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Right to health, a comparative law perspective

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Abstract

This study forms part of a larger Comparative Law project which seeks to present the right to health in a broad range of legal systems around the world. After analyzing applicable constitutional sources, federal legislation and leading case law, the definition and content, scope and limits, and evolution of Canada's right to health are explored.

The subject of this study is the Canadian legal system.

This study begins with an overview of selected historic dangers to Canada's health, challenges of the Covid-19 pandemic, and how such historic tragedies help contextualize and nurture national health needs and duties towards emergence of a right to health. It then explores leading constitutional, statutory and jurisprudential developments at the confluence of health law and human rights as sources of a right to health. While a right to health is not expressly enumerated in the Canadian Constitution, diverse fundamental rights of the Canadian Charter of Rights and Freedoms have been significant drivers of access to medically necessary services and a protectorate of health-related values. Many such rights have proved pivotal in Canada's early Covid litigation. As well, federal human rights law, federal legislation on health services and national public health and safety regulations, underscore the vital role that such laws play in accessing, protecting and promoting human health. The document concludes with an exploration of the contours of the right to health – its definitions, scope and breadth, and its interface with fundamental rights to liberty, security of the person, equality, bodily integrity, privacy, etc. Such Charter rights have reformed Canadian law on abortion, euthanasia, health information privacy, solitary confinement. The study suggests that Canada's right to health encompasses and transcends access to health care. The right is not static; but, dynamic and iterative. It continues to evolve on a spectrum from a narrow right to health services, to a right to health protection, towards a broader right to determinants of health. The right draws on and synergizes with correlative, health-related dignitary rights. Together, they comprise facets of a right to health in diverse contexts. As they advance, a more robust and developed right to health seems likely to emerge in Canadian law.

AUTHOR

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List of abbreviations

art.	article
BFOQ	Bona Fide Occupational Qualification
CanLII	Canadian Legal Information Institute
CCLC	Civil Code of Lower Canada
CHRA	Canadian Human Rights Act
CHRT	Canadian Human Rights Tribunal
Covid	Coronavirus, COVID-19
CSDA	Controlled Drugs and Substances Act
ed.	edition
FDA	Food and Drugs Act
GNDA	Genetic Non-Discrimination Act
ICESCR	International Convention on Social, Economic and Cultural Rights
IFHP	Interim Federal Health Program
JAMA	Journal of the American Medical Association
LTC	Long Term Care
MAID	Medical Assistance in Dying
nº.	number
NYT	New York Times
p.	page
para	paragraph
paras	paragraphs
pp.	pages
PIPEDA	Personal Information Protection and Electronic Documents Act
POGG	Peace, Order and Good Government
QPHA	Quebec Public Health Act

RLLSP	Right to Life, Liberty & Security of Person
SCC	Supreme Court of Canada
s.	section
UNDHR	Universal Declaration on Human Rights
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples
UNDRIPA	United Nations Declaration on the Rights of Indigenous Peoples Act
UNESCO	United Nations Educational, Scientific and Cultural Organization
vol.	volume
WHO	World Health Organization
WWII	2nd. World War

Executive summary

This study explores Canada's right to health largely as expressed through Canadian federal law.

Part I begins by summarizing selected historical and contemporary dangers to the health of Canadians, including the challenges of the global Covid pandemic. It then summarily explores the notion of a right to health through the lenses of 19th – 21st century legal developments. The interaction between legal responses and historic health urgencies help contextualize and nurture national health needs and duties towards the emergence of a right to health. The rest of the study devotes its analysis to exploring and developing such incipient issues and questions

Part II examines relevant constitutional and selected statutory provisions of Canadian federal law. It first explores a basic constitutional question under Canadian federalism: who has jurisdiction over health? The answer flows the content and the distribution of powers between the Parliament of Canada and provincial and Indigenous governments. The analysis of respective powers and responsibilities indicates that responsibility for health matters is shared. The federal quarantine, broad criminal law, spending, interprovincial, immigration and international powers thus complement provincial powers over provincial public health, hospitals and health care professions. A second relevant constitutional dimension is then noted: the historically recent constitutional reforms that have reshaped the Canadian legal and cultural landscape largely through adoption of the Canadian Charter of Rights and Freedoms. Relevant fundamental Charter rights and standards are introduced towards further exploration, below in Part III, of Charter jurisprudence relevant to a right to health.

Against this constitutional background, selected federal statutes concerning or expressive of health matters are reviewed. They range from those governing health services, federal health protection laws and federal human rights legislation. As regards the latter, for example, Canada's new Genetic Non-Discrimination Act and the older Canadian Human rights Act advance the equality right not to be discriminated against on the basis of health/disability status in accessing employment or public services. Canada's recently updated privacy legislation outlines standards for protecting personal health information in the federal private sector. Canada's national health insurance law and federal health services statutes for Immigrants, Veterans, inmates, and Indigenous peoples, arguably and imperfectly advance access to basic health services. The statutory analysis of Canada’s federal quarantine laws and drug safety laws indicates that for over a century, they have helped to advance public health protections for Canadians; by both shielding the nation from infectious disease and by ensuring the safety and efficacy of modern diagnostic, drug, and therapeutic products, like Covid tests, vaccines and respirators. Though the study focuses on federal law, the section also briefly overviews a provincial public health law, as a sample of provisions that have played a key role in the Covid pandemic.

Part III reviews some of Canada's leading jurisprudence expressive of the concept of the right to health. The cases involve classic human rights on health matters, followed by a sampling of trends in Canada's early Covid litigation. Many of the classic cases involve landmark decisions on complex questions often presented before the Supreme Court of Canada. The cases have vindicated key rights: such as a right to free and informed consent in medical procedures; a right to decline medically necessary treatment; a right to reproductive autonomy; a right to disability-related accommodations to ensure equitable access to hospital and medical services; a right to privacy in bodily fluids; special protections for the health of prisoners and those in the care or custody of the state; and a limited constitutional right to treatment.

Much of the case law has revolutionized Charter jurisprudence and has reformed law by removing undue criminal law or governmental barriers to accessing hospital treatment, safe abortion services, medically assisted dying, addiction treatment. The jurisprudence indicates that despite the silence of Canada's Constitution on a right to health, Charter rights have been a major driver of citizen access to medically necessary health services and a protectorate of the human person and associated dignitary values. These include fundamental rights to equality, life, liberty and security of the person; protection against cruel and unusual punishment and treatment. Charter analyses have also proved central to Canada's Covid jurisprudence. Thus far, it has tended to uphold Covid mitigation norms as necessary and proportionate measures protective of the public health and common good.

Part IV explores the concept, content and limits of a right to health through three lenses: as part of modern international human rights law; as a prism of rights sculpted over time on a pedestal of Canadian laws; and through case studies. One case study explores part of Children's right to health protection. Another explores the right to participate in scientific progress. The three lenses help us understand Canada right to health as an iterative, dynamic right. It continues to evolve across the spectrum from a narrow right to healthcare, towards a broader right to determinants of health, and perhaps beyond. Structurally, the right draws on – and is built and synergized by – a prism or constellation of correlative, health-related human dignitary rights that comprise its diverse facets. These include, for example, a right to universal health care and to special health services for vulnerable populations; a right to free and informed consent, a right to health information privacy; a right to physical and mental integrity; a right to health protection; an equality right not to be discriminated against on the basis of health status. Dynamic evolution of the right to health means that the correlative dignitary rights of its diverse facets may not be at the same point in the trajectory from a legal concept, to a moral inspiration, to an emerging or developed legal right. The contours of the right to health, its challenges and limits, are then explored in several contexts: including individual versus collective dimensions, the balancing of the right against other important freedoms, its intersection or impact with Canadian abortion, assisted dying, and data protection laws. Part IV concludes by noting some legal uncertainties or grey areas, in Canada's right to health, that pose challenges today and for the future.

I. Introduction

I.1. Basic data: Historical dangers to health in Canada and the impact of the COVID-19 pandemic

After summarizing selected historic dangers posed to the health of Canadians, this section then highlights some of the health challenges and impact of the Covid pandemic in Canada.

I.1.1. Some Historic Health Dangers

Even a brief look back at major historic national health dangers to Canada, confirms that the Covid pandemic conforms to many forgotten patterns of previous national public health crises. A few decades before Canada formally assembled into a nation, colonial Canada experienced the first of periodic lethal epidemics. According to one analyst, cholera arrived in North America in 1832, as one of the first of global transmissible diseases that prompted international and national controls.[1] That summer, some 3,800 people died. Cholera is an acute intestinal illness transmitted by a highly contagious bacteria that propagates in unsanitary water, food, and sewer conditions, such as those abundant on passenger ships laden with immigrants from Europe to Canada in the middle of the 19th Century. To respond to the danger, a quarantine station off Grosse Island, Quebec was established in the 1830s, as a screening and control measure of immigrant ships coming from the Atlantic Ocean, and up the St. Lawrence Seaway into Canada. By the 1870's cholera, yellow fever, small pox and like internationally transmissible dangers would help prompt federal quarantine legislation within years of the formal founding of Canada (see Section II.4.2.1, below).

After the turn of the Century, as many nations were embroiled in World War I (WWI), the so-called "Spanish Flu" made its way to Canada. According to the Government of Canada, the disease arrived at port cities of Quebec, Montreal and Halifax, before spreading east and west. Quarantine stations were insufficient to contain the untreatable influenza, as it spread via humans traveling largely via rail across Canada. A commemorative plaque now stands in Victoriaville, Quebec where the first non-military cases of the flu were reported after thousands of visitors assembled there in August of 1918 to attend a religious conference.[2] The influenza pandemic raged from 1918-20 and ultimately claimed some 50,000 Canadians, just less than the 60,000 Canadian soldiers killed in four years of WWI (1914-18). According to one analyst, a lack of local and national coordination was thought to contribute to poor containment of the influenza. Indeed, criticized for failing to provide resources and coordination to public health authorities across the country, the federal government responded to the crisis by founding the federal Department of Health in 1919.[3]

If such legal reforms and the building of public health infrastructure underline important responses to national health crises, medical and scientific innovations would also help address imminent dangers to Canada's health. For example, Canada still has survivors from the ravages

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1 BILSON, G.: *A Darkened House: Cholera in the 19th Century*, University of Toronto Press, Toronto, 1980, 222 pp.

2 *Ibid*.

3 See HUMPHRIES, M. O.: *The Last Plague: Spanish Influenza and the Politics of Health in Canada*, Toronto University Press, Toronto, 2013, 348 pp. The Department opened in the summer of 1919, to immediately address such issues as quarantine, health diseases of returning WWI troops, the health and care of immigrants, and collaboration with the provinces on public health matters. See *An Act respecting the Department of Public Health*, SA 1919, c 16.

of polio. It had reigned for much of the first half of the 20th century, thriving in summer times, with a notable epidemic in 1953. A Canadian documentary summarizes its defeat in Canada.[4] To paraphrase it: *in 1954, Canada joined US research efforts in the discovery of polio vaccines, by collaborating in clinical trials that enrolled two million children in the US and Canada. Research at Connaught Labs at the University of Toronto, helped manufacture the polio tissue culture for the vaccine. The Salk polio vaccine was licensed in 1955, and infections rates dropped 90% within five years*. Such international scientific collaboration would also yield modern biotechnological breakthrough treatments for the HIV/AIDS crisis that afflicted North America in the 1980s and 1990s. (See discussion in Section IV.1.3.2, below)

Canada would be obliged to draw on a modern if chaotic combination of biomedical technology and classic public health screening and isolation to confront the lethal health challenges of the Covid pandemic.

I.1.2. Covid Strikes Canada

Like many nations, since March 2020, Canada has struggled to confront the collision of health, economic, social and legal challenges wrought by the unprecedented Covid pandemic. To sample some of the health and policy dimensions, the following highlights elements from Canada's Covid waves and then summarizes key health impacts. The selection is necessarily limited; it does not pretend to do justice to the complexity, depth, and scope of Covid responses. In portraying them, it should also be noted that, with few exceptions, Canada imposed few uniform rules on commercial and school closings, access to hospitals, home confinements, mask wearing, declarations of emergencies, etc. The mosaic owes to Canada's allocation of federal - provincial responsibilities, as explained in Part II., below.

I.1.2.1 Selected highlights from Covid's waves

They include the following (dates are approximate):

- *1st Wave, Alpha, March - August 2020:*

  The World Health Organisation's declaration of a global Covid pandemic in early March provokes a cascade of crisis responses in Canada. Several provinces declare state of emergencies that largely freeze previous normal activities, save "essential services." The result is national "confinement/lock-down/shelter-in place" norms. From 14-23 March 2020, the Federal government seals Canada's boarders to all but essential travel, urges Canadians to return home, and helps coordinate such re-entry. The health care system is overwhelmed with Covid cases. In April, Quebec and Ontario request federal military medical assistance for long-term care homes. By late May as Covid cases ease, some provinces ease restrictions. In June, the Quebec government apologizes for a death toll that exceeds 5,000, with most in long-term care facilities. In July, Quebec becomes the first province to require indoor masking.

- *2d Wave, Beta, Autumn 2020 – Winter 2021:*

  In December, Health Canada approves Pfizer and Moderna vaccines. As cases exceed 3,000 per day in early January, Quebec imposes 20h-5h curfew with heavy fines. The curfew expires in May 2021.

[4] CANADIAN BROADCAST COMPANY, "A History of Polio in Canada", 1994, online: https://www.cbc.ca/player/play/1402909859.

- *3d Wave, Gamma, Spring- Summer 2021:*

  With guidance from both the Public Health Agency of Canada, and provincial public health authorities, provinces prioritize the rollout of vaccines for long-term care facilities, seniors, those with serious health conditions, etc. Millions of Canadians receive their first and second doses of vaccines over the next six months.

- *4th Wave, Delta, Summer - Autumn 2021:*

  Beginning in September, Quebec requires proof of vaccine status for those 13 and older to access non-essential public services: restaurants, commercial centres, cinemas, bars, cultural and sporting events, etc.

- *5th wave, Omicron A, Autumn 21 - Winter 22:*

  In Quebec, university teaching is deemed an essential service such that institutions must balance online teaching with return to class aspirations and associated protocols. As of September 2021, Canada eases border restrictions by authorizing entry to travelers fully vaccinated at least 14 days prior to entry. Effective February 2022, entering travelers may show proof of negative Covid results test by either PCR or antigen testing.

- *6th wave, Omicron B, Spring 2022*:

  Effective February, Quebec (and other provinces) begin phasing out vaccine passport requirements for commerce; effective mid-March, vaccine passport requirements are suspended for all including long-term care facilities, gyms and restaurants. Commerce and cultural events slowly recommence. Provinces schedule relaxation of social distancing and mask wearing requirements in many sectors. The federal government retains mask mandates for federally regulated national travel and covid screening and covid negative documentation for international travel.

I.1.2.2 Statistical Portrait

The following portrays some key Covid outcomes in Canada. The numbers should be read with the understanding that they are not rigorously assembled on a scientific basis, but rather to show some of the overall impact of Covid.

- *Cases:*

  As of spring 2022, Canada had experienced over 3.7 million cases. Canada's two most populated provinces — Ontario and Quebec — account for most cases. According to the New York Times Coronavirus World Map, Canada has a case rate per 100,000 of 10,205, in comparison to 43,000 in France, over 30,000 in Germany; 33,000 in the UK; 24,000 in the US and Sweden; 9,000 in Cuba.[5]

- *Deaths:*

  As of spring 2022, Canada was nearing 40,000 deaths from Covid, with some 70% of those death in people 70 years or older. In a sampling by John Hopkins University of some 20 nations significantly affected by Covid in early 2022, Canada ranked in the lower third of

[5] NEW YORK TIMES, "Coronavirus World Map: Tracking the Global Outbreak: Reported Cases, Deaths and Vaccinations by Country" (NYT Map), online: https://www.nytimes.com/interactive/2021/world/covid-cases.html.

charted death rates per 100,000. The death rates/100,000 ranged from US, 300; France, 250; Portugal, 225; Germany, 165; Canada, 105; Japan, 23.[6]

- *Long-Term Care (LTC) Infections & Deaths:*

  Canada's LTC sector has been disproportionately impacted by infections and death in the early waves of the pandemic. According to the Canadian Institute for Health Information, *"[b]etween March 1, 2020, and August 15, 2021, over 56,000 residents and 22,000 staff in Canada's LTC and retirement homes were infected with COVID-19, resulting in more than 14,000 deaths among staff and residents."*[7] Such dire statistics has led analysts to note the systemic impact: *"(...) LTC facilities in Ontario and Quebec were not able to protect their residents. Approximately 80% of COVID-19-related deaths in Canada involved persons living in LTC facilities. COVID-19 exposed significant structural deficiencies in the way these facilities are staffed (e.g., temporary workers might regularly shift from one LTC facility to another) and weak infection prevention and control practices."*[8] Once Canada approved its first vaccines, LTC facilities were prioritized in vaccine deployment. Within the first months of 2021, some 95% of residents had received a first dose, and this *"high vaccination-rate reduced both infection and deaths among LTC residents by over 90%."*[9]

- *Vaccinations:*

  As of early 2022, over 75 million Covid doses have been administered in Canada since December 2020.[10] Some 4 of 5 Canadians have been "fully vaccinated." According to the New York Times, by spring 2022, the rate of those "fully vaccinated" in Canada neared 83%; comparable rates vary in other nations like Finland, 77%; USA 66%; UK 74%; France 79%; Spain 86%, Cuba 87%.[11]

I.2. Brief historical development of the recognition of the right to health in the Canadian legal order

From an historical perspective, has a right to health gradually gained legal recognition in Canadian law? The long answer to the question is explored through the course of this study. The short answer is two fold. First, throughout the history of Canada explicit recognition of dimensions of the right arguably has gained currency in recent decades. Secondly, absent explicit and clear recognition, much of this study focuses on exploring implicit recognition through diverse, relevant sources of Canadian human rights law and health law. Doing so, involves analyzing, tracing and interpreting the trajectory of the concept and definition, to aspritational or inspirational principles, towards recognition and development of the right. Section IV.1 below explores such issues more closely.

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[6] JOHN HOPKINS UNIVERSITY, "Coronavirus Resource Center Worldwide Mortality Analysis", online: https://coronavirus.jhu.edu/map.html.

[7] CANADIAN INSTITUTE OF HEALTH INFORMATION, "Covid-19's impact on long-term Care", December 2021, online: https://www.cihi.ca/en/covid-19-resources/impact-of-covid-19-on-canadas-health-care-systems/long-term-care [*CIHI*].

[8] DETSKEY A.S., BOOCH, I.I.: "Covid-19 in Canada—Experience and Response", JAMA, 2020; 324(8), pp. 743-744 (p.743), online: https://jamanetwork.com/journals/jama/fullarticle/2769439.

[9] CIHI, *op. cit.*

[10] GOVERNMENT OF CANADA, "Covid-19 Vaccination in Canada", 2022, online: https://health-infobase.canada.ca/covid-19/vaccine-administration/#a1.

[11] NYT Map, *op. cit.*

Accordingly, this study examines important aspects of dimensions of a right to health as they have evolved and emerged in different sources of Canadian law.

I.2.1. 19th Century

FRAME 1

Quarantine Act, 1872, section 2

The Governor in Council may from to time make such Regulations as he thinks proper (…) concerning the landing of passengers or cargoes from such vessels, (…) as may be thought best calculated to preserve the public health; and for ensuring the due performance of Quarantine, by and in respect of vessels, passengers, goods or things arriving at or in the neighbourhood of any port or place within Canada (...)[12].

Do Canadian legal instruments from the 19th century speak of a right to health? The analysis in Part II, below, shows they do not. But the analysis also shows that statutes such as Canada's original federal quarantine law and its original food and drug safety law directly address national public health and safety standards and duties vital to Canadians' health. The quote above from the 19th Century Quarantine law is one example. Similarly, the legislative creation of Canada's federal Ministry of Health after the turn of the century came in partial response to national needs to manage the so-called "Spanish Influenza".

Conceptually and practically, as explored below, such public health and safety acts would seem, at least, to advance a health protection dimension of a right to health.

I.2.2. 20th Century

FRAME 2

WHO, Health Aspects of Human Rights 1976.

"Historically, and in contrast with the early introduction of other rights, the right to health was one of the last to be proclaimed in the constitutions of most countries in the world. There are no rights to health in eighteenth and nineteenth century constitutions, whereas a number of other rights are specifically mentioned."

The quote from the WHO expresses the aspirations and inspirations of the international community immediately after the Second World War (WWII). The analysis below, in Part II, indicates that when Canada adopted its Charter of Rights in Freedoms in the 1980's, it made no mention of a right to health. But our analysis will explore how the fundamental rights to equality, privacy, and life, liberty and security of the person – amongst others – removed some legal and governmental barriers to citizens accessing medically necessary treatment. We shall also examine how passage of federal health laws, like the Canada Health Act, help advance access to health services. If a right to health includes a right to access medically essential care, then such developments would seem part of Canada's right to health.

[12] *Quarantine Act*, SC 1872, c 27, section 2.

I.2.3. 21st Century

As Lisa FORMAN states:

> *"[t]his pandemic may catalyze responses to pre-existing challenges within health and human rights, changing our understanding of the responsibilities governments have to protect domestic and global health. It may also promote a deeper inquiry into the ways the inequities are reinforced by our institutions, systems and actors including with human rights and health....Now more than ever we need to transform the right to health to meet the challenges of this moment and to push towards a far different understanding of health justice.*[13] *"*

This quote expresses the need, challenges and hope of advancing a right to health amid the bewilderment of the Covid Age. If legal reforms of the 19th century express a right to health protection, and the human rights revolution of the 2oth century express a right to access health services, Covid would come to test and show how a right to health thrives best with both needs. Indeed, Canada and its citizens have depended heavily on both health protection laws and access to life saving vaccines to navigate the perils of the pandemic. We explore more deeply below, in Part V, what a 21st century analysis reveals how diverse laws and human rights contribute to a modern conception and facets of Canada's right to health.

[13] FORMAN, L.: "The Evolution of the Right to Health in the Shadow of COVID-19", *Health and Human Rights Journal*, vol.22 (1), 2020 Jun, pp. 375-378, online: https://www.hhrjournal.org/2020/04/the-evolution-of-the-right-to-health-in-the-shadow-of-covid-19/.

II. Constitutional and infra-constitutional provisions

II.1. Canadian Constitution

The Canadian federation consists of 10 provinces, 3 territories, the Government of Canada and diverse Indigenous peoples. The predominant legal source of the federation is the Canadian Constitution.

Does Canada's Constitution speak of, or recognize, a right to health?

Canada joins several hundred nations of the international community in answering the first part of the question with a no. According to a 2008 report by the World Health Organization and the UN Office of High Commissioner on Human Rights, the *"right to health or health care is recognized in at least 115 constitutions."*[14] Canada's constitution expressly mentions neither the word "health" nor "health care."[15] A reading of that UN report also indicates that, by contrast, the constitutions of such nations as South Africa, India and Ecuador respectively speak of *"the right to access to health care services"*, *"the duty of the State (…) to improve public health"* and *"a guarantee of the right to health."*[16] The Constitution of Canada does not thus expressly speak of a right to health.

Does the silence of the Canadian Constitution on a right to health mean that it recognizes no such right? The answer to this question is more challenging. It requires nuanced legal reasoning and analysis. For instance, it depends partly on how one defines the right to health, how one interprets and applies to that definition relevant provisions of the Canadian Constitution, and what we understand by "recognition of the right." For instance, if we include a constitutional right to food or nutrition within a broad definition of a right to health, Canadian jurists would seem likely to say that the Courts have yet to recognize such a right grounded on the Canadian Constitution. If we include a right to refuse involuntary treatment within a definition of a right to health, then jurists are more likely to say that the courts have adjudged that the Canadian Constitution grounds a right to refuse state-mandated or authorized involuntary treatment. They would hasten to add that such a right is not absolute and may be justifiably infringed. Even more jurists would agree that the Canadian Constitution has become a source of law for some facets of "a right to health." As such, if recognition of the right to health means that the Canadian Constitution serves as a legal source for a right to health, then the answer is yes.

