The Future of Health Care Accountability: A Human Rights Approach

Martha Jackman

THE PAPER ARGUES THAT there is an urgent need in Canada for a human rights approach to health care accountability. Taking as its starting point that health care decision-making must respect Canadian *Charter* and international human rights guarantees, the paper contends that accountability mechanisms, both in relation to the overall performance of the health care system and individual access to care, must be designed to reflect and reinforce these fundamental human rights principles, not only as a matter of domestic and international legal obligation, but in order to be effective. To make this case, the paper first provides a brief overview of the concrete steps governments have taken towards implementing the various accountability reforms that have been put forward in Canada over the past twenty years. It then considers the implications of the absence of a human rights approach to health care accountability, particularly for those whose needs are least well served within the current system. The paper goes on to suggest that what is required, moving forward, is not only the recognition that health care is a fundamental right, but the creation of institutions and mechanisms capable of enforcing that right at both the access to care and system performance levels. The paper points to the *Alternative Social Charter* as one possible model for achieving effective accountability within the health care system: a critical reform for the

DANS CE TEXTE, L'AUTEURE soutient qu'il est urgent que le Canada adopte une approche axée sur les droits de la personne à l'égard de la responsabilisation en matière de soins de santé. En prenant comme point de départ que la prise de décisions en matière de soins de santé doit respecter la *Charte canadienne des droits et libertés* et les garanties internationales en matière de droits de la personne, l'auteure préconise la conception de mécanismes de responsabilisation, tant en ce qui a trait au rendement global du système de santé qu'à l'accès individuel aux soins, qui reflètent et viennent renforcer les principes des droits humains fondamentaux, non seulement pour se conformer à nos obligations juridiques nationales et internationales, mais également afin d'être efficaces. Pour étayer cette suggestion, l'auteure dresse d'abord un bref aperçu des mesures concrètes que les gouvernements ont prises en vue de mettre en œuvre les diverses réformes recommandées au Canada au cours des vingt dernières années relativement à la responsabilisation. On examine ensuite les conséquences de l'absence d'une approche fondée sur les droits de la personne à cette responsabilisation, tout particulièrement pour les personnes que le système actuel sert le moins bien. L'article poursuit en prônant qu'il faut, dorénavant, non seulement reconnaître que les soins de santé sont un droit fondamental, mais créer en outre des institutions et des mécanismes capables

future of health and human rights in Canada.

de voir à l'application de ce droit tant au niveau de l'accès aux soins de santé qu'au niveau du rendement du système. On souligne dans cet article comment la *Charte sociale* pourrait être un modèle permettant d'atteindre une responsabilisation efficace au sein du système de santé, soit une réforme essentielle pour l'avenir du droit à la santé et des droits de la personne au Canada.

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I. INTRODUCTION

Barriers to accessing health care services, especially as they affect vulnerable and marginalized groups in Canadian society, undermine life, security of the person, and equality guarantees under the *Canadian Charter of Rights and Freedoms*.[1] They are also incompatible with the underlying principles of the *Canada Health Act*[2] and the publicly funded medicare system,[3] section 36 of the *Constitution Act, 1982*,[4] and Canada's international human rights obligations.[5] And, while other human rights violations, such

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

2 RSC 1985, c C-6 [*Canada Health Act*].

3 See generally Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada*, November 2002 Final Report (Saskatoon: CFHCC, 2002) at xvi [*Romanow Commission*]; Senate, Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians: The Federal Role — Volume One: The Story So Far* (March 2001) at 45 (Chair: The Honourable Michael J L Kirby) [Senate, *The Health of Canadians*]; National Forum on Health, *Canada Health Action: Building on the Legacy*, vol 1 (Ottawa: Health Canada, 1997) [National Forum on Health, *Canada Health Action*].

4 Being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 ("Parliament and the legislatures, together with the government of Canada and the provincial governments, are committed to . . . (c) providing essential services of reasonable quality to all Canadians" at s 36(1)).

5 *Universal Declaration of Human Rights*, GA Res 217A (III), UNGAOR, 3rd Sess, Supp No 13, UN Doc A/810 (1948) 71 at art 25(1); *International Convention on the Elimination of All Forms of Racial Discrimination*, GA Res 2106 (XX), UNGAOR, 20th Sess, Supp No 14, UN Doc

as poverty and colonialism, are more significant determinants of health, access to health care remains the primary focus of Canadian health policy and spending.[6] Ensuring the accountability of health care decision-making affecting access to care is therefore critical from the perspective of indigenous people; people living in poverty; those with mental illnesses or addictions; people with disabilities; refugees and new immigrants; and other groups experiencing significant health-related disadvantage.[7]

A/6014 (1965) 47 at art 5(e)(vi); *Convention on the Elimination of All Forms of Discrimination Against Women*, 18 December 1979, 1249 UNTS 13, art 12 [*CEDAW*]; *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976, accession by Canada 19 May 1976), art 12(1) [*ICESCR*]; *International Covenant on Civil and Political Rights*, 19 December 1966, 999 UNTS 171, art 6; *Convention on the Rights of the Child*, GA Res 44/25, UNGAOR, 44th Sess, Supp No 49, UN Doc A/44/49 (1989) 166 at art 24; *Convention on the Rights of Persons with Disabilities*, GA Res 61/106, UNGAOR, 61st Sess, Supp No 49, UN Doc A/61/49 (2006) 65 at art 25 [*CRPD*]; *United Nations Declaration on the Rights of Indigenous Peoples*, GA Res 61/295, UNGAOR, 61st Sess, Supp No 49, UN Doc A/61/49 (2007) 1 at art 2, 24 [*UNDRIP*].

6 See generally Martha Jackman, "Law as a Tool for Addressing Social Determinants of Health" in Nola M Ries, Tracey M Bailey & Timothy Caulfield, eds, *Public Health Law and Policy in Canada*, 3rd ed (Markham, Ont: LexisNexis Canada, 2013) 91; William Lahey, "Medicare and the Law: Contours of an Evolving Relationship" in Jocelyn Downie, Timothy Caulfield & Colleen M Flood, eds, *Canadian Health Law and Policy*, 4th ed (Markham, Ont: LexisNexis Canada, 2011) 1 [Lahey, "Medicare and the Law"]; Dennis Raphael, ed, *Social Determinants of Health: Canadian Perspectives*, 3rd ed (Toronto: Canadian Scholars' Press, 2016) [Raphael, *Social Determinants*].

7 See e.g. Canada Without Poverty and Citizens for Public Justice, *Dignity for All: A National Anti-Poverty Plan for Canada* (Canada Without Poverty/Citizens for Public Justice, 2015) at 23–25 [*National Anti-Poverty Plan*]; Yvonne Boyer, *Moving Aboriginal Health Forward: Discarding Canada's Legal Barriers* (Saskatoon: Purich Publishing, 2014) [Boyer, *Aboriginal Health*]; Manal Guirguis-Younger, Ryan McNeil & Stephen W Hwang, eds, *Homelessness & Health in Canada* (Ottawa: University of Ottawa Press, 2014) [Guirguis-Younger, *Homelessness and Health*]; Canadian Human Rights Commission, *Report on Equality Rights of Aboriginal People* (Ottawa: Canadian Human Rights Commission, 2013) at 45–52 [CHRC, *Aboriginal People*]; Canadian Human Rights Commission, *Report on Equality Rights of People with Disabilities* (Ottawa: Minister of Public Works and Government Services, 2012) at 80–98 [CHRC, *People with Disabilities*]; Dennis Raphael, *Poverty in Canada: Implications for Health and Quality of Life*, 2nd ed (Toronto: Canadian Scholars' Press, 2011) at 223–63; Toba Bryant, Dennis Raphael & Marcia Rioux, eds, *Staying Alive: Critical Perspectives on Health, Illness, and Health Care*, 2nd ed (Toronto: Canadian Scholars' Press, 2010) [Bryant, *Staying Alive*]; Senate, Standing Senate Committee on Social Affairs, Science and Technology, *A Healthy, Productive Canada: A Determinant of Health Approach* (June 2009) at 9 (Chair: The Honourable Wilbert Joseph Keon); Canadian Population Health Initiative, *Reducing Gaps in Health: A Focus on Socio-Economic Status in Urban Canada* (Ottawa: Canadian Institutes for Health Information, 2008) at 1–2; Senate, Standing Senate Committee on Social Affairs, Science and Technology, *Out of the Shadows at Last: Transforming Mental Health, Mental Illness and Addiction Services in Canada* (May 2006) (Chair: The Honourable Michael J L Kirby) [Senate, *Out of the Shadows*]; Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on

As United Nations Special Rapporteur on the Right to Health, Paul Hunt, affirms:

> Because of the complexity, sensitivity and importance of many health policy issues, it is vitally important that effective, accessible and independent mechanisms of accountability are in place to ensure that reasonable balances are struck by way of fair processes that take into account all relevant considerations, including the interests of disadvantaged individuals, communities and populations.[8]

At its most basic level, accountability has been defined as "the process of being called 'to account' to some authority for one's actions."[9] In her review of the accountability regimes governing federal social transfers, including the *Canada Health Act*, Barbara Cameron describes accountability as: "a relationship between parties whereby one party is answerable to the other for the performance of commitments or obligations that are evaluated against criteria or standards known to the parties, and sanctions are applied for failure to meet the commitments."[10] What is not lacking within the Canadian health care system—federal and provincial/territorial—are human rights based "commitments", "obligations", "criteria", or "standards". These can be found in the right to health guarantees under article 12 of the *International Covenant on Economic, Social and Cultural Rights* ("*ICESCR*"); in sections 7 and 15 of the *Charter*;[11] as well as in the program

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Population Health and Health Security, *Reducing Health Disparities—Roles of the Health Sector*, Discussion Paper (Ottawa: Public Health Agency of Canada, 2004) at iv.

8 Paul Hunt, *Promotion and Protection of All Human Rights, Civil, Political, Economic, Social and Cultural Rights: Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*, UNHRC, 7th Sess, UN Doc A/HRC/7/11 (2008) at para 64 [Hunt, *Report of the Special Rapporteur*].

9 Richard Mulgan, "'Accountability': An Ever-Expanding Concept?" (2000) 78:3 Public Administration 555 at 555 [Mulgan, "Accountability"]. As Mulgan defines it: "accountability has a number of features: it is *external*, in that the account is given to some other person or body outside the person or body being held accountable; it involves *social interaction and exchange*, in that one side, that calling for the account, seeks answers and rectification while the other side, that being held accountable, responds and accepts sanctions; it implies *rights of authority*, in that those calling for an account are asserting rights of superior authority over those who are accountable, including the rights to demand answers and to impose sanctions" (*ibid*).

10 Barbara Cameron, "Accountability Regimes for Federal Social Transfers: An Exercise in Deconstruction and Reconstruction" in Martha Jackman & Bruce Porter, eds, *Advancing Social Rights in Canada* (Toronto: Irwin Law, 2014) 129 at 132 [Cameron, "Accountability"].

