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Charter Rights & Health Care Funding: A Typology of Canadian Health Rights Litigation

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I. INTRODUCTION

As biomedical technologies continue to advance, Canadian Medicare, like other health care systems around the world, faces an ever more difficult task of meeting rising consumer expectations with finite resources. Although it is commonly accepted that some limits on the coverage of the public health care system are necessary in the interest of sustainability, there is as yet no consensus among the Canadian public on where those limits should be drawn. While the *Canada Health Act* mandates public funding for “medically necessary” hospital services and “medically required” physician services,¹ it offers no definition of what constitutes medical necessity. As such, the exact list of medical procedures and treatments to be covered by the public health insurance plans has traditionally been left to be negotiated between the provinces and their respective medical associations. These decisions, as one would expect, are often ripe for contest.

By way of legal challenges, over the past decade the Canadian public has demanded a greater role in the decision-making process with regard to the allocation of health care resources. On their quest, health consumers in Canada have employed a variety of legal strategies, including launching mass tort claims, requesting administrative reviews, and bringing

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1. Canada Health Act, R.S.C., ch. C 6, § 2 (1985).

constitutional challenges. For example, in *Cilinger v. Centre Hospitalier de Chicoutimi*, a class action was certified against twelve Quebec hospitals for having allowed breast cancer patients to wait longer than the medically recommended eight weeks for radiation therapy.² In *Stein v. Quebec*, a Quebec man successfully argued that the refusal by an administrative tribunal to pay for his out-of-country cancer treatment was patently unreasonable considering the amount of time he had waited to receive the procedure in the province.³ In *Lalonde v. Ontario*, the Ontario government's decision to restructure a francophone hospital was challenged by area residents and quashed by courts on the ground that it failed to comply with the constitutional principle of protection of minorities.⁴

Of these lawsuits, those based on the *Canadian Charter of Rights and Freedoms*⁵ arguably gain the highest profile. Since its enactment in 1982, the *Charter* has provided constitutional protection for Canadians' basic rights and freedoms against infringement from laws or state actions.⁶ Section 24(1) of the *Charter* stipulates that anyone whose rights are violated "may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances."⁷ As such, increasingly health consumers in Canada are turning to their *Charter* rights – most notably the right to life, liberty and security of the person guaranteed under section 7 and the equality rights under section 15 – as another avenue to contest governmental limits on publicly funded health care. In the face of growing wait times within the public health care system,

2. *Cilinger c. Centre Hospitalier de Chicoutimi*, [2004] R.J.Q. 2943 (Can.), *aff'd* [2004] R.J.Q. 3083 (Sup. Ct.).

3. *Stein v. Quebec* (Tribunal administratif), [1999] R.J.Q. 2416 (Sup. Ct.).

4. *Lalonde v. Ontario* (Health Services Restructuring Commission), [2001], 208 D.L.R. (4th) 577 (Ont. C.A.), *aff'd* (1999), 181 D.L.R. (4th) 263 (Ont. Div. Ct.).

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

6. *See id.* § 52(1). This provision affirms the supremacy of the Constitution of Canada and stipulates that "any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect."

7. *See id.* § 24(1). Kent Roach has argued that although section 24(1) allows applicants to seek both positive and negative remedies, with respect to health rights litigation, courts have generally been more inclined to grant negative remedies because of their simplicity. For example, in *Chaoulli*, the majority of the Supreme Court of Canada noted that "the [applicants] 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." *Chaoulli v. Quebec* (Attorney General), [2005] 1 S.C.R. 791, 2005 SCC 35 (Can.). As such, although it was possible for the applicants in *Chaoulli* to seek positive remedies, their decision to seek only a negative remedy arguably made their positions more attractive to the Court. *See* Kent Roach, *The Courts and Medicare: Too Much or Too Little Judicial Activism*, in *ACCESS TO CARE, ACCESS TO JUSTICE: THE LEGAL DEBATE OVER PRIVATE HEALTH INSURANCE IN CANADA* 184, 193-95 (Colleen M. Flood, Kent Roach & Lorne Sossin, eds., 2005).

the *Charter* has now been used to challenge the statutory prohibition on private health insurance as well, as seen in the case of *Chaoulli v. Quebec*.

Such phenomenon of relying on litigation as a means towards socio-political reform has been termed by scholars as “legal mobilization.”⁸ It entails an organized effort to influence policy outcomes by asserting one’s rights, thus reframing a socio-political issue into a legal one.⁹ In the context of health care resource allocation, attempts at legal mobilization coincide with a growing demand from patients to hold administrators and providers of health care accountable vis-à-vis them as consumers of the services.¹⁰ To-date, such health rights litigation has had mixed successes in the Canadian courtrooms.¹¹ The juridical outcomes of health rights litigation, however, often do not tell the whole story about their actual ramifications on the Canadian health care system. Whereas some legal successes have yet to be fully implemented on the ground, some cases that failed in the courtrooms have nonetheless rallied political support around the cause and even instigated policy changes.¹²

In this paper, we will analyze the impact on Canadian Medicare resulting from legal actions, focusing specifically on lawsuits argued on the basis of the *Charter* because of their nation-wide implications and rights-based nature. Our goal is to devise a typology for health rights litigation in Canada, taking into consideration not only legal outcomes but also the subsequent effects of these cases on governmental policies and public sentiments. In so doing, we seek to expose the limitations of *Charter* challenges in effecting the resource allocation desired by health consumers. At the extreme end of these limitations is the potential for negative court decisions to foreclose efforts at reform launched outside of the courtroom. Meanwhile, we will showcase the possibility of attaining health policy changes through well organized advocacy campaigns despite courtroom losses. We argue that the impact of health rights litigation on the publicly-funded health care depends heavily on political contexts. It follows that, on the micro level, health rights advocates and legal counsels should not only assess the merits of their cases, but also weigh the likelihood of their endeavours accomplishing the sought-after changes against potential

8. Christopher P. Manfredi & Antonia Maioni, *The Last Line of Defence for Citizens: Litigating Private Health Insurance in Chaoulli v. Quebec*, 44 OSGOODE HALL L.J. 249, 251 (2006).

9. *Id.* at 250-51; See e.g., Christopher P. Manfredi & Antonia Maioni, *Reversal of Fortune: Litigating Health Care Reform in Auton v. British Columbia*, 29 SUP. CT. L. REV. (2d) 111 (2005) (illustrating legal mobilization).

10. PATRICK J. MONAHAN, *CHAOULLI V. QUEBEC AND THE FUTURE OF CANADIAN HEALTH CARE: PATIENT ACCOUNTABILITY AS THE ‘SIX PRINCIPLE’ OF THE CANADA HEALTH ACT* (2006), http://www.cdhowe.org/pdf/benefactors_lecture_2006.pdf.

11. See Manfredi & Maioni, *supra* note 8.

12. *Id.*

negative political repercussions before proceeding with *Charter* challenges. On the macro level, one needs to look beyond the successes or failures of the lawsuits themselves to truly ascertain whether or not a rights-based approach to health care is achieving progressive or regressive outcomes.¹³

II. FORMULATION OF TYPOLOGY

The two variables implicated in our typology of health rights litigation are the juridical outcomes of the cases and the impact of the lawsuits on the Canadian health care landscape. With respect to the first variable, final court decisions can be bifurcated into those found in favour of plaintiffs and those against. In terms of the second variable, our focus is on the effect of health rights litigation on shaping public discourse, instigating policy development and bringing about changes in service coverage and delivery. To ascertain these impacts, we reviewed opinion polls, editorials, news stories, journal articles, book chapters and reports published by the governments and NGOs. By cross tabulating these two variables, we identify at least five outcomes that may result from health rights litigation.

First, successful *Charter* challenges can lead to courts granting Canadians a positive right to a particular therapy, or to care within reasonable time limits. Provided the courts' ruling is faithfully observed by governments and service providers, this is arguably the best result that plaintiffs could hope for when initiating legal actions. As will be discussed further in the next section, health rights litigation has only very rarely, if

13. We consider progressive distribution of health resources as consisting of a system that is funded according to one's ability to pay while it provides services on the basis of one's medical needs. In other words, there should be a decoupling of health care provision from patients' ability to pay. A regressive form of health resources allocation, on the other hand, places greater financial burden on those less well-off, who often are in turn more disadvantaged by the social determinants of health. Viewed in this light, the Supreme Court of Canada's decision in *Chaoulli* to allow for the sales of private health insurance, for example, is considered by us to have a regressive impact on the public health care system. However, we acknowledge that it is not always an easy task to characterize the impact of health rights litigation in such a binary manner. For instance, in *Auton*, the Supreme Court rejected a *Charter* challenge by families of autistic children who were seeking public funding for ABA/IBI treatments. *Auton v. British Columbia (Attorney General)*, [2004] 3 S.C.R. 657, 2004 SCC 78 (Can.). On the one hand, this ruling can be characterized as affecting a regressive outcome. Since many of these families were unable to pay for ABA/IBI programs out-of-pocket, denial of public health coverage would effectively leave the medical needs of these autistic children unattended. On the other hand, some experts have questioned the empirical evidence regarding the effectiveness of the ABA/IBI treatment. They argue that public funding for ABA/IBI treatments, given their high price tag and questionable medical benefits, would divert resources from other health programs whose clinical benefits may be better established but enjoy less public attention and/or political support. From this perspective, one may consider the *Auton* decision as progressive. For further discussions on the cost-effectiveness of ABA/IBI treatment, see Greschner & Lewis, *infra* note 1755.

ever, brought about the enforcement of positive rights in Canada. The closest we believe that Canadian plaintiffs have come is to successfully establish a right to equal treatment in respect of access to certain health services through litigation (e.g. sign language interpretation services for the hearing impaired) but then to see it largely fail to be implemented on the ground. As such, juridical successes followed by under-enforcement of the court orders represent another potential outcome of health rights litigation in our typology. This second outcome is possible because the governments may lack the infrastructure or capacity necessary to comply with the court orders or simply may lack the political will to do so.

The third potential outcome of *Charter*-based health rights litigation is the establishment of a negative right. That is, health consumers can successfully convince courts to invalidate a piece of legislation or a government action that has unconstitutionally interfered with their access to certain medical treatments or services. Most health rights challenges that have succeeded in Canada fall into this category.¹⁴ The rights conferred by courts in these cases, nevertheless, are only negative in nature. As such, although the governments may not legally prohibit Canadians from accessing certain health care, they equally do not have the legal obligation to actively make these services readily available. Consequently, these lawsuits do not necessarily give rise to barrier-free access to the sought-after health services by consumers, and the practical impact of these lawsuits on the allocation of health care resources has thus far remained limited.

The prior three outcomes all flow from the direct consequences of a legal decision. In contrast, health consumers can fail in their legal pursuit of a right but galvanize public support, or at least soften resistance, in the process. That is, *Charter*-based health rights litigation, due to its high profile, can instigate public discourses around the issue in question. In some cases, public sympathy towards the plaintiffs' circumstances has put pressure on the governments to undertake political actions.¹⁵ Although this fourth possible outcome of health rights litigation may be interpreted by some as suggesting that there is no downside to initiating such legal actions, the fifth and last outcome in our typology serves as a cautionary tale. In these cases, not only did the health rights challenges fail in the courtrooms, but they also set back the momentum of accomplishing the desired changes through political means as the governments are content with leaving the

14. See e.g., *R. v. Morgentaler*, [1988] 1 S.C.R. 30, 1988 SCC 90 (Can.) (striking down government intrusion in the form of criminal sanctions regarding abortion); *Rodriguez v. British Columbia (Attorney General)*, [1993] 3 S.C.R. 519 (Can.) (assisted suicide); *R. v. Parker*, [2000] 49 O.R. (3d) 481 (Can.) (marijuana possession).

15. See Ellie Venhola, *Goliath Arisen: Taking Aim at the Health Care Regime in Auton*, 20 J. LAW & SOC. POL'Y 67, 68 (2005).

final words on the issues to courts.

In the next section, we will elaborate on these various outcomes that may result from health rights litigation. Specific cases will be drawn to clarify and support our typology.

III. TYPOLOGY OF HEALTH RIGHTS LITIGATION

A. *Positive Right to Health, and Successful Implementation*

The best outcome that health consumers can arguably hope for when launching health rights litigation is to have the courts pronounce a legal entitlement to the sought-after medical services, and to subsequently have the governments take positive measures to ensure such services are accessible to consumers. Unlike the constitutions of some countries,¹⁶ the Canadian *Charter* does not confer a freestanding positive right to health care. As such, Canadian legal scholars and patients who seek to establish entitlements to public-funded health services have grounded their endeavours primarily in two sections of the *Charter*, namely sections 7 and 15. Section 7 of the *Charter* provides that “[e]veryone 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.”¹⁷ Some scholars have argued that this section is capable of being interpreted by courts to include a positive right to accessible medical care.¹⁸ In addition, some have built their claims on the non-discrimination guarantee enshrined in section 15(1) of the *Charter*, which states: “Every individual is equal before and under the law and has the right to 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.”¹⁹ While section 15(1) does not protect a positive right to health care *per se*, when the denial of certain health services to a section of the population is found by courts to be discriminatory, this provision can oblige the governments to take positive actions towards remedying such inequality.

In *Gosselin v. Quebec*, the Supreme Court of Canada wrestled with the

16. See e.g., S. AFR. CONST. 1996 § 27 (subsection 1(a) stipulates: “Everyone has the right to have access to health care services, including reproductive health care”).

17. *Charter*, *supra* note 5, at §5, s. 7.

18. See e.g., Lorne Sossin, “Towards a Two-Tier Constitution? The Poverty of Health Rights,” in Colleen M. Flood, Kent Roach & Lorne Sossin, eds., *ACCESS TO CARE, ACCESS TO JUSTICE: THE LEGAL DEBATE OVER PRIVATE HEALTH INSURANCE IN CANADA* 161, 170-71; Martha Jackman, *DISCUSSION PAPER NO. 31: THE IMPLICATIONS OF SECTION 7 OF THE CHARTER FOR HEALTH CARE SPENDING IN CANADA* 5-8 (Saskatoon: Commission on the Future of Health Care in Canada, 2002).

19. *Charter*, *supra* note 5, at §5.

scope of section 7 – namely, whether its guarantee applies to socioeconomic as well as legal rights, and whether it entails positive in addition to negative rights – in the context of social assistance.²⁰ Arbour J. in dissent, with L’Heureux-Dube J. concurring on point, answered both questions affirmatively.²¹ They were of the view that section 7 extends protection to cases involving not only legal rights but also economic rights.²² Arbour J. argued that “[a]s s. 7 jurisprudence has developed, new kinds of interest, quite apart from those engaged by one’s dealings with the justice system and its administration, have been asserted and found to be deserving of s. 7 protection.”²³ She further characterized the rights guaranteed by section 7 as containing both negative and positive dimensions. That is, “in certain contexts the state’s choice to legislate over some matter may constitute state action giving rise to a positive obligation under s. 7.”²⁴ Accordingly, in the dissent’s view, the Quebec government’s decision to legislate in regards to welfare meant that it had assumed positive obligations to ensure the amount of social assistance would meet the basic needs of recipients.²⁵ The government’s failure to meet its obligations would therefore violate the welfare recipients’ right to security and, in some cases, life. Drawing a parallel between social assistance and health care, both dealing with necessities of life, this very reasoning can be used to support the claim that section 7 gives Canadians a positive right to have access to basic health care.