So let us overview the Constitution and some key elements that arguably serve as sources of law for facets of a right to health. Those sources flow from two major constitutional reforms in Canada. The first reform, the Constitution Act 1867,[17] drew the former British and French colonies and jurisdictions into federal, provincial and territories of the new confederation called Canada. Our focus will be on the allocation or division of powers and responsibilities concerning health matters. The second reform came over a century later in 1982[18] with the

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[14] UN Office of the High Commissioner for Human Rights (OHCHR), *Fact Sheet No 31, The Right to Health* (2008), No 31 at 10, online (pdf): https://www.refworld.org/docid/48625a742.html [*OHCHR, The Right to Health*].

[15] See *Constitution Act, 1867* (UK), 30 & 31 Vict, c 3, reprinted in RSC 1985, Appendix II, No 5 [*Constitution Act, 1867*]. See also *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Constitution Act, 1982*].

[16] OHCHR, *The Right to Health*, *op. cit*. at 11.

[17] *Constitution Act, 1867*, *op. cit.*

[18] *Constitution Act, 1982*, *op. cit.* Amongst other things, the Act also included new protection for Indigenous peoples.

adoption – inter alia – of Canada's constitutional human rights instrument, the *Canadian Charter of Rights & Freedoms*.[19]

II.2. Distribution of "Health" Powers

Because the Constitution makes no reference to health, one perennial constitutional question is who has jurisdiction over health: the federal or provincial governments? One orthodox political and public refrain has long been, the provinces. Is that conventional wisdom accurate? Logic and theory indicate that is one of three answers to the jurisdictional question: (i) a plenary power of the provinces, (ii) a plenary power of the federal government, or (iii) a power shared by both. The question has repeatedly and pointedly bedeviled Canada in recent decades as the nation has sought to address sometimes novel legal issues presented by the HIV/AIDS crisis, regulation of maritime and air pollution, new reproductive technologies like human embryo research or surrogate motherhood, national norms on organ transplantation and tissue replacement technology, genetic testing in employment and insurance domains.

The most cogent answer, we would submit, is that legal analysis indicates the federal and provincial/territorial governments share jurisdiction over health.

Sections 91 and 92 of the *Constitution Act*, 1867[20] outline the distribution of powers between the Parliament of Canada and the provincial legislatures. Partly because of the terminology used, the provincial/territorial responsibilities over health are more conspicuous and intuitive than those of the federal government. Under section 92, in addition to its jurisdiction over civil rights and local works within their borders, the provinces have jurisdiction over the *"establishment, management and maintenance of hospitals, asylums, charities (…)"*.[21] The section has long been relied upon to regulate hospitals, health institutions, health professionals, etc. Under section 91, the federal government has jurisdiction *inter alia* over *"quarantine"*, *"national defence"*, *"criminal law"*, *"federal undertakings"*, *"public debt and money"* (spending power) and federal laws enacted for the *"Peace, Order and Good Government of Canada"* (POGG power).[22] The federal government has relied on the criminal law power to prohibit and regulate therapeutic drugs. It has relied on its spending power to legislate minimal national norms for provincial health insurance plans. It has relied on its POGG power to promulgate some national environmental standards that impact environmental health. It has relied on the *"federal undertaking power"*, to develop occupational health, health information privacy, and human rights norms for both the federal government and federally regulated industries, like and telecommunications, broadcast companies, national transporters, rails and airlines, national financial institutions. When conflicts arise in areas of shared jurisdiction *"it is the federal law which prevails under the paramountcy doctrine."*[23] The issue of federal and provincial jurisdiction over health matters, therefore, is central to understanding the relevant right, duties and standards that inform Canada's right to health.

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[19] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Canadian Charter*].

[20] *Constitution Act, 1867*, *op. cit*. sections 91-92.

[21] *Ibid*, s 92.

[22] *Ibid*, s 91.

[23] HOGG, P.W.: *Constitutional Law of Canada*, 5th ed., Thomson Carswell, vol.1, Toronto, 2007, chapter 16, section 16.1, pp. 483-401. See also HOGG, P.W.: *Constitutional Law of Canada*, Student edition, Thomson Reuters, 2018.

II.3. Canadian Charter & "Health" Rights

FRAME 3

SCC, R v. Morgentaler, (1988), p. 46

Although no doubt it is still fair to say that courts are not the appropriate forum for articulating complex and controversial programmes of public policy, Canadian courts are now charged with the crucial obligation of ensuring the legislative initiatives pursued by our Parliament and legislatures conform to the democratic values express in the Canadian Charter of Rights & Freedoms.[24]

As part of the constitutional reforms of the 1982, Canada incorporated into its Constitution the Canadian *Charter of Human Rights & Freedoms*.[25] From an international perspective, the *Charter* may be regarded as a pan-Canadian human rights instrument that includes many of the basic human rights articulated in the *Universal Declaration of Human Rights* of 1948[26] and the *International Covenant on Civil and Political Rights*, of 1966,[27] to which Canada is a signatory.[28]

From a national perspective, the Charter has generally proved revolutionary in at least three respects. First, it required government – federal, provincial, municipal – laws and policy to be reviewed and modernized for their compliance with Charter principles. Second, over the four decades since its adoption, the Supreme Court of Canada and the highest courts of the provinces have interpreted and applied the Charter to advance human rights and check government initiatives and restrictions across varied sectors of society, including those affecting access to reproductive health, substance abuse therapy, assisted suicide, Covid-19 public health restrictions, prisoner access to essential health services. As will be seen, the *Charter* thus has been a major driver of the evolving dimensions of the right to health in Canada. Thirdly, the *Charter* has heightened Canadian public education and discourse on human rights principles and values impacting the health domains. This becomes especially provoking when dimensions of health rights collide, such as the collective right to public health protections and an individual's freedom from government compelled medical treatment, as in public health decrees on mandatory vaccinations for health care workers.

The *Charter* does not expressly speak of health. But substantive rights and freedoms that significantly implicate dimensions of a right to health include the following:[29]

FRAME 4

Canadian Charter, sections 1, 7-9, 12, 15

Limits on Rights and freedoms, section 1

"The Canadian Charter of Rights and Freedoms *guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."*

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[24] *R v Morgentaler*, [1988] 1 SCR 30 at para 46.

[25] *Canadian Charter*, *op. cit.*

[26] *Universal Declaration of Human Rights*, GA Res 217A (III), UNGAOR, 3rd Sess, Supp No 13, UN Doc A/810 (1948) 71, online (pdf): https://www.refworld.org/docid/3ae6b3712c.html [*Universal Declaration of Human Rights*].

[27] *International Covenant on Economic, Social and Cultural Rights* 1966, 16 December 1966, 999 UNTS 171, entered into force January 1976, accession by Canada 19 May 1976, online: https://www.ohchr.org/en/instruments-mechanisms/instruments/international-covenant-economic-social-and-cultural-rights [*ICCPR*].

[28] See discussion of International human rights law, below, section IV.1.1.

[29] *Canadian Charter*, *op. cit.* sections 1, 7-9, 12, 15.

Life, Liberty & Security of person, section 7

"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, […]."

Search or seizure, section 8

"Everyone has the right to be secure against unreasonable search or seizure."

Detention or Imprisonment, section 9

"Everyone has the right not to be arbitrarily detained or imprisoned"

Treatment or punishment, section 12

"Everyone has the right not to be subjected to any cruel and unusual treatment or punishment."

Equality & Non-Discrimination, section 15

"Every individual 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."

In Part III, below, we explore some of the leading cases that illustrate how these fundamental freedoms have advanced and given concrete meaning to a right to health.

To understand the potential impact and limitations of the Charter, its application, workings, and legal remedies deserve attention. For instance, section 32 of the *Charter* indicates that its scope of application is limited to government.[30] As such, while it applies to laws, policies, or practices of municipal, provincial, territorial and federal governments, it does not directly apply to non-governmental entities. This raises a question of whether entities like universities, hospitals, or private entities authorized by government to carry out governmental functions, qualify as government for Charter purposes. The application of the Charter to government complements and contrasts with the federal *Canadian Human Rights Act*[31] and analogous provincial equality human rights statutes, which apply to government, non-governmental and private entities. Other limitations are noteworthy. For instance, as with international human rights instruments, a violation of a Charter right, may be justified in exceptional circumstances as a reasonable limit.[32] As further explained in Part III of this study, under section 1 of the *Charter*, the Supreme Court of Canada has articulated a rigorous test for governments seeking to justify pressing, limited and proportional, and objectively necessary infringements of basic human rights. This is illustrated in SCC case law below. Because section 1 involves a balancing inquiry, its functions indicate that precious human rights that bear on a right to health may not be absolute. Finally, when a proffered governmental justification does not qualify as a necessarily justified violation, then the court faces a decision of what Charter remedy ought to be imposed. As will be seen in the discussion of leading SCC cases, the Court has sometimes imposed exacting, powerful remedies that vindicate facets of a right to health and that hold government accountable for its democratic Charter responsibilities. This has emerged as a notable dimension of some landmark cases.

[30] *Ibid*, s 32.

[31] See discussion of the Act, below, in section II.4.3.1. *Canadian Human Rights Act*, RSC 1985, c H-6.

[32] Section 1 of the *Canadian Charter*, *op.cit.* See also *R v Oakes*, [1986] 1 SCR 103.

II.4. Canadian Federal Legislation

Canadian federal laws demonstrate and regulate important facets of Canada's right to health, including access to health services (section II.4.1.); protecting citizen public health and safety (section II.4.2.), and protecting against discrimination related to health status in federal domains (section II.4.3.). The following offers samplings of each.

II.4.1. *Federal Health Services Statutes*

The Government of Canada has enacted diverse federal legislation and implementing regulations that: (i) articulate a national framework and standards for Canada's universal health insurance, and (ii) entitle, and provide health services to, populations for which the federal government has special responsibilities. The latter includes active or past members of the Canadian military, federal inmates, refugees, and Indigenous peoples.

II.4.1.1 The Canada Health Act

If access to health care or services is considered an important facet of a right to health, then Canada's universal health insurance regime helps to advance that right.

The march towards publicly funded universal health care for Canadians began, concretely, in the West of Canada after WWII. A 2018 *Lancet* article by Martin and colleagues sketches the chronology.[33] In 1947, the province of Saskatchewan introduced the first publicly funded hospital insurance plan in North America. By the 1960s, several provinces had adopted the approach. In 1964, a Royal Commission urged the adoption of universal comprehensive health care for Canada. The federal government responded with the federal *Medical Care Insurance Act*, which legislated federal financing of provincial health insurance plans *"that meet the criteria of comprehensiveness, portability, universality, and public administration."*[34] In 1984, the adoption of the *Canada Health Act*[35] (CHA) added "accessibility" as a criterion.

Accordingly, since 1984, as the Preamble of the CHA indicates, the Parliament of Canada has *"deemed that access to high quality health care is 'critical' to the continuing health and welfare of the people of Canada."*[36] The CHA proclaims *"reasonable access"* to health services without *"financial or other barriers"* to be a primary goal of Canadian health care policy.[37] Through the spending power of the Constitution, the federal government conditions federal transfer of monies to support provincial health insurance regimes on the following criteria.

FRAME 5

Canada Health Act
Criteria for Provincial/Territorial Medicare insurance Plans

Public administration	Provincial or territorial healthcare insurance plans must be administered by a public authority responsible to the provincial/territorial government on a non-profit basis. Healthcare services may be provided by private entities if insured persons are not charged for the services (CHA s. 8(1)(a)).

[33] MARTIN D. ET AL: "Canada's Universal Health-Care System: Achieving Its Potential", *Lancet*, vol. 391(10131), pp. 1718-1735, 2018, online: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7138369/.

[34] MARTIN ET AL: *ibid* (p.1720).

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

[36] *Ibid*.

[37] *Ibid*.

Comprehensiveness	"Insured health services" must be insured by the provincial/territorial health insurance plan (CHA s.9).
Universality	All "insured persons" must be entitled to insured health services in the province/territory (CHA, s.10).
Portability	Three (3) months is the maximum period of residency required to be eligible for insured services. (CHA s. 11 (1)(a)). Plans must provide insurance coverage for beneficiaries temporarily outside the province/ or country, CHA s.11 (1)

Source: TIEDEMANN, M.: *The Canada Health Act: An Overview*. Library of the Parliament of Canada, n.º 2019-54-E, Ottawa, December 2019, ii and 14 pp.

The CHA has exerted a diverse impact on Canadian health care, health policy, and on the health of Canadians, as Canada faces important challenges amid and beyond Covid-19. International and scholarly reports indicate that some 99% of Canadians enjoy universal health care insurance.[38] That high percentage arguably evinces the right to universal medical insurance in a nation that enjoys a highly regarded health care system. With such accomplishments, challenges remain, however. Insurance coverage does not guarantee easy and prompt access to care. Because provincial health insurance coverage plans may differ in important respects, for example, large or significant differentials challenge the CHA principle of universality and thus health equity. If the lack of a binding national definition of "medically necessary" services affords provinces considerable flexibility in specifying covered care, it may also detract from national uniformity.[39] Moreover, the United National Special Rapporteur on Health has recently visited Canada. In her 2018 report, she notes that since the CHA does not require provincial or territorial governments to cover services provided outside of hospitals by healthcare personnel other than doctors, access to services like physiotherapy, psychotherapy and occupational therapy may be compromised.[40] Moreover, since neither the CHA nor all provincial/territorial governments cover prescription medications, mental health or addiction services, rehabilitation services, or dental and vision care, such excluded health services are largely left to employer benefit packages.[41] Even within covered services, the CHA accessibility principle and individual health become acutely compromised by waiting lists for accessing family doctors, some elective procedures, and even higher risk urgent surgeries. The acute care demands of Covid have periodically exacerbated waiting list and delayed health services. When a provincial health plan forbids the purchase of private health insurance to cover services provided by the public system, but system delays impose increasing health risks to citizens in the health care queue, are the prohibitions reasonable, necessary, and justifiable? From a right to health perspective that prioritizes individual access to medically necessary care, such prohibitions frustrate the right. The SCC has found that an overreaching provincial ban on private insurance for medical services may violate fundamental human rights. The case is discussed in section III.7., below.

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38 See MARTIN ET AL: *op. cit*.

39 TIEDEMANN, M.: *The Canada Health Act: An Overview*, Library of Parliament Research Publications, nº. 2019-54-E, Ottawa, December 2019, ii and 14 pp.

40 UN SPECIAL RAPPORTEUR, "Report of Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Canada", UN Doc A/41/34/Add. 2, 2019 (para. 37), online: *OHCHR* https://www.ohchr.org/EN/HRBodies/HRC/RegularSessions/Session41/Documents/A_HRC_41_34_Add.2.docx.

41 *Ibid* at para 38.

II.4.1.2 Indigenous Peoples, Canadian Forces, Refugees & Penitentiary Health Services Statutes

Diverse federal statutes outline eligibility or entitlements and standards for the provision of health services to specific populations for which the federal government has special responsibilities. Many of the statutes complement the CHA definition of "insured person",[42] which expressly excludes from provincial responsibility, Canadian Forces members, federal inmates, and those who have yet to become entitled to provincial health service coverage. These statutes arguably provide a legal source for affected populations' right to health services.

II.4.1.3 Immigrants & Refugees: Interim Federal Health Program (IFHP)

Complementing the CHA, and arising out of responsibilities for immigration, the IFHP *"provides limited temporary coverage of health benefits"* to some new refugees who have yet to become eligible for provincial or territorial health insurance.[43] Most provincial health insurance plans require 90 days of legal residency in the province to qualify for coverage. So, the IFHP offers interim coverage for those eligible, such as refugee claimants, resettled refugees, victims of human trafficking, etc. Coverage may include vaccinations, basic health services, and limited vision, dental services, and prescription drug coverage.

The Government of Canada has administered IFHP for roughly half a century.[44] However, a 2012 governmental Order in Council imposed significant programmatic cuts that prompted a Charter challenge. In *Canadian Doctors for Refugee Care et al v Canada*[45], the Federal Court of Canada reasoned that since Canada has wide discretion to fund or not fund the program, it has no positive obligation to do so under the Charter's section 7 protection of "security of the person." But the basis and consequences of the cuts must also withstand scrutiny on other Charter rights. The court found the government cuts discriminatory, because they were based on a country of origin (CO) basis that resulted in significantly diminished health benefits for CO immigrants compared to non-CO immigrants.[46] Moreover, the court reasoned that the nature and scope of the cuts so acutely affect vulnerable immigrants, like children, as to shock the conscience and outrage Canadian standards of decency, as to subject them to "cruel and unusual treatment", in violation of section 12.[47] The court did not find the Charter violations justified.[48] It therefore struck down the changes and ordered the government to provide health benefits to one of the directly affected plaintiffs.

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42 See *Canada Health Act*, *op. cit*. s 2.

43 See Order in Council PC 157-11/848, (1957); *Order Respecting the Interim Federal Health Program*, SI/2012-26, (2012), online: https://laws-lois.justice.gc.ca/eng/regulations/SI-2012-26/FullText.html. See also GOVERNMENT OF CANADA, "Interim Federal Health Program: Review the Policy", 17 February 2022, online: https://www.canada.ca/en/immigration-refugees-citizenship/corporate/mandate/policies-operational-instructions-agreements/interim-federal-health-program-policy.html.

44 PC 157-11/848 (1957), *op. cit*.

45 *Canadian Doctors for Refugee Care v Canada (Attorney General)*, 2014 FC 651.

46 *Ibid* at para 751.

47 *Ibid* at para 610.

48 *Ibid* at para 1075.

II.4.1.4 Federal Inmates Health Service Law

Canadian inmates housed in federal prison have a statutory entitlement to basic health services. The *Federal Corrections and Conditional Release Act*[49] requires Correction Services Canada to provide "essential health care" to some 14,000 federal inmates under its charge.

Section 86 of the Act mandates that:

FRAME 6

Federal Corrections and Conditional Release Act, section 86

(1) The Service shall provide every inmate with

(a) essential health care; and

(b) reasonable access to non-essential health care.

(2) The provision of health care... shall conform to professionally accepted standards.[50]

Those statutory duties are supplemented by common law duties and applicable Charter human rights obligations.[51]

II.4.1.5 Canadian Forces & Veterans Health Services Laws

Both the *Veterans Affairs Act*[52] and *Canadian Forces Act*[53] provide a statutory basis for access to health benefits that complements the CHA and provincial health insurance laws.

For example, adopted under the Veterans Affairs Act, Veterans Health Care Regulations[54] provide eligible Veterans supplemental health care or home, personal and long term care benefits that supplement the health insurance coverage benefits of the provinces in which a Veteran resides. Similar benefits and services are offered through the Canadian Forces Health Services for eligible members.[55]

II.4.1.6 The Indian Act, Its Modern Progeny & Indigenous Health Services

One distinguishing feature of Canada over more than the last century has been its evolving legal relationship with Indigenous peoples or those historically regarded as "Indians." Recent decades have witnessed an explosion of court cases, royal commissions, a search for national truth and reconciliation for past wrongs, policy reforms, and transformative legal relations that have significantly increased the legal rights of Indigenous peoples and their movement towards self-government. Two pieces of existing legislation illustrate old and newer approaches to federal legal relations involving the health of Indigenous peoples.

The Indian Act of 1872, survives in its amended form,[56] as a legal relic of what many Indigenous voices consider Canada's blighted colonial past. It was enacted shortly after the 1867

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49 *Federal Corrections and Conditional Release Act*, SC 1992, c 20 [*CCRA*].

50 *Ibid*, s 86.

51 *Brazeau v Canada (Attorney General)*, 2020 ONCA 184.

52 *Department of Veterans Affairs Act*, RSC 1985, c V-1.

53 *Canadian Forces Members and Veterans Re-establishment and Compensation Act*, SC 2005, c 21.

54 *Veterans Health Care Regulations*, SOR/1990-594.

55 See *Compensation and Benefits Instructions for the Canadian Forces*, c 211 Service Benefits for Ill and Injured Members of the Canadian Armed Forces, online: https://www.canada.ca/en/department-national-defence/corporate/policies-standards/compensation-benefits-instructions/chapter-211-ill-injured-benefits.html.

56 See *An Act to Amend and Consolidate the Laws Respecting Indians*, SC 1876, c 18 [*Indian Act 1876*]; *Indian Act*, RSC

Constitutional reforms that created Canada. The reforms – specifically section 91(24) of the Constitution Act – conferred jurisdiction over *"Indians, and Lands Reserved for Indians"* to the federal government.[57] As the federal government interpreted and implemented its responsibilities, it did so over health matters. Canadian scholars have documented, for example, the growth of federal *"Indian Hospitals"* largely in western Canada in the 1930s; they accelerated in the post WWII era, with the newly created federal Department of Health and Welfare and its division of Indian Health Services.[58] In 1953, the Indian Act *"was amended (…) to include the Indian Health Regulations. Amongst other things, the regulations "made it a crime for Indigenous people to refuse to see a doctor, to refuse to go to hospital, and to leave hospital before discharge."*[59]

The reign of Canada's Indian Hospitals largely ran from post WWII to the 1970s with tuberculosis sanatoriums and treatment, primary care services, social segregation, and even medical experiments undertaken at some 22 institutions.[60] Mistreatments from that era are part of Canada's ongoing truth and reconciliation process for Indigenous justice, and part of a billion dollar law suit against the federal government.[61] It remains to be seen whether such litigation and national dialogue shall meaningfully help to heal Canada's relationship with one of it founding peoples.

If the Indian Health Regulations of the 1950s seem to condone a coercive-paternalistic model of health services that treated Indigenous peoples like wards of the State, has the residue of that model faded? Canada's existing Indian Act suggests not.

Section 73 of the *Indian Act*[62] enables the Government to enact regulations on diverse matters concerning vehicles, animal life, sanitation and medical treatment, etc.:

FRAME 7

Indian Act, section 73

(1) The Governor in Council may make regulations

(a) for the protection and preservation of fur-bearing animals, fish and other game on reserves;

(b) for the destruction of noxious weeds and the prevention of the spreading or prevalence of insects, pests or diseases that may destroy or injure vegetation on Indian reserves;

(c) for the control of the speed, operation and parking of vehicles on roads within reserves;….

(f) to prevent, mitigate and control the spread of diseases on reserves, whether or not the diseases are infectious or communicable;

(g) to provide medical treatment and health services for Indians;

1985, c I-5.

57 *Constitution Act, 1867*, *op. cit.* s 91(24).

58 See, e.g., Lux, M.K.: *Separate Beds: A History of Indian Hospitals in Canada, 1920s-1980s*, University of Toronto Press, Toronto, 2016, xii and 273 pp.

59 Lux, M.: "Indian Hospitals in Canada", *The Canadian Encyclopaedia*, 17 July 2018, online: https://www.thecanadianencyclopedia.ca/en/article/indian-hospitals-in-canada.

60 *Ibid*.

61 See *Canada (Attorney General) v First Nations Child and Family Caring Society of Canada*, 2021 FC 969; *First Nations Child and Family Caring Society of Canada et al. v Attorney General of Canada (for the Minister of Indian Affairs and Northern Development Canada)*, 2019 CHRT 39; *First Nations Child and Family Caring Society of Canada et al. v Attorney General of Canada (for the Minister of Indian Affairs and Northern Development Canada)*, 2016 CHRT 2.

62 *Indian Act*, *op. cit.* section 73.

(h) to provide compulsory hospitalization and treatment for infectious diseases among Indians; (…)

(k) to provide for sanitary conditions in private premises on reserves(…);

The control of disease, the regulation of medical care and health services, and treatment illustrate dimensions of Indigenous peoples' right to health. It seems doubtful that the coercive provisions of the Act would withstand a Charter challenge. Some of these issues are further discussed in Part III, below.

II.4.1.7 Declaration on the Rights of Indigenous Peoples Act

In contrast to the Indian Act, a new federal law adopted by Canada endorses a human rights-based approach to informing the legal relations with Indigenous peoples, including in the health domain.

