CHARTER REVIEW AS A HEALTH CARE ACCOUNTABILITY MECHANISM IN CANADA

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I. Introduction

Not surprisingly, given the degree to which Canadians perceive access to health care as a fundamental right, the accountability of the health care system in Canada has become a major health reform issue. With growing debates over the accessibility of the publicly funded system, especially around the issue of waiting times for care, questions have been raised about who health care decision-makers are accountable to, how, and for what decisions. Catherine Régis explains the source and importance of the public's expectation of accountability in this area:

> Pourquoi devrions-nous mettre l'emphase sur la valeur d'imputabilité dans l'administration des … systèmes de santé au Canada?… Premièrement, elle représente maintenant une composante essentielle des attentes des Canadiens face à leurs gouvernements et à la gestion publique … Deuxièmement, la demande pour une imputabilité accrue est liée à la crise de légitimité dans les institutions gouvernementales et le manque de confiance envers les médecins, ainsi que les revendications pour une plus grande participation citoyenne dans les choix d'orientation d'un programme social au cœur des préoccupations de l'électorat.[1]

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1 Catherine Régis, "La valeur de l'imputabilité dans l'allocation des ressources au Canada: Une perspective de politiques publiques" (2008) 2 McGill Journal

Notwithstanding widespread agreement that reform is needed, and the many promising proposals that have been put forward over the past decade to make health care decision-making more accountable to patients and to the public, few concrete steps have been taken to implement such change.[2] In the absence of effective mechanisms within the health care system itself, judicial review under the *Canadian Charter of Rights and Freedoms*[3] has been identified as an alternate avenue of health care accountability, particularly in relation to decisions affecting access to care. Colleen Flood and Michelle Zimmerman have noted:

> Canadian courts can do much to improve the transparency of health care decision-making by providing a forum whereby government officials are obligated to justify their health care decisions … The benefit of a *Charter* challenge is that it can serve both as a forum for deliberation of resource allocation, and as a catalyst for wider public debate upon both the rationing choice in the particular case and the policies of rationing in general.[4]

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of Law and Health 47 at 55; see also: Cathy Fooks & Lisa Maslove, *Rhetoric, Fallacy or Dream? Examining the Accountability of Canadian Health Care to Citizens* (Ottawa: Canadian Policy Research Networks, 2004) at 1; Cathy Fooks & Steven Lewis, *Romanow and Beyond: A Primer on Health Reform Issues in Canada* (Ottawa: Canadian Policy Research Networks, 2002) at 12-13.

2 Health Council of Canada, *Rekindling Reform: Health Care Renewal in Canada, 2003-2008* (Toronto: Health Council of Canada, 2008); Fooks & Maslove, *ibid.* at 3; Régis, *ibid.*; Susan V. Zimmerman, *Mapping Legislative Accountabilities* (Ottawa: Canadian Policy Research Networks, 2005) at 18; Nola M. Ries & Timothy Caulfield, *Accountability in Health Care and Legal Approaches* (Ottawa: Canadian Policy Research Networks, 2004) at iv; Julia Abelson & François-Pierre Gauvin, *Engaging Citizens: One Route to Health Care Accountability* (Ottawa: Canadian Policy Research Networks, 2004) at 2-3; Catherine Régis, "Enhancing Patients' Confidence in Access to Health Care: The Ontario or Québec Way?" (2004) 12 Health L.J. 243 at para. 53; Colleen M. Flood, Duncan Sinclair & Joanna Erdman, "Steering and Rowing in Health Care: The Devolution Option?" (2004) 30 Queen's L.J. 156; Canadian Healthcare Association, *Towards Improved Accountability in the Health System: Getting from Here to There* (Ottawa: Canadian Healthcare Association Press, 2001).

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

4 Collen M. Flood & Michelle Zimmerman, "Judicious Choices: Health Care

Flood, Zimmerman and others have also pointed out that, while rights-based *Charter* review is increasingly being used as a means of calling decision-makers to account for resource allocation and other choices that affect access to care, this has not always been effective from the point of view of *Charter* litigants, or for the health care system more broadly.[5] The Supreme Court of Canada's decision in *Chaoulli v. Quebec (Attorney General)* has drawn harsh criticism in this regard.[6] As Byron Sheldrick remarks: "Leveraging access through the courts is costly and time consuming and may produce policy outcomes that are undesirable from the perspective of both the state and the user groups." [7]

The following paper will examine *Charter* review as an accountability mechanism in this crucial area of social rights. The first part of the paper will briefly survey a number of decided cases and ongoing legal claims relating

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Resource Decisions and the Supreme Court of Canada" in Jocelyn Downie & Elaine Gibson, eds., *Health Law at the Supreme Court of Canada* (Toronto: Irwin Law, 2007) 25 at 54. See also Régis, *supra* note 1 at 60-63; William Lahey, "Medicare and the Law: Contours of an Evolving Relationship" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds., *Canadian Health Law and Policy*, 3rd ed. (Markham: LexisNexis, 2007) 1 at 57.

5 Christopher P. Manfredi & Antonia Maioni, "Reversal of Fortune: Litigating Health Care Reform in *Auton v. British Columbia*" (2005) 29 Sup. Ct. L. Rev. 111 at 136; Colleen M. Flood, Mark Stabile & Carolyn Tuohy, "What is In and Out of Medicare? Who Decides?" in Colleen M. Flood, ed., *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006) 15 at 29; Nola M. Ries & Timothy Caulfield, *supra* note 2 at 8.

6 2005 SCC 35, [2005] 1 S.C.R. 791 [*Chaoulli* (S.C.C.)]. See : Marie-Claude Prémont, "L'affaire *Chaoulli* et le système de santé du Québec: cherchez l'erreur, cherchez la raison" (2006) 51 McGill L.J. 167; Colleen M. Flood, Kent Roach & Lorne Sossin, eds., *Access to Care: Access to Justice – The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005); Jeff A. King, "Constitutional Rights and Social Welfare: A Comment on the Canadian *Chaoulli* Decision" (2006) 69 Mod. L. Rev. 631; Martha Jackman, "The Last Line of Defence for [Which] Citizens?: Accountability, Equality and the Right to Health in *Chaoulli*" (2006) 44 Osgoode Hall L.J. 349 (the author acted as counsel to the Charter Committee on Poverty Issues and the Canadian Health Coalition in their intervention in the case).

7 Byron Sheldrick, "Judicial Review and the Allocation of Health Care Resources in Canada and the United Kingdom" (2003) 5 Journal of Comparative Policy Analysis: Research and Practice 149 at 163.

to access to health care in order to identify the range of concerns motivating recourse to *Charter* litigation in this context. Against that backdrop, the paper will go on to consider why *Charter* review has, to date, been of limited effectiveness as a health care accountability mechanism. In particular, the paper will point to judicial reluctance to seriously engage with rationing of publicly funded health care services – the reasons why or the ways in which decisions are made – as a *Charter* issue. The paper will conclude by suggesting that, until access to publicly funded health care is recognized by Canadian courts as a fundamental right, *Charter* review will do little to improve the accountability of health care decision-making in Canada.

II. Recourse to the *Charter* as an accountability mechanism

In a context where access to care is perceived as a matter of fundamental right,[8] the inability to obtain medically necessary services provides the most obvious impetus for much of the health-related *Charter* litigation that has taken place in Canada over the past decade. For example, in *Cameron v. Nova Scotia (A.G.)*,[9] the plaintiffs – a childless couple – argued that lack of health insurance coverage for ICSI, a form of *in vitro* fertilization treatment, discriminated against the infertile and thus violated section 15 of the *Charter*.[10] The

8 While the right to health care is not explicitly enshrined in Canadian law, the iconic status of the *Canada Health Act* and the medicare system; Canada's international obligations pursuant to the *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 U.N.T.S. 3 [*ICESCR*]; and *Charter* guarantees of equality and security of the person all support the existence of a right to health care in Canada. See Nola M. Ries, "Charter Challenges" in Downie, Caulfield & Flood, eds., *supra* note 4 at 539.

