enactment. However, in seeking the meaning of the Canadian Constitution, the courts may be informed by international law. Our concern is not with Canada's international obligations qua obligations; rather, our concern is with the principles of fundamental justice. We look to international law as evidence of these principles and not as controlling in itself. [321]

This statement of the framework for the application of international law on the interpretation of the "principles of fundamental justice" makes no mention of the "principle of conformity" or the "relevant and persuasive" tests. The approach taken by the Court has been criticised:

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[319] *Re Motor Vehicle Act (British Columbia) s 94(2)* [1985] 2 SCR 571, at 113.

[320] Young, Margot, "The Other Section 7" (2013 62 SCLR 2d 3) at para 58-59, quoting Sopinka in *Suresh v Canada*, *supra* note 68, para 44.

[321] *Suresh* SCC, *ibid* para 60.

> If one sets knowledge of Canada's legal obligations wholly aside in construing the *Charter,* one is left with no reason to resort to international law save curiousity. Such an approach would undermine one of the *Charter's* great purposes, namely to secure for Canadians in their domestic law the rights and freedoms that are their due under international law.[322]

Despite their approach, the Court concluded that deportation where there was a substantial risk of torture was a human rights violation in international law, and that this norm "informed" the content of the principles of fundamental justice. In the result, the Court found in favour of the Appellant on other grounds that the procedures did not meet the standard of fairness required.

The test for a principle of fundamental justice as cited by McLachlin CJ in *Canadian Foundation* requires the Court to conclude that it constitutes a legal principle, that there is a consensus that the principle is vital to our notion of justice and that it can be identified with precision.[323] The conclusion reached by the majority in *Canadian Foundation* was that the principle of "best interests" as reflected in the *Convention on the Rights of the Child,* did not meet the second branch of the test as it was not considered pre-eminent and therefore presumably "fundamental", but only one principle among many that must be balanced against countervailing values.[324] Based on the Canadian jurisprudence, while it is clear that the Court can consider international jurisprudence in relation to the principles of fundamental justice under section 7, it is not clear that this is a mandatory requirement. However, it has been noted that: "it is difficult to imagine how a person might be

[322] Freeman and Van Ert, *International Human Rights Law*, *supra* note 4 at 198.

[323] *Canadian Foundation, supra* note 286, para 9-11

[324] *Canadian Foundation, ibid.*

deprived of her life, liberty or security of the person contrary to international law but consistently with international law."[325]

In the next section, the implementation of Canada's international health rights obligations through the *Charter* will be examined, first through an empirical review of select Supreme Court of Canada *Charter* rights cases in order to determine whether and how international health rights were argued, in contrast with how the case was decided. I will then turn to several recurrent themes in relation to health rights in examining how the courts have approached health rights challenges.

[325] Van Ert, *Using International Law*, supra note 245 at 353.

Chapter 5 Protecting the right to health in Canadian courts

In Canada, human rights find constitutional protection in the *Charter of Rights and Freedoms.*[326] Unlike many other constitutional democracies, there is no court in Canada with exclusive jurisdiction over the interpretation of the constitution, including the *Charter*. However, the Supreme Court of Canada, as the country's highest court, has the last word in cases that manage to reach them, and so it is to that Court that I will look for jurisprudence regarding the *Charter*, as the 'primary vehicle' for the implementation of international health rights obligations. As noted by the Supreme Court of Canada:

> Our *Charter* is the primary vehicle through which international human rights achieve a domestic effect …In particular, section 15 (the equality provision) and section 7 (which guarantees the right to life, security and liberty of the person) embody the notion of respect of human dignity and integrity.[327]

The cross section of cases available for analysis with respect to economic and social rights, including health rights, is limited, even some 40 years after the ratification of the *ICESCR* and *ICCPR,* and 35 years after the *Charter* was proclaimed. This may be attributable in part to the very limited number of leave applications granted by the Court as gatekeeper in civil cases – cases that would typically engage social and economic rights including health related rights.[328]

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[326] *Canadian Charter of Rights and Freedoms supra* note 141; see also s 36(1) of the Constitution Act, 1982, *supra* note 141, which provides additional commitments regarding "essential public services of reasonable quality."

[327] *R v Ewanchuk* [1999] 1 SCR 330, judgment of L'Heureux Dube, at para 73.

[328] For an analysis of the SCC's gatekeeper function, in granting leave to appeal in civil equality rights cases under s 15, see Ryder, Bruce and Taufiq Hashmani, "Managing *Charter* Equality Rights: The Supreme Court of Canada's Disposition of Leave to Appeal Applications in Section 15 Cases, 1989-2010," 2010) 51 SCLR (2d) 505 where the authors analysis of the disposition of leave applications involving s 15 claims suggest a diminishing focus on equality rights by that Court.

In this chapter, I set out to examine how theory meets reality in the court's interpretation of the *Charter* based on international human rights jurisprudence. I do this in three ways. First, I examine statements Canada has made to UN bodies regarding its approach to implementation of its UN treaty obligations. I briefly highlight the challenges in this approach before turning to my empirical study. In this study, I focus on five Supreme Court of Canada cases that engage health interests. I examine the docket, including the facta of their parties. I examine how the parties used international human rights jurisprudence in their submissions, whether that jurisprudence was relied upon by any member of the Court, and when it was, what framework the Court applied. Finally, I assess whether the outcomes in those five cases are consistent with the international right to the highest attainable standard of health. In the last section of this chapter, I will broaden my focus beyond the Supreme Court of Canada, in examining the approach taken by the litigants and the courts, in cases that involve access to health related goods and services. The influence of a negative rights framework, in excluding interpretations of the *Charter* that include 'positive' rights, such as the right to health, will be critically examined.

5.1 Canada's implementation of Article 12 of the *ICESCR*

Canada has chosen not to formally incorporate its *ICESCR* treaty obligations, including Article 12, the right to the highest attainable standard of health, by way of specific enabling legislation.[329] In reports to international treaty bodies, the Canadian

[329] See Canada, *Core Document* (2013) *supra* note 219 at 120, 121, and the critique of this position offered by the CESCR, *supra* at note 89, at 35, 39, 40; see for instance the recommendation that "federal, provincial and territorial legislation be brought in line with the

government has claimed that economic and social rights are protected through pre-existing legislation and policies. In terms of pre-existing legislation, like other areas of economic and social rights, Canada typically takes the position that prior to treaty ratification, Canadian law is brought into compliance with the treaty obligations, and that direct legislative incorporation is unnecessary.[330] Notwithstanding this position, Canada identifies the *Charter* as the 'primary vehicle' through which Canada meets its international human rights treaty obligations.[331] In order to examine how those outside of government seek protection of their human rights, it is to the Supreme Court's implementation of Article 12, through *Charter* interpretation, that I will turn to next.

In 1998, in reply to the 'list of issues' posed by the CESCR, the government of Canada stated as follows:

> CESCR: In 1993 the Government informed the Committee that section 7 of the *Charter* at least guaranteed that people are not to be deprived of basic necessities and may be interpreted to include rights under the Covenant, such as rights under article 11. Is that still the position of all governments in Canada?
>
> Canada (Government Response): The Supreme Court of Canada has stated that section 7 of the *Charter* may be interpreted to include the rights protected under the Covenant (see decision of *Slaight Communications v. Davidson* [1989] 1 S.C.R. 1038). The Supreme Court has also held section 7 as guaranteeing that people are not to be deprived of basic necessities (see decision of *Irwin Toy v. A.*-

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State party's obligations under the Covenant, and that such legislation should protect poor people in all jurisdictions from discrimination because of their social or economic status" at 39.

[330] See Canada, *Core Document*, 2013 *ibid*; see also Laura Barnett "Canada's Approach to Treaty Making" (Library of Parliament, Ottawa, 2012) at 3.3.

[331] Canada, *Core Document*, 2013, *ibid* para 90-98. See also Canada, *Core Document*, 1998, *supra* note 222, para 115-123; while the focus of the analysis in this paper is upon implementation through *Charter* interpretation, this is not to ignore other non *Charter* legal strategies to protecting health interests, which include administrative appeals and judicial review as well as tort claims and class actions. Similarly, this is not to ignore health rights advocacy through engagement at the international level with UN treaty monitoring bodies, UN Special Rapporteurs and the *ICCPR* optional protocol complaint process.

> *G. Québec*, [1989] 1 S.C.R. 927). The Government of Canada is bound by these interpretations of section 7 of the *Charter*.[332]

In Canada's 1998 third periodic report to the UN under the *ICESCR*, it noted that human rights "standards" are taken into account in interpreting and applying *Charter* provisions:

> The Supreme Court of Canada has also emphasized the importance of taking international human rights standards into account in interpreting and applying the *Charter*, particularly those contained in treaties that Canada has ratified.[333]

In Canada's 2004 fourth periodic report, it softened its position:

> International conventions ratified by Canada do not *ipso facto* acquire the force of law in the country unless incorporated in domestic legislation. The *Canadian Charter of Rights and Freedoms* applies to all governments in Canada and protects many of the human rights recognized by international conventions and covenants. To a large extent, these treaties are implemented by additional legislative and administrative measures.[334]

And further that:

> Measures adopted by all governments in Canada are subject to review under the *Canadian Charter of Rights and Freedoms.* This ensures uniformity of protection across Canada regarding the civil and political rights guaranteed by the *Charter*, and further that *economic and social measures in all jurisdictions*, and those relating to children or other subject matters covered by human rights conventions,

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[332] Canada, Federal Government Response to Issues raised by the CESCR, June 10 1998, at para 53; retrieved at http://www.canadiansocialresearch.net/uncan.htm; the federal government has since removed links to these documents from its website.

[333] Canada, Third periodic report to the CESCR, 1998; see also Canada, *"Federal Responses", Canada's Third Periodic Report on the Implementation of the ICESCR, ibid* 1998: "The Supreme Court of Canada has stated that section 7 of the *Charter* may be interpreted to include the rights protected under the Covenant (see decision of *Slaight Communications, supra* note 301). The Supreme Court has also held section 7 as guaranteeing that people are not to be deprived of basic necessities (see decision of *Irwin Toy v. AG Québec*). The Government of Canada is bound by these interpretations of section 7 of the *Charter*"; as cited in *Victoria (City) v Adams* [2008] BCSC, *supra* note 4.

[334] Canada, Fourth periodic report to the CESCR, 2004, UN Doc E/C.12/4/Add.15 at 16.

> *satisfy the same criteria set forth in the Charter regarding such matters as non discrimination and due process***.** [335]

In Canada's 2013 *Core Document*, the wording had changed: international human rights were described as "relevant" to determining the ambit of *Charter* rights:

> International treaty documents that Canada has ratified can inform the interpretation of domestic law. This doctrine is of particular importance in the context of the *Canadian Charter of Rights and Freedoms.* Human rights treaties are relevant in determining the ambit of rights protected by the *Charter*.[336]

The Canadian government appears to have backed off its claimed distinction in treatment of civil and political "rights" as opposed to economic and social "measures" that are entitled to a more limited protection of "non discrimination and due process." No authority was given by the government for the distinction. Since 1993, it is troubling to note that the Canadian government's position regarding the rights protected in the *ICESCR* appears to have become weaker rather than stronger.

5.2 Article 12 not codified in the Charter

The lack of explicit health rights provisions in the *Charter* presents particular challenges with respect to the implementation of the *ICESCR* through *Charter* interpretation. However, as decisions such as Justice Abella's in *SFL* make clear, there is no longer, if there ever truly was, a requirement for 'similar' wording between the *Charter* and Canada's international human rights obligations. In practical terms, however, the relevance of international human rights sources becomes more obvious in cases where the substantive treaty obligation and the *Charter* provision share similar wording.

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[335] Canada, Report to the CESCR, 2004, *ibid* at 19; for an identical reference see Canada, Core Report, 1998, *supra* note 214, at 140(a) (emphasis added).

[336] Canada, *Core Document*, 2013, *supra* note 219 at para 90-98 and para 128.

In addition to differences in wording between the *Charter* and the *ICESCR*, implementation is complicated by the fact that the *ICESCR* contains two types of obligations: often defined as those of 'conduct', and those of 'result.'[337] Obligations of conduct are derived from the concept of "progressive realisation" where state parties are required "to take steps" within "available resources," "to achieve the full realisation of the right." [338] Such obligations are sometimes described as "less justiciable."[339] Obligations of result are duties that require the state party to take immediate steps to respect, protect or fulfill the right. In international law, health rights under the *ICESCR* that are of immediate effect require the state party to implement a plan for their fulfillment, to protect the minimum core obligation, and to prevent their discriminatory application.[340]

In arguing for human rights protection in the area of health, advocates have relied upon section 7, section 12 and section 15 of the *Charter* to support their claims. Section 15, the equality rights guarantee, is substantially similar to the *ICESCR* standard for to non-discrimination, but offers nothing unique to health rights. Section 12, the right to be free from 'cruel and unusual treatment and punishment' under the *Charter,* mirrors Article 7 of the *ICCPR*, but again fails to reflect fulfillment of a right to health. While none of these sections explicitly protect the right to health, section 7, particularly the right not to be deprived of 'security of the person' except in accordance with the principles of

[337] Van Ert, *Using international law, supra* note 245 at 328.

[338] *ICESCR*, *supra* note 16 at Article 2.1.

[339] Van Ert, *Using international law, supra* note 245 at 328.

[340] See earlier discussion in relation to "minimum core obligations" in section 3.6.

fundamental justice, provides the greatest potential for a substantive guarantee of health rights.

5.3 International health rights in the Supreme Court of Canada

In this section, I will take an empirical approach in examining how international jurisprudence is used by litigants in their appeal submissions, and what explicit influence those submissions have on judicial outcomes. The choice of methodology in this section was driven by the following question: in cases in which the Supreme Court of Canada could have interpreted *Charter* rights in light of international health rights under Article 12, why did the Court fail to address those rights in its decision? Among the questions I examined were: whether health or other international human rights were argued, and what framework was used in analysing the relevance of those international rights. On the *Charter* side, despite the fact that section 7 is my main focus, two of the most important cases about access to healthcare services, *Eldridge v BC* and *Auton v BC,* were decided on the basis of section 15 of the *Charter*, and so they are included as well.[341]

In an adversarial system, the parties to the litigation drive the framing of the issues and the evidence, so it is important to know whether the parties in their submissions address international human rights law. In order to reach any conclusions about the Court's application of, or in most cases failure, to apply principles of interpretation in relation to international health rights, the parties' submissions were examined to determine if international human rights jurisprudence was included. This is followed by a comparison

[341] See *Eldridge, supra* note 221, and *Auton v BC* [2004] SCC 78.

of those submissions to the judicial reasoning in the case in order to determine whether they were addressed by the Supreme Court of Canada.

The steps in this research were:

1. Whether international sources were relied on by any of the parties to the litigation;
2. How those international sources were interpreted and applied in the submissions to the Court;
3. How the Court used those international sources, if at all, in its reasons for judgment;
4. When international human rights were cited, what framework the Court applied in applying international sources; and
5. Whether the relevant international health rights jurisprudence was consistent or inconsistent with the reasons for judgment.

The choice of cases was driven by my interest in health related interests under the *Charter*. In terms of the five cases selected, I focussed on the Supreme Court of Canada, in part for practical reasons, given its superior resources in making facta publicly available. The initial focus was initially on the facta of the parties, and then on the interveners, especially in cases where the parties made no submissions regarding international human rights.

I will start my review with two of the most important access to health care cases, *Eldridge* and *Auton,* which were decided under section 15 of the *Charter*. In *Eldridge,* often described as the most progressive case of adverse effect discrimination under section 15 affecting access to health care services, the Court issued a declaration that the failure to provide sign language interpreters where necessary for effective communication in the delivery of medical services was discriminatory under section 15 and not a

reasonable limit under section 1 of the *Charter*.[342] Thus access to the publicly insured Medicare health services formed the basis of the section 15 violation. Following *Eldridge* came *Auton,* where a unanimous Court rejected a claim that the failure to include autism therapy as an insured medical service was discriminatory towards children with autism.[343] Chief Justice McLachlin, speaking for the Court, distinguished LaForest J's decision in *Eldridge* on the basis that it provided access to health benefits already conferred by law and enjoyed by all (insured health services) whereas in *Auton,* the claim was for a health service (autism therapy) not conferred by law. At bottom, the impact of the Court's decision was to restrict access to publicly insured health services for children.

I will then examine three section 7 claims involving health interests, *Chaoulli, Insite* and *Gosselin.* In *Chaoulli,* the Court found that Quebec legislation prohibiting private health insurance violated section 7 by impinging on the right to life and security of the person; the decision raises troubling questions concerning protection of the public interest in health rights.[344] Thus, the legislative restriction on access to private health insurance formed the basis of the violation, at the expense of potentially adverse effects on access to the publicly insured health care system. Most recent is the case of *Insite* where a divided Court found that the federal government's failure to grant a criminal code exemption to a supervised injection facility, an approved service under the BC Medical Services Commission, was a violation of section 7 as a deprivation of life and security of the person in a manner that was disproportionate and thus not in accordance with the

[342] *Eldridge, supra* note 221.

[343] *Auton, supra* note 341.

[344] *Chaoulli v Quebec*, *supra* note 177.

principles of fundamental justice.[345] The government restriction on access to publicly insured health care services formed the basis for the violation under section 7. Finally, in a category of its own lies the case of Louise Gosselin, where a divided Court found that age-based reductions in social assistance were not contrary to section 7- despite the enormous negative impacts on Gosselin's health.[346] While unarticulated, access to the determinants of health was squarely in issue in *Gosselin.*

5.4 *Eldridge v British Columbia*: accessibility in healthcare

5.4.1 Background

In *Eldridge v BC*, arguably the high water mark of adverse effect discrimination in Canadian jurisprudence, the Supreme Court of Canada dealt with access to health care services for people with disabilities.[347] The Court found that the BC government's failure to fund sign language interpretation for deaf patients violated their equality rights and gave the government six months to implement an order to provide interpretation services "where necessary for effective communication in the delivery of medical services."[348] The Court ruled that the ability to communicate was fundamental to the adequacy of healthcare services and that financial barriers undermined access. Thus it ruled that the BC Health Services program violated section 15 of the *Charter*, in failing to provide deaf

[345] *PHS Community Services Society v. Canada (AG) (Insite), supra* note 4.

[346] *Gosselin v Quebec* [2002] SCC 84.

[347] *Eldridge, supra* note 221.

[348] *Eldridge, ibid* at para 29.

people with sign language interpreters so that they could communicate effectively with their health care providers and that this gap was discriminatory on the basis of disability.

By way of background, the Court considered evidence that although the BC government funded American Sign Language (ASL) interpreters in various contexts, including child welfare investigations, in educational settings, within the justice system, and for vocational training and job placements, it had refused to provide comparable services in the "medical setting" including both regular family doctor appointments as well as hospital treatment.[349]

The appellants, a group of several plaintiffs who had experienced similar barriers in accessing the BC health system, testified that they had been deaf since birth, and their language was American Sign Language. Their doctors were unable to communicate in ASL. The appellants understanding of spoken English (through lip reading) was limited. Expert testimony was presented which established that written English was not an effective means of communication.[350] In dealing with their health issues, which included both chronic illness as well as childbirth, the BC health system had failed to provide them with an adequate means of communicating with their health providers.[351] In terms of their standard of living, the evidence also showed that deaf persons are likely to be

[349] *Eldridge*, Appellants Factum, para 49.