Although the majority of the Supreme Court did not go as far as did Arbour and L’Heureux-Dube JJ., their examination of section 7 jurisprudence did lead them to accept the possibility that section 7 “could be read to encompass economic rights”²⁶ and that “one day s. 7 may be interpreted to include positive obligations.”²⁷ Nonetheless, they concluded that this case did not warrant such interpretation of section 7 as there was insufficient evidence concerning the alleged economic hardship experienced by young welfare recipients.²⁸ Cases subsequent to *Gosselin* have seemingly confirmed the applicability of section 7 to socioeconomic contexts – most notably, in *Chaoulli*, section 7 rights were found to have been triggered by a legislative prohibition against purchase and sale of

20. *Gosselin v. Quebec (Attorney General)*, [2002] 4 S.C.R. 429, 2002 SCC 84 (Can.).

21. *Id.* at paras. 311-29 (Arbour J., dissenting); *id.* at para. 141 (L’Heureux-Dube J., dissenting).

22. *Id.* at paras. 311-13 (Arbour J., dissenting).

23. *Id.* at para. 317.

24. *Id.* at para. 328.

25. *See id.*

26. *Gosselin* *supra* note 20, at para. 81 (majority opinion).

27. *Id.* at para. 82.

28. *Id.* at para. 83.

private health insurance in the face of long wait times.²⁹ Despite these findings, it remains unclear as to when positive state obligations under section 7 may arise. On the one hand, Canadian courts have repeatedly cited *Gosselin* as authority for the proposition that section 7 may, under the right circumstances, confer positive duties upon the governments.³⁰ As such, it is conceivable that health rights litigation grounded in section 7 could one day compel the government to provide certain medical services as necessities of life. On the other hand, the courts have been equally persistent in declining to interpret section 7 in such a positive light when invited by claimants to do so. For example, in *Flora v. Ontario Health Insurance Plan*, the Ontario Court of Appeal ruled that the constitutional jurisprudence hitherto concerning section 7 did not impose a positive obligation on the government to fund out-of-country medical treatments even when the procedures were considered life-saving.³¹ This reluctance to recognize 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 the competing priorities that they entail, as falling under the responsibility of the executive rather than the judiciary. As a case in point, Binnie and LeBel JJ. cautioned in *Chaoulli* against founding a positive right to health care upon section 7 because to do so would necessitate the courts to determine the scope of health services and the length of wait times reasonably required by the Constitution.³² While such an argument has been criticized by scholars such as Lorne Sossin,³³ it remains one of the most significant hurdles to infusing section 7 with positive state obligations.

Besides section 7, governments in Canada may also be under a positive obligation to provide certain health services pursuant to section 15(1) of the *Charter*. In *Andrew v. Law Society of British Columbia*, the Supreme Court of Canada described the purpose of section 15 as “to ensure equality in the formulation and application of the law.”³⁴ The Supreme Court went on to elaborate in *Law v. Canada* that section 15(1) aims at “assuring human

29. See also *Victoria (City) v. Adams*, [2008] 88 B.C.L.R. (4th) 116 (Can.) (triggering section 7 in the context of housing).

30. See e.g., *Flora v. Ontario Health Ins. Plan*, [2008] 91 O.R. (3d) 412, para. 105 (Can.).

31. *Flora*, 91 O.R. (3d) 412, at para. 108.

32. *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791, paras. 161-279, 2005 SCC 35 (Can.) (Binnie & LeBel JJ., dissenting).

33. Sossin, *supra* note 18, at 171-73 (arguing that what the courts are asked to do in such instances is no different from, say, when the courts are asked to determine how much delay in holding a hearing is unconstitutional). He opined that courts “can provide guidelines or tests or criteria that ensure compliance with the *Charter* without running the public programs,” thus ensuring the division of power. *Id.*

34. *Andrews v. Law Soc’y of B.C.*, [1989] 1 S.C.R. 143, 1989 SCC 2 (Can.).

dignity by the remedying of discriminatory treatment.”³⁵ As such, the equality rights protected under section 15 are not positive *per se*. In other words, one cannot invoke section 15 to demand the governments to proactively address existing inequalities in society. However, section 15(1) prohibits state actions or legislations that discriminate a segment of the population on the basis of race, national or ethnic origin, colour, religion, sex, age, mental or physical disability, or some analogous grounds.³⁶ That is, once the governments have taken certain actions or enacted legislations that are discriminatory in nature, section 15(1) imposes positive obligations upon the governments to eliminate such acts of discrimination. According to McIntyre J. in *Andrew*, the concept of discrimination is two-fold: first, it may manifest as perpetuation of prejudice or disadvantage against groups of individuals due to their personal characteristics; and, second, discrimination can take the form of stereotyping, where individuals are treated solely in accordance to their association with a group rather than on the basis of actual merits and capacities.³⁷

In the context of contesting health resource allocation, section 15 may be triggered by health consumers in at least two ways. If a provincial government decides to make certain medical services available to some but not others, and if such differential treatment can be shown to have violated the dignity of those denied services, then section 15(1) may be used in court to establish an entitlement to the health services at issue.³⁸ Moreover, even when a health program appears to treat everyone in the same manner, section 15(1) may still be engaged if such equal treatment in fact fails to take into account the unique need or circumstances of certain groups or individuals.³⁹ According to the Supreme Court of Canada, identifying and remedying this type of discrimination, termed “adverse effect discrimination,” is of particular importance to people with disability.⁴⁰ It was said that “[t]he government will rarely single out disabled persons for discriminatory treatment. More common are laws of general application that have a disparate impact on the disabled.”⁴¹ For instance, in *Eldridge v. British Columbia*, the Supreme Court ruled that while all British Columbians might access a set of health services free of charge, the extent to which deaf individuals could benefit from the health care system was in

35. *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497, para. 52, 1999 SCC 675 (Can.).

36. *See Charter*, *supra* note 5, at § 15(1).

37. *See R. v. Kapp*, [2008] 2 S.C.R. 483, para. 18, 2008 SCC 41 (Can.).

38. *See Andrews*, *supra* note 34, at 1 S.C.R. 143.

39. *See id.*

40. *Eldridge v. British Columbia (Attorney General)*, [1997] 3 S.C.R. 624, para. 64, 1997 SCC 327 (Can.).

41. *Id.* at para. 64.

actuality compromised vis-à-vis other patients since they were not provided sign language interpretation and therefore faced unique challenges in communicating with health care providers.⁴² The non-provision of sign language interpretation was therefore found in violation of section 15(1).⁴³

Whether it is grounded on the basis of section 7 or achieved indirectly through section 15, successful juridical finding of a positive right to publicly funded health services needs to be implemented in the real world to achieve a lasting impact for patients. Although theoretically possible, to date health rights litigation in Canada has not, in our view, engendered an outcome where the positive obligations found by courts with respect to certain medical services are then satisfactorily discharged by the governments. On the one hand, courts have not yet actualized the possibility of section 7 being interpreted as giving rise to a positive socioeconomic right. On the other hand, as will be discussed in more detail in the next section, on the only occasion to our knowledge where the Supreme Court of Canada has recognized an entitlement to publicly financed health services based on section 15 – namely, in *Eldridge* – the provinces' implementation of the court decision has been disappointing.⁴⁴

B. Positive Right to Health, but Failed Implementation

The second potential outcome that may result from health rights litigation involves the successful establishment of a positive right in court followed by failures to have it enforced on the ground.

In *Eldridge*, the Supreme Court was faced with the question of whether deaf patients are entitled to government funded sign language interpretation

42. *Id.* at para. 71.

43. *Id.* at para. 80.

44. See also Sossin, *supra* note 18, at 170-73. Although our typology has categorized health rights litigation into those seeking positive rights versus those seeking negative rights, Kent Roach and Lorne Sossin have questioned whether it is fruitful for jurists to continue to engage in this line of dichotomized debate. According to Roach, rather than framing an action as based on either a positive or a negative right, a more productive exercise would be to analyze health rights litigation based on the remedies sought and/or granted. Our reservation with the remedy-based analysis, however, is that Canadian courts have at times categorically refused to entertain claims of positive rights as in *Flora*. In such cases, the success or failure of a litigation arguably hinges on the characterization of the rights that one aims to establish rather than the nature of the remedies that one seeks flowing from the rights infringement. That is, in these cases, courts have sometimes ruled that the applicant's rights - being positive in nature - are not *per se* protected under the *Charter*, instead of recognizing the applicant's rights but refusing to grant a certain remedy. As such, we see the value in structuring a typology based on the positive/negative rights dichotomy. On the other hand, Sossin has argued against the distinction between positive and negative rights on the basis that such dichotomy is illusory. See Sossin, *supra* note 18 and accompanying text. While we do not dispute Sossin's observation, we wish to emphasize that the goal of our typology is mainly to devise a framework for analysing Canadian health rights litigation to-date rather than to steer the judiciary towards a certain path of normative changes.

while accessing medically necessary hospital and physician services.⁴⁵ Up until 1990, medical interpretation for deaf persons in the lower mainland of British Columbia had been provided privately by a not-for-profit organization.⁴⁶ This service, however, was discontinued in September 1990 when the non-profit agency no longer had the means to financially support it and the agency's request for government funding was denied.⁴⁷ The plaintiffs in this case, who were deaf and communicated through American Sign Language, claimed that after the termination of the free medical interpreting program their access to interpreters at hospitals was severely hindered by financial barriers.⁴⁸ They argued that the government's failure to step in and finance medical interpreting services amounted to a violation of section 15 of the *Charter* as it deprived deaf patients of the equivalent quality of care received by other patients.⁴⁹

In a unanimous judgement in favour of the plaintiffs, the Supreme Court characterized effective communication as "an integral part of the provision of medical services."⁵⁰ It observed that "miscommunication can lead to misdiagnosis or a failure to follow a recommended treatment," particularly in situations of emergency.⁵¹ The Court went on to stipulate that the non-provision of medical interpreting services for deaf patients, in light of the fact that other patients can communicate with their health providers free of charge, constituted an unequal benefit of the law in a manner that violated deaf individuals' human dignity.⁵² Furthermore, this infringement of deaf persons' equality right could not be exempt by section 1 of the *Charter* as it could not be considered "demonstrably justified in a free and democratic society."⁵³ The thrust of the Court's ruling with respect to section 1 was that offering sign language interpretation for the entirety of British Columbia would cost only be \$150,000, or approximately 0.0025 percent of the province's health care budget at the time.⁵⁴ The complete refusal by the government to finance medical interpreting services in such context was seen as failing to minimally provide for the deaf persons' *Charter* rights.⁵⁵

To remedy this unconstitutionality, the Supreme Court gave the government of British Columbia six months to explore its policy options

45. *Eldridge*, 3 S.C.R. 624, at para. 1.

46. *Id.* at para. 3.

47. *Id.*

48. *Id.* at para. 71.

49. *Id.*

50. *Id.* at para. 69.

51. *Eldridge*, *supra* note 45, at para. 69.

52. *Id.* at para. 71.

53. *Charter*, *supra* note 5, at § 1.

54. *Eldridge*, 3 S.C.R. 624, at para. 65.

55. *Id.*

and implement the necessary changes.⁵⁶ The Court held that, upon the expiration of this grace period, it would be expected that “sign language interpreters will be provided where necessary for effective communication in the delivery of medical services.”⁵⁷ British Columbia responded to the court order in two phases. On April 14, 1998, shortly before the six-month grace period was about to expire, the provincial government introduced a 24-hour toll-free line (both voice and TTY) whereby deaf patients could request for medical interpreters in emergency situations.⁵⁸ The second phase of the government response was scheduled to take place in August of that year where publicly-funded interpretation services for deaf patients accessing non-emergency hospital and physician services would be provided.⁵⁹ Publicly financed interpreters would supposedly be also available to deaf patients’ caregivers and deaf parents of hearing patients.⁶⁰ However, the medical interpreting program would not cover interpreters at physiotherapy, massage, dental and chiropractor appointments.⁶¹

Technically, the application of the *Eldridge* decision could be interpreted as limited to British Columbia since the province was the sole direct party to the case and the Supreme Court had relied on province-specific health care figures in justifying its findings under section 1.⁶² Nevertheless, constitutional law scholars such as Kent Roach have criticized this narrow reading of the case, arguing that “it is untenable to think that general constitutional law issues decided by the Supreme Court of Canada must be re-litigated on a province-by-province basis. Such an expensive and costly approach would make remedies illusory for disadvantaged groups affected by the Court’s decisions.”⁶³ These criticisms notwithstanding, in July 2000, almost three years after the release of the *Eldridge* decision by the Supreme Court, the government of Ontario became just the second Canadian province to provide publicly funded sign language interpretation in health care settings.⁶⁴ To-date, British Columbia and Ontario remain the only

56. *Id.* at para. 96.

57. *Id.* at para. 70.

58. Kent Roach, *Remedial Consensus and Dialogue under the Charter: General Declarations and Delayed Declarations of Invalidity*, 35 U.B.C. L. REV. 211, 228-29 (2002); See also Press Release, B.C. Govt., Medical Sign Language Interpreter Services Introduced in British Columbia (Apr. 8, 1998), reprinted in MOUNTAIN EAR May 1998, at 5, <http://www.chha-nsb.com/Newsletters/ARCHIVE/SPEAK19.pdf>.

59. *Id.*

60. Prince George Citizen, *British Columbia: Expanded Interpretive Service for Deaf Funded*, VANCOUVER SUN, Dec. 12, 1998, at B1.

61. *Id.*; See also Western Inst. for the Deaf & Hard of Hearing, Medical Interpreting Services, http://www.widhh.com/services_medicalinterpreting.html (last visited Mar. 29, 2010).

62. See *Eldridge*, *supra* note 45, 3 S.C.R. 624.

63. Roach, *supra* note 58, at 230.

64. Editorial, *Deaf Rights Victory Paves Way for Change*, THE TORONTO STAR, Sept. 16,

provinces that have followed through with the Supreme Court's order in *Eldridge*.⁶⁵ It is therefore not surprising that disability groups and activists have voiced their disappointment with the governments' implementation of the *Eldridge* decision thus far. For example, the Canadian Association of the Deaf has identified the need to enforce the *Eldridge* ruling across Canada as a top advocacy issue for deaf people in relation to health care.⁶⁶ David Lepofsky, a legal activist whose writing was quoted by La Forest J. in the *Eldridge* judgement, observed the outcomes resulted from the case as follows: "It was a big court breakthrough but the impact has been weak because governments have never lived up to their obligations."⁶⁷

Even in the two provinces where free medical interpreting services are available, there have been concerns with timely access to sign-language interpreters. In Ontario, the health-related sign language interpretation programs were initially given a budget of \$4.7 million per year.⁶⁸ In comparison to the \$150,000 annual cost that the Supreme Court had estimated for a comparable program in British Columbia,⁶⁹ the amount of funding from the Ontario government would seem to be more than sufficient.⁷⁰ However, this figure, according to the Canadian Hearing Society, represented only half of what was actually necessary to establish and operate an effective interpretation system in Ontario.⁷¹ Assuming the estimate by the Canadian Hearing Society was accurate, its significance was arguably two-fold. On the one hand, the real cost to operate a medical sign language interpretation program, being much more expensive than the Supreme Court had found in *Eldridge*, might have contributed to the slow uptake of the Court's order by Canadian provinces. On the other hand, an interpretation service founded upon an overly optimistic cost estimate would soon be proven incapable of meeting the actual needs of deaf persons. In 2006, a *Toronto Star* newspaper article identified a serious lack of sign language interpreters in Ontario, which had left deaf patients

2000, at RL02.

65. Ann Silversides, *Outcome of Health Related Changes is Sometimes Surprising*, CAN. MED. ASS'N J. NEWS, Oct. 9, 2009, http://www.cmaj.ca/earlyreleases/9oct09_legal_challenges.dtl.