9 (1999), 172 N.S.R. (2d) 227, 524 A.P.R. 227 (S.C.) [*Cameron* (S.C.) cited to N.S.R.]; aff'd (1999), 204 N.S.R. (2d) 1, 177 D.L.R. (4th) 611 (C.A.) [*Cameron* (C.A.) cited to N.S.R.]; leave to appeal to S.C.C. refused, [2000] 1 S.C.R. viii, 190 N.S.R. (2d) 198 (note). For an analysis of the *Cameron* case , see Barbara von Tigerstrom, "Equality Rights and the Allocation of Scarce Resources in Health Care: A Comment on *Cameron v. Nova Scotia*" (1999-2001) 11 Const. Forum Const. 30; Daphne Gilbert & Diana Majury, "Infertility and the Parameters of Discrimination Discourse" in Dianne Pothier & Richard Devlin, eds., *Critical Disability Theory: Essays in Philosophy, Politics, Policy, and Law* (Vancouver: University of British Columbia Press, 2006) 285.

10 Section 15 of the *Charter* guarantees that: "Every individual is equal before and

trial court rejected the plaintiffs' claim on the grounds that ICSI was not "medically required."[11] A majority of the Nova Scotia Court of Appeal agreed with the appellants that the exclusion of the treatments from the province's health insurance plan had a discriminatory impact on the infertile relative to the fertile, for whom "every aspect of having children" was covered by medicare.[12] However the Court of Appeal concluded that, given competing health spending priorities, the decision not to fund ICSI was a reasonable limit on the appellants' rights under section 1 of the *Charter*.[13]

In *Flora v. Ontario (Health Insurance Plan, General Manager)*[14] the plaintiff was diagnosed with liver cancer and, after consulting several Ontario specialists, was told that he was not a suitable candidate for a liver transplant and that he had six months to live. The plaintiff subsequently underwent a "living-related" liver transplant at a private hospital in England. He sought reimbursement of the $450,000 cost of the treatment from the Ontario Health Insurance Plan (OHIP), which turned down his request.[15] He then applied to the provincial Health Services Appeal and Review Board, which confirmed the treatment did not meet the regulatory requirement that it be "generally accepted in Ontario as appropriate for a person in the same medical circumstances" as the plaintiff.[16] The plaintiff appealed the Board's decision to the Ontario Divisional Court, which concluded that his section

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under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability."

11 *Cameron* (S.C.), *supra* note 9 at paras. 102, 154-58.

12 *Cameron* (C.A.), *supra* note 9 at para. 122.

13 *Ibid.* at para. 236. Section 1 provides that the *Charter* "guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."

14 2008 ONCA 538, (2008), 91 O.R. (3d) 412 [*Flora* (C.A.)], aff'g (2007), 83 O.R. (3d) 721, 278 D.L.R. (4th) 45 (Sup. Ct. Div. Ct.) [*Flora* (Div. Ct.) cited to O.R.].

15 *Flora* (Div. Ct.), *ibid.* at paras 2-6.

16 *Ibid*. at para. 43; for a discussion of the funding regime for out-of-province treatment and the Board's decision-making process, see Flood, Stabile & Tuohy, *supra* note 5 at 23-26; David Baker & Faisal Bhabha, "Universality and Medical Necessity: *Charter* Remedies to Individual Claims to Ontario Health Insurance Funding" (2004) 13:1 Health Law Review 25.

7 *Charter* rights[17] had not been infringed since he remained free to seek the care he wanted outside the province.[18] The Ontario Court of Appeal upheld the trial court's conclusion that lack of OHIP funding for all out-of-country medical treatments did not violate section 7 of the *Charter*.[19]

Unmet needs at a more systemic level also provide a significant impetus for *Charter* litigation. For example, in *Eldridge v. British Columbia (A.G.)*,[20] the appellants, who were born deaf, alleged that British Columbia's failure to provide medical interpretation services violated their equality rights under section 15 of the *Charter*. The Supreme Court of Canada unanimously agreed that the appellants had been denied the equal protection and benefit of the publicly funded health care system. In Justice LaForest's view: "In order to receive the same quality of care [as hearing persons], deaf persons must bear the burden of paying for the means to communicate with their health care providers, despite the fact that the system is intended to make ability to pay irrelevant."[21]

In *Auton (Guardian ad litem of) v. British Columbia (A.G.)*,[22] the parents of four autistic children relied on *Eldridge*[23] to challenge the province's refusal to fund their children's intensive behavioural autism treatment. The result, they argued, was a discriminatory failure to meet the particular health needs of children with autism. The petitioners were successful at trial and on appeal.[24] However, the Supreme Court of Canada rejected their argument that lack of provincial funding for intensive autism treatment violated

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17 Section 7 of the *Charter* provides that: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."

18 *Flora* (Div. Ct.), *supra* note 14 at para. 168.

19 *Flora* (C.A.), *supra* note 14 at para. 102; see *also C. (C.) (Litigation Guardian of) v. Ontario Health Insurance Plan* (2009), 95 O.R. (3d) 48, 305 D.L.R. (4th) 538 (Sup. Ct. Div. Ct.), applying the *Flora* decision.

20 [1997] 3 S.C.R. 624, 1 W.W.R. 50 [*Eldridge* cited to S.C.R.].

21 *Ibid.* at para. 71. For a discussion of the *Eldridge* case, see: Dianne Pothier, "*Eldridge v. British Columbia (A.G.)*: How the Deaf Were Heard in the Supreme Court of Canada" (1998) 9:2 N.J.C.L. 263.

22 2004 SCC 78, [2004] 3 S.C.R. 657 [*Auton* (S.C.C.)], rev'g 2002 BCCA 538, [2003] 1 W.W.R. 42 [*Auton* (C.A.)]; aff'g 2000 BCSC 1142 , [2000] 8 W.W.R. 227 [*Auton* (S.C.)].

23 *Supra* note 20.

24 *Auton* (S.C.); *Auton* (C.A.), *supra* note 22.

the *Charter*. In her judgment for the Court, Chief Justice McLachlin found that, because autism services were a "recent and emergent"[25] therapy that was not included among the "core" physician services funded under the province's health insurance legislation, the petitioners were not deprived of a benefit "provided for by the law" within the meaning of section 15 of the *Charter*.[26]

In other cases, patients are invoking the *Charter* because they are unable to access publicly funded health care services in a timely way. For example, in *Cilinger c. Quebec (P.G.)*,[27] the applicant sought to launch a class action against the Quebec government in relation to delays in breast cancer patients' access to radiation treatment. In particular, the applicant alleged that failure to ensure that patients could obtain radiation treatment within eight weeks of surgery interfered with their physical and psychological integrity and thereby violated their section 7 rights. While the Superior Court held that the applicant could proceed against the 12 publicly funded hospitals providing radiation services in the province, it found, and the Quebec Court of Appeal agreed,[28] that the class action could not be brought against the provincial government itself. The Court concluded that the province's health budget decisions were political in nature, and were not amenable to *Charter* review.[29]

In *Jane Doe 1 v. Manitoba*,[30] the plaintiffs challenged the significant delays in access to abortion services caused by the exclusion of abortions performed

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25 *Auton* (S.C.C.), *supra* note 22 at para. 56.

26 *Ibid*. at para. 35. For a discussion of the *Auton* case, see Michelle Dawson, "An Autistic Victory: The True Meaning of the *Auton* Decision" online: No Autistics Allowed <http://www.sentex.net/~nexus23/naa_vic.html>; Keith Syrett, "Priority-Setting and Public Law: Potential Realised or Unfulfilled?" (2006) 7 Medical Law International 265; Ellie Venhola, "Goliath Arisen: Taking Aim at the Health Care Regime in *Auton*" (2005) 20 J.L. & Soc. Pol'y 67.