[350] *Eldridge*, App Factum para 42

[351] *Eldridge*, App Factum, para 1-20

unemployed or underemployed, and none of the Appellants had the financial means to pay for ASL interpretation services.[352]

Rather than basing their case on a right to health, the Appellants appeared to accept that the government was under no *constitutional* obligation to provide "publicly funded medical services."[353] Instead they focussed on the neutrality of the law (neither the medical services or hospital legislation provided for interpretation services), which they claimed was discriminatory in its effect, in depriving deaf persons of "equal access" to a government benefit program.[354] During oral argument, they refined their claim, attacking the exercise of executive discretion in failing to provide interpretation services, rather than the legislation itself.[355]

5.4.2 Submissions on behalf of the appellants

The Appellants failed to cite any international human rights sources in their factum, in relation to *Charter* interpretation. They relied instead on human rights jurisprudence both in Canada and the United States.[356]

5.4.3 Submissions of the respondent AGBC

In response, the BC AG presented a two-fold argument: that hospital boards were private actors entitled to exercise their discretion in apportioning their resources and therefore

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[352] *Eldridge*, App Factum para 45

[353] *Eldridge*, App Factum at 59

[354] *Eldridge*, App Factum at 74

[355] *Eldridge*, *supra* note 221, at para 24.

[356] *Eldridge,* App Factum at 81-85.

not subject to the *Charter,* and that ASL interpreters were not "medically necessary" and no different from the other health related supports and services not included in the public scheme.[357] Like the Appellant, the AG made no reference to international human rights in their written submissions.

5.4.4 Submissions of the interveners

The various provincial government interveners made no reference to international human rights authorities in their submissions. Among the six non-governmental interveners, there was one reference to international human rights. In the factum filed on behalf of the *Charter* Committee on Poverty Issues (CCPI), the interveners linked non-discrimination and the right to health under the *ICESCR*.[358] They argued that international jurisprudence established a government obligation to take "positive action" to reduce disadvantage, and that consistent with principles of *Charter* interpretation in *Slaight*, section 15 should be interpreted to include comparable positive obligations.[359]

5.4.5 Decision in *Eldridge*

In its decision, the Supreme Court of Canada ignored the submissions of the intervener CCPI, and made no reference to international sources or health rights in its interpretation of section 15 of the *Charter*. In a unanimous decision, LaForest J held that in effectively

[357] *Eldridge*, Respondents Factum at 100.

[358] *Eldridge*, CCPI Factum at 16.

[359] *Eldridge*, CCPI Factum at 17-19.

denying the deaf of effective communication in medical services, the adverse effects of a facially neutral benefit scheme constituted a violation of their equality rights.[360]

5.4.6 Limitations of the decision

In failing to include section 7 as a ground, the litigants restricted the substantive inquiry into access to health care as a constitutional right. Turning to section 15, despite the introduction of international human rights jurisprudence by one of the interveners, a number of relevant international health rights principles were overlooked by the parties and the Court. In overlooking the intervener's submissions concerning the substantive protection provided for health rights in international human rights law, the Court missed an opportunity to analyse the issue of access to health care.

Based on the findings of fact in *Eldridge,* the *effect* of the government action was not only a failure to accommodate the deaf, but also an effective *denial of access to health services*. In addressing the severity of the "economic prejudice or denial of a benefit" under section 15, Canada's international human rights obligations are relevant. Much as section 15 and section 7 are said to be "mutually reinforcing" so in international jurisprudence rights are considered "indivisible and interrelated."[361]

Particularly in relation to the issue of access to health services raised in *Eldridge*, Canada is obligated to take immediate steps to realise the right to health through:

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[360] *Eldridge*, *supra* note 221, at para 77.

[361] *Gosselin*, *supra* at note 346, see reasons of L'Heureux-Dube J, at 144; *Vienna Declaration*, *supra* note 58.

> The creation of conditions, which would assure to all medical service and medical attention in the event of sickness.[362]

In addition, with respect to children, Canada has agreed to:

> The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child[363]

Canada is required to take the necessary steps for full realisation of these rights. The same protection towards children has been identified as being contained in both the right to life under the *ICCPR*, where the Human Rights Committee has commented that the state is obligated to "adopt positive measures," specifically "all possible measures to reduce infant mortality and increase life expectancy."[364]

Access to health care for mothers and children is the subject of specific protection in *Convention for the Elimination of Discrimination Against Women (CEDAW)*, in addition to the right to health information, including family planning.[365] *CEDAW* guarantees "free" and "appropriate" services to women in connection with pregnancy.[366]

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[362] *ICESCR, supra* note 116, Art 12.2(d)

[363] *ICESCR, ibid* Art 12.2(a)

[364] *ICCPR*, *supra* note 116, Art 6; See United Nations, HRC, General Comment No 6 (1982) *supra* note 199.

[365] *CEDAW*, *supra* at note 51, Art 10(h), 12.2.

[366] *CEDAW*, *ibid* Art 12.2.

The *CRC* provides that states are obligated to provide "*appropriate* pre natal and post natal health care for mothers" and to ensure that parents and others have access to education and information concerning child health.[367]

Effective communication is necessary for the realisation of these rights, especially those associated with health information. Reference to Canada's international health rights obligations would have clarified what is otherwise a vague aspect of the decision, in terms of the "flexibility" of the standard associated with "effective communication."[368] It would also have allowed the Court to provide more specific guidelines to the government about how to choose from the "myriad" of options in providing interpretation services, one that guaranteed parents and children access to health care services through effective communication.[369]

The Court's deference to executive discretion in creating a "flexible" standard for what constitutes "effective communication," and in declining to provide injunctive, in place of declaratory, relief represented a weak response to a human rights violation. What followed was a breakdown in effective implementation of *Eldridge* across Canada. As Colleen Flood and Brandon Chen point out, the impact of *Eldridge* cannot be judged solely on the outcome of the court decision.[370] As they put it, "On the macro level, one needs to look beyond the successes or failures of the lawsuits themselves to truly

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[367] *CRC, supra* at note 52, Art 24.2 (b)(d)(e) [emphasis added].

[368] *Eldridge, supra* note 221, at para 82.

[369] *Eldridge, ibid* at para 96.

[370] Flood, Colleen and Y. Y. Brandon Chen, "*Charter* Rights and Health Care Funding: A Typology of Canadian Health Rights Litigation" [2010] 19 Canadian Ann of Health Law 479.

ascertain whether or not a rights based approach to health care is achieving progressive or regressive outcomes."[371] In this typology, progressive outcomes are defined as the distribution of health resources according to need, not ability to pay, while regressive outcomes undermine the universal healthcare system in Canada.

While BC eventually implemented the decision in *Eldridge*, it exceeded the six month deadline and excluded certain health care services.[372] Other provincial health care systems, with the exception of Ontario, failed to follow the direction laid out in the Court's judgment: none incorporated interpretation services for deaf patients in their healthcare budgets. While Supreme Court of Canada decisions are considered binding across Canada, this must be based on the technical distinction that the health program under scrutiny was a matter of provincial jurisdiction. However, the Flood and Chen argue that this approach requires a very narrow reading of *Eldridge* given that the same conditions apply in all provinces, based on the *Canada Health Act*.[373] In the absence of subsequent court challenges in other provincial jurisdictions, *Eldridge* stands as an illustration of the barriers faced by disadvantaged communities in enforcing their substantive rights.

[371] Flood and Chen, *ibid* at 482.

[372] Flood and Chen, *ibid* make the point that the BC government's implementation of the SCC decision actually took more than six months, and was not extended to services such as dental, physiotherapy, chiropractor or massage (at 490, note 61).

[373] Flood and Chen, *ibid* at 490; quote Kent Roach, "Remedial Consensus and Dialogue under the *Charter*: General Declarations and Delayed Declarations of Invalidity," 2002, 35 UBCL 211, 228-29 at note 58.

One of the most critiqued aspects of rights-based litigation, is its shaky record with respect to implementation. At the remedial stage, where a declaration is made by the court, rather than "reading in" to the legislative provision to make it *Charter* compliant, the flexibility and deference accorded to government by the courts opens the door to selective implementation. The Court's approach in *Eldridge* can be contrasted with *Vriend,* where a majority of the Court ruled that under inclusive legislation, namely the failure to provide protection based on sexual orientation in the Alberta human rights code, deprived the claimants of equal protection and benefit of the law, and "read in" the omitted ground as a requirement of the code.[374]

A more careful consideration and reliance on Canada's international human rights obligations in interpreting the section 15 obligation in *Eldridge* might have provided clearer direction to governments of their human rights obligations. Developing *Charter* interpretations that fully address Canada's international human rights obligations would have the added benefit of strengthening the implementation of such decisions.

5.5. *Auton v British Columbia*: discrimination in healthcare

5.5.1 Background

In *Auton,* the Supreme Court of Canada was faced with a claim that the failure to include autism treatments for children in the list of "medically necessary" health care services that received public funding was discriminatory.[375] The claimants, a group of parents of children with autism and their children, claimed the denial created a "two tier" health

[374] *Vriend v Alberta* [1998] 1 SCR 493 at 88.

[375] *Auton, supra* note 341.

care system, in which only those who could afford to pay, were able to obtain treatment. They sought funding from three provincial government ministries, including health, for specialised "ABA/IBI" therapy. However, the trial judge found that the case raised "primarily a health issue" and narrowed her decision to the Ministry of Health. She agreed with the claimants that the denial of funding for ABA/IBI treatment was discriminatory, as it disadvantaged children with autism as compared with their peers without this disability, and it was not justified under section 1 of the *Charter* because it undermined the universality of the health care system.[376] While the appellants original claim included grounds under both section 15 and section 7 of the *Charter,* the trial judge, and the British Columbia Court of Appeal, in allowing the claim based on section 15, found it unnecessary to deal with the section 7 grounds.

Before the Supreme Court of Canada, the claimant's cross appeal on section 7 was summarily rejected because the Court found that it was not supported by the limited record and submissions. As a result, the Supreme Court decision is focussed primarily on the section 15 analysis, and particularly the comparator group, which the court found to be "non disabled or persons without a mental disability" seeking funding for treatment, variously described as: "non-core," "emergent," "important to health," and only "recently recognised as medically necessary." Before the BC Court of Appeal, as a result of the trial judge's narrowing of the case to health, the discriminatory impact of the decision not to fund the treatment was restricted to comparisons based on health needs. The characterisation of the treatment as exclusively 'health care' while not decided, was

[376] *Auton, ibid* para 14.

open for debate.[377] Underlying the discriminatory impact of the denial of funding for children with autism was a health care system that favoured doctors and hospitals over community based treatment options.[378]

5.5.2 Submissions by the parties

Canada's international human rights obligations were cited by the rights claimants in relation to the cross appeal under section 7 of the *Charter*.[379] They made a general reference to the *ICESCR,* without citing any specific provisions or making any argument. In the second instance, the rights claimants made specific reference to the *Convention on the Rights of Children* in support of their argument under section 7 of the *Charter,* and the interpretation of the principles of fundamental justice.[380] They cited the interpretive principle articulated in *Slaight Communications* that the *Charter* should be interpreted to provide rights protections at least as broad as similar international rights documents.[381] In relation to the *Convention on the Rights of the Child*, the claimants cited Article 3 (best interests), and Article 23 (the rights of children with a disability), and Article 24 (the highest attainable standard of health.) In addition, they linked the international recognition of children's rights to the common law *parens patriae* doctrine in arguing for

[377] In a subsequent court challenge, the claimants sought funding for the same treatment through the education system: see *Wynberg v Ontario* [2006] O.J. No. 2732 OCA.

[378] *Auton,* Interveners DAWN, LEAF factum para 8; and see para 25: "A critical flaw in the appellant's position lies in its narrow conception of health services that is focussed on hospitals and doctors is based on the "normal" (physical) ailments of the non-disabled. The design of the health services system around doctors and hospitals is geared to the usually temporary and/or curable conditions of the non-disabled."

[379] *Auton,* Factum of the Respondent on Appeal and Appellant on the Cross Appeal Auton et al, at para 51, 58, 68, 67.

[380] *Auton,* Factum, Auton et al, at 68, Convention on the Rights of the Child, Art 3 (best interests), 23 (rights of children with disabilities), 24 (right to highest attainable standard of health).

[381] *Auton,* Factum, Auton et al, at 67.

an effective and meaningful remedy under section 24(1) of the *Charter*. However, this aspect of the argument lacked any reference to specific authorities or interpretive principles. In the next paragraph of the factum, possibly in relation to these international norms, the claimants argued that section 7 includes "positive" obligations, without defining what they mean by a positive obligation. The submissions with respect to Canada's international human rights obligations were relevant but cursory, and lacked an analysis that ties them to any particular aspect of the interpretation of section 7, either in terms of "life, liberty and security of the person" or the "principles of fundamental justice." The failure to refer to the general comments of the treaty monitoring bodies concerning health rights, also represented an oversight. In relation to the main discrimination claim under section 15, the rights claimants failed to draw any link between Canada's international obligations and section 15. The Attorney General of British Columbia and the eight other provincial government interveners ignored these references to international human rights authorities in their submissions.[382]

5.5.3 Submissions of the interveners

Two of the non-government interveners cited international sources. The intervener group "Families for Early Autism Treatment" (FEAT) cited Canada's international obligations towards children under the *Convention on the Rights of the Child*, as well as Article 12 of the *ICESCR*, in support of the protection and promotion of child welfare, as a principle of fundamental justice under section 7, in a manner similar to the rights claimants. However, no international human rights sources were cited in relation to section 15 of the

[382] *Auton,* Factums of the AG BC, AG Can, AG Nfld and Lab, AG NS, AG NB, AG PEI, AG Que, AG Ont, and AG Alta.

Charter. The claimants also relied on the *Baker* decision for the principle of the paramountcy of best interests in decisions affecting children.[383]

The factum filed on behalf of both the Canadian Association for Community Living (CACL) and the Council of Canadians with Disability (CCD) cited a number of relevant international sources. In addition to Article 12 of the *ICESCR,* they cited three declarations of the General Assembly, but made no distinction between binding and non-binding sources of international jurisprudence. They suggested that based on these international obligations, any justification of a limitation on equality rights under section 1 was subject to a "high standard of justification" but failed to cite any specific authority to that effect. Instead of relying on the presumption of conformity enunciated in *Slaight,* they cited the weaker formulation in *Baker,* that international human rights obligations are "relevant and persuasive" and part of the context in *Charter* interpretation.[384]

5.5.4 Decision in *Auton*

Madam Chief Justice McLachlin, speaking for a unanimous Court, overturned the decision under appeal in finding that "what the public health system provides is a matter for Parliament and the legislature."[385] In relation to the government obligation with respect to health, McLachlin CJ makes no reference to the international sources cited by the rights claimants and non-government interveners. The Court also fails to engage in any meaningful way with section 7, finding that the evidence and submissions do not

[383] For a discussion of *Baker*, see Part 4.8.

[384] *Auton*, Factum of CACL and CCD at 35.

[385] *Auton*, *supra* at note 341 at 2.

support the claim. While the Court's limited reasoning in relation to section 7 deals exclusively with the principles of fundamental justice, given the evidence of the psychological impacts of the deprivation of treatment on children with autism, an infringement of the "security of the person" appears to have been likely. In its treatment of the principles of fundamental justice, the Court fails to address whether Canada's compliance with the "highest attainable standard of health," as a binding international human rights obligations under the *CRC* and the *ICESCR,* could be considered as one of those principles. Such analysis would then have required an analysis of the international health rights jurisprudence in relation to children's health.

In relation to section 15, the Court received no submissions on the applicable international health rights law. Based on its technical section 15 analysis, the focus was not on access to health services, but rather differences in treatment. The Court's choice of comparator group resulted in the conclusion that that no one had access to the type of treatment the claimants were looking for. The government obligation was restricted to services "authorised by law" in a non discriminatory manner.[386] In referring to "law," McLachlin CJ restricts herself to legislation. She concludes that autism treatment was not a benefit authorised by law, in this case the relevant BC health services legislation and the *Canada Health Act.* The phrase "authorised by law" effectively immunises non-legislative government action from any meaningful human rights review. In the context of publicly insured healthcare services, this leaves little room for judicial review of government action to fund, or not to fund, a particular health care service.

[386] *Auton*, *ibid* at 3.

In addition, the Court found that disability was not the basis of the government exclusion. It distinguished *Eldridge* on the basis that the claimants were not seeking to extend the definition of "medically necessary" to new treatments, but to obtain equal access to health services available to all.

5.5.5 Limitations of the decision

The failure to fully address the section 7 claim in the context of the case resulted in a restricted analysis, from the point of view of access to health care. Based on earlier caselaw, the child claimants certainly had a strong argument with respect to the violation of their section 7 right to "security of the person." In terms of the principles of fundamental justice, the Court missed an important opportunity to engage with the substantive obligations on government to take into account the irreversible effects of a deprivation of access to healthcare on children, based on international law sources.

In terms of section 15, Canada's international human rights obligations include obligations that are of immediate effect and not subject to progressive realisation, in particular the provisions for the "healthy development of the child" and the "creation of conditions" that will ensure medical services to all.[387] Under the *CRC*, Canada has committed to "pursue full implementation" of the child's right to "necessary medical

[387] *ICESCR*, *supra* note 16, Art 12 (a) (d).

assistance and health care." Strangely, in terms of children with disabilities, the language in the *CRC* is considerably weaker, directed at state "recognition:"

> 2. States Parties recognize the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child.[388]

Non-discrimination in access to health services is considered a core obligation and subject to immediate rather than progressive realisation.[389] In a similar fashion, in addition to protecting the child's right to life, Canada is obligated to "ensure to the maximum extent possible the survival and *development* of the child."[390] Child development is considered to be closely aligned with children's health rights under the *CRC.*[391]

As a principle of interpretation, courts elsewhere have found that delays or barriers in accessing health services are discriminatory, based on the restricted time span in which health interventions may be effective in the development of the child.[392] For example, in Brazil, where the health right obligations with respect to children contained in the *ICESCR* and *CRC* obligations have been directly incorporated into the Constitution, courts have ruled that children are entitled to priority in the exercise of the right to health,

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[388] *CRC*, *supra* note 52, Art 23(2).

[389] *ICESCR, supra* note 16, Art 12, Art 2.2 GC 14 GC 20.

[390] *CRC, supra* note 52, Art 6; see also child's health rights at *CRC* Art 24.

[391] Nolan, Aoife, "The child's right to health and the courts" in Harrington and Stuttaford eds, *Global Health and Human Rights* (Routledge, NY, 2010) at 141.

[392] Piovesan, Flavia "Impact and Challenges of Social Rights in the Courts," in Langford ed, *Social Rights Jurisprudence*, *supra* 21, at 187.

based on the principle that "childhood cannot wait." Several Brazilian courts have held that waiting lists for children are a *prima facie* violation of children's right to health.[393] Thus, the Brazilian courts' interpretation of health rights, based on international human rights jurisprudence, bears little resemblance to the reasoning of Canadian courts in addressing similar issues of discrimination with respect to children and their timely access to healthcare. Canadian courts have yet to engage with the immediacy of children's needs in relation to their interpretation of *Charter* protections although there seems no reason in principle why they should not carry equal weight in Canadian courts.

Part of the reason why international jurisprudence is less often cited in relation to section 15, is that the Canadian jurisprudence in relation to section 15 is largely consistent with the international non-discrimination jurisprudence. Canada is committed to the immediate realisation of the right of non-discrimination in the provision of health services.[394] Canada's international obligations include both direct and indirect or adverse effect discrimination.[395] Despite the outcome in *Auton,* both the Court's approach to equality rights under section 15, and the international jurisprudence have rejected the formal approach to equality rights (also known as the "similarly situated" test) in favour of a broad effects based approach.[396]

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[393] Piovesan*, ibid* at 187; see also Aoife Nolan, "The child's right to health and the courts" *supra* note 391, at 146.

[394] *ICESCR, supra* note 16, Art 2 and 12

[395] United Nations, CESCR, GC 20, *supra* note 71, para 10.