66. CAN. ASS'N OF THE DEAF, DEAF ISSUES: HEALTH CARE, http://www.cad.ca/en/issues/health_care.asp.

67. Helen Henderson, *In The Shadows No More; After 25 Years of Activism, The Emphasis is Finally on Ability Not Disability*, TORONTO STAR, Mar. 15, 2008 at L1.

68. Editorial, *supra* note 64.

69. *Eldridge*, 3 S.C.R. 624, at para. 87.

70. Based on the Supreme Court of Canada's figure (i.e. \$150,000 per annum, *Eldridge*, 3 S.C.R. 624, at para. 87) and having adjusted for population differences and inflation, the medical sign language interpretation program should cost approximately \$485,000 annually. This is almost ten times less than the initial budget allocated by the Ontario government.

71. Editorial, *supra* note 64.

vulnerable to miscommunication with health providers particularly in emergency situations.⁷² The metropolitan Toronto area was reportedly hit the hardest by the interpreter shortage.⁷³ While there were up to 30,000 deaf Torontonians, there were only two sign language interpreters available for after-hour emergencies at the time.⁷⁴ Exacerbating the problem was the fact that there was only one school in the province that offered interpreter education programs, introducing merely four new sign language interpreters a year to the pool.⁷⁵ Similar interpreter shortage has also been experienced in British Columbia.⁷⁶ It has been reported that it may take more than two weeks for a deaf person in the province to get an appointment with an interpreter.⁷⁷ Such inaccessibility to sign language interpreters, especially in times of crisis, clearly runs against the spirit of the *Eldridge* decision which emphasized the centrality of effective communication in the delivery of health care.⁷⁸

To our knowledge, since the advent of the *Charter*, there have only been twelve cases in which the Supreme Court of Canada has ruled a state action or some legislation unconstitutional on the ground of section 15.⁷⁹ Of these successful cases, *Eldridge* appears to be the only one that deals directly with health resource allocation. However, the trajectory of the *Eldridge* case – namely, courtroom successes in establishing positive obligations upon the governments followed by unsatisfactory fulfilment of these obligations – is by no means unique. For example, in *Little Sisters v. Canada*, the Supreme Court of Canada found, *inter alia*, that Customs officials had discriminatorily applied the obscenity law to target gay and lesbian materials imported into the country and therefore violated section 15(1).⁸⁰ Specifically, the Court declared that Canada Customs had failed “to extend to the [claimants] the equal benefit of fair and expeditious treatment of their

72. Anna Piekarski, *Deaf Lack Help in Crises*, TORONTO STAR, July 25, 2006, at B1.

73. *Id.*

74. *Id.*

75. *Id.*

76. Allison Cross, *Phone Service Lures Away Deaf Interpreters*, VANCOUVER SUN, May 9, 2008, at B5.

77. *Id.*

78. *Eldridge*, 3 S.C.R. 624, at para. 69.

79. See MARY HURLEY, OTTAWA PARL. INFO. & RESEARCH SERV., CHARTER EQUALITY RIGHTS: INTERPRETATION OF SECTION 15 IN SUPREME COURT OF CANADA DECISIONS 17-31 (2007). Hurley compiled a list of section 15 cases decided by the Supreme Court of Canada as of March 2007. See *id.* There were a total of fifty-two cases, of which twelve were successful. A review of Supreme Court of Canada cases post-March 2007 revealed another seven cases where alleged violations of section 15 were at issue. In all seven cases, the section 15 claims were dismissed by the Court.

80. *Little Sisters Book & Art Emporium v. Canada*, [2000] 2 S.C.R. 1120, para. 154, 2000 SCC 69 (Can.).

imported goods without discrimination based on sexual orientation.”⁸¹ Following the case, the federal government arguably had a positive duty to remedy such a failure. Nonetheless, the claimants have since alleged that while seizures of their imported materials by Customs officials had stopped during litigation, the practice resumed no less than two weeks after the Supreme Court decision was released, prompting them to launch another lawsuit against the federal government.⁸² As such, it is not unperceivable that if future health rights litigation again gives rise to positive entitlement it may once more, like *Eldridge*, fall into this second category of our typology instead of the first.

The aftermath post-*Eldridge* serves as a sombre reminder that even a successful juridical recognition of a positive right to health services is not in and of itself sufficient to effect sought-after changes in practice. As seen in *Eldridge* and *Little Sisters*, the Supreme Court of Canada’s preferred remedy in dealing with unconstitutionality appears to be a declaration of invalidity or just a declaration of entitlement rather than an injunction that details the exact measures required of the governments to correct the illegality.⁸³ While a declaratory remedy affords much flexibility to the governments in formulating an appropriate policy response, the benefits of which are best illustrated in the case of *Chaoulli*, as will be discussed later, it also runs the risk of being taken advantage of by the governments to circumvent the Court’s rulings.⁸⁴ As mentioned, most Canadian provinces have not developed a medical sign language interpretation program following *Eldridge*. Although the implementation of such programs understandably takes time and resources, government inactions more than ten years after the court decision would seem to suggest that these provinces have apparently interpreted the *Eldridge* ruling in its narrowest light such that they do not believe they are bound by the Court’s finding of unconstitutionality. Even in the provinces where initial steps seem to have been taken in response to the court order, there are doubts in the governments’ commitment to support the medical sign language interpreter program with necessary monetary and human resources over the long run. Legal scholars such as Kent Roach and Geoff Budlender have therefore recommended Canadian courts to take on a greater role in supervising the

81. *Id.*

82. Patrick Brethour, *Little Sisters Closing Book on Legal Battle*, GLOBE & MAIL, Jan. 23, 2007, at S1.

83. Roach, *supra* note 58, at 227.

84. See *Little Sisters*, 2 S.C.R. 1120, at para. 258 (Iacobucci J., dissenting) (“[D]eclarations are often preferable to injunctive relief because they are more flexible, require less supervision, and are more deferential to the other branches of government. However, declarations can suffer from vagueness, insufficient remedial specificity, an inability to monitor compliance, and an ensuing need for subsequent litigation to ensure compliance.”).

implementation of the governments' remedial measures.⁸⁵ However, if it indeed happens, such juridical development will likely take some time. At present, it appears that the limitations of the legal system will unfortunately be borne by the claimants since they will often need to engage in post-litigation advocacy efforts to exert political pressure to ensure that the governments continue to fulfil their legal obligations overtime.

C. Negative Rights in the Canadian Health Care System

In the majority of health rights litigation where Canadian health consumers have enjoyed juridical successes, negative rights rather than positive rights have been obtained.⁸⁶ Most frequently, these lawsuits involve the repeal of some legislative prohibition against a specific therapy or a certain way of financing the health care system on the ground that it violates the *Charter*-guaranteed right to life, liberty and security of the person and is not justifiable under section 1.⁸⁷ As such, the rights established by health consumers in these cases are the liberty to be free from government interference when accessing a specific health service or resource. The effect of these negative rights on the governments' allocation of health care dollars tends to be limited in comparison to that of positive rights. Once the legislative ban in question is removed, these negative rights do not further give rise to corresponding obligations upon the governments to publicly provide the once-prohibited services. Despite this limitation, as legal challenges of this nature are increasingly targeting the very structure of Medicare financing – namely the prohibition against private health insurance – with some successes, juridical finding of even a negative right may nonetheless have significant ramifications for the Canadian public

85. See Kent Roach & Geoff Budlender, *Mandatory Relief and Supervisory Jurisdiction: When is It Appropriate, Just and Equitable?*, 122 S. AFR. L.J. 325, 345-51 (2005). Roach and Budlender suggest that governments may fail to comply with a court's constitutional ruling due to inattentiveness, incompetence or intransigence. Insofar as these reasons for non-compliance represent increasingly severe constitutional breach, they argued that courts should issue escalating levels of remedies accordingly - ranging from general declaration to detailed mandatory interdicts with courts retaining supervisory jurisdiction. See also Roach, *supra* note 58.

86. Our review of case laws yielded a total of nineteen cases (up to August 2009) in which the Canadian *Charter* was relied upon by health consumers to demand public funding for certain therapies or to access care in a timely manner. In seven of these cases, health consumers were successful in their *Charter* claims. Of them, *Eldridge* was the only one where a positive entitlement to a specific health program was found. See also Ran Hirschl, 'Negative' Rights v. 'Positive' Entitlements: A Comparative Study of Judicial Interpretation of Rights in an Emerging Neo-Liberal Economic Order, 22 HUM. RTS. Q. 1060, 1074-76 (2000) (finding a total of 371 *Charter*-based cases decided by the Supreme Court of Canada between 1982 and 1999. In 131 of these cases, *Charter* rights were successfully invoked, consisting of 117 negative rights claims and fourteen involving positive and collective rights).

87. See *Charter*, *supra* note 5, at § 1.

health care system.

i. Access to Treatment and Therapy

The case of *R. v. Morgentaler*, where the constitutionality of the criminal ban on abortion was under challenge, is an example of health consumers successfully asserting a right to access a particular medical service without state interference.⁸⁸ Section 251 of the *Criminal Code* at the time prohibited all abortions unless it was found by the therapeutic abortion committee of an approved hospital that the continuation of pregnancy would endanger the woman's life or health.⁸⁹ This criminal provision was struck down by the Supreme Court for having unjustifiably contravened women's right to security of the person as protected under section 7 of the *Charter*.⁹⁰ Chief Justice Dickson held that the impugned provision not only threatened women's physical integrity by removing from them the power of deciding whether to undergo therapeutic abortions but also imposed serious psychological stress upon women.⁹¹ Furthermore, in his opinion, the approval process stipulated in the *Criminal Code* caused unnecessary delays for women who were legally entitled to abortion services and consequently undermined these women's wellbeing.⁹² In his concurring opinion, Justice Beetz went further to contend that the *Charter* protection over one's security of the person "must include a right of access to medical treatment for a condition representing a danger to life or health, without fear of criminal sanction."⁹³ Wilson J., who also ruled in favour of revoking the criminal ban on abortion, arguably took the broadest view.⁹⁴ She argued that the criminal law provision in question not only violated women's right to security of the person but also their right to liberty.⁹⁵ She opined that "[t]he right to 'liberty' contained in s. 7 guarantees to every individual a degree of personal autonomy over important decisions intimately affecting his or her private life."⁹⁶ Women's decision over whether to terminate a pregnancy, because of its notable psychological, economic and social consequences, falls under this protected category.⁹⁷

Although neither Beetz J.'s interpretation of the right to security of the person nor Wilson J.'s understanding of the right to liberty represented the

88. *Morgentaler*, 1 S.C.R. 30, at para. 38.

89. Canada Criminal Code, R.S.C. 1970, ch. C-34, § 251.

90. *Morgentaler*, 1 S.C.R. 30, at para. 32.

91. *Id.* at para. 32.

92. *Id.* at para. 36.

93. *Id.* at para. 34 (Beetz J., concurring).

94. *Id.* at para. 36 (Wilson J., concurring).

95. *Morgentaler*, 1 S.C.R. 30 at para. 36-37.

96. *Id.*

97. *Id.* at para. 37.

majority opinion in *Morgentaler*, they nonetheless forewarned the governments to exercise extra caution when utilizing criminal law in a non-nuanced manner to deal with complex health care issues.⁹⁸ Subsequently, there have been a number of cases in which courts repealed criminal law provisions that indiscriminately barred the access to certain therapies from all Canadians regardless of any special circumstances. As a case in point, in *R v. Parker*, the Ontario Court of Appeal ruled that the complete prohibition against possession of marihuana intruded upon the right to liberty and security of the person of those who genuinely required the substance for medicinal purposes, and such intrusion was not in accordance with the principles of fundamental justice or the justified limitations in a free and democratic society.⁹⁹ In reaching its decision, the Ontario court adopted the views of both Beetz and Wilson JJ. on the scope of section 7 rights.¹⁰⁰ Similarly, in *PHS Community Services Society v. Canada*, the British Columbia Supreme Court invalidated Canada's absolute and unqualified ban on possession and trafficking of controlled substances on the ground that it violated the section 7 rights of injection drug users who were in need of harm reduction therapy.¹⁰¹

Initially, these legal successes seemed to have prompted the kind of policy changes sought by activists. Subsequent to the decision of *Morgentaler*, except for an unsuccessful attempt that was defeated by the Senate in 1991, there have been no legislative actions at the federal level to recriminalize abortion.¹⁰² Since 1995, abortion has been recognized by the federal government as a medically necessary service and should be publicly funded by the provinces pursuant to the *Canada Health Act*.¹⁰³ As for medicinal marihuana, the government of Canada decided not to appeal the appellate court's ruling in *Parker*.¹⁰⁴ It introduced the *Marihuana Medical Access Regulations* ("MMAR")¹⁰⁵ in summer 2001. Under these regulations, individuals suffering from debilitating symptoms associated with medical

98. *Id.* at para. 36, 38.

99. *See R v. Parker*, [2000] 49 O.R. (3d) 481, para. 190 (Can.).

100. *Id.* at para. 93. In the criminal law context "liberty includes the right to make decisions of fundamental personal importance" and, therefore, "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 deprivation of security of the person." *Id.* at paras. 92, 97.

101. *PHS Cmty. Servs. Soc'y v. Can. (Attorney General)*, 2008 BCSC 661, paras. 152-53, 158 (Can.).

102. Sandra Rodgers, *Abortion Denied: Bearing the Limits of Law*, in COLLEEN FLOOD, JUST MEDICARE: WHAT'S IN, WHAT'S OUT, HOW WE DECIDE 107, 110-11 (2006).

103. *Id.* at 115.

104. CAN. AIDS SOC'Y, CANNABIS AS THERAPY FOR PEOPLE LIVING WITH HIV-AIDS: "OUR RIGHT, OUR CHOICE", 20 (2006).

105. *Marihuana Medical Access Regulations*, S.O.R./2001-227 (Can.) [hereinafter MMAR].

conditions such as multiple sclerosis, spinal cord injury/disease, cancer, HIV/AIDS, severe arthritis, and epilepsy are now eligible to possess and grow marihuana for personal use.¹⁰⁶ Lastly, as a result of the *PHS* case, Canada's only legal supervised injection site located in Vancouver (i.e. Insite) – which has been operating since 2003 on the basis of a special exemption under section 56 of the *Controlled Drugs and Substances Act*¹⁰⁷ – is allowed to continue its service provision after June 30, 2008, the date that its exemption was due to expire.¹⁰⁸ Whether *PHS* will stand as an affirmation of patients' rights under section 7 remains to be seen. The federal government recently lost an appeal of *PHS*, but in the process the *ratio* of the case has changed, with section 7 issues falling into the background.¹⁰⁹ The British Columbia Court of Appeal relied on a division of powers analysis, ruling that the provincial government had authority to create safe injection sites, under its jurisdiction over health care. Citing the *doctrine of interjurisdictional immunity*, the Court ruled that the federal government could not use its criminal law powers to thwart the province's strategy for improving the health of intravenous drug addicts. At the time of writing, the federal government is deciding whether to appeal the decision.¹¹⁰

Notwithstanding such preliminary successes, however, access to therapies like abortion, medical marihuana, and safe injection programs has by and large remained difficult in Canada following decriminalization. In fact, with respect to abortion, there have been reports suggesting that accessibility of services actually declined after the *Morgentaler* decision. In 1986, two years before *Morgentaler*, there were a total of 643 hospitals in Canada with obstetrics capacity, of which 225 (i.e. 35%) provided therapeutic abortions.¹¹¹ In contrast, in 2003, a study conducted by the Canadian Abortion Rights Action League found that only 123 of Canada's 692 hospitals (i.e. 17.8%) offered abortion services.¹¹² The percentage of

106. *See id.*

107. Controlled Drugs and Substances Act, 1996 S.C., ch. 19, § 56 (Can.) ("The Minister may, on such terms and conditions as the Minister deems necessary, exempt any person or class of persons . . . from the application of all or any of the provisions of this Act or the regulations if, in the opinion of the Minister, the exemption is necessary for a medical or scientific purpose or is otherwise in the public interest.").