27 [2004] R.J.Q. 2943 (C.A.) [*Cilinger* (C.A.)], aff'g *Cilinger c. Centre hospitalier de Chicoutimi*, [2004] R.J.Q. 3083 (C.S.) [*Cilinger* (C.S.)], leave to appeal to S.C.C. refused, 30703 (July 14, 2005).

28 *Cilinger* (C.A.), *ibid.* at para. 17.

29 *Ibid*. For a discussion of the *Cilinger* case see: Lorian Hardcastle, "Case Comment: *Cilinger c. Centre Hospitalier de Chicoutimi*" (2006)14:3 Health Law Review 44.

30 2004 MBQB 285, 189 Man. R. (2d) 284 [*Jane Doe1* (Q.B.)]; rev'd 2005 MBCA 109, 195 Man. R. (2d) 309[*Jane Doe1* (C.A.)]; leave to appeal to S.C.C. refused, 31224 (February 23, 2006).

outside public hospitals from Manitoba's health insurance plan. In response to the province's motion to dismiss their claim, the Court of Queen's Bench granted summary judgment in favour of the plaintiffs on the grounds that the Supreme Court of Canada's *R. v. Morgentaler*[31] decision was sufficient precedent for recognizing that the serious harm caused by delays in access to abortion violated the *Charter*. As the trial judge concluded: "there is no reason or logic behind the impugned legislation which prevents women from having access to therapeutic abortions in a timely way."[32] Nor, in his opinion, could the restriction be justified under section 1 of the *Charter*.[33] On appeal, the Manitoba Court of Appeal agreed with the province that, in view of the complexity and importance of the issues raised in the case, the evidence before the trial court on the motion was insufficient, and a full trial was needed.[34]

The need to make reasonable resource allocation choices is a reality in all health care systems.[35] However, a perception that health care decision-making is driven exclusively by cost-savings objectives also contributes to the demand for *Charter* review. For example, in *Shulman v. College of Audiologists and Speech Language Pathologists of Ontario*,[36] the applicants, who included hearing impaired individuals and organizations representing the deaf and hard-of-hearing, challenged the province's decision to stop funding hearing aid evaluations and re-evaluations performed by audiologists operating independently of physicians. The choice to de-list these services was made by a body created by agreement between the Ontario Medical Association (representing doctors in the province) and the Ontario Ministry of Health, a body that was charged with finding $50 million per year in savings through

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31 [1988] 1 S.C.R. 30, 44 D.L.R. (4th) 385 [*Morgentaler*].

32 *Jane Doe1* (Q.B.), *supra* note 30 at para. 73.

33 *Ibid.* at paras. 85-86.

34 *Jane Doe1* (C.A.), *supra* note 30 at para. 29. For a discussion of access to abortion in Canada see: Sanda Rodgers, "Abortion Denied: Bearing the Limits of Law" in Flood, ed., *Just Medicare*, *supra* note 5 at 107.

35 See generally Keith Syrett, *Law, Legitimacy and the Rationing of Health Care: A Contextual and Comparative Perspective* (New York: Cambridge University Press, 2007); Flood, Stabile & Tuohy, *supra* note 5 at 16; Christopher Newdick, "Accountability for Rationing – Theory into Practice" (2005) 31:1 J.L. Med. & Ethics 660.

36 [2001] 155 O.A.C. 171, 90 C.R.R. (2d) 82 (Sup. Ct. Div. Ct.) [*Shulman* cited to O.A.C.].

changes to the province's schedule of insured services.[37] The applicants argued that this decision violated section 15 because of its adverse impact on the deaf and hard-of-hearing, a disproportionate number of whom are also poor.[38] The Divisional Court rejected the applicants' claim that the de-listing created discriminatory barriers to care and instead concluded that the hearing-impaired were treated no differently than others.[39]

In *Association pour l'accès à l'avortement c. Québec (P.G.)*,[40] the applicant brought a class action challenging the province's failure to cover the full costs of abortions performed in private abortion clinics, notwithstanding the requirement under Quebec's *Health Insurance Act*[41] that medically necessary services delivered by physicians be fully insured. The trial court found that the government was fully aware that public hospitals and health centres could not meet the demand for abortion services, and that the private clinics relied upon to fill the gap could not remain in operation without charging patients $200-$300 above the amount refunded by the province.[42] The trial judge agreed with the applicants that the government's cost-saving decision had put it and the provincial health insurance agency in violation of provincial law.[43] While she rejected the applicant's *Charter* claim on the grounds that the harm was not caused by the *Health Insurance Act* itself, but rather by the province's failure to respect it,[44] she found the province liable under the *Civil code of Quebec*[45] and ordered it to compensate women the amounts they were extra-billed for abortions – a total of over $11,000,000.[46]

Competing conceptions of the proper role of the state and the market in ensuring access to care provide a final impetus for several recent *Charter*

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37 For a discussion of this process see Colleen M. Flood & Joanna N. Erdman, "The Boundaries of Medicare: Tensions in the Dual Role of Ontario's Physician Services Review Committee" (2004) 12 Health L.J. 1.

38 *Supra* note 36 at para. 20.

39 *Ibid.* at paras. 28, 31. For a discussion of the *Shulman* case, see: *supra* note 37 at 13-14.

40 2006 QCCS 4694, [2006] R.J.Q. 1938 [*Association pour l'accès à l'avortement*].

41 R.S.Q. c. A-29, s. 3.

42 *Supra* note 40 at paras 60-63; 80-83, 97-100.

43 *Ibid.* at paras 104-107, 112.

44 *Ibid*. at para. 131.

45 Art. 1457.

46 *Supra* note 40 at paras. 101-112.

cases. The most notorious example is *Chaoulli v. Quebec (A.G.)*.[47] The plaintiffs in *Chaoulli*, a physician and an elderly patient who had experienced delays obtaining two hip replacements, invoked the *Charter* not to question Quebec's failure to provide access to a particular service within the public system, but rather to challenge the prohibition on private health insurance and funding under Quebec's *Health Insurance Act*.[48] Based on her review of the evidence, the trial judge concluded that the ban was necessary to protect the integrity of the publicly funded system and so was in accordance with sections 7, 15, and 1 of the *Charter*.[49] The Quebec Court of Appeal dismissed the plaintiffs' appeal,[50] which a majority of the Supreme Court nevertheless allowed. Justice Deschamps held that the ban on private insurance violated the Quebec *Charter of Human Rights and Freedoms*.[51] In their concurring judgment, Chief Justice McLachlin, Justices Bastarache and Major held that, since other OECD countries with multi-payer systems "have successfully delivered to their citizens medical services that are superior to and more affordable than the services that are presently available in Canada,"[52] Quebec's ban on private insurance was also an arbitrary measure that violated section 7 Canadian *Charter* principles of fundamental justice[53] and could not be justified under section 1.[54]

The *Chaoulli* decision is being relied upon in several ongoing *Charter* challenges by patients in Ontario, Alberta and British Columbia. In *Toussaint v. Canada (Attorney General)* [55] the applicant, a Grenadian woman who came to

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47 *Chaoulli* (S.C.C.), *supra* note 6; see Prémont, *supra* note 6; Flood, Roach & Sossin, eds., *supra* note 6.

48 *Supra* note 40. Similar prohibitions exist in most Canadian provinces/territories; see generally Colleen Flood & Tom Archibald, "The Illegality of Private Health Care in Canada" (2001) 164 Canadian Medical Association Journal 825.

49 *Chaoulli c. Quebec (P.G.)*, [2000] R.J.Q. 786, J.Q. No. 479 (C.S.) [*Chaoulli* (C.S.) cited to R.J.Q.].