[396] United Nations, CESCR GC 20 *ibid* para 8

The approach taken in *Auton* has been criticised for undermining an indirect or adverse effect approach to discrimination in its interpretation of section 15 of the *Charter.* Reference to international jurisprudence, in particular the CESCR's general comment 20, could have strengthened the section 15 argument based on substantive discrimination, especially as it impacts children. The Court has recently abandoned the requirement of a comparator group that "mirrors" the characteristics of the claimants.[397] However, just as the original doctrine as expressed in *Auton* ignored international jurisprudence, the Court's change in direction in relation to section 15 was taken without express reference in the reasons for judgment to international sources.[398] It would appear that the Court is determined to go it alone, in breach of both Canadian and international law, in its approach to the interpretation of section 15 and non-discrimination in the *Charter.*

5.6 *Chaoulli v Quebec*: Access to private health insurance

5.6.1 Background

In *Chaoulli v Quebec,* the claimants, Jacques Chaoulli, a Quebec doctor, and Jacques Zeliotis, an individual who claimed he had been subject to unreasonable delays in obtaining health care in the public system, challenged the provincial legislative ban on private health insurance in Quebec. Although the courts below held the legislative restriction was an infringement of the claimants section 7 right to security of the person, and contrary to the principles of fundamental justice, they held the violation was justified

[397] *Withler v Canada, supra* note 164 at para 40.

[398] *Withler, ibid.*

given the "pressing and substantial objective" of protecting the publicly insured health care system.

The Supreme Court of Canada was divided on whether Quebec legislation limiting private health insurance was consistent with section 7 of the *Canadian Charter*, and whether the rights infringement under the Quebec *Charter* was justified. By a bare majority, the Court ruled the legislation was inconsistent with the Quebec *Charter*.[399] In an influential minority judgment on the alleged violation under section 7 of the *Charter*, Chief Justice McLachlin expressed the view, reminiscent of her decision in *Auton,* that there is no "freestanding right to health care" in Canada:

> The *Charter* does not confer a freestanding constitutional right to health care. However, where the government puts in place a scheme to provide health care, that scheme must comply with the *Charter*.[400]

The lack of consensus within the Court, and the ultimate rejection of the *Charter* as a basis for the decision by the majority, leaves the reasoning in relation to the *Charter* as *obiter.*

5.6.2 Submissions on behalf of Chaoulli and Zeliotis

Chaoulli cites numerous international sources in his factum to the Supreme Court of Canada in relation to the interpretation of the "principles of fundamental justice" in section 7, including:

- *ICESCR* Article 9 (social security)

[399] *Charter of Human Rights and Freedoms*, R.S.Q., c. C-12, preamble, s 1.

[400] *Chaoulli*, *supra* note 183, para 104; this statement is one of the most often quoted and influential *obiter* in recent s 7 jurisprudence, especially given that Chaoulli was decided on non Canadian *Charter* grounds.

- *ICESCR* Article 12 (highest attainable standard of health),
- CESCR General Comment 14 concerning Article 12
- CESCR General Comment 3 regarding the "state obligation"
- Reports submitted by Canada concerning implementation of the *ICESCR*
- Two decisions of the Human Rights Committee (the treaty monitoring body) under the *ICCPR.*[401]

The Appellant's reference to these authorities is made in the absence of any discussion of the reception and implementation of international human rights law in Canada, and fails to address any interpretive principles, or make any distinction between binding and non-binding sources. The omission of any discussion of an interpretive framework or principles means that the reference to international sources of law appears as an afterthought, in the absence of any real argument.

Chaoulli relied upon Article 12 and the CESCR General Comment 14 with respect to the "highest attainable standard of health" in arguing that the "monopole d'Etat" (state monopoly) on health care services violates these international obligations.[402] The submissions lacked a framework and analysis.

5.6.3 Submissions of the respondents

Of the Respondents, the Attorney General (AG) of Canada, responded to Chaoulli's international human rights arguments, but the AG of Quebec did not. The AG of Canada replied to Chaoulli's reference to Article 9 (social security) of the *ICESCR,* by arguing that the provision is not applicable because it is limited to income supports in the event of

[401] *Chaoulli*, Factum of Jacques Chaoulli at 189.

[402] *Chaoulli*, Factum of Jacques Chaoulli *ibid*.

illness. However, no authority was cited for their position. In interpreting health rights in Article 12 of the *ICESCR*, the AG of Canada relied on the CESCR General Comment 14 saying:

> the values underlying the second provision (Article 12), namely access to health care services regardless of ability to pay and protection of vulnerable groups, are consistent with the values underlying the Canadian health care system.[403]

The AG of Canada simultaneously reject the Appellants' reliance on resolutions of the UN Commission on Human Rights, based on arguments that they are "non-binding." This position at least demonstrates an awareness of the distinction between binding and non-binding sources of international law. More generally, perhaps invoking the Court's reasoning in *Baker,* the AG of Canada argued that "the values underlying the Canadian health care system" were consistent with international health rights in protecting access to health care services regardless of ability to pay, and by vulnerable groups.[404] However, in the argument concerning common "values," the AG suggested that states are not required to "include…rules" arising from Canada's international treaty obligations:

> International law, which in any event does not require states to include in their constitutional legislation the rules arising therefrom, is of no benefit to the claims made by appellant Chaoulli.[405]

While technically correct, this argument fails to address the Court's interpretive principles, which aims at achieving conformity between binding treaty obligations and "constitutional legislation" in the form of the *Charter.* The AG also relies on Article 2 of

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[403] *Chaoulli,* Respondent AG Can Factum, para at 39.

[404] *Chaoulli,* Respondent AG Can Factum, at para 38-41.

[405] *Chaoulli,* Respondent AG Can Factum at 41.

the *ICESCR,* in support of its position that international law does not require legislative implementation, without referencing interpretation principles.

The AG of Canada also made extensive reference to World Health Organisation reports that challenge the efficacy and equity of private health care systems and "market oriented approaches" but argued in favour of deference to the legislature and the wisdom of Parliament in addressing complex social problems, characterising the case involving political choices.[406] However, the AG failed to distinguish the non-binding nature of these international sources. The argument also skirts the most important interpretive principle enunciated by the Court, that the Canadian constitution should be construed to confer human rights protections at least as great as those contained in Canada's international treaty obligations.[407]

The failure to articulate a clear framework of analysis for the relevance of the international jurisprudence undermined the arguments put forward by both the appellants and the respondents, and may have contributed to the Court's failure to take up the interpretive challenge presented by the international jurisprudence.

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[406] *Chaoulli*, Respondent AG Can Factum at 54-56.

[407] See *Divito*, *supra* note 68, as cited in *SFL supra* note 58, para 64; and at para. 23, "the *Charter* should be presumed to provide at least as great a level of protection as is found in the international human rights documents that Canada has ratified".

5.6.4 Submissions of the interveners

None of the remaining provincial governments who intervened in the case made reference to the international human rights arguments put forwarded by the Appellant Chaoulli.[408]

The *Charter* Committee on Poverty Issues (CCPI), in defending the constitutionality of the legislative restrictions on private health insurance, cited a number of international sources. More importantly, it cited the relevant interpretive principles in advocating for "access to health care without financial barriers" based on Canada's international human rights obligations.[409] The submissions failed to distinguish between non-binding (General Comments in relation to the *ICESCR*) and binding (*ICESCR* 12(1) (2)(d) "creation of conditions") sources. The CCPI cited the CESCR General Comment 14 regarding health rights, including the determinants of health, a functioning public health service, and the obligation to provide for healthcare without discrimination based on "social origin, birth, property or other status."[410] The submissions also referred to the reports of the treaty monitoring body on Canada, as well as Canada's own reports.

[408] See *Chaoulli,* Factums filed on behalf of BC, Saskatchewan, Ontario.

[409] *Chaoulli,* CCPI factum, at 31.

[410] *Chaoulli,* CCPI factum, at 35

The CCPI argued that Canada, with the agreement of Quebec, having ratified the *ICESCR* and other human rights instruments, had recognized access to health care as a fundamental human right and not simply a governmental "policy objective". As a result CCPI argued that both levels of government were obligated under the *ICESCR* to promote an interpretation of domestic law that ensured appropriate remedies for violations of the right to health. CCPI also argued that the impugned legislative provisions were a critical component of Canada and Québec's joint obligations under the *ICESCR* to ensure the equal enjoyment of the right to health without discrimination, and to adopt necessary legislative measures to guard against threats to equality of access posed by privatization, such as the introduction of private health insurance.[411]

5.6.5 Decision in *Chaoulli*

In three separate sets of reasons, seven members of the Supreme Court, including the dissenting judgement, ignored the submissions concerning international health rights in their interpretation of the Quebec and Canadian *Charter*. This is another decision, where health interests lay at the core of the *Charter* claim, yet similar to *Eldridge* and *Auton*, the Court ignored the interpretive significance of international health rights, and the relevant submissions of the parties.

The Supreme Court of Canada's failure to address Canada's international human rights treaty obligations can be contrasted with Justice Piche's decision at trial, in which she referenced the 1978 Alma-Alta Declaration and a WHO report by way of expert evidence concerning health system reform. Under "authorities cited by Jacques Chaoulli" the

[411] *Chaoulli,* CCPI factum, at 52, 53.

trial decision refers to the *ICCPR* and "multilateral treaties to which Canada is a party."[412] With respect to the scope of section 7 and whether it included economic rights, Justice Piche quoted Dickson's decision in *Irwin Toy* with respect to the significance of Canada's international social rights obligations in interpreting the interests protected under section 7.

In the Supreme Court of Canada, the Justices were divided on whether the legislative restriction on private health insurance violated section 7 of the *Charter.* Ultimately, the case was decided on the basis of the Quebec *Charter*, pursuant to Justice Dechamps reasons, with Chief Justice McLachlin and Justice Major joining in the result. After the appellants failed to show a violation of the principles of fundamental justice both at trial and on appeal, the Supreme Court of Canada granted them an order striking down Quebec's legislative restrictions on the purchase of private health insurance based on a violation of the right to security of the person under Article 1 of the Quebec *Charter*, that was not justified under Article 9.1, based on a finding that the evidence that a two tier system could exacerbate wait times in the public system was inconclusive.[413] In addressing the evidence and submissions concerning the remedial impact on those unable to afford or ineligible for private healthcare insurance - the elderly, the chronically ill, and the poor - the Court also ignored Canada's international obligations concerning non-discrimination in access to health care services.

[412] *Chaoulli v Quebec* [2000] RJQ 786 at 64, 65, 207,

[413] *Chaoulli v Quebec*, SCC, *supra* note 183, para 84.

The issues under section 7 of the *Canadian Charter*, are dealt with in two separate sets of reasons. Chief Justice McLachlin and Justice Major posed the issue whether delays caused by wait lists in the public healthcare system violate section 7, whereas Justice LeBel (speaking for himself and two others) characterised the issue as what is constitutionally required for "reasonable health services" under section 7, referencing the Court's earlier decision in *Auton*.[414] Both judgements agreed that some Quebeckers may find their life and security of the person are placed at risk as a result of being deprived of the right to purchase private insurance.[415]

In what has become one of the most quoted passages from *Chaoulli,* found in an *obiter* passage in a minority opinion, Chief Justice McLachlin stated "The *Charter* does not confer a freestanding constitutional right to healthcare. However, where the government puts in place a scheme to provide health care, that scheme must comply with the *Charter*."[416] In her reasons concerning arbitrariness as a principle of fundamental justice, however, she makes no reference to Canada's international health rights obligations in her interpretation of section 7 of the *Charter*. Similarly, LeBel finds that the test for arbitrariness -- a law be proven to be inconsistent with its objectives – was not met on the evidence.[417] He finds that the 'social consensus' regarding what constitutes 'reasonable

[414] *Chaoulli,* SCC, *ibid* para 163.

[415] *Chaoulli,* SCC, *ibid* para 191.

[416] *Chaoulli,* SCC, *ibid* para 104.

[417] *Chaoulli*, SCC, *ibid* para 264.

health services' is absent, and thus fails to meet the test as a principle of fundamental justice.[418]

5.6.6 Limitations of the decision

In the various opinions contained in *Chaoulli,* the Court failed to explore both the substance of Canada's international health rights obligations, as well as the principles governing their application to *Charter* interpretation. In her decision, Chief Justice McLachlin rejects a "freestanding" right to healthcare in Canada, in her interpretation of the principles of fundamental justice under section 7, thus limiting the scope for judicial review based on the *Charter* to government action – namely the "scheme to provide healthcare" – rather than inaction. In effect, the Chief Justice is saying that the *Charter* protects an individual against the state by ensuring that a government 'scheme' or system does not offend *Charter* rights. However, in the face of government inaction, or failure to provide a health care program, according to McLachlin CJ's reasons, there could be no violation of the principles of fundamental justice under section 7 of the *Charter.* In embracing an exclusively negative rights framework of analysis under the principles of fundamental justice, *Chaoulli* exemplifies the risk presented by judicial review of publicly funded programs in the face of individual human rights claims, in the absence of explicit legislative protection for social and economic rights.

In ignoring the international jurisprudence, McLachlin CJ's reasons in *Chaoulli* leave many questions unanswered concerning the interplay between section 7 and health rights.

[418] *Chaoulli,* SCC, *ibid* para 209.

Canada's obligations under Article 12 of the *ICESCR* include "the creation of conditions which would assure to all medical service and medical attention in the event of sickness."[419] This binding treaty obligation would have had direct ramifications next to the evidence concerning the negative impacts on Medicare on parallel private health insurance. In a similar vein, access to health care has been interpreted to include a requirement of availability, acceptability and affordability, for *everyone*.[420] Similarly the *Convention on the Rights of the Child* protects the right to the provision of medical assistance and health care to all children, with an emphasis on the development of primary health care.[421] With respect to women's rights, *CEDAW* states that state parties "shall ensure" "appropriate services" in relation to pregnancy and child-birth.[422] With respect to persons with disabilities, their rights include health services specifically designed to identify, minimise and prevent further disabilities.[423] In interpreting Article 12 of the *ICESCR*, the CESCR has commented that it does not guarantee any particular model of health care delivery, whether private or public, yet the right to the "highest attainable standard of health" guarantees accessibility to health facilities, goods and services:

> States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities.[424]

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[419] *ICESCR*, *supra* note 16, Art 12.1(d).

[420] United Nations, CESCR, *General* Comment 14, *supra* note 25, at 12(b)

[421] See *CRC*, *supra* note 52, Art 24.

[422] See *CEDAW*, *supra* note 56, Art 12.

[423] See *CRPD, supra* note 56, Art 25.

[424] United Nations, CESCR, *General Comment 14 (2000), supra* note 25, para 19.

Accessibility has been interpreted to include economic accessibility. Economic accessibility suggests that health facilities, goods and services must be affordable:

> Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households.[425]

While there is no obligation on Canada to incorporate its international human rights obligations in the Constitution, the government of Canada has repeatedly pointed to the *Charter* as one of the main ways in which it implements its international human rights obligations. Given the close relationship between Article 12 and the issue of what constitutes reasonable access to health care services in *Chaoulli,* it is unfortunate that the various members of the Court who gave reasons concerning section 7, including McLachlin CJ and LeBel J, failed to situate their analysis of the right to life and 'security of the person" within the scope of Canada's obligations under the *ICESCR*. The same could be said of Dechamps J's judgement, in relation to Article 9.1 of the Quebec *Charter*, accepting the government's justification for the infringement of rights.

Chief Justice McLachlin's claim that her approach in *Chaoulli* follows the earlier decision in *Morgentaler v R* is revealing.[426] In *Morgentaler,* the issue was whether the criminal liability imposed on individual women in accessing abortion services was a violation of the principles of fundamental justice. It said nothing about the scope of publicly insured health care services. Thus, the functioning of the publicly insured health

[425] United Nations, CESCR, *General Comment 14 (2000), ibid* para 12(b)(iii).

[426] *Morgentaler, supra* note 177.

care system was not in issue as the case was framed in *Morgentaler,* but was at the forefront in *Chaoulli.* It can be argued that in removing criminal sanctions that operate as a barrier to health care services, cases like *Morgentaler* and *Carter* are consistent with international health rights jurisprudence, whereas given the findings of the trial judge that access to private insurance could undermine the public system, the outcome in *Chaoulli* represents a departure from the international jurisprudence.[427]

What protection exists for public or private health insurance in the international jurisprudence? The short answer is that there is no direct protection. However, while states are entitled to deference in their choice of what constitutes 'appropriate means' for implementing their human rights treaty obligations, the result must achieve accessibility, availability, affordability, and access for children, women and persons with disabilities, among others. Based on the evidence in *Chaoulli,* it could be argued a restriction on private health insurance was an "appropriate means" to safeguard accessibility for vulnerable persons.

The international health rights law also has significance for the interpretation of section 1. The negative impact on the publicly insured health system of permitting parallel private health care insurance in Quebec was highly contested. Insofar as it undermines access to health care services, such as result would run counter to Canada's international treaty obligations. A review of the international jurisprudence with respect to "accessibility" would have broadened the Court's analysis of the test for justification under section 1 of

[427] *Morgentaler, ibid; Carter v Canada, supra* note 216.

the *Charter*, specifically whether the objective of supporting the accessibility of the publicly insured health care system was pressing and substantial, and rationally connected to the restriction on private health insurance, and whether it met the proportionality test, in that the deleterious consequence were outweighed by the benefits of such a restriction. Elsewhere, the Court has considered international human rights sources in interpreting the "principles of fundamental justice" as well as the government objectives at the justification stage under a section 1 analysis.[428]

It has been argued that the outcome in *Chaoulli* undermines the domestic implementation of Canada's international health rights obligations, both in terms of health rights and non-discrimination:

> The conception of the right to health care put forward by the majority in *Chaoulli* is clearly a negative rather than a positive one, one that falls far short of Canada's obligations under the ICESCR to guarantee 'to the maximum of its available resources' the right of everyone to the highest attainable standard of health, including access to medical service without discrimination based on "social origin, poverty, birth or other status. [429]

Since the *Chaoulli* decision, as this review will show, other courts, including the Court itself, have largely embraced the negative rights approach to section 7 of the *Charter* articulated by McLachlin CJ in her dissenting reasons in *Chaoulli*.

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[428] See *Canadian Foundation*, *supra* note 286; and *Slaight, supra* note 301.

[429] Jackman, Martha, "*Charter* Remedies for Socio-economic Rights Violations: Sleeping Under a Box?" retrieved at http://ssrn.com/abstract=2006574, at 288.

5.7 *PHS Community Services Society v British Columbia [Insite]*: removing legal barriers to healthcare services

5.7.1 Background

Following a decision by the government British Columbia to approve and fund a supervised injection site in Vancouver, known as "Insite," the health facility was granted an exemption under the *Controlled Drugs and Substances Act (CDSA)* to permit it to operate without risk of criminal prosecution for possession or trafficking in narcotics. Based on a "harm reduction" model of preventive health care, the evidence showed that the Insite medical clinic had been highly successful in reducing mortality caused by drug overdose and, over time, in reducing addicts' dependence on drugs. However, in 2006, the federal Minister in charge refused to grant a renewal of the exemption from criminal prosecution, effectively meaning that the facility could no longer operate. In response, the PHS Society, in charge of operating the Insite medical clinic, challenged the constitutionality of the criminal provisions, both on jurisdictional and *Charter* grounds, claiming that the legislative criminal sanctions on workers and users operated in such a way as to prevent access to healthcare services. They were successful first at trial and then on appeal in the BC Court of Appeal, based on the concept of "interjurisdictional immunity," which created a protected zone in which the province could operate within its exclusive jurisdiction over health, without risk of federally imposed criminal sanction.