Enacted in 2021, the Canada's *United Nations Declaration on the Rights of Indigenous Peoples Act*[63] outlines principles to realign government relations with Indigenous peoples by recognizing past wrongs and drawing on principles of the *UN Declaration of the Rights of Indigenous Peoples*[64] to guide actions forward:

FRAME 8

United Nations Declaration on the Rights of Indigenous Peoples Act, Preamble

Whereas Indigenous peoples have suffered historic injustices as a result of, among other things, colonization and dispossession of their lands, territories and resources;

Whereas the Government of Canada rejects all forms of colonialism and is committed to advancing relations with Indigenous peoples that are based on good faith and on the principles of justice, democracy, equality, non-discrimination, good governance and respect for human rights;

Whereas the implementation of the Declaration can contribute to supporting sustainable development and responding to growing concerns relating to climate change and its impacts on Indigenous peoples;

These lofty principles may translate into policy and law by three means.

First, the Act, affirms the Declaration *"as a source for the interpretation of Canadian law."*[65] Reliance on the Declaration may thus help courts and Parliament implement legal reforms that rid Canada of anachronisms like the paternalistic provisions of the *Indian Act*.

Secondly, the UNDRIPA arguably commands such positive reform by its affirmation that the *"Government of Canada must (…) take all measures necessary to ensure that the laws of Canada are consistent with the Declaration."*[66]

Thirdly, the Act thus embraces the UN Declaration provisions that speak to facets of the right to health. Article 21 of the Declaration, for example, proclaims that *"Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of (…) housing, sanitation, health (…)"*[67] . The Article also notes the needs of vulnerable subpopulations of Indigenous peoples by underlining "the state's

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63 *United Nations Declaration on the Rights of Indigenous Peoples Act*, SC 2021, c 14 [*UNDRIPA*].

64 *United Nations Declaration on the Rights of Indigenous Peoples*, GA Res 61/295, UNGAOR, 61st Sess, Supp No 53, UN Doc A/Res/61/295 (2007), online (pdf): https://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf [*UNDRIP*].

65 *UNDRIPA*, *op. cit.* preamble.

66 *Ibid*, s 5.

67 *UNDRIP*, *op. cit.* art 21.

responsibility to pay particular attention to the rights and needs of elders, women, youth, children and persons with disabilities."[68] Article 23 includes health within Indigenous peoples right to self-development: *"In particular, Indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them (...)"*[69]. Article 24 affirms the *Universal Declaration of Human Rights of 1948* declaration on health as applied to Indigenous peoples' traditional and modern health needs:[70]

FRAME 9

United Nations Declaration on the Rights of Indigenous Peoples, article 24

"(1) Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, all social and health services.

(2) Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right."

The UN Declaration and Canada's enabling UNDRIPA legislation serve as important sources of law for facets of a right to health for Indigenous peoples.

II.4.2. Federal Health Protection Statutes

If a right to health includes duties and standards regarding the protection of the health and safety of the citizenry, then two federal statutes help illustrate that facet. For the Quarantine Act[71] and Food and Drug Act have worked well over a century towards protecting Canadian's national public health.

II.4.2.1 Quarantine Act

FRAME 10

Quarantine Act, 2005, section 4

"The purpose of this Act is to protect public health by taking comprehensive measures to prevent the introduction and spread of communicable diseases."[72]

As illustrated in the above discussion of the *Quarantine Act 1871*, the power to quarantine stands as one of the more ancient and more invasive public health powers that nations have invoked to protect the health of the citizenry from infectious diseases. Based on the federal quarantine (and arguably the criminal law) power of the Constitution, Canada's *Quarantine Act* empowers Canada to isolate, inspect, detain people, products and cargo, vessels and vehicles reasonably suspected of having or spreading a communicable disease in transit to and from Canada.[73]

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68 *Ibid*.

69 *Ibid*, art 23.

70 *Ibid*, art 24.

71 See *Quarantine Act*, SC 1872, c 27; *Quarantine Act*, RSC 1985, c Q-1; *Quarantine Act*, SC 2005, c 20.

72 *Ibid.*

73 *Ibid*.

The Act's broad health protection purposes are enabled by extraordinary measures. In addition to those noted above, they range from ordering medical examinations, destruction of goods, ordering travellers to report to public health authorities, opening suitcases and containers, seeking arrest warrants for non-compliant travellers, seeking warrants to enter dwelling places, prohibiting entry of persons into Canada. Given the potential invasion of one's person, bodily integrity and individual mobility, the Act outlines court procedures for warrants and limits officials' discretion. A quarantine officer, for instance, shall not detain a traveller, *"if the quarantine officer has reasonable grounds to believe that the traveller does not pose a risk of significant harm to public health."*[74] The text requires an objective basis for the belief and a risk of "significant harms" that surpass the theoretical or minimal.

If the *Quarantine Act* and Regulations have provided authority to inspect 100,000s of European immigrants to Canada at Quebec's Grosse-Île Quarantine Station in the 19th century, and to ensure safe and expeditious cross border transit of human organs and bodily parts for transplantation in the 20th Century, the Act has also served as the legal source of some of Canada's unprecedented travel and isolation restrictions to combat the spread of Covid in this 21st century. Section 58 of the Act enables the Government of Canada to prohibit – or subject to conditions – persons entering Canada, if there has (i) been an outbreak of a communicable disease in a foreign country that would pose an *"imminent and severe risk to public health in Canada"*, (ii) those entering Canada may introduce or spread the disease, and (iii) no other reasonable alternatives are available to prevent its spread.[75] The section has been has been the basis of the requirement that Canadians returning home by car submit to quarantine for 14 days during the first waves of Covid. It has also been the legal authority for sealing Canadian borders or restricting non-essential travel during the pandemic, for vaccination requirements for entry and egress, and for the summer 2021-winter 2022 requirement that Canadians returning by air submit to a Covid test and isolate for up to 72 hours at border quarantine hotels, at the travellers' expense, while awaiting negative results. The requirements have been challenged as violating Charter rights of liberty and security of person, or against arbitrary detention or cruel and unusual treatment.[76] The courts have routinely rejected challenges to the latter federal public health orders.[77]

II.4.2.2 From Adulteration Statutes to the Food, Drug, Medical Devices Act

Like other countries in the 1900s, Canada was touched by adulterated food, alcohol and drugs. The age of quackery may seem a distant century in the mists of time. But desperate searches for remedies or cures transcend eras in the face of deathly, unrelenting public health crises. In the throes of Canada's cholera epidemic in 1835, for instance, a product called Dwight Remedies was advertised and offered in Quebec to treat cholera and its debilitating diarrhea.[78] In the second half of the 19th Century, Montrealers could turn to elixirs, tonic invigorators, medicine wines, to try to alleviate their ailments. For instance, "Paines Celery Compound" was particularly recommended for women's nervous disorders, depression, rheumatism. The label

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[74] *Ibid*, s 32.

[75] *Ibid*, s. 58.

[76] See *Spencer v Canada (Health)*, 2021 FC 621.

[77] *Ibid*. See also the parallel cases noted below in section III.8.

[78] GOULET, D.: "Cures and Quackery: The Rise of Patent Medicines", McCord Museum, online http://collection.mccord.mcgill.ca/scripts/viewobject.php?section=162&Lang=1&tourID=VQ_P2_1_EN&seqNumber=20.

of "Pecacuanha Wine" – composed of "Diaphoretic and Emetic" that induced vomiting – read:[79]

> *Useful in colds, coughs, diarrhoea as an emetic for infants (…)*
>
> *Prepared by SL Lyman,*
> *Chemists and Druggists,*
> *Place D'Armes, Montreal.*

Adulterated drug or foods products may present several ills. They misrepresent the content, quality, and therapeutic effect of a product. The deceit in doing so may impact public trust and confidence in all such products, including those not adulterated. Adulteration thus gives unfair competitive advantage to those adding less expensive, or poorer quality ingredients. Deceptive advertising of such goods defrauds the market. What is more, adulteration may impact individual and community health. Impurities in a health product may harm individual well-being; in the extreme they may cause death. Doing so peddles misinformation to patients; it violates the principles of free and informed assumption of the risks and benefits of the product. It may also undercut the opportunity to take alternative treatments that improve health.

For such reasons, Canada introduced a new definition of adulteration into the federal *Adulteration Act of the 1875*.[80] It defined *"adulterated"* as a product differing *"from the standard of strength, quality or purity"* of scientific pharmaceutical compendiums (pharmacopoeis) or from the advertised or professed standard under which it is sold.[81] One analyst, looking back at the history and purpose of the *Adulteration Act*, underscores the purposes of adulteration bans and consumer health protection: *"The purpose of all of the legislation is the protection of the public. The federal legislation is concerned with the protection of the public health, as well as the prevention of fraud in the manufacture and sale of drugs. (…) Injury to the public health and fraud have always been considered to be crimes. It follows that a function of the criminal law will be the protection of the public health and the prevention of fraud."*[82]

The rationales and revised standards on food and drug adulteration continue today in Canada's Food & Drug & Medical Devices Act (FDA):[83]

> *The FDA aims at ensuring, the safety and efficacy of drugs or devices intended for medical use by the consuming Canadian public. Administered by Health Canada…,. [i]ts historic purpose and functions have been to regulate or prohibit the manufacture or sale of adulterated or misbranded food, drugs and like products potentially "injurious to health and safety." Cosmetics and medical devices have been regulated by the Act since 1939.*[84]

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79 *Ibid*, online: http://collection.mccord.mcgill.ca/scripts/viewobject.php?section=162&Lang=1&tourID=VQ_P2_1_EN&seqNumber=20.

80 *An Act to impose License Duties on Compounders of spirits, amend the Act respecting Inland Revenue, and to prevent the Adulteration of Food*, 1st Sess, 21st Parl, ch 8, 39 (1874), online: https://heinonline.org/HOL/P?h=hein.ssl/sscan0307&i=116.

81 STEIB, E.W.: "Drug Adulteration: Detection and Control in Canada", *Pharmacy in History*, vol.18, nº.1, University of Wisconsin Press, 1976, pp. 17-24.

82 CURRAN, R.E.: "Drug Legislation in Canada", *Food, Drug, Cosmetic Law Journal*, vol. 11, nº.11, 1956, pp. 590-601.

83 *Food and Drugs Act*, RSC 1985, c F-27.

84 LAW REFORM COMMISSION OF CANADA, *Procurement and Transfer of Human Tissues and Organs* (Ottawa: Law Reform Commission of Canada, 1992) at 117-118, online: https://archive.org/details/procurementtrans00lawr/page/n3/mode/2up.

Complementing provincial regulations of health professionals and hospitals, the FDA thus imposes a proactive model of legal prohibition and regulation. It first bans the sale or offering of drugs and like therapeutics that have prospered since the late 19th century; it then exempts from the prohibition therapeutics that qualify for federal licensure and regulation. "Drugs" includes traditional therapies like vaccines, pain killers, prescription and over-the counter medications, and more novel ones like blood products, genetic therapies, human growth hormone. "Medical devices" range from contact lenses, respirators, and thermometers to bandages or implantable bio-synthetic heart valves, to pregnancy test kits. The Act generally requires drug and medical device manufacturers to present exacting scientific evidence on the therapeutic product submitted for licensure. For new drug approval, for instance, FDA regulations require the submission to *"contain sufficient information and material to enable the Minister to assess the safety and effectiveness of the new drug (…) "*[85]. The submission shall also document chemical and manufacturing information, dosing, quality, and purity data, labelling protocols, etc.

The data and evidence on safety and effectiveness usually flows from human drug testing from clinical trials, which are also regulated by FDA Regulations.[86] Following pre-clinical research and laboratory and animal testing, clinical trials for humans typically move through three phases. Phase I trials involve small numbers of human participants with a focus on safety and dosing. Phase II safety trials expand testing to involve a larger number of participants. Phase III moves from safety to testing drug efficacy. Clinical trial results are reviewed by government scientists, expert advisory drug committees and scholarly peers. Research undertaken by international pharmaceutical companies may mean that clinical trials are conducted simultaneously in different nations. Such was the case for the Polio vaccine in the 1950s, and for the Covid vaccine data that pharmaceutical companies submitted to Health Canada in December 2020. The need occasions legal and scientific harmonization and coordination with sister nations. In 2020, to speed licensure beyond the several year process typically required, Health Canada adopted an *Interim Order (IO) Respecting the Importation, Sale and Advertising of Drugs for Use in Relation to COVID-19*.[87] The IO established special regulations during the public health urgency to facilitate and expedite safe access to effective Covid-19 drugs and vaccines. According to Health Canada, *"authorizations under this Interim Order will be granted only if Health Canada determines that the benefits and risks of the product are supported by evidence that the drug is safe, effective and of high quality."*[88]

Importantly, for instance, the IO authorizes Health Canada to expedite approval of Covid drugs already licensed by a "trusted" foreign drug regulatory authority, such as the US Food & Drug Administration or the European Medicine Agency. This path has been critical because Canada generally lacks manufacturing capacities for new Covid vaccines. Once Health Canada adds a foreign licensed vaccine to its list, a manufacturer like Pfizer can seek prompt approval. The IO requires manufacturers to submit scientific evidence on safety, efficacy, and quality. In practice, then, an application that claims a drug has minimal and known safety risks and 90% effectiveness in the prevention or treatment of Covid must be validated by Health Canada's

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85 *Food and Drugs Regulations*, CRC 2021, c 870, s 08.002.1 (2).

86 *Ibid*, s 05.

87 *Interim Order Respecting the Importation, Sale and Advertising of Drugs for Use in Relation to COVID-19*, (2020), online: https://www.gazette.gc.ca/rp-pr/p1/2020/2020-10-03/html/notice-avis-eng.html#nb1.

88 See GOVERNMENT OF CANADA, "Information and Application Requirements for Drugs Authorized Under the Interim Order: Guidance Document", online: https://www.canada.ca/en/health-canada/services/drugs-health-products/covid19-industry/drugs-vaccines-treatments/interim-order-import-sale-advertising-drugs/guidance.html.

approval process based in part on clinical trials evidence generated in the US, for example; and confirmed or rejected by Health Canada. Rexmir, for the treatment of acute Covid symptoms, was approved on an expedited basis in July 2020. Health Canada also granted expedited approvals to the Pfizer, Moderna, AstraZeneca and Johnson & Johnson adult vaccines in early 2021, and for vaccines for children aged 5-11 in late 2021. Beyond vaccines, towards the broader range of Covid therapeutics, Health Canada reported that in the first six months of 2021, it "approved: 27 clinical trials; 3 vaccines; 182 hand sanitizers; 96 disinfectants; and 167 medical devices (25 test kits)."[89]

Since drugs are licensed on the calculus that the known net health benefits clearly outweigh the known risks, as proven by safety and efficacy data, how should the law manage unknown or unforeseen risks, scientific uncertainty, and post-licensure developments? It does so in part by developing and refining a coherent post-licensure surveillance system.

If the tragic international Thalidomide Affair from the 1960s stands as a constant historical reminder of post-licensure needs, so do the more recent origins of Vanessa's Law in Canada. Both tragedies begot law reform.

Vanessa Young was a 15-year-old Ontario student who fell into sudden cardiac arrest before her parents one evening of March 2000. Unfortunately, emergency room doctors pronounced her dead later that eve at the hospital. Vanessa had been taking Prepulsid, a drug prescribed for gastroenterological issues. Unbeknownst to her – and apparently some of her doctors – international reports and recommendations had advised that the drug was contraindicated for patients with the eating disorder bulimia, for which she had consulted specialists. Within months of Vanessa's death, the drug was withdrawn from the North American market. A year later, a coroner's report on her death advanced dozens of recommendations to increase drug safety, incident reporting, and safety information-sharing standards. Her father has since passionately advocated for drug safety reforms.

In partial response, in 2014, Canada enacted the *Protecting Canadians from Unsafe Drugs Act (Vanessa's Law)*.[90] *Vanessa's Law* amended the *FDA* to strengthen the regulation of therapeutic products. It increased the post-licensing powers and responsibilities of Health Canada: to recall therapeutic products, to impose enforcement fines, to mandate heightened reporting for identified risks. For example, effective 2019, it became mandatory for hospitals to report "serious adverse drug reactions (ADRs)" and medical device incidents to Health Canada. Under recently revised regulations, a serious ADR includes drug reactions that require or prolong patient hospitalization, result in persistent or significant disability or incapacity, is life-threatening, or results in death.[91] Existing regulations had already required manufacturers to report adverse events. Reports from diverse sources accumulate evidence of post-licensure safety issues. Such reporting measures are intended to improve Health Canada's ability to collect safety information of licensed drugs and devices, to better monitor them and initiate timely remedial action on serious health risks.

Practically, these and like reporting channels integrate into the *Canadian Adverse Events Following Immunization Surveillance System* (CAEFISS), a federal, provincial, and territorial

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89 GOVERNMENT OF CANADA, "Mid-Year Update: Health Products Approved in 2021", (4 October 2021), online: https://www.canada.ca/en/health-canada/services/drugs-health-products/highlights-reports/mid-year-update-2021.html.

90 Bill C-17, *An Act to amend the Food and Drugs Act*, 2d Sess, 41st Parl, 2013, (assented to 6 November 2014), SC 2014, c 24.

91 *Food and Drugs Regulations*, *op. cit.* s 01.001(1.1). See the parallel incident reporting standards of the *Medical Devices Regulations*, SOR/98-282 (2021), s. 59 et seq.

public health post-market vaccine safety surveillance system. The system draws on reports from local and provincial sources for a national monitoring system for adverse reactions to immunizations, like the Covid vaccines. For example, by February 2022, the system had counted some 8,000 serious adverse events from some 80 million Covid-19 vaccines administered in Canada. Analysis of that data has led the Public Health Agency of Canada to identify important "active safety signals" that are monitored, such as a disproportionately higher number of cases of inflammation of the heart muscle (myocarditis) for those under 40.[92]

II.4.3. *Federal Human Rights Acts*

Three Canadian federal human rights laws structure facets of the right to health. Two are anti-discrimination statutes – *the Canadian Human Rights Act* and the *Genetic Discrimination Act* – protect equality dimensions of health. A third statute concerns health information privacy. It is discussed in Section IV. 2.6, below.

The equality right to be free from discrimination on the basis of health status flows in part from two Canadian federal statutes.

II.4.3.1 Canadian Human Rights Act

Based on the right to equality, the *Canadian Human Rights Act (CHRA)* is the federal statutory analogue to section 15 of the *Canadian Charter* in that it prohibits discrimination based on protected grounds of, *inter alia*, race, ethnicity, national origin, sex or gender, sexual orientation, religion, disability.[93] While the Charter applies to government, the CHRA applies to both government or private conduct in the federally regulated public or private sector. The Act enables those discriminated against to file a complaint with the Canadian Human Rights Commission. The Commission investigates complaints, endeavours to settle them and may refer unresolved complaints the Canadian Human Rights Tribunal (CHRT). The Commission also offers advisory guidance and policy statements on discrimination issues. Despite recommendations to do so,[94] the Act does not specify "health" as a protected ground. Accordingly, the primary ground most likely to protect against health status discrimination is disability. The SCC has given a broad, purposive, contextual and multidimensional approach to interpreting real or perceived disability:

> *By placing the emphasis on human dignity, respect, and the right to equality rather than a simple biomedical condition, this approach recognizes that the attitudes of society and its members often contribute to the idea or perception of a "handicap". In fact, a person may have no limitations in everyday activities other than those created by prejudice and stereotypes.*[95]

Disability protections are supplemented by other grounds that implicate health status. For instance, in *Brooks v. Canada Safeway*[96] a pregnant employee sued a supermarket chain for the failure of its health and disability benefits package to include pregnancy leave payments

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92 GOVERNMENT OF CANADA, "Reported Side Effects Following COVID-19 Vaccination in Canada" (updated 10 December 2021), online: https://health-infobase.canada.ca/covid-19/vaccine-safety/.

93 *Canadian Human Rights Act*, RSC 1985, c H-6. [*CHRA*].

94 JONES, D.J.: "Selected Legal Issues in Genetic Testing: Guidance from Human Rights", *Health Policy Working Papers*, Health Canada, Ottawa, 2001, vi and 77 pp., online: https://publications.gc.ca/site/eng/9.558007/publication.html.

95 *Quebec (Commission des droits de la personne et des droits de la jeunesse) v Montréal (City); Quebec (Commission des droits de la personne et des droits de la jeunesse) v Boisbriand (City)*, [2000] 1 SCR 665 at para. 77.

96 *Brooks v Canada Safeway Ltd.*, [1989] 1 SCR 1219.

during her four months of absence. Her lack of illness meant she did not qualify. Pregnancy, with illness might have. The employer argued the benefits package offered limited coverage. The SCC found the plan under inclusive; it adversely and solely impacted pregnant women. The court held that discrimination on the basis of pregnancy is discrimination on the basis of sex.

While Brooks arose under Manitoba law, because all Canadian provinces have anti-discrimination statutes that parallel the CHRA,[97] such leading cases regarding health related or disability discrimination have constructed a deepening, enriched national jurisprudence that informs the interpretation and application of the CHRA and its provincial equivalents. The jurisprudence advances the right to be free, in diverse societal spaces, from discrimination due to prejudicial attitudes, practices, and mistreatment regarding health status.

A few leading cases illustrate further important dimensions. *Thwaites v Canada*,[98] for instance, resonates from a previous global pandemic. In it, an HIV-infected electronic operator aboard a naval destroyer was demoted once his HIV status became known. The HIV epidemic in Canada provoked numerous employment discrimination cases and important human rights guidance.[99] The facts in *Thwaites* indicated adverse impact discrimination. Once that is proven, the onus shifts to the employer (the Navy), to justify the discriminatory action. It may do so on the basis that a "bona fide occupational qualification" (BFOQ) requires the position to be HIV-free (s. 7 of CHRA); or, if not, that an HIV infected employee under the circumstances could not individually be accommodated because doing so imposes an "undue hardship." Both employer defenses require showing objective necessity in the circumstances. That an employer's equality duty requires accommodation up to the point of undue hardship combined with the BFOQ defense, indicate that the right to be free from disability discrimination is not absolute. In *Thwaites*, the military failed to prove either the BFOQ or the undue hardship defense. By contrast, in a SCC case involving an employee with recurrent mental and physical illness that had resulted in absenteeism for 960 days during seven years of employment, the company demonstrated that its rescheduling, reconfiguration of work station, reassignments, incremental returns to work, and like initiatives over the years reasonably discharged the duty to accommodate.[100] The employee's inability to return to work meant further accommodation posed an undue hardship; her dismissal was justified. Canadian disability discrimination law has also begun to address whether obesity qualifies as a disability,[101] how to address addiction and drug use in safety-sensitive workplaces,[102] and has mandated parity between employee benefits coverage for physical illness and mental illness.[103] Today, it struggles to apply definitions, disclosure requirements, and like principles

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97 SHEPPARD, C.: *The principles of equality and non-discrimination, a comparative law perspective - Canada*, Comparative Law Library Unit, European Parliamentary Research Service (EPRS), November 2020, VIII and 64 pp., reference PE 659.362 (original English version); See also SHEPPARD, C.: *Les principes d'égalité et de non-discrimination, une perspective de droit comparé - Canada*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), février 2022, X et 92 pp., référence PE 698.937 (French translation with added comments and update).

98 *Thwaites v Canadian Armed Forces*, 1993 CanLII 342 (CHRT), 19 CHRR 259.

99 See JONES D.J., SHEPPARD, C.: "AIDS and Disability Employment Discrimination in and Beyond the Classroom", *Dalhousie Law Journal*, vol.12, issue 1, 1989, pp. 103-130, online: https://digitalcommons.schulichlaw.dal.ca/cgi/viewcontent.cgi?article=1543&context=dlj.

100 *Hydro-Québec v Syndicat des employé-e-s de techniques professionnelles et de bureau d'Hydro-Québec, section locale 2000 (SCFP-FTQ)*, 2008 SCC 43.

101 *Turner v Canada (Attorney General)*, 2012 FCA 159.

102 *Milazzo v Autocar Connaisseur Inc.*, 2005 CHRT 5.