50 *Chaoulli c. Quebec (P.G.)*, [2002] R.J.Q. 1205, J.Q. No. 759 (C.A.) [*Chaoulli* (C.A.) cited to R.J.Q.].

51 R.S.Q. c. C-12, ss. 1, 9.1; *Chaoulli* (S.C.C.), *supra* note 6 at para. 100.

52 *Chaoulli* (S.C.C.), *ibid.* at para. 140.

53 *Ibid.* at paras. 149-153.

54 *Ibid.* at paras. 155-157. For a discussion of Quebec's legislative response to the *Chaoulli* case, see Marie-Claude Prémont, "Clearing the Path for Private Health Markets in Post-Chaoulli Quebec" (2008) Special Ed. Health L.J. 237.

55 *Toussaint v. Canada (Attorney General)*, 2010 FC 810, 323 D.L.R. (4th) 338 [*Toussaint*];

Canada as a visitor 1999 and who has lived in Ontario as an undocumented migrant since then, is challenging the rejection of her application for health coverage under the Interim Federal Health (IFH) Program, which provides access to federally funded health services for refugees and certain categories of immigrants who are ineligible for coverage under provincial health insurance plans. While she supported herself and paid out-of-pocket for any medical care she received until then, the applicant became increasingly ill and was forced to stop working in 2006 as a result of serious diabetes-related and other major health problems. Because she did not have OHIP coverage[56] and had no fixed income, the applicant was unable to obtain medical treatment she urgently required. Relying on the majority's reasoning in *Chaoulli*,[57] the applicant claimed that, given her inability to access private insurance or care, excluding her from the IFH Program violated her section 7 rights to life and to security of the person and, in light of the *Eldridge* decision,[58] her section 15 right to equal access to health care without discrimination based on disability and citizenship. As she asserted in regard to the rejection of her request for IFH Program coverage: "[T]he exclusion … is contrary to basic tenets of our legal system: it is discriminatory, contrary to section 15 and to international human rights law, and hence not in accordance with the principles of fundamental justice."[59]

At trial, the Federal Court found that, by exposing her to a risk to her life as well as to long-term and potentially irreversible negative health consequences, the applicant's exclusion from IFH Program coverage violated her section 7 right to life, liberty and security of the person.[60] However the Court concluded that this exclusion did not violate the principles of fundamental justice. In Justice Zinn's view:

> I see nothing arbitrary in denying financial coverage for health care to persons who have chosen to enter and remain in Canada illegally. To grant such coverage to those persons would make Canada

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see: Angus Grant, "The Interim Federal Health Program" *Crossing the Line* 12:2 (January 2010), online: Ontario Bar Association <http://www.oba.org/En/imm_en/newsletter_en/v12n2.aspx#Article_4>.

56 *Toussaint, ibid*. at para. 17.

57 *Supra* note 6.

58 *Supra* note 20.

59 *Toussaint, supra* note 55 (Memorandum of Argument at para. 42).

60 *Ibid.* at para. 91.

> a health-care safe-haven for all who require health care and health care services. There is nothing fundamentally unjust in refusing to create such a situation.[61]

Justice Zinn also rejected the applicant's section 15 claim on the grounds that her exclusion from the IFH Program was based on her "immigration status" rather than on the prohibited grounds of disability or citizenship.[62] The applicant has appealed the decision and the case is ongoing.

The plaintiff in *Murray v. Alberta (Minister of Health)*[63] launched a class action against the province of Alberta for its refusal to fund the "Birmingham Procedure," described in his statement of claim as less invasive than traditional hip replacement surgeries. After being advised that it was not publicly insured for patients over 55 years of age, the plaintiff underwent the procedure on his left hip at a local private surgical clinic, at a cost of approximately $23,000. The following year, having been informed that the procedure could no longer be performed at all on patients over 55, the plaintiff travelled to Montreal for right hip replacement surgery, at a cost of over $5,000.[64] In his statement of claim, the plaintiff alleges that the prohibition on private health insurance under provincial health insurance legislation and Alberta's refusal to fund the Birmingham Procedure prevented access to treatment and forced the plaintiff and other class members to pay out-of-pocket for health care services, thereby violating their *Charter* rights.[65]

In *McCreith v. Ontario (A.G.)*[66] the plaintiffs are challenging Ontario's single-payer health care system as public interest litigants and on their own behalf. Lindsay McCreith, who suffered a sudden onset of seizures in January 2006, purchased a MRI in Buffalo, New York in February 2006, to avoid a

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61 *Ibid*. at para. 94.

62 *Ibid.* at paras. 81-83.

63 2007 ABQB 231, [2007] 445 A.R. 1 (Q.B.) [*Murray*].

64 *Ibid.* (Statement of Claim at paras. 7-27). In addition to this surgical cost, the plaintiff also incurred $500 in post-operative physical therapy costs and $15,514.83 in travel and accommodation costs.

65 *Ibid.* (Statement of Claim at para. 29). In its Statement of Defence, the province of Alberta denies that the plaintiff or any other prospective class member has been denied access to care or that failure to provide the Birmingham Procedure to patients over 55 years of age violates the *Charter*; see *ibid*. (Statement of Defence at paras. 18-22).

66 *McCreith v. Ontario (A.G.)*, Toronto 07-CV-339454PD3 (Ont. Sup. Ct.) [*McCreith*].

projected 4 month wait for this diagnostic service in Ontario; and he underwent surgery to remove a brain tumour in Buffalo in March 2006, to avoid a further 3 month wait to consult an Ontario specialist. His application to be reimbursed the US$27,650 he paid for the surgery was rejected by OHIP because he had not sought pre-approval for the procedure.[67] In March 2005, Shona Holmes began to experience headaches and vision disturbances. A May 2005 MRI confirmed the presence of a brain cyst. Unable to obtain an appointment to see a local neurologist until July and an endocrinologist until September, Ms. Holmes travelled to the Mayo Clinic in Arizona for a diagnosis in June 2005 and she returned to Arizona for surgery to remove the cyst in August.[68] Ms. Holmes' application to OHIP for a reimbursement of the $95,000 cost of her out-of-province diagnosis and treatment was rejected on the basis that the surgery had not been recommended by an Ontario neurosurgeon prior to the surgery being performed in Arizona.[69] In their statement of claim, the plaintiffs in *McCreith* argue that the province's monopoly over the provision of health care "depriv[es] Ontarians of the opportunity to secure timely access to essential health care services and … of the right to make fundamental personal choices with regard to their life and health" and they seek a declaration that legislative restrictions on access to private insurance and care violate section 7 of the *Charter* and must be struck down.[70]

Finally, in *Schooff v. Medical Services Commission*,[71] the *Chaoulli* case is being relied upon by a number of private surgical clinics in British Columbia, including one co-owned by former Canadian Medical Association presi-

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67 *Ibid.* (Amended Statement of Claim at paras. 69-91).

68 It has been reported that while Ms. Holmes claimed, in U.S. media interviews, TV advertisements, and Congressional hearings relating to President Obama's health care reforms, that she was forced to go to the United States for life-saving surgery for a brain tumour, she was in fact treated for a benign cyst; see Julie Mason, "Time for a reality check on CNN's 'reality check'" *The Windsor Star* (27 July 2009) A6.

69 *Supra* note 66 (Amended Statement of Claim at paras. 92-115).

70 *Ibid.* (Amended Statement of Claim at paras. 1, 62). In its Statement of Defence, the province of Ontario argues that, since the plaintiffs have outstanding appeals before the Health Services Appeal and Review Board, their claims are premature and, further, that Ontario's health insurance system is in full compliance with the *Charter*; see *ibid*. (Statement of Defence at paras. 17-26).