The Supreme Court of Canada agreed with the result, but disagreed with the reasoning based on interjurisdictional immunity. It substituted its own reasons. While the Court avoided finding that the criminal sanctions contained in the legislation violated the

Charter, it held that the Ministerial refusal to grant an exemption violated the claimants' rights under section 7. The decision has been identified as defending access to publicly insured healthcare services in Canada, but the positive rights assertion embodied in the decision appears tenuous, given that the BC government supported the health care programming offered by Insite, and that it was exclusively the threat of criminal sanction that stood in the way of such programs. The Minister was in effect ordered to "get out of the way" of people's access to a health care program that was otherwise available. In addition, the *Insite* decision has not resulted in more supervised injection health facilities in Canada: despite the extensive litigation defending the program, in 2016 the Vancouver program remains the only example of this type of healthcare facility in Canada.[430]

5.7.2 Submissions of the parties

In *PHS v BC*, the Appellant Health Service and health providers made no reference to Canada's international human rights obligations in their factums even though they argued that the *CDHA* legislation violated the claimants' right to life and security of the person in effectively denying them access to necessary health care services.[431]

Neither the Respondent Attorney General of Canada, nor the Respondent Attorney General of BC (whose submissions were limited to supporting British Columbia's

[430] Voell, MR, "PHS Community Services v Canada (AG): Positive Health Rights, Health Care Policy and Section 7 of the *Charter*" [2011] Windsor Rev of Leg and Soc Iss 41 at 55.

[431] *PHS v BC*, Appellants Factum; however at paragraph 115 they dispute the argument, dismissed by the OCA in *supra* note 178, that drug possession laws are justified under s 1 because they support Canada's compliance with its international treaty obligations to control the trafficking of illicit drugs.

jurisdiction under the doctrine of interjurisdictional immunity) refer to Canada's international human rights obligations, although the federal government referenced its international treaty obligations to eliminate drug trafficking, in defending the legislation under section 1. In a case involving access to health care, these represent significant omissions.

5.7.3 Submissions of the interveners

Of the nine interveners in the case, two made substantial submissions based on international jurisprudence. [432] The Canadian HIV/Aids Legal Network, the International Harm Reduction Association, and Cactus Montreal, filed a joint submission that made extensive reference to international law in relation to arguments that the law was arbitrary and thus contrary to principles of fundamental justice under section 7.[433] In terms of a framework of analysis for the application of the international jurisprudence, they relied on the softer "relevant and persuasive" test, in interpreting section 7 of the *Charter*.[434] In the context of the federal government's decision to withhold a renewal of the statutory exemption, they specifically relied upon the presumption against regressive measures by

[432] The interveners were: AG Que, BCCLA, BC Nurses Union, CCLA, CMA, Canadian Public Health Association, Peter Aids Foundation, Vancouver Coastal Health Authority, Real Women; of these only the BC Nurses Union and the Canadian HIV Aids *et al* submissions referenced international human rights sources, although Real Women supported the governments reference to its international treaty obligations with respect to the prevention of drug trafficking.

[433] See Canadian HIV/AIDS et al, Factum, para 17-25; The treaties cited included the UDHR Article 25(1), ICESCR, Article 12, CEDAW Article 12 (1) (women's health rights), and the CRC Article 24 (children's health rights), as well as the Constitution of the World Health Organisation.

[434] Canadian HIV/Aids, at para 18, 21; sources include human rights treaties, as well as the UDHR and WHO Constitution, as well as reports of the special rapporteur, general comments of the CESCR and a press release from the OHCHR as well as reports from the WHO with respect to HIV/AIDS policy and the need to support access to harm reduction services.

government, based on general comment 14 in relation to access to healthcare. [435] They also cited Article 12 of the *ICESCR* in support of the inclusion of 'harm reduction services' as part of access to health care service, specifically in the "prevention, treatment and control of disease" as well as the "creation of conditions which would ensure access to…medical services and medical attention." The UN General Assembly's declarations in 2001 and 2006 concerning HIV/AIDs were also cited, specifically in relation to support for harm reduction services, as were the World Health Organisations reports on HIV/AIDS, the report of the Special Rapporteur on the Right to Health, the Committee on Economic, Social and Cultural Rights concluding observations on the Ukraine, and a press release from the UN Office of the High Commissioner on Human Rights, all to similar effect. While the submissions identify highly relevant and persuasive sources, they make no distinction between binding obligations contained in treaties Canada has ratified, and press releases from the High Commissioner on Human Rights, in terms of their weight or legal significance. An approach that fails to distinguish between binding and non-binding sources runs the risk of undermining the impact of international sources.

The BC Nurses' Union relied upon the *ICESCR* in arguing that the *CDSA* interferes with the fulfillment of Canada's international obligations with respect to health in restricting access to healthcare services.[436] In their submissions, they argued that the restriction is arbitrary as it fails to protect the life and health of vulnerable people.

[435] Canadian HIV/Aids, at 23 citing CESCR General Comment 14 at 33.

[436] BCNU Factum at para 6, 22, 23 citing ICESCR Art 12.1 (c), (d).

5.7.4 Decision in *Insite*

The parties and interveners framed their submissions primarily around the constitutionality of the *CDSA* legislation.[437] However, in a unanimous decision, McLachlin CJ held that it was the Minister's refusal to grant an exemption under the *CDSA* legislation, not the legislation itself, that resulted in the *Charter* breach, thus deciding the case on an issue not raised in the pleadings or factums filed by the parties.

The Court held that the failure to grant an exemption in exposing workers and clients to the risk of criminal sanctions impinged on access to health care services and thus infringed the right to life and security of the person. The effect of the refusal was found to be arbitrary, as it undermined the objective of the *CDSA*, of protecting public health and safety, and the negative effects were grossly disproportionate to any potential benefit. As a result, the Court held that the refusal to grant an exemption was contrary to the principles of fundamental justice. [438] Given these findings, the Court ruled that a section 1 analysis was unnecessary.[439]

The Court made no reference to the international law contained in the submissions of the two interveners. One is left to speculate as to the reasons for the omission, but the failure again reflects an understanding that the case was less about government's responsibility

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[437] *PHS v BC supra* note 4, at 36; see also Factums filed on behalf of the parties and the interveners, none of which address the issue of the Minister's discretion in granting a statutory exemption.

[438] *PHS v BC*, *supra* note 4, at 136.

[439] *PHS v BC*, *ibid* at 15 and 20.

to support access to health care, and more about removing government restrictions on people's ability to provide for their own health. While Insite happened to be provincially government funded, the Court's reasoning could just have easily applied to a private health care facility reserved for the very wealthy, and really says little or nothing about accessibility, affordability or availability of health care services.

5.7.5 Limitations of the decision

Given the lengthy submissions with respect to international sources that demonstrate the arbitrariness of the government action and their relevance to the BC government's objective in providing a supervised injection site, it is surprising that the Court fails to include any international references. As cited by the Canadian HIV/AIDs Legal Network, under Article 12 of the *ICESCR,* one of Canada's health rights obligations is to provide for "the prevention, treatment and control of epidemic, endemic, occupational and other diseases."[440] As a binding treaty obligation, the interveners argued that it was a relevant and persuasive factor in interpreting the principles of fundamental justice. The submissions on this point would have been strengthened by additional references to jurisprudence from the CESCR, which has interpreted health prevention as a core obligation, meaning that it is "immediately realisable." The CESCR has included within the right "the establishment of prevention and education programmes for behaviour-related health concerns" and indicated that addictions are included within that category.[441]

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[440] *ICESCR*, *supra* note 16, Art 12.2(c).

[441] United Nations, CESCR, GC 14, *supra* note 25 at 16.

Ironically, five years earlier in responding to a question from the CESCR concerning government programs specifically targeted to improve homeless persons' access to health care, Canada relied upon the supervised injection program in BC as evidence that it was fulfilling its health rights obligations under the *ICESCR*.[442]

5.8 *Gosselin v Quebec*: social determinants of health

5.8.1 Background

While *Gosselin* is not often included in the category of health rights cases, the negative health consequences of government action in reducing social assistance lie at its core. In 1986, Quebec reduced social assistance benefits by 30 per cent to recipients under the age of thirty. To qualify for full benefits, under thirty year olds were required to enrol in a work placement program. However, insufficient work placements were available. There is ample evidence in this case that the legislated exclusion of young adults from the full benefits of the social assistance regime substantially interfered with their interests protected by section 7, in particular their right to "security of the person." Welfare recipients under the age of thirty were allowed $170/month. The various remedial programs put in place in 1984 simply did not work: a startling 88.8 percent of the young adults who were eligible to participate in the programs were unable to increase their benefits to the level payable to adults aged 30 and over. In these conditions, the physical

[442] Canada, 2006 Report to the CESCR, *supra* note 89.

and psychological security of young adults was severely compromised during the period at issue. [443]

On behalf of those affected by cuts to social assistance, Louise Gosselin brought a court application alleging that the social assistance provision violated s 15, based on age discrimination, as well as her right to security of the person under section 7 of the *Charter* and her right to an "acceptable standard of living" under section 45 of the Quebec *Charter*, which provides that:

> Every person in need has a right, for himself and his family, to measures of financial assistance and to social measures provided for by law, susceptible of ensuring such person an acceptable standard of living.

Gosselin introduced evidence demonstrating the negative health consequences resulting from the "dismal living conditions" that undermine the health of those living in poverty.[444] Medical experts testified that the poor not only have more health problems but also are more severely affected by ill health.[445] Expert evidence linked malnourishment and undernourishment, as well as inadequate housing, access to housing, food, clothing, electricity and hot water to negative health outcomes among the poor.[446] Particularly vulnerable to health problems were expectant mothers and children.[447] In addition to physical health problems, expert medical evidence established that depression, suicide, anxiety and other mental health problems were particularly evidence among poor

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[443] *Gosselin, supra* note 346, Arbour J at 272; elsewhere L'Heureux-Dube J describes this as a breach of Gosselin's "physical and psychological integrity" at 130.

[444] *Gosselin*, *ibid* at 373.

[445] *Gosselin*, *ibid* at 373.

[446] *Gosselin, ibid* at 373-4.

[447] *Gosselin, ibid* at 374.

First Nations youth as well as the homeless.[448] The Appellant's evidence demonstrated the inadequacy of the government social assistance program through its negative impact on the health of recipients. By ensuring that housing, electricity, food and clothing were inaccessible or unaffordable, she argued that the negative impact of the cuts to social assistance on health, undermined her "security of the person" under section 7 of the *Charter*.

5.8.2 Submissions of the parties

International human rights figured importantly in the appellant's factum, and were addressed in the response filed by the Attorney General of Quebec. The Supreme Court of Canada also received factums from several interveners who also relied heavily on international human rights sources and authorities.

The Appellant relied on international human rights treaties in interpreting both section 45 of the *Quebec Charter*, and section 7 of the *Canadian Charter*, arguing that both protected the right to an adequate standard of living and social security by reliance on Article 11 and Article 9 of the *ICESCR*. Gosselin argued that both *Charters* should be interpreted in conformity with Canada's international obligations.[449] In particular, she relied upon the state's obligation to provide effective remedies for rights violations, arguing for an interpretation of the Quebec *Charter* that results in an enforceable right, rather than an aspirational goal.

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[448] *Gosselin*, *ibid* at 376.

[449] Gosselin, Appellant's Factum, at 51-52, 161, 176, 183.

The Attorney General of Quebec, in referring to the international jurisprudence, correctly identified that its legal value was derived from its role as an interpretive tool, not as a enforceable legal obligation. However, in relation to section 7 of the *Charter*, they argued that social security is not a constitutional right in Canada, and that there is no obligation in international law that the right be "constitutionalised."[450] In providing a scheme of social assistance, the Quebec government claimed it had satisfied its international obligation under Article 9, to provide a system of social security. It suggested that the international jurisprudence, as it existed in 2001, should not be used to judge Quebec's social security schemes in 1987-89 but failed to explain the basis of this submission.[451] The Attorney General of Quebec noted that the state's obligation is one of "progressive realisation" ("assurer progressivement") of the rights contained in the *ICESCR,* but fail to explain the significance of this to the case.[452]

5.8.3 Intervener submissions

The Ontario Attorney General, an intervener, responded to the arguments based on international human rights as follows:

> The international sources and other interpretative aids cited by the interveners merely emphasize the non-justiciability of government obligations to relieve poverty. Assisting Canadians in poverty to meet their basic needs is an important political and social responsibility, but it is not a constitutional obligation.

[450] *Gosselin,* Respondents Factum at 225,226.

[451] *Gosselin,* Respondents Factum at 228.

[452] *Gosselin*, Respondents Factum at 227.

Ontario argued that the courts should not intervene because "the definition of poverty is fundamentally subjective" and that the problem is "highly complex and multi-faceted.[453] Similarly, Ontario argued that section 7 does not contain a "justiciable" guarantee of an adequate standard of living.[454] In response to intervener submissions relying on the CESCR general comments, Ontario argued that "the Court should likewise reject the notion that the general commentaries of the CESCR could assist courts to establish minimum guaranteed income levels for Canadians under *Charter* section 7."[455]

The Attorney General of Alberta intervened to argue that while international documents "may be instructive in interpreting the *Charter*, such documents do not impose free standing obligations in Canada…because in Canada there is no federal treaty implementation power."[456] The argument is ingenuous, given that in successive reports to the UN treaty monitoring body, Canada has described a process that requires provincial review, prior to the decision by Ottawa to ratify an international human rights treaty.[457] Alberta submitted that "social assistance is a matter of economics and all courts…have decided that economic matters are not within section 7 of the *Charter."*[458]

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[453] *Gosselin*, AG Ont Factum at para 57.

[454] *Gosselin*, Transcript of oral submissions of Janet Minor on behalf of the Ontario AG at 97.

[455] *Gosselin*, Factum of the AG of Ont, para 55.

[456] *Gosselin*, AG Alta, at 28.

[457] See for instance Canada's most recent *Core Document*, 2013, *supra* note 219 at 121; "Prior to ratification of a human rights treaty, all jurisdictions in Canada review their legislation for consistency with the treaty. Where existing legislation and policies fulfill the obligations under the treaty, no new measures are required. On occasion, legislation may be amended or new laws enacted to ensure compliance with the treaty. After ratification, these issues are taken into account in drafting future legislation where relevant."

[458] *Gosselin*, Factum AG Alta, at 24.

In addressing the "interpretive presumption that legislative provisions should be consistent with international law" the submissions from Alberta failed to consider the significance of international sources in interpreting the *Charter*, instead concluding that there is no international requirement of a certain standard or absolute parity in social assistance benefits.[459] *Baker* was cited for the relevance of international law to the "values" and "contextual approach to statutory interpretation."[460] The argument then slid neatly into a comparative law analysis, that juxtaposed the laws of various foreign jurisdictions as to their constitutional and legislative social protections, in order to show that individual responsibility and requirements to work in order to qualify for welfare exist in places like Japan and New Zealand. In referring to foreign law, these arguments failed to draw any distinction between Canada's international treaty obligations and a comparative law approach to interpreting the Constitution.

In responding to the appellant's international human rights arguments, the Attorney General of BC stated that international human rights "legislation" may serve as an "interpretative aid," but only when it is not inconsistent with the Canadian constitution.[461] However, BC also argued that in the absence of explicit constitutional language protecting "economic rights," section 7 should not be interpreted to include "financial aid" in the form of social assistance. It distinguished Article 25 of the UDHR and Article 11.1 of the *ICESCR* from section 7 on that basis. BC argued deference to the legislature in matters affecting "social and economic policy" and cited social assistance as a "classic

[459] *Gosselin,* AG Alta, at 29-30.

[460] *Gosselin*, AG Alta, at 29.

[461] *Gosselin,* AG BC at 92-93.

example" of this type of policy, leaving no room for judicial review.[462] The argument leaves no scope for "interpretation" of general constitutional language in favour of social and economic rights guaranteed under international law.

The intervener factum of the National Association of Women and the Law (NAWL) cited the *Convention on the Elimination of Discrimination against Women*'s treatment of social and economic rights, the protection of women's autonomy and decisionmaking in relation to reproductive health, as well as access to proper nutrition during pregnancy. They also referred to the *ICESCR* protection in relation to access to food, shelter and clothing, Articles 11 and 12, as well as the right to health in Article 12 under the *ICESCR*.[463] In terms of interpreting section 15 of the *Charter*, the factum linked Canada's international treaty obligations to the importance of the interests affected. It argued that section 7 and section 15 are "expressions of Canada and Quebec's intention to give life to their international human rights obligations" and the "primary vehicle" through which international treaty obligations achieve "domestic effect."[464] It concluded that poverty affects the enjoyment of all other human rights.[465] In addition to the treaties themselves, it referenced opinions of the CESCR in monitoring Canada's compliance, with respect to the impact of poverty on women's vulnerability to domestic violence.[466]

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[462] *Gosselin,* AG BC at 31-32..

[463] *Gosselin,* NAWL Factum, para 56.

[464] *Gosselin*, NAWL Factum, para 57 and 65.

[465] *Gosselin*, NAWL Factum, para 58.

[466] *Gosselin,* NAWL Factum, para 64.

The submissions on behalf of the intervener the Center for International Rights and Democracy focused on the narrow issue of the justiciability of *ICESCR* rights. Based on international sources, the Center argued that the rights contained in the *ICCPR* and those in the *ICESCR* impose identical obligations on government.[467] Similarly, it contested the distinction between negative and positive rights put forward in the factum of the respondent Attorney General of Quebec.

The submissions on behalf of the intervener, *Charter* Committee on Poverty Issues (CCPI) addressed many of the fundamental uses of international human rights law in interpreting the *Charter* based on Canadian jurisprudence. They cited both the presumption of conformity first adopted by the Court in *Slaight* as well as the "relevant and persuasive" interpretative approach relied upon in *Baker.*[468] They present a range of international sources were presented by the Charter Committee concerning the proper interpretation of section 7 including both "security of the person" and "principles of fundamental justice."[469] The sources include the *UDHR*, Article 9 (the right to social security) and Article 11 (the right to an adequate standard of living) of the *ICESCR*, as well as Article 6 (the right to life) of the *ICCPR.* In addition, reference was made to decisions and concluding observations of the Human Rights Committee, monitoring the implementation of the *ICCPR*.[470] Canada's submissions to and the responses of the CESCR were also cited.

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[467] *Gosselin*, ICHRDD Factum at 3; this is echoed in para 47 of the factum of the Commission du droits des personne et des droits de la jeunesse.

[468] *Gosselin,* CCPI factum para 16 and 17; see *Slaight supra* note 301 and *Baker supra* note 250.

[469] *Gosselin*, CCPI factum para 35 and 37.

[470] *Gosselin*, CCPI factum para 18,-20, 34-38..

5.8.4 Decision in *Gosselin*

In the five separate sets of reasons in *Gosselin*, international human rights are mentioned in four instances, all restricting its application to section 45 of the *Quebec Charter.* Chief Justice McLachlin in her majority judgment, rejects all three claims under section 7 and section 15 of the *Canadian Charter,* as well as under section 45 of the *Quebec Charter,* finding that no human rights violations had occurred as a result of the Quebec government's decision to exclude under 30 year olds from full social assistance benefits. In relation to the international jurisprudence, she does not consider any international human rights law in relation to section 7 or section 15 of the *Charter,* but restricts her reasoning on this point to the *Quebec Charter.* She compares the wording of Article 11(1) of the *ICESCR* and Articles 22 and 25(1) of the UDHR to the wording of section 45 of the Quebec *Charter,* in concluding that its wording is "equivocal" and therefore non justiciable. Using similar reasoning to the arguments put forward by the Quebec government, she concludes that while the Quebec *Charter* imposed an obligation on government to put some social assistance measures in place – the Court cannot review the wisdom of those measures.[471] This approach is "consistent with the respective institutional competence of courts and legislatures when it comes to enacting and fine-tuning social policy." Thus, international human rights law is distinguished and "social policy" is placed outside the purview of the Court.

