

Health Care in Canada: Does a Health Care System Based on Shared Values Ensure Respect for the Right to Health?

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The Canadian publicly-funded, single-payer health system, while often praised, has not been free from recent stresses and strains. While few Canadians wish to change fundamentally their health care system, many see the necessity for substantial improvements.

Two recent developments are reflective of the concerns that many Canadians share regarding their health care system, in particular with regard to waiting times for non-emergency health services, the shortage of doctors and other health professionals, and the rising costs of pharmaceuticals. In 2002 the Royal Commission on the Future of Health Care in Canada published its final report, "Building on Values: The Future of Health Care".¹ Referred to as the Romanow Report after the Chief Commissioner, Roy Romanow, the report reaffirmed the basic values underpinning the universal, single-payer health care system in Canada, while outlining some 47 detailed and costed recommendations for substantial improvements in the system.

In a decision concerning waiting times for health services in Quebec's public health system, in 2005 the Canadian Supreme Court in *Chaoulli v. Quebec*² declared that provincial restrictions on purchase of private insurance for healthcare services covered by the government plan in Quebec violated the right to security of the person under the Quebec Charter of Human Rights and Freedoms. The Court held that where the publicly funded system does not provide timely access to health care, individuals should not be prevented from accessing the same services through private insurance, arguing that "access to waiting lists is not access to health care". While the

decision was applicable only in Quebec, it nonetheless had the potential for wide repercussions since nearly all Canadian provinces had similar private health insurance provisions.

The Romanow Report and the *Chaoulli* decision could suggest an erosion of some of the fundamental aspects of the Canadian health system. Have the basic elements of the Canadian public health system survived despite these recent developments? To answer this question, it is first necessary to examine the history of the Canadian health system, and the fundamental values on which it is based. We will then turn to the Romanow Report and the *Chaoulli* judgment.

Canada's value-based health care system

Canada has long been party to key international human rights treaties which include the human right to the highest attainable standard of health. For many observers, the Canadian health care system appears to be grounded in core elements of the right to health including the availability, accessibility, and acceptability of quality health goods, services and facilities,³ with due attention to underlying determinants of health related to lifestyle and the environment.⁴ Yet the phrase “right to health” is not used in the Canadian Charter of Rights and Freedoms and to date there has been an apparent reluctance to give legal recognition to health as a human right in Canada. While most Canadians consider access to health care to be a human right, the terms “right to health” or “right to health care” are not mentioned explicitly in any of the documents establishing the Canadian health care system.

“Values” rather than “rights” is the term used in the founding documents to describe the ideological basis of the Canadian health system. Grounded in notions of equity, fairness and solidarity, these values have often been reiterated and were reaffirmed in the Romanow Report: Universality, portability, comprehensiveness, accessibility and public administration. For Canadians, according to the Romanow Report, these values are linked to their understanding of citizenship: “Canadians consider equal and timely access to medically necessary health care services on the basis of need as a right of citizenship, not a privilege of status or wealth.”

The Canadian system of health insurance is a government programme, referred to as a universal single-payer system. The programme is financed both by provincial taxes, imposed directly on those who can afford to pay,

and by federal contributions. Canadians freely choose their own physician, but the physician is reimbursed by the Government. Medical associations negotiate with the Government on the amount of reimbursement. Under the Canada Health Act, extra-billing and user fees for insured services are prohibited, and the federal government withholds contributions to any provincial plan which permits the purchase of private insurance for the same benefits covered under the government plan.

When receiving health care, or a stay in a hospital, patients show a healthcare card and are not required to make a direct payment. The system is universal, since all Canadians are required to belong to the system. Persons with low income are provided with care even if they are unable to contribute to the system. Portability is ensured; they may freely move to different provinces and the national system and the new provincial system remain fundamentally the same, with certain provincial variations.

Canadians may also freely choose their hospitals for treatment. The same facilities, however, are not available in all hospitals. Only a limited number of MRIs (magnetic resonance imaging machines), for example, will be available in a particular geographic area.