71 *Schooff v. Medical Services Commission*, 2009 BCSC 1596, [2009] B.C.J. No. 2309

dent Dr. Brian Day, in an action alleging that British Columbia's restrictions on private insurance and care violate section 7 of the *Charter*.[72] The clinics' *Charter* claim was launched in response to a petition brought by a number of patients[73] against B.C.'s Medical Services Commission, challenging the provincial government's failure to enforce the ban on extra-billing by the private clinics, contrary to the *Medicare Protection Act*.[74] In an interim proceeding, the B.C. Supreme Court granted the province's request for an injunction compelling the private clinics to submit to an audit to determine whether they are engaging in illegal billing practices under the *Act*. The case is ongoing.[75]

III. The failure of *Charter* review as an accountability mechanism

As the foregoing review of the case law demonstrates, patients and those advocating on their behalf have achieved limited success in their quest for *Charter*-based review of health care decision-making. Some litigants, such as in *Auton* and in *Jane Doe1*, have won their cases at the trial level, but have seen these favourable rulings reversed on appeal. Others, such as in the *Association pour l'accès à l'avortement* case, have prevailed in their legal claims, but on non-*Charter* grounds. In the thirteen years since the Supreme Court's landmark decision in *Eldridge*, the *Chaoulli* decision is the notable exception to this record of *Charter* losses. As Colleen Flood, Lance Gable and Lawrence Gostin summarize the situation:

> *Charter* review is not running amok over governmental decision-making within Medicare … on the other hand, it is not doing much

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72 *Ibid*. (Statement of Claim at paras. 24-29).

73 *Ibid*.; *Canadian Independent Medical Clinics Assn. v. British Columbia (Medical Services Commission)*, 2010 BCSC 927, [2010] B.C.J. No. 1323; see: Tom Sandborn, "Supreme Court Showdown for Private Clinics" *The Tyee* (7 September 2009), online: The Tyee <http://thetyee.ca/News/2009/09/07/PrivateClinicShowdown/>.

74 *Medicare Protection Act*, R.S.B.C. 1996, c. 286

75 *Supra* note 71 at para. 139; on appeal, the B.C. Court of Appeal held that the trial judge need not have granted an injunction, as the *Medicare Protection Act* made adequate provision for orders facilitating audits where required; *Cambie Surgeries Corp. v. British Columbia (Medical Services Commission)*, 2010 BCCA 396, [2010] B.C.J. No. 1766 (C.A.) at para. 45.

> to improve the quality of decision-making either; it is not sending signals to decision-makers that they must be fair, open and transparent. Rather the Supreme Court is signalling that it rarely wants to get involved in the allocation issue within social programs.[76]

Canadian courts have, for the most part, been highly reluctant to seriously engage with the *Charter* as a health care accountability mechanism. In particular, judges at both the trial and appellate levels are avoiding the key issue underlying most access to health claims – that is, whether health care rationing decisions comply with the procedural and substantive requirements of the *Charter*. As the cases described above illustrate, Canadian courts are sidestepping these issues in two ways: first, by exercising undue deference to governments and their delegates within the health care system in cases where health funding choices are involved and, second, by relying on a negative conception of the right to health care in their interpretation and application of the *Charter*.

The high level of judicial deference in cases where governments are being called upon by patients to defend their spending choices is illustrated in a number of decisions. For example, in *Cameron*,[77] the appellants challenged both the exclusion of ICSI from Nova Scotia's health insurance plan and the province's failure to maintain an independent administrative process for reviewing such decisions. In 1997, based on an agreement between the organization representing physicians in the province and the provincial Department of Health, intrauterine insemination was one of several procedures removed from the list of provincially insured services in order to achieve projected savings of $2.5 to $3 million annually.[78] The Nova Scotia Court of Appeal observed that, while "the primary benchmark for deinsurance was that it would not adversely affect the general health of the patient,"[79] the delisting occurred without consultation with the two physicians who performed the procedure in Nova Scotia.[80] In terms of the administrative recourse available to challenge such decisions, the Court

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76 Colleen M. Flood, Lance Gable and Lawrence O. Gostin, "Introduction: Legislating and Litigating Health Care Rights Around the World" (2005) 33 J.L. Med. & Ethics 636 at 676.

77 *Cameron* (S.C.), *supra* note 9.

78 *Cameron* (C.A.) *supra* note 9 at para. 65.

79 *Ibid*.

80 *Ibid*. at para. 121.

noted that the responsibilities of the province's Medical Services Commission were transferred to the provincial Department of Health in 1976 and, as a consequence, the Commission's independent review procedure was lost.[81]

In response to the appellants' challenge to the province's failure to maintain an independent appeal process for disputed claims, the Court concluded that: "While from the perspective of consumers of health care, it would be desirable to have an independent tribunal to review decisions of the Department to fund or not to fund procedures, there is no requirement at law that such an appellate procedure be part of the scheme."[82] As for the defunding decision itself, the Court took note of the appellants' characterization of the process for deciding what services were eligible for provincial health insurance coverage: "The list, they say, is compiled without reference to principle; it is compiled in the arbitrary discretion of bureaucrats in consultation with the body responsible for representing the economic interests of medical practitioners."[83] However, the Court reprised the government's claims that pressures on the provincial health care budget were extreme; that Nova Scotia had suffered cuts to federal health funding while provincial health care costs continued to rise; that priorities for expenditures were continually reviewed; and that meritorious programs had not been approved because of lack of funds.[84]

In dealing with the *Charter* claim in *Cameron*, the Court was demonstrably unwilling to engage in the level of review the appellants were seeking in regard to either the decision-making process or the substance of the funding decision at issue. As the Court of Appeal concluded:

> The evidence makes clear the complexity of the health care system and the extremely difficult task confronting those who must allocate the resources among a vast array of competing claims … The policy makers require latitude in balancing competing interests in the constrained financial environment. We are simply not equipped to sort out the priorities. We should not second guess them, except in clear cases of failure on their part to properly balance the *Charter* rights of individuals against the overall pressing objective of the

81 *Ibid*. at para. 34-36.
82 *Ibid*. at para. 104.
83 *Ibid*. at para 98.
84 *Ibid*. at paras. 219-224.

> scheme under the *Act* … We must necessarily show considerable deference to the decision makers in this exercise.[85]

In the *Shulman* case,[86] a similar decision-making process to the one at issue in *Cameron* resulted in the de-funding of audiologists' services in Ontario. As the plaintiffs in *Shulman* described it: "The government and the Ontario Medical Association negotiated these cuts behind closed doors, as part of their process to set fees for the province's physicians. Not only did the government not consult with any deaf or hard of hearing persons … they also failed to consult with the … Specialists … who treat them."[87] In rejecting the plaintiffs' *Charter* claim, the Court in *Shulman* warned: "The healthcare system is vast and complex. A court should be cautious about characterizing structural changes to OHIP which do not shut out vulnerable persons as discriminatory, given the institutional impediments to design of a healthcare system by the judiciary."[88]

In the *Cilinger* case, the Quebec Court of Appeal likewise deferred to the government's health funding choices to the point of deeming these to be non-justiciable:

> C'est essentiellement le cadre législatif et réglementaire mis en place pour baliser l'utilisation des ressources et faire échec aux dépassements budgétaires qui est dans la mire de l'appelante. Ces décisions sont à la fois discrétionnaires et souvent le résultat des inévitables arbitrages des agents de l'État entre les différents enjeux sociétaux. Il est donc incontestable … que le débat se situe dans la sphère politique et est, par conséquent, soustrait à l'action des tribunaux.[89]

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85 *Ibid*. at para. 234, 236-37.

86 *Supra* note 36.

87 Consumer Coalition for Access to Audiological Services, News Release, "Ear Nose and Throat Specialists Asked to Support Their Patients" (9 October 2001).

88 *Supra* note 36 at para. 43.