103 *Battlefords and District Co-operative Ltd. v Gibbs*, [1996] 3 SCR 566.

developed largely for physical ailments to invisible, stigmatizing disabilities like mental illness.[104]

Beyond disability, a recent landmark case further demonstrates that other protected grounds against discrimination may advance the right to health. In *Canada v First Nations Family and Caring Society*,[105] the Federal Court upheld a landmark Canadian Human Rights Tribunal judgment against the federal government for chronic and systemic, wilful and reckless racial/ethnic discrimination against children in Indigenous communities. The discrimination arose from long-term underfunding—as compared to non-Indigenous communities – of Indigenous child and family services. The tribunal had documented the pattern of discriminatory underfunding and its dire consequences beyond the disproportionately high number of Indigenous children in foster care. The decision upheld $40,000 damages per child to compensate for the discriminatory harms, dignitary harms, loss of freedom, pain and suffering, and serious psychological injury.

The *First Nations Child* case is grounded partly on the special obligation the Government owes Indigenous peoples, and partly on novel discrimination reasoning based on so-called "Jordan's principle." Jordan's principle is a "child-first" doctrine for placing the health and welfare of Indigenous children paramount when jurisdictional conflicts or uncertainties arise to cloud prompt governmental or institutional action to the detriment of children. Jordan principle[106] first arose after the death in a Manitoba hospital of a five-year old Indigenous child named Jordan. Jordan could not access recommended home care because of a federal-provincial dispute over home medical care costs. Following the tragedy, the Canadian House of Commons adopted a motion: henceforth, governments should apply a child-first principle to ensure no gaps or delays in services to Indigenous children. The principle was later invoked by another court to order home care funding, equivalent to that received by non-Indigenous families – for an indigenous adolescent with multiple medical afflictions.[107] Governments have since expressed their support of Jordan's principle.[108]

In previous rulings, however, the CHRT had found that the federal government invoked Jordan's principle in policy and funding decisions but had routinely and improperly done so in ways that undermined its purpose and application. The result was discriminatory service gaps, delays and denials of health services with tragic results: e.g., *"a child requiring medical equipment due to anoxic brain damage during a regular medical procedure (…); failure to provide emergency mental health counselling and treatment aimed at preserving life; the refusal to provide services for a teenager with disabilities; (…) an infant who required an essential medical diagnostic test for which Canada would not provide travel funding (…)* (citations omitted)"[109]. Notably, the

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[104] *Lafrenière v Via Rail Canada Inc.*, 2019 CHRT 16.

[105] *Canada (Attorney General) v First Nations Child and Family Caring Society of Canada*, 2021 FC 969 at paras 195-200.

[106] Compare BLACKSTOCK, C.: "Toward the full and proper implementation of Jordan's Principle: An elusive foal to date", *Paediatric Child Health*, vol. 21, article 5, 2016, pp.245-246 245, online: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4933052/ and SINHA, V., & SHEPPARD C. ET AL.: "Substantive Equality and Jordan's Principle: Challenges & Complexities", *Journal of Law and Social Policy*, vol. 35, article 2, 2021, pp. 21-43, online: https://digitalcommons.osgoode.yorku.ca/cgi/viewcontent.cgi?article=1422&context=jlsp.

[107] *Canada (Attorney General) v Pictou Landing First Nation*, 2014 FCA 21.

[108] See, e.g., GOVERNMENT OF CANADA, "Fact Sheet: Jordan's Principle" (2016), online: https://www.canada.ca/en/health-canada/news/2016/07/fact-sheet-jordan-s-principle-addressing-the-needs-of-first-nations-children.html.

[109] *First Nations Child & Family Caring Society of Canada et al. v Attorney General of Canada (representing the Minister of Indigenous and Northern Affairs Canada), 2020 CHRT 36 at para 3. See also First Nations Child & Family Caring Society of Canada v Attorney General of Canada (for the Minister of Indian and Northern Affairs Canada), 2016*

CHRT had also relied on international instruments like the *Convention on the Rights of the Child* and the UNDRIP to guide its interpretation of Indigenous children's right to access health and child services.[110]

The First Nations Caring cases and Jordan's principle affirm fundamental human rights propositions, including: that Indigenous children have a substantive equality right not to be discriminated against in accessing urgent, life-threatening service needs and essential child and health services that protect and promote health and well-being. Such principles are consonant with a child's right to health.

II.4.3.2 Genetic Discrimination Act

Derived from the discovery of recombinant DNA in the early 1970's and the mapping of the human genome in the 2000s, modern genetic testing technology presents a classic example of how the fruits of the life sciences biotechnological revolution bring both societal benefits and burdens.[111] How does society harness this novel magic wand that peers into the human to diagnose genetic illness or to foresee genetic predisposition, especially for carriers of genes potentially predictive of future illness?

Genetic testing and screening technologies thus press modern society with ethico-legal riddles and questions on why to screen, and what to do with results.

Screen & Treat: Should we require genetic screening of newborns? Such screening is premised on the view that the state justifiably compels it for serious heritable illness like Phenylketonuria (PKU) because early treatment significantly reduces serious newborn illness. Since 2014, to aid *"the detection, prevention and control of screenable diseases in newborns"*, the province of Saskatchewan has mandated newborn blood testing for such treatable disorders as PKU.[112] Untreated PKU may lead to seizures, irreversible brain damage, and severe intellectual disabilities.[113]

Screen & Monitor: Should genetic screening be incorporated into occupational medicine for health surveillance of employees at risk for illness due to genetic carrier status for such illnesses as sickle cell anemia?[114]

Screen & Advise: For genetic disorders that run in families, to whom do genetic counsellors or physicians owe their duties: uniquely to an individual patient, or to family members at serious risk of imminent danger for heritable disease?

Screen & Exclude: Do employers and insurers have a right to know the genetic disorders or predisposition of workers with genetic disease or predisposition, like genetic disease that kills or severely disables most carriers by the age of 40?

CHRT 2.

110 Ibid at para 9. The *UNDRIP* is discussed above in section II.4.1.7.; the Convention is discussed below in part IV.

111 JONES, D.J.: "Selected Legal Issues in Genetic Testing", *op. cit.*

112 Saskatchewan, *Public Health Act*, c P-37.1 c P-37.1; Regulation 15, s 8.

113 US NATIONAL INSTITUTES OF HEALTH, "Consensus Development Conference Statement", *Phenylketonuria: Screening and Management*, October 16-18, 2000, online: https://www.nichd.nih.gov/publications/pubs/pku/sub3.

114 Compare US CONGRESS OFFICE OF TECHNOLOGY ASSESSMENT, *Genetic Monitoring and Screening the Workplace.*, U.S. Government Printing Office, Washington, 1990, iii and 262 pp., OTA-BA-455, online: https://www.princeton.edu/~ota/disk2/1990/9020/9020.PDF; ASHFORD, N.A. ET AL.: *Monitoring the Worker for Exposure and Disease*, Scientific, Legal and Ethical Consideration in the use of Biomarkers, John Hopkins University Press, Baltimore, 1990, 224 pp.

Screen & Engage: Do populations – like some Indigenous peoples with unique or particular genetic health conditions – have the right to engage as partners in designing the questions, interpreting the results and enjoying associated benefits of university and like research concerning their population?[115]

For more than the last three decades, Canada and the international community have sought answers to such questions, through: (i) scholarship and reflection in the fields of medicine, bioethics and law; (ii) interdisciplinary dialogue and policy guidance, and (iii) law reform. For instance, the Law Reform Commission of Canada's Protection of Life project devoted considerable thought and resources to bioethical-legal quandaries.[116] In the early 1990s, Professor KNOPPERS'S think-piece for the Commission, on genetic heritage and human dignity, examined major issues including "genetic discrimination" in insurance and the workplace.[117] A decade later, a Health Canada interdisciplinary committee convened experts and analyses on genetic testing. One report argued that to advance a human right to genetic privacy and an equality right to genetic non-discrimination, Canada should adopt a general prohibition on genetic testing in the workplace and require non-discriminatory use of genetic information when it may be exceptionally used for justifiable purposes in narrow instances.[118] Canada also actively contributed to UN instruments that articulate relevant principles and guidance, such as UNESCO's *Universal Declaration on the Human Genome* (1997), its *Universal Declaration On Human Genetic Data* (Oct 2003); and its *Universal Declaration on Bioethics & Human Rights* (2005).[119] The latter urged nations to invoke universal principles and shared ethical values to take appropriate measures, including legislation, on such matters.

It is this context that over a decade later, Canada joined parallel initiatives in other nations by enacting the *Genetic Non-Discrimination Act (GNDA)*.[120] It addresses one prominent human rights issue of the genetic revolution. Intended to ban and prevent genetic discrimination, the Act prohibits genetic testing and non-consensual use of genetic test results when "obtaining good and services" or "entering into" or continuing terms or conditions of ... "contracts." Researchers and health care practitioners are exempted. The Act amended the Canada Labour Code and added "genetic characteristics" as a prohibited ground of discrimination into the CHRA. As a result, the GNDA prohibits employers and insurance companies from requesting individuals to undergo genetic testing and prohibits the non-consensual access to or use of genetic testing results.

As such, if the right to health includes an equality right not to be discriminated against on the basis of genetic health status and a privacy right to personal health information, then the GNDA advances those rights.

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[115] JONES, D.J., BUSH, P.L., MACAULAY, A.C.: "Beyond Consent: Respect for Community in Genetic Research", *Encyclopaedia of Life and Sciences (eLS) John Wiley & Sons*, Ltd: Chichester, May 2014, 12 pp., online: https://www.crcaih.org/assets/Beyond_Consentt.pdf.

[116] JONES, D.J.: "*Health Law and Bioethics – Requiem or Renaissance for* the *Law Reform Commission of Canada",* Annuals of the Royal College of Physicians and Surgeons of Canada, 29 (3), 19965, pp. 167-170.

[117] KNOPPERS, B.: "Human Dignity and Genetic Heritage", *Protection of life series*, a Study prepared for Law Reform Commission of Canada, Ottawa, 1991, 93 pp.

[118] JONES, D.J: *op. cit*. See also JONES, D.J.: "Selected Legal Issues in Genetic Testing: Guidance from Human Rights", *Health Policy Working Papers*, Health Canada, Ottawa, 2001, vi and 77 pp., online: https://publications.gc.ca/site/eng/9.558007/publication.html.

[119] *See UNESCO Declarations*, online*: https://en.unesco.org/about-us/legal-affairs/instruments/declarations*.

[120] SC 2017, c 3.

II.5. Provincial Law: the example of Quebec

While the focus of this report is Canadian federal law, it is important to underline the leading role the provinces play in the delivery of health services. Such delivery operates on a broad and diverse infrastructure of provincial law that enables and regulates health services. It includes laws on public health insurance, the regulation of health professionals, hospitals, and health care institutions, etc. Such laws help effect a right to accessing health care. The rights, duties and standards found in other provincial laws – e.g., those regarding public health, mental health, occupational safety and health, human rights, privacy – touch other facets of the right to health.

The following profiles a provincial law that gives content to an important dimension of a right to health—that is, governmental duties, standards and powers to protect the public health from contagion, diseases and other menaces. The right derives from the formal duties and special powers incumbent on government to protect the health of its citizenry.

Quebec's *Public Health Act* (QPHA)[121] outlines responsibilities, standards, and procedures for common public health issues like the fluoridation of drinking water, health promotion and prevention, ongoing surveillance of the health of the population, reportable diseases, compulsory treatment or prophylactic measures. The Act also outlines both general and emergency public health powers directly relevant to the risks and mitigation measures prompted by the Covid pandemic. Quebec relied on such powers to adopt some of the more ubiquitous and strict Covid mitigation measures across North America.

II.5.1. General Powers to Contain Public Health Threats

The QPHA provides that, when in the course of a public health investigation a public health director forms the opinion that "there exists a real threat to the health of the population", the director may, *inter alia*, adopt orders: to seize and destroy contaminated animals or plants; to clean or disinfect premises; to evacuate buildings and close premises; to exclude non-immunized persons from school, work or like places of assembly; when necessary, to isolate for up to 72 hours those who refuse treatment; and to implement other measures necessary to decrease or eliminate a public health threat. (s. 106)

II.5.2. Public Health Emergencies

The QPHA also enables government to declare a public health emergency when a *"serious threat"* to the *"health of the population requires immediate application"* of emergency measures to protect public health. (s. 118) Note the proportionality logic in the declaration of public health emergency. It requires the higher threshold finding of a *"serious threat"*, versus a *"real threat"* for general public health containment powers.

Public Health Emergency Powers:

Once a formal public health emergency is declared, the Act empowers the Government or Minister of Health with extraordinary and diverse, broad, and specific measures. These include the power: to order compulsory vaccinations; to compel individuals to share confidential information with the government; to close educational institutions or places of assembly; to install sanitary facilities; to evacuate, restrict or prohibit access to at-risk areas, and to implement "any other measure necessary" to protect the public health. (s.123) Because such emergency powers are broad and are reserved for the extraordinary circumstances of a public health emergency, declarations of public health emergencies expire after 10 days. (s.119) They

[121] Quebec, *Public Health Act*, CQLR, c. S-2.2.

may be renewed as needed. As of mid-winter 2022, Quebec has been under a state of public health emergency since first declared in March 2020. The declaration has been renewed nearly 100 times since then.[122]

The Act also provides for the enforcement of orders before a court for those refusing compliance. (s. 126). As such, in recent years the courts have authorized public health officers to apprehend uncooperative citizens reasonably suspected of having active tuberculosis and require them to submit to medical examination and treatment that includes hospitalization in isolation.[123]

II.5.3. Vaccines: Registry & Injury Compensation

Two distinct programs – under sections 61-78 of the QPHA – bear relevance to Covid vaccinations and the right to health. One concerns a vaccine registry to record all vaccinations received by persons in Quebec. Registries facilitate public health epidemiology and documentation. But they raise confidentiality and data protection issues of access, security, and disclosure of stored data. (Such issues are explored below in section IV.2.6.).

The second program regards compensation for those injured by vaccines. For decades, Quebec has been the sole Canadian province to provide a statutory no-fault compensation program for those injured by immunizations or vaccines. It was legislated partly in reaction to a tragic, unsuccessful vaccine injury compensation case from Quebec that reached the Supreme Court of Canada in the 1980s.[124] When citizens with vaccine injuries go uncompensated, we may ask if the result is just. For, as in the Covid era, public health authorities and health professionals regularly encourage or sometimes require individuals to vaccinate for school, work, for health promotion and protection. As a public health initiative, vaccine campaigns benefit both the individual and the health of the population. But it is the individual who primarily assumes the small risks of vaccine injury. Indeed, the societal calculus is that the public health will benefit from mass vaccination, knowing that a small percentage of individuals risk being injured.

When the small risks of vaccine injury materialize into serious personal injury or death, then both the health risks and resulting financial risks lay concentrated on the injured individual and family. The public benefits; the individual suffers. As in the Quebec case, in fault-based personal injury systems a host of technical legal factors typically conspire to result in no compensation for vaccine injuries, after years of litigation. No fault vaccine compensation regimes respond to this (mis)allocation of risk-benefits, by helping shift the risks and costs of injury to society as a whole. From a distributive justice perspective, the redistribution of risks-benefits through no fault vaccine compensation programs is thus consistent with public health justice. They also help to remove financial disincentives to participating in mass vaccination programs. For such reasons, in December 2020 – months after Covid struck – the Government of Canada announced a vaccine compensation program for *"serious and permanent"* injury from vaccines authorized by Health Canada.[125] Such redistributive justice concerns help nurture and sustain an individual and society's collective right to health protection.

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[122] GOVERNMENT OF QUEBEC, "Measures adopted by Orders in Council and Ministerial Orders in the context of the COVID-19 pandemic", online: https://www.quebec.ca/en/health/health-issues/a-z/2019-coronavirus/measures-orders-in-council-ministerial-orders.

[123] *Bouchard c. T.A.*, 2018 QCCQ 4744.

[124] *Lapierre v. A.G. (Que.)*, [1985] 1 SCR 241.

[125] "Vaccine Injury Support Program" (2020), online: www.vaccineinjurysupport.ca.

III. Selected Relevant Case Law

Significant facets of the right to health in Canada have been deliberated, have evolved, and have sometimes advanced through the adjudicatory model of societal decision-making – that is, litigation through the courts. One may argue that the cases have helped build Canada's right to health. Typically, the cases have presented a narrow question or issue with potentially profound legal consequences. The following first discusses selected landmark health law and human rights cases of Canada, and then surveys important Covid-19 cases.

Before turning to the substantive principles elaborated in these cases, a jurisdictional note gives context to the rulings. Many of the judgments have been rendered by the highest court of Canada or the highest courts of the provinces or territories—that is the Supreme Court of Canada (SCC) and the Courts of Appeal of the Provinces. In contrast to other federal jurisdictions like the United States, access to the SCC is broadened by the fact that it serves as the highest court of appeal for the courts of Canada. Leave to appeal to the SCC is of right in some criminal law cases and at the discretion of the SCC for all non-criminal cases. So even cases that do not pose a *"federal question"* may be heard by the SSC. Concretely, the difference means that comparatively more private health law disputes are heard by the SCC than by the US Supreme Court. The SCC thus has comparatively more opportunities to interpret, apply and evolve health law jurisprudence.

The cases are explored through the questions they presented often to the highest courts of Canada.

III.1. What Must Health Professionals Disclose to Secure a Patient's Free & Informed Consent to Medical Procedures?

In 1980, the Supreme Court of Canada was asked to uphold or vacate a lower court decision that had awarded a patient $225,000 to compensate injuries against a surgeon who allegedly performed a procedure for the patient without valid consent.[126] The surgery left the patient impotent and partly paralyzed. The quality of the surgery was not in question. Rather, the patient argued that consent was defective and negligent due to the surgeon's failure to disclose the risk of stroke inherent in the procedure. Had the patient been appropriately advised of the risk, he claimed, he would have forgone or delayed the operation. He would have done so because he was some 18 months from full pension and disability benefits.

The question before the Court in *Reible v Hughes* was: what is the standard and elements of valid patient consent to non-emergency, elective surgery?[127]

The Court articulated what has become Canada's modern standard for patients' *free and informed consent*.[128] It did so by drawing on common law principles of Canadian and US law. First, it made clear that this was not an instance of non-consensual touching, or battery. Battery, it explained, is reserved for cases of fraud, of interventions beyond the scope of consent, or cases without consent. Second, the Court indicated that in this and other instances of negligent consent, the doctor has a duty secure the patient's free and informed consent based on discussion of the risks, benefits and alternatives of the procedure. Alternatives include foregoing a proposed medical procedure. Third, the scope of disclosure for risks must include special or unusual, and material risks – that is, those risks that a reasonable patient

[126] *Reibl v Hughes*, [1980] 2 SCR 880.

[127] *Ibid.*

[128] *Ibid* at 888-889.

under the circumstances would consider material or relevant to the patient's deliberative process. A risk of death or risk of high disability would be considered "special or unusual," meaning the risk of stroke would be so considered. Such disclosure should enable professional-patient dialogue and questions to which professionals have a duty to respond. Finally, the Court emphasized that the doctrine of free and informed consent is patient-centered—that is, not what the reasonable professional would think relevant, but what a reasonable patient would need to make an informed decision. Since the surgeon had failed to disclose the risk of stroke, as a special or unusual risk, the patient had proved the case of negligent disclosure. The patient would still have to prove that negligent disclosure caused patient injury, by showing that a reasonable patient under the circumstances would then have likely declined the operation and avoided the risk of injury, had he or she been fully informed of the risks.

Reible became a landmark case. Aligning itself with principles of US case law and rejecting the professional deference model of British case law, *Reible* did so partly because of its rejection of the heretofore reigning paternalistic model of medicine epitomized in the phrase "doctor knows best." Instead, grounded on the ancient common law principle of self-determination, *Reible* embraces and proclaims a citizen's right – even as an ill, vulnerable patient dependent on health professionals' expertise – of self-determination and autonomy over what is done to one's body and health in the medical system. In theory, a patient-centred doctrine of free and informed consent gives concrete meaning to the high principles of human autonomy, by enabling patients knowingly to mange their physical and bodily integrity by assuming and allocating the risks and benefits of treatment on one's person. It thus accords with dignitary values and modern human right principles.

III.2. Do Patients Have the Right to Decline Medically Necessary Treatment?

A decade after *Reible*, two lower court cases in Ontario and Quebec captured national and legal attention over an adult's right to refuse or decline treatment. The cases made explicit what was implicit in the principles of free and informed consent. That is, since the duty to respect the right of informed consent requires professional disclosure of the risks, benefits and alternatives to recommended treatment, foregoing treatment remains an option normally open for patients. But what if declining treatment highly increases the risk of serious illness or death?

FRAME 11

Ontario, Court of Appeal, 1990, Malette v. Shulman, para III

The right of self-determination which underlies the doctrine of informed consent also obviously encompasses the right to refuse medical treatment. A competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternate form of treatment, even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community. Regardless of the doctor's opinion, it is the patient who has the final say on whether to undergo the treatment.

In the Ontario case of *Malette v. Shulman*,[129] the issue was whether an adult Jehovah Witness could refuse life-saving blood transfusion via his handwritten note in his pocket that said "no blood transfusion" for situations when he was unconscious in a medical emergency. The emergency room physician had ignored the note, transfused the patient, and was later sued

[129] *Malette v Shulman*, [1990] 72 OR (2d) 417 (ONCA).

for battery: the non-consensual touching of the patient. The court underlined two rationales for the emergency exception to the informed consent doctrine: the law privileges life-saving interventions and presumes that most unconscious patients would welcome emergency life-saving interventions. In this instance, however, the patient's card documents valid written refusal by a patient with full mental capacity who had anticipated his incapacity and had specifically written to decline blood transfusions in an urgency. The circumstances rebut a legal presumption of consent. The court concluded the doctor was obliged to honour the card, as a valid patient choice to refuse treatment:

In the Quebec case of *Nancy B v Hotel Dieu*,[130] the issue was whether an adult female has the right to terminate ventilator care, even if doing so risks death. A 27-year-old women afflicted with an irreversible disease for which she had become hospitalized and ventilator-dependent, requested a court order to cease treatment. The Court grounded its analysis on the informed consent standards of the Civil Code of Quebec:[131]

FRAME 12

CCLC, art. 19-19.1

The human person is inviolable. No one may cause harm to the person of another without his consent or without being authorized by law to do so. No person may be made to undergo care of any nature… except with his consent.

The Court also invoked the SCC common law decision of *Reible*, Quebec academic commentary and case law, and the Quebec *Code of Ethics of Physicians* to conclude that:

FRAME 13

Quebec Superior Court, 1992, Nancy B v Hotel Dieu, para 33 and 44

The logical corollary of this doctrine of informed consent is that the patient generally has the right not to consent; that is the right to refuse treatment and to ask that it cease where it has already begun.[132]

It therefore clearly follows… that Nancy B, whose consent in this regard was freely given and informed, is entitled to require that the respiratory support treatment being given her cease.[133]

The Court drew on the reasoning of US case law over the previous decade to indicate that the cessation of treatment invoked no criminal liability, as withdrawal of the respirator would not cause death, but *"allow nature to take its course."*[134]

Taken together, the Quebec and Ontario cases affirm that the right of self determination in patients' free and informed consent includes a corollary: a right to refuse medical care judged necessary to preserve patient health or life.

This may seem confounding or incoherent, especially if a "right to health" is deemed instrumental to attaining high levels of physical well-being. It is less so, if a right to health embraces diverse, pluralistic values that sometimes interface or conflict. The WHO definition of health transcends physical well-being.[135] These tensions are further explored below. For

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[130] *Nancy B. v Hotel-Dieu de Quebec*, [1992] RJQ 361.

[131] Art 19-19.1 CCLC, online: http://www.bibliotheque.assnat.qc.ca/guides/fr/le-code-civil-du-quebec-du-bas-canada-a-aujourd-hui/51-code-civil-du-bas-canada.

[132] *Nancy B*, *op. cit*. at para 33.

[133] *Ibid* at para 44.

[134] *Ibid* at para 61.