108. Rod Mickleburgh, *Safe-Injection Clinic Wins Legal Reprieve*, GLOBE & MAIL, May 28, 2008, at A9.

109. *PHS Cmty. Servs. Soc'y v. Can. (Attorney General)*, 2010 BCCA 14, para. 177 (Can.).

110. Ian Bailey, *Injection Court Can Stay Open*, B.C. Court Rules, GLOBE & MAIL, Jan. 15, 2010, at A1.

111. RAYMOND TATALOVICH, THE POLITICS OF ABORTION IN THE UNITED STATES AND CANADA: A COMPARATIVE STUDY 211 (1997).

112. CANADIAN ABORTION RIGHTS ACTION LEAGUE (CARAL), PROTECTING ABORTION RIGHTS IN CANADA 13 (2003). According to the Canadian Abortion Rights Action League,

Canadian hospitals with abortion services further decreased to 15.9% in 2006.¹¹³ Particularly, as of 2008, there remained no hospitals or clinics in Prince Edward Island (P.E.I) that would perform abortion.¹¹⁴ Women from P.E.I. who require therapeutic abortions must therefore obtain such procedures out-of-province and subsequently seek reimbursement from the public health insurance plan.¹¹⁵

Even at hospitals where abortion services are supposedly available, access is sometimes restricted to those having received physician referrals¹¹⁶ and those who are within the gestational limits.¹¹⁷ Furthermore, according to Canadians for Choice, when women try to contact these hospitals to enquire about therapeutic abortions, they often encounter staff members who are unaware of the availability of such services or unwilling to provide the requested information. Unsolicited anti-choice counselling, which at times has referred to myths and inaccuracies about abortion, or referral to anti-choice organizations is also common.¹¹⁸ As such, many women end up having to travel outside of their areas of residence to find a medical facility that is able and willing to perform abortions, thus incurring significant travel and accommodation expenses. In addition, in some provinces like New Brunswick, where abortions performed at clinics are not publicly funded, women who cannot access abortions at hospitals are left to

the reasons behind the decreasing number of abortion providers are multi-fold. To a certain extent, the decline can be explained by the fact that since *Morgentaler* abolished the legally required therapeutic abortion committees in hospitals, there is no longer an obligation for hospitals to have at least one trained abortion doctor on staff. Also contributing to the decline is the trend to amalgamate religious and secular hospitals, which has left publicly-funded Catholic institutions as the sole provider of reproductive health services in many communities across Canada. In many cases, these Catholic hospitals do not provide abortion services. For example, it was observed that of 127 hospital mergers that took place between 1990 and 1998, half led to the elimination of at least some, if not all, reproductive health services that had previously been available.

113. JESSICA SHAW, CANADIANS FOR CHOICE, *REALITY CHECK: A CLOSE LOOK AT ACCESSING ABORTION SERVICES IN CANADIAN HOSPITALS* 15 (2006).

114. *Abortion Information Line Disconnected*, CBS NEWS, Jan. 29, 2008, <http://www.cbc.ca/canada/prince-edward-island/story/2008/01/29/abortion-line.html>.

115. Tatalovich, *supra* note 111, at 32 (a woman who wishes to have her abortion publicly funded must first receive approval from a Prince Edward Island doctor who deems such procedure as medically necessary, and subsequently have the doctor submit a request for funding to the province's Department of Health and Social Services).

116. Sanda Rodgers, *Women's Reproductive Equality and the Supreme Court of Canada*, in *HEALTH LAW AT THE SUPREME COURT OF CANADA* 189, 214 (Jocelyn Downie & Elaine Gibson eds., 2006) (noting that in New Brunswick, for instance, the referrals of two physicians are required to access abortion services).

117. Tatalovich, *supra* note 111, at 15. A national survey of hospitals found that, among those responded, 1 would only perform abortions up to 10 weeks of gestation, 9 would do so up to 12 weeks, 3 up to 13 weeks, 6 up to 14 weeks, 1 up to 15 weeks, 3 up to 16 weeks, 1 up to 18 weeks and 2 up to 20 weeks. *Id.*

118. *Ibid.*, at 42-44.

pay for their procedures, ranging between \$500 and \$750, out of pocket.¹¹⁹ This financial burden poses a particular access barrier to women from marginalized communities, including youth, those who are poor, and those who live in rural and northern areas.

The situation of access to medicinal marihuana under the *MMAR* tells a similar tale. It is frequently reported that there are approximately 400,000 Canadians who utilize marihuana for therapeutic reasons.¹²⁰ However, by June 2006, there were less than 1,400 people who were legally permitted to possess marihuana under the *MMAR*.¹²¹ This figure only rose to fewer than 2,400 people in February 2008.¹²² Many of the factors that have contributed to this low participation rate mirror the access barriers mentioned in regards to abortion. Whereas some women seeking therapeutic abortions are uninformed of where and how to access services and are sometimes given false information by hospital staffs, some individuals who meet the eligibility criteria under the *MMAR* are unaware of or are misinformed about the federal medical marihuana program.¹²³ Others are unwilling or unable to undergo the application and yearly renewal processes that are perceived as overly complex; applicants must not only complete the necessary forms, obtain passport-type photographs and gather the required signatures from a physician, but also cover the costs thereof.¹²⁴ Just as the requirement of physician referrals in the abortion setting sometimes left women in peril of being denied services by doctors with anti-choice beliefs, the need to attain physician declaration and signatures under the *MMAR* has in some cases impeded patients' access to medicinal marihuana because of unsupportive doctors.¹²⁵

Even for people who have successfully registered in the federal medical marihuana program, there have been significant barriers concerning access to marihuana from licit sources. Pursuant to the *MMAR*, authorized individuals may obtain marihuana by purchasing it from the government, by attaining seeds from Health Canada and growing their own crops, or by designating a person to grow for them.¹²⁶ However, only less than 1 in 5 authorized users in Canada have chosen to acquire their marihuana from the

119. *Ibid.*, at 24.

120. CAN. AIDS SOC'Y, *supra* note 10404, at 1.

121. *Ibid.*

122. Brian Preston, *Eight Years of Reefer Madness; Why Can't Ottawa Deliver a Sensible, Humane Medicinal-Marijuana Program?* NAT'L POST, Feb. 27, 2008, at A18. In comparison, in Oregon – with a population one-tenth of that of Canada – there were 15,000 individuals registered in its medical marihuana program. *Id.*

123. See CARAL, *supra* note 12012.

124. *Ibid.*, at 33.

125. *Ibid.*, at 34-35.

126. *MMAR*, *supra* note 105, at § 70.

government as some users have questioned the quality and potency of state-provided marihuana.¹²⁷ Given the compromised health status of many of these authorized users, the number of people who elect to cultivate their own marihuana has also remained low.¹²⁸ While it is possible for patients to designate another person to grow marihuana for them, up until May 2009 the *MMAR* prohibited each designated grower to produce marihuana for more than one authorized user,¹²⁹ thus largely eliminating the financial incentive for anyone wishing to become a licensed grower.¹³⁰ Consequently, many medical marihuana users are forced to access their marihuana through the black market, often from questionable suppliers and at high prices.¹³¹

Access for intravenous drug users in Canada to harm reduction programs post-*PHS* does not fare much better, either. Although the court order secured the legal basis for Insite to remain open in the short-term, as the federal government has decided to appeal the decision,¹³² the site's long-term viability remains uncertain. Further, given that Insite has been operating at its full capacity,¹³³ some advocates had hoped that the *PHS* case would encourage similar safe injection facilities to be established elsewhere in Canada. Despite some initial interest expressed immediately after the release of the *PHS* decision, in August 2008 the Quebec government announced that it would not proceed with opening a safe injection site in Montreal at this time.¹³⁴ As such, Insite remains the only legal supervised injection facility in Canada.

These issues of access illustrate the limitations of health rights litigation that only brings about negative rights. Sanda Rodgers, who has written extensively about the access barriers to abortion services post-*Morgentaler*,

127. *Sftekopoulos v. Canada* (Attorney General), [2008] 3 F.C.R. 399, para. 19 (Can.). [*Sftekopoulos*].

128. *Hitzig v. R.*, [2003] 231 D.L.R. (4th) 104, para. 40 (Can.).

129. Tim Naumetz, *Cabinet Tweaks Medical Marijuana Rules After Losing Court Case*, CAN. PRESS, May 26, 2009, available at http://ca.news.yahoo.com/s/capress/090525/health/health_marijuana_cabinet (discussing the increase the number of medical marihuana users to whom each licensed grower can supply from one to two.).

130. *Hitzig*, 231 D.L.R. (4th) 104, at para. 70.

131. *Id.* at para. 22.

132. "Ottawa in Court bid to Shut Safe Injection Site", THE CANADIAN PRESS, (Apr. 27, 2009), http://www.ctvbc.ctv.ca/servlet/an/local/CTVNews/20090427/BC_insite_court_lawyers_090427/20090427/?hub=BritishColumbiaHome.

133. Amy Husser & Meagan Fitzpatrick, *Tories to Appeal Insite Decision; Ottawa to Fight Court Ruling that Allows for Injection-Drug Users to Stay Open*, VANCOUVER SUN, May 30, 2008, at B1 ("The site's advocates point out that it is operating at full capacity, with up to 800 people using it every day."). See also *PHS Cmty. Servs. Soc'y v. Can.* (Attorney General), 2008 BCSC 661, para. 85 (noting that there have been more than 8000 individuals that accessed Insite since its inception and the facility operated near capacity).

134. Aaron Derfel, "We want safe injection sites here: coalition; Health minister urged to reconsider policy" *The [Montreal] Gazette* (Aug. 23, 2008) A6.

observed:

“[T]he reasoning in *Morgentaler* suggests the actual limits of its impact, as well as the increasingly narrow legal topography of the cases that follow. . . . There is no suggestion of any state obligation to provide women with appropriate and timely access to means by which they can control their reproduction so as to enhance their equality. There is no constitutional impediment to state interference with women’s bodily security so long as the state involvement is properly procedural. Current impediments to abortion continue to track exactly these fault lines.”¹³⁵

That is, at the very least, a pronouncement of a negative right means that the governments are free to take a laissez-faire approach in regards to the development and administration of the health services in question, notwithstanding aforementioned decreasing number of service providers, financial and administrative barriers and in some cases unsupportive care professionals. Aside from removing the unconstitutional criminal sanctions, the governments are not under a legal obligation to actively ensure the accessibility of therapies such as abortion, medical marihuana and harm reduction programs.

Moreover, successful establishment of a negative right does not prevent the governments from restricting service access altogether. As these cases are concerned with specific legislative provisions, it is possible for the governments to introduce new laws to replace those struck down by courts. If problems arise with respect to the constitutionality of these new pieces of legislation, it will be again up to health consumers to bring their concerns to courts, thus disadvantaging those who do not have the time or financial resources to do so. For instance, after section 251 of the *Criminal Code* was revoked by the *Morgentaler* ruling, many provinces sought to re-establish restrictions to abortion services by introducing their own laws and regulations, which in turn sparked a series of legal challenges across Canada.¹³⁶ While many of these provincial legislations were successfully repealed by courts, some of these cases were not resolved until having reached the Supreme Court of Canada years later.¹³⁷ Even more frustrating

135. Rodgers, *supra* note 116 at 206-207.

136. See e.g. *British Columbia B.C. Columbia Civil Liberties Association v. British Columbia B.C. (A.G.)* (1998), B.C.L.R. (2d) 189 (under challenge was British Columbia Regulation 54/88, which excluded abortion as a medically necessary and therefore public-funded service except when it was performed in a hospital and when there was a significant threat to the mother’s life); *Lexogest Inc. v. Manitoba (A.G.)* (1993), 85 Man.R. (2d) 8 (a Manitoba regulation that refused funding for costs of abortions unless they were performed at hospitals was under challenge).

137. See *R v. Morgentaler*, [1993] 3 S.C.R. 463 (the Nova Scotia *Medical Services Act*, which outlawed privatization of certain therapeutic procedures including abortion, was found in violation of the federal government’s criminal law jurisdiction and therefore unconstitutional); *Morgentaler v. New Brunswick (A.G.)* (1995), 156 N.B.R. (2d) 205 leave

to health consumers was arguably the failed attempt to overturn Prince Edward Island's *Health Services Payment Act Regulations*, which limit the province's insurance coverage of abortions to only those performed at hospitals and deemed by the provincial Health and Community Service Agency to be medically necessary, effectively recreating the unconstitutional approval scheme under section 251 of the *Criminal Code* for those unable to pay out of pocket.¹³⁸

The policy development in regards to medical marihuana post-*Parker* tracks a similar trajectory. As mentioned, patients registered in the medical marihuana program consistently face difficulties accessing marihuana from legal sources, partly because of the restriction under the *MMAR* that each designated grower could only provide marihuana to one authorized user. After the medical marihuana users successfully challenged the constitutionality of such restriction for having arbitrarily violated their rights to liberty and security of the person,¹³⁹ Health Canada responded in May 2009 by announcing that it would increase the number of users to whom each licensed grower can supply from one to two.¹⁴⁰ This policy change has drawn criticism from medical marihuana advocates as it is unlikely to create the necessary financial incentive for would-be growers and thereby increase the licit supply of marihuana. For this reason, some have predicted that the new regulation will eventually be repealed by courts as well.¹⁴¹ However, as this dialogue between the judiciary and the federal government drags on, patients who are in need of marihuana as medication will unfortunately continue to bear the risks associated with obtaining marihuana on the black market.

While the experiences subsequent to *Morgentaler*, *Parker* and *PHS* expose the limitations of negative legal rights in furthering health

to appeal to S.C.C. refused, 24623 (August 17, 1995) (provisions in New Brunswick's *Medical Act* that considered performing abortions outside of hospitals a form of professional misconduct were found *ultra vires* the provincial heads of power).

138. *Morgentaler v. Prince Edward Island (Minister of Health and Social Services)* (1996), 144 Nfld. & P.E.I.R. 263 (P.E.I.S.C. (A.D.)). The sole issue in this case was whether the provincial Health Services Payment Act authorized the P.E.I. Health and Community Services Agency to make a regulation that would effectively deny public payment for therapeutic abortions unless such procedures are performed in hospitals and deemed medically required; the Court of Appeal answered this question affirmatively. Because this case does not involve a constitutional challenge, it is important to note that it neither overturn *Morgentaler* [1988] nor recreate the criminal prohibition scheme. That said, this decision does make legal abortions practically inaccessible to women who cannot afford to pay privately unless their requests to undergo therapeutic abortions are considered medically necessary and the procedures are performed at hospitals.

139. *Morgentaler*, *supra* note 88, *Sfetkopoulos*, leave to appeal to S.C.C. refused, 32944 (April 23, 2009).