89 *Cilinger* (C.A.), *supra* note 27 at para 16. "It is essentially the legislative and regulatory framework set up to balance resources and to prevent budgetary overruns that is the appellant's focus. These decisions are both discretionary and often the result of the inevitable state balancing of competing social interests. It is therefore indisputable ... that the debate belongs within the political sphere and is, consequently, removed from the purview of the courts" [translated by author].

The courts in these and other cases appear to be endorsing, with a minimal degree of scrutiny, decisions and decision-making processes that patients have found so wrong or unfair that they have resorted to *Charter* litigation as a means of recourse, notwithstanding the difficulty and expense of doing so.[90] This undue level of judicial deference reinforces the perception that, notwithstanding the constitutional significance of the interests engaged, there is no real accountability of decision-making in this area.

The second way in which Canadian courts are avoiding the difficult issues raised by patients in their access to health care claims is by adopting a narrow, negative-rights based approach to the *Charter*. In *Auton*, for example, the Supreme Court declared that: "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 way."[91] The failure of British Columbia's health insurance regime to fund anything other than "core" therapies delivered by physicians was not discriminatory, in Chief Justice McLachlin's view, because it was "an anticipated feature of the legislative scheme."[92] This negative-rights based conception of the right to health care is even clearer in the majority's judgment in *Chaoulli*, where Chief Justice McLachlin held, albeit in *obiter*, that while the *Charter* "does not confer a free standing constitutional right to health care,"[93] Quebec's ban on private insurance was objectionable because it prevented "ordinary" Quebec residents from securing private insurance that would enable them to obtain private health care in order to avoid delays in the public system.[94] In her view, rather than requiring the government to take affirmative measures to ensure universal access to health care, section 7 of the *Charter* demanded state inaction: the appellants must be free to buy their own health care without government interference.

Where the appellants succeeded in having their right to private care affirmed in *Chaoulli*, the majority's negative interpretation of the *Charter* doomed the plaintiff's claim to publicly funded care in the *Flora* case.[95] The

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90 See generally Angela Campbell, "Pathways to and from the Supreme Court of Canada for Health Law Litigants" in Downie & Gibson, eds., *supra* note 4 at 365.

91 *Auton* (S.C.C.), *supra* note 22 at para. 41.

92 *Ibid*. at para. 43.

93 *Chaouilli* (S.C.C.), *supra* note 6 at para. 104.

94 *Ibid*. at paras. 111, 124.

95 *Flora* (Div. Ct.), *supra* note 14.

trial court in *Flora* distinguished the *Chaoulli* decision on the grounds that, "in the case at bar, the government has not prohibited anything … the Regulation does not in any way restrict an individual from securing his or her own health care or in arranging his or her own treatment."[96] The Court found that, while the government's decision as to whether or not to fund a particular treatment "may certainly impact a person's s. 7 interests, such an effect is not the type of infringement contemplated by s. 7. If it were, it would seem that the burden of the government would be limitless."[97] On that basis, the Court held that it was unnecessary to deal with the plaintiff's argument that the province's refusal to fund his out-of-country liver transplant was arbitrary, and so not in accordance with section 7 principles of fundamental justice.[98]

The Court of Appeal in *Flora* agreed with the trial court's finding that: "the reach of s. 7 does not extend to the imposition of a positive constitutional obligation on the Ontario government to fund out-of-country medical treatments, even where the treatment in question proves to be life-saving in nature."[99] Thus, like the majority in *Chaoulli*, the Court of Appeal was of the view that, so long as the plaintiff remained free to purchase his own medically necessary care, his *Charter* rights were not engaged.

IV. The way forward

By adopting an excessive degree of deference to government spending choices and a negative conception of the right to health care, Canadian courts have avoided squarely addressing the rationing of health services – the reasons why or the ways in which it occurs – as a fundamental *Charter* issue. In cases like *Auton* and *Shulman*, courts have resisted dealing with the question of whether rationing, either through the exclusion of particular services from public health insurance plans or the *de facto* operation of waiting lists, is consistent with *Charter* equality values at a substantive level, as required by section 15. In cases like *Cameron* and *Flora*, they have also failed to address the fundamentally important issue of whether the decision-making process around the rationing of health care services is principled and just, in accordance with the procedural and substantive requirements

96 *Ibid*. at para. 174.
97 *Ibid*. at para. 204.
98 *Ibid*. at paras. 188-90.
99 *Flora* (C.A.), *supra* note 14 at para. 108.

of section 7 of the *Charter*. And, since few section 7 or 15 health claims have succeeded, governments have rarely or never been called upon to show that their rationing decisions do in fact constitute reasonable and justifiable limits within the meaning of section 1 of the *Charter*.

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

In particular, section 15 of the *Charter* enables courts to examine health care decision-making in light of substantive equality principles. Direct and systemic barriers to care, such as the refusal to fund interpretation services in the *Eldridge* case; the refusal to provide health insurance coverage in the *Toussaint* case; the termination of funding for audiologists' services in the *Shulman* case; and the limits on abortion funding in the *Jane Doe1* case, can be reviewed for their discriminatory impact on people with disabilities, women, and other disadvantaged groups.[100] For its part, section 7 of the *Charter* provides a basis for assessing the process whereby access to care decisions are made within the publicly funded system, such as the decision not to fund liver transplant surgery in *Flora* or a particular form of hip replacement surgery in *Murray*; decisions as to the level of funding provided for radiation or for abortion services in the *Cilinger* and *Association pour l'avortement* cases; or the choice to de-list particular treatments, such as in the *Cameron* case.

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100 See Martha Jackman, "Health Care and Equality: Is There a Cure?" (2007) 15 Health L.J. 87; Donna Greschner, "How Will the Charter of Rights and Freedoms and Evolving Jurisprudence Affect Health Care Costs?" in Gregory P. Marchildon, Tom McIntosh & Pierre-Gerlier Forest, eds., *The Romanow Papers, Volume 3: The Governance of Health Care in Canada* (Toronto: University of Toronto Press, 2004) 83.

In considering whether there has been full compliance with the principles of fundamental justice under section 7, courts can question whether decision-making is transparent, participatory and informed or instead arbitrary or driven by private rather than public interests.[101] Finally, in cases like *Jane Doe1* or *Cameron*, where section 7 or section 15 rights violations have been found, governments have an opportunity to demonstrate that decision-making affecting access to care, including decisions not to fund or to terminate funding for particular health services, complies with the requirements of section 1 of the *Charter*. In light of the evidence presented by the parties, courts can verify a government's claims that cost savings decisions are rational and evidence-based – as opposed to merely reactive, speculative, or the product of stereotypes and systemic patterns of neglect in relation to the health interests and needs of disadvantaged groups. Conversely, where a claimant is seeking access to care for which there is little or no evidence of clinical effectiveness, or where the benefits of a particular treatment are clearly outweighed by its risks and costs, the decision to ration or to deny access can be upheld as a reasonable and justifiable limit on *Charter* rights.[102]

The *Eldridge*[103] case provides a compelling illustration of the value of *Charter* review as an accountability mechanism in this regard. A central issue in *Eldridge* was whether British Columbia's failure to fund sign language interpretation services was a reasonable or justifiable limit on the equality rights of the deaf. At trial, the plaintiffs in *Eldridge* filed evidence that the B.C. Ministry of Health had earlier turned down two requests by the Western Institute for the Deaf for provincial funding that would have allowed that non-profit organization to continue providing medical interpretation services to deaf patients in the Lower Mainland free of charge. The Institute's first request for funding was rejected out of hand. The Institute's second request

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101 See generally Martha Jackman, "The Implications of Section 7 of the Charter for Health Care Spending in Canada" in Gregory P. Marchildon, Tom McIntosh & Pierre-Gerlier Forest, eds., *The Romanow Papers, Volume 1: The Fiscal Sustainability of Health Care in Canada* (Toronto: University of Toronto Press, 2004) 110 at 121-8.