[135] See WHO definition in GOVERNMENT OF CANADA, "What is Health?", online: https://www.canada.ca/en/public-

now, the cases of *Nancy B* and *Malette* permit us to acknowledge that if the right to self determination and individual liberty are integral to a "right to health", then respecting individual health decisions may not always result in prioritizing individual physical well-being.

III.3. Does the Canadian Constitution Recognize a Right to Access to Safe Abortion Services Free of Criminal Constraints?

In Toronto in the 1980s, Dr. H Morgentaler and colleagues opened a clinic to offer abortion services to women who had not received a certificate of approval from a therapeutic abortion committee of an accredited hospital. At the time, such approval was required by s.251 of Canada's *Criminal Code*. Morgentaler was a Montreal-based reproductive freedom activist who had established abortion clinics across the country and had already unsuccessfully challenged criminal law prohibitions in the Supreme Court.[136] In this case, he was indicted for intent to procure an abortion in contravention of section 251. Morgentaler argued that the criminal code provision violated half a dozen Charter rights including equality, liberty, security of the person, freedom of conscience – all impinging women's rights to reproductive choices.

Three aspects of *R v Morgentaler* help explain its landmark impact on health as a human right jurisprudence. First, the court acknowledged abortion is a divisive societal issue – provoking national, international controversy and legal angst.[137] The court noted that while democratic legislatures have a primary role in addressing such matters, Canada's recent adoption of the *Charter of Right & Freedoms* clothes the court with new, paramount duties:

FRAME 14

SCC, 1988, R v Morgentaler, p. 46

Although no doubt it is still fair to say that courts are not the appropriate forum for articulating complex and controversial programmes of public policy, Canadian courts are now charged with the crucial obligation of ensuring that the legislative initiatives pursued by our Parliament and legislatures conform to the democratic values expressed in the Canadian Charter of Rights and Freedoms.[138]

In other words, interpreting and applying the Charter obliged the Court sometimes directly to address controverted health and human rights issues of the day.

Second, the Court recognized that a criminal ban and sanctions on particular medical procedures may place citizen-patients and their health professionals before an unconscionable, tragic choice: respect the criminal law or pursue sanctionable treatment for one's health.

Third, despite the intuitive option of basing its analysis on the discriminatory impact of abortion obstacles on women, the Court concluded that because the criminal law barriers significantly impacted health, they engage women's right to "security of the person" that section 7 of the Charter requires government to respect. Section 7 has both substantive and procedural interests. Section 251 inflicted substantive harms by: (i) infringing women's bodily integrity; (ii) significantly increasing physical risks to health or life; (iii) and harming psychological integrity or mental health:

health/services/health-promotion/population-health/population-health-approach/what-is-health.html.

136 *R. v. Morgentaler, 1988, CanLII 90 (SCC), [1988], 1 SCR 30*, *op. cit.*

137 *Ibid* at p. 158.

138 *Ibid* at p. 46.

FRAME 15

SCC, 1988, R v Morgentaler, abstracts pp. 56-60 and p. 90

(…) State interference with bodily integrity and serious state-imposed psychological stress, at least in the criminal law context, constitutes a breach of security of person. …Not only does the removal a decision-making power threaten women in a physical sense; the indecision of knowing whether an abortion will be granted inflicts emotional stress (...).[139]

Security of person must include a right of access to medical treatment for a condition representing a danger to life or health with fear of criminal sanction.[140]

The Court was persuaded by documented scientific evidence on the harms and flaws imposed. Only a minority of Canadian hospitals had functional therapeutic abortion committees. Few could be reasonably staffed in conformity with statutory requirements, and the legislative, procedural and operational standards for committee approval or denial of certificates were highly ambiguous. Geographical gaps and administrative delays imposed by the implementing regime effectively prevented meaningful access to local therapeutic abortion facilities and thus imposed financial, emotional and physical burdens on pregnant women. The delays increased the risk of post-operative complications and compelled some women to seek more dangerous abortion procedures.[141] The Court concluded that "all these problems with the procedure stipulated in s.251 … is "a failure to comply with principles of fundamental justice."[142] It struck down the section. A concurring opinion by the first female Justice of Canada's Supreme Court found that the therapeutic abortion committee regime also unjustifiably infringed women's liberty and freedom of conscience.

Morgentaler has become a cultural icon for women's reproductive autonomy and reproductive health. Its affirmation that the right to security of the person "protects the physical and mental integrity of the person"[143] would emerge, in the next decades, as a leading source of an emerging constitutional right to health in other landmark cases of accessing controverted, morally divisive health services.

III.4. Do Those with Severe Hearing Impairment Have a Constitutional Right to Sign Language Interpretation Services to Access Hospital Care?

In *Eldridge v British Columbia (Attorney General)*,[144] the two patients who brought the case before the SCC were deaf. For years, they had enjoyed access to their local hospital and doctors in Vancouver through the sign language interpretation services that were funded by a non-profit community agency. When that funding stopped, the non-profit and the patients sought continued interpretation services under provincial health insurance laws. But the implementing authority for the provincial *Hospital Insurance Act* and the *Medical and Health Care Services Act* had decided not to fund sign language services in the health care setting. The

139 *Ibid* at paras 56-60.

140 *Ibid* at para 90.

141 *Ibid* at para 101.

142 *Ibid* at para 33.

143 *Ibid* at para 37.

144 *Eldridge v British Columbia (Attorney General)*, [1997] 3 SCR 624.

patients turned to the courts seeking declarative and injunctive relief, arguing that the funding decision violated their Charter equality rights to accessing health services.

The Supreme Court of Canada ruled that the effective exclusion of deaf patients from provincial health and hospital insurance coverage unjustifiably discriminates on the basis of disability, in contravention of the Charter's section 15 equality protections. It found that both hospitals and the implementing authority for the provincial insurance plans are subject to the Charter as they implement specific governmental functions and services. It accepted evidence that the absence of interpreters impairs deaf persons' ability to communicate effectively with health care providers, undermines their needs for informed consent and *"thus increases the risk of misdiagnosis and ineffective treatment (…). This risk is particularly acute in emergency situations."* (paras. 5, 69) The Court had little difficulty qualifying this as a case of adverse effects discrimination:

FRAME 16

SCC, 1997, Eldridge v British Columbia (Attorney General), para 80

In my view, therefore, the failure of the Medical Services Commission and hospitals to provide sign language interpretation where it is necessary for effective communication constitutes a prima facie violation of the s. 15(1) rights of deaf persons. This failure denies them the equal benefit of the law and discriminates against them in comparison with hearing persons. [145]

Once a violation of equality rights is found, the government has the onus, under section one of the Charter, to show the discrimination is "demonstrably justified in a free and democratic society". Applying the tests for doing so, the court was unpersuaded:

FRAME 17

SCC, 1997, Eldridge v British Columbia (Attorney General), para 84

Assuming without deciding that the decision not to fund medical interpretation services for the deaf constitutes a limit "prescribed by law", that the objective of this decision controlling health care expenditures — is "pressing and substantial", and that the decision is "rationally connected" to the objective, I find that it does not constitute a "minimum impairment". [146]

The Charter remedy, the court concluded, was to declare the funding failure unconstitutional and to direct the province to provide funding and services consistent with section 15. The court suspended application of the declaration for six months for the government to assess and implement an effective option.

An open question since *Eldridge* is how broad and deep does its logic or holding reach. In other words, when should Charter equality principles alter provincial health insurance non-coverage decisions to command funding? A more recent equality decision by the SCC left undisturbed a provincial decision not to fund applied behavioral therapy for autism.[147] The decisions need to be coherently reconciled to guide future equality jurisprudence involving health insurance or health service coverage.

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[145] *Ibid* at para 80.

[146] *Ibid* at para 84.

[147] *Auton (Guardian ad litem of) v British Columbia (Attorney General)*, 2004 SCC 78.

III.5. Do Patients Have a Constitutionally Protected Right of Privacy in Bodily Fluids

Shortly after the Canadian Charter took effect, the Supreme Court of Canada had the opportunity to respond to this question in a landmark decision, *R v Dyment*.[148]

The case arose following a single car accident after the vehicle left the highway in the Maritimes. The unconscious passenger of the car was transported to the hospital for emergency medical treatment. Without authorizing legislation or a judicial warrant, the investigating constable received a sample of the blood that had been drawn for medical purposes. The hospital shared the blood sample without the knowledge or consent of the patient, and the forensic blood tests revealed a criminally high level of blood alcohol. The patient was convicted of impaired driving. Afterwards, he moved to suppress the evidence arguing that his bodily fluids had been unlawfully used in violation of the Charter.

The Supreme Court of Canada agreed. It concluded that section 8 Charter protections against "unreasonable searches and seizures" extend to one's bodily fluids. While the concurring majority opinions agreed that privacy was violated by unreasonable search or seizure, Justice La Forest's opinion deconstructed the dignitary interest of privacy for the modern age. He drew on a then recent government report that touched on privacy needs, standards, and rights both traditionally and through the computer age. Conceptually, privacy law, he noted, may protect three zones: territorial/spatial, personal, and informational privacy.

FRAME 18

SCC, 1988, R v Dyment, para 22

Finally, there is privacy in relation to information. This too is based on the notion of the dignity and integrity of the individual (...). In modern society, especially, retention of information about oneself is extremely important. We may, for one reason or another, wish or be compelled to reveal such information, but situations abound where the reasonable expectations of the individual that the information shall remain confidential to the persons to whom, and restricted to the purposes for which it is divulged, must be protected.[149]

All three zones of privacy were implicated by the search and seizure in the case. For example, non-consensual taking of one's blood invades one's physical person as "a serious violation of the sanctity of a person's body". Information privacy too was infringed: "the use of a person's body without his consent to obtain information about him, invades an area of personal privacy essential to the maintenance of human dignity."[150] The patient was entitled to a reasonable expectation of privacy in his blood that was entrusted to the hospital for one purpose and used without authorization, compelling circumstances, or consent for another purpose. Citizens' reasonable expectations of privacy in one's bodily fluids implicate ethic0-legal issues regarding one's genetic, HIV, controlled substance, viral or health status and associated stigmatization, discrimination or adverse treatment. Such issues echo those explored in 1976 by a WHO working group on Health and Human Rights as it reflected on need for re-visioning human privacy in the hospital and in society amidst the computer and data sharing revolutions. The contours of a right to health information privacy are explored below, in section IV.2.6.

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148 *R v Dyment*, [1988] 2 SCR 417.

149 *Ibid* at para 22.

150 *Ibid* at para 27.

III.6. Do prisoners with mental illness have a Constitutional right to be free from solitary confinment?

In 2019, the question of whether the Canadian Charter limits or enjoins prison use of solitary confinement came before the Supreme Court of Canada. One prominent issue concerns the heightened vulnerability of persons with a disability or mental illness to the harms of solitary confinement. Two provincial Courts of Appeal had recently answered the above question affirmatively. Those cases were granted leave to appeal by the SCC in 2020. However, in an unusual procedural coup de theatre several months later, the appeals were discontinued. Thus, SCC review of the question awaits another day.

Meanwhile, the reasoning from the Courts of Appeal suggests that Canada's constitution likely forbids indefinite or prolonged solitary confinement for prisoners. The courts relied on different principles of the Charter to reach similar conclusions. In 2019, the Court of Appeal of British Columbia concluded that solitary confinement may contravene section 7 of the Charter.[151] The Court found that forced prolonged or indefinite solitary confinement deprives federally incarcerated inmates of "life, liberty and security of the person" in a manner that is so "grossly disproportionate to the objectives of the law that it offends the fundamental norms of a free and democratic society."[152]

The same year, the Ontario Court of Appeal concluded that prolonged and indefinite solitary confinement inflicts on prisoners "cruel and unusual treatment or punishment" contrary to section 12 of the Charter.[153] Such solitary confinement, it found, "causes foreseeable and expected harm which may be permanent, and which cannot be detected through monitoring until it has already occurred."[154] Both courts deemed the authorizing legislation defective for failing to provide independent review of the decision to place an inmate in solitary confinement. Both courts thus struck down the offending provisions of Canada's *Corrections and Conditional Release Act*.[155] Both courts interpreted the *Charter* infringements in light of extensive evidence of harms documented through international studies, recommendations and norms, like the UN's Nelson Mandela Rules.[156] Based on decades of interdisciplinary research and analysis, the Mandela Rules restrict solitary confinement to short times for strictly exceptional cases, and ban its use for vulnerable populations, such as children and adults with mental illness or physical disabilities.

In June 2019, in response to the Courts of Appeal rulings, the Government of Canada legislated reforms to the legislation that had been struck down.[157] In 2021, another Ontario Court of Appeal judgment upheld a $30 million damage award against a government prison in part for previous prolonged use of solitary confinement that violated sections 7 and 12 of the Charter for inmates with serious pre-existing psychiatric illness. The prison had routinely placed in solitary confinement inmates with mental health or suicide alerts, and for years had no policy

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151 *British Civil Liberties Association v Canada (Attorney General)*, 2019 BCCA 228.

152 *Ibid* at para 167.

153 *Canadian Civil Liberties Association v Canada (Attorney General)*, 2018 ONCA 1038.

154 *Ibid* at para 5.

155 *CCRA*, *op. cit.*

156 United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) UNGAOR, 70th Sess., UN Doc A/Res/70/175 (2015), online (pdf): *OHCHR* https://www.ohchr.org/sites/default/files/Documents/ProfessionalInterest/NelsonMandelaRules.pdf.

157 Bill C-83, *An Act to amend the Corrections and Conditional Release Act and another Act*, SC 2019, c 27.

requiring assessment of such inmates' mental wellbeing by a "physician, psychiatrist or other mental health worker."[158]

III.7. Does the Charter Right to Life, Liberty & Security of Person Provide a Constitutional Right to Treatment? A Quintet of Cases

As Canada nears the fourth decade of its adoption of the Canadian Charter, the question of whether it affords a constitutional right to therapeutic treatment remains open. On the basis of the following cases, some may argue yes; some will argue no. Still, following the reasoning of *Morgentaler*, a quintet of landmark cases has incrementally offered contextually affirmative answers to the discrete health access questions presented. The questions all reached the highest courts of Canada; most before the SCC. Through them, the Court has repeatedly affirmed that governments cannot unjustifiably interfere with access to necessary health services in ways that undermine the Charter's section 7 rights to life, liberty or security of the person (RLLSP).

As with *Morgentaler*, most cases in the quintet involved criminal law prohibitions preventing or limiting therapeutic access to medically necessary care or health services. Such bans compel citizens towards an unconscionable choice: respect the criminal law, or pursue one's best health interests. The bans may thus (i) infringe decisional autonomy and free and informed consent about health and bodily integrity; (ii) increase or aggravate risks to life, physical or mental integrity, and (iii) involve state-imposed psychological suffering.

As with *Morgentaler*, most of the quintet of cases swept aside criminal prohibitions barring access to sometimes controversial treatments or health services. *Morgentaler* involved health services to terminate pregnancy. These cases involved accessing end-of-life care in the form of medically assisted death, innovative substance abuse health services, self-use of medical marijuana.

On the latter, RLLSP issues arose from bans on the medical use of marijuana. In ***R. v Parker***,[159] the question before the Ontario Court of Appeal was: does the blanket prohibition on the possession and cultivation of illegal drugs in the federal *Controlled Drugs and Substances Act* (CDSA) violate the Charter RLLSP of citizens who use marijuana for medical purposes?

Following two childhood head injuries, plaintiff Parker had suffered severe epilepsy for 40 years with serious, frequent and "potentially life threatening" seizures unabated by brain surgery and conventional medications. The seizures sometimes left him unconscious, and he was hospitalized more than 100 times for seizure-related injuries. His physician advised Parker to discontinue some of his conventional medications because of their severe side effects. The physician also recommended, as medically necessary for "optimal seizure control," the regular use of marijuana in conjunction with some prescription medication. The advice was based partly on Parker's initial experience with the recreational use of marijuana and then more regular documented medical use over the years. With daily use of marijuana, Parker experienced no or few seizures. Without use, within three days Parker experienced 3-5 grand mal seizures and other seizures each day. (para.27). An independent study had also confirmed a marked decrease in frequency and hospitalization for patients using medical marijuana. (para. 35) Parker was prosecuted and convicted for illegal cultivation and possession of a prohibited substance under the CDSA federal narcotic and controlled substance law.

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158 *Francis v Ontario*, 2021 ONCA 197. See also *Brazeau*, *op. cit*.

159 *R v Parker*, 49 OR (3d) 481 (ONCA).

The highest court of Ontario found that Parker's conviction and the blanket ban on medical use of marijuana infringed his LLSP rights. Relying partly on *Morgentaler*, the Court found the ban seriously infringed Parker's "liberty" interest with the threat of prosecution and prison, as liberty protects *"the right to make decisions of fundamental personal importance"* such as in this instance *"the choice of medication to alleviate effects of illness with life threatening consequences."* (para.92). The Court also found that the ban infringes security of the person, which protects the right to make choices concerning one's body and control of one's physical and psychological integrity free from the interference by criminal prohibition (para. 110). The ban was ill justified: it swept too broadly to include those who required medical marijuana to preserve health; and it did little to advance the goals of the CDSA (para. 144).The Court struck down the blanket prohibition, suspended its invalidation for 12 months to allow Parliament to make amendments, and exempted Parker from the prohibition.

In response to *Parker*, in 2001, Canada amended the CDSA to adopt *Medical Marijuana Medical Access Regulations*. The amendments provided some restricted medical access to marijuana while prohibiting the possession or cultivation of non-dried forms of it. Over a decade after *Parker*, the latter ban was challenged. In ***R v Smith***[160], the SCC drew on both *Parker* and *Morgentaler* to invalidate the ban: it infringed liberty and security of person by its threat of imprisonment, by foreclosing reasonable medical choices, and by forcing medical users to choose between legal but inadequate treatment or illegal but effective treatment. The Court found the infringement unjustified: it was deemed arbitrary and inconsistent with principles of fundamental justice, contradictory and disserving of the goal of protecting public health and safety. For instance, it forced medical users to assume the greater risks of smoking dried marijuana rather than allowing them to ingest it.

In ***Canada v PHS Community Service Society***,[161] the Supreme Court of Canada relied on similar reasoning to mandate the continued operation of the most effective supervised drug injection therapy clinic in North America. Drawing on medical literature and decades of European experience, PHS had established the Insite clinic in 2003 as part of a harm reduction pilot project to address rampant addiction and overdoses and to contain hepatitis and HIV spread by infected needles on the Lower East Side of Vancouver. The astronomic deaths and illness in the neighbourhood had prompted authorities to declare public health crises in the 1990s.

Insite had innovatively moved away from traditional abstinence theory towards a harm reduction approach. It controversially provided those with addiction a safe, clean facility site where they could inject drugs under medical supervision without fear of arrest and prosecution. Insite operated 24 hours per day with nurses, counsellors, and support staff. Reviewing the evidence, the Court noted, the "experiment has proven successful. Insite has saved lives and improved health." (para. 19) To enable the experiment from 2003-2008, local, provincial and federal authorities had innovated a supportive legal framework whereby Insite was granted a medical or scientific exemption from the criminal prohibitions on possession and trafficking of illegal drugs under the federal *CDSA*. The Act empowers the Minister of Health to issue exemptions. When the exemption was not renewed by a new federal government, PHS challenged the denial as an infringement of Charter Rights.

The SCC agreed. The Court found that the failure to grant the exemption infringes section 7 Charter rights to life, liberty and security of person not in accordance with principles of fundamental justice. The prohibition impacts access to effective health services. The ban on possession, for example, compromises the professional liberty interests of Insite staff by

[160] *R v Smith*, 2015 SCC 34.

[161] *Canada (Attorney General) v PHS Community Services Society*, [2011] 3 SCR 134.

disabling them from providing medical supervision and counselling to clients. The ban on possession, in turn, disables clients from accessing and using Insite's "lifesaving and health-protecting services;" depriving them of potentially lifesaving medical care, thus engaging their rights to life and security of the person. Clients' rights are further compromised because the ban increases clients' morbidity and mortality risks by denying access to clean equipment and more sanitary injection practices, and effective addiction health services:

FRAME 19

SCC, 2011, Canada (Attorney General) v PHS Community Services Society, para 93

Where law creates a risk to health by preventing access to health care, a deprivation of the right to security of person is made out.[162]

The Court found the transgressions inconsistent with principles of fundamental justice. It deemed the denial of the exemption arbitrary and grossly disproportionate. As the Court explained, the latter means a governmental response to a problem is *"so extreme as to be disproportionate to any legitimate government interest (…): Insite saves lives. Its benefits have been proven (...). The effect of denying the services of Insite to the population it serves is grossly disproportionate to any benefit that Canada might derive from presenting a uniform stance on the possession of narcotics."* (para. 133) The Court mandated the federal Minister of Health to grant the exemption.

A few years after the Insite decision, the SCC drew on more than a quarter century of section 7 Charter jurisprudence to decide a landmark judgment on physician assisted dying (PAD) in ***Carter v Canada***.[163] The case had been brought by a number of organizations and suffering, seriously ill patients, including one who eventually journeyed to Switzerland for physician assisted dying.

The Court framed the citizen's and societal dilemma:

FRAME 20

***SCC, 2015, Carter v Canada (Attorney General)*, para 1**

It is a crime in Canada to assist another person in ending her own life. As a result, people who are grievously and irremediably ill cannot seek a physician's assistance in dying and may be condemned to a life of severe and intolerable suffering. A person facing this prospect has two options: she can take her own life prematurely, often by violent or dangerous means, or she can suffer until she dies from natural causes. The choice is cruel.

The question before the Court was: does the blanket criminal law prohibition on assisted suicide unjustifiably infringe the right to life, liberty, and security of the person? Two decades before, in the narrow 5-4 decision of *Rodriguez v Canada*,[164] the Court recognized the infringement of security of person; however, it had upheld the prohibition as an infringement justified by overriding concerns for the sanctity of life, protection of the vulnerable from abuse, and the morass of legal, moral and policy uncertainty on how to erect a more accommodating regime for medical assistance in dying. In *Carter*, the Court also found that the ban infringes Charter rights. For instance, the Court noted that the right to life is engaged where law imposes an increased risk of death; (para. 62) it agreed with the lower court that the ban may

[162] *Ibid*, para 93.

[163] *Carter v Canada (Attorney General)*, 2015 SCC 5.

[164] *Rodriguez v British Columbia*, [1993] 3 SCR 519.

deprive individuals of life, by inducing some to end their lives prematurely, for fear that they would become incapable of doing so when further disabled or when suffering becomes intolerable (para 57-58). Moreover, the ban infringed other dignity rights of the person:

FRAME 21

***SCC, 2015, Carter v Canada (Attorney General),* para 66**

An individual's response to a grievous and irremediable medical condition is a matter critical to their dignity and autonomy. The law allows people in this situation to request palliative sedation, refuse artificial nutrition and hydration, or request the removal of life-sustaining medical equipment, but denies them the right to request a physician's assistance in dying. This interferes with their ability to make decisions concerning their bodily integrity and medical care and thus entrenches on liberty. And, by leaving people like Ms. Taylor to endure intolerable suffering, it impinges on their security of the person.

If the broader findings of infringements parallel those in the *Rodriguez* case over 20 years before, the Court distinguished that prior reasoning by finding the infringement inconsistent with principles of fundamental justice (s.7) and unjustified (s.1). The fundamental justice inquiry of section 7 and the overbreadth analysis of section 1, respectively require that infringing legislation be neither "arbitrary" nor "overbroad." Because the blanket ban is rationally connected to a goal of protecting vulnerable patients, it was not arbitrary. But, the Court reasoned, it suffered over-breadth by protecting those who are not vulnerable, such as competent, fully informed patients who are free from duress or coercion. (para. 86). Furthermore, the blanket prohibition did not meet the section 1 "minimum impairment" of rights requirement that obliges government to show no less drastic means will achieve its legislative goal of protecting the vulnerable. The SCC agreed with the trial court finding that the risks associated with physician assisted death can be limited and reasonably managed by less drastic infringements with a more permissive regime built with strict procedural safeguards, informed consent standards, routine professional assessment of decisional capacity, etc. (para. 115-117). The trial court based its findings on extensive evidence of the legal intricacies, workings, risk-benefit analyses, and interdisciplinary data on physician assisted death experienced over the last decades in select European nations.