140. *See id.*

141. *Ibid.*

consumers' access to certain therapies and treatments, in the following section, we consider the potential ramifications of the same type of health rights litigation – namely, the successful revocation of particular legislative prohibition – when it is directed at the fiscal foundation of Canadian Medicare.

ii. Access to Private Health Insurance

Since its inception, the Canadian health care system as we now know has provided public financing for medically necessary hospital and physician services on a first-dollar basis.¹⁴² This coverage structure has largely been supported on two grounds: first, access to health care should be on the basis of need instead of ability to pay, and second, a flourishing private tier will draw resources away from the public health care system and threaten its long-term sustainability.¹⁴³ Over the years, provinces have employed a myriad of legislative schemes to curtail the development of a parallel private health care sector, ranging from direct prohibition of private insurance for publicly covered services to provisions that eliminate financial incentives for physicians to opt out of the public plan.¹⁴⁴

In *Chaoulli*,¹⁴⁵ the validity of Quebec's ban on private health insurance was challenged by Dr. Chaoulli and Mr. Zeliotis – the former was a physician who had unsuccessfully applied for a license to open an independent private hospital in the province whereas the latter was a Quebecker who had suffered from numerous health conditions and encountered difficulties accessing timely care in the public health care system. They alleged that the provincial laws in question were in breach of patients' rights as guaranteed under section 1 of Quebec's *Charter of Human Rights and Freedoms*¹⁴⁶ and under section 7 of the Canadian *Charter*. In a 4-to-3 decision, the Supreme Court agreed with the petitioners and repudiated the prohibition of private insurance on the basis of the *Quebec Charter*. Justice Deschamps, penning for the majority, ruled that in

142. Canada Health Act, *supra* note 1, ss. 18 and 19 (These two sections of the *CHA* require provincial insurance plans to outlaw, respectively, extra-billing and user charges in order to qualify for federal funding. Consequently, physicians are neither allowed to bill patients for some or all of the health care costs, nor permitted to charge patients fees that exceed what are payable by the provincial governments for the medical services in question.).

143. See e.g. *Chaoulli*, *supra* note 7, paras. 49-50 (Deschamps J. described the objectives of the Quebec legislation barring private health insurance as to ensure equality of access and to safeguard the quality of care provided by the public system).

144. Colleen M. Flood & Tom Archibald, "The Illegality of Private Health Care in Canada" (2001) 164 Can. Med. Assoc. J. 825.

145. See Manfredi & Maioni, *supra* note 9.

146. *Charter of human rights and freedoms*, R.S.Q. c. C-12, s. 1 ("Every human being has a right to life, and to personal security, inviolability and freedom.") [*Quebec Charter*].

the context of long wait lists, some patients who could have otherwise obtained timely services through private insurance unfortunately died, while many others suffered from pain and suffering before they would receive treatments in the public system. As such, the impugned laws were held to have contravened health consumers' right to life and personal inviolability. In other words, the decision afforded Quebeckers a negative right to be free from government interference when purchasing private health insurance.

Furthermore, three of the four majority judges in *Chaoulli*, whose opinion was written by McLachlin C.J.C. and Major J., also found the legislative prohibition in question to have infringed upon the Canadian *Charter*. In addition to the right to life, they held that the right to security of the person under section 7 of the *Charter* was engaged in this case as delays in treatment could result in clinically significant detriments to patients' health. The justices went on to embark on a crude international comparison of health systems and concluded that the presence of a parallel private sector would not necessarily undermine the quality of the public health care regime.¹⁴⁷ The intrusion upon patients' right to life and security of the person by Quebec's private health insurance ban was therefore found arbitrary and not in keeping with the principles of fundamental justice or the reasonable limits allowed under section 1 of the *Charter*. As Justice Deschamps decided not to rule on this aspect of the case, the Supreme Court was ultimately split over the constitutionality of the prohibition against private health insurance.

The advent of *Chaoulli* has added fuel to the intense debate over the role of the private sector in Canadian Medicare. Immediately upon the release of the Supreme Court decision, opinion leaders on both sides of the ideological divide utilized the print media as an avenue to weigh in on the ruling and to predict, and hopefully influence, future health policy developments.¹⁴⁸ Those who saw privatization as a solution to the ills of the Canadian health care system praised the decision for having taken the first step towards necessary reform.¹⁴⁹ Supporters of the public system, on the other hand, feared that the *Chaoulli* case would lead to a full-fledged two-

147. For a thorough discussion on the flaws of the Supreme Court's international comparative exercise, see Colleen Flood, "*Chaoulli*: Political Undertows and Judicial Riptides" (2008) Special Edition Health L. J. 211.

148. Amelie Quesnel-Vallee *et al.*, "In the Aftermath of *Chaoulli v. Quebec*: Whose Opinion Prevailed?" (2006) 175 Can. Med. Assoc. J. 1051 (there were a total of 290 opinion editorials published in the Canadian print media during the first six months since the release of *Chaoulli*, with those for and those against private health insurance almost evenly divided).

149. See e.g. Kazi Stastna & Irwin Block, "Champions of private health care take pride in ruling" *The Ottawa Citizen* (10 June, 2005) A3; Charlie Fidelman, "Supreme Court opens door to two-tier health system; 'Gutsy' judgement will spur reform, proponents of private care predict" *The [Montreal] Gazette* (10 June, 2005), A1; Jason Markusoff, "'Alberta government very pleased with this decision'" *Edmonton Journal* (19 June, 2005) A3.

tier regime where access to services would be improved for the privileged few on the back of the majority of Canadians.¹⁵⁰ However, almost everyone seemed to agree that the *Chaoulli* judgement would have a transformative effect on the Canadian health care landscape.¹⁵¹

In our opinion, the greatest impact that has resulted from the *Chaoulli* decision to-date is the transformation of the two-tier system from a largely discounted proposition into a legitimate policy option for Canadian health care reform. The waning support for the public regime among physicians as reflected by the policy directives of the Canadian Medical Association (CMA) post-*Chaoulli* is a telling case in point. As recent as in 2004 when the CMA sought to intervene in the *Chaoulli* case, then President-Elect of the organization, Dr. Albert Schumacher, was quoted as stating that the CMA had “a special interest and concern in ensuring that patients have timely access to quality health care within a well-funded public health care system.”¹⁵² No sooner than two months after the release of the Supreme Court ruling in 2005, however, the majority of delegates at the annual CMA meeting endorsed a motion that supported private health care and private health insurance for patients who could not access timely treatment in the public regime.¹⁵³ At the CMA meeting the following year, the delegates again passed a number of resolutions concerning what it termed the “public-private interface,” including a call for the repeal of provincial legislations that bar physicians from practicing in both the private and public sectors.¹⁵⁴ This prohibition of double dipping has been part and parcel of provinces’ regulatory scheme to prevent a flourishing private health care system. At the same time, a motion for the CMA to “[u]rge governments to recognize that parallel private health insurance for medically necessary physician and

150. See e.g. Sam Shortt, “Ruling won’t improve health care” *The Ottawa Citizen* (15 June, 2005), A15; Scott Sinclair, “Opening the gate for a Trojan horse” *The Toronto Star* (30 June, 2005), A31; Lawrie McFarlane,

“Commentary: Supreme Court Slaps For-Sale Sign on Medicare” (2005) 173 *Can. Med. Assoc. J.* 269.

151. See e.g. Cristin Schmitz, “Court ruling will likely spark legal challenges: ‘It fundamentally reshapes the landscape’” *Calgary Herald* (10 June, 2005) A6; Mark Kennedy, “Historic health ruling: Decision will transform Canada’s health system” [*Saskatoon*] *Star-Phoenix* (10 June, 2005) A1; “Editorial: Private Medical Care Comes to Canada,” (2005) 173 *Can. Med. Assoc. J.* 225.

152. Patrick Sullivan, “CMA granted right to intervene in key Supreme Court case” *Health Care News* (Jan. 26, 2004), Canadian Medical Association, http://www.cma.ca/index.cfm?ci_id=4592&la_id=1.

153. Barbara Sibbald, “CMA okays private health care for waiting patients” (2005) 173 *Can. Med. Assoc. J.* 585.

154. Barbara Sibbald, “CMA’s direction on the public-private interface” (2006) 175 *Can. Med. Assoc. J.* 1047 [CMA Direction]. In 2007, the CMA released a vision paper that reaffirmed the call to remove the ban on double dipping. See CMA, *It’s Still About Access! Medicare Plus: CMA Policy Statement* (Ottawa: Canadian Medical Association, 2007).

hospital services is inconsistent with the principle that access to medical care must be based on need and not ability to pay” was rejected.¹⁵⁵

In spite of such legitimization that private financing now enjoys in Canadian health policy discourse, so far the actual impact of *Chaoulli* on Medicare has been rather limited in comparison to the transformative potential of the case that many anticipated.¹⁵⁶ As *Chaoulli* was decided on the basis of the *Quebec Charter*, its application does not extend beyond the province of Quebec. Similar prohibition of private health insurance in other provinces remains in force. Even within Quebec, the negative and contextualized nature of the right established in this case has provided the provincial government some room for policy manoeuvre. In the immediate aftermath of *Chaoulli*, the Quebec government had initially contemplated overturning not only its ban on private insurance but also its prohibition against the practice of double dipping even though the Supreme Court ruling did not actually require it to do so. Significant lobbying and efforts on the part of health law and health policy scholars eventually helped persuade the Quebec government to abandon this plan.¹⁵⁷ As the court decision is specific to the private health insurance ban, once the provision concerned is repealed, the Quebec government does not have a legal obligation to proactively overturn other laws likewise designed to discourage the flourishing of a private health care sector. In fact, since the finding of the *Quebec Charter* breach in this instance is hinged upon the context of long wait lists in the public system, the government could have even kept the prohibition of private health insurance intact so long as the problem of long wait times is properly addressed. Taking advantages of these facts, the Quebec government’s formal response to the *Chaoulli* decision arguably demonstrates a balanced approach.¹⁵⁸ In 2006, the Quebec legislature passed Bill 33: *An Act to Amend the Act respecting health services and social services and other legislative provisions*,¹⁵⁹

155. CMA Direction, *ibid*.

156. See e.g. Douglas Thomson & Dennis Jeanes, “Info – One Year after *Chaoulli* – Uncertainty and Clinical Gridlock”, online: (2007) 73 Can. Orthopaedic Assoc. Bull. 4 <<http://www.coa-aco.org/coa-bulletin/issue-73/>> (“Quebec’s formal response, in terms of an expected huge increase in private services, hasn’t come to pass and isn’t likely to in the near future.”).

157. TATALOVICH, *supra* note 111, at 222.

158. For a more detailed discussion on Quebec’s response to the *Chaoulli* decision, see Colleen M. Flood & Sujith Xavier, “Health Care Rights in Canada: The *Chaoulli* Legacy” in Andre den Exter, ed., *International Health Law: Solidarity and Justice in Health Care Access* (Portland, Oregon: Maklu, 2008). See also Marie-Claude Premont, “Clearing the Path for Private Health Markets in Post-*Chaoulli* Quebec” (2008) Special Edition Health L. J. 237.

159. Bill 33, *An Act to amend the Act respecting health services and social services and other legislative provisions*, 2nd Sess., 37th Leg., Quebec, 2006 (assented to 13 December 2006), S.Q. 2006, c. 43.

which provides for a range of measures to facilitate the fulfilment of wait time targets in the public system.¹⁶⁰ At the same time, Bill 33 liberalizes the complete ban on private health insurance to allow the sale and purchase of insurance for hip, knee and cataract surgeries.¹⁶¹ However, if the Quebec government delivers on its promise of a shorter wait time for these procedures,¹⁶² the public's demand for private insurance coverage in these three areas will likely be insignificant. Why buy private health insurance if timely treatment is assured in the public health care system?¹⁶³ Did I not read something recently about Quebec revisiting this restrained approach to private insurance?

As already seen in the contexts of abortion and medical marihuana, the negative nature of the rights rendered by courts not only has implications for governments' subsequent policy development, but it may also affect the extent that health consumers have access to the services sought after. The *Chaoulli* decision does not require that the Quebec government ensures consumers' access to private health insurance. As private insurers commonly prorate their premiums according to the perceived risks of the insured, those with the most immediate need for health insurance such as the elderly and the chronically ill will likely face the greatest financial barriers to acquiring coverage. In fact, individuals whose risks are considered to be too high are often excluded from private health insurance coverage all together. A survey conducted in 2005 found that 58% of Canadian doctors believed that their patients would either not qualify for or

160. See e.g. *ibid.*, ss. 7, 8, 17(1). Sections 7 and 8 of Bill 33 create a centralized mechanism for the management of wait lists by hospitals for specialized and super-specialized services. The Director of Professional Services is responsible for ensuring that each clinical department manages its wait times accordingly. If there are long wait times for specific specialized medical services in a region, s. 17(1) of the Act empowers the Health Minister to take measures to implement alternative procedures to alleviate the strain and ensure reasonable standards are maintained. See also Marie-Claude Premont, "Crunch time for public health care in Quebec" *The Toronto Star* (17 November 2006) A21.

161. *Ibid.*, s. 42.

162. In a discussion paper published in the wake of *Chaoulli* and before the enactment of Bill 33, the Quebec government sets out a wait time guarantee of 6 months for hip, knee and cataract surgeries. The same document also provides that if a patient waits for more than 6 months, the government will pay for treatment in a private clinic. If the wait exceeds 9 months, then the patient may receive care out-of-province at public expense. See Ministère de la Santé et des Services Sociaux (Quebec), *Guaranteeing Access: Meeting the Challenges of Equity, Efficiency and Quality* (Quebec City: Government of Quebec).

163. "No one wants Quebec's limited private health insurance: Province OK'd private insurance to speed up knee, hip and cataract surgery" *CBC News* (30 March 2009), online: *CBC News* <<http://www.cbc.ca/canada/montrealstory/2009/03/30/mtl-health-insurance-interest-0330.html>>. But see Marie-Claude Premont, *supra* note 158. Premont took a more critical view on the wait time guarantees adopted by the Quebec government, arguing that it effectively serves as a mechanism that pumps public health dollars to the private market.

be unable to afford private health insurance even if it were available.¹⁶⁴ Ironically, at sixty-five years of age and with pre-existing heart and hip conditions, Mr. Zeliotis, the patient at the centre of the *Chaoulli* case, would have likely been one of those left uninsured by the private health insurers notwithstanding his legal success.¹⁶⁵

Having observed *Chaoulli's* relatively contained impact to-date, it behoves us to caution supporters of the public health care system against breathing a premature sigh of relief as the *Chaoulli's* legacy for Medicare may not yet have played out in its entirety. In the wake of the *Chaoulli* success, proponents of private medicine have launched lawsuits of similar nature across Canada. In Alberta, Mr. William Murray is presently seeking certification of a class action against the province for the damages he allegedly sustained from being denied access to a special form of hip replacement procedure by the public health insurance plan. He argues, *inter alia*, that the denial of public coverage in conjunction with sections of the *Alberta Health Care Insurance Act*¹⁶⁶ that effectively prevent treatment access outside of the government-run regime violates his rights under section 7 of the *Charter*.¹⁶⁷ In Ontario, an ongoing case initiated by Mr. Lindsay McCreith and Shona Holmes points to the wait time problems in the province and calls into question the constitutionality of provincial regulations that are designed to suppress the expansion of the private health care sector.¹⁶⁸ The constitutional validity of similar provisions under British Columbia's *Medicare Protection Act*¹⁶⁹ is also being contested by the Canadian Independent Medical Clinic Association along with five private surgery clinics in that province represented by Dr. Brian Day, a past president of the CMA.¹⁷⁰ Unlike *Chaoulli*, however, this second wave of cases are challenging not only laws prohibiting private health insurance but also other laws working in conjunction therewith to curtail the development of a thriving private health care sector.¹⁷¹ From this perspective, if

164. Barbara Sibbald, "Questions Raised about Private Insurance" (2005) 173 Can. Med. Assoc. J. 585.

165. Colleen M. Flood, "*Chaoulli's* Legacy for the Future of Canadian Health Care Policy" (2006) 44 Osgoode Hall L. J. 273 at 309.

166. *Alberta Health Care Insurance Act*, R.S.A. 2000, c. A-20.

167. *Murray v. Alberta (Minister of Health)* (2007), 76 Alta. L.R. (4th) 118, headnote, para. 2. See also Tatalovich, *supra* note 111, at 224-225.