11 See *Charter*, *supra* note 1. Section 7 of the *Charter* states: "Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice." Section 15(1) of the *Charter* provides: "Every in-

criteria of the *Canada Health Act*[12] itself. Missing in Canada are mechanisms to secure the "answerability" of health care decision-makers for the performance of, and to impose "sanctions" for failure to meet, these domestic and international human rights obligations. This core feature of accountability, "external scrutiny and sanctions"[13] as Richard Mulgan puts it, is largely non-existent within the Canadian health care system.[14] In the words of Catherine Régis:

> Deux éléments sont nécessaires pour que l'imputabilité dépasse le stade de valeur certes louable pour en arriver à un standard susceptible d'application. Il s'agit de la présence d'un devoir de *justification* des décideurs et l'imposition de *conséquences* si cette justification est insatisfaisante. Ces éléments définissent ce qui est nécessaire pour qu'une véritable dynamique d'imputabilité se mette en place . . . dans les systèmes de santé au Canada.[15]

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

12 *Canada Health Act*, *supra* note 2. The Preamble to the *Canada Health Act* explicitly recognizes that "Canadians [. . .] desire a system of health services that will promote physical and mental health and protection against disease" and that "continued access to quality health care without financial or other barriers will be critical to maintaining and improving the health and well-being of Canadians." The *Canada Health Act*'s five program criteria of public administration, comprehensiveness, universality, portability, and accessibility are designed to ensure that provincial governments delivering federally-funded health programs and services comply with the *Canada Health Act*'s objective of ensuring access to care based on need, rather than ability to pay; *Romanow Commission*, *supra* note 3 at xvi; Senate, *The Health of Canadians*, *supra* note 3 at 45; National Forum on Health, *Canada Health Action*, *supra* note 3; Lahey, "Medicare and the Law", *supra* note 6; Commission on the Future of Health Care in Canada, "Strengthening the Foundations: Modernizing the *Canada Health Act*", by Colleen M Flood & Sujit Choudhry, Discussion Paper No 13 (CFHCC, August 2002) [Flood & Choudhry, *Modernizing the CHA*].

13 Mulgan, "Accountability", *supra* note 9 at 571. See also Jean-Louis Denis, "Accountability in Healthcare Organizations and Systems", Editorial (2014) 10 Healthcare Policy 8 at 8 [Denis, "Accountability"].

14 For a discussion of the strengths and limits of two provincial accountability mechanisms that do exist, Québec's Protecteur du citoyen and Ontario's Health Services and Appeal Review Board, see Catherine Régis, "The Accountability Challenge in Health Care: The Contribution of a Health Ombudsman" (2014) 4:1 J Arbitration & Mediation 87; Caroline Pitfield & Colleen M Flood, "Section 7 'Safety Valves': Appealing Wait Times Within a One-Tier System" in Colleen M Flood, Kent Roach & Lorne Sossin, eds, *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) 477; Catherine Régis, "Enhancing Patients' Confidence in Access to Health Care: The Ontario or Québec Way?" (2004) 12 Health LJ 243 [Régis, "Enhancing Patients' Confidence"].

15 Catherine Régis, "La valeur de l'imputabilité dans l'allocation des ressources au Canada : Une perspective de politiques publiques" (2008) 2 McGill JL & Health 47 at 54 [Régis, "La

The relationship between human rights and accountability is well established internationally. In particular, the *ICESCR* guarantees "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,"[16] "without discrimination of any kind,"[17] and it identifies "the prevention, treatment and control of . . . diseases [and] medical service and medical attention in the event of sickness"[18] as central components of that right. The *ICESCR* and the UN Committee on Economic, Social and Cultural Rights' *General Comment No. 14*, outline Canada and other State Parties' obligations to protect and promote the right to health, including the requirement to put in place effective accountability mechanisms to ensure that health rights are respected and enforced.[19] As Paul

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valeur de l'imputabilité"]. See also Raisa B Deber, "Thinking About Accountability" (2014) 10 Healthcare Policy 12 at 13 [Deber, "Accountability"]; The Conference Board of Canada, "The Canadian Health Care Debate: A Survey and Assessment of Key Studies", by Gabriela Prada & Tamara Brown (Ottawa: TCBC, May 2012) at 2; William Lahey, "New Governance Regulation and Managerial Accountability for Performance in Canada's Health Care Systems" in Robert P Kouri & Catherine Régis, eds, *Grand Challenges in Health Law and Policy* (Cowansville, QC: Éditions Yvons Blais, 2010) 243 [Lahey, "New Governance"]; Antonia Maioni, "A Decade of Health Care Commissions" (2008) Health Innovation Forum, online: <www.healthinnovationforum.org>; Cathy Fooks & Steven Lewis, *Romanow and Beyond: A Primer on Health Reform Issues in Canada* (Ottawa: Canadian Policy Research Networks, November 2002) at 12–13; Flood & Choudhry, *Modernizing the CHA*, *supra* note 12.

16 *ICESCR*, *supra* note 5, art 12(1). While the *ICESCR* was ratified by Canada in 1976 with the approval of the provinces, its provisions have not been directly incorporated into Canadian law. This places Canada in violation of its obligations under article 28 of the *ICESCR*, which provides that its provisions "extend to all parts of federal States without any limitations or exceptions." See generally Bruce Porter, "International Human Rights in Anti-Poverty and Housing Strategies: Making the Connection" in Martha Jackman & Bruce Porter, eds, *Advancing Social Rights in Canada* (Toronto: Irwin Law, 2014) 33 [Porter, "Making the Connection"].

17 *ICESCR*, *supra* note 5, art 2(2) provides that: "The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social original, property, birth or other status." Article 3 further requires States Parties to ensure "the equal right of men and women to the enjoyment" of all *ICESCR* rights.

18 *Ibid*, art. 12(2)(c)–(d).

19 *The Right to the Highest Attainable Standard of Health* (*General Comment No 14*), UNCESC, 22nd Sess, UN Doc E/C.12/2000/4 (2000) at paras 11, 57–59 [*General Comment 14*]; Hunt, *Report of the Special Rapporteur*, *supra* note 8 at paras 51, 65; Helen Potts, *Accountability and the Right to the Highest Attainable Standard of Health* (Colchester, UK: Human Rights Centre University of Essex, 2008) [Potts, *Accountability*]; Helen Potts, *Participation and the Right to the Highest Attainable Standard of Health* (Colchester, UK: Human Rights Centre University of Essex, 2007) at 15 [Potts, *Participation*].

Hunt summarizes this requirement: "[r]ights imply duties, and duties demand accountability."[20]

In Canada, however, the prevailing view remains, as Roy Romanow expresses it, that health care "is not a legal construct, but rather, a political construct"[21] and that, in the words of Christopher Manfredi, "the question of what kind of health care system Canada should have is simply not amenable to resolution through the language of legal rights."[22] The question of how to increase accountability has been at the forefront of Canadian health reform debates over the past twenty years; however, political-based, value-based, or consensus-based frameworks have been preferred. After two decades of discussions and promises of change, as Steven Lewis puts it, "the missing piece appears to be enforceable accountability."[23]

This paper argues that a new human rights based approach to accountability is required: one that explicitly accepts that Canadian *Charter* and international human rights are implicated in health care decision-making, and that ensures effective "scrutiny and sanctions"[24] where systemic or individualized decisions made by governments or their delegates within the publicly funded system undermine, rather than reinforce, those rights.[25] I will suggest that such a human rights approach to health care accountability is essential not only to bring Canada into compliance with its *Charter* and international obligations, but also in order to be effective, especially from the perspective of disadvantaged groups.

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20 Hunt, *Report of the Special Rapporteur*, *supra* note 8 at para 65; Alicia Ely Yamin, "Will We Take Suffering Seriously? Reflections on What Applying a Human Rights Framework to Health Means and Why We Should Care" (2008) 10:1 Health & Hum Rts 45 at 49.

21 The Honourable Roy J Romanow, "In Search of a Mandate?" in Colleen M Flood, Kent Roach & Lorne Sossin, eds, *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) 521 at 528.

22 Christopher P Manfredi, "Déjà Vu All Over Again: *Chaoulli* and the Limits of Judicial Policymaking" in Colleen M Flood, Kent Roach & Lorne Sossin, eds, *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) 139 at 154.

23 Steven Lewis, "Canadian Health Policy Since Romanow: Easy to Call for Change, Hard to Do" (Discussion Paper, delivered at the Monieson Centre for Business Research in Healthcare, 13 June 2013) (2013) Queen's Health Policy Change Conference Series at 10. See also Canadian Medical Association, *Health Care Transformation in Canada: Change That Works, Care That Lasts* (Ottawa: Canadian Medical Association, 2010) at 24–25 [CMA, *Health Care Transformation*]. For a discussion of health care accountability reform, see Part II, below.

24 Mulgan, "Accountability", *supra* note 9 at 571.

25 Paul Hunt & Gunilla Backman, "Health Systems and the Right to the Highest Attainable Standard of Health" (2008) 10 Health & Hum Rts 81 at 89 [Hunt & Backman "Health Systems"].

To make this case, I will first provide a brief overview of the concrete steps that governments have taken towards implementing the various accountability reforms put forward in Canada over the past twenty years at the system performance and access to care levels. Using abortion services as an example, I will then consider the implications of the absence of a human rights approach to accountability, particularly for those whose needs are least served within the current system. I will go on to suggest that what is required, going forward, is not only the recognition that access to health care engages fundamental rights, but the creation of institutions and mechanisms designed to provide "accessible, transparent and effective mechanisms of accountability"[26] for health care decision-making. I will point to the *Alternative Social Charter*[27] as one possible model for achieving such accountability: a critical reform for the future of health and human rights in Canada.

II. HEALTH CARE ACCOUNTABILITY REFORM: WHAT PROGRESS HAS BEEN MADE?

The call for greater health care accountability has been a constant refrain in all major health care system reviews in Canada, stretching back to the 1997 report of the National Forum on Health.[28] Although no action was taken in response to the Romanow Commission's explicit recommendation in 2002 that accountability be included as a new principle under the *Canada Health Act*, this issue has continued to dominate the health reform agenda:

> [P]rovincial and federal commissions and task forces asked to review the health care system have highlighted major challenges in the structure, design, funding, management and outcomes of the Canadian health care system[.] While strengthening accountability mechanisms was not seen as a magic bullet . . . it was seen as a necessary underpinning to achieve many of the reforms proposed[.][29]

26 Hunt, *Report of the Special Rapporteur*, *supra* note 8 at para 65.

27 "Alternative Social Charter" (27 March 1992), online: Social Rights in Canada <socialrightscura.ca> [*Alternative Social Charter*]; "Draft Social Charter" in Joel Bakan & David Schneiderman, eds, *Social Justice and the Constitution: Perspectives on a Social Union for Canada* (Ottawa: Carleton University Press, 1992) 155 at Appendix I.