102 See generally Donna Greschner, "*Charter* Challenges and Evidence-Based Decision-Making in the Health Care System: Towards a Symbiotic Relationship" in Flood, ed., *Just Medicare*, *supra* note 5 at 42; Donna Greschner & Steven Lewis, "*Auton* and Evidence-Based Decision-Making: Medicare in the Courts" (2003) 82 Can. Bar Rev. 501.

103 *Supra* note 20.

was reviewed by a health ministry official who recommended that $150,000 in annual funding be granted. The trial judge cited an internal memorandum from the ministry's Executive Committee – the body that ultimately turned down the Institute's funding request – explaining its negative decision as follows: "it was felt to fund this particular request would set a precedent that might be followed up by further requests from the ethnic communities where the language barrier might also be a factor."[104]

In coming to the conclusion that British Columbia's failure to provide publicly funded interpretation services for the deaf violated the *Charter*, the Supreme Court of Canada was not persuaded by the government's argument that "recognition of the appellants' claim will have a ripple effect throughout the health care field, forcing governments to spend precious health care dollars accommodating the needs of myriad disadvantaged persons."[105] The Court characterized the government's evidence as 'conjectural,'[106] and held that the refusal to fund interpretation services, at an estimated annual cost of 0.0025 percent of the provincial health care budget, could not be justified under section 1 of the *Charter*.[107] In the words of Justice LaForest:

> In summary, I am of the view that the failure to fund sign language interpretation is not a "minimal impairment" of the s. 15(1) rights of deaf persons to equal benefit of the law without discrimination on the basis of their physical disability. The evidence clearly demonstrates that, as a class, deaf persons receive medical services that are inferior to those received by the hearing population … The government simply has not demonstrated that this unpropitious state of affairs must be tolerated in order to achieve the objective of limiting health care expenditures.[108]

In terms of the specific health service at issue in *Eldridge*, the provincial government's refusal to provide sign language interpretation services for the deaf as an insured service, and the justification advanced by health ministry officials for this decision, were in no way evidence-based. The govern-

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104 *Eldridge v. British Columbia (Attorney General)* (1992), 75 B.C.L.R. (2d) 68, [1992] B.C.J. No. 2229 (B.C.S.C.) at 75.

105 *Supra* note 20 at para. 91.

106 *Ibid.* at para. 92.

107 *Ibid.* at para. 87.

108 *Ibid.* at para. 94.

ment did not undertake any assessment of the actual health and financial costs versus benefits of providing interpretation services for the deaf before making its decision. As the Charter Committee on Poverty Issues argued in its intervention in *Eldridge*:

> As the evidence presented at trial makes clear, the cost of providing interpretation services represents a modest expenditure relative to total provincial health care spending. Moreover, without interpretation services, persons who are deaf are at heightened risk of having their medical conditions misdiagnosed, of requiring more frequent and lengthy physician and hospital visits, of receiving inadequate preventive care, and of receiving care which is inappropriate or delayed. Providing interpretation services may well reduce rather than increase provincial health care expenditures. Under section 1, government bears the onus of proof, and in this case, the province has failed to establish that public funds were actually saved.[109]

The particular funding decision that was challenged in the *Eldridge* case is symptomatic of a broader problem of inequality of access to health care services for people with disabilities in Canada – one that has been well documented.[110] The decision to refuse funding for interpretation services in *Eldridge* reflected and perpetuated a discriminatory lack of attention to the core health care needs of the deaf at all levels of the system, from the Ministry of Health through to individual hospitals and health providers. The decision-making process at issue was arbitrary, opaque and discriminatory. The underlying reasons for the decision – a concern that other minority language groups would make similar demands for services and its purported cost-savings – were equally suspect. Absent pursuing a *Charter*-based claim before the courts, the plaintiffs in *Eldridge* had no effective means of holding

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109 *Ibid.* (Factum of the Intervener Charter Committee on Poverty Issues at para. 44) (the author acted as co-counsel to the Charter Committee on Poverty Issues in the case); see also Ries, *supra* note 8 at 562-564.

110 Health Council of Canada, *Health Care Renewal in Canada: Clearing the Road to Quality* (Toronto: Health Council of Canada, 2006) at 80; Human Resources and Social Development Canada, *Advancing the Inclusion of Persons With Disabilities* (Ottawa: Government of Canada, 2004) at 80-81; Canadian Council on Social Development, *Disability Information Sheet No. 9, 2003, The Health and Well-being of Persons With Disabilities* (Ottawa: Canadian Council on Social Development, 2003); Jackman, *supra* note 100 at 113.

health care decision-makers accountable for their rationing choice. The availability of *Charter* review enabled them to challenge the discriminatory intent and effects of the government's decision in relation to interpretation services; to expose the inadequacies and inequities of the decision-making process that was employed to make it; and to demand that the government demonstrate, rather than merely assert, that its decision was rational as a matter of health policy and spending, quite apart from its deleterious impact at the level of fundamental rights.

The situation in *Eldridge* is akin to the one at issue in the more recent *Toussaint* case.[111] In applying for coverage under the IFH Program in May 2009, the applicant explained that she was unable to pay for the medical care she required and that, given the severity of the health problems she faced, accessing the IFH Program was a matter of life and death.[112] In July 2009 the applicant received, as Justice Zinn described it, a "short" decision from an official within the Health Management Branch of Citizenship and Immigration Canada stating that, because the applicant was not a refugee claimant, a resettled refugee, a person detained under the *Refugee Protection Act*, or a Victim of Trafficking in Persons, her request for IFH Program coverage could not be approved.[113]

In her claim, the applicant described the decision-making process that resulted in her being refused access to health coverage – a decision Justice Zinn found "exposed her to a risk to her life as well as to long-term, and potentially irreversible, negative health consequences:" [114]

> No consideration appears to have been given of alternative means of obtaining necessary healthcare. There is no transparency, predictability, rationality or accountability to the decision to disqualify the Applicant from access to healthcare. The Applicant was not given any reasons for her disqualification from the benefit which she could address or respond in any meaningful way. She was simply told she was ineligible because she did not belong to one of a list of groups who are provided the benefit.[115]

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111 *Toussaint, supra* note 55.
112 *Ibid.*(Memorandum of Argument at para. 11.)
113 *Ibid.* at para. 19.
114 *Ibid.* at para. 91.
115 *Ibid.* (Memorandum of Argument at paras. 39.)

Dr. Manuel Carballo, a Professor of Clinical Public Health at Columbia University and an expert called by the applicant in the case, described the irrationality of the federal government's refusal to extend health care coverage to undocumented migrants as a matter of health policy, quite aside from its negative impact on human rights:

> Those who would argue against the equal provision of essential health care to undocumented migrants do so without due reference to the evidence … To deny this vulnerable groups access to health care is both contrary to the principles of universal access and human rights and short-sighted in terms of public health and sustained socio-economic development. This is being increasingly recognized and the number of countries committed to providing health care to undocumented migrants is growing. They are doing so not only out of a spirit of humanitarianism, but also on the basis of the evidence that undocumented migrants do not abuse health care services, do not arrive looking for health care, and are eager to work and "fit in". Further, they recognize that prevention, early diagnosis and treatment of illness in this vulnerable population will provide savings in the longer term.[116]

The courts have a vital role to play in ensuring that rationing decisions, such as the ones at issue in *Eldridge* and in *Toussaint*, are subject to open and rigorous *Charter* scrutiny. In some cases this will result in decisions being overturned. In other cases, where limits on access to care are fair and evidence-based, government choices are likely to be upheld. The role of *Charter* review in this context is not simply to provide an adjudicative recourse of last resort for decisions that adversely affect access to care, or to guarantee any patient or group of patients a specific outcome. Rather *Charter* review ensures that health care decision-making is properly informed by values of fundamental justice and substantive equality. This constitutional entitlement to a rights-informed accountability framework for health care decision-making is particularly important where rationing choices raise systemic concerns in relation to vulnerable groups – situations like in *Eldridge* or in *Toussaint*, where no other meaningful safeguards exist.