168. Lindsay McCreith and Shona Holmes and the Attorney General for the Province of Ontario (Statement of Claim filed at Ontario Superior Court of Justice 5 September 2007) [McCreith statement of claim]. See also Tatalovich *supra* note 111, at 226-229.

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

170. Megan Stewart, "Clinics take legal action in fight for private health care" *GLOBE & MAIL* (29 January, 2009) S1.

171. For example, in addition to Ontario's prohibition of private health insurance, McCreith and Holmes are challenging the ban on direct billing (i.e. the practice where health practitioner bills patients directly for the services provided instead of billing the provincial

successful, the implication of these cases for the Canadian health care system could be much greater than that of *Chaoulli*.

In sum, our discussions about health rights litigation that succeeds in establishing a negative right – whether with respect to a certain therapeutic procedure or to private health care financing – track a pattern of access difficulties to the services in question following judicial proceedings. To a large extent, such access barriers could be attributed to the fact that a finding of a negative right simply repeals an impugned legislation, thus allowing the governments to leave intact other existing restrictions on the health services or to introduce new policy constraints. A negative right also does not legally compel the governments to take steps to ensure accessible services. When left unchecked, unfortunately, these limitations of the law are frequently borne by the most marginalized individuals in society. However, our discussions are not intended to trivialize the accomplishments that have indeed been, or could potentially be, achieved by health consumers through this type of health rights litigation. In fact, as we have stressed, successful *Charter* challenges against laws that hinder the growth of a private health care sector may have a great impact upon the future of Canadian Medicare. Instead, our intention has merely been to highlight the limitations of negative rights-based health litigation and how such limitations may be experienced by health consumers on both policy and service access fronts. We argue that it is the responsibility of advocates and legal counsels to clearly communicate such realities to the litigants and to properly manage the complainants' expectations with respect to the legal action. It should also be understood that advocacy efforts are often required subsequent to the legal proceedings in order to facilitate treatment access, or, in *Chaoulli*-like cases, to ensure the governments do not go beyond what the courts ordered and forego their responsibilities of guaranteeing health care access on the basis of need rather than ability to pay.

D. Unsuccessful Litigation, but Positive Policy Outcomes

Whereas the above three types of health rights litigation illustrate the potential limitations of relying on successful legal challenges to instigate access to certain health services, the fourth category of health rights litigation in our typology shows that, conversely, a defeat in the courts does not necessarily settle these access questions once and for all. Occasionally, there have been cases that involved particularly sympathetic factual circumstances, and the publicity surrounding the defeat of these *Charter*

insurance plan), extra billing (i.e. the practice where health practitioner bills patients for an amount exceeding what is receivable for the service under the public insurance plan) and facility fees charged by independent health facilities. See *McCreith* statement of claim, *supra* note 168.

challenges has generated considerable public backing for the litigants' causes. As such, even when the lawsuits ultimately turned out to be unsuccessful for health consumers, they nonetheless succeeded in reshaping the discursive landscape regarding the health services in question. At times, the resulting pressure from the public has proven to be so great that it has led the governments to forfeit a courtroom victory, funding therapies after being told by the courts that they are not legally obliged to do so. The quest to have Intensive Behavioural Intervention (IBI) – a form of autism treatment that incorporates a special technique termed Applied Behavioural Analysis (ABA) – covered by Medicare is exemplary of this type of health rights litigation.

In *Auton*,¹⁷² four preschoolers with autism and their parents launched a *Charter* challenge against the province of British Columbia for failing to fund a comprehensive, universal ABA/IBI program. At the time of trial, government-financed ABA/IBI programs in British Columbia were limited to an early intervention program plus a number of autism treatment centres that offered some behaviour-based therapy. While the former was severely underfunded and as a result only had a capacity to serve six children, the latter, according to experts, lacked the necessary intensity, duration, and early onset to achieve the desired treatment outcomes.¹⁷³ Considering that the cost of well administered ABA/IBI therapy could range between \$45,000 and \$60,000 annually,¹⁷⁴ without public coverage, the treatment would be practically inaccessible to most children with autism. The plaintiffs argued that intensive, early intervention ABA/IBI programs were medically necessary for autistic children and should be universally funded by the public health insurance plan akin to health services similarly required by children with other forms of disabilities or illnesses. The government's failure to do so, the plaintiffs alleged, unjustifiably discriminated against children with autism on the basis of disability and therefore contravened section 15(1) of the *Charter*. Both the Supreme Court of British Columbia and the province's appellate court agreed.¹⁷⁵

The Supreme Court of Canada, however, overturned the lower courts' rulings and held that the plaintiffs' equality rights were not engaged in this instance. In the unanimous decision written by McLachlin C.J.C., the Court

172. *Auton v. British Columbia* (Attorney General), [2004] 3 S.C.R. 657 [*Auton*], para. 1, 2004 SCC 78 (Can.).

173. *Ibid.*, *Id.* at para. 8.

174. *Ibid.*, *Id.* at para. 5.

175. *Auton v. British Columbia* (Attorney General), [2000], 78 B.C.L.R. (3d) 55 (Sup. Ct.), para. 139, *aff'd* (2005), [2002] 6 B.C.L.R. (4th) 201 (C.A.), para. 139. *But see* Donna Greschner & Steven Lewis, "Auton and Evidence-Based Decision-Making: Medicare in the Courts", 82 Can. Bar Rev. 501, 506-08 (2003) (criticizing both trial and appellate courts' decisions in *Auton*, arguing that public funding for ABA/IBI was not supported by empirical evidence concerning the cost-effectiveness of the treatment.).

emphasized that section 15(1) of the *Charter* merely guaranteed Canadians, *inter alia*, “equal benefit of the law without discrimination.”¹⁷⁶ Since the *Canada Health Act* and the provincial *Medicare Protection Act* only required British Columbia to finance medically necessary services performed at hospitals or provided by physicians, public funding for ABA/IBI programs – which were delivered by therapists outside of hospitals – did not amount to a benefit conferred by law and therefore did not trigger the equality clause in the *Charter*. The province was legally free to decide whether to cover ABA/IBI therapy under its public health insurance plan. As such, *Auton* was distinguished from *Eldridge* in that the latter dealt with differential access to health care services that were prescribed by law. Furthermore, the Court noted that when compared to autistic children, non-disabled persons or individuals suffering from a disability other than autism were equally denied public funding for medical procedures that were emergent in nature and fell outside of the core health services defined by law notwithstanding such procedures that might be important for their health. Therefore, the plaintiffs were said to have failed in establishing a differential treatment by the government.

Despite having found against the plaintiffs, the plights of children with autism and their families were apparently not lost on the minds of the Supreme Court justices. In her judgement, McLachlin C.J.C. actually acknowledged the forcefulness of the arguments advanced by the plaintiffs and expressed sympathy for the petitioners’ cause.¹⁷⁷ The majority of the Canadian public also seemed to be in support of the plaintiffs’ endeavour in this case. According to a survey conducted by Ipsos-Reid approximately one month after the release of the Supreme Court’s decision, a staggering 89 percent of Canadians believed that the cost of IBI treatment should be covered by Medicare.¹⁷⁸ This level of support echoed the views expressed in the opinion editorials, columns and letters-to-the-editor published in the print media in the wake of *Auton*, most of which voiced a sense of disappointment, and at times even outrage, with the court ruling.¹⁷⁹ One columnist, however, offered a more positive perspective by observing that “a lot [had] been gained by the failed legal action” as the *Auton* case had “raised public sensibility with respect to autism to a level that governments

176. *Charter*, *supra* note 5, s. CAN. CONST. part I, § 15.

177. *Auton*, *supra* note 172, 3 S.C.R. 657, at para. 2.

178. “Ipsos-Reid, Canadians support autism treatment” *The Vancouver Sun* (21 December, 2004), at B3.

179. See, e.g. John Ivison, “Ottawa must now address another injustice” *National Post* (23 November, 2004), at A6 [Ivison]; Justin Himmelright, “Autistic kids deserve better” *National Post* (23 November, 2004), at A19; Jennifer Ralph, “Cowardly ruling” *Ottawa Citizen* (24 November, 2004), at A13.

now [would] be hard-pressed to ignore.”¹⁸⁰

Indeed, notwithstanding the *Auton* ruling, the general trend in Canada has been for the provincial and territorial governments to finance ABA/IBI programs at least partially. Even before the *Auton* case went to trial, public funding for IBI therapy had been made available in Alberta, Ontario, Prince Edward Island, Newfoundland and Manitoba.¹⁸¹ Whereas in British Columbia, by the time the case reached the Supreme Court of Canada, the province’s autism programs already began offering up to \$20,000 per year to families with autistic children under age six to help them purchase ABA/IBI therapy. For families with autistic children between the ages of six and eighteen, the province provided up to \$6,000 per year per child.¹⁸² While the outpour of public support for government-funded ABA/IBI programs subsequent to the *Auton* decision did not contribute to these policy developments, it arguably played a role in preventing these ABA/IBI-related benefits from being clawed back after the governments’ legal obligations to provide such services were absolved by the Supreme Court. As a case in point, the public outcry against *Auton* actually prompted the British Columbia Minister of State for Early Childhood Development to respond with an opinion editorial in the *National Post*, in which she declared that “[t]he B.C. government [was] committed to continuing to provide funding and services to children and youth with autism spectrum disorder” and that “[t]he Supreme Court decision [did] not – and [would] not – alter that commitment.”¹⁸³ In fact, across Canada, not only has the existing public funding for ABA/IBI continued post-*Auton*, but in some cases new resources have also been allocated to these treatment programs, contrary to what one might expect after a failed legal action. For example, less than two weeks following the release of the Supreme Court’s decision, the government of Nova Scotia announced that it would direct \$4 million towards early intervention IBI therapy.¹⁸⁴ In Ontario, government spending on services for children and youth with autism more than doubled between 2003 and 2006, allowing the number of children receiving IBI to increase by approximately 70 percent during this time.¹⁸⁵ By the end of 2006, all Canadian jurisdictions with the exception of Nunavut provided some public

180. Janice Harvey, “Funding autism therapy is the right thing to do” [*Saint John*] *Telegraph-Journal* (24 November, 2004).

181. *Auton*, *supra* note 172, 3 S.C.R. 657, at para. 11.

182. B.C. MINISTRY CHILD. & FAM. DEV., *Autism Spectrum Disorder – Autism Programs* (2007), http://www.mcf.gov.bc.ca/spec_needs/pdf/eligibility_autism.pdf.

183. Linda Reid, “Autism support” *National Post* (25 November, 2004), at A23.

184. Department Press Release, Dep’t of Health, “Good News for Children with Autism” *News Release* (2 December 2004), <<https://www.gov.ns.ca/news/details.asp?id=20041202004>>.

185. “Ontario expanding supports for children and youth with autism”, *NewsWire* (16 June, 2006), at 1.

funding towards ABA/IBI therapies.¹⁸⁶

At the federal level, within days of the *Auton* ruling, several members of the Canadian Parliament across political parties tabled a petition calling for the amendment of the *Canada Health Act* so that provincial funding for ABA/IBI therapy would be compulsory.¹⁸⁷ Although such attempts at legislative reform have not yet been fruitful, since the release of the *Auton* decision, a private member's bill seeking for the mandatory funding of ABA/IBI has been tabled at almost every session of Parliament since the release of the *Auton* decision.¹⁸⁸ In addition, a campaign for a national autism treatment strategy was launched by Senator Jim Munson in the wake of *Auton*.¹⁸⁹ In 2006, based on Senator Munson's motion, the issue of autism treatment funding was referred by the Senate to its Standing Committee on Social Affairs, Science and Technology for further study.¹⁹⁰ In the final report published in 2007, the Committee called on the federal government to collaborate with the provinces and territories to develop a comprehensive strategy on autism treatment and support, and recommended that the federal government assist with the financing of autism therapies.¹⁹¹ Although these developments have not yet yielded concrete policy changes, they are nonetheless indicative of the success of *Auton* in placing the issue of autism treatment funding on the federal government's political agenda.¹⁹²

186. Odette Madore & Jean-Rodrigue Pare, *Provincial and Territorial Funding: Programs for Autism Therapy* Ottawa: Library of Parliament, PRB 06-22E (2006). See also Hon. Art Eggleton et al., *The Standing Senate Committee on Social Affairs, Science, & Technology, Final Report on the Enquiry on the Funding for the Treatment of Autism: Pay Now or Pay Later: Autism Families in Crisis* (Ottawa: Library of Parliament, 39TH PARL. (1st Sess. 2007) at 7 [Senate Autism Report]. But see Kristen Yu, "The words within", *CTV News* (22 March 2008), <http://www.ctv.ca/servlet/ArticleNews/print/CTVNews/20080320/WFIVE_CarlyStory_080320/20080322/?hub=WFive&subhub=PrintStory> (in addition to the to Nunavut, the news article listed Northwest Territories as having no formal ABA/IBI programs, citing sources from Autism Society of Canada.) [Yu].

187. Ivison, *supra* note 179, at A6.

188. See Bill C-459, *An Act to amend the Canada Health Act (Autism Spectrum Disorder)*, 38th Parl., 1st Sess., (2005; Bill); C-304, *An Act to provide for the development of a national strategy for the treatment of autism and to amend the Canada Health Act*, 39th Parl., 1st Sess., (2006; Bill); C-211, *An Act to amend the Canada Health Act (Autism Spectrum Disorder)*, 39th Parl., 2nd Sess., (2007); C-360, *An Act to amend the Canada Health Act (Autism Spectrum Disorder)*, 40th Parl., 2nd Sess., (2009).

189. Ivison, *supra* note 179, at A6.

190. *Debate of the Senate (Hansard)*, Vol. 143, Issue 27 (22 June 2006) at 1800 (Hon. Noel Kinsella); SEN. DEB., 39th Parl., 1st Sess., at 648 (June 22, 2006).

191. Senate Autism Report, Comm. on Soc. Aff., Sci. & Tech., *supra* note 186, at 21.

192. For the purpose of our typology, we have narrowly assessed the policy impact of *Auton* insofar as it relates to governments' funding towards ABA/IBI programs. However, it is important to note that in a system of finite resources, the increasing share of public funding enjoyed by children with autism necessarily implies a corresponding decrease of resources for some other populations. The "positive policy outcomes" that we seek to describe in this section should therefore be read in light of this larger context.

However, in the absence of a national strategy, the extent of funding for ABA/IBI therapies remains at the discretion of provinces and territories. As a result, there are significant variations among publicly financed ABA/IBI programs across the country. Whereas Alberta offers each child with autism up to \$60,000 a year for ABA/IBI treatment until the age of eighteen, in most provinces ABA/IBI is partially funded and only for autistic children less than six years of age.¹⁹³ For example, up until 2005, Ontario's Intensive Early Intervention Program only provided IBI for children with autism aged two to five.¹⁹⁴ In *Wynberg*,¹⁹⁵ the constitutionality of this age-based funding scheme in Ontario was challenged by thirty-five autistic children and their families. The thrust of the plaintiffs' *Charter* challenge was threefold. First, they contended that, in contravention of section 15(1) of the *Charter*, autistic children age six and over were discriminated against juxtaposed to those between ages two and five because of their inaccessibility to government-funded IBI programs. Second, and also on the basis of section 15(1), the Ontario government was said to have discriminated against school-aged children with autism by failing to provide them with appropriate special education programs in the form of ABA/IBI while special education services were made available to children with other forms of disabilities. Third, the plaintiffs argued that the non-provision of publicly funded IBI programs deprived autistic children of the right to make essential life decisions about themselves as well as any reasonable prospect of meaningful participation in the community, and therefore unjustifiably violated their right to liberty and security of the person as protected by section 7 of the *Charter*.