28 National Forum on Health, *Canada Health Action*, *supra* note 3.

29 Cathy Fooks & Lisa Maslove, *Rhetoric, Fallacy or Dream? Examining the Accountability of Canadian Health Care to Citizens* (Ottawa: Canadian Policy Research Networks, March 2004) at 1 [Fooks & Maslove, *Accountability*]. See also Senate, Standing Senate Committee on Social Affairs, Science and Technology, *Time for Transformative Change: A Review of the*

Researchers have noted that overlapping policy, program, and legal relationships and responsibilities add to the health care accountability challenge in Canada. Federal, provincial, territorial, municipal, and First Nations governments; professional and other health regulatory bodies; regional and local health authorities; and institutional and individual health service providers share responsibility for ensuring access to care, quality of care, and overall improvement of health outcomes. Those targeted by health policies and programs include individual patients in receipt of services, particular patient sub-groups, broader communities, and society as a whole.[30] While the difficulties of designing and implementing effective accountability mechanisms in such an environment are universally acknowledged, there is an equal consensus that accountability remains a key, if illusive, health reform objective.[31]

2004 Health Accord (March 2012) at 69–70 (Chair: The Honourable Kelvin K Ogilvie) [Senate, *Time for Transformative Change*]; Council of the Federation, *From Innovation to Action: The First Report of the Health Care Innovation Working Group* (Ottawa: The Council of the Federation, July 2012) at 23; Canadian Medical Association, *Report of the Advisory Panel on Resourcing Options for Sustainable Health Care in Canada* (Ottawa: Canadian Medical Association, July 2011) at 12; "Canadians Support Greater Accountability in Health Care: Nine in Ten (87%) Think a Patient Health Charter Should be Required Under the Next Federal-Provincial Health Care Funding" (22 August 2011), online: Ipsos <www.ipsos-na.com>; CMA, *Health Care Transformation*, *supra* note 23 at 24–25; Health Council of Canada, *Rekindling Reform: Health Care Renewal in Canada, 2003–2008* (Ottawa: Health Council of Canada, 2008) at 25, 35 [HCC, *Rekindling Reform*].

30 See generally Katherine Fierlbeck & William Lahey, eds, *Health Care Federalism in Canada: Critical Junctures and Critical Perspectives* (Montreal: McGill-Queen's University Press, 2013); William Lahey, "Medicare and the Law", *supra* note 6; Lorne Sossin & Steven J Hoffman, "Evaluating the Impact of Remedial Authority: Adjudicative Tribunals in the Health Sector" in Robert J Sharpe & Kent Roach, eds, *Taking Remedies Seriously* (Ottawa: Canadian Institute for the Administration of Justice, 2009) 521.

31 Fooks & Maslove, *Accountability*, *supra* note 29; Alana Klein, "Participation and Accountability: New Avenues for Human Rights Engagement with the Distribution of Health Resources in Canada" in Martha Jackman & Bruce Porter, eds, *Advancing Social Rights in Canada* (Toronto: Irwin Law, 2014) 309; Deber, "Accountability", *supra* note 15; Denis, "Accountability", *supra* note 13; Lahey, "Medicare and the Law", *supra* note 6 at 71; Lahey, "New Governance", *supra* note 15; Régis, "La valeur de l'imputabilité", *supra* note 15; Colleen M Flood & Michelle Zimmerman, "Judicious Choices: Health Care Resource Decisions and the Supreme Court of Canada" in Jocelyn Downie & Elaine Gibson, eds, *Health Law at the Supreme Court of Canada* (Toronto: Irwin Law, 2007) 25 at 54; Susan V Zimmerman, *Mapping Legislative Accountabilities* (Ottawa: Canadian Policy Research Networks, February 2005) at 18; Nola M Ries & Timothy Caulfield, *Accountability in Health Care and Legal Approaches* (Ottawa: Canadian Policy Research Networks, May 2004) at iv [Ries & Caulfield, "Accountability"]; Julia Abelson & François-Pierre Gauvin, *Engaging Citizens: One Route to Health Care Accountability* (Ottawa: Canadian Policy Research Networks, April 2004) at 3; Régis, "Enhancing Patients' Confidence", *supra* note 14 at 259; Colleen M Flood,

In this section of the paper, I will provide a brief overview of the concrete measures that have been adopted by the federal government and in some provinces/territories in response to the numerous proposals aimed at improving accountability, both in terms of the overall performance of the publicly funded system and in relation to individual access to care. I will then consider the limitations of those reforms from a human rights perspective.

A. The Implementation of Proposed Reforms

1. Accountability at the System Performance Level

Federal and provincial/territorial governments have taken some follow-up steps to recommendations by the Romanow Commission and others for improving accountability at the health care system performance level. For example, following a comprehensive review in that province, the Saskatchewan Commission on Medicare (the Fyke Commission) concluded that new accountability measures were required to address the quality, and not simply the accessibility, of publicly funded care at a system-wide level.[32] On that basis, the Fyke Commission called for the creation of an independent "quality council" with a broad mandate to set evidence-based performance indicators; make recommendations to reduce clinical error and variations in practice; and assess the value-for-money of new drugs and technology, among other new accountability measures.[33]

In response, in 2002 the Saskatchewan government enacted the *Health Quality Council Act*,[34] establishing the Saskatchewan Health Quality Council. The *Act* describes the objects of the Council as including: monitoring and assessing the quality of health services available in Saskatchewan; monitoring existing and developing new clinical standards of health care; assessing the effectiveness of new and existing health technologies; and researching and evaluating prescription drug prescribing practices, utilization, and review and approval processes.[35] Since its establishment, the Council has engaged in a wide range of activities in all of these areas.[36]

Duncan Sinclair & Joanna Erdman, "Steering and Rowing in Health Care: The Devolution Option?" (2004) 30 Queen's LJ 156.

32 Saskatchewan, Commission on Medicare, *Caring for Medicare: Sustaining a Quality System* (Regina: Saskatchewan Health—Policy and Planning Branch, 2001) at 7 [*Fyke Commission*].

33 *Ibid* at 40–53.

34 SS 2002, c H-0.04.

35 *Ibid*, s 5.

36 See generally Saskatchewan Health Quality Council, *About HQC*, online: <www.hqc.sk.ca>.

In Alberta, the Premier's Advisory Council on Health for Alberta (the Mazankowski Council) recommended that a permanent expert panel be created, and specific criteria be established for determining what types of treatments, services, and drugs should be publicly insured, with a view to ensuring evidence-based review and a transparent decision-making process for these decisions.[37] The Alberta government responded to the Mazankowski report by establishing an Expert Advisory Panel to Review Publicly Funded Health Services, but the government ultimately rejected the Panel's 2003 proposal for a provincial health services review board that would make decisions on funding for new and existing health services and treatments.[38]

At the national level, the Health Council of Canada was established in 2004, pursuant to the recommendations of the Romanow Commission and the *2003 First Ministers' Accord on Health Care Renewal*.[39] Funded by Health Canada, the Council included representatives of all provincial/territorial governments except Alberta and Quebec. In its 2008 report, the Council described its goals as being "to deepen public understanding[;] to support the health care community[;] and to monitor and report on the successes achieved and challenges encountered in the pursuit of a sustainable and high-performing health care system."[40] The Council's annual reports examine health reform measures undertaken at the federal and provincial/territorial level since the 2003 and 2004 *Health Accords*.[41] In its *Progress Report 2011*,[42] the Council noted that health quality councils "are working to improve delivery and accountability by reporting on what is needed to improve the

37 Premier's Advisory Council on Health for Alberta, *A Framework for Reform: Report of the Premier's Advisory Council on Health* (Edmonton: PACH, 2001) at 45–46 [*Mazankowski Council*].

38 Alberta, Expert Advisory Panel to Review Publicly Funded Health Services, *The Burden of Proof: An Alberta Model for Assessing Publicly Funded Health Services* (Edmonton: Alberta Health and Wellness, 2003); Nola M Ries, "Charter Challenges" in Jocelyn Downie, Timothy Caulfield & Colleen M Flood, eds, *Canadian Health Law and Policy*, 4th ed (Markham, Ont: LexisNexis Canada, 2011) 614 at 647 [Ries, "Charter Challenges"]. For a discussion of the review process that was put in place, see Henry Z Borowski, Jon Brehaut & David Hailey, "Linking Evidence from Health Technology Assessments to Policy and Decision Making: The Alberta Model" (2007) 23:2 Intl J Technology Assessment in Health Care 155.

39 *Romanow Commission*, *supra* note 3 at 52–59; Flood & Choudhry, *Modernizing the CHA*, *supra* note 12 at 22; First Ministers' Meeting on Health, *2003 First Ministers' Accord on Health Care Renewal*, Doc 800-039 (5 February 2003) [*2003 Health Accord*]; Senate, *Time for Transformative Change*, *supra* note 29 at 8.

40 HCC, *Rekindling Reform*, *supra* note 29 at 3.

41 *2003 Health Accord*, *supra* note 39; First Ministers' Meeting of Health, *A 10-Year Plan to Strengthen Health Care*, Doc 800-042 (16 September 2004) [*2004 Health Accord*].

42 Health Council of Canada, *Progress Report 2011: Health Care Renewal in Canada* (Toronto: HCC, 2011).

quality of health care services"[43] in British Columbia, Alberta, Saskatchewan, Ontario, Quebec, and New Brunswick. However, the Council observed that "[the 2003 and 2004 *Health Accords*] promise some broad solutions, but contain few concrete targets, leaving it to individual governments to identify priorities and set targets to meet the needs of their residents."[44]

In its 2012 review of the 2004 *Health Accord*, the Standing Senate Committee on Social Affairs, Science and Technology recommended that the federal government work with Health Canada to promote the development of health-quality council concepts.[45] However, in April 2013, the federal Minister of Health announced instead that funding of the Health Council of Canada would cease with the expiry of the *Health Accords* in March 2014.[46] As a result, this important pan-Canadian system performance accountability mechanism has been lost.

2. Accountability at the Access to Care Level

Beyond reforms at the system performance level, some efforts have also been made by federal and provincial/territorial governments to implement health covenants or patient charters as a means of improving accountability at the access to care level.[47] In New Brunswick, the Premier's Health Quality Council recommended the enactment of a "Health Charter of Rights and Responsibilities" to clarify individual rights and responsibilities vis-à-vis the health care system.[48] The *Health Charter of Rights and Responsibilities*

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43 *Ibid* at 24.

44 *Ibid*. See also Health Canada, "Reporting on Health Indicators" in *Report of the Auditor General of Canada to the House of Commons* (Ottawa: Office of the Auditor General of Canada, 2008) at ch 8.