As the *Chaoulli* decision is directly applicable only in Quebec, the ultimate influence of the decision outside of the province is not yet clear. Within Quebec, some 100 doctors have opted out of the public system altogether. A Quebec proposal would allow hospitals to sub-contract to private clinics for hip and knee replacements as well as cataract surgery, in the event that the public system is not able to provide the care within six months. In 2006, Ralph Klein, then Premier of Alberta, proposed an Alberta Government plan permitting doctors to work in the public system and offer private services at the same time, while admitting that it may violate the Canada Health Act.⁵

Origins of the Canadian health care system: The role of the province of Saskatchewan

The province of Saskatchewan, a western Canadian province with a scattered, relatively small population, has played an extraordinary role in the development of the present Canadian health care system. The basic aspects of the Canadian federal health care system were adopted in 1965 following extensive hearings throughout the country led by a federal Royal Commission on the Delivery of Health Services, headed by Justice Emmett Hall

of Saskatchewan. Roy Romanow, the head of the most recent Commission studying the Canadian health care system, was a former Premier of Saskatchewan. It is not surprising that the two most important Royal Commissions on health care have been led by citizens of Saskatchewan.

What explains the central role played by this sparsely populated province on the development of the Canadian health care system? Credit is usually given to Tommy Douglas, Premier of Saskatchewan from 1944 to 1960, whose influence led to the adoption in 1962 of the Saskatchewan Medical Care Act, a precursor of and major influence on the modern Canadian system. But what influenced Tommy Douglas? In 1944, the Co-operative Commonwealth Federation (the CCF), a socialist party, won the provincial election in Saskatchewan and formed official opposition in the three provinces of British Columbia, Manitoba and Ontario. The CCF led to the creation of the New Democratic Party (NDP), as it is known today. The CCF philosophy was more similar to the thinking of the Fabian Society in England than to the Communist Parties of Europe. It was a unique product of the situation of the prairie provinces. One of its early manifestos emphasized that citizens were entitled to a properly organized public health system.

As Tommy Douglas, a Baptist Minister, became a leader of the Party and the Premier of Saskatchewan, social ideas had begun to take hold in the Province. Following his own experience with health problems in childhood, Douglas had developed a firm belief in universal access to public health care, a belief he maintained throughout his tenure as both Minister of Health and Premier.⁶ By the end of Douglas's period as Premier, Saskatchewan had established a progressive, public, universal health care system – a controversial development at the time – and Saskatchewan had become established, in Canadian minds, as a leader in health care. The progressive influence of Saskatchewan on health care developments in Canada continued through the Royal Commission reports of Emmett Hall, who recommended a joint federal/provincial system that would cover the costs of preventive health care services, including preventive, and hospital care for all Canadians, and of Roy Romanow.

Challenges to the Canadian health care system

The Romanow Report

The 2002 Report of the Royal Commission on the Future of Health Care in Canada, headed by Roy Romanow, was a significant development in the

recent history of the Canadian health care system. While pointedly reaffirming the basic values of the Canadian system – universality, portability, comprehensiveness, accessibility and public administration – it made such extensive criticisms of the system and suggestions for improvement that it seemed to some to implicitly question the fundamental aspects of the system. Yet the Commission’s mandate was not to question the basis of the Canadian system but rather to engage Canadians in a national dialogue on the future of health care and make recommendations “to ensure the long-term sustainability of a universally accessible, publicly funded health system.”

Not all reactions to the Romanow Report were positive. The 2003 *Saskatchewan Law Review*,⁷ which ran ten articles analyzing the Romanow Report, stated in its introduction that:

“Despite the general approval of the Romanow Report, the underlying current of these articles is one of dissatisfaction: The authors recognize that in trying to review such a broad topic as Canada’s health care system, the Report, not unexpectedly, comes up short on many issues.”⁸

In general, however, Canadians welcomed the Romanow Report’s conclusions and supported its recommendations for improvement. With attention to improving equitable access to and quality of health care, addressing the social determinants of health, enhancing transparency and accountability, and focusing on the health needs of marginalized populations, many of the report’s recommendations are consistent with promotion of the right to health.

The report recommended the establishment of a Canadian health covenant which would outline Canada’s collective vision for health care and update the Canada Health Act, notably to add a sixth principle of “accountability” to address concerns that citizens lack sufficient information to hold duty-bearers accountable for delivering on health care. It recommended revisions to the relationship between the provinces and the federal government in relation to health care financing, an increase in federal funding and the creation of five new targeted funds to address immediate priorities until the minimum federal funding threshold is met. It addressed the need to make the health system more comprehensive by integrating priority home care services within the Canada Health Act and

improving prescription drug coverage, improving timely access to quality care through special initiatives to improve wait list management, and fostering a national personal electronic health record system. It suggested the establishment of a Health Council of Canada to analyze and assess the national health system.