The Court thus held that the Canadian Criminal Code's absolute prohibition on physician assisted death unjustifiably infringes the right to life, liberty and security of the person in a manner not in accordance with the principles of fundamental justice. The provision was invalidated "to the extent that it prohibits physician-assisted death for a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes enduring suffering that is intolerable to the individual in the circumstances of his or her condition." (para. 127)

The Court struck down the provision and suspended its invalidation for 12 months, to afford the government an opportunity to undertake legislative reforms consistent with the opinion. The legislative reforms are discussed in section IV.2.4., below.

Of the quintet of landmark RLLSP cases expressive of a right to health over the last decades, ***Chaoulli & Zeliotis v Quebec***[165] does not involve criminal law barriers to controversial health services. Rather, it concerned access to medical care restricted by Quebec public health insurance laws that prohibited governmental reimbursement of health care services procured in the private sector, if those services were available in the public system. The law parallels

[165] *Jacques Chaoulli and George Zeliotis v Quebec (Attorney General),* 2005 SCC 35.

conditions stipulated by the *Canada Health Act* for provision of federal funds to provincial health insurance plans (see section II.2, above). The plaintiffs argued that Quebec's resulting waiting lists for accessing some publicly insured health treatments seriously compromised patients' health, including risks of death. Said otherwise, they claimed the legal ban prevents ill patients on public waiting lists from seeking available private care, thus aggravating their health conditions.

The question before the SCC was: is it a violation of the Canadian Charter's protections of RLLSP – and the Quebec Charter equivalent – to prohibit private insurance for health care, when the result subjects patients to longer treatment delays with resultant risks of physical and psychological harm?

The Court responded with a qualified yes in a fractured, narrowly decided judgment. Three justices replied no. Three justices replied yes, under the both the Canadian and Quebec Charter. A fourth justice, in the plurality majority, replied yes under the Quebec Charter. In other words, four justices agreed the law unjustifiably infringed the *Quebec Charter*.

Drawing on *Morgentaler* – which ruled that state-occasioned therapeutic delays that impact physical and mental health may infringe federal Charter rights – the Court found that the health risks from the waiting list delays – some patients with cardiovascular illness may die awaiting surgery; mortality risks increase less than 1% per month – infringe the right to life and security of the person. (paras. 37, 43). The Court applied the Canadian Charter jurisprudence to the Quebec Charter's parallel protection of "personal inviolability." Inviolability, the Court noted, is "a very broad right," broader than the word "security," and similarly encompasses physical and mental inviolability (para.41). The majority concluded that the government had failed to justify the ban on private insurance as minimally impairing of a patient's right to security of person/inviolability, given international evidence of a wide range of less drastic measures available to preserve the quality and viability of the public health care system. (paras 81-84; 126-31). Three of the four majority justices deemed the government ban "arbitrary" and not in accordance with principles of fundamental justice. The majority thus found an unjustified infringement of the Quebec Charter.

It is noteworthy that three of the four majority justices also agreed that the Canadian Charter "does not confer a freestanding constitutional right to health care." (para 104). The *Chaouli* case has inspired ample commentary and subsequent waiting lists litigation.

III.8. Canada's Emerging COVID Case Law: A Sampling

As of late 2021, few COVID legal cases had come before Canadian courts; even fewer had reached the high courts of Canada. By the Winter of 2022, significantly more cases were flowing into the courts. Still, Canada's relative "paucity" of high court cases contrasts significantly with nations like France, India and the United States, even though some of Canada's provincial and federal Covid public health measures have been amongst the strictest in North America.

Beyond the flow of cases, at least four other prominent features mark the landscape of Canada's Covid case law. First, a notable number of cases involve family law disputes between parents over diverse Covid issues and their children. For instance, in early 2020 the highest Court of Alberta applied the child best interests doctrine to resolve a conflict between divorced parents over the safety of their three children's travel to Brazil. The Court adopted the view that important risks of Covid contagion made it an imprudent time to travel there,

even though the children were fully vaccinated.[166] Similarly, in early 2022, the highest Court of Quebec affirmed lower court rulings that upheld – over the father's objections – a mother's substitute consent to vaccinating her 14 year old child against Covid. The courts ruled that given the incapacity of the child and the looming menace and risks from diverse Covid variants, the child's best interests supported vaccination.[167]

Second, many of the 2020-21 wave of cases involved requests for preliminary injunctions to enjoin governmental public health measures like mandatory masking, quarantine, or closures and limitations on gatherings, etc. Preliminary injunctions may serve to test a case before a full trial on the merits, meaning that some cases may be abandoned after the preliminary injunction phase, while others proceed to the full trial. To secure a preliminary injunction, one must show (i) there is a serious issue to be tried; (ii) without the injunction one will suffer irreparable harm; and (iii) the balance of convenience favours the party seeking the injunction.[168] It may be less difficult to establish the seriousness of the issue. But it proves more difficult to show irreparable harm and to prove that the balance of inconvenience weighs in favour of suspending or limiting health measures, given the unprecedented illness and deaths from the Covid pandemic crisis.

Thirdly, then, such challenges help explain why Canadian courts have tended to reject injunction requests from affected entities or citizens. Some courts have denied ones that seek to enjoin or modify public health orders. For instance, two unsuccessful cases involved parents or teachers seeking to modify government return-to-school Covid protocols by adding compulsory social distancing, mask wearing[169] or rapid covid testing.[170] More typically, courts have rejected injunctions that sought to enjoin Canada's border testing or quarantine requirements,[171] masking requirements in stores,[172] or mandatory vaccination documentation requirements for federal or federally-regulated workers[173] and for Quebec health care workers.[174]

In the latter Quebec case, for example, the Court concluded that government's reliance on public health emergency measures and employment proof of vaccination protocols to counter viral spread in the health sector of society was entitled to deference.[175] Similar court deference to public health expertise and interventions was expressed in a case upholding a British Columbia public health officer's order restricting gatherings and events in 2020-21. There, the court acknowledged that the public health orders curtailed religious gatherings and thus infringed worshippers' religious freedoms. But the court found them justified under the Charter, as reasonable and proportional measures – limited in duration and regularly reassessed and revised as science evolves – necessary to address evolving risks:

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166 *Ferrari v Berezowsky*, 2022 ABCA 34.

167 *A c B*, 2022 QCCA 325.

168 *RJR-MacDonald Inc. v Canada (Attorney General)*, [1995] 3 SCR 199.

169 *Trest v British Columbia (Minister of Health)*, 2020 BCSC 1524.

170 *Fédération Autonome de l'Enseignement c Dubé*, 2021 QCCS 1506.

171 *Spencer*, *op. cit*. See also, *Monsanto v Canada (Health)*, 2020 FC 1053 and *Canadian Constitution Foundation v Attorney General of Canada*, 2021 ONSC 4744.

172 *Platania c Procureur Général du Québec*, 2021 QCCS 3627.

173 *Lavergne-Poitras v Canada (Attorney General)*, 2021 FC 1232; *Neri v Canada*, 2021 FC 1443.

174 *Lachance c Procureur général du Québec*, 2021 QCCS 4721.

175 *Ibid*.

FRAME 22

***Supreme Court of British Columbia, 2021, Beaudoin v British Columbia,* para 240**

The dangers that Dr. Henry's G&E [gathering & event] Orders were attempting to address were the risk of accelerated transmission of the Virus, protecting the vulnerable, and maintaining the integrity of the healthcare system. Her decision was made in the face of significant uncertainty and required highly specialized medical and scientific expertise. The respondents submit, and I agree, that this is the type of situation that calls for a considerable level of deference (…).[176]

A parallel Quebec case on religious gatherings similarly found that the provincial restrictions infringed religious freedoms. But the Court accorded less deference. The Court let stand much of the order, but modified the restriction on the number of people who could gather. It did so, based in part on ambiguity in the order and partly because the court ruling modifying the order was more accommodating and proportional.[177] The logical effect of the judgment was that government had failed to show the necessity of more restrictive measures.

Finally, as suggested by the latter case, successful challenges to public health measures need to discredit the scope, necessity, or proportionality of Covid mitigation measures with compelling evidence of significant harms to Charter rights. The onus for justifying Charter infringements remains on government. But the cases also indicate that if government has a choice between arguably less invasive Covid mitigation means in the face of high risks, evolving science and dynamic public health uncertainty, then courts tend to defer to the reasonable discretion of public health officials, unless necessity is undemonstrated. One of the courts to first uphold Canada's quarantine and testing requirements for international travelers against an injunction confirmed their necessity: "the challenged measures are a rational response to a real and imminent threat to public health, and any temporary suspension of them would inevitably reduce the effectiveness of this additional layer of protection."[178]

By contrast, a lack of necessity and proportionality was tragically illustrated in Montreal early in 2021. The first week of that year, Quebec imposed a 21h-5h evening curfew order that expired in May. Slightly a week after it took effect, on 17 January 2021, when the evening temperatures reached -5 to -7C, 51-year-old Raphael André was found frozen to death in an outside portable public toilet not far from a city homeless shelter. He was an itinerant Inuit. After his death, the Mayor of Montreal and the federal government called on Quebec to exempt homeless people from the curfew. The Prime Minister of Quebec refused. He argued that exemptions risk being abused: people might seek to impersonate the homeless as a way of skirting the curfew.[179] A legal clinic filed suit to enjoin the application of the curfew to persons in homeless situations. The Court found that the curfew caused grave, irreparable harms to people in homeless situations by adversely and disproportionally discriminating against them; it further concluded that the curfew infringed the life, liberty and security of persons in homeless situations contrary to the Canadian and Quebec Charters. On the balance of conveniences, the court reasoned that exempting itinerants from the curfew would not undermine public health but would abate Charter infringements. It suspended the curfew for them.[180]

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176 *Beaudoin v British Columbia,* 2021 BCSC 512, para 240.

177 *Conseil des juifs hassidiques du Québec c Procureur général du Québec,* 2021 QCCS 281.

178 *Spencer*, *op. cit.* at para 114.

179 DUCAS, I.: "Legault refuse d'exempter les itinerants" *La Presse* (19 January 2021), online: https://www.lapresse.ca/covid-19/2021-01-19/couvre-feu/legault-refuse-d-exempter-les-itinerants.php.

180 *Clinique juridique itinérante c Procureur général du Québec,* 2021 QCCS 182.

Following such early court rulings in 2020-21—that regularly denied injunctions sought by individuals or institutions against the early wave of governmental public health orders—by late 2021-early 2022, a second wave of injunctions had also begun to emerge in Canada. The second wave notably flowed from government. It involved public health officers seeking to enforce Covid mitigation measures against those non-compliant with or defying public health orders. In a few Ontario cases, for instance, courts granted governmental requests to enjoin the continued operation of entities or businesses that refused to adhere to Covid mitigation measures.[181] As such, one court concluded that there were reasonable and probable grounds—based on regional Covid counts and the scientific literature—for the public health officer to believe that enforcement of indoor masking and vaccine passport orders against a sports bar-restaurant were necessary to decrease imminent risks from the pandemic.[182] Similar cases are noted in the discussion of health rights and economic rights in section IV.2.3.

[181] See, e.g. *Piggott v Comber*, 2021 ONSC 7998; *Ontario v Old Colony Mennonite Church*, 2021 ONSC 4638.

[182] *Oglaza v J.A.K.K. Tuesdays Sports Pub Inc.*, 2021 ONSC 7701; aff'd *Hale v Oglaza*, 2022 CanLII 9122 (ON HSARB).

IV. The Concept of the Right to Health and its current and possible future limits

IV.1. The concept of right to health

This section discusses the concept, definition and content of a right to health from three legal perspectives: as part of modern international human rights law (section IV.1.1.); as a prism of rights sculpted on a pedestal of Canadian laws (section IV.1.2.) and; as illustrated in two case studies (section IV.1.3.).

IV.1.1. International Human Rights Law

In the three quarters of a century since the "right to health" was proclaimed both a fundamental right and universal aspiration of the international community, nations, scholars, advocates, institutions have sought to give substantive and actual content to it. The post-World War II order that created the United Nations included the notion in the founding of the specialized UN body on health, the World Health Organisation. In 1946, the preamble of the WHO constitution proclaimed that: "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." Framed as such, it would seem an egalitarian inalienable right of world citizens. Two years later, the Universal Declaration on Human Rights (UNDHR) proclaimed that: "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care…" In the UNDHR, the right commingles with the right to a standard of living. The association with socio-economic rights continued two decades later when the UN adopted the *International Convention on Social, Economic and Cultural Rights* of 1966 (ICESCR). Canada signed the Convention the same year. Article 12 of the ICESCR both reaffirms enjoyment *"of the right to the highest attainable health"* as a fundamental right, and specifies that ICESCR signatories agree to take steps necessary: (a) to improve infant-maternal health and child development, (b) to improve "environmental and industrial hygiene;" (c) for the prevention, treatment and control of epidemic, endemic, occupational and other diseases; and (d) to create "conditions which would assure to all medical service and medical attention in the event of sickness." The right thus covers broad domains, including corresponding governmental duties for the access and improvement of health care services for particular vulnerable populations. Over the decades, rights to health would be included in international human rights treaties such as *the International Convention on the Elimination of All Forms of Racial Discrimination* (1965),[183] the *Convention on the Elimination of All Forms of Discrimination Against Women* (1979)[184], *Convention on the Rights of the Child* (1989)[185], the *International Convention on the Protection of the Rights of all Migrant Workers and Members of their Families*

[183] Article 5(e)(iv) indicates nations agree to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right to equality before the law in the enjoyment of diverse rights, including economic, social, and cultural ones, like the: "The right to public health, medical care, social security and social services."

[184] Article 14 of the convention notes "[t]he right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction." And the right to "have access to adequate health care facilities, including information, counselling and services in family planning."

[185] Art. 24 provides that: "State Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services."

(1990),[186] *Council of Europe (Oviedo) Convention on Human Rights and Biomedicine (1999)*,[187] the *Convention on Rights of Persons with Disabilities* (2006).[188] Canada is a signatory to all of these treaties with the exception of the *Convention on Migrant Workers* and the *Oviedo Convention*. In 2000, a report of a specialized UN Committee reflected on some 50 years of progress on the right to health and considered it in light of the evolving interdisciplinary understanding of the parameters of health. The Committee distinguished a "right to be healthy" from a "right to health" that contains both freedoms and entitlements; it interpreted the right to health broadly:[189]

> *"The Committee interprets the right to health is an inclusive right, extending not only to timely and appropriate health care but also to the determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.*[190]*"*

The view grounds a broad right to health on associated rights to "determinants of health." Since such determinants range from accessing safe drinking water to health care, one may ask if all such health determinants are equal. Global diversity on various health-related conditions and resources suggest that national contexts will often define short and long-term needs and priorities. But the Covid pandemic reminds us that catastrophic global health events will sometimes define international and national urgencies and priorities. National responses to the pandemic also show that ready access to effective health care is a primary determinant of health. Unsurprisingly, then, a right to access health care services has regularly been included in modern human rights treaties noted above and consumes much of the international right to health literature.

Even this cursory review of the concept of the right to health expressed under international human rights instruments indicates important features. If the right to health would seem to lack a singular or uniform international definition of its elements, scope, and application, some may regard it as a vacuous, indeterminate right. But human rights in public international law are often expressed by principles and purposes that enable institutions and nations to interpret and apply them in context. As a fundamental freedom, the right to health may impose corresponding duties and confer health related entitlements. It may not be strictly confined to medical or health services domains, even if they underline pressing health care priorities. The right tends not to be narrowly defined. Indeed, when broadly conceived, its breadth implicates socio-economic and environmental rights. The right to health infuses and aligns with other universal fundamental freedoms and rights. It has thus become part and parcel of the modern human rights revolution that has unfolded since WWII.

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[186] Articles 28, 43 and 45 indicate migrant workers and their families shall have access to medical care, social and health services "on the basis of equality of treatment with nationals of the State involved."

[187] COUNCIL OF EUROPE (Oviedo), *Convention on Human Rights and Biomedicine, 1999*, art 3, online: https://www.coe.int/en/web/conventions/full-list?module=treaty-detail&treatynum=164 [Oviedo Convention].

[188] Article 25: "States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. States Parties shall take all appropriate measures to ensure access for persons with disabilities to health services….."

[189] UN COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS. General Comment No. 14: The Right to the Highest Attainable Standard of Health (article 12 of the International Covenant on Economic, Social and Cultural Rights.) Geneva, 2000, paras 8-9.

[190] *Ibid*, para 11.

IV.1.2. Canada's Evolving Right to Health

Against this international context, how do we characterize or understand the legal contours of Canada's right to health? Our foregoing review affords some five insights on Canada's experience.

First, our review indicates that the conceptual, definitional, and legal boundaries of Canada's right to health continue to unfold. In theory, a right to health may be individual or collective, positive or negative, explicit or implicit. It may be narrowly or broadly defined, construed or envisaged. Within such a spectrum, how is or should the right be defined? The research and analysis for this study primarily scanned leading Canadian constitutional and federal statutes, cases and legal sources, duties and standards that advance the dignitary right to the promotion and protection of human health. The analytical scope is inspired in part by international norms such as the UNDHR and WHO's broad definition of health, and its reference to the right to the highest standard of health in its founding Constitution.

Thus, our working understanding and definition does not confine a right to health to the right to health care. Doing so risks ignoring enlightening interdisciplinary thought, international treaties and standards to which Canada is bound, and would ill account for Canada's evolving health and human rights history and legal experience. For instance, if the right to health were narrowly understood to include only a universal right to health care, then Canada's Health Act of the mid-1980s might consume one's focus because the Act legislated universal health insurance coverage. A narrow focus on health care may also recognise the role that Canada's fundamental rights litigation under the Charter has played in vindicating rights to controversial health services, like abortion, medically assisted death, and addiction therapy. But a narrow focus may slight other Charter and landmark cases on the right to be free from involuntary treatment, the right to decline medically necessary care, or the right to health information privacy in and beyond the health care setting. An exclusive focus on medical or health care may also overlook the poignant health protection roles that public health laws played to prevent illness and save lives by containing cholera epidemics in the 19th century, HIV and SARS in the 20th century and the Covid pandemic in the 21st century. Even beyond concerns of reducing health to medical/health care, important legal premises endorse a broad conception of the right to health. For to promote human dignitary rights as part of the highest and most fundamental values of modern democracy, their interpretation is typically given a broad and purposive approach under Canadian law.

Secondly, Canada offers no sole, clear and authoritative legal source for the definition, scope, and application of a right to health. This insight and much of our analysis reposes on the intimate relation between legal rights, duties, and sources of law:

> *"From a legal perspective, a violation of rights normally entails a breach of some legal duty. Rights… are intimately related to corresponding legal duties. In other words, legal rights are made meaningful because of the rights-duties dynamic they impose on human relations…*
>
> *Recognizing the right-duties dynamic is also important when identifying, analyzing and interpreting sources of law. International legal instruments, national constitutions, statutes and court rulings are all standard sources of law. Such sources are the reservoir for defining the particular rights and duties at issue".*[191]

[191] JONES, D.J.: "Selected Legal Issues in Genetic Testing: Guidance from Human Rights", *Health Policy Working Papers, Health Canada*, Ottawa, 2001, vi and 77 pp., (pp. 7-8), online: https://publications.gc.ca/site/eng/9.558007/publication.html, discussing HOHFELD, W., "Fundamental Legal Conceptions as Applied in Juridical Reasoning" (1913) 23 *Yale Law Journal* 16.

The Canadian Constitution's textual silence on "health", and the Supreme Court of Canada's finding of no "free standing Charter right to health care", do not obscure the role of Charter jurisprudence as a leading driver and source of health-related human rights over the last four decades. (See sections II.3. and III.7., above.) Other legal sources inform the right to health.

Thirdly, then, the absence of a sole legal source for Canada's right to health means that the right flows from diverse, multiple legal sources. Canada's right to health is multi-sourced.

Indeed, a veritable constellation of related rights flow from diverse legal sources, to structure – like a crystal prism – different faces or facets of Canada's right to health. It is multifaceted. Visually, Canada's right to health may be seen as a prism of rights.

Fourthly, the different faces of the prism of rights have not emerged simultaneously, meaning that one face is not likely to be at the same stage as another in its evolution from concept or aspiration, toward full legal development with clear duties and standards. Some may still be aspirational.[192] Some enjoy wide recognition and application, grounded on diverse sources in statutory, constitutional law, common law, civil law. For example, our discussion in section IV.2.5, below, of the health related "right to physical integrity" indicates it is widely recognised in diverse legal sources and contexts. Other rights are inchoate or nascent. Still others are emerging. The latter may include the "right to a healthy environment." If the concept has yet to be recognized under the Canadian Charter,[193] it is expressed in the Quebec Charter[194] more likely as aspirational than justiciable. At the federal level, 2021-22 legislation proposes to include the "right to a healthy environment" in the *Canadian Environmental Protection Act*.[195] Moreover, following development of a federal statutory-regulatory framework on potable water in 2013,[196] the "right to safe-drinking water" has been endorsed in 2020 federal legislation regarding Indigenous people.[197] The right also forms the basis of an 8$ billion settlement, in 2021, between Canada and Indigenous communities following their class action lawsuit.[198] Such developments indicate that the faces of Canada's right to health are not static. They are dynamic, iterative, evolving.

Fifthly, the Canadian experience accords with a broad, multifaceted, dynamic right to health sculpted and structured on diverse fronts or faces over time by complementary and interactive synergistic dignitary rights. Dynamic and synergistic mean that faces of the right to health may emerge, interact, and reflect one another as the structure evolves through diverse contexts or eras. "Twinning" is a phenomenon that happens when one face of a prism crystal or gemstone develops and intersects or builds upon another and affects gemstone structure. Such phenomena apply to faces of the right to health. Some involve negative rights or freedoms that shield individuals from harm, such as a right to be free from cruel and unusual treatment or punishment. Some involve positive rights, such as a right to access health services. In

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192 E.g., on socio-economic dimensions, see SHEPPARD, C.: "'Bread and Roses': Economic Justice and Constitutional Rights", *Oñati Socio-Legal Series,* vol. 5, nº. 1, 2015, pp. 224-245, (p. 237).

193 BOYD, D.R.: "No Taps, No Toilets: First Nations and the Constitutional Right to Water in Canada", *McGill Law Journal,* vol. 57, nº. 1, 2011, online: https://lawjournal.mcgill.ca/article/no-taps-no-toilets-first-nations-and-the-constitutional-right-to-water-in-canada/.

194 BOYD, D.R., & MARFARLANE, E.: "SHOULD environmental RIGHTS BE IN THE CONSTITUTION?" *POLICY OPTIONS POLITIQUE* (MARCH 2014) ONLINE: *INSTITUTE FOR RESEARCH ON PUBLIC POLICY* HTTPS://POLICYOPTIONS.IRPP.ORG/FR/MAGAZINES/SECOND-REGARD/BOYD-MACFARLANE/.

195 Bill S-5, *An Act to Amend the Canadian Environmental Protection Act, 1999*, 1st Sess, 44th Parl, 2022 (first reading 9 February 2022).

196 See *Safe Drinking Water for First Nations Act*, SC 2013, c 21.

197 *UNDRIPA*, discussed above in section II.4.1.7.

198 *Tataskweyak Cree Nation et al. v Canada (A.G.)*, 2021 MBQB 276.

practice, some societal spaces and contexts entwine both positive and negative rights. For instance, the analysis in section II.4.1.4, above, indicates that the right to health of inmates in Canada implicates a positive statutory right to "essential health services." It is complemented by a negative right to be free from non-consensual treatment or research or injurious solitary confinement. (section III.6., above).

Frame 23, below, illustrates leading facets that structure and advance Canada's evolving right to health.