45 Senate, *Time for Transformative Change*, *supra* note 29 at 70.

46 Health Council of Canada, Press Release, "Federal Government Announces That it Will Wind Down its Funding Support of the Health Council of Canada" (25 April 2013); Health Council of Canada, *Better Health, Better Care, Better Value for All: Refocusing Health Care Reform in Canada* (Toronto: HCC, 2013) at 3; Catherine Cross, "Advocates Decry Health Council's Demise" (2013) 185:9 CMAJ 756.

47 For an overview of Canadian proposals and models from other jurisdictions, see Mark Ammann & Tracey Bailey, "Alberta's Patient Charter: Is it a Course Worth Charting?" (2011) 19:2 Health L Rev 17 [Ammann & Bailey, "Alberta's Patient Charter"]; Colleen M Flood & Tracey Epps, "Waiting for Health Care: What Role for a Patients' Bill of Rights?" (2004) 49 McGill LJ 515; Margaret Smith, *Patient's Bill of Rights—A Comparative Overview* (Ottawa: Library of Parliament, 2002); Quebec, Conseil de la santé et du bien-être, *Analyse sommaire des déclarations, des lois et des chartes des droits en matière de santé et de bien-être* (Sainte-Foy: Conseil de la santé et du bien-être, 2005).

48 New Brunswick, *Health Renewal: Report from the Premier's Health Quality Council* (Fredericton: Office of the Premier, 2002) at 78–81 [*New Brunswick Premier's Council*].

Act (Bill 60)[49] was introduced and debated shortly before the legislature was dissolved for a general election in May 2003. Bill 60 recognized that accountability was an important aspect of the provincial health care system and it stated, among other provisions, that every resident of the province had the right to timely access to health care services, as well as to investigation of complaints.[50] After the election, the subject matter of Bill 60 was referred to a legislative committee for further study. Following public hearings, the Select Committee on Health Care submitted a report recommending the adoption of a revised version of the Health Charter, but a new bill was not introduced.[51]

In Saskatchewan, the 2009 report of the Patient First Review Commissioner recommended that Saskatchewan adopt a "Charter of Patient Rights and Responsibilities" that would include a range of over-riding principles, such as fairness, accountability, and transparency; a set of patient rights, including dignity, safety, and informed decision-making; mechanisms for recourse or appeal; and a statement of patient responsibilities, such as maintaining a healthy lifestyle.[52] In June 2015, Saskatchewan's Minister of Health explained that, after careful consideration, the province decided not to act on the patient charter proposal, but instead to develop a "patient and family-centered care framework" as a principle of health care service delivery whereby "[h]ealth providers strive to ensure patients have the information they need in order to make informed decisions"[53] and "[w]here possible, each patient's personal needs are considered in the provision of care."[54]

In Alberta, a new *Alberta Health Act*[55] was enacted in December 2010, pursuant to the recommendations of the Minister's Advisory Committee

49 Bill 60, *Health Charter of Rights and Responsibilities Act*, 5th Sess, 54th Leg, New Brunswick, 2003.

50 *Ibid*, s 3(1).

51 New Brunswick, *Journals of the Legislative Assembly*, 55th Leg, 2nd Sess, (27 April 2005); see Ries & Caulfield, "Accountability", *supra* note 31 at 21–22, 27.

52 Saskatchewan, Patient First Review Commissioner, *For Patients' Sake: Patient First Review Commissioner's Report to the Saskatchewan Minister of Health* (Saskatoon: Saskatchewan Ministry of Health, 2009) at 31 [*Patient First Review*].

53 Saskatchewan, Ministry of Health, *Patient First Review Update: The Journey So Far and the Path Forward*, by the Honourable Dustin Duncan (Regina: Government of Saskatchewan, 2015) at 12.

54 *Ibid*.

55 SA 2010, c A-19.5 [*Alberta Health Act*]. For a critique of the *Act* and the process leading up to it, see Diana Gibson & Colleen Fuller, "The New Alberta Health Act: Risks and Opportunities—Report I: Risks of the Alberta Health Act", Discussion Paper (Edmonton: Park-

on Health and a province-wide consultation.[56] Subsection 2(1) of the *Act* directs Alberta's Minister of Health and Wellness to establish a Health Charter "to guide the actions" of health care authorities, providers, and patients in the province.[57] Subsection 2(2) affirms that the Health Charter must "recognize that health is a partnership among individuals, families, communities, health providers, organizations that deliver health services, and the Government of Alberta, and acknowledge the impact of an individual's health status and other circumstances on the individual's capacity to interact with the health system, but [. . .] not be used to limit access to health services."[58] Section 3 of the *Act* provides for the appointment of a Health Advocate whose role, pursuant to section 4 of the *Act*, includes reviewing complaints that "a person has failed to act in a manner consistent with the Health Charter."[59] Under section 5 of the *Act*, the Health Advocate may, following review of a complaint, make appropriate recommendations "to any person" and, failing compliance, may submit a report on the matter to the Minister.[60] Section 14 requires public input into regulation-making by the Minister and Cabinet under the *Act*, including in regard to regulations establishing the Health Charter, and the Health Advocate's powers, duties, and complaints process.[61]

The *Alberta Health Act* was proclaimed into force on January 1, 2014, and the *Health Advocate Regulation* was adopted on April 1, 2014.[62] Whether and how the new Alberta regime will improve the accountability of health care decision-making remains an open question. Commenting on the *Act* and *Health Advocate Regulation*, the Alberta Medical Association wondered how conflicts between patients' expectations and government priorities would ultimately be resolved:

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land Institute, 2010); Diana Gibson & Colleen Fuller, "The New Alberta Health Act: Risks and Opportunities—Report II: Access, Quality and Affordability: Real Health Care Change for Albertans", Discussion Paper (Edmonton: Parkland Institute, 2010).

56 Alberta, Minister's Advisory Committee on Health, *A Foundation for Alberta's Health System: A New Legislative Framework for Health* (Edmonton: Alberta Health Services, 2010) at 16; Legislative Assembly of Alberta, *Putting People First—Part One: Recommendations for an Alberta Health Act*, by Fred Horne (Edmonton: Legislative Assembly of Alberta, 2010).

57 *Alberta Health Act*, *supra* note 55, s 2(1).

58 *Ibid*, s 2(2).

59 *Ibid*, s 3–4.

60 *Ibid*, s 5.

61 *Ibid*, s 14. For information on the Health Advocate and regulations establishing the Health Charter, see *ibid*, ss 12–13.

62 *Health Advocate Regulation*, Alta Reg 49/2014.

> The charter should . . . provide clarity about where accountability lies when policies of the government appear to be at odds with a group of patients or an individual patient. How will the Health Advocate deal with such situations? What is the responsibility of government to reconcile such differences when patients are presenting legitimate needs and concerns that are not aligned with current policy?[63]

As one respondent at a disability and anti-poverty community health forum in Calgary framed the issue: "Is the Charter enforceable? How? By what process?"[64]

B. The Limits of Existing Reform Proposals: What is Left Out?

1. The Invisibility of Health as a Human Right

In her assessment of the Romanow Commission's *Final Report*, Donna Greschner observes that it "omits almost completely any discussion of one primary method of regulating relationships between governments and citizens: rights."[65] She points out that, although the *Charter* "regulates all government activity pertaining to health care, it is mentioned only twice [and that] the word 'right' rarely appears . . . . It is as if the health care system operates on one planet and the judicial system on another."[66] The same critique holds true for other system performance accountability reforms put forward in Canada over the past two decades. As discussed above, proposals have been made for independent processes to identify unmet needs, gaps in services, and inefficiencies that create barriers to care; for establishing wait-time benchmarks and targets; and for creating evidence based assessments of new treatments, drugs, and technologies.[67] Yet these recommendations

63 Alberta Medical Association, "Alberta Medical Association Commentary: Draft *Alberta Health Act* Health Charter and Advocate Regulation" (March 2014) at 6, online: Alberta Health <www.health.alberta.ca/documents/AHA-Feedback-AMA-2.pdf>; Ammann & Bailey, "Alberta's Patient Charter", *supra* note 47.

64 Darrell Howard, Colleen Huston & Kimberly Matthews, on behalf of Poverty Talks, Disability Action Hall and the Calgary Ability, "Submission to the Alberta Health Advocate and Health Charter Project Team" (3 March 2014) at 4, online: Alberta Health <www.health.alberta.ca/documents/AHA-Feedback-Calgary-Ability-Network.pdf>. See also Ammann & Bailey, "Alberta's Patient Charter", *supra* note 47 at 25.

65 Donna Greschner, "Public Law in the Romanow Report" (2003) 66 Sask L Rev 565 at 568 [Greschner, "Public Law"].

66 *Ibid*.

67 See *Fyke Commission*, *supra* note 32 at 40–53; *Mazankowski Council*, *supra* note 37 at 45–46; Quebec, Commission d'étude sur les services de santé et les services sociaux, *Emerging Solutions: Report and Recommendations* (Quebec: Commission d'étude sur les services de

contain no framework for ensuring that national, provincial/territorial, or local decision-making at the system performance level complies with the basic requirements of the Canadian *Charter* or Canada's international human rights obligations, in terms of either substance or process.

Similarly, absent from the New Brunswick Council, Saskatchewan Patient First Review, Canadian Medical Association, and other proposals for the adoption of health covenants or patient charters as a means of improving the accountability of decision-making at the access to care level, is any reference to relevant domestic or international right to health guarantees.[68] Most striking in this regard is subsection 2(4) of the new *Alberta Health Act*, which contains the explicit *caveat* that:

> A failure of a person to act in a manner that is consistent with the Health Charter does not in itself give rise to
> (a) a cause of action or other legal enforceable claim, or
> (b) proceedings in any court or before any body or person having the power to make decisions under an enactment.[69]

In an environment in which barriers to care directly engage life, security of the person, and equality guarantees, the lack—whether intentional or not—of human rights informed mechanisms for ensuring that health care decision-making complies with Canada's constitutional or international human rights obligations represents a major defect in the current approach to accountability within the health care system.

2. The Failings of the Current Approach: Access to Abortion

Canadian governments' ongoing failure to ensure women's access to reproductive health services and, in particular, to abortion, offers a concrete illustration of why a human rights approach to accountability is both important and necessary. As the non-profit group Canadians for Choice and earlier reports by the Canadian Abortion Rights Action League document, women across Canada continue to face direct and systemic barriers to

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santé et les services sociaux, 2001) at 160 [*Clair Commission*]; CMA, *Health Care Transformation*, *supra* note 23 at 27.

68 See *New Brunswick Premier's Council*, *supra* note 48; *Patient First Review*, *supra* note 52 at 31; CMA, *Health Care Transformation, supra* note 23 at 8–9; IRPP Task Force on Health Policy, *Recommendations to First Ministers* (Montreal: Institute for Research on Public Policy, 2000) at 22 [on file with author]; Québec, Le Conseil de la santé et du bien-être, *Déclaration des droits et des responsabilités en matière de santé et de bien-être* (*Avant- projet*) (Sainte-Foy: Le Conseil de la santé et du bien-être, 2005).