The report also contained detailed recommendations to address disparities in health and access to health care for rural and remote populations, and outlined a “new approach to Aboriginal health”, including the establishment of Aboriginal Health Partnerships responsible for developing policies and providing services towards improving the health of Aboriginal peoples. While Canada’s health care system is considered a model, albeit with weaknesses, the serious and persistent disparities in the health status of Aboriginal peoples as compared with other population groups merits particular attention from a human rights perspective.

The health status of aboriginal peoples in Canada

Canada appears to have a relatively good system of health care – generally comprehensive, universally accessible and of good quality. But the health status of important Canadian populations, in particular Canada’s Aboriginal peoples, continues to differ considerably from that of the general population. In recent years the gap in life expectancy of registered First Nations people as compared with other Canadians has been estimated at 7.4 years for men and 5.2 years for women. In many places Aboriginal people are more likely to be exposed to substance abuse and other lifestyle-related illness, and the suicide rate among Aboriginal Canadians is reportedly three times that of the general Canadian population.⁹

Together with the National Aboriginal Health Organization, the Romanow Commission co-hosted a national forum on Aboriginal health which brought together people from First Nations, Metis, Inuit and urban Aboriginal communities to exchange experiences and views on the future of health care. From the outcome of these discussions, the Commission concluded that there is a need for an entirely new approach, “one that tackles the root causes of health problems for Aboriginal peoples, cuts across administrative and jurisdictional barriers, and focuses squarely on improving the health of Aboriginal peoples”.¹⁰ The report stressed that partnerships between the government and Aboriginal peoples should look beyond

narrow health issues and consider “broader conditions that help build capacity and good health in individuals and communities, such as nutrition, housing, education, employment and so on.”¹¹

Recognizing health as a human right can help to underscore the importance of human health as more than access to health care, to include socio-economic determinants such as the environment, access to clean drinking water and food, and adequate housing, as well as health promotion. The right to health also helps to shift the focus beyond national averages, highlight the disparate health status of marginalized populations and ultimately ensure that health systems are designed and implemented to meet the health needs of all.

Chaoulli v. Quebec

In this decision, the Canadian Supreme Court effectively struck down provisions in the Quebec health care system that prevented insurers from covering the same benefits as are covered by the public system. Section 15 of the Health Insurance Act of Quebec and section 11 of the Hospital Insurance Act prohibited the purchase of private insurance which, the appellants argued, violated their rights under section 1 of the Quebec Charter of Human Rights and Freedoms and section 7 of the Canadian Charter of Rights and Freedoms.¹²

The majority of the Court reasoned that wait times for certain procedures under the government health programme “increase the patient’s risk of mortality or the risk that his or her injuries will become irreparable” and that “many patients on non-urgent waiting lists are in pain and cannot fully enjoy any real quality of life”. The majority held that these amounted to a violation of the right to life and personal inviolability under the Quebec Charter, and that the violation was not justifiable under section 9.1 of the Charter. The majority held that while the prohibition on private insurance has a rational connection with the objective of preserving the public health plan, such a prohibition is not strictly necessary to protect the integrity of the public plan as other less intrusive measures could be taken to achieve the same objective.

The *Chaoulli* case is considered highly controversial: The narrow 4–3 split decision apparently caught many in the health policy community by surprise and has since been widely criticized by legal and health policy commentators.¹³ It presented a potentially threatening legal intrusion into

health policy in that it suggested there are legal or constitutional limits on the permissible length of wait times, without necessarily providing any direction as to the definition of those limits. According to one commentator, the decision left healthcare administrators and policy experts concerned that it foreshadowed “fundamental change in the ground rules governing Canada’s publicly funded healthcare system without any clear road map of what direction such change could or would take.” In practical terms, however the decision appears to have had very little impact on the foundations of medicare in Canada, other than perhaps to have spurred much-needed attention to issues of wait-list reductions and the shortage of human resources for health in Canada.