Many parallels can be drawn between *Wynberg* and *Auton* in terms of juridical outcomes and the policy developments post-litigation. Like *Auton*, despite initial successes at trial, the plaintiffs in *Wynberg* were ultimately unsuccessful. The Ontario Court of Appeal rejected the petitioners' age-based section 15(1) claim, holding that the age cut-off in this instance was based on expert findings that suggested autistic children between the ages of two and five would benefit from the ABA/IBI therapy the most. The plaintiff's second argument – a disability-based section 15(1) claim – was refuted for lack of evidence that the existing education services were inadequate for students with autism and that ABA/IBI constituted the only appropriate special education program for this population. Lastly, the

193. Yu, *supra* note 186.

194. Rosemary Thompson, "Ontario removing age limit for autism therapy", *CTV News* (3 September, 2006), http://www.ctv.ca/servlet/ArticleNews/story/CTVNews/20060901/autism_aba_therapy_060701/20060903/.

195. *Wynberg v. Ontario*, 252 D.L.R. 10 (Can.), *rev'd*, (2006), 82 O.R. (3d) 561 (C.A.), *rev'd* (2005), 252 D.L.R. (4th) 10 (Ont. S.C.J.), leave to appeal to S.C.C. refused, 31713 (April 12, 2007) [*Wynberg*], *appeal denied*, [2007] 234 O.A.C. 397 (Can.).

petitioners' section 7 claim was dismissed as the court reiterated that Canadian jurisprudence had not yet founded a positive right upon this section of the *Charter*. However, echoing developments surrounding the *Auton* decision, the provincial government decided to remove the age limit from its publicly funded ABA/IBI programs before the *Wynberg* decision was released. In response to public confusion post-*Wynberg* over the government's commitment to autism funding, the Ontario Minister of Children and Youth Services wrote an op-ed in the *Toronto Star*, assuring Ontarians that "the . . . government [would] continue to provide services and support to autistic children regardless of age."¹⁹⁶ As such, the *Wynberg* case represents another example of health rights litigation that failed in the courtrooms but nonetheless played a part in instigating policy changes sought-after by health consumers.

While for the purpose of our typology we have highlighted the positive developments with respect to government funding for ABA/IBI programs subsequent to *Auton* and *Wynberg*, it was not our intention to suggest that autistic children's access to these therapies have since become problem-free. Like the situation with many health services, Canadian families are often faced with long wait times when attempting to access ABA/IBI programs for their autistic children. For example, in Quebec, children suspected of having autism could wait for a year or longer before receiving an official assessment; once diagnosed, it could take these children another two years to receive publicly funded treatment.¹⁹⁷ In Ontario, although a total of 1,400 autistic children were receiving government-funded IBI therapies in 2008, there were also 1,100 children waiting in line at the same time.¹⁹⁸ In light of these challenges with service access, we acknowledge that the present state of the publicly financed ABA/IBI programs falls short of the comprehensive and universal scheme demanded by the plaintiffs in *Auton* and *Wynberg*. Nevertheless, given that the governments have no legal obligations to provide ABA/IBI, the level of public funding that the therapy currently receives is reflective of the extent of support from the Canadian public on the issue, instigated in part by the failed but highly publicized lawsuits.

This type of health rights litigation – where unsuccessful *Charter* challenges have triggered public support for the health services in question

196. Mary Anne Chambers, "Ontario committed to helping autistic children", *Toronto Star* (12 July, 2006), at A23.

197. Charlie Fidelman, "Families hamstrung by wait lists; 'Window of opportunity for these children is closing'", *The Montreal Gazette* (7 April, 2008) at A1.

198. Rob Ferguson, "Autistic children face therapy delay: funding has more than tripled under Liberals, but expert says it has not kept up with demand", *TORONTO STAR* (8 August, 2008), at A15.

– is not unique to the context of autism treatment. The *Rodriguez* case,¹⁹⁹ which dealt with the issue of end-of-life care, arguably followed a similar pattern of juridical and political outcomes. Sue Rodriguez was a 42-year-old mother who suffered from amyotrophic lateral sclerosis, a neurodegenerative illness commonly known as Lou Gehrig's disease. During the course of the disease, most patients become bedridden and gradually lose the ability to speak and to ingest food. In most instances, the illness is terminal within two to three years of first diagnosis as it causes wasting of the muscles used in respiration. With her health conditions rapidly deteriorating, Ms. Rodriguez sought to take control of the circumstances surrounding her prospective death. She hoped to have an intravenous device installed by a medical practitioner that would allow her to end her life at a time of her choosing. To do so, she launched a *Charter* challenge to invalidate the criminal prohibition against aiding or abetting a person to commit suicide, arguing that the blanket ban violated her rights under sections 7 and 15(1).

In a 5-to-4 decision, however, the Supreme Court of Canada denied Ms. Rodriguez's request. Although the majority agreed that the right to security of the person under section 7 of the *Charter* encompassed the right to make choices regarding one's own body and to control one's physical and psychological integrity, it was held that the intrusion into such right by the criminal provision in question was in line with the principles of fundamental justice. That is, according to the majority of the Court, the prohibition against assisted suicide served the important function of preserving the sanctity of life and protecting the vulnerable in society. As for Ms. Rodriguez's equality rights argument, the Court found that even if the concerned criminal sanction contravened section 15 of the *Charter*, such infringement was justified under section 1 as it properly struck a balance between the right to personal autonomy and the society's respect for human life.

Despite Ms. Rodriguez's unsuccessful legal battle, supporters of assisted suicide and voluntary euthanasia believed that "she [had] won an incredibly important victory in single-handedly putting this question of the right to death with dignity on the national political agenda."²⁰⁰ In fact, as Ms. Rodriguez's case was winding through the judicial system, the tragic circumstances that gave rise to her legal action had brought much media attention to her case, which in turn generated significant public sympathy and support for her cause. In 1992, a Gallup Poll result revealed that 77% of

199. *Rodriguez v. British Columbia* (Attorney General), [1993] 3 S.C.R. 519. (Can).

200. Robin Brunet, "In the Court of Public Opinion: The Rodriguez Case Could Lead to Softer Laws on Assisted Suicide" (1993), 5:7 B.C. Report 33; see also Margaret Otlowski, *Voluntary Euthanasia and the Common Law* (Oxford University Press, 1997) at 382 [Otlowski].

Canadians agreed with the practice of euthanasia when the patient had previously made a formal request in writing. Another poll conducted in 1993 by Angus Reid found that a comparable 76% of Canadians supported the right to die for terminal patients who wished to end their lives.²⁰¹

Further adding to such public sympathy was the fact that, in February 1994, Ms. Rodriguez committed suicide with the assistance of an unnamed physician. In the wake of her death, the federal government pledged to allow a free vote in the House of Commons on whether to legalize assisted suicide and euthanasia.²⁰² Although no government-initiated bills on the subject of end-of-life care have ever been introduced in Parliament, a number of private member's bills have been tabled over the years, including several by Svend Robinson, who has become one of the strongest supporters of Sue Rodriguez's endeavour.²⁰³ Although these attempts at legislative change have remained unsuccessful to-date, as in the case of *Auton*, they nevertheless reflect the significant pressure faced by Parliament to act on the issue of assisted dying post-Rodriguez.

Even in the absence of legislative reform, the current legal status of euthanasia in Canada has been described by experts in the field as "*de jure* murder but *de facto* a considerably less serious crime."²⁰⁴ For example, Jocelyn Downie's review of cases up to 2001 where the defendants faced criminal charges for having conducted euthanasia revealed that, out of ten cases, murder charges were laid in eight, and of these, only in one instance – namely, *R. v. Latimer*²⁰⁵ – was the defendant actually convicted of murder

201. *Id.* at 262.

202. Peter O'Neil, "Rodriguez's death brings issue of right to die to forefront of our national conscience: Free vote of MPs suggested on doctor-assisted suicides" *Vancouver Sun* (15 February, 1994) at B6.

203. Marlisa Tiedemann & Dominique Valiquet, *Euthanasia and Assisted Suicide in Canada*, Ottawa: 91 Parliamentary Information and Research Services, 18-20 (2008) at 17-20 (discussing Robinson's introduction of a bill calling for the legalization of physician-assisted suicide in December 1992 and again in February 1994 upon Ms. Rodriguez's death). In 1997, he introduced a motion to have a special committee established for the preparation of a bill on euthanasia and assisted-suicide. In 2005 and again in 2008, Francine Lalonde tabled another private member's bill that would have removed criminal sanctions against assisted suicide under certain circumstances.

204. Jocelyn Downie, *Dying Justice: A Case for Decriminalizing Euthanasia and Assisted Suicide in Canada*, Univ. of Toronto Press, at 38 (2008).

205. *R. v. Latimer*, [2001] 1 S.C.R. 3, para. 19-21 (Can.) [*Latimer*]. Robert Latimer was charged with second degree murder for having killed his daughter, who had a severe form of cerebral palsy. He argued that, in so doing, he was helping to alleviate his daughter's suffering. At trial, the jury convicted Mr. Latimer but recommended a sentence of one-year imprisonment and one year of probation despite second degree murder carries a mandatory minimum life sentence with no possibility of parole for 10 years. Upon appeal, the sentence given by the jury was overturned and the mandatory minimum sentence was imposed by both the Saskatchewan Court of Appeal and the Supreme Court of Canada. Although the end result of the *Latimer* case seems to go against the proposition that euthanasia has become *de facto* a less serious crime than murder, judging by the original sentence imposed by the jury,

and sentenced to a prison term.²⁰⁶ Cases since Downie's study have generally resulted in similar outcomes.²⁰⁷ As recent as in December 2008, a Quebec man was acquitted by the jury for assisting his disabled uncle to commit suicide.²⁰⁸ While we may reasonably suspect that the *Rodriguez* case and the outflow of public support thereafter might have contributed to this jurisprudential trend, the impact of *Rodriguez* was most clearly demonstrated in the case of *R. v. de la Rocha*.²⁰⁹ In 1993, after taking part in the suicide of a terminally ill patient, Dr. Alberto de la Rocha arranged a plea bargain with the Crown where he pled guilty to the charge of administering a noxious thing in exchange of the prosecution dropping the second degree murder charge. According to the prosecutor, one of the motivations for agreeing to the plea bargain was "the fact that the Sue Rodriguez case was unfolding at the same time and the Gallup Polls were indicating that eight out of ten favoured her."²¹⁰ In the end, Dr. de la Rocha was given three years of probation. As such, though it has not yet brought about legislative change, the *Rodriguez* case arguably has effected the liberalization of the blanket criminal sanction against assisted suicide and voluntary euthanasia insofar as it has been able to influence the prosecutorial discretion and the views of jurors.

E. Unsuccessful Litigation, and Lost Political Momentum

While cases like *Auton*, *Wynberg*, and *Rodriguez* illustrate the possibility for health consumers to obtain the desired medical services through political means despite unsuccessful attempts at establishing a legal entitlement, they should not be misconstrued as suggesting that there are no downsides to launching *Charter*-based health rights litigation. Naturally, in the absence of significant public pressure, the tendency is for governments to treat the failed legal actions by health consumers as conclusive in the debate of whether to fund the services in question. Advocates who subsequently seek to obtain public funding through political recourse are therefore faced with at least two sizable hurdles. On the one hand, they need to convince the governments that, notwithstanding the lack of legal

it would appear that at least some jurors indeed see the offence of euthanasia in such light.

206. Downie, *supra* note 204, at 38-43.

207. McCreith, *supra* note 165, at 11-12. For example, in 2004, Evelyn Martens was acquitted by a British Columbia court for assisting in the suicides of two terminally ill elderly women. That same year, Marielle Houle was sentenced by a Quebec court to three years of probation for aiding and abetting the suicide of her 36-year-old son. In 2006, an Ontario man also received three years' probation for helping his wife commit suicide.

208. Marianne White, "Quebec man acquitted in assisted suicide case; Ottawa under renewed pressure to change law," *Edmonton Journal* (13 December, 2008), at A4.

209. *R. v. de la Rocha*, (1993), WL 1447201 (Ont. Gen. Div.).

210. Downie, *supra* note 204, at 39-40.

obligations to do so, financing the said medical procedures would be in their best interest. On the other hand, given that juridical findings also carry considerable weight in the court of public opinion, advocates need to persuade Canadians as well that some injustice has been done and that their endeavour to request government funding serves the public interest and thus deserves the public backing. When failing to meet such challenges, unsuccessful health rights litigation could stifle public discourses concerning the medical services in question and set back political momentum towards obtaining governmental funding that has been built up hitherto. The issue of whether to cover assisted reproductive technologies under Canadian Medicare, which was at the centre of the *Cameron* case,²¹¹ is an example of this last category of our typology.

Alex Cameron, a lawyer, and Cheryl Smith, a medical doctor, were a married couple who had had difficulties conceiving. As a result, Mr. Cameron took part in four cycles of intra cytoplasmic sperm injection (ICSI) – a specialized form of in vitro fertilization (IVF) – while Ms. Smith underwent two frozen embryo transfers. After incurring approximately \$40,000 in medical costs, the couple remained unsuccessful in their attempts at conception.²¹² In 1997, they launched a *Charter* challenge against the province of Nova Scotia demanding the outlays of their fertility treatments be reimbursed and the costs of IVF and ICSI be covered under the public insurance plan. Their argument was two-fold: IVF and ICSI should be considered medically necessary procedures as stipulated in the *Canada Health Act* and the province's *Health Services and Insurance Act*,²¹³ and, even if such medical treatments could not be so characterized, the denial of coverage was in violation of section 15(1) of the *Charter* as it discriminated against infertile individuals relative to those who are fertile.

The Nova Scotia Court of Appeal rejected the Camerons' claim. Relying on the testimonies of medical experts, the Court opined that IVF and ICSI were not medically necessary because of their high costs, limited success rates and the health risks involved therein. With respect to the plaintiffs' *Charter* challenge, the majority of the court ruled that the government's refusal to fund IVF and ICSI indeed amounted to a violation of the plaintiffs' equality rights. That is, considering that fertile couples enjoyed full coverage of birth-related health services under Medicare, the plaintiffs were treated differently because of their physical disability and such differential treatment furthered the existing vulnerability of infertile persons, thus undermining their human dignity. Yet, the judges went on to

211. *Cameron v. Nova Scotia (Attorney General)*, [1999] 204 N.S.R. (2d) 1, (C.A.) [Cameron].

212. *Id.* at para. 8-9.

213. *Health Services and Insurance Act*, R.S.N.S. 1989, c.h. 197 (2008).

hold that the breach of section 15(1) by the provincial government in this case was justifiable under section 1. They found that the government's objective to control health care costs were pressing and substantial, and by refusing to fund IVF and ICSI but not other infertility treatments, the means taken by the government herein was proportionate to the end of cost containment.

As the plaintiffs' request for leave to appeal the decision was denied by the Supreme Court of Canada in 2001,²¹⁴ the appellate court's ruling in *Cameron* has become the leading Canadian case law in regards to health consumers' right, or lack thereof, to publicly funded IVF and ICSI procedures. Since the *Cameron* decision, there remains no jurisdiction in Canada that funds ICSI, and public coverage of the costs of IVF has been minimal. As a program that predates *Cameron*, Ontario pays IVF through its public health insurance plan, but only for women with complete blockages in both Fallopian tubes and for a maximum of three cycles.²¹⁵ According to statistics from 2006, only 10% of IVF performed in Ontario and 5% in Canada were paid for publicly.²¹⁶ In 2009, ten years after *Cameron*, Quebec will become just the second province in Canada where women will have access to Medicare-funded IVF treatments for up to three attempts.²¹⁷

214. *Cameron*, *supra* note 211, 204 N.S.R.2d 1, at para. 246.