69 *Alberta Health Act*, *supra* note 55, s 2(4).

abortion services more than twenty-five years after the *R v Morgentaler*[70] decision.[71] Few Canadian hospitals provide abortion services, with most of these located in urban areas near the US border.[72] The process for obtaining an abortion, wait-times, gestational limits, and the availability of counselling services vary greatly between provinces/territories and from hospital to hospital.[73] Uninformed and anti-choice hospital staff members and health care professionals create additional barriers for women seeking abortions.[74] Canadians for Choice concludes: "People often think that because abortion was legalized in 1988, it is easy for a woman to access the procedure. Such thoughts are far from the truth."[75]

Barriers to abortion services, and the legal challenges they have generated,[76] speak to the more generalized problem and highlight the failings of

70 [1988] 1 SCR 30, 44 DLR (4th) 385.

71 See Jessica Shaw, *Reality Check: A Close Look at Accessing Abortion Services in Canadian Hospitals* (Ottawa: Canadians for Choice, 2006) [Canadians for Choice, *Reality Check*]; Childbirth by Choice Trust, *Abortion in Canada Today: The Situation Province-by-Province* (Toronto: Childbirth by Choice Trust, 2006); Canadian Abortion Rights Action League, *Protecting Abortion Rights in Canada: A Special Report to Celebrate the 15th Anniversary of the Decriminalization of Abortion in Canada* (Ottawa: Canadian Abortion Rights Action League, 2003); André Picard, "Province's Refusal to Fund Private Abortion Clinics is a Travesty of Justice" (17 April 2014), Picard on Health (blog), online: <picardonhealth.tumblr.com>; Sandeep Prasad, "There Are Still Many Barriers to Abortion in Canada" (27 September 2015), HuffPost Living Canada (blog), online: <www.huffingtonpost.ca>.

72 Canadians for Choice, *Reality Check*, *supra* note 71 at 15. The percentage of hospitals providing abortion services ranged from a high of 100% in Nunavut (1/1 hospital) to a low of 6% in Alberta (6/100 hospitals); 4% in Manitoba (2/52 hospitals); 4% in New Brunswick (1/28 hospitals); and no abortion services at all in Prince Edward Island (*ibid* at 2).

73 *Ibid* at 14–15.

74 *Ibid* at 42–45; Sanda Rodgers & Jocelyn Downie, "Abortion: Ensuring Access", Guest Editorial (2006) 175:1 CMAJ 9; Daphne Gilbert, "Let Thy Conscience Be Thy Guide (But Not MY Guide!): Physicians and the Duty to Refer" (2016) 10:2 McGill JL & Health (forthcoming). See e.g. Protection of Consciousness Project, "Submission to the College of Physicians and Surgeons of Ontario Re: Professional Obligations and Human Rights" (20 February 2015), online: <www.consciencelaws.org/publications/submissions/submissions-013-001-cpso.pdf>; *Christian Medical and Dental Society et al v College of Physicians and Surgeons of Ontario* (20 March 2015), Ottawa 15-63717 (Ont Sup Ct) (Notice of Application), online: <www.cmdscanada.org/my_folders/CPSO_CPSS/2015_03_20_Notice_of_Application.pdf>.

75 Canadians for Choice, *Reality Check*, *supra* note 71 at 4. Similar barriers exist to access to medical abortion, or the termination of pregnancy by pharmaceutical means; see Erin Nelson, "Regulating Reproduction" in Jocelyn Downie, Timothy Caulfield & Colleen M Flood, *Canadian Health Law and Policy*, 4th ed (Markham, Ont: LexisNexis Canada, 2011) 295 at 300–301 [Nelson, "Regulating Reproduction"].

76 *Association pour l'accès à l'avortement c Quebec* (*PG*), 2006 QCCS 4694, [2006] RJQ 1938; *Jane Doe 1 v Manitoba*, 2004 MBQB 285, 189 Man R (2d) 284, rev'd 2005 MBCA 109, 195 Man R (2d) 309, leave to appeal to SCC refused, 31225 (23 February 2006).

the current approach to accountability. Accountability at the system performance level, including by means of public reporting, evidence-based performance indicators, benchmarks, expert monitoring, and independent oversight, is clearly required. However, none of the system performance accountability mechanisms recommended or adopted at the federal or provincial/territorial levels have drawn attention to this discriminatory gap in women's access to reproductive health care services.[77] The absence of a human rights framework for assessing the performance of the health care system has translated into an absolute lack of accountability in an area of health services that is crucial to women's substantive equality.

Nor is it any more likely that the reforms proposed or implemented at the access to care level would operate as effective accountability mechanisms in respect to the difficulties experienced by individual women in obtaining abortion services. Some health covenant and patient charter proposals recommend that overriding principles, such as fairness, freedom from discrimination, transparency, dignity, and respect for individuals, inform all health care decision-making. Others suggest that supporting processes or mechanisms, such as patient advocates or ombudspersons, be put in place for addressing patients' questions and concerns; for providing referrals; for investigating individual complaints; for mediating or resolving disputes; and for overseeing the implementation of health covenants or patient charters within the existing health care system.[78]

However, none of these recommendations for increasing accountability of decision-making at the access to care level adopt a human rights approach. The non-justiciable character of new health covenants or patient charter rights is made explicit under the proposed *Alberta Health Act*.[79] In other reform proposals, no human rights informed review process is set out and, in terms of remedies or sanctions, the ultimate enforceability of health covenants or patient charter rights remains uncertain or non-existent.

If human rights based accountability mechanisms were available, the issue of abortion access would be easily framed and named: failure to ensure timely access to publicly-funded abortion services is a direct infringement of women's *Charter* rights to life, liberty, security of the person,

77 Sanda Rodgers, "Abortion Denied: Bearing the Limits of Law" in Colleen Flood, ed, *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006) 107 at 116–17 [Rodgers, "Abortion Denied"].

78 See Fooks & Maslove, *Accountability*, *supra* note 29.

79 *Alberta Health Act*, *supra* note 55.

and equality.[80] Sanda Rodgers affirms that "[d]iscriminatory delivery of medically necessary health services needed only by women is clear sex discrimination."[81] Denial of abortion access also violates Canada's international human rights obligations under the *ICESCR* and the *International Convention on the Elimination of all Forms of Discrimination Against Women*.[82] As United Nations Special Rapporteur Anand Grover stressed, in a 2011 report to the UN General Assembly, "[t]he right to sexual and reproductive health is an integral component of the right to health . . . . States must take measures to ensure that legal and safe abortion services are available, accessible, and of good quality."[83]

3. The Implications of the Lack of a Human Rights Framework

As outlined above, there has been clear reluctance to adopt a human rights approach to health care accountability in Canada. For example, in outlining the scope and objectives of its proposed "Health Covenant for Canadians," the Romanow Commission articulates what can be taken as a shared view among health covenants and patient charter proponents: "[t]he value of a Covenant lies . . . in the fact that it reflects the consensus of Canadians as affirmed by their governments, not in the establishment of new rights that would be subject to legal interpretation and ultimately decided by the courts rather than by Canadians themselves."[84] As Donna Greschner remarks:

> In proposing a Covenant that lacks judicial enforceability, the Report harkens back to the pre-*Charter* era, in which disputes about fundamental

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80 See generally Nelson, "Regulating Reproduction", *supra* note 75 at 296–303; Joanna N Erdman, "In the Back Alleys of Health Care: Abortion, Equality, and Community in Canada" (2007) 56 Emory LJ 1093; Jocelyn Downie & Carla Nassar, "Barriers to Access to Abortion Through a Legal Lens" (2007) 15 Health LJ 143; Rodgers, "Abortion Denied", *supra* note 77; Sanda Rodgers, "Misconceptions: Equality and Reproductive Autonomy in the Supreme Court of Canada" in Sheila McIntyre & Sanda Rodgers, eds, *Diminishing Returns: Inequality and the Canadian Charter of Rights and Freedoms* (Toronto: LexisNexis Canada, 2006) 271.

81 Rodgers, "Abortion Denied", *supra* note 77 at 121.

82 See *ICESCR*, *supra* note 5; *CEDAW*, *supra* note 5.

83 *Interim Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard Physical and Mental Health*, UNGAOR, 66th Sess, UN Doc A/66/254 (3 August 2011) [UNGAOR, 66th] at paras 6, 29; see also United Nations Committee on Economic, Social and Cultural Rights, *Concluding Observations on the Sixth Periodic Report of Canada*, UN Doc E/C.12/CAN/CO/6 (4 March 2016) [CESC, *Concluding Observations*] at paras 51–52.

84 *Romanow Commission*, *supra* note 3 at 49. For information about the Health Covenant for Canadians, see UNGAOR, 66th, *supra* note 83 at 48–52.

> values were settled almost exclusively in the political sphere. Although this faith in the political process is refreshing, . . . the Covenant's purely political status should have been accompanied by arguments justifying the rejection of legally enforceable norms as a basic feature of health care reform. Without such arguments, the position is, indeed, a faith-based one.[85]

In the case of access to abortion, it is difficult to imagine that the political-based, values-based, or consensus-based approach to accountability endorsed by the Romanow Commission, the *Alberta Health Act*, or other health review bodies would in fact operate to address the systemic barriers that exist in many parts of the country, or to remedy the discriminatory denial of individual women's access to the full range of reproductive health services.[86] It is equally doubtful whether proposed system performance and access to care-related accountability reforms would respond effectively to longstanding inequities in indigenous access to health care services;[87] under-funding of mental health and addiction treatment;[88] and other access issues, such as denial of medicare to undocumented migrants and refugees[89] and the criminalization of intravenous drug-related health services,[90] that have been the object of recent *Charter* litigation as well as

85 Greschner, "Public Law", *supra* note 65 at 571.

86 Rodgers, "Abortion Denied", *supra* note 77.

87 See e.g. Billie Allan & Janet Smylie, "First Peoples, Second Class Treatment: The Role of Racism in the Health and Well-Being of Indigenous Peoples in Canada", Discussion Paper (Toronto: Wellesley Institute/Well Living House, 2015) [Allan & Smylie, *Role of Racism*]; Boyer, *Aboriginal Health*, *supra* note 7; Senate, *Time for Transformative Change*, *supra* note 29 at 41–45; Health Council of Canada, *Progress Report 2013: Health Care Renewal in Canada* (Ottawa: HCC, 2013) at 35–36; Constance MacIntosh, "Indigenous Peoples and Health Law and Policy: Responsibilities and Obligations" in Jocelyn Downie, Timothy Caulfield & Colleen M Flood, eds, *Canadian Health Law and Policy*, 4th ed (Markham, Ont: LexisNexis Canada, 2011) 575; Janet Smylie & Michelle Firestone, "The Health of Indigenous Peoples" in Raphael, *Social Determinants*, *supra* note 6 at 434.