FRAME 23

Evolving Faces of Canada's Right to Health:
Synergistic, Correlative Dignity Rights

(Nota: + = a nascent or inchoate right likely to emerge or crystalize within the next decade)

Right to Universal Health Care	Right to a Safe Workplace
Right to Medical Care for Special Populations (e.g., minors, prisoners, veterans, Indigenous persons, institutionalized patients)	Right to be Free from Undue, Harmful State Barriers to Medically Necessary Therapies or Health Services
Right Not be Discriminated Against – on Basis of Health or Disability – in Employment, Education, Public Services	Right Not be Discriminated Against in Accessing Health Services
Right to be Free from Cruel & Unusual Treatment or Punishment	Right to Health Information Privacy & Confidentiality
Right to Physical & Mental Integrity	Right to Decline Treatment
Right to Health Protection: from communicable or inimical diseases, toxic or hazardous substances, adulterated or unsafe therapeutic products	Right to Participate in Health Science Progress & Benefits (e.g., access to established, emerging, experimental, life-saving scientific therapies)
Right to Free & Informed Consent in Health Services	Right to Healthy Environmental, including water, lands & air+
Right to Food+	Right to Housing+

As Frame 23 suggests, a broad robust, and meaningful right to health is derived and structured from a constellation of diverse, complementary and synergistic dignitary rights. For instance, Canada's waiting list litigation demonstrates that even citizens who enjoy a statutory right to universal health insurance are not thereby entitled in practice to prompt, effective access to medically necessary treatment. Charter rights to life, liberty and security may sometimes compel access. Yet, a right to treatment neither ensures a patient a right to free and informed consent, nor its corollary right to decline recommend treatment. These complementary facets of a robust right to health respectively protect autonomous decisions, and bodily and mental integrity. Other rights synergize the interplay between health care and public health. As diverse waves of the Covid pandemic have washed over Canada, its unprecedented wake has reminded citizens of the life-saving force and value of health protection rights, duties, and standards. Smart quarantine and public health laws protect citizens from inimical and lethal public infections. Smart federal drug and medical devices laws have enabled a right to safe, effective innovative therapy in Covid vaccines, diagnostic home tests, and hospital respirators.

IV.1.3. Case Studies: Children's Right to Health & the Right to Participate in Health Science Progress & Benefits

In conjunction with section IV.2. below, the following two case studies profile particular issues and facets of Canada's right to health.

IV.1.3.1 Case Study: Medical Neglect Law: Protecting a Child's "Right to Health"?

If the right to health imposes corresponding duties to protect the health and well-being of persons dependent on others, then Canadian medical neglect legislation is a relevant source of law.

Canada has enacted a legal infrastructure of complementary proactive and reactive child health protection legislation. The proactive regime is built on provincial child protection legislation. The reactive regime is built on Canada's federal criminal code that permits prosecution of parents, spouses, and others for failure to provide "necessities of life," including medically necessary care. Together, the regimes outline a rudimentary right not to have one's health or life endangered by neglect of special health protection duties owed, amongst others, by parents to children.

IV.1.3.1.a) Provincial Child Health Protection & Neglect Statutes

Every Canadian province and territory has enacted child protection legislation.[199] The statutes are intended to address acute circumstances when an act or omission of a person is likely to endanger a child's well-being such that the child is in need of protection. Common examples of endangerment include physical harm; danger of abuse, physical or emotional neglect; likelihood of sexual abuse; deprivation of necessary health care; being in the care of a person whose conduct endangers the child's life, health, or emotional well-being.[200]

Typically, the laws are intended to protect children's health, safety, and welfare through at least three avenues. First, they include within the meaning of a "child in need of protection," those under the age of 16 or 19 (depending on statutory definitions of a child) who are at risk of physical injury, medical neglect, or abuse. Medical neglect includes, for example, parental failure to seek medically necessary care or treatment. Secondly, the laws generally impose reporting duties on those who have reasonable grounds to suspect that a child is "in need of protection." The duty thus extends to health professionals, teachers, social workers, counsellors, police officers and like professionals regularly involved with children, the obligation to formally advise authorities of a child at risk. Third, such statutes establish specialized government authorities or entities called child protection agencies (CPAs) to discharge special duties under the Acts. CPAs intervene to evaluate the risk, process, and coordinate interdisciplinary support, remove the child from danger, help secure health interventions for children, etc. The existence of this legislative and administrative framework by no means ensures that child protection systems discharge their duties optimally, as indicated by recent formal inquiries into the deaths and abuse of children in families which were being monitored by local child protection agencies.[201]

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[199] MIKELBERG, D.: *Child and Youth Protection and Canadian Law*, 2nd ed, Emond Publishing, 2019, 378 pp.

[200] GOVERNMENT OF CANADA, "Provincial and Territorial Child Protection Legislation and Policy" (2018), online: https://www.canada.ca/en/public-health/services/publications/health-risks-safety/provincial-territorial-child-protection-legislation-policy-2018.html.

[201] See, *e.g.,* QUEBEC BUREAU DE CORONER (Me. G Kamel), *Rapport d'enquête concernant le décès de Rosalie Gagnon,* 2019-00263.

On another scale of tragic circumstances, one ethico-legal quandary that Canadian families, children, health professionals, hospitals, courts, and society periodically confront arises when a child from a Jehovah's Witness family refuses life-saving blood transfusions. Such are classic instances of potential medical neglect in the annals of child protection and human rights law. For instance, for a 9-year-old judged too young to consent, do parental autonomy and religious beliefs prevail, thus imperilling the health or life of the child? Or does the state obligation to protect children unable to protect themselves prevail, to preserve life and health? How should that conflict of rights and values be resolved for a 14–16-year adolescent whose maturity and decision-making capacity lies somewhere between the adult and the child of tender years? If the 9-year-old child is transfused even over parental objections, one might argue that a child's right to emergency or necessary health care is vindicated. One might also argue, counter-intuitively, that the "right to health" is vindicated when a competent 16-year-old accepts or rejects a medically recommended transfusion, so long as she does so strictly consistent with the requirements of free and informed consent. The latter view recognizes that an expansive understanding of a "right to health" sometimes may lead to less optimal medical outcomes, because the right arguably includes the primacy of individual autonomy consistent with the dignity of free human choice.

The Supreme Court of Canada has confronted such blood transfusion conundrums within child protection legislation regimes in recent decades. It has upheld regimes that are consistent with Canada's Charter of Rights and Freedoms and consonant with the *International Convention on the Rights of the Child*.[202]

IV.1.3.1.b) Criminal Medical Neglect for the Failure to Provide "Necessaries of Life"

Canada's Criminal Code exemplifies a reactive regime to neglect. It punishes medical and like neglect after it happens. The Code's "necessaries of life" provision provides as follows:

FRAME 24

Criminal Code, section 215

215(1) Everyone is under a legal duty

(a) as a parent, foster parent, guardian or head of a family, to provide necessaries of life for a child under the age of sixteen years;

(b) to provide necessaries of life to their spouse or common-law partner; and

(c) to provide necessaries of life to a person under his charge if that person

i. is unable, by reason of detention, age, illness, mental disorder, or other cause, to withdraw himself from that charge, and

ii. is unable to provide himself with necessaries of life.

Offence

(2) Every person commits an offence who, being under a legal duty within the meaning of subsection (1), fails without lawful excuse to perform that duty, if

(a) with respect to a duty imposed by paragraph (1)(a) or (b),

i. the person to whom the duty is owed is in destitute or necessitous circumstances, or

[202] See, e.g., *AC v Manitoba*, *op. cit*. Article 24 of the Convention recognizes the right of the child "to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation for health."

ii. the failure to perform the duty endangers the life of the person to whom the duty is owed, or causes or is likely to cause the health of that person to be endangered permanently; or

(b) with respect to a duty imposed by paragraph (1)(c), the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be injured permanently.

This provision of Canada's criminal code functions, in essence, partly as a standard that penalizes gravely harmful omissions of care that may be regarded as criminal child or elder abuse or neglect. As the Supreme Court of Canada has explained:

FRAME 25

SCC, 1993, R v Naglik, para 1

… [the section] makes the failure to fulfil the duty to provide necessaries an offense where 'the failure to perform the duty endangers the life of the person to whom the duty is owed or causes or is likely to cause the health of that person to be endangered permanently. It thus punishes a marked departure for the conduct of reasonably prudent parent in the circumstances where it [is] objectively foreseeable that the failure to provide necessaries of life would lead to a risk of danger to the life or a risk of permanent endangerment to...health of the child.[203]

Since this involves the criminal law, the offense requires the government to prove such elements as a "marked departure" from duties by a standard of proof of beyond a reasonable doubt.

So, what constitute "necessaries of life" whose deprivation risks permanently endangering health or life? For well over a century, Canadian courts have understood "necessaries of life" to include medicines and medical treatment.[204] An important line of such cases has thus involved severe illness or death of children allegedly due to parental failure to provide medically necessary, timely treatment of bacterial infection[205] acute anemia requiring blood transfusion,[206] acute diabetes requiring insulin,[207] life threatening diphtheria[208]. "Necessaries" extend beyond medical care to include adequate food, nutrition, and hygiene. For instance, several criminal elder abuse cases have involved those deprivations.[209]

IV.1.3.2 Case Study: A Right to Participate in Health Science Progress & Benefits?

FRAME 26

Universal Declaration of Human Rights, 1948, art. 27, para 1

1. Everyone has the right freely to participate in the cultural life of the community, to enjoy the arts and to share in scientific advancement and its benefits.

As the quote indicates, the right to participate in scientific advancements was proclaimed a universal human right in the post WWII international documents developed around the

203 *R v Naglik*, [1993] 3 SCR 122., para 1.

204 See *The King v Lewis*, 1903 CanLII 112 (ON CA).

205 *R v Stephan*, 2021 ABCA 82.

206 *R v Cyrenne*, 1981 CanLII 3147 (ON SC).

207 *R v Tutton*, [1989] 1 SCR 1392.

208 LEWIS, *op. cit.*

209 ROMANA, L.: "Elder Abuse: Failing to Provide the Necessaries of Life to Older Adults is a Crime" *Advocacy Centre for the Elderly's Newsletter* (Fall 2009), online: http://www.advocacycentreelderly.org/appimages/file/Failing%20to%20Provide%20the%20Necessaries%20of%20Life%20is%20a%20Crime.pdf.

establishment of the United Nations in 1948. Two decades later, the right to participate was enshrined in the *International Covenant on Economic, Social and Cultural Rights*. Under article 15, nations *"recognize the right of everyone to enjoy the benefits of scientific progress and its applications."*[210]

Are those international standards and declarations reflected in a right to health in Canada?

To begin to answer the question, we may ask what a right to share in scientific advancement and benefits means? Does "sharing in scientific advancement" equal "enjoying the benefits of scientific progress"? One the one hand, they may be seen as equivalent: sharing the benefits of scientific progress by consuming the outputs of scientific/technological developments. On the other hand, the textual differences may highlight differences in the scope and roles of how to share. For instance, might citizens also share in "scientific advancement" through non-consumptive roles: *e.g.*, (i) sharing in the financing of research; (ii) volunteering in or conducting research projects; (iii) debating, prioritizing, evaluating and even deciding the content of the scientific research agenda or individual research projects? These latter roles underscore citizen participatory rights in the research, development and diffusion of science. The spectrum of roles one may enjoy under a right to participate in scientific progress ranges from health consumerism to democratic citizen participation in the frontiers of science.

If sharing in scientific advancement is conceived broadly, then dimensions of the right to participate have some legal grounding in Canada. Four examples illustrate how.

First, and most conspicuous, access to the fruits of scientific progress have been illustrated in two of Canada's pandemic crises that have spanned almost four decades. Shortly after the discovery of HIV in the early 1980s, the average life span of persons living with AIDS was about one year. Today, those living with HIV in North America largely live a normal life span. A major contributor to the difference of living with chronic viral infection lies in its advanced management via a sequence of HIV therapies that accelerated after the first antiretroviral drug discoveries. Following clinical trials in the late 1980s, AZT was licensed in early 1991 by Health Canada as the first drug to treat HIV infection. Based on ground-breaking research by Montreal scientists on the companion drug 3Tc, safer and more effective triple drug therapy for HIV became standard therapy in the mid-1990s. The fact that after those medical triumphs three decades of research have yet to yield a vaccine to prevent HIV/AIDS attest to the lightening time in which vaccines were developed for the Covid pandemic. As section I.1.2.2 .indicates, 3 of 4 Canadians have been fully vaccinated.

Such de facto access to Covid vaccines or breakthrough HIV treatments, however, does not indicate a legal right to them. In both pandemics, for example, prison inmates encountered barriers to accessing innovative treatment. The section II analysis, above, indicates that Canadian inmates may turn to a statutory right to essential medical care and a constitutional right to be free from cruel and unusual treatment as a legal basis to access such treatments. In other words, other correlative rights in the universe of the right to health may buttress and help implement the right to participation in the fruits scientific advances.

A second dimension of a right to participate in scientific progress is illustrated by a question. Does a right to health include or confer a right to experimental drug treatments or therapies? Exigent and tragic medical circumstances may make for a compelling moral right. The circumstances may arise for a particular patient. For example, one afflicted with a rare

[210] "General discussion on a draft general comment on article 15 of the ICESCR: on the right to enjoy the benefits of scientific progress" (9 October 2018), online: *OHCHR* https://www.ohchr.org/EN/HRBodies/CESCR/Pages/Discussion2018.aspx.

condition who has no or few effective treatments might claim a need and right to access a promising research drug with early positive results. The need may also arise for groups, as recent and historic examples illustrate. In the autumn of 2021, some parents of school-aged children, then ineligible for Covid vaccines in North America, sought to enrol them in paediatric clinical research trials being conducted. One desperate parent succeeded in enrolling two of her three children, aged 8 and 5, in two of the 8,000 plus slots that were soon filled in the Pfizer and Moderna trials.[211] Similar and associated claims for access poignantly arose during the early days of the HIV/AIDS pandemic, in the late 1980s. The absence of a treatment in the throes of the deadly HIV virus placed high-risk populations at risk of perishing. That high peril essentially meant that to avoid hopeless death and to benefit from public science, clinical trials for HIV treatment offered hope. HIV activists argued, and dramatically protested, for access to the experimental therapies then under exploration in early HIV clinical trials. According to one Canadian scholar, those so affected may be entitled to a "catastrophic right" of access, meaning "special therapeutic freedoms for those catastrophically ill."[212] Under then and existing Canadian law and policy, access to experimental therapies comes through normal clinical trials or through Health Canada's Special Access Program (SAP). Regulations adopted under Canada's federal Food and Drug Act authorize exceptional access to as yet unlicensed therapeutic products like emerging drugs or medical devices.[213] Health Canada administers the regulations and SAP, and has explained the rationale for such access:

> *Through SAP, health care professionals may request access to non-marketed drugs to treat patients with serious or life-threatening conditions. Access to these drugs is only considered when conventional therapies have failed, are unsuitable or are unavailable.*[214]

The program and law on which it is based would seem to confer no broad catastrophic right to access unlicensed experimental therapies. Absent a positive legal right to them, citizens may still enjoy a negative right of eligibility[215] – that is, a right to be fairly considered for eligibility and to not be excluded from participation on discriminatory grounds.[216]

Thirdly, lessons from the HIV/AIDS pandemic cast light on another dimension of participating in scientific advancement. For beyond access to experimental therapies, HIV activists had a broader agenda for which they dramatically confronted the scientific, pharmaceutical, government and regulatory enterprise. In 1988, three years after the discovery of the virus, they invaded and occupied office buildings on the research campus of the US National

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211 SCHOCH, D.: "Parents of Young Children Desperately Seek Vaccine Trials", *New York Times (*11 September 2021), online: https://www.nytimes.com/2021/09/11/health/children-covid-vaccine-trials.html.

212 See DIXON, J.E.: *Catastrophic Rights: Experimental Drugs & AIDS*, New Star Books, Vancouver, 1990, 131 pp.

213 *Food and Drugs Regulations*, ss C.08.010, C.08.011.

214 GOVERNMENT OF CANADA, "Health Canada's Special Access Program: An Overview" (2021), online: https://www.canada.ca/en/health-canada/services/drugs-health-products/special-access.html. The Program has previously been referred to as the Emergency Drug Release Program. See Canada House of Commons, "Standing Committee on Health, Sub-Committee on HIV/AIDS, Compassionate Access to Investigational Therapies" (1996), online: https://www.ourcommons.ca/Content/archives/committee/352/sant/reports/02_1996-10/sant-02-report-e.html [Compassionate Access].

215 Compassionate Access, *ibid*: *A positive right means a right to be provided with some good. A negative right means a right to be free from interference.….[A] positive catastrophic right to drugs imposes a corresponding duty on those who have drugs or on those who manufacture drugs to supply these therapies; but this may not always be possible... [There]. . . is the tendency of both ethics and law to grant fuller recognition of negative rights than positive rights. [. . .] Secondly, even if the modern social contract between citizens includes rights to treatment, it is clear that such rights are not absolute. A patient's right to health care does not imply that he or she has the right to be supplied with all treatments*.

216 GOVERNMENT OF CANADA, "Interagency Advisory Panel on the Ethics of Research Involving Humans, Advisory Opinion: Reasonably Designed Inclusion and Exclusion Criteria and Applicable Human Rights Legislation" 2003.

Institutes of Health (NIH) outside Washington DC. They wrote to the lead research scientist for the US governmental AIDS response, a Dr. Anthony FAUCI. They critiqued access to – and the pace, content and design of – the existing experimental drug approval process. One notable group was the AIDS Coalition to Unleash Power (ACT UP), which dramatically led much of the critique, with chapters in North American cities like New York, San Francisco, Toronto, and Vancouver. A year after the NIH protests, they stormed the Montreal International AIDS Conference and refused to leave:

> *We were there to hold science itself accountable…. – to demand, in the words of ACT UP's "National AIDS Treatment Research Agenda –" that "people with AIDS and their advocates participate in designing and executing drug trials," and that research be driven by people's needs and not just by the interests of drug companies…*[217]

They persuasively also argued that as both the ultimate consumer and primary research participants, those with HIV should have a right to participate in the medical and regulatory design and process of HIV research. After recoiling from such unorthodox claims, FAUCI and others eventually agreed to meet and hear ACT up concerns. Upon the death of the US ACT UP leader, Dr. FAUCI recently observed:

> *[H]e changed the relationship between the afflicted community with a given disease and the scientific and regulatory community that has such a great impact on them…. He has changed the way we think…*[218]

Arguably, the advocacy for direct citizen participatory inclusion in the research enterprise was a claim for procedural, participatory and (re)distributive justice. The latter concerns the claim for affected citizen's decisional involvement in (re)allocating research risks and benefits. The advocacy brought scrutiny to the obscure regulatory world of experimental therapy research and the clinical trials practice. The critique re-imagined a novel participatory "partnership" of citizen democratic involvement in human research. On both sides of the US-Canadian border, those who volunteer for research would gradually shed the label research "subjects' to become research "participants". Other elements of the participatory model have been adopted in Canada.[219] Legal and policy reforms for fast-tracking drugs for "life-threatening illnesses" advanced in the US[220] in the late 1980s, and have been adopted in Canada[221] for non-covid and covid drugs.

Fourthly, a right to participate in scientific advancement by evaluating health research has limited recognition in federal law. Canada adheres to the international model of prospective review of the ethical and scientific merits of proposed research by interdisciplinary ethics review committees. Most such committees in Canada are university based; they are mandated

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[217] GOLDBERG, R.: "When PWAs First Sat at the High Table", *ACT UP*, July 1998, online: https://actupny.org/documents/montreal.html. For a detailed accounting of the ACT UP movement, see FRANCE, D., *How to Survive a Plague: The Inside Story of How Citizens and Science Tamed AIDS*, Knopf, New York, 2016, 640 pp.

[218] FINNEGAN, M.: "WATCH: Fauci remembers AIDS activist Larry Kramer for 'extraordinary courage" *Public Broadcasting Service*, 28 May 2020, online: https://www.pbs.org/newshour/health/watch-fauci-remembers-aids-activist-larry-kramer-for-extraordinary-courage.

[219] See GOVERNMENT OF CANADA, "Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans – TCPS 2 (2018)" at c 4 (fairness & equity in research participation), online: https://ethics.gc.ca/eng/policy-politique_tcps2-eptc2_2018.html.

[220] US FOOD AND DRUG ADMINISTRATION, "Drugs Intended to Treat Life – Threatening and Severely Debilitating Illnesses" 53 Fed Register 41516 (21 October 1988), affecting at 21 Code of Federal Regulation 312, 314.

[221] See GOVERNMENT OF CANADA, "Guidance for Industry - Priority Review of Drug Submissions" (6 February 2009), online: https://www.canada.ca/en/health-canada/services/drugs-health-products/drug-products/applications-submissions/guidance-documents/priority-review/drug-submissions.html.

by a university-government agreement to adhere to federal research ethics standards, the *Tri Council Policy Statement on Research Involving Humans*, (TCPS).[222] Under the TCPS, research ethics committees approve, disapprove or recommend changes to proposed health research. The committee membership must include public citizen laypersons along side lawyers, scientists and ethicists.[223] For research involving drugs and medical devices, Canadian federal law also mandates the inclusion of community members in the membership of research ethics committees reviewing proposed clinical trials research for new drugs and medical devices.[224] The policy and statutory duty of regulated institutions to include such citizens in the research process confers a general right of eligibility for citizen participation in the ethical review of health research.

IV.2. The contours and limits of the right to health

IV.2.1. Individual right *versus* collective right: A right to health protection?

The concept of an individual versus a collective right captures the classic duality or binary paradigm of individual versus societal interests in classic human rights thought. That is, one transcendent role of modern human rights is to shield citizens from undue governmental, institutional or collective invasion of such cherished democratic values and fundamental freedoms as personal liberty, bodily integrity, freedom of conscience, freedom from discrimination, and decisional autonomy. Such negative rights are thought to preserve the liberty and dignity of the individual. They may be justifiably infringed and sometimes overridden only in exceptional circumstances. The discussion in Part II above of the Charter and Covid litigation and human rights statutes underline key examples. The discussion below in sections IV.2.2, IV.2.5 – of exceptionally necessary limits of individual mobility and physical integrity rights offer – other examples.

Such limits raise a poignant question: may urgent or pressing societal health needs express, or be thought of as, a collective right to health?

A number of considerations suggest that Canadian citizens and society do indeed share a collective right of health protection as part of its modern democratic social contract.

First, since Canada's inception in the 19thCentury Canada has regularly evolved its health protection laws for the common good. Canada's federal quarantine and public health laws emerged in the 19th century, extended to the Food, Drug and medical Device laws and regulations of the 20th Century and have undergone a veritable renaissance amid Covid pandemic needs now in the 21st Century. (See Part II, above).

Secondly, that evolution demonstrates that public and health protection an essential, unique role of government. One may argue that government draws on its protective responsibilities to act in a fiduciary role to protect the community, the nation and the common health and safety needs of citizenry. Public health protection laws thus delegate individual and collective health interests to government to act for the safety, health and survival of society. The delegation confers special police powers to government to command protective initiatives, such as public health, environmental health and public safety measures. One may further argue that such public health powers derive from the paternalistic *parens patrie* logic of the state: to help those who cannot help them selves. Typically, *parens patrie* applies to those

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[222] TCPS, *op. cit.*

[223] *Ibid,* art. 6.4: https://ethics.gc.ca/eng/tcps2-eptc2_2018_chapter6-chapitre6.html#a.

[224] *Food & Drug Regulations*, *op, cit*., C.05.001.

lacking the capacity to act. If pandemic carnage will likely be avoided only by concerted action that individual citizens alone are powerless (or situationally incapacitated) to execute, then delegation of individual needs and shared accord to act is consistent with public health, self defence, and public health measures for the common good.

Thirdly, for such reasons, we may regard this aggregation of needs, interests, and responsibilities as the collective rights dimension of a right to health.