Conclusion

The Romanow Report and the Supreme Court decision in *Chaoulli* each addressed major criticisms of the Canadian health care system, including lengthy wait times for non-life threatening medical procedures. But do these criticisms amount to an attack on the fundamental characteristics of the Canadian system? It is doubtful: While there is demand for major improvement, in particular to address the shortage of human resources, reduce wait times and address the rising costs of pharmaceuticals, most Canadians apparently are basically happy with their system compared with other health systems, particularly the system in the neighbouring United States.¹⁴ The Romanow Report and the *Chaoulli* decision both reiterate the importance of the values on which the Canadian health system are based. There will continue to be calls for improvement to the system, but probably not many demands for the adoption of a system vastly different to the present single-payer universal health care system.

In relation to Canada’s foreign and domestic health policy, the Romanow Report notes that “Canadians believe that access to health care is a fundamental human right” and that Canada should “move from merely talking about health as a human right to taking more concrete action to assist in improving the health of people beyond Canada’s borders”.¹⁵ Looking to the future, a move beyond a restatement of values towards an explicit recognition of health as a human right, both in health policy documents and through the court system, would help to align the Canadian health system more closely with Canada’s international human rights obligations.

- * The author would like to acknowledge with gratitude Lisa Oldring for her contribution to this chapter.
- 1 Roy J. Romanow, *Building on Values: The Future of Health Care in Canada*, Final Report of the Commission on the Future of Health Care in Canada (Ottawa: Government of Canada, 2002).
 - 2 *Chaoulli v. Quebec* (Attorney General), 2005 SCC 35 (Canada 2005).
 - 3 Canada is party, inter alia, to the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Elimination of Racial Discrimination. A detailed definition of the right to health is contained in Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14 on the right to the highest attainable standard of health*, 11 August 2000, UN Doc. E/C.12/2000/4.
 - 4 Canada hosted the First International Conference on Health Promotion, which led to the adoption of the Ottawa Charter for Health Promotion in November 1986, WHO/HPR/HEP/95.1, available at www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf.
 - 5 See 'Alberta's Health Care Proposals Cause Alarm', *Prairie Messenger*, 8 March 2006, at 1 and 7; 'Alberta Policies Could Affect Whole Country', *Prairie Messenger*, 15 March 2006, at 3 and 7; 'Private Health Care will not save Canadian Medicine', *Prairie Messenger*, 12 September 2007, at 7.
 - 6 Thomas H. McLeod and Ian McLeod, *Tommy Douglas: The Road to Jerusalem* (Toronto: Fifth House Publishers, 2004).
 - 7 See *Saskatchewan Law Review*, Volume 66 (2003) which contains ten articles on various aspects of the Romanow Report.
 - 8 *Ibid.*
 - 9 According to the Royal Commission on Aboriginal Peoples (1995).
 - 10 Romanow, *supra* note 1, at 212.
 - 11 *Ibid.*, at 227.
 - 12 The Committee on Economic, Social and Cultural Rights referred to the *Chaoulli* decision in its concluding observations on Canada's periodic report in 2006, noting that "courts should take account of Covenant rights where this is necessary to ensure that the State Party's conduct is consistent with its obligations under the Covenant": UN Doc. E/C.12/CAN/CO/4, para. 36.
 - 13 For a summary of reactions to the decision, see P Monahan, *Chaoulli v Quebec and the Future of Canadian Health Care: Patient Accountability as the "Sixth Principle" of the Canada Health Act*, C.D. Howe Institute Benefactors Lecture, Toronto, 29 November 2006, available at http://www.cdhowe.org/pdf/benefactors_lecture_2006.pdf.
 - 14 For an interesting recent comment, see Sara Robinson, '10 Myths About Canadian Health Care, Busted', *AlterNet: Health and Wellness* (February 15, 2008), available at <http://www.alternet.org/healthwellness/76032>. See also Virginia Leary, 'So Close and Yet So Different: The Right to Health Care in the United States and Canada', in Rhonda E. Howard-Hassmann and Claude E. Welsh, Jr (eds.), *Economic Rights in Canada and the United States* (Philadelphia: University of Pennsylvania Press, 2006).
 - 15 Romanow, *supra* note 1, at 240 and 242. See also Donna Greschner, 'A Colloquy on the Romanow Report: Public Law in the Romanow Report', 66 *Saskatchewan Law Review* 565, at 566 (2003): "Indeed, in the [Romanow] Report the word 'right' rarely appears. As a related consequence of this omission, there is almost no mention of the courts, which are the primary rights-enforcement bodies. It is as if the health care system operates on one plane and the judicial system on another."

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