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116 *bid.* (Affidavit of Manuel Carballo at paras. 45-46). For a discussion of the intersection of disability and health in the immigration context, see Constance MacIntosh, "Wealth Meets Health: Disabled Immigrants and Calculations of 'Excessive Demand'" in Downie & Gibson, eds., *supra* note 4 at 293.

V. Conclusion

While the issue of the accountability of the Canadian health care system is being debated at the political and health policy levels, individual patients and groups acting on their behalf are resorting to *Charter* litigation as an immediate means of challenging decisions that affect access to care. Canadians see access to health care based on medical need rather than on ability to pay as a fundamental right. In the words of the Romanow Commission on the Future of Health Care in Canada: "Canadians consider equal and timely access to medically necessary services on the basis of need as a right of citizenship, not as a privilege of status or wealth."[117] As the foregoing survey of *Charter* claims illustrates, patients draw a direct connection between access to health care and the right to life, liberty and security of the person under section 7 of the *Charter*, and they see access to health care as a key component of the right to equal protection and equal benefit of the law under section 15.

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

It is evident that judicial recognition of a constitutional right to publicly funded health care based on need, rather than on ability to pay, does not yet exist in Canada. While courts in other constitutional democracies have shown increasing willingness to impose positive obligations on governments to ensure access to health care, social security, housing and other socio-economic rights, the Canadian judiciary stands out in its conservatism in this

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117 Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada – Final Report* (Saskatoon: Commission on the Future of Health Care in Canada, 2002) at xvi (Chair: Roy J. Romanow) [Romanow Commission].

regard.[118] Since the inception of the *Charter,* judges in Canada have, with rare exceptions, adopted a deferential, negative rights based approach to socio-economic rights, including the right to health care. In clear contradiction of Canada's obligations under the *International Covenant on Economic, Social and Cultural Rights*[119] and other international human rights treaties,[120] they have frequently held that governments have no affirmative duty to ensure that individuals, particularly those who are members of socially or economically disadvantaged groups, do in fact have the means to enjoy *Charter* rights to life, liberty, security of the person andequality.[121]

The defects of this "thin and impoverished" vision of the *Charter*, as Justice LaForest characterized it in *Eldridge*,[122] are especially glaring in the health care context. In *Chaoulli*, Chief Justice McLachlin approved the remedy being sought by the appellants, which she described as follows:

> The appellants do not seek an order that the government spend more money on health care nor do they seek an order that waiting times for treatment under the public health care scheme be reduced. They only seek a ruling that because delays in the public system place their health and security at risk, they should be allowed to take out insurance to allow them to access private services.[123]

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

119 *ICESCR*, *supra* note 8.

120 See generally: Brigid Toebes, *The Right to Health as a Human Right in International Law* (Oxford: Intersentia/Hart, 1999).

121 See for example, Bruce Porter, "Twenty Years of Charter Equality Rights: Reclaiming Expectations" in Sheila McIntyre & Sanda Rodgers, eds., *Diminishing Returns: Inequality and the Canadian Charter of Rights and Freedoms* (Markham: NexisLexis, 2006) 23; Kerri A. Froc, "Is the Rule of Law the Golden Rule? Accessing 'Justice' for Canada's Poor" (2008) 87 Can. Bar. Rev. 459; Margot Young, "Section 7 and the Politics of Social Justice" (2005) 38 U.B.C. L. Rev. 539; Martha Jackman, "Remedies for Socio-economic Rights Violations: Sleeping under a Box?" in Robert J. Sharpe & Kent Roach, eds., *Taking Remedies Seriously* (Montreal: Canadian Institute for the Administration of Justice, 2009) 279.

122 *Supra* note 20 at para. 73.

123 *Chaoulli* (S.C.C.), *supra* note 6 at para. 103.

This argument, accepted by three members of the Court in *Chaoulli*, that the *Charter* does not guarantee the right to receive medically necessary care, but only the right to buy it free from government constraint, is not only offensive from a moral point of view, but unconvincing in terms of the language and interpretive context of the *Charter*.[124] The applicant in *Toussaint* describes the implications for her and others in her situation of such a reading of the *Charter*:

> Unlike the patients considered in *Chaoulli*, who had the financial resources to purchase private healthcare insurance, the Applicant in the present case lives in poverty and is unable to pay for either private health care or for private insurance. The remedy sought by more affluent applicants in *Chaoulli* would be entirely ineffective in vindicating the present Applicant's rights under s. 7.[125]

Equally objectionable is the call by the dissenting justices in *Chaoulli* for deference to government health policy choices, to the point of suggesting that nothing in the Canadian constitution would preclude the adoption of a U.S. style health care system.[126] Against the backdrop of Canada's domestic and international human rights commitments, Bruce Porter questions the failure of both the majority and the minority of the Court in *Chaoulli* to create any meaningful framework for government accountability in relation to access to health care, particularly for those unable to afford, or ineligible to obtain, private insurance or care:

> As noted by the dissenting judges, the majority decision [in *Chaoulli*] lays down no manageable constitutional standards which the state might try to meet. What, then, are constitutionally required reasonable health services? What is treatment within a reasonable time? What are the benchmarks? How short a waiting list is short enough? The dissenting judges ask these questions rhetorically, but these are the very issues that a court must be prepared to consider – and to give governments direction on – in assuming their role of guardians

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124 See generally Jackman, *supra* note 6; Bruce Porter, "A Right to Health Care in Canada: Only If You Can Pay For It" (2005) 6:4 ESR Review 8; Lorne Sossin, "Towards a Two-Tier Constitution? The Poverty of Health Rights" in Flood, Roach & Sossin, eds., *supra* note 6 at 161.

125 *Toussaint*, *supra* note 55 (Memorandum of Argument at para. 27.)

126 *Chaoulli* (S.C.C.), *supra* note 6 at para. 176.

> of the constitutional rights of all, including those who rely on the state for access to necessary health care.[127]

Public opinion surveys consistently show that an overwhelming majority of Canadians across all demographic groups support the public health care system and public solutions for strengthening it, over expanding private services.[128] And while equal access to health care is recognized as a defining national value, every major health system review undertaken in Canada over the past decade has concluded with a call for improved health care accountability, "as a necessary underpinning to … reform proposals and an important concept in enhancing the link of citizens – as patients and tax payers – to the system they cherish."[129] Excessive judicial deference to government funding choices, and the courts' unwillingness to rigorously review either the substance or the process of health care decision-making in light of *Charter* principles, is out of touch with Canadians' understanding of the social significance of the medicare system and their conception of health care as a fundamental right. Until Canadian courts understand health care decision-making, including health care rationing, as engaging constitutional values of equality and fundamental justice, there is a grave danger that *Charter* litigation in this area will continue to generate *ad hoc* and unprincipled judicial rulings. As the *Chaoulli* decision so clearly illustrates, the current approach to *Charter* review risks further undermining the publicly funded system and the right to health of all Canadians, rather than reinforcing accountability in this crucial area of social rights.

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127 Porter, *supra* note 124 at 10.

128 André Picard, "Canadians back 'public solutions' to improve care, poll finds" *The Globe and Mail* (12 August 2009) A15; Nick Nanos, "Canadians Overwhelmingly Support Universal Health Care; Think Obama is on the Right Track in United States" *Policy Options* (November 2009) 12; *supra* note 117 at xvi.

129 Fooks & Maslove, *supra* note 1 at 1; Romanow Commission, *ibid.* at xix.