In contrast, L'Heureux Dube J accepts that the legislation infringes section 7 and section 15 of the *Charter,* as well as section 45 of the Quebec *Charter.* As to the international

[471] *Gosselin*, *supra* note 346 at para 93.

human rights sources, she applies them exclusively to her interpretation of the *Quebec Charter,* concluding that section 45 was intended to implement Canada's international commitments under Article 11.1 of the *ICESCR*. She ignores their application to section 7, despite the submissions. She cites both the *ICESCR*, and the concluding observations of the CESCR concerning Canada, but makes no distinction between binding and non-binding sources. She also cites the "minimum core" requirement of adequate means to provide the basic necessities of life. Based on this principle, she finds that the legislation reducing social assistance entitlements for under 30 year olds violates the right to "an acceptable standard of living" under section 45 of the Quebec *Charter*.[472]

In a separate opinion, Bastarache J references the dissenting reasons of Robert J, of the Quebec Court of Appeal, and his reliance on the *ICESCR* in interpreting section 45 of the Quebec *Charter*.[473] Justice Bastarache concludes that while section 45 does create an obligation on the Quebec government to provide an 'acceptable standard of living,' it is a right without a remedy: "I would find that while the section appears to create some form of right to a statutory social assistance regime providing a minimum standard of living, in this case, that right is unenforceable."[474] The reasons of LeBel J echo the reference to Canada's international treaty obligation with respect to an adequate standard of living in Article 11 of the *ICESCR*, as well as the conclusion that, while section 45 appears to mirror Article 11, it is unenforceable, saying: "It therefore seems obvious that the Quebec

[472] *Gosselin, ibid* at para 146; in a similar fashion, Bastarache J referenced international sources in interpreting s 45 of the Quebec *Charter* to require a positive right to a minimal standard of living (at para 301). However, he found that s 45 was not included in the remedial provisions of the *Charter*, and thus was aspirational not enforceable.

[473] *Gosselin, ibid* para 300.

[474] *Gosselin, ibid* para 304.

legislature did not intend to give the social and economic rights guaranteed by the Quebec *Charter* independent legal effect."[475] Both LeBel and Bastarache fail to address the relevance of international human rights law to their interpretation of section 7, section 15 or section 1 of the *Canadian Charter,* however, both agree that the legislation is contrary to section 15 and not justified under section 1.

It is unfortunate, given the wealth of international jurisprudence on point, that Justice Arbour's judgment, cited most frequently in support of a positive obligation on government under section 7 of the *Charter*, makes no reference to international human rights law. She finds that the Quebec legislation violates the government's positive obligation to protect the "security of the person" under section 7. She interprets section 7 as imposing two independent obligations, to protect life, liberty and security of the person on the one hand, and the principles of fundamental justice on the other. Given her interpretation of section 7, and her finding of a violation of security of the person in the case, she considers it unnecessary to address the principles of fundamental justice. She determines that the infringement is not justified under section 1. *Gosselin* provides a good example of how similarities in wording, such as between section 45 of the *Quebec Charter* and Article 11 of the *ICESCR,* make it easier to apply international human rights jurisprudence, and in the absence of those similarities, how the relevance of international sources to the interpretation of section 7 of the *Charter* appears to be lost.

[475] *Gosselin, ibid* para 304.

5.8.5 Limitations of the decision

Read together, the extensive submissions to the Supreme Court provided ample basis for consideration of the international jurisprudence in interpreting section 7 and section 15 of the *Charter*. In addition, the submissions correctly reference the principles of interpretation enunciated by Dickson in *PSERA* and by the majority in *Slaight.*[476] The Court chose not to address the submissions in relation to section 7 of the *Charter*, or the more limited representations of NAWL in relation to section 15 concerning rights protected under *CEDAW*. This omission was a missed opportunity in *Charter* interpretation. In the intervening years, the Court has not been presented with another comparable opportunity to consider the interpretation of the "principles of fundamental justice" in relation to social security or an adequate standard of living, protected in the *ICESCR*.

However, given the evidence concerning the health impacts of the reduction in social assistance benefits, and the resulting barriers to accessing adequate housing, medicine and food, the close connection between the social determinants of health and human rights is easily found. Article 12 of the *ICESCR*, particularly in relation to the "prevention…of disease," has strong relevance based on the facts in *Gosselin.* The inclusion of health rights, in the parties' submissions would have provided the Court with an alternative perspective on the impact of the deprivation, independent of what were

[476] See *Slaight supra* note 301.

characterised as 'economic' interests. The international law with respect to the core obligations and the social determinants of health under Article 12, while not binding, would have provided "relevant and persuasive" sources for the interpretation of section 7. In addition, conformity with the international law on non-retrogressive measures, contrary to the Quebec government's reduction of social assistance entitlements, might have succeeded in establishing that the ensuing deprivation was not in accordance with the principles of fundamental justice. As a result, the burden of justifying the infringement under section 1 of the *Charter* would have shifted to the Quebec government. At this stage of the *Charter* analysis, the countervailing international importance of the determinants of health, in comparison with the objective of providing incentives to work that were identified by the government, might have undermined its proffered justification for the reduction in benefits and changed the outcome.

In their application of the international jurisprudence to section 45 of the Quebec *Charter,* Justices Bastarache, and LeBel found that it incorporated Article 11 of the *ICESCR* but overlooked the right to a judicial remedy. This is a core tenet of international human rights law even in relation to social and economic rights, in which there is a heavy burden on the government to justify taking regressive measures, such as Quebec had done. Despite representations from CCPI, this principle of international law in relation to social and economic rights was ignored, in favour of an interpretation that identified the obligation as "aspirational" and therefore non-justiciable.

Health interests have attracted the protection of section 7 under the right to security of the person and the right to life.[477] Given the myriad health consequences caused by inadequate access to housing, food, and medicine, it is worth considering why the determinants of health were not identified as an aspect of the "security of the person." An interpretation of the "security of the person" that includes the social determinants fits well within the approach adopted in *Chaoulli* and *PHS.* The consequence would be a requirement to examine the right to health from the perspective of social and economic disadvantage, as opposed to the universal need to access health care. Viewing health from this point of view challenges our focus on health as a function of access to health care. More recent cases like *Adams v Victoria,* discussed elsewhere in this paper, provide a link between social determinants, like housing, with health.[478] The concept of a positive government obligation in relation to section 7, however, remains elusive.

5.9 Conclusion

In each of the five cases that form part of this survey international human rights law was presented and argued by at least one of the parties. This is not immediately apparent from the decisions, given the paucity of regard and often the silence of the Court with respect to those submissions. Despite the evolution of the Canadian jurisprudence since *Eldridge,* the first case in this survey, was decided in 1997, the parties' understanding of international human rights law and the domestic law about its implementation is uneven

[477] See *Morgentaler*, *supra* note 177; *Rodriguez v BC* [1993] 3 SCR 519; *Chaoulli, supra* note 183; *PHS*, *supra* note 4; *Adams v Victoria*, *supra* note 4.

[478] *Adams supra* note

and in many cases weak. A number of submissions make no use of international human rights sources and that cite no interpretive principles at all, leaving the Court to determine their significance or even relevance. A few submissions distinguish between binding and non-binding sources of international law. In each case, however, at least one submission reflects the Canadian caselaw on the presumption of conformity of domestic law with Canada's international obligations enunciated in *Slaight*, as well as their use as a "relevant and persuasive" aid in statutory interpretation.

In the three main cases where health interests have been considered in relation to section 7 of the *Charter*, that is *Insite*, *Chaoulli* and *Gosselin,* the Supreme Court failed to apply the principle of conformity or the "relevant and persuasive" approach to interpretation of the *Charter*. In *Gosselin,* despite clearly relevant submissions regarding social and economic rights in the *ICESCR,* the Court was silent on the role of international law in interpreting section 7. However, while not explicitly addressing the international jurisprudence, McLachlin CJ left the door open to the possibility that section 7 includes positive obligations or remedies for government inaction, but blamed "insufficient evidence" to conclude that section 7 did not protect "adequate living standards."[479]

Despite what were sometimes detailed submissions concerning the international social rights, the Court failed to give their reasons for declining to address what appeared to be relevant international law. With the exception of *Eldridge,* where the submissions were limited to one intervener, in each case the Court was provided with multiple submissions

[479] *Gosselin, supra* note 346, para 82.

that invoked interpretive principles and relevant international jurisprudence. As a result, it is difficult to speculate on the basis for their limited consideration of international law. In none of the decisions examined, *Eldridge, Auton, Gosselin, Chaoulli* or *Insite*, does the majority decision address the relevance of international law in their interpretation of the *Charter*.

In *Gosselin*, a divided Court reached opposite conclusions regarding the relevance of international law to the interpretation of section 45 of the Quebec *Charter*. Justice L'Heureux-Dube found that the Quebec *Charter* was intended to reflect Article 11 of the *ICESCR*, and so was justiciable, while Chief Justice McLachlin concluded that section 45, was "equivocal" and essentially aspirational in character rather than legally enforceable. However, neither the principle of conformity nor the "relevant and persuasive" approach was cited by either judge. Justices LeBel and Bastarache in separate reasons, found section 45 reflected Article 11 but did not provide a remedy for its violation, contrary to the *ICESCR* requirement to provide "appropriate means" of redress for human rights abuses.[480]

In relation to three of the five cases surveyed (*Chaoulli*, *Insite*, and *Gosselin*), this study explored how international law could have provided clearer standards on the interaction between section 7 of the *Charter* and Canada's international health rights obligations with respect to access to health care and the social determinants of health. In *Eldridge* and *Auton,* where section 7 was not relied upon or played a minor role, but where access

[480] CESCR, *General Comment 9, supra* note 72, para 14.

to publicly insured health care services lay at the center of the dispute, it is useful to consider how concepts such as accessibility, affordability, acceptability, minimum core obligations and the priority accorded children's health interests might have informed the result. Certainly the submissions of the parties in each case could have benefited from stronger and more persuasive arguments. Most submissions lacked a clear understanding of interpretive principles, and the submissions with respect to international law seemed more of an afterthought than an argument. On the substantive side, the parties' submissions failed to make reference to key international health rights law, including Article 12 of the *ICESCR* and interpretive documents such as the CESCR's general comment 14.

It is also worth reflecting on how the Supreme Court's approach to international sources of health rights stands in dramatic contrast to other social and economic rights, such as labour rights, about which the Court has made regular, if not consistent, reference to international treaty obligations. Despite submissions regarding positive obligations, accessibility and affordability as protected aspects of health rights in international law, the Court's approach in *Chaoulli* and *Insite* reflects a view of human rights in which individual liberties are protected solely *against* state interference. To the extent that this negative rights approach to human rights protection is at odds with the state obligation in international social and economic rights jurisprudence, international law represents an inconvenient and thus ignored source of human rights law in Canada.

5.10 International health rights and domestic accountability

Thus far in this review of the implementation of international human rights, and in particular rights in relation to health, it is clear that health as a human right has not been satisfactorily analyzed, much less embraced, by the Supreme Court, some 35 years after the introduction of the *Canadian Charter of Rights and Freedoms.* A first step towards a more thorough approach would be to move Canada's binding international human rights obligations from their current treatment by the Court as an occasional and discretionary afterthought, to a mandatory part of the framework of *Charter* interpretation.

Accountability for health rights implementation is addressed at the international level only in non-binding ways by UN treaty monitoring bodies that are limited to an advisory function.[481] However, in states around the world domestic accountability through human rights litigation, particularly in jurisdictions where social rights find constitutional protection, is growing. In Canada, since the introduction of the *Charter* in 1982, the courts' powers for breaches of human right have been extended to invalidating laws, construed as unconstitutional and to imposing remedial obligations. While the *Charter* provides the framework for the implementation and enforcement of international human rights, progress in the area of health rights remains glacially slow.

Rights accountability through human rights litigation in Canada faces three main limitations derived from the judicial process. The first limitation is that government

[481] Bayefsky, Anne, *supra* note 61, at p 16; the function of the treaty monitoring bodies includes providing opinion and recommendations regarding state reports and individual complaints about state compliance with the treaty, as well as "general comments" or interpretations of the treaty. While they have the power to consider state to state complaints, in fact no interstate complaints have been filed to date.

action or inaction must be contested before the court can rule on whether it is consistent with Canada's human rights obligations; in the meantime unconstitutional laws continue in force. Next, a judge can only deal with issues on a case by case basis as they are presented, rather than a general review of systems or principles for human rights compliance. Finally, a judge cannot initiate but is dependent upon others to present a properly drafted claim. These limitations are relevant but in the case of health rights they appear not to be the only obstacles to accountability through the courts. The Supreme Court has been presented with opportunities in a number of cases to address health rights through *Charter* interpretation. The parties' submissions often contained both a framework for interpretation as well as argument on the substantive content of health rights law. While the drafting of the claim and the submissions can be criticised, the Court was provided with appropriate sources to address international social and economic rights when interpreting both section 7 and section 15 of the *Charter.*

As matters stand currently in Canada, despite Dickson's statement of principle in *Slaight* that the *Charter* provides at least as great protection to human rights as Canada's international obligations, the Supreme Court in interpreting the *Charter* often fails to consider international human rights norms. The *Slaight* principle and the Court's subsequent behavior can be reconciled in two ways: first if the Court concludes that the *Charter* protection exceeds what exists in international human rights law, or if it concludes that it is not relevant. In either event, the failure of the Court to explain its rationale for failure to consider international law sources leaves us in the dark. This can be contrasted with the comments of the Committee of the *ICESCR,* on the obligations of domestic courts in the implementation of the treaty:

> Within the limits of the appropriate exercise of their functions of judicial review, courts should take account of Covenant rights where this is necessary to ensure that the State's conduct is consistent with its obligations under the Covenant. Neglect by the courts of this responsibility is incompatible with the principle of the rule of law, which must always be taken to include respect for international human rights obligations.[482]

Neglect of the court's obligation to "take account of Covenant rights" is said by the Committee to be incompatible with the rule of law, where law is interpreted to include international social and economic rights obligations. Based on both Canadian and international jurisprudence it is clear that all sources of human rights law, including international law, form part of the interpretive framework. It is also inconsistent with other human rights decisions of the Court outside of socio-economic rights, where international jurisprudence has been applied to the interpretation of the principles of fundamental justice under section 7[483]

From the submissions filed with the Supreme Court of Canada in *Chaoulli,* it is apparent that international jurisprudence with respect to Article 12 of the *ICESCR* and Canada's international human rights obligations in general were argued. However, the separate reasons of the Court make no reference to those submissions. Similarly, in *PHS* and *Auton* the Court is silent in respect of the submissions based on international law. In this context, Chief Justice McLachlin's statement – "no freestanding right to health care" - cannot be attributed to an oversight in the factum or argument in relation to Article 12 and the requirements of accessibility and affordability in health care. In the absence of

[482] CESCR, *General Comment 9*, *supra* note 72, para 14.

[483] See *Suresh*, *supra* note 68, para 60, in relation to "deportation to torture"; see also *Canadian Foundation, supra* note 286, in relation to the concept of "best interests"

reasons, it is impossible to know what interpretation of Article 12 the Court considered, or why it was deemed to be unnecessary to the section 7 analysis as part of the "principles of fundamental justice." But the fact that the Court chose not to address the submissions at all, is itself at odds with the international health rights law.

In addition, McLachlin CJ's *obiter* statement regarding the lack of protection for health care as a freestanding right appears redundant in the context of the case where in fact there was a health scheme in place, which she proceeds to review in finding it unconstitutional. In the larger context, in Canada, where government has put in place "a scheme to provide health care" in every jurisdiction, it is clear that the impact of the statement is to curtail the role of the courts. An interpretation of section 7 that requires government action, based on the wording "deprived of," means that it is restricted to reviewing the law on the books, rather than judicial review of gaps in accessibility or inequalities caused by government failure to act, and ignores economic disadvantage in addressing the affordability of health care. The reasoning behind this position appears to be that because government does not cause poverty or ill health, it is not legally or constitutionally responsible to fix the problem. It reflects a support for a view of human rights in relation to health that acts as a brake on government intervention rather than requiring government to fulfill its obligations to protect access to health care goods and services, or the social determinants of health.

The obstacles to interpretations of the *Charter* consistent with Article 12 include those claims that government inaction is immune from *Charter* review that the *Charter*

imposes no obligations on government to protect or promote the rights of the poor or other disadvantaged groups, and the view that socio-economic rights, including health, are simply not protected under the *Charter*. To the extent that alternative views more inclusive of health rights exist at the judicial level, they have not been clearly addressed through *Charter* interpretation.

5.11 Health and the Charter: positive/negative rights

In addressing the relevance of the international human rights law in *Charter* interpretation, the Supreme Court of Canada's jurisprudence has been the main focus of this thesis. As outlined earlier in this chapter, one of the most significant challenges in the application of international social and economic rights jurisprudence to the *Charter* is the dissimilar wording of those provisions. While section 7 does not mention health explicitly, both the protection of "life" and "security of person" have been interpreted by the courts to incorporate health interests.[484] In addition, international jurisprudence (although not health rights law explicitly) has been applied to interpretations of the "principles of fundamental justice."[485]

However, one of the reasons Canadian courts dismiss the relevance of international sources of social and economic rights, including health rights, to the interpretation of the *Charter* is the perception that the *Charter* was not intended to protect those rights, and,

[484] For a discussion of international health rights in relation to s 7, see Margot Young, "The Other Section 7" (2013) *supra* note 320; the right to "life, liberty and security of the person" find an international parallel in Article 3 of the *UDHR*, *supra* note 29 although the *ICCPR* and the *ICESCR* lack comparable wording.

[485] Young, Margot, *ibid* at 59 summarising the impact of international jurisprudence on the interpretation of the "principles of fundamental justice" under s. 7.

separately, that they are not the appropriate body to make decisions that will have redistributive impacts. Since the many health rights denials emanate from social inequality and often demand solutions that lie towards the "positive" end of the rights spectrum, requiring government action and redistributive remedies, the issue over the scope of *Charter* protections is particularly significant. It is to the scope of *Charter* protections and the Canadian jurisprudence impacting health rights to which I will turn to next.

One of the main areas of dispute in the interpretation of section 7 is whether it includes what is commonly referred to as "positive rights" or in other words, whether it imposes obligations on government to take action to ensure adequacy in the substantive right to health including the affordability of health care goods and services as well as the determinants of health.[486] In the context of the international law on health rights, as reviewed in Chapter 3, there is a clear obligation on government to "fulfill" health rights, by "creating the conditions…which would assure to all medical service" as well as the "prevention…of disease."[487] As reviewed earlier in this Chapter, a majority of the Supreme Court of Canada in *Auton* and *Gosselin* shied away from imposing such obligations and failed to address the significance of the international jurisprudence with respect to access to health care and the social determinants of health in their interpretation of the *Charter* in these cases.

[486] For a view countering positive rights see for instance Cross, Frank, "The Error of Positive Rights," 2001 48 UCLA L. Rev. 857.

[487] *ICESCR, supra* note 16 at Article 12.