215. Elizabeth Payne, "OHIP falls under the knife", *Ottawa Citizen* (18 February, 1994), at A1; see Natalie Alcoba, *The Right to Bear Children; Politics, Ethics Muddy Couple's Fight for Fertility Treatment*, NAT'L POST, Aug. 22, 2009, at A1 (The legality of Ontario's IVF funding scheme, however, is currently being contested. In August 2009, Amir Attaran and his wife Ana Ilha filed a complaint with the Human Rights Tribunal of Ontario. They alleged that the IVF funding restrictions in Ontario discriminates against infertile individuals and therefore violates the provincial human rights code.); Jeff Nisker, *Socially Based Discrimination against Clinically Appropriate Care*, 181 CAN. MED. ASS'N J. 764, 764 (2009) A1. (In an editorial published in September 2009, the Canadian Medical Association Journal (CMAJ) – of whose Editorial-Writing Team Attaran is a member – came out in support of Attaran's human rights complaint, arguing that public funding of IVF would reduce the need for infertile women to have multiple embryos implanted at once and therefore would decrease the costs associated with multiple births.); Similar economic arguments have been cited by the Ontario Expert Panel on Infertility and Adoption in its August 2009 report, which recommended the provision of "public funding for three cycles of IVF under certain conditions." See "Expert panel releases report on infertility and adoption in Ontario" *CNW Group* (26 August 2009), <<http://www.cnw.ca/en/releases/archive/August2009/26/c7687.html>>. Judging from these recent developments, it would appear that, a decade after *Cameron*, advocacy efforts to have IVF publicly funded are finally picking up momentum again. However, as noted in the CMAJ editorial, public support on this issue seems to have remained questionable. Given such lacklustre public sentiment, it begs the question whether Attaran's legal action, if turns out to be unsuccessful, may run the risk of setting back the political movement as *Cameron* did.

216. Edward Hughes, "Access to Effective Fertility Care in Canada" (2008), 30 J. GRICS & GYNAECOLOGY, Can. 389 at 390 (2008).

217. *Id.* (explaining that prior to the policy change, Quebec had been offering a refundable tax credit of up to \$6,000 per annum to couples for costs associated with IVF);

Such low level of state funding for assisted reproductive technologies sets Canada starkly apart from most other countries that also have a universal health care system.²¹⁸ For example, since 2000, Australia's Medicare Safety Net has been offering an 80 percent rebate on the costs of IVF with no restrictions on the number of treatment cycles that a woman can undergo.²¹⁹ Beginning in 2006, the Australian government also funds ICSI as a treatment for severe male infertility.²²⁰ In New Zealand, qualified female patients currently receive public funding for up to two cycles of IVF;²²¹ since 1998, the government has been covering the expenses of ICSI as well where the procedure is required in conjunction with IVF.²²² Many European countries similarly provide funding for IVF. In the U.K., where access to publicly financed IVF has been found to be among the lowest in Europe,²²³ the National Institute for Clinical Excellence recommends the provision of up to three cycles of IVF by the National Health Service to qualified women,²²⁴ and almost all primary care trusts now offer at least one

Ingrid Peritz, *Kissing Babies Isn't Enough*, GLOBE & MAIL, Nov. 22, 2008, at F3 (After years of advocacy campaign – which has significantly benefited from the support of Julie Snyder, a high-profile TV personality in Quebec – during the 2008 provincial election campaign Premier Jean Charest pledged to expand Quebec's health care coverage to include two cycles of IVF if re-elected. According to his campaign platform, couples who require more IVF treatments after the two publicly funded attempts would continue to receive the tax credit.); Environics Communications, *Ontario Standing Still while Quebec Meets Election Promise by Funding In-vitro Fertilization*, CNW GROUP, April 24, 2009. After having won the election, in April 2009, the Quebec government sought to fulfill its campaign promise by introducing Bill 26, *An Act respecting clinical and research activities relating to assisted procreation*, 1st Sess., 39th Leg., Quebec, 2009 (assented to 19 June 2009). According to the government announcement, the new Quebec program will pay for up to three cycles of IVF treatments.

218. Jeff Nisker, "Distributive Justice and Infertility Treatment in Canada" (2008), 30 J. GRICS & GYNAECOLOGY, Can. 425 at 426 (2008); See also Edward G. Hughes & Mita Giacomini, "Funding In Vitro Fertilization Treatment for Persistent Subfertility: The Pain and the Politics", 76 Fertility & Sterility 431 at 432 (2001).

219. See Hughes & Giacomini, *supra* note 218; see also Melissa Jenkins, "Fed: IVF public funding cuts rumoured ahead of May budget", *Associated Press General News* (7 May, 2009); Julie Robotham, "Budget removes safety net for IVF parents", *Sydney Morning Herald* (8 May, 2009). However, in May 2009, the Australian government introduced a cap on the amount of rebate that one can claim each year from the Medicare Safety Net for IVF costs.

220. Carol Nader, "Public funds to stay in fertility treatment" *The Age* (30 November, 2006), at 5.

221. MINISTRY OF AGRIC. AND FORESTRY, "Funding for Second IVF Cycle" Rural Bulletin 7 (August 2004), available at <http://www.maf.govt.nz/mafnet/publications/ruralbulletin/>.aug-04/aug-04-06.htm>.

222. NEW ZEALAND PRESS ASS'N, "HFA Changes Fertility Treatment Criteria" (12 July 1998).

223. "UK nearly last among European countries offering access to IVF" *The Herald* (2 July 2009), <<http://www.theherald.co.uk/misc/print.php?artid=2517651>>.

224. National Institute for Clinical Excellence, *Assessment and Treatment for People with Fertility Problems: Understanding NICE Guidance – Information for People with*

free IVF treatment cycle.²²⁵

In addition to going against the international trend, the dearth of public funding for IVF in Canada runs afoul of the recommendations put forth by the country's Royal Commission on New Reproductive Technologies. Struck by Prime Minister Brian Mulroney in 1989, the Royal Commission was tasked with investigating the public interest implications of emerging reproductive technologies, including IVF. In its final report published in 1993, the Royal Commission found, *inter alia*, that "[t]he importance of having children [was] such, that if there [were] safe and effective ways to help people otherwise unable to achieve that goal, Canadians [thought] that in a caring society they should be provided."²²⁶ The Royal Commission went on to find that, among all the evidence related to IVF that were available, the effectiveness of the medical procedure was best demonstrated in helping women with complete Fallopian tube blockages overcome their infertility. As such, it was strongly recommended that IVF for this group of women be funded by the government-run health insurance plans.²²⁷

The *Cameron* decision, in our opinion, has significantly contributed to the present funding void in Canada with respect to IVF and ICSI. Foremost, the court's finding that IVF and ICSI do not constitute medically necessary procedures means the decision to fund is wholly at the discretion of provincial governments. As such, while other western countries have moved in the opposite policy direction, Canadian provinces have continued to rely on such characterization of IVF and ICSI as a reason to refuse coverage. For instance, the British Columbia Ministry of Health has maintained the position that "the Medical Services Plan relied on the advice of the medical profession in determining the medical necessities of procedures. To date, there has been no indication from the medical profession that it considers IVF to be medically necessary."²²⁸ Moreover, the *Cameron* court explicitly mentioned in its decision the Royal Commission's call for public financing of IVF.²²⁹ The court's subsequent holding that the government's refusal to cover IVF expenses is justified on the ground of cost containment, even in situations where women are diagnosed with blocked Fallopian tubes, effectively permits the provinces and territories to carry on ignoring the recommendations from the Royal

Fertility Problems, Their Partners and the Public, (Feb. 2004).

225. *Funding for Fertility in the U.K. – Interactive Map: Does your PCT or Health Board Follow the NICE/EAGISS Guideline?* (June 2008) <<http://www.infertilitynetworkuk.com/FundingforFertility/>>.

226. Patricia Baird, "Proceed with Care: New Reproductive Technologies and the Need for Boundaries", 12 J. Assisted Reproduction. & Genetics 491, 493 (1995).

227. *Id.* at 494.

228. Hughes, *supra* note 216, at 389.

229. *R. v. de la Rocha*, WL 1447201 (Ont. Gen. Div.). at para 99, 203 (1993).

Commission so long as they toll the bell of tight resources. Any political momentum that the Royal Commission had contributed towards the quest for public IVF funding was arguably lost.

At the same time, the *Cameron* case did not appear to be as successful as *Auton* and *Rodriguez* in regards to enlisting public support for the plaintiffs' plight. In fact, in comparison to the outpour of public sympathy in the wake of *Auton* and *Rodriguez*, the public response to the *Cameron* case seemed relatively mute. A review of the print media yielded only a handful of opinion editorials and letters to the editors that commented on the lawsuit, most of which questioned the medical necessity of infertility treatments and disapproved of the Camerons' demand for public IVF funding.²³⁰ Consequently, the governments have been under little pressure to deviate from the status quo and have been satisfied with simply relying on the *Cameron* ruling as the bottom line concerning IVF and ICSI funding.

In the end, by losing their legal battle, the Camerons not only failed to have their medical costs reimbursed but also inadvertently stifled, at least for a notable period of time, the political movement towards Medicare-funded IVF. From this perspective, cases in this last category of our typology arguably represent the worst case scenario for health consumers. Therefore, parties interested in launching *Charter*-based health rights litigation should be adequately informed of this potential outcome so that it may be weighed against the benefits sought. That is, in addition to assessing the soundness of their legal arguments, prospective litigants should contemplate questions such as: Is the political landscape going to be sympathetic towards their endeavour? And, if their legal action turns out unsuccessful, will there be an organized advocacy campaign ready to step in and continue pursuing the cause through political means? If the answers to these questions are negative, the lessons learned from cases like *Cameron* suggest that health consumers should seriously consider if there are other avenues besides *Charter* challenges, for example through administrative law or lobbying, that can equally resolve the funding issues in question but may involve less downside risks.

IV. CONCLUSION

In this paper, we examined the growing number of cases in Canada in which health consumers seek to rely on their *Charter* rights to gain access to certain therapies or to care within reasonable wait times. Our main concern is that, as Canadian courts become increasingly willing to entertain

230. See, e.g. J.J. Forrestal, "In vitro not a necessity", *Globe and Mail* (29 July 1998), at A14; Naomi Lakritz, "Infertile couples not covered under the Charter; Governments do not owe couples babies, no matter how much the couples think they deserve them", *Calgary Herald* (18 February, 1999), at A16.

health rights-based claims and thus being implicated in the allocation of health resources, there is a corresponding need for a more holistic assessment of how the rights discourse is impacting on Canadian Medicare. Is health rights litigation facilitating a more progressive distribution of health resources in favour of marginalized groups that are in greatest need? Or, is the pursuit of health rights having a regressive effect on the universal health care system as some health law and policy scholars have feared? According to Aeyal Gross, tensions exist between a human rights enterprise that has traditionally focused on the individuals and universal health care systems that are founded upon collective aspirations.²³¹ By resorting to individualistic rights, health consumers run the risk of inviting the courts to focus on a narrow set of facts and to ignore the larger context in which a public health care system must operate, namely the need to prioritize competing interests under resource constraints. Moreover, as access to justice often favours those with resources, health rights litigation may in turn be exploited to recreate the same access imbalance in the health care setting.²³² So, how does the rights discourse unfold in Canadian Medicare in reality? To properly answer this question, we argue that one has to look beyond the juridical outcomes of the cases and consider also the policy developments following the conclusion of legal proceedings, and hence our typology.

Many legal commentators who examined the *Charter* jurisprudence surrounding access to care have suggested that Canadians' pursuit of the right to health has largely rendered Medicare more regressive than progressive. For example, by juxtaposing the *Chaoulli* decision with *Auton*, Sujit Choudhry has described the current state of health rights in Canada as: "those who can afford private health care have won the right to exit the system, while those trapped in the system without the means to exist get no help at all."²³³ Analysis of the outcomes of Canadian health rights litigation based on our typology which also takes into account the policy fallout post-litigation, however, reveals a more nuanced finding. While *Chaoulli* undoubtedly illustrates how the rights-based approach may be used to enable queue jumping for those that can afford to pay, Choudhry's observation that less resourced individuals "get no help at all" arguably

231. Aeyal M. Gross, "The Right to Health in an Era of Privatisation and Globalisation", in *Exploring Social Rights: Between Theory and Practice* 289 (Daphne Barak-Erez & Aeyal M. Gross, eds, 2007).

232. Donna Greschner, "Charter Challenges and Evidence-Based Decision Making in the Health Care System: Towards a Symbiotic Relationship", in *Just Medicare: What's In, What's Out, How We Decide* 42, 44 (Colleen M. Flood, ed., 2006).

233. Sujit Choudhry, "Worse than *Lochner*?", in *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada*, 75, 94. (Colleen M. Flood, Kent Roach & Lorne Sossin, eds., 2005).

requires further delineation. In *Auton* and *Wynberg*, although the rights claimants were denied legal recourses, they were ultimately successful in acquiring the sought-after therapies through political means. Whereas in *Cameron*, not only was the litigation unsuccessful but it also undercut the reform efforts launched outside of the courtroom for a significant period of time. It appears that the denial of a rights claim, like the pronouncement of a right, carries with it normative and rhetorical significance and, among the socially marginalized groups, those less vocal and less organized would tend to be worst positioned in shielding their advocacy efforts from such repercussions.²³⁴

Furthermore, our typology suggests that when taking the policy implications into consideration, the progressive potential of successful health rights litigation – such as *Eldridge*, *Morgentaler*, *Parker* and *PHS* – has thus far been severely circumscribed. On the one hand, negative rights have a limited effect on facilitating access to care. As seen in the aftermath of *Morgentaler*, decriminalization alone neither guarantees public funding of the therapies in question nor ensures service provision, leaving health consumers – particularly those less resourced – with essentially an empty right. On the other hand, a positive right to therapy can be in danger of being under-enforced in the absence of a judicial mechanism that properly supervises the state's remedial measures. When one contrasts the provinces' underperformance of their positive obligations post-*Eldridge* with Quebec's initial plan post-*Chaoulli* to liberalize the restrictions on private health care beyond what the Supreme Court of Canada had required, the potential for health rights litigation to instigate a more progressive distribution of health resources in Canada becomes highly suspect.

In sum, analysis based on our typology illustrates that one needs to examine both legal and policy outcomes of health right litigation to determine whether a progressive or regressive change has been effected. We echo Aeyal Gross in arguing that “[r]ealising rights is not a simple matter; indeed, it is the outcome of complex negotiations between different entities, public and private, and is effected through vigorous political and legal work.”²³⁵ As such, if the pursuit of health rights and the scholarly analysis thereof become solely concerned with the juridical decisions, one runs the risk of either missing the nuanced impact of a rights paradigm on marginalized groups, or being complacent with a pronouncement of rights that may be hollow in reality. As a logical next step, we propose that this typology be used to review health rights litigation in other countries. Such

234. *R. v. de la Rocha*, (1993) WL 1447201 (Ont. Gen. Div.), at para. 299. According to Gross, “we must recall that rights have normative and rhetorical significance in any discussion of society's responses to human needs.” Arguably, when a rights claim is denied by courts, the decision carries with it a similar normative and rhetorical significance.

235. *Id.*

an exercise may allow us to gauge whether countries with an expressed constitutional right to health enjoy greater successes in realizing progressive health funding allocation. It may also shed light on how a health rights discourse unfolds when it is invoked in an administrative law, rather than constitutional law, context. Furthermore, a comparative analysis between developed and developing countries may reveal the extent to which a rights-based approach could be influenced by resources available. Through such a holistic examination, we will then be able to properly scrutinize the right to health and steer it towards a more progressive path.