88 See e.g. Mental Health Commission of Canada, *Informing the Future: Mental Health Indicators for Canada* (Ottawa: MHCC, 2015); Canadian Mental Health Association, Ontario, *2015 Pre-Budget Submission* (2015) at ii, online: CMHA <ontario.cmha.ca/files/2015/02/CMHA-Ontario-Pre-Budget-Submission-2015.pdf>; CMA, *Health Care Transformation*, *supra* note 23 at 3; Lahey, "Medicare and the Law", *supra* note 6 at 59–60.

89 See e.g. *Toussaint v Canada*, 2011 FCA 213, 343 DLR (4th) 677, aff'g 2010 FC 810, 323 DLR (4th) 338; *Canadian Doctors for Refugee Care v Canada (AG)*, 2014 FC 651, 458 FTR 1.

90 See e.g. *Canada (AG) v PHS Community Services Society*, 2011 SCC 44, [2011] 3 SCR 134; Margot Young, "Sleeping Rough and Shooting Up: Taking British Columbia's Urban Justice Issues to Court" in Martha Jackman & Bruce Porter, eds, *Advancing Social Rights in Canada* (Toronto: Irwin Law, 2014).

criticism from United Nations bodies monitoring Canada's compliance with its international human rights obligations.[91]

Whether justified on the basis of resource constraints and competing priorities within the health care system, or grounded, as in the case of abortion, in overt discrimination rather than financial concerns, many of the most persistent barriers to health care are a direct manifestation of sexism, racism, and other forms of systemic inequality within Canadian society.[92] It is, therefore, hardly surprising that the preferred political or consensus-based approach to accountability has been largely ineffectual. From the perspective of the individuals and groups whose needs are least served within the current system, the absence of a human rights accountability framework reflects and reinforces social and economic disadvantage and marginalization, and thus represents a major weakness in most, if not all, of the health care accountability reform proposals that have been advanced or adopted in Canada to date.

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91 See e.g. CESCR, *Concluding Observations*, *supra* note 83 at paras 19, 49–50; *Working* Group on the Universal Periodic Review, *Compilation Prepared by the Office of the High Commissioner for Human Rights, in Accordance with Paragraph 15(b) of the Annex to Human Rights Council Resolution 5/1—Canada*, UNHRCOR, 4th Sess, A/HRC/WG.6/4/CAN/2 (2008) 1 at paras 12, 23; *Consideration of Reports Submitted by States Parties Under Articles 16 and 17 of the Covenant: Concluding Observations of the Committee on Economic, Social and Cultural Rights—Canada*, UNCESCROR, 36th Sess, Supp No 2, UN Doc E/C.12/CAN/CO/4 & E/C.12/CAN/CO/5 (2006) 1 at paras 15, 57. See generally Porter, "Making the Connection", *supra* note 16.

92 See e.g. Truth and Reconciliation Commission of Canada, *Honouring the Truth, Reconciling for the Future* (Toronto: James Lorimer & Company, 2015) vol 1 at 322–23; Allan & Smylie, *Role of Racism*, *supra* note 87; *National Anti-Poverty Plan*, *supra* note 7; Canadian Human Rights Commission, *Report on Equality Rights of Women* (Ottawa: CHRC, 2015) at 55–64; Boyer, *Aboriginal Health*, *supra* note 7; CHRC, *People with Disabilities*, *supra* note 7; Marcia Rioux, "The Right to Health: Human Rights Approaches to Health" in Toba Bryant, Dennis Raphael & Marcia Rioux, eds, *Staying Alive: Critical Perspectives on Health, Illness, and Health Care*, 2nd ed (Toronto: Canadian Scholars' Press, 2010) at 93; Ann Pederson, Dennis Raphael & Ellisa Johnson, "Gender, Race, and Health Inequalities" in Toba Bryant, Dennis Raphael & Marcia Rioux, eds, *Staying Alive: Critical Perspectives on Health, Illness, and Health Care*, 2nd ed (Toronto: Canadian Scholars' Press, 2010); Senate, *Out of the Shadows*, *supra* note 7; Chrystal Ocean, *Policies of Exclusion, Poverty & Health: Stories From the Front* (Duncan, BC: Wise Society, 2005); Joan M Gilmour, "Creeping Privatization in Health Care: Implications for Women as the State Redraws its Role" in Brenda Cossman & Judy Fudge, eds, *Privatization, Law and the Challenge to Feminism* (Toronto: University of Toronto Press, 2002) 267.

III. A HUMAN RIGHTS APPROACH TO HEALTH CARE ACCOUNTABILITY

A. Accountability from an International Human Rights Perspective

As suggested at the outset of the paper, the objective of a human rights approach to accountability is to ensure accountability for compliance with domestic and international human rights norms. The risk that "[w]ithout accountability, human rights can become no more than window-dressing"[93] is well-understood at the international level.[94] Helen Potts describes what accountability entails in reference to the right health under article 12 of the *ICESCR*:

> Accountability is the process which requires government to show, explain and justify [and which] also provides rights-holders with an opportunity to understand how government has discharged its right to health obligations. As part of the process, if it is revealed that there has been a failure on the part of government or its agents to fulfil the obligations contained in the right to the highest attainable standard of health, rights-holders are entitled to effective remedies to redress this failure.[95]

Potts identifies the three requirements—monitoring; explanation and justification; and remedy—that are common to human rights and classical definitions of accountability.[96]

With respect to the role of monitoring, Potts observes: "[a]s both a prospective and retrospective process, [accountability] necessarily includes the monitoring of conduct, performance and outcomes. It . . . requires the incorporation of monitoring into all aspects of [health] policy development and implementation."[97] Paul Hunt also underscores the importance of monitoring as a key aspect of accountability,[98] pointing to the specific role of health indicators as a means of showing whether or not a country's

93 Potts, *Accountability*, *supra* note 19 at 2.

94 Hunt, *Report of the Special Rapporteur*, *supra* note 8 at para 51; Potts, *Accountability*, *supra* note 19 at 2, 6–7.

95 Potts, *Accountability*, *supra* note 19 at 13. See also Potts, *Participation*, *supra* note 19 at 15.

96 Potts, *Accountability*, *supra* note 19 at 13. See generally Mulgan, "Accountability", *supra* note 9; Cameron, "Accountability", *supra* note 10.

97 Potts, *Accountability*, *supra* note 19 at 13. See also *General Comment 14*, *supra* note 19 at paras 57–58.

98 *Report of the Special Rapporteur*, *supra* note 8 at para 65; Hunt & Backman "Health Systems", *supra* note 25 at 87.

health system is improving, particularly from the perspective of disadvantaged individuals and communities:

> [A]n effective health system must include appropriate indicators and benchmarks; otherwise, there is no way of knowing whether or not the State is improving its health system and progressively realizing the right to the highest attainable standard of health. Moreover, the indicators must be disaggregated on suitable grounds, such as sex, socio-economic status and age, so that the State knows whether or not its outreach programmes for disadvantaged individuals and communities are working.[99]

In addition to monitoring, Potts explains that "accessible accountability mechanisms to provide a forum for explanation and justification"[100] must also be available. As Paul Hunt summarizes this second key feature of accountability: "[i]n the context of a health system, there must be accessible, transparent, and effective mechanisms of accountability to understand how those with responsibilities towards the health system have discharged their duties."[101] Potts suggests that this core component of accountability need not be confined to human rights bodies and courts, but can take place in a variety of settings.[102] Paul Hunt and Gunilla Backman concur that, in the context of health systems, "there are many different types of accountability mechanisms, including Health Commissioners, democratically elected local health councils, public hearings, patients' committees, impact assessments, maternal death audits, judicial proceedings, and so on."[103]

The third obligatory feature of human rights accountability in health care systems is the availability of sanctions and remedies for the non-fulfilment of governments' right to health obligations.[104] Potts elaborates: "[r]ights-holders are . . . entitled to effective remedies when government has failed to discharge its right to health obligations. These remedies may take the form of restitution, rehabilitation, compensation, satisfaction, or guarantees of non-repetition."[105] Potts, Hunt, and Backman also point out that, while article 12 of the *ICESR* requires that States Parties, including Canada,

99 Hunt, *Report of the Special Rapporteur*, *supra* note 8 at para 48. See also Potts, *Accountability*, *supra* note 19 at 14–16; CESCR, *Concluding Observations*, *supra* note 83 at para 62.

100 Potts, *Accountability*, *supra* note 19 at 13.

101 Hunt, *Report of the Special Rapporteur*, *supra* note 8 at para 65.

102 Potts, *Accountability*, *supra* note 19 at 13, 17–27.

103 Hunt & Backman, "Health Systems", *supra* note 25 at 89.

104 Potts, *Accountability*, *supra* note 19 at 13, 28–29.

105 Potts, *Accountability*, *supra* note 19 at 12.

provide accountability by way of judicial recourse, remedies may also be made available through other quasi-judicial or non-judicial mechanisms, so long as these are effective, transparent, accessible, and independent.[106]

Whatever the setting or mechanism, the participation of affected individuals and groups is an essential element of human rights accountability.[107] Potts explains: "Participation and accountability are interdependent. The government has an obligation to ensure that institutional mechanisms are in place to enable the participation of people and groups [. . .] in the accountability process: in monitoring for accountability, in accountability mechanisms and in the implementation of remedies[.]"[108] Hunt and Backman make a similar point, stating that governments have a responsibility to "establish institutional arrangements for the active and informed participation of all relevant stakeholders, including disadvantaged communities."[109]

In short, while evidence-based monitoring of the performance of the health care system is essential, a human rights approach goes further. Human rights accountability also calls for enforceable mechanisms for requiring governments and their delegates to explain and justify their decision-making; for imposing sanctions or ordering remedies where governments' action or inaction violates right to health care guarantees; and for enabling the participation of affected individuals and groups throughout. In concluding his Special Rapporteur's report to the UN, Paul Hunt recaps what a human rights approach to accountability demands and offers: "the right to the highest attainable standard of health requires an effective mechanism to review important health-related decisions [. . .] Accountability can be used to expose problems and to identify reforms that will enhance health systems for all."[110]

B. Moving Forward: The *Alternative Social Charter* Model

Among other proposals to address the accountability gap that exists in Canada with regard to socio-economic rights generally, the *Alternative Social Charter*, put forward by the National Anti-Poverty Organization during the

106 Potts, *Accountability*, *supra* note 19 at 29; Hunt & Backman, "Health Systems", *supra* note 25 at 89.

107 Potts, *Accountability*, *supra* note 19 at 13; Potts, *Participation*, *supra* note 19.

108 Potts, *Participation*, *supra* note 19 at 28. See also Hunt, *Report of the Special Rapporteur*, *supra* note 8 at para 41.