The supposed distinction between positive and negative rights generally places social and economic rights in the former category and civil and political rights in the latter category. The adjudication and enforcement of negative rights are viewed as within the institutional competence of the courts, and positive rights are seen as outside the judiciary's legitimate mandate. This characterization has been rejected at the international level, where it has been pointed out that:

> Neither ESC [economic, social and cultural] rights nor civil and political rights as a whole offer a single model of obligations or enforcement. No particular right can be reduced only to a single duty on the State, such as a duty to refrain from acting, or a duty to do or provide something. The traditional distinction that civil and political rights impose only negative duties and ESC rights entail only positive duties, for States, is inaccurate. Every human right imposes an array of positive and negative obligations. It is incorrect to say that any particular right has only one kind of duty associated with it. This challenge to the justiciability of ESC rights as a whole is based on a false distinction that overestimates the differences between civil and political rights and ESC rights on this basis.[488]

Although considered by many to constitute a 'false distinction,' in this lexicon, "negative" (or civil and political) rights and obligations are equated with state non-interference, and are enforceable by the courts because they promote private responsibility by curtailing government intervention or regulation. "Positive" (often described as 'social, economic or cultural') rights are seen as outside the proper realm of the judiciary because they require public expenditures that lie within the control of the democratically elected legislature. Negative rights protections are perceived as largely revenue neutral while positive rights protections undermine the legislature's role, by forcing the redistribution of government funds.[489]

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[488] International Commission of Jurists, Courts and the Legal Enforcement of Economic and Social Rights (ICJ, Geneva, 2008), at 10-11

[489] ICJ, *ibid.*

Some aspects of the negative/positive rights distinction have been challenged on the facts by critics who point out that negative rights protections, such as cases on delay under the right to a fair trial, also force government expenditures in the outfitting of additional court rooms, judges, and court time, albeit in the justice sector.[490] The distinction also runs counter to the international human rights jurisprudence on the state's obligation, which includes duties to both "respect" and "fulfill" human rights – thus covering the full negative/positive rights spectrum. The problem of the supposed distinction between positive and negative rights and obligations was approached from the viewpoint of "justiciability" by the UN Committee on Economic, Social and Cultural Rights:

> While the general approach of each legal system needs to be taken into account, there is no Covenant right which could not, in the great majority of systems, be considered to possess at least some significant justiciable dimensions. It is sometimes suggested that matters involving the allocation of resources should be left to the political authorities rather than the courts. While the respective competences of the various branches of government must be respected, it is appropriate to acknowledge that courts are generally already involved in a considerable range of matters which have important resource implications. The adoption of a rigid classification of economic, social and cultural rights which puts them, by definition, beyond the reach of the courts would thus be arbitrary and incompatible with the principle that the two sets of human rights are indivisible and interdependent. It would also drastically curtail the capacity of the courts to protect the rights of the most vulnerable and disadvantaged groups in society.[491]

Taking a more functional approach, the UN Special Rapporteur on Health, Paul Hunt noted that the justiciability of health rights might in fact improve the efficiency and accessibility of health systems, just as the right to a fair trial has impacted the justice system. Judicial review is seen as an essential mechanism to correct legislative 'mistakes' with respect to health policy that undermine health rights:

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[490] United Nations, Human Rights Council, Report of the Special Rapporteur on the right to health, *supra* note 40, para 109-123.

[491] CESCR, *General Comment 9*, *supra* note 72, para 10.

> In this context, the right to the highest attainable standard of health can play a similar role in relation to the health system as the right to a fair trial plays in relation to a court system…
>
> Also, because health policymakers and others sometimes make mistakes, the right to the highest attainable standard of health requires an effective mechanism to review important health-related decisions. Under the right to health, those with responsibilities should be held to account so that misjudgments can be identified and corrected. Accountability can be used to expose problems and identify reforms that will enhance health systems for all.
>
> Just as the right to a fair trial has been used to strengthen systems of justice, so the right to health can be used to strengthen health systems.[492]

However, commentators have observed that the view that "positive rights," which includes health rights and most other socio-economic rights, are not justiciable, has a strong influence in Canada on *Charter* interpretations:

> While the enforcement of negative rights is seen to be within the traditional purview of the courts, it is argued that judicial enforcement of positive rights raises issues of institutional legitimacy and competence so problematic as to render socioeconomic rights non-justiciable. Instead, socio-economic rights violations are characterized as matters of social policy, rather than fundamental human rights, which governments alone are empowered to address free from judicial interference and the constraints of *Charter* review.[493]

In the Canadian context, Porter and Jackman have commented that in the context of section 7, the preference for negative rights interpretations has meant that "broadly framed guarantees, such as the rights to life and security of the person are whittled down to freedom from government interference and stripped of their social rights content."[494]

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[492] United Nations, Human Rights Council, *Report of the Special Rapporteur on the right to health*, *supra* note 40, at 121-123.

[493] Jackman, Martha, "*Charter* Remedies for Socio-economic Rights Violations: Sleeping Under a Box?" *supra* note 429 at 284.

[494] Jackman and Bruce Porter in *Advancing Social Rights in Canada*, *supra* note 38 at 14.

The difficulties faced by social and economic rights claimants before the Supreme Court of Canada has been summed up as follows:

> Interrelated arguments that government inaction is immune from *Charter* review; that the *Charter* imposes no positive obligations on governments to protect or promote the rights of the poor or other disadvantaged groups and that socio-economic rights are not included under the *Charter*, have all created serious obstacles to poverty-related *Charter* challenges. [495]

Conversely, the limitations of the negative rights framework in improving health systems have been documented in a recent review of judicial decisions in Canadian health rights cases. In their study, Flood and Chen focus on "health consumers" who "seek to rely on their *Charter* rights to gain access to certain therapies or to care within reasonable wait times."[496] They categorise their selection of cases based on the nature of the claim (positive or negative), the court decision (successful or unsuccessful), and the subsequent impact of the court decision on public policy. In relation to 'positive rights,' Flood and Chen note that:

> This reluctance to recognise positive social rights under the *Charter* may be explained by, inter alia, the philosophy of some judges that see spending decisions, and the balancing of competing priorities that they entail, as falling under the responsibility of the executive rather than the judiciary.[497]

Flood and Chen point out that even when successful, negative rights claims do not in fact guarantee improved access to healthcare services. The removal of a legislative impediment does not guarantee an affirmative policy response. They reference empirical research demonstrating the ongoing inadequacy of publicly funded abortion services in

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[495] Jackman, Martha "Constitutional Castaways" 2010 50 SCLR 2d 297 at 309.

[496] Flood and Chen, *supra* note 370, at 523.

[497] Flood and Chen, *ibid* at 486.

many provinces despite the Supreme Court of Canada's decision 25 years ago in *Morgentaler* that struck down the barriers imposed by the Criminal Code. [498] They also point to the ongoing barriers to the use of medical marijuana, no longer the subject of the criminal law as a result of the Ontario Court of Appeal decision in *Parker*. Significant hurdles remain to the legal use of medical marijuana in the form of inadequately publicly funded services and complex bureaucratic processes that impose substantial obstacles, especially for those who face disadvantages like poverty, rural isolation, and discrimination. [499] In those cases, while court successes lead to government policy changes, the "impact on allocation of resources has thus far remained limited."[500]

Despite the limitations of the 'negative rights' approach to health, its influence in Canada prevails. In *Gosselin*, the dichotomy appears firmly in place and a restrictive interpretation of section 7, in keeping with the negative rights framework, won the day. Justice Arbour, in dissent, addressed the issue head on; finding that section 7 imposed a government obligation to fulfill the right to an adequate standard of living. At all stages of her section 7 analysis, including the violation, the "state deprivation," and under the principles of fundamental justice, Arbour J rejected the argument that section 7 requires some direct "state interference."[501] In relation to the violation of life and security of the person, she noted that in the *Charter* as a whole, the Court has accepted that a number of rights impose a positive obligation, including under-inclusive labour law legislation

[498] *Morgentaler*, *supra* note 177.

[499] *Parker v R, supra* note 178.

[500] Flood and Chen, *supra* note 370 at 483.

[501] *Gosselin, supra* note 346, para 319-29.

regarding "freedom of association," as well as the right to a fair trial within a reasonable time, minority language rights, the right to an interpreter in a penal proceeding.[502]

Madam Justice Arbour relied on the Court's decision in *Dunmore v Ontario,* where a majority gave guarded support for the protection of "positive" rights under section 2(b) in dealing with labour rights – albeit in an instance of under inclusive legislation under section 15.[503] However, *Dunmore* has subsequently been criticized for restricting judicial scrutiny to areas where the government has chosen to legislate, i.e. where the government has taken action.[504] Nevertheless, *Dunmore* serves as an example of those cases where legislative gaps or omissions have been successfully challenged through discrimination claims based on under inclusive legislation. In addition to *Dunmore,* the exclusion from human rights protection in *Vriend* was found to be discriminatory. In *Vriend,* the Court relied on the analogous ground of sexual orientation in section 15 in finding the provincial human rights code discriminatory in its failure to include sexual orientation as a protected ground. The Supreme Court rejected McClung JA's decision for the Alberta Court of Appeal that the *Charter* did not apply to omissions or failure to act under section 32. In relation to cases where the legislature failed to act at all (for instance, where no human rights legislation exists) the majority included this discussion of the court's proper role in relation to positive rights:

> It is also unnecessary to consider whether a government could properly be subjected to a challenge under section 15 of the *Charter* for failing to act at all, in

[502] *Gosselin*, *ibid* para 320.

[503] *Dunmore v Ontario* [2001] SCC 94 para 29.

[504] See Jackman, *Charter Remedies, supra* note 429, para 24.

> contrast to a case such as this where it acted in an under inclusive manner. It has been held that certain provisions of the *Charter*, for example those dealing with minority language rights (section 23), do indeed require a government to take positive actions to ensure that those rights are respected. [cites omitted].
>
> It has not yet been necessary to decide in other contexts whether the *Charter* might impose positive obligations on the legislatures or on Parliament such that a failure to legislate could be challenged under the *Charter*. Nonetheless, the possibility has been considered and left open in some cases…However, it is neither necessary nor appropriate to consider that broad issue in this case.[505]

In *Vriend,* at the remedy stage, the Supreme Court of Canada imposed what have been described as a "positive" obligation on government, as the Court "read in" in the Alberta human rights code the ground of sexual orientation.[506] These cases demonstrate that positive obligations on government to address gaps and take action are not antithetical to the rights protected in the *Charter,* and by analogy can be relied upon to extend the interpretation of section 7 to include positive obligations.

Similar positive obligations have been included at the remedy stage under the *Charter*, even where they have substantial budgetary implications. In *Schachter v Canada*, the Supreme Court addressed the impact of the *Charter* remedy, including cost implications.[507] The trial judge relied on the grounds of parental status, in finding that the exclusion of biological fathers from parental leave benefits provided through the publicly administered employment insurance program was discriminatory. The Crown conceded the violation at trial. The trial judge then employed the remedy of "reading in"

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[505] *Vriend, supra* note 374 at para 63, 64.

[506] Jackman, Constitutional Remedies, *supra* note 416.

[507] *Schachter v. Canada* [1992] 2 SCR 679.

to the employment insurance legislation to achieve a result that was consistent with the protection of equality rights. In the meantime, the federal government amended the employment insurance legislation so that parental benefits would be available to all biological and adoptive parents on an identical basis – but the benefit was equalised downwards by reducing the number of weeks of leave from 15 to 10. The Supreme Court criticised the Crown's decision to appeal solely on the issue of remedy – since by conceding the violation, the Court was deprived with evidence relevant to s 1, and left it in a "factual vacuum" about the extent of the violation and the purpose of the legislation. Ultimately, the Court upheld the trial judge on the issue of remedy, in ruling that courts have the power to "read in" or "read down" legislation under s 52 of the *Charter*. It noted that any remedy granted by the court has budgetary repercussions:

> the question is not whether the courts can make decisions that impact on budgetary policy; it is the degree to which they can appropriately do so.[508]

While Mr. Schachter lost on the issue of remedy, based on the Court's finding that there was no need for one as a result of the repeal of the provision and amendment of the legislation to allow for identical compensation of biological and adoptive parents, it established the principle that government bears positive obligations under the *Charter* at least at the remedial stage.

However, in contrast to *Dunmore, Vriend* and *Schachter,* stands the case of *Auton* in which the Supreme Court of Canada upheld the exclusion of children with autism from

[508] *Schachter, ibid* at 709; for an illuminating review of the impact of *Charter* remedies on rights claiming, and the perverse effect of the negative/positive rights framing on remedies, see Jackman, Martha, "*Charter* Remedies for Socio-economic Rights Violations: Sleeping Under a Box?" *supra* note 429.

the publicly insured health benefits scheme. The trial judge's decision (upheld by the Court of Appeal but overturned by the Supreme Court of Canada) is revealing in this regard:

> The trial judge went on to find that the discrimination was not justified under section 1 of the *Charter*. She accepted that the government was entitled to judicial deference in allocating finite resources among vulnerable groups, but held that this did not immunize its decision to deny funding for ABA/IBI from *Charter* review, given that the exclusion of ABA/IBI therapy undermined the "primary objective" of Medicare legislation, namely the provision of "universal health care" [509]

In *Auton,* in reversing the decisions of the courts below, the Supreme Court also distinguished *Eldridge* as follows:

> Eldridge was concerned with unequal access to a benefit that the law conferred and with applying a benefit-granting law in a non-discriminatory fashion. By contrast, this case is concerned with access to a benefit that the law has not conferred. For this reason, Eldridge, does not assist the petitioners.[510]

While not explicitly referencing the issue of judicial competence in allowing the government's appeal and rejecting the rights claim, the Supreme Court did say:

> It is not open to Parliament or a legislature to enact a law whose policy objectives and provisions single out a disadvantaged group for inferior treatment…*On the other hand, a legislative choice not to accord a particular benefit absent demonstration of discriminatory purpose, policy or effect does not offend this principle and does not give rise to section 15(1) review*. *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.[511] [emphasis added]

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[509] *Auton, supra* at note 341, as cited by the Supreme Court of Canada, at 14.

[510] *Auton, ibid* at 38.

[511] *Auton, ibid* para 41, 46

In other words, the Supreme Court of Canada decided it could not review the legislature's failure to act, even where it results in a deprivation of rights, unless 'discriminatory purpose' or intentional discrimination could be proven – an almost impossible task and inconsistent with Canadian human rights jurisprudence that did away with the requirement of intent years earlier.[512] Unlike *Dunmore, Vriend* and *Schachter,* the result in *Auton* reflects the 'negative rights' framework, where an under-inclusive government program, characterized as a "legislative choice not to accord a particular benefit" is immunized from *Charter* review. While not cited by Chief Justice McLachlin in her unanimous ruling in *Auton, Dunmore* represents the principle that the government is obligated to protect the "freedom" of agricultural workers to organize, where that government inaction "substantially orchestrates, encourages or sustains the violation of fundamental freedoms" by private actors.[513] However, unlike *Auton,* access to government funded benefits programs was not in issue in *Dunmore*. Despite encouraging words in *Schachter* to the effect that the government obligation extends to statutory benefits, the collective legal impact of these decisions culminating in *Auton* leaves the question of the courts willingness to exercise their power to order governments to fulfill their human rights obligations up in the air, if not in a state of confusion.

[512] See *Andrews v Law Society of BC*, *supra* note 143, at 19; "discrimination may be described as a distinction, whether intentional or not but based on grounds relating to personal characteristics of the individual or group, which has the effect of imposing burdens, obligations or disadvantages on such individual or group not imposed upon others, or which withholds or limits access to opportunities, benefits and advantages available to other members of society."

[513] *Dunmore supra* note 503 at para 26 and 27; the Court relied heavily on international law in its interpretation of the state obligation in relation to collective bargaining.

Returning to the analysis of social and economic rights in relation to section 7 in *Gosselin,* Arbour J rejected the argument that the phrase "deprived of" in section 7 requires proof of causation based on direct state interference, holding that it could include "withholdings" or in other words state inaction, that create barriers to enjoyment of rights.[514] In relation to the "principles of fundamental justice" she concluded that those principles are not restricted to dealing with the "justice system and its administration." She found support for this view in Lamer J's reasons in *New Brunswick v J(G),* where the court held that the principles of fundamental justice in section 7 included a right to state funded counsel in child protection proceedings:

> "The omission of a positive right to state-funded counsel in section 10 ... does not preclude an interpretation of section 7 that imposes a positive constitutional obligation on governments to provide counsel in those cases when it is necessary to ensure a fair hearing."[515]

The principles applied to the "state omission" to provide access to legal representation for those who could not afford a lawyer. Thus, *J(G)* joins the list of cases involving under inclusive legislation, in omitting protection for certain groups, as a source of positive obligation under section 15.[516]

In *Gosselin,* in agreeing with Arbour J's reasoning on section 7, Justice L'Heureux-Dube noted that, generally speaking, the court should defer to government on "allocative choices" but that where the government itself had set a minimum level of assistance, as

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[514] *Gosselin, supra* note 346, para 321.

[515] *New Brunswick (Minister of Health & Community Services) v. G. (J.) supra* note 93 at para 107.

[516] *Gosselin, supra* note 346, para 328; citing *Dunmore supra* note 503 and *Vriend supra* note 374.

the Quebec government had done in that case, the court could review the standards set by the government. [517] Chief Justice McLachlin, CJ, on the other hand, while not rejecting the future possibility of the courts finding that section 7 may impose a "positive" obligation on government, noted that:

> I do not believe that there is sufficient evidence in this case to support the proposed interpretation of section 7. I leave open the possibility that a positive obligation to sustain life, liberty, or security of person may be made out in special circumstances. However, this is not such a case. The impugned program contained compensatory "workfare" provisions and the evidence of actual hardship is wanting. The frail platform provided by the facts of this case cannot support the weight of a positive state obligation of citizen support.[518]

As previously noted, in *Gosselin,* none of the members of the Court referred to the international human rights jurisprudence in interpreting section 7 of the *Charter.* While the Supreme Court of Canada ostensibly left the door open to 'positive rights' or human rights violations based on state inaction under section 7, in the intervening years they have not revisited the issue.[519]

The interpretation of section 7 to restrict it to government interference, has the effect that "advantaged social classes are able use the law's seeming neutrality to disguise the advancement of their own interests."[520] Martha Jackman has explored the extent to which the failure to interpret the *Charter* so as to include positive state obligations,

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[517] *Gosselin,ibid* para 142-3.

[518] *Gosselin,ibid* para 83.

[519] The record of denials of leave applications demonstrate that opportunities to revisit the issue have been offered the Court; see for example the denial of leave to appeal in *Toussaint v Canada* [2011] SCCA 412 *supra* note 231.

[520] Brinks, Daniel and Varun Gauri, "The law's majestic equality? The distributive impact of litigating social and economic rights," (World Bank, Washington, 2012,), at 2.

undermines its relevance for those living in poverty who require state action to realise their basic rights to health, food, housing and other necessities of life, creating what she describes as "constitutional castaways."[521] The relevance of the international jurisprudence about rights enforcement and the imposition of the state's obligation to fulfill economic and social rights, while not ignored by the litigants, appears to have been so far disregarded by the Supreme Court, in addressing the scope and government obligation to fulfill the human rights dimension of section 7.

In two more recent cases, the Federal Court had the opportunity to consider positive obligations in the context of a section 7 claim regarding access to health care services for non-citizens including refugees and undocumented migrants. The first case involves an application by Nell Toussaint, whose life and health were placed at significant risk as a result of the fact that she was poor and could not afford to pay for health care. Based on her immigration status, she was excluded both from the provincial health care plan, and the federal government Interim Federal Health Program (IFHP).[522] Under section 7 the trial judge found that there was a violation of her life and security of the person: "the applicant's exclusion from…coverage exposed her to a risk to her life as well as to long term, and potentially irreversible, negative health consequences…." The Court ultimately rejected the s 7 claim, holding that it was not contrary to the "principles of fundamental justice."[523] Toussaint had applied to the Federal Court, following the rejection of her

[521] Jackman, Constitutional Castaways, *supra* note 495; the phrase "constitutional castaways" is borrowed from McLachlin CJ's reasons in *Prosper v NS,* [1994] 3 SCR 236 at 302.

[522] *Toussaint v Canada supra* note 231.

[523] 2010 FC 810, *ibid,* at para 94

application by the IFHP, relying both on traditional grounds of statutory interpretation and section 7 and section 15 of the *Charter*. Both the trial and appeal courts rejected her claims.[524]

In terms of the international jurisprudence including Article 12 of the *ICESCR*, the trial judge found that because it had not been implemented through legislation it had no legal effect.[525] The Court ignored the framework for *Charter* interpretation established in *Slaight, Hape, Divito* and now affirmed in *SFL,* that mandates the courts to interpret the *Charter* so as to provide human rights protections at least as broad as binding international human rights obligations.

At the Federal Court of Appeal level, Stratas J, in referring to the international human rights jurisprudence cited by the appellant, including binding treaty obligations, allowed that "the court can be assisted by these sources" in interpreting the "principles of fundamental justice" under section 7 of the *Charter*.[526] This weak formulation of the

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[524] Having exhausted her domestic remedies, Nell Toussaint has filed a communication with the UN Human Rights Committee: Application for review filed with the UN Human Rights Committee (HRC) on Civil and Political Rights (ICCPR), Communication 2348/2014; see also, Canada, Order in Council, Privy Council, P.C. 157-11/848 June 20, 1957; retrieved from http://www.socialrightscura.ca/documents/legal/tousaint%20IFBH/Order-in-Council%20P.C.%20157-11%20848,%20effective%20June%2020,%201957.pdf

[525] *Toussaint*, Zinn J, *supra* note 231, at 70; while the Order in Council which created the IFHP program of healthcare for immigrants, predated Canada's ratification of the ICESCR, ICCPR and CERD, Canada's international human rights obligations with respect to health were clearly relevant and applicable to the *Charter* claim; for the legal authority for the health care program see Order in Council, Privy Council, P.C. 157-11/848 June 20, 1957; retrieved from http://www.socialrightscura.ca/documents/legal/tousaint%20IFBH/Order-in-Council%20P.C.%20157-11%20848,%20effective%20June%2020,%201957.pdf

[526] *Toussaint*, FCA, *supra* at note 231, at 87; Submissions on behalf of Toussaint, included Canada's obligations under Article 6 of the ICCPR (right to life), Article 12 of the ICESCR (right

interpretive framework for international law is not consistent with *Hape* and *Divito* (*Toussaint* was decided before *SFL*). The Federal Court of Appeal found that Toussaint failed to prove that the IFHP was the "operative cause" of her "injury," instead concluding that it was her illegal status.[527] Thus the court essentially found that because the government did not cause her illegal status that it was not responsible for the barriers she faced in accessing health care, despite the fact that it was government policy that excluded her from health care protection.

The reasoning concerning the government obligation in providing access to health care services can be contrasted with the Supreme Court's decision in *PHS* (decided after *Toussaint*) where a unanimous Court, in considering access to health care service for those with dangerous drug addictions, explicitly rejected the argument that the claimant should suffer the consequences of their immoral activities:

> The second strand of [the government of] Canada's choice argument is a moral argument that those who commit crimes should be made to suffer the consequences. On this point it suffices to say that whether a law limits a *Charter* right is simply a matter of the purpose and effect of the law that is challenged, not whether the law is right or wrong. The morality of the activity the law regulates is irrelevant at the initial stage of determining whether the law engages a section 7 right.[528]

Similarly, it could be argued that *Toussaint's* immigration status was irrelevant to whether her right to life and liberty had been violated contrary to the principles of fundamental justice. The Court's conclusion on this point can also be contrasted to

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to the highest attainable standard of health) as well as Article 5 of CERD (non discrimination based on race).

[527] *Toussaint, supra* note 231, para 58, 72.

[528] *PHS*, *supra* note 4, McLachlin CJ at para 102.

Chaoulli where the majority of the Court had no difficulty reaching the conclusion that the restriction on private health insurance caused the violation to life and security of the person, rather than poor individual choices that lead to the Appellant's health difficulties.[529] Justice Stratas ignores *Chaoulli* on this point.

Reference to international human rights jurisprudence would have provided an alternative to the focus on "state deprivation" in determining the relevance of causation; a pivotal issue that served ultimately as one of the bases for the Appeal Court's rejection of the section 7 claim. The international typology of state obligations to respect and fulfill human rights provides as follows:

> The obligation to respect requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health.
>
> Finally, the obligation to fulfill requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health.[530]

Instead, the Court's analysis reflected an understanding of government obligations, which is limited to the obligation to "respect" that is characteristic of an approach to human rights based on 'negative rights.' The Court's emphasis on Ms Toussaint's illegal immigration status as the source of the violation of her rights runs counter to international

[529] *Chaoulli, supra* note 183, see for example para 133 where McLachlin CJ and Major J find that the legal restriction on private insurance endangers health; and Dechamps J at para 45 where she makes a finding that the legislative prohibition on private insurance violates life and security of the person.

[530] United Nations, CESCR, General Comment 14, *supra* note 25 at 33; see also *ICESCR supra* note 16, Art 2.1.

health rights principles that prohibit the state party "from limiting access to health services as a punitive measure."[531]

The scope of the obligation to fulfill health rights is particularly apparent in the wording of Article 12 of the *ICESCR*, which includes as a state obligation "the creation of conditions which would assure to all medical service and medical attention in the event of sickness" and "the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education…appropriate treatment of prevalent diseases, illnesses, injuries and disabilities, [and] the provision of essential drugs."[532] Imposing a burden on rights claimants to prove causation operates as a barrier where either under inclusion, or government inaction is the source of the deprivation and ignores government international obligations to take positive action towards the realisation of health rights.

In *Toussaint,* the Federal Court of Appeal's application of international human rights law to the principles of fundamental justice under section 7 is swift and superficial. In just three paragraphs it determines that it is not necessary to address the application of international law to the interpretation of section 7 of the *Charter* because the appellant has failed to "reach first base."[533] In characterising *Toussaint's* claim as one requiring

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[531] United Nations, CESCR, General Comment 14 (2000), *ibid* para 34.

[532] United Nations, CESCR, General Comment 14 (2000), *ibid* para 43; *ICESCR,* supra note 16, Art 12.

[533] *Toussaint*, *supra* note 231, para 87; citing *R. v. Malmo-Levine,* [2003] SCC 74 at para 114-129,634, where the Court identified that in order to constitute a principle of fundamental justice, in addition to being recognised as a "legal" principle, there must be a consensus that the principle is fundamental or vital to the societal notion of justice, that it must be of "controlling

"government to provide access to health care to everyone inside our borders," Stratas J suggests that the Appellant has failed to articulate a viable principle of fundamental justice.[534] The Court, quoting McLachlin CJ's judgment in *Chaoulli* as well as lower court decisions, adopts the statement that there is no "constititutional freestanding right to health care" in Canada.[535] However, stunningly, Stratas J fails to cite McLachlin CJ's important qualification to this statement (that served as a basis for a finding of a government breach in *Chaoulli*) that where the government has put into place a health care system it must accord with the principles of fundamental justice.[536] In addition, Stratas J appears to treat international human rights law as an afterthought to be applied only where an infringement of a principle of fundamental justice has been determined, rather than a source of those principles.[537] The approach is contrary to Canadian jurisprudence in other contexts, where international human rights have been applied in interpreting the principles of fundamental justice under section 7.[538] In interpreting the scope of the "principles of fundamental justice" in *Toussaint,* the international jurisprudence concerning state justification would have provided additional interpretative guidance. Under international law, the state justification for derogation of rights must be

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importance," and that it must provide a manageable standard against which the deprivation of life, liberty or security of the person can be measured.

[534] *Canadian Doctors, supra* note 93 at para 76, 86-88.

[535] *Toussaint, supra* note 231, at 77, 78.

[536] *Chaoulli, supra* note 183, para 104.

[537] *Toussaint, supra* note 231, para 57, quoting the Trial decision, "the applicant's exclusion from…coverage [under the Order in Council] has exposed her to a risk to her life as well as to long term, and potentially irreversible, negative health consequences…."

[538] See *Suresh*, *supra* note 68; as noted in Young, Margot, "The Other s 7" (2013) *supra* note 320, para 10 and note 31.

"proportional."[539] To meet the threshold of proportionality, the derogations must be the "least restrictive," of limited duration, and subject to review.[540] Reference to these international criteria in interpreting the principles of fundamental justice, would have would have required the Court to examine whether the impact on Toussaint's life and security of the person met the test of proportionality. Unfortunately, in dismissing the applicability of international health rights, these criteria for considering what constitutes a principle of fundamental justice under section 7 were overlooked.[541]

Following the outcome in *Toussaint*, the federal government repealed the 1957 OIC and replaced it with an even more limited health care policy, which explicitly restricted eligibility for Interim Federal Health Program (IFHP) benefits, by basing eligibility on immigration status rather than health care needs.[542] This policy retrenchment by the Canadian government sparked a new court challenge before the Federal Court, and a further claim that the 2012 IFHP violates the *Charter.*

In *Canadian Doctors for Refugee Care v Canada,* the applicants (including three individual applicants who faced significant health risks, and who were also poor and unable to pay for their own health services) challenged the new federal government

[539] See for instance, United Nations, CESCR, General Comment 14 (2000), *supra* at note 25 at 29; where proportional is defined as "least restrictive."

[540] United Nations, CESCR, General Comment 14(2000)*, ibid* at 28 and 29.

[541] As previously noted, the Supreme Court dismissed the application for leave to appeal in *Toussaint, supra* note 231.

[542] Order Amending the Order Respecting the Interim Federal Health Program, 2012 P.C. 2012-945 June 28, 2012, SI/2012-49 July 18, 2012.

policy.[543] The basis for the *Charter* claim was that the restrictions on publicly insured health care created a risk to life and security of the person under section 7, constituted cruel and unusual treatment under section 12, and discriminated between classes of recipients based on prohibited grounds of national origin under section 15.[544] The Federal Court found in favour of the Applicants under section 12 and section 15, but rejected the claim under section 7.

The federal government's appeal of the trial judge's decision was adjourned as the 2015 federal election day approached, and ultimately withdrawn following the government's defeat in that election by the incoming Liberal government, which announced that it would reinstate access to health care as it existed under the former federal policy.[545] At the time of writing, the details of that new policy have not been made available, but there is no indication that it will expand coverage to people like Nell Toussaint.

In finding that the IFHP violated the applicant's section 12 and section 15 rights, Justice McTavish rendered an extensive and carefully reasoned decision in which she rejected the section 7 claim on the basis that because the government did not create poverty and health problems, they were not responsible to fix them. The applicants' argued the case as one did not involve a positive duty on government, because the government had withdrawn "a previously available service." In dismissing the relevance of this

[543] *Canadian Doctors, supra* note 93.

[544] *Canadian Doctors for Refugee Care*, *ibid.*

[545] See Government of Canada, November 9, 2015 announcement retrieved at http://news.gc.ca/web/article-en.do?nid=1019909.

distinction, the Court held that "under the current state of the law" section 7 does not include a 'positive right' to state funding for health care:[546]

> I have also concluded that the applicants' section 7 *Charter* claim cannot succeed, as what they seek is to impose a positive obligation on the Government of Canada to fund health care for individuals seeking the protection of Canada. The current state of the law in Canada is that section 7 guarantees to life, liberty and security of the person do not include a positive right to state funding for health care. [547]

At the same time the Court notes that the fiction that people can provide for their own health care is "illusory:"

> I fully recognize that the right of those affected to pay for their own medical treatment will be a largely illusory one, given the fact that most of those affected by the 2012 modifications to the IFHP will be economically disadvantaged individuals.[548]

Elsewhere in its decision, the Court considered the international law at length. However, as a result of its conclusion regarding the lack of *Charter* protection for a right to state funded health care, the Court failed to apply the international principles to the section 7 claim. Once again, the international jurisprudence appears to be an embellishment, once the scope of the principles of fundamental justice and state deprivation has already been determined, rather than a possible source of interpretation for the scope of the principles themselves.

When the Court did apply international jurisprudence, its use was is limited to an interpretation of section 12 of the *Charter,* and in particular what constitutes 'cruel and

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[546] *Canadian Doctors, supra* note 93, at 571.

[547] *Canadian Doctors, ibid* para 1077.

[548] *Canadian Doctors, ibid* 564.

unusual treatment,' as well as section 15 and non-discrimination against children.[549] In terms of a framework for interpretation, while citing both the "relevant and persuasive" approach as well as the presumption that the *Charter* provides human rights protection at least as great as its international obligations, the Court made no distinction as to which perspective it would apply or why.[550] The Court also relies upon both the *Convention on the Rights of the Child (CRC),* and a 1982 decision of the US Supreme Court based on the Equal Protection clause of the US Constitution, concerning government denial of funding for education for children of illegal immigrants, without distinguishing, in weight or importance, the US case law from the international human rights jurisprudence.[551] The Court concludes that the treatment of children under the IFHP does not meet the *CRC* obligation to ensure the 'survival and development of children to the maximum extent possible.'[552]

In *Canadian Doctors*, the applicants' framing of their argument appears to be based upon an attempt to fit their claim within a negative rights framework. Similarly, their approach to section 15 chose an intentional, direct form of discrimination:

> For these reasons, I have concluded that while is it open to government to assign priorities and set limits on social benefit plans such as the IFHP, the intentional targeting of an admittedly poor, vulnerable and disadvantaged group takes this situation outside the realm of ordinary *Charter* challenges to social benefit programs. [553]

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[549] *Canadian Doctors, ibid*.

[550] *Canadian Doctors, ibid* para 444-445.

[551] *Canadian Doctors, ibid* para 666 where it refers to *Plyler v Doe* [1982] 102 S.Ct. 2382.

[552] *Canadian Doctors, ibid* para 659.

[553] *Canadian doctors, ibid* para 687.

Based on this reasoning, it is fair to conclude that if the Court had been faced with a situation where all refugees were subject to the same inferior but identical treatment, including complete denial of access to health care benefits, the Court would have found no basis to intervene.

The Court's rejection of a right to state-funded health care, without even examining the international jurisprudence on point, results in an interpretation of section 7 that fails even to consider, much less embrace, international health rights. While the applicants were successful under section 12 (cruel and unusual treatment) and section 15 (direct discrimination), their success was short lived, as a result of the weak remedy that flowed from the 'negative rights' paradigm employed by the Court. The Court's declaration that the IFHP violated section 12 and section 15 led the federal government to decide not only to revoke the Order in Council that served as the only legal basis for the IFHP, but to opt for no replacement, and instead to institute a discretionary substitute health care program that the applicants claimed was no better than the first. If the trial judge expected that health care services would be reinstated, her order failed in this regard as the remedy allowed the government maximum flexibility to provide or not provide health care on its own terms. An approach, which dealt head on with access to health care services for those who cannot afford them under section 7, would have had greater potential to avoid such an unsatisfactory result.

Judicial deference to government interference with health rights, using the negative rights paradigm, has had an enduring impact in Canada, both in terms of the claims that it

allows, and the claims that it rejects. In the category of successful cases, the Supreme Court of Canada has ruled that government cannot arbitrarily restrict access to the private purchase of health services, essentially finding that government should get out of the way of those people who are capable of independently purchasing health-related goods and services in circumstances where the public system involved unreasonable wait times. In section 7 cases such as *Parker* (criminalisation of medical marijuana is unconstitutional), *Morgentaler* [1988] (criminal code sanctions on abortion are a risk to life and security of the person and overbroad), *Rodriguez* and *Carter* (criminal code provisions restricting access to assisted suicide are overbroad and thus contrary to principles of fundamental justice), and *Chaoulli* (legislative restriction on private health insurance violates section 7) courts have determined that government imposed restrictions on access to healthcare services that create a risk to life or security of the person constitute an infringement of section 7 rights.[554]

The outcome of the *PHS* litigation, in restricting the exercise of the Minister's discretion in withholding a statutory exemption, while leaving the constitutional validity of the statute itself untouched, falls neatly within the category of "negative" rights cases, by ensuring that government gets out of the way of private actors in their access to existing healthcare services, and restricting remedial options to their narrowest possible formulation. No other supervised injection sites have been authorised since the Court's decision, due in part to the numerous hoops that such facilities must leap through to

[554] *Parker*, supra note 178; *Morgentaler v R* [1988] *supra* note 177; *Rodriguez, supra* note 477; *Carter, supra* note 216; *Chaoulli, supra* note 183; In *Rodriguez* the Court found that the limitation on rights was justified under s 1.

justify the exercise of discretion in their favour. Some commentators have sought to characterise the case as yielding potential for judicial activism in protecting access to healthcare. While it is true that the case supported an evidence-based approach to the evaluation of government objectives in protecting public health, the case itself reflects the protection of individual freedom at the expense of government public health regulation through the criminal law.[555]

Underlying the apparent Canadian judicial preference for a negative rights framework lies an uneasiness with what Arbour J described in *Gosselin* as the 'allocative' impacts or cost consequences of an interpretation of the *Charter* that imposes positive state obligations. In a recent review examining the changing role courts have played in the determination of *Charter* claims, particularly in relation to costs, Hester Lessard remarks that:

> Our *Charter* has come of age in a neo-liberal era, one in which whatever political consensus there once was regarding distributive justice has splintered and dissolved. It is also an era in which courts do not hesitate to ask where and when "dollars" should trump rights, and where and when the market, rather than the state, should be left to distribute the basic resources on which individual security depends. Indeed, in *Chaoulli v. Quebec (Attorney General),* a number of judges embrace the notion that the market is the ultimate source of security for individual Canadians and that government efforts at redistribution, such as the national medical care program, should not impede access to the market by economically advantaged individuals seeking a faster, more efficient satisfaction of their basic medical needs. Under this model, the private (individual) not the public (state) has a primary and relatively enlarged responsibility for well-being.[556]

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[555] Voell, Matthew, "PHS Community Services Society v Canada (Attorney General): Positive Health Rights, Health Care Policy, and Section 7 of the *Charter*" *supra* note 430.

[556] Lessard, "Dollars Versus [Equality] Rights": Money and the Limits on Distributive Justice" *supra* note 37 at 3.

While the financial consequences of the Court's rulings are viewed as relevant to the court's reasoning or judicial outcomes, it is the lack of a principled framework for addressing the issue of cost that concerns the author:

> It is unrealistic to expect courts to seriously engage with questions of distributive justice under the *Charter* unless there is a better, more transparent approach to assessing budgetary impacts and to factoring them into the overall framework for adjudicating rights.[557]

In the realm of health rights, the unfortunate aspect of this direction in the *Charter* jurisprudence is that it flows in the opposite direction from the social science research about eradicating health rights violations through addressing gaps in accessibility to both health care and the social determinants of health. Thus the Canadian human rights jurisprudence stands at odds with the evidence on health protection.[558]

Not the existence, but the extent of the fiscal responsibility of the state's obligation in relation to health is a big problem. In international jurisprudence, the state is required to use the "maximum of resources" in realising human rights. But how should a court define "resources"? Do they include both indirect as well as direct costs? Do they consider costs over time, as health outcomes decline? Do resources include tax changes that could reduce or enlarge those resources? What does "maximum" mean in the context of determining whether the poor are getting their fair share? These are significant

[557] Lessard, *ibid* at 10.

[558] A recent exception to this, is the Supreme Court of Canada's review of the government's claim regarding its public health objectives in *PHS* where the Court ruled that the objectives were not rationally connected to the means, see *PHS* at 291.

issues that the Supreme Court of Canada has yet to tackle in any way in relation to health rights.