109 Hunt & Backman "Health Systems", *supra* note 25 at 83.

110 Hunt, *Report of the Special Rapporteur*, *supra* note 8 at para 122.

Charlottetown Accord[111] constitutional reform discussions, provides a concrete example of a human rights approach to accountability that is directly applicable in the current health care context.[112] Referencing Canada's international and domestic human rights commitments, the *Alternative Social Charter* formally recognizes access to health care as a right, affirming that "everyone has an equal right to well-being, including a right to . . . health care that is comprehensive, universal, portable, accessible, and publicly administered, including community-based non-profit delivery of services."[113] The *Alternative Social Charter* further requires that federal and provincial/territorial legislation, regulations, policy, and practice be interpreted and applied in a manner consistent with that right.[114] Two distinct mechanisms are outlined in the *Alternative Social Charter* for ensuring governments' accountability with respect to their health and other social rights obligations: first, a Social Rights Council and, second, a Social Rights Tribunal.[115]

1. The Social Charter Framework

The Social Rights Council has the primary responsibility for evaluating the extent to which laws and practices respect the rights recognized in the *Alternative Social Charter*.[116] The Council has the mandate to establish and revise standards for evaluating government performance; compile information and statistics; and encourage governments to engage in "active and meaningful consultations" with disadvantaged groups.[117] The Council can require governments to provide any necessary information and reports; it can hold inquiries; and it has the power to make recommendations to the appropriate government or legislative body, which must, in

111 Canada, Minister of Supply and Services, *Consensus Report on the Constitution: Charlottetown (final text)*, (Ottawa: MSS, 1992).

112 The author was involved in the drafting of the *Alternative Social Charter*, *supra* note 27. For a discussion of its history and objectives, see Jennifer Nedelsky & Craig Scott, "Constitutional Dialogue" in Joel Bakan & David Schneiderman, eds, *Social Justice and the Constitution: Perspectives on a Social Union for Canada* (Ottawa: Carleton University Press, 1992) 59. For information about other proposals for health care accountability, see e.g. *National Anti-Poverty Plan*, *supra* note 7 at 34–37; Martha Jackman & Bruce Porter, "Women's Substantive Equality and the Protection of Social and Economic Rights under the Canadian Human Rights Act" in Status of Women Canada, ed, *Women and the Canadian Human Rights Act: A Collection of Policy Research Reports* (Ottawa: Status of Women Canada, 1999) 42.

113 *Alternative Social Charter*, *supra* note 27, s 1.

114 *Ibid*, s 5.

115 *Ibid*, Parts II–III.

116 *Ibid*, s 9(1).

117 *Ibid*, s 9(2).

turn, respond within a fixed period of time.[118] The Council is designed to be independent with a membership composed of individuals with demonstrated socio-economic rights experience, drawn from both government and disadvantaged groups, and with sufficient public funding to carry out its functions.[119]

For its part, the Social Rights Tribunal is responsible for receiving and considering petitions by individuals and groups who allege that health and other social rights have been infringed.[120] The Tribunal can review legislation, regulations, programs, policies, or practices, including obligations under federal-provincial agreements.[121] It has the power to hold hearings; it can request information from, or the intervention of, the Social Rights Council; and it can order whatever measures it deems to be required to bring a government into compliance with the *Alternative Social Charter*.[122] A remedial order issued by the Tribunal "shall not come into effect until [. . .] the relevant legislature has sat for at least five weeks, during which time the [Tribunal's] decision may be overridden by a simple majority vote"[123] of the legislature in question. The Tribunal must be accessible to members of disadvantaged groups and their representative organizations including, if necessary, through the provision of public funding, and one third of Tribunal members must be appointed from among such groups.[124]

At the system performance level, the *Alternative Social Charter* allows for accountability of the type called for by the Fyke, Mazankowski, Romanow, and other health review commissions, including by way of public reporting, performance indicators, expert monitoring, and independent oversight.[125] At the access to care level, as various health covenants and patient charter proposals have recommended, the *Alternative Social Charter* affirms a set of overriding principles for health care decision-making "to respect, protect and promote [the right to health care] of all members of

118 *Ibid*, ss 9(3)–(4). Upon receipt of a Council recommendation, a government or legislature has three months to respond.

119 *Ibid*, ss 9(8)–(9), 9(7).

120 The main purpose of the Tribunal is "the consideration of selected petitions alleging infringements that are systemic or that have significant impact on vulnerable or disadvantaged groups and their members" (*ibid*, s 10(2)).

121 *Ibid*, s 10(3).

122 *Ibid*, ss 10(9), 10(5).

123 *Ibid*, s 10(7)(a).

124 *Ibid*, ss 10(10), 10(12).

125 See Part II(1), above, for a discussion of these health review commissions and their reports.

Canadian society, and, in particular, members of its most vulnerable and disadvantaged groups."[126]

In contrast to the largely symbolic approach that typifies most health care accountability reform proposals, however, the obligations, standards, and processes set out in the *Alternative Social Charter* for assessing performance, and the remedies for non-performance, are enforceable ones. Together, the Social Rights Council and the Social Rights Tribunal are fully empowered and equipped to engage not only in the monitoring, but the enforcement, of "conduct, performance and outcomes"[127] that are necessary to ensure effective accountability of health care decision-making, whether it be at the system performance or the access to care levels.

Finally, the accountability model proposed in the *Alternative Social Charter* can readily be put in place at the federal level, with the Council and Tribunal reporting to Parliament, or at the provincial/territorial level, with the two bodies reporting to the relevant provincial/territorial legislature(s).

2. The Social Charter Framework and Access to Abortion

The ongoing problem of access to abortion services, discussed earlier, provides a concrete illustration of how the institutional mechanisms set out under *Alternative Social Charter* would operate in practice to guarantee the type of human rights accountability that is currently lacking within the health care system.

The failure by the federal, provincial, or territorial governments to address individual and systemic barriers to abortion within their respective jurisdictions, in contravention of Canada's international human rights obligations, the *Charter*, and the *Canada Health Act*, would also directly infringe the right to "health care that is comprehensive, universal, portable, accessible, and publicly administered" under section 1(b) of the *Alternative Social Charter*.[128] Under the *Alternative Social Charter* framework, governments could be held accountable for their actions and inaction in relation to women's access to abortion services in two ways.

First, the Social Rights Council would have the power to investigate the performance of the health care system at a systemic level, whether by holding inquiries, by demanding that relevant information be provided by governments, or by undertaking its own studies and research in rela-

126 *Alternative Social Charter*, *supra* note 27, s 1.

127 Potts, *Accountability*, *supra* note 19 at 13; *General Comment 14*, *supra* note 19 at paras 57–58.

128 *Alternative Social Charter*, *supra* note 27, s 1(b).

tion to abortion services.[129] Should the Council find, as previous studies have shown, that serious problems exist across the country or in a particular region or province, including lack of services, lack of funding, and inadequate regulation of health care providers, among other barriers, the Council would be empowered to recommend to the relevant legislature or government what actions must be taken to remedy the situation.[130] In a clear break from the overwhelming silence of many Canadian governments, including successive federal governments, on this issue, the legislature or government in receipt of the Council's recommendations would be required to respond to the Council's findings and recommendations within a set period of time.[131]

Second, where a government or legislative response is inadequate, or independently of any action or recommendation by the Social Rights Council, an individual or group could also bring a petition directly before the Social Rights Tribunal, alleging an infringement of the right to access abortion as a component of the right to health care.[132] The Tribunal could hold hearings; issue a decision that the right to health had been infringed; hear submissions from petitioners and governments as to the measures required to address the problem and necessary timeline for action; and order that specific measures be taken to guarantee access to abortion services.[133] Should a government be unwilling to comply with the Tribunal's order, Parliament or the provincial/territorial legislature in question would be required to override that order by a majority vote.[134] Otherwise, the measures ordered by the Tribunal to ensure access to abortion services would have to be implemented, with the potential for continuing oversight or scrutiny by the Council or the Tribunal.[135]

In the event that Parliament or a legislature rejects the Tribunal's order, it would remain open to a woman directly affected, or to a public interest group defending women's reproductive rights, to seek judicial review of the government's decision on the grounds that the decision infringes sections 7 and 15 of the *Charter*.[136] In such a case, the Council or

129 *Ibid*, ss 9(2)–(3).
130 *Ibid*, s 9(2)(e).
131 *Ibid*, s 9(4).
132 *Ibid*, s 10(1).
133 *Ibid*, ss 10(4)–(6).
134 *Ibid*, s 10(7).
135 *Ibid*, ss 10(6)–(7).
136 See *Charter*, *supra* note 1 ("[t]his Charter applies (a) to the Parliament and government of Canada in respect of all matters within the authority of Parliament including all matters

Tribunal's decision would be of direct benefit to the parties, as well as to the court hearing and deciding the *Charter* claim. This is in sharp contrast to the current situation, where the only remedy available to individuals or groups looking to challenge barriers to abortion or other violations of health-related rights is to seek judicial review under the *Charter*, and where the courts must deal with such claims as a matter of first impression, without the advantage of the Social Rights Council or Tribunal's evidence-based reasoning, evidentiary findings, and substantive findings.

In advocating for a rights-based anti-poverty and housing strategy for Ontario, Bruce Porter has summarized what human rights accountability seeks to achieve:

> Aspirational commitments and targets would be transformed into enforceable human rights obligations that would influence decisions and policies across the full range of government activities. Under the rights-based model, accountability mechanisms would thus be linked to the ability of affected individuals and groups to claim and enforce social rights when decisions are being made that threaten their wellbeing.[137]

Whether in the case of abortion; mental health and addiction services; health care services for persons with disabilities; refugee and migrant health; or longstanding inequities in access to health and health care by indigenous people in Canada, a human rights approach, such as the one adopted under the *Alternative Social Charter*, has the potential to promote these human rights objectives and real progress towards the long-standing goal of meaningful accountability within the health care system.

IV. CONCLUSION

Cathy Fooks and Linda Maslove make the point that:

> Accountability has become a common term used in health care reform discussions in Canada. It's a good word. It conjures up processes in which citizens might come to understand where their tax dollars go, why certain policy decisions are made, or where they can turn if they are dissatisfied

relating to the Yukon Territory and Northwest Territories; and (b) to the legislature and government of each province in respect of all matters within the authority of the legislature of each province" at s 32(1)).

137 Bruce Porter, "Designing and Implementing Rights-Based Strategies to Address Homelessness and Poverty in Ontario" (2013) 4:4 Social Rights Advocacy Centre Exchange Working Paper at 3–4. See also *National Anti-Poverty Plan*, *supra* note 7.

> with the care they receive. It hints at an environment in which a health care system might take responsibility for improving the health of the population.[138]

While improving accountability has been a key recommendation in all major health system reviews undertaken at the federal and provincial/territorial levels over the past twenty years, as the first part of the paper documents, two decades of discussions and proposed reform in Canada have yielded little concrete change. The core elements of accountability—monitoring, explanation, justification, and remedies—continue to be lacking at both the system performance and access to care levels.[139] In a context where barriers to care have significant human rights implications, especially for individuals and groups already experiencing health-related disadvantage, and where access to health care based on need, rather than ability to pay, is widely perceived as "a right of citizenship, not a privilege of status or wealth,"[140] the ongoing failure by Canadian governments to implement effective, accessible, and independent mechanisms of accountability for health care decision-making is a matter of serious concern.