Opposing the 'negative rights' defenders, are those who argue that social rights litigation, including access to publicly funded health care and social assistance, can strengthen political and legal legitimacy against 'market fundamentalism.'[559] In this analysis, the judiciary provides the legislature with 'deniability' against external fiscal bodies that might otherwise impose austerity measures that undermine public benefit programs.[560] This view has yet to find expression in the Canadian context. In Canada, however, *Charter* review has been highlighted as a potentially important 'accountability' measure in the face of government inaction in protecting social rights.[561]

5.12 International human rights principles in Canadian courts: a summary

A review of both Supreme Court of Canada as well as other jurisprudence affecting health interests reveals that courts rarely invoke the international right to health. On the other hand, it is also apparent that failure to cite international sources is not a bar to a favourable rights friendly outcome. An example of this phenomenon is found in *Eldridge*, arguably the most progressive non-discrimination case involving health rights

[559] For views for and against; see Scheppele, Kim, "Realpolitik defence of social rights" (2004) Texas L R 82(7) 1921-1961 at 3-4 where she charts the influence of 'market fundamentalism' and its impact on human rights, and Cross, Frank, "The error of positive rights", (2001), 48 UCLA LR 857.

[560] Schepple, *ibid.*

[561] Jackman, Martha, "*Charter* Review as a Healthcare Accountability Measure in Canada" (2010) 18 Health L.J. 1.

in Canada.[562] Despite receiving written arguments and authorities that included extensive references to relevant international human rights jurisprudence, neither the minimum core obligation to non-discrimination in the provision of healthcare, nor the principle of accessibility in Article 12, the right to the highest attainable standard of health in the *ICESCR* were addressed by the Court in its decision. While the outcome in *Eldridge* is clearly consistent with Canada's international health rights obligations, the absence of clear reasoning with respect to accessibility and affordability have restricted its impact in subsequent cases such as *Auton.*

Even in cases where international human rights are invoked, it is not clear what role, if any, international norms play in the outcome. In *R v Parker,* Rosenberg J, of the Ontario Court of Appeal, ruled under section 7 that the criminal prohibition on possession of marijuana for medicinal purposes forced Parker to "choose between his health and imprisonment" and "violates his right to liberty and security of the person."[563] The Court of Appeal held that the denial of access to medical marijuana (after the trial judge found as a fact that there was no other drug available that was equally effective in controlling his symptoms), was a violation of Parker's security of the person: "...I conclude that deprivation by means of a criminal sanction of access to medication reasonably required for the treatment of a medical condition that threatens life or health constitutes a deprivation of security of the person."[564]

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[562] *Eldridge*, *supra* note 221.

[563] *Parker v R, supra* note 178, para 10; the Court also found a violation in the restriction of Parker's individual autonomy to make healthcare decisions to meet his needs.

[564] *Parker v R, ibid* at 97.

The Court cited Article 12 of the *ICESCR*, emphasizing 12.2(d): "the creation of conditions that would assure to all medical service and medical attention in event of sickness."[565] Unfortunately, the Court's decision contains no reasoning concerning the impact of this obligation. Access to medical marijuana would have fitted within the category of "essential medicines," part of the minimum core obligations identified by the CESCR as being protected under article 12, but no reference to this obligation is found in the judgment and there is no reasoning with respect to the application of Article 12.2(d), at either the violation, justification or remedy stage of the matter.[566]

Adams represents a successful challenge to a municipal bylaw, which imposed an absolute prohibition on the erection of shelter in a public park, based on the "risk of serious harm to health" to homeless people. [567] Natalie Adams was homeless in Victoria and like many others unable to find a bed in a shelter due to inadequate supply. A municipal by-law prohibited her from erecting a structure for protection from the elements while she slept outdoors. The trial judge referred to evidence concerning the health impacts of homelessness in concluding that the prohibition infringed section 7. While the remedy and outcome of the case has been criticised for its negative rights framework, *Adams* is a case in which both at trial and on appeal, the courts embraced the

[565] *ICESCR*, supra note 16, Article 12; *Parker, ibid* para 148; the reference to Art 12 appears to be in response to the Crown's argument that the criminal provisions of the *CDSA* were necessary in order to meet Canada's international obligations to combat illicit drugs at para 147; in his reasons, Rosenberg appears to be balancing the treaty obligations to control the trade in illicit drugs with the right to health, perhaps coming to the conclusion that one cancelled out the other.

[566] CESCR, General Comment 14 (2000), *supra* note 25, para 43.

[567] *Victoria (City) v Adams*, *supra* note 4.

presumption of conformity between the *Charter* and international human rights law and endorsed the use of international sources in interpreting the *Charter*. [568]

However, despite extensive evidence concerning the "risk of serious harm to health" resulting from the municipal prohibition, neither the trial judge nor the BC Court of Appeal referenced the relevant health rights jurisprudence, including Article 12. The Court cited instead a range of international jurisprudence (making no distinction between binding and non binding sources) concerning housing, including Art 11.1 of the *ICESCR* (the right to an adequate standard of living), as well as the UDHR, CESCR General Comment 4 (Forced evictions), and a UN Report entitled "the Habitat Agenda."[569] However, the Court then failed to make explicit its use or application of this authority in its interpretation of the *Charter.* Like *Parker,* the Court was clearly sympathetic to the use of international sources, but it's reasoning failed to find a link between those obligations and the *Charter*.

Gosselin is not typically categorised as a health rights case, yet evidence concerning the health impacts of the Quebec government's social assistance policy was reviewed by the Supreme Court. Expert evidence established the link between poverty and ill health, showing that malnourishment and undernourishment also lead to significant health problems.[570] Madam Justice Arbour, in dissent, speaking for herself and L'Heureux-Dube

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[568] See Jackman, *Charter* Remedies, *supra* note 429; see also *Adams*, BCCA, *ibid* at para 33-35; and *Adams* BCSC *ibid*.

[569] *Adams,* BCSC, *ibid* at para 85-92.

[570] *Gosselin, supra* note 346 at 374.

J, held that as a result of the health risks resulting from the restriction on welfare benefits for those under 30, section 7 interests were engaged:

> The minimum level of welfare is so closely connected…to one's basic health (or security of the person) and potentially survival (life) that it appears inevitable that a positive right to life, liberty and security of the person must provide for it."[571]

In her section 7 analysis, she found that there was a positive right to a basic level of social assistance. However, in relation to the health interests at stake, neither Arbour J nor any other of the justices in that case makes any reference to article 12 or international health rights. The outcome, a dismissal of the claim to *Charter* protection of a "basic means of subsistence," effectively undermines the right to health, in terms of access to a minimal level of adequate food and shelter.[572]

Similarly in *Chaoulli*, the various members of the Supreme Court ignore the implications of international health rights in their interpretation of the Quebec and the Canadian *Charter*. This is another decision where health interests lie at the core of the claim, yet Article 12 is not even cited. The central problem posed in the case was the unacceptable delay caused by waiting lists in the public healthcare system. The appellants were successful in obtaining an order striking down Quebec's legislative restrictions on the purchase of private health insurance. In granting this remedy, the Supreme Court of Canada ignored evidence that a two tier system could exacerbate wait times in the public system, and impact those who cannot afford or are ineligible for private healthcare insurance: the elderly, the chronically ill and the poor. Chief Justice McLachlin, in

[571] *Gosselin, ibid* para 358 and 373; where Arbour notes that health risks engage the security of the person.

[572] United Nations, CESCR, General Comment 14 (2000), *supra* note 25, at 43.

expressing her opinion *in obiter* that "there is no freestanding right to health in Canada" makes no reference to Canada's international health rights obligations in her interpretation of section 7 of the *Charter*. The outcome undermines the domestic implementation of Canada's international health rights obligations, both in terms of health rights and non-discrimination:

> The conception of the right to health care put forward by the majority in Chaoulli is clearly a negative rather than a positive one, one that falls far short of Canada's obligations under the *ICESCR* to guarantee 'to the maximum of its available resources' the right of everyone to the highest attainable standard of health, including access to medical service without discrimination based on "social origin, poverty, birth or other status.[573]

This survey of the Canadian jurisprudence involving health related claims demonstrates that courts rarely cite international human rights jurisprudence, and when they do, they almost never cite Article 12. Courts often do not make distinctions between binding and non-binding sources of international law. Even where Article 12 is cited, such as the *Parker* decision, it is not clear what role if any it plays in the interpretation of the *Charter*, at any of the rights violation, justification and remedy stages of the analysis. The primary interpretative document, General Comment 14, was not cited in the cases surveyed. Unlike labour rights cases where non-binding but persuasive sources of international human rights jurisprudence are cited with regularity, in the context of health rights, such sources are largely ignored.

[573] Jackman, *Charter* Remedies, *supra* note 429, at 288.

Why do courts rarely invoke international human rights law in examining cases involving health? It has been suggested that the failure to cite or apply international law is the result of the absence of a necessary framework of analysis.[574] In the wake of decisions such as *SFL,* this claim will be harder to maintain, given the clear formulation of a test and its application to the legislative provision banning the right to strike. At bottom it may relate less to the absence of a framework of analysis, or the weakness of the arguments or pleadings, or the complexity of the task of correlating dissimilar wording between the international instruments and the *Charter*. The failure to implement health rights through *Charter* interpretation may owe more to the nature of the claim, in terms of the redistributive requirements of fully realising a right to health.[575] The income inequalities inherent in health problems may present the biggest challenge and the most important reason to continue to claim health rights based on international law in Canadian courts.

[574] Van Ert, *Using international law, supra* note 245 at 233.

[575] A right to health that recognises access, affordability, and availability in medical care as well as the social determinants of health including housing, food, social security and an adequate standard of living.

Chapter 6 Conclusion

Health and inequality are inextricably linked – more clearly now than ever thanks to research on the impact of income inequality on population health, especially the ways that outcomes are allied to the social determinants of health, like clean water and adequate housing, rather than technological breakthroughs in medical care. The focus on growing social and income inequality and its negative consequences for society as a whole, in terms of health and social problems – provide the context for this study on the implementation of international health rights in Canadian courts.

Gaps in health outcomes in Canada and elsewhere in the world have a disproportionately negative effect on the marginalised and politically powerless in our society. When democratically elected governments feel free to ignore these social policy issues, solutions outside legislatures become important. Advocating for the human right to health through the courts represents one such possible avenue to achieve a more equitable redistribution of health related benefits. In this context, the relevance of international human rights treaty obligations, in offering an approach to health as a human right that is not explicitly provided for in Canada's domestic laws or constitution, is particularly significant. The concern with health is fundamental to the fulfillment of all human rights The right to health forms the bedrock for the exercise of other human rights; when one's health or very existence are at stake, the freedom to voice opinions, to vote, or to work become virtually meaningless.

The health of the health system in Canada has been a national focus of public policy debates now for more than a decade. At the same time, there is recognition that health care is no longer the sole preserve of family doctors and hospitals, and that health care alone will not resolve public health inequities. Current gaps in Canada's Medicare system include community care, dental care, pharmacare, mental health, and other preventive measures. Government policy has left as much as 30% of Canadian's health care needs to the vagaries of the private marketplace. On the other hand, the social determinants of health – including access to adequate levels of primary health care, housing, food, and clean water need to form part of the 'health agenda' alongside health care. The epidemiological research demonstrates that measures, including human rights that serve to combat income inequality will benefit society as a whole and not just the poor.

Since its ratification of the *ICESCR* in 1976, Canada has been under a binding treaty obligation to provide its citizens with the right to the highest attainable standard of health. However, neither the federal nor provincial governments have chosen to explicitly incorporate health rights into the constitution, human rights codes, or legislation. The *Charter of Rights and Freedoms,* which came into effect in 1982, does not explicitly implement Canada's international obligations in relation to health. Both Canada's constitutional arrangements, including responsibility for international treaty making and division of powers, as well as the dualism of Canada's reception of international law, create a complex, unwieldy and sometimes unfriendly environment for the implementation of social and economic rights, including health rights. In Canada, health

continues to be viewed primarily as a matter of social policy within the exclusive preserve of government policy makers. In Canadian courts, health as a legal right, has met with considerable opposition based on traditional views concerning institutional competence and the proper role of the judiciary as a body that protects individuals against rights violations cause by government action, rather than inaction. However, in relation to the right to health, the distinction between government action and inaction, as between the concept of positive and negative rights, is contrary to Canada's international treaty obligations. The deference by the courts to the legislature in these circumstances has been justified on a number of factors. The prospective impact of the decision, and the difficulties of monitoring and supervising court orders in the area of social policy serve as a deterrent to judicial action. The impact on public finances as well as the multiplicity of competing interests serves as well to discourage judicial interpretations of the *Charter* that would place positive obligations on government.

The importance of the international jurisprudence in relation to health lies in the link it draws between income inequality and human rights in dealing with accessibility, affordability, non-discrimination and the social determinants of health. The right to health in the international jurisprudence is multi-faceted – it is not the right to "be healthy" but rather the right to the *means* to be healthy – including a functioning, accessible and affordable medical system as well as access to the social determinants of health such as clean water, adequate food, and appropriate housing. The right to health includes a government obligation not to discriminate, including on the basis of poverty, to ensure the pathways to health are accessible to all. The government's obligation to respect,

protect and fulfill these rights includes a duty to ensure adequate redistribution of wealth to honour these commitments, within "available resources." The principles of interpretation adopted by the Supreme Court of Canada provide that while litigants cannot directly rely on this right in a Canadian court, they can rely on it for purposes of interpreting the *Charter*. The courts in turn are obligated to interpret the *Charter* so as to avoid violating the right because it is protected in international law. While this framework has been strengthened considerably since it was first enunciated, it has not always been consistently applied. There remains a significant gap between judicial words and actions. The judiciary's failure to consider international human rights in interpreting the *Charter* has been attributed to a lack of understanding concerning the complexities of treaty implementation in Canada's domestic laws, the multitude and complexity of international human rights jurisprudence, as well as the latent view that international standards are unnecessary because domestic constitutional law and human rights protections are sufficient to resolve disputes.

The purpose of this study was first to examine the development of the framework of analysis for the interpretation of the *Charter* in relation to Canada's binding international human rights treaty obligations. It then moved to an examination of the extent to which litigants are relying upon international jurisprudence before the Supreme Court of Canada in interpreting section 7 of the *Charter*, in cases where health interests are at stake, and the approach taken by litigants in their submissions to the Court. Finally, the approach taken by the Court in considering those submissions regarding the international

jurisprudence in relation to health rights, and other social and economic rights, was reviewed.

The most difficult issue remains whether the judiciary will treat social and economic rights, and health rights in particular, as a necessary source in interpreting s 7 of the *Charter,* despite the lack of textual similarities. Based on the review of the cases before the Supreme Court of Canada concerning those rights, it appears that the Court is not yet at a point where it considers international law to be a necessary step in the analysis of the *Charter*. However, the framework of analysis for international jurisprudence in relation to *Charter* interpretation does include the following attributes:

- Binding treaty obligations are subject to a presumption of conformity.
- Non-binding sources of international human rights law now are more clearly treated as "relevant and persuasive" sources of interpretation of the *Charter*.
- "Similar" wording between the text of the international human rights law and the *Charter* provision is no longer a criteria for the application of international law to the interpretation of the *Charter*.
- In the absence of similar wording, it must be shown that the intent and purpose of the international treaty provision is congruent with the *Charter* provision.
- Ambiguity in the legislative provision under consideration is not required in order to trigger the consideration of international law to the interpretation of the statute.

In addition, in relation to judicial review of administrative action, the values in international human rights law, form part of the context for statutory interpretation.

Some areas of continued controversy that require further attention include:

- Should Canadian jurisprudence require a consideration of international human rights jurisprudence in all cases of *Charter* interpretation and if not, how are the exceptions to be defined?
- What is the test for rebuttal of the presumption that the *Charter* interpretations will be consistent with international human rights jurisprudence?
- In the absence of similar wording between *Charter* provisions and international human rights treaty obligations, how is common intent/purpose established in order to determine whether social and economic rights in the *ICESCR*, including health, fall within the scope of section 7 of the *Charter*?
- Where a consensus concerning the scope and content of the international obligation is lacking in the international jurisprudence, what is the framework to be used by Canadian courts in addressing this dissonance and coincidentally to avoid the critique of 'cherry picking' interpretations to suit a pre-selected outcome?

Based on the empirical review of Canadian jurisprudence involving health related claims it is clear that relevant international sources are often ignored in relation to *Charter* interpretation. Looking at the submissions to the Supreme Court of Canada over a 14 year span, while the quality and strength of the submissions regarding international human rights and the framework for interpretation of the *Charter* vary over time, the Court's reluctance to engage with the international jurisprudence in the area of health rights cannot be explained by the failure of litigants to bring forward arguments for an interpretation of the *Charter* that conforms to that jurisprudence. While the absence of a coherent framework of analysis by courts may have contributed to the failure to properly

apply international law based on recent Supreme Court of Canada judgements, it appears that a consensus around a coherent framework is emerging. However, the vexing problem of when international human rights jurisprudence will be considered in court remains. It appears that courts often treat submissions based on international jurisprudence as an optional not mandatory part of the analysis. As a result, in cases involving health interests, courts continue to ignore Article 12 of the *ICESCR* - part of Canada's binding international obligations - in interpreting section 7 of the *Charter*. Even where Article 12 is cited, such as in the *Parker* decision, it is not clear what role if any the international jurisprudence plays in the court's interpretation of the *Charter*, at the rights violation, justification or remedy stage of the analysis. In addition, unlike labour rights cases, where non-binding but persuasive sources of international human rights jurisprudence are cited with regularity, in the context of health rights, such sources have been largely ignored. The primary interpretive document in relation to international health rights, the CESCR's General Comment 14, was not cited in any of the cases surveyed.

In cases where international human rights law has been overlooked it had the potential to deepen the interpretation of *Charter* rights. For instance, in 'successful' *Charter* cases such as *Eldridge* and *Insite*, the international jurisprudence in relation to health would have extended the court's consideration of barriers in accessing the Canadian health care system - to include poverty and intersectional grounds of discrimination such as gender and disability. In 'unsuccessful' rights claims, such as *Chaoulli, Insite* and *Gosselin*, reference to international health rights jurisprudence would have clarified how section 7

interacts with the *ICESCR* and Canada's other international health rights commitments in the area of affordability, accessibility and access to adequate social assistance.

The approach to international health rights jurisprudence stands in dramatic contrast to regard for international labour rights, concerning which the Supreme Court of Canada has made regular, if not consistent, reference to international treaty obligations. Why have labour rights been so much more readily embraced, as opposed to health rights? Is it because they represent a form of collective rather than individual rights, or because they are perceived as imposing less fiscal restraint on government, or perhaps because they simply don't involve the poor directly? In *SFL,* international jurisprudence played an important role in the Court's decision to overturn their previous decision, that placed the 'right to strike' outside the scope of *Charter* protections of 'freedom of association,' and to reinterpret the same *Charter* provision as providing human rights protection of the right to strike. The labour rights in the *Charter* can now be said to be in conformity with the rights in the *ICESCR.* Based on *SFL,* there is room for optimism in the implementation of the social and economic rights enshrined in the *ICESCR*, including health rights. Another significant breakthrough in *SFL,* is that the majority and the dissenting judgements both included an analysis of the international jurisprudence: international human rights obligations were not ignored.

More than three decades after Canada's adoption of legal obligations for health rights resulting from its ratification of the *ICESCR* and the constitutionalisation of human rights through the *Charter*, it is time to reflect on the pace of the implementation of health

rights in Canada. To the extent that the negative rights approach to human rights protection is at odds with the state obligation in international social and economic rights jurisprudence, the international model of health rights represents an inconvenient and thus ignored source of domestic human rights law. The hesitancy by courts towards health rights through *Charter* interpretation may derive from the nature of the claim and the redistributive requirements of fully realising a right to health that recognises access, affordability, and availability in both medical care as well as the social determinants of health including housing, food, social security and an adequate standard of living. The health and social impact of inequality presents the most compelling reason to continue to champion and claim health rights based on international law in Canadian courts.

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