As I have previously described, in the absence of alternative accountability mechanisms within the health care system itself, Canadian courts are being called upon to fill the vacuum.[141] In and beyond the abortion context, patients and those advocating on their behalf have sought *Charter* review of decision-making processes affecting individual access to care and they have turned to the courts to challenge unmet needs and barriers to care at a more systemic level.[142] As the Supreme Court of Canada's judgments in *Auton (Guardian ad litem of) v British Columbia (AG)*[143] and *Chaoulli v Quebec (AG)*[144] illustrate, however, *Charter* litigation as a standalone accountability mechanism raises serious issues, not only for the par-

138 Fooks & Maslove, *Accountability*, *supra* note 29 at 3.

139 For information about the core elements of accountability, see Potts, *Accountability*, *supra* note 19 at 13.

140 *Romanow Commission*, *supra* note 3 at xvi.

141 See generally Martha Jackman, "Charter Review as a Health Care Accountability Mechanism in Canada" (2010) 18 Health LJ 1 [Jackman, "Charter Review"]; Ries, "Charter Challenges", *supra* note 38; Colleen M Flood & YY Brandon Chen, "Charter Rights & Health Care Funding: A Typology of Canadian Health Rights Litigation" in Robert P Kouri & Catherine Régis, eds, *Grand Challenges in Health Law and Policy* (Cowansville, QC: Éditions Yvon Blais, 2010) 187 [Flood & Chen, "Charter Rights"].

142 Jackman, "Charter Review", *supra* note 141.

143 2004 SCC 78, [2004] 3 SCR 657.

144 2005 SCC 35, [2005] 1 SCR 791.

ties directly involved, but for the health care system as a whole.[145] In both *Auton* and *Chaoulli*, the Court eschewed a rigorous evidence-based analysis in favour of a narrow, negative rights approach to the governments' health and human rights obligations and its own remedial authority. In neither case was the Court attentive to the dual concerns that animate human rights accountability in relation to health: "ensuring that health systems are improving, and the right to the highest attainable standard of health is being progressively realized, for all."[146] While health care decision-making clearly engages *Charter* and international human rights, in the period since the Supreme Court's landmark decision in *Eldridge v British Columbia (AG)*,[147] the courts have, for the most part, failed to intervene in a manner that positively reinforces accountability in this area, particularly from the point of view of disadvantaged groups.[148]

145 See generally Marie-Claude Prémont, "L'accès aux soins de santé et les droits économiques et sociaux : un face à face périleux" in Pierre Bosset & Lucie Lamarche, eds, *Droit de cité pour les droits économiques, sociaux et culturels : La Charte québécoise en chantier* (Cowansville, QC: Éditions Yvon Blais, 2011) 235 at 267–70; Ries, "Charter Challenges", *supra* note 38; Flood & Chen, "Charter Rights", *supra* note 141; Jackman, "Charter Review", *supra* note 141; Keith Syrett, "Rationing in the Courts: Canada" in Keith Syrett, *Law, Legitimacy and the Rationing of Health Care: A Contextual and Comparative Perspective* (Cambridge, UK: Cambridge University Press, 2007) at 179; Martha Jackman, "'The Last Line of Defence for [Which?] Citizens': Accountability, Equality, and the Right to Health in *Chaoulli*" (2006) 44:2 Osgoode Hall LJ 349; Régis, "La valeur de l'imputabilité", *supra* note 15 at 60–62; Marie-Claude Prémont, "L'affaire *Chaoulli* et le système de santé du Québec : cherchez l'erreur, cherchez la raison" (2006) 51 McGill LJ 167; Christopher P Manfredi & Antonia Maioni, "'The Last Line of Defence for Citizens': Litigating Private Health Insurance in *Chaoulli v Quebec*" (2006) 44:2 Osgoode Hall LJ 249; Colleen M Flood, Kent Roach & Lorne Sossin, eds, *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005); Christopher P Manfredi & Antonia Maioni, "Reversal Of Fortune: Litigating Health Care Reform in *Auton v British Columbia*" (2005) 29 SCLR 111; Bruce Porter, "A Right to Healthcare in Canada: Only If You Can Pay for It", Case Comment, (2005) 6:4 ESR Rev 8.

146 Hunt, *Report of the Special Rapporteur*, *supra* note 8 at para 101.

147 [1997] 3 SCR 624, 151 DLR (4th) 577.

148 See e.g. *Allen v Alberta*, 2014 ABQB 184 at para 53, 586 AR 205; the Court of Queen's Bench rejected, as unsupported by the evidence, the plaintiff's *Charter* claim that Alberta's prohibition on private health insurance "creates or exacerbates wait times thereby preventing access to care" and should, like Quebec's ban on private insurance in *Chaoulli*, be struck down. See also *Allen v Alberta*, 2015 ABCA 277, 389 DLR (4th) 422 ("[h]aving established a universal health care system, governments are *prima facie* entitled to put in place provisions that protect that system, and prevent its abuse. They are entitled to ensure that the system remains truly "universal", in the sense that there is not a parallel system for the wealthy, and another for ordinary Canadians. The concept of equality of access is consistent with the core values of Canadian democracy. Provisions designed to safeguard these aspects of the health care system are *prima facie* demonstrably justified in a free and democratic so-

International treaty monitoring bodies, such as the United Nations Committee on Economic, Social and Cultural Rights, have criticized Canada's failure to recognize that "[t]he right to the highest attainable standard of health gives rise to legally binding obligations"[149] and to ensure that "[a]ny person or group victim of a violation of the right to health [has] access to effective judicial or appropriate remedies[.]"[150] However, the Committee also acknowledges that enforcement does not need to rely exclusively on courts, and has suggested that, while judicial review must be available, alternative accountability mechanisms can also operate to ensure that health and other socio-economic rights are respected.[151] Paul Hunt and Gunilla Backman explain:

> In the context of health systems, there are many different types of accountability mechanisms, including Health Commissioners, democratically elected local health councils, public hearings, patients' committees, impact assessments, maternal death audits, judicial proceedings, and so on. An institution as complex and important as a health system requires a range of effective, transparent, accessible, and independent accountability mechanisms.[152]

The Supreme Court of Canada has repeatedly endorsed former Chief Justice Dickson's assertion that "the *Charter* should generally be presumed

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ciety" at para 37). But see *Tanudjaja v Canada (AG)*, 2013 ONSC 5410, 116 OR (3d) 574, aff'd 2014 ONCA 852, 123 OR (3d) 161, leave to appeal to SCC refused, 2015 CanLII 36780 (SCC); the Ontario Superior Court and a majority of the Ontario Court of Appeal relied on *Chaoulli* in granting Canada and Ontario's motion to dismiss a *Charter* challenge to government action and inaction relating to homelessness without a hearing on the evidence, including extensive expert evidence documenting the severe negative effects of homelessness on health and the barriers experienced by homeless people in accessing health care. See also Social Rights in Canada, "Charter Challenges to Homelessness and Violations of the Right to Adequate Housing in Canada: *Tanudjaja v Canada*, online: <socialrightscura.ca>; Margot Young, "Charter Eviction: Litigating Out of House and Home" (2015) 24 J L & Soc Pol'y 46; Guirguis-Younger, *Homelessness and Health*, *supra* note 7.

149 Hunt, *Report of the Special Rapporteur*, *supra* note 8 at para 66. See generally Bruce Porter & Martha Jackman, "International Human Rights and Strategies to Address Homelessness and Poverty in Canada: Making the Connection" (2013), Ottawa Faculty of Law Working Paper No 2013-09.

150 *General Comment 14*, *supra* note 19 at para 59. See also Porter, "Making the Connection", *supra* note 16.

151 Hunt, *Report of the Special Rapporteur*, *supra* note 8 at para 100; Potts, *Accountability*, *supra* note 19 at 17–24; Eibe Riedel, "The Human Right to Health: Conceptual Foundations" in Andrew Clapham & Mary Robinson, eds, *Realizing the Right to Health* (Zurich: rüffer & rub, 2009) 21 at 32–33.

152 Hunt & Backman, "Health Systems", *supra* note 25 at 89.

to provide protection at least as great as that afforded by similar provisions in international human rights documents which Canada has ratified."[153] In the words of Chief Justice McLachlin and Justice LeBel: "the *Charter*, as a living document, grows with society and speaks to the current situations and needs of Canadians. Thus Canada's *current* international law commitments and the current state of international thought on human rights provide a persuasive source for interpreting the scope of the *Charter*."[154] As outlined above, the interdependence between rights and accountability is clearly recognized in the *ICESCR*, to which Canada is a party.[155] Article 12 explicitly affirms the right to health, and the *ICESCR* and *General Comment 14* together outline Canadian governments' obligations to put in place "effective, transparent, accessible and independent accountability mechanisms"[156] to ensure that health rights are respected and can be enforced.[157]

From this domestic and international human rights perspective, going forward, it is necessary for federal and provincial/territorial governments to accept and affirm that access to health care is a basic human right, and to put in place institutions and mechanisms capable of providing meaningful accountability for failures to respect that right. As argued above, a human rights framework for decision-making that affects access to care is not only called for as a matter of sound health policy, but is essential if discriminatory barriers to access are to be remedied. Whether by means of the *Alternative Social Charter* or some other model, Canadian governments must begin to seriously engage with a human rights approach to health care accountability. Otherwise, the future prospects for genuine reform in this area remain dim, to the detriment of both health and human rights in Canada.

153 *Reference Re Public Service Employee Relations Act (Alberta)*, [1987] 1 SCR 313 at 349, 38 DLR (4th) 161. See also *Slaight Communications v Davidson,* [1989] 1 SCR 1038, 59 DLR (4th) 416; *Baker v Canada (Minister of Citizenship and Immigration)*, [1999] 2 SCR 817, 174 DLR (4th) 193; *R v Ewanchuk*, [1999] 1 SCR 330, 169 DLR (4th) 193; *Health Services and Support—Facilities Subsector Bargaining Assn v British Columbia*, 2007 SCC 27 at para 70, [2007] 2 SCR 391 [*Health Services Assn*].

154 *Health Services Assn*, *supra* note 153 at para 78. See also *Divito v Canada (Public Safety and Emergency Preparedness)*, 2013 SCC 47 at para 19, [2013] 3 SCR.

155 Potts, *Accountability*, *supra* note 19 at 14–16; *General Comment 14*, *supra* note 19 at paras 57–58.

156 Hunt & Backman, "Health Systems", *supra* note 25 at 89.

157 *General Comment 14*, *supra* note 19 at para 59.