Finally, the Canadian Charter exemplifies a human rights mechanism—in the modern democratic social contract – that rigorously mediates important conflicts between individual fundamental freedoms and collective public health and safety interests. When public health needs are demonstrably justified as a public necessity, courts and society judge the collective intervention as an exceptional necessity for the common good. Such judgments give legal effect to a public philosophy and ethics of what I might call "justifiable beneficent utilitarianism." As the World Health Organization noted decades ago regarding compulsory public protection measures:

> *"The Benthamite principle of "the greatest happiness of the greatest number" requires that society should abrogate the right of the individual to unlimited free choice in certain circumstances. Such limitations of personal freedom may consist in the prohibition of certain actions…"*[225]

Utilitarianism unconstrained may run afoul of cherished democratic freedoms and values, like the right to bodily integrity. So compulsory public health interventions must be justifiable. They may be justified as reasonable when their goal, means and impact coherently and strictly align. Indeed, given an important public health goal, the most optimal, effective and just public health interventions will be those that impose the least degree of infringement of freedoms necessary to maximize the public health benefits of the population. So we collectively gain. Hence, compulsory Covid mitigation measures like masking, social distancing, testing or vaccination and quarantine requirements – in travel and public transport domains, the workplace, schools, long term care facilities, border crossings – may impose varying degrees of invasion of one's physical integrity and persona. When such collective compulsory public measures collide with the individual right to physical integrity, Canadian Charter jurisprudence frames the operative question: are the measures reasonably justified as objectively necessary and proportionate. (See sections IV.2.5, IV.3, below).

IV.2.2. Right to health and freedom of movement (quarantine, lockdowns, etc.)

Two kinds of cases – respectfully involving federal public health restrictions on international travel and provincial restrictions on inter-provincial travel – illustrate the clash between mobility rights and justifiable restrictions thereon necessitated by public health protection for the common good.

The first case arose when a family – seeking to attend the funeral services of a recently deceased father – was prevented from doing so by public health orders prohibiting departures to and arrivals from a sister province. In *Taylor v Newfoundland*[226], the Court agreed with the family that the restriction infringed citizen's "mobility rights" under section 6 of the Canadian Charter. But the Court also agreed with the government that controlling the spread of COVID in the province was a legitimate, "pressing and substantial objective." The question was

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[225] WHO, *Health Aspects of Human Rights: With Special Reference to Developments in Biology and Medicine* (Geneva, 1976), online: https://apps.who.int/iris/handle/10665/37450.

[226] *Taylor v Newfoundland and Labrador*, 2020 NLSC 125.

whether the restrictions were demonstrably justified as a proportionate and necessary restriction. The Court rejected the contention that less drastic alternative measures like traveller testing, self-isolation, and contact tracing would prove effective to contain transmission risks. The Court discussed and partly relied on a leading early 20th century US Supreme Court decision of *Jacobson v Massachusetts*.[227] *Jacobson* upheld a state's mandatory vaccination law as necessary for public health protection of the common good. The Newfoundland Court similarly affirmed the public health authorities view that the border closures were required:

> *While restrictions on personal travel may cause mental anguish to some, and certainly did so in the case of Ms. Taylor, the collective benefit to the population as a whole must prevail. COVID-19 is a virulent and potentially fatal disease. In the circumstances of this case Ms. Taylor's Charter right to mobility must give way to the common good.* [228]

A second line of cases involve challenges to federal *Quarantine Act* standards for international travel. The Act and the cases are respectively discussed in sections III.2. and III.8., above. In those cases, the courts denied injunctions against mandatory testing and temporary quarantine measures for those entering or returning to Canada. The measures impacted but did not prohibit travel between Canada and the US. The courts did not find infringements of Charter mobility rights.

IV.2.3. Right to health and freedom of trade (lockdown of stores, bars, restaurants, etc.)

Many stringent and invasive public health measures for the Covid pandemic – curfews, capacity-restrictions in restaurants, the closure of bars and nightclubs for months, locking of office buildings, stoppage and restrictions on international travel – have severely curtailed or arrested commercial trade in vital sections of Canada's economy. Such measures thus impact contracts and employment. Does the tension between competing societal needs pit a right to health against the freedom of trade? Some may consider the tension a direct collision between saving health/human life or saving employment and the economy. If so, it raises difficult ethical, political and public policy issues. National public health initiatives and economic initiatives[229] have certainly sought to navigate and balance the sometimes conflicting values of health and the economy through the ebb and flow of the Covid pandemic.

In the Canadian context, such a conflict might better be understood by a few legal observations on freedom of trade.

First, jurisdiction over trade and commerce is shared between the federal and provincial governments with particular constitutional allocations of responsibilities. For instance, amongst other national economic concerns, the federal government has responsiblities for regulating international and interprovincial trade notably under the federal trade and commerce power of the Canadian Constitution. In constrast to US federalism, the power has been narrowly interpreted.[230] Canadian federalism in trade matters is thus guided by a priniciple of appropriate "jurisdictional balance."[231] As such, provincial acts and regulatory measures that in "essence and purpose" restrict or limit the free flow of goods on

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227 *Jacobson v Massachusetts*, 197 U.S. 11 (1905).

228 Taylor, *op. cit.* at para. 496.

229 Canadian legislation enacts diverse initiatives and financial support for workers, businesses, and organizations with income loss or economic hardship from Covid. See *Covid-19 Emergency Response Act*, SC 2020, c 5.

230 HOGG: *op. cit.* section 20.1.

231 *R v Comeau*, [2018] 1 SCR 342.

interprovincial trade are more likely to run afoul of federal free trade standards; by contrast, provincial measures that target and impact public health contagion – like provincial border vaccine check points – with "incidental effects" or impacts on interprovincial trade, are less likely to violate federal free trade principles.[232]

Secondly, in contrast to facets of the right to health, commercial-economic rights tend not to enjoy fundamental protections under the Charter. Concepts like a fundamental liberty to contract or to protect private property have been less prominent in modern Canadian law. This contrasts with the commercial-economic rights culture of the US, Canada's biggest trade partner. When the Charter was drafted, for instance, the US model of a fundamental "right to life, liberty and *property*" was avoided in favour of the international human rights model of a "right to life, liberty, nd *security of the person*."[233] The Supreme Court also distinguishes "economic rights fundamental to human life or survival" from "corporate-commercial economic rights."[234] The latter are less protected, while the former align with socio-economic rights outlined in the ICESCR, which Canada has ratified.

IV.2.4. Right to Health and Right to Life: Abortion and Euthanasia

Over the last decades, as controversial beginning of life and end of life issues have arisen[235], Canada has debated, litigated and legislated such issues as abortion and euthanasia. The SCC judgments on abortion (*Morgentaler*) and assisted suicide (*Carter*) are discussed in section III.7., above. Those decisions significantly advanced Canadian's access to these ever controversial medical procedures. For some, such access will be considered part of modern society's right to health. Others will argue that increased access is contrary to the right to life.[236]

The following outlines the federal government's response to the SCC's *Carter* and subsequent rulings that struck down portions of the Canada's Criminal Code.

Canada finds itself erecting an innovative and evolving legal framework for Medical Assistance in Dying (MAID), following a quarter century of Charter litigation that generated criminal law reforms in 2016 and 2021.[237] The sometimes tormented evolution of the framework reflects a continuing societal quest for the just balancing and application of the high public values and

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[232] See *ibid*.

[233] See art 3 of the UDHR.

[234] See *Irwin Toy Ltd. v Quebec (Attorney General)*, [1989] 1 SCR 927, *op. cit*., per DICKSON, CJ., pp. 1003-4. See also *Gosselin v Quebec (Attorney General)*, [2002] SCC 84, per Arbour J, dissenting, para 311.

[235] See JONES, D.J.: "Brief of the Law Reform Commission of Canada to the Royal Commission on New Reproductive Technologies" *Health Law in Canada*, 13: 1, pp. 119-124.

[236] In an arguable twist of factual or conceptual irony, in Canada's landmark physician assisted suicide case the SCC found that because evidence showed that the criminal code prohibition on it had lead some patients to end their lives earlier the regime resulted in a deprivation of the "right to life." See *Carter*, *op. cit*. section III.7. The SCC jurisprudence has recognized a state interest in "the sanctity of life" in euthanasia cases and a state interest in "protecting life" in abortion cases. See *Rodriguez* & *Morgentaler*, *op. cit*. section III.7.

[237] In contrast to the *Rodriguez* case, the SCC's Carter case prompted the Canadian Parliament to adopt Bill C-14, Legislation on Medical Assistance in Dying, received royal assent on 17 June 2016 (see *Carter* and Rodriguez discussed above in section, III.7). The 2016 reform was complemented by Bill C-7, An Act to amend the Criminal Code (medical assistance in dying), received royal assent on 17 March 2021, Statutes of Canada 2021, c. 2. It resulted from the federal Minster of Justice's decision not to appeal, to the highest court of Quebec or to the Supreme Court of Canada, the Quebec judgement of *Truchon c Procureur général du Canada*, 2019 QCCS 3792. In *Truchon*, a Quebec Superior Court ruled that the "reasonably foreseeable natural death" requirement of the Criminal Code and the parallel end-of-life requirement of Quebec law unjustifiably infringed the right to equality and the right to life, liberty and security of the person of the Canadian Charter. Instead of appealing the decision, the federal government seemed to acquiesce to it by again amending the federal criminal code, this time with Bill C-7.

legal principles like protection of life, equality, respect for patient autonomy and bodily integrity, human dignity, and safeguards to protect the vulnerable. The collision and reconciliation of many of these resonate in the *Carter* decision. As a result of the litigation and legislative reforms, Canada's MAID framework today is situated between such relatively permissive European regimes as Belgium or Switzerland and the more restrictive regimes found in selected states of the USA. For example, unlike Belgium, Canada does not authorize MAID for those under 18 years of age.[238] And unlike the US, Canada's eligibility requirements do not require seriously ill patients with an incurable disease or disability to be diagnosed with a "terminal illness" that will lead to death within six months.[239] Rather, as a result of a 2017 Quebec court ruling that declared the previous "reasonably foreseeable natural death" requirement unconstitutional,[240] the 2021 legislative amendments to the Criminal Code now also provide MAID eligibility to those patients whose death is "not reasonably foreseeable," so long as they satisfy additional procedural safeguards.[241]

Based on the federal Criminal Code, Canada's legislative MAID regime applies throughout the country. The regime encompasses both professionally administered MAID by a physician or a nurse practitioner – after formal request by a patient – and self-administered medication prescribed and/or provided by a physician or nurse practitioner.[242] Frame 27, below, outlines some basic elements of the MAID regime, such as eligibility requirements, professional responsibilities, procedural protections, etc.

FRAME 27

Canada's Basic Eligibility Requirements for Medical Assistance in Dying

- For those 18 over with decision-making capacity
- Be eligible for publicly funded health care services
- Make a written, witnessed, voluntary request
- Provide free and informed consent
- Have a serious and incurable illness, disease or disability (excluding mental illness until 2023)
- Be in an advanced state of irreversible decline in capability
- Have enduring and intolerable physical or psychological suffering that cannot be alleviated under conditions the person considers acceptable
- Have two independent doctors and/or nurse practitioners confirm patient eligibility requirements
- For patients whose natural death is not reasonably foreseeable, respect additional procedural protocols

Source: *Criminal Code of Canada,* s. 241.2 et seq. See also the Quebec's *Act Respecting End-of-Life Care*, chapter S-32.0001, for its parallel legislation

238 BEHRENDT, C.: *Le droit à la santé une perspective de Droit comparé - Belgique*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), mars 2022, IX et 74 pp., référence PE 729.344.

239 See, e.g., *Patient Choice and Control at End of Life Act (2013),* 18 Vermont Statutes Annotated s. 5281 (10).

240 *Truchon*, *op. cit.*

241 *Criminal Code*, s. 241(3)10.

242 Compare Health Canada's and Justice Canada's overviews of MAID: GOVERNMENT OF CANADA, "Medical assistance in dying", online: https://www.canada.ca/en/health-canada/services/medical-assistance-dying.html; Government of Canada, "Canada's new medical assistance in dying (MAID) law", online: https://www.justice.gc.ca/eng/cj-jp/ad-am/bk-di.html.

The regime also mandates important professional reporting,[243] data gathering and monitoring standards. Federal Regulations for the Monitoring of Medical Assistance in Dying have been promulgated to specify them. For instance, the regulations outline diverse duties regarding data collection, professional reporting of MAID deaths, and annual reporting by the federal Minster of Health. According to Health Canada's 2020 Annual Report, reported MAID deaths have grown from 1,018 in 2016 to 7,595 in 2020, for a total of 21,589 for that period; 69% of the 2020 cases involved cancer, with a loss of ability to engage in meaningful activities being the most commonly cited intolerable physical or psychological suffering.[244]

To address diverse, unresolved issues, Canada's MAID regime is bound for refinements and continued evolution for the next years. For example, following consultation, the federal government shall update the *Regulations for the Monitoring of MAID* to conform to the 2021 legislation. Governmental and professional groups shall continue to ponder whether and how mature adolescents might become eligible for MAID. Similarly, following extensive debate, the 2021 legislation deferred until 2023 the inclusion within the MAID regime of those who otherwise satisfy the eligibility requirements and whose sole underlying condition is mental illness or mental disability.[245] Whilst some consider the exclusion discriminatory[246] and others consider it justified protection of the vulnerable, the delay is intended to afford time to identify and resolve residual issues, and to craft fair and effective implementing protocols.

IV.2.5. Right to health, Right to physical integrity

The right to physical integrity is a corollary, dignitary right and facet of the right to health.

As the case law discussion in Part III., above, indicates, the right to physical integrity protects (i) against non-consensual touching of one's person, (ii) the general right of competent adults to decisional autonomy for health interventions or treatment, (iii) the right of corporal autonomy regarding the assumption of the physical risks and benefits upon one's person; (iv) the right to decline or refuse recommended health interventions deemed medically necessary, even if they may lead to death.

In Canada, one's dignitary right to physical or bodily integrity is grounded on diverse sources of private and public law. These include, for instance, the common law doctrine of battery and free and informed consent to health interventions, the principle of inviolability of the person and the medical consent provisions of in Quebec civil law, sundry provincial statutes governing health care treatment for adults and minors who lack capacity, the Canadian Charter right to liberty and security of the person and the Charter right to be free from cruel and unusual treatment or punishment. Sometimes such rights converge to protect bodily and related dignitary interests. For instance, the Canadian courts have recently invoked both cruel and unusual punishment and security of person theories to limit solitary confinement of prisoners, and the injuries to both physical and mental integrity. (See section III.7, above.)

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[243] For Health Canada's, guidance on professional reporting, see Government of Canada, "Guidance for reporting on medical assistance in dying", online: https://www.canada.ca/en/health-canada/services/medical-assistance-dying/guidance-reporting-summary/document.html#2.0.

[244] Health Canada, *Second Annual Report on Medical Assistance in Dying in Canada 2020*, (June 2021), online: *Government of Canada* https://www.canada.ca/en/health-canada/services/medical-assistance-dying/annual-report-2020.html.

[245] *Criminal Code*, s. 241(2)2.1.

[246] SHEPPARD, C. & JONES., D.J.: "Bill C-7's Express Exclusion of Individuals Whose Sole Underlying Medical Condition Is Mental Illness from Canada's Evolving Medically Assisted Death Regime: (Un)Justified Human Rights Discrimination?", Brief to the Senate of Canada Standing Committee on Legal and Constitutional Affairs, Faculty of Law, McGill University, February 2021, 14 pp., online: https://sencanada.ca/content/sen/committee/432/LCJC/Briefs/ColleenSheppardandDerekJones_e.pdf.

Similarly, the high courts of Canada have upheld the right of a person – who had been civilly committed by the province under its mental health statutes – to refuse psychotropic medication: "The right to refuse unwanted medical treatment is fundamental to a person's dignity and autonomy."[247]

These doctrines and principles admit of exceptions. For example, the doctrine of free and informed consent to health care typically recognizes exceptions when medical emergencies arise, when patients waive the right, when otherwise legitimately authorized by law, or when other complementary special consent or authorizing laws and procedures apply for those lacking capacity. Nor are the Charter protections of the right to physical integrity absolute. They recognize limited, demonstrably necessary exceptions. For instance, governments intent on imposing mandatory vaccinations must comply with applicable statutory authority; they also bear the onus of justifying the measure as objectively necessary, proportionate and minimally invasive of a violation of the Charter right to liberty and security of the person.[248] If government can do so, the measured will be justified. The precise necessities and proportionate balancing likely depend on the specific context and facts. But if the public health goal may be meaningfully advanced by less burdensome measures – e.g., effective testing –, the onus of proof will not have been met.

Indeed, the latter scenario raises an important question: because articulation of the right to physical integrity in the health domain has largely arisen in the context of patient' rights in medical care settings, how do such principles and exceptions apply in the public health context? Part of the answer comes from the voluntary dimension of many Canadian public health immunization and vaccine policies — that is, unless mandated or compelled under particular conditions or statutes, vaccine administration generally falls within the principles of free and informed consent for treatment. Another part of the answer comes from SCC Charter jurisprudence. The case law review in Part III, above, indicates how at least since the *Morgentaler* decision, in the early days of the Canadian Charter, the right to liberty and security of the person protects both physical and mental integrity of the person.

Amid Morgentaler's rich progeny, the reasoning in *A.C. vs. Manitoba (Director of Child and Family Services)*,[249] sheds light on the outer contours of the right. In upholding the constitutionality of a provincial statutory regime of substitute decision-making in medical treatment for children and adolescents in need of health protection, the SCC explained the basis of the right to bodily integrity and its potential limits:

FRAME 28

SCC, 2009, A.C. v. Manitoba, para 100

Security of the person has an element of personal autonomy, protecting the dignity and privacy of individuals with respect to decisions concerning their own body. It is part of the persona and dignity of the human being that he or she have the autonomy to decide what is best for his or her body. This is in accordance with the fact (...). that "s.7 was enacted for the purpose of ensuring human dignity and individual control, so long as it harms no one else (…)"[250]

For instance, in terms of interpersonal harms, both occupational and public health laws respectively seek to prevent harms to co-workers and public health. Such laws engage varying

[247] *Starson v Swayze*, 2003 SCC 32 at para 75 citing *Flemming v Reid*, (1991) 4 OR (3d) 74 ONCA.

[248] See discussion of Charter LLSP cases law in section III.8., above and the discussion of court rejection of preliminary injunctions seeking to stop governmental orders requiring proof of vaccination, in section III.8.

[249] *AC v Manitoba (Child and Family Services)*, 2009 SCC 30 at para 100 quoting *Rodriguez*.

[250] *Ibid.* at para 100.

degrees of physical integrity for those employed or otherwise active in sectors of society with risks that reasonable regulation may abate or contain. Three examples show how. First, federal regulations requiring atomic energy workers to wear radiation dosimeters impose minor infringements of employee physical integrity, so as to monitor and protect individual, co-worker and public safety.[251] Secondly, as discussed below in section IV.2.6, Canadian federal transportation laws condition the licensure of pilots on mandatory periodic medical interventions to prevent, detect or monitor medical conditions that may present important transportation safety risks. Thirdly, beyond recent Covid requirements, some Canadian provinces require regular immunizations for first responders, day care workers, and primary school students as a condition of employment or school attendance.[252]

Such mandated health measures are designed to impose reasonable conditions or restrictions on individual freedoms and rights, so as to preserve and protect public safety and health from collective harms. The point was emphasized in the Canadian court decision (discussed in section IV.2., above) that upheld New Brunswick's Covid public health restrictions on out-of-province travel, though they infringed individual mobility rights: "the collective benefit to the population as a whole must prevail… Charter right[s] …must give way to the common good."

IV.2.6. Right to Health: Privacy, Confidentiality and Data Protection

The right to privacy is a corollary, dignitary right and facet of a right to health. Especially within the context of health, privacy includes rights to confidentiality and rights to data protection. Legal sources for the right range from international law, the Canadian Charter, federal and provincial statutes, common and civil law standards, to enforcable codes of ethics of health professionals. A sampling of two leading Supreme Court of Canada decisions and one of Canada's national data protection laws underscores key concepts and principles of a right to health information privacy.

FRAME 29

SCC, 1988, *R v Dyment*, para 27

(...)the use of a person's body without his consent to obtain information about him invades an area of personal privacy essential to the maintenance of his human dignity.[253]

As the above quote from a criminal case involving non-consensual drug testing of blood samples illustrates, privacy is a fundamental right expressive of human dignity and autonomy. The case, *R v Dyment*, is discussed above in section III.5. In it, the Court referred to privacy as the right to be let alone, which protects territorial, bodily, and informational integrity under the search and seizure provisions of the Charter. In constrast to European Court of Human Rights (ECHR) and U.S. case law, the constitutional right to privacy in Canada has thus far been less equated with the freedom to make personal health decisions.[254]

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[251] See Canada, *Radiation Protection Regulations*, SOR/2000-203.

[252] See, e.g., in Ontario's *Ambulance Act*, General, O Reg 257/00; *Immunization of School Pupils Act*, RSO 1990, c I.1; *Child Care and Early Years Act*, 2014, SO 2014, c 11, Sch 1.

[253] *R v Dyment*, [1988] 2 SCR 417 at para 27.

[254] But see, Justice Wilson's concurring opinion in the reproductive autonomy case of *Morgentaler*, *op. cit*. It draws on privacy in a way that parallels the US reproductive autonomy case of *Roe v Wade*, 410 US 113 (1973) and the ECHR case law on the right to refuse medical treatment and the end-of-life care right to decide how and when to end one's life. See European Court of Human Rights, "Guide on Article 8 of the European Convention on Human Rights: Right to respect for private and family life, home and correspondence" (31 August 2021), online: https://www.echr.coe.int/documents/guide_art_8_eng.pdf.

Four years after *Dyment*, the SCC analyzed the confidentiality dimension of privacy in the health care context. In *McInerny v Macdonald*,[255] a patient sued to access her medical record which the hospital had refused to share. In exploring such questions as who "owns" a medical record in the absence of legislation, the Court underlined that patients divulge or entrust personal health secrets to medical professionals for diagnostic and treatment purposes. True, it is health professionals with obligations of confidentiality who typically consolidate patient information into a medical file or electronic record that professionals and hospitals regularly hold and possess. Still, the information itself is held in trust and processed for patient benefit. Patients thus have a legal interest akin to owning the content of the medical file: their medical information. So reasoned the Court. It ruled that patients should have a general right to access their medical records, subject to narrow exceptions such as if disclosure would trigger a significant likelihood of substantial adverse harm to patient physical or mental health.

In this therapeutic process, health professionals' duties of confidentiality serve important functions. They protect the privacy, dignity, and informational integrity of patients. They encourage or enable a therapeutic dialogue between vulnerable patients and expert health providers, thus enhancing the trust-based patient-provider relationship. The privacy and facilitation functions optimally combine to benefit individual patients therapeutically. Doing so, advances our collective public interest in health.

Many such purposes, principles, and exceptions concerning health information privacy have been partly codified in some federal and provincial privacy statutes. For instance, many resonate in Canada's most modern federal data protection legislation, the *Personal Information Protection and Electronic Documents Act* (PIPEDA).[256]

Enacted in 2000, in part to respond to European privacy requirements for the international sharing of protected data, PIPEDA outlines standards for the collection, use and disclosure of personal information processed in federal works, undertakings or business in the course of commercial activities of Canada's federally regulated private sector.[257] The Act is overseen by the Privacy Commission of Canada, whose enforcement powers were broadended when the Act was updated in 2015 and 2019. PIPEDA thus regulates personal information privacy standards for national banking, transportation, internet and telecommunications companies in interprovincial commercial activities for many of Canada's largest national corporations, such as the Bank of Montreal, Bell Canada, Air Canada, ViaRail, etc.

Frame 30 captures some of PIPEDA's leading information privacy principles, including access and accuracy, minimizing data collection and disclosures, consent and data security.

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255 *McInerney v MacDonald*, [1992] 2 SCR 138.

256 *Personal Information Protection and Electronic Documents Act*, SC 2000, c 5 (as amended).

257 *PIPEDA* is complemented in the federal public sector by the Federal Privacy Act, RSC 1985, c P-21.

It has been described as follows: The federal Privacy Act offers informational privacy protection by imposing data protection standards on the federal government. It is intended to prohibit the unwarranted collection, use and disclosure of personal information. The Act requires the government to (a) collect only the personal information it needs to operate its programs, (b) tell the individual how that information will be used, and(c) take all reasonable steps to ensure the accuracy and completeness of the information collected. Section 4 of the Act says that "no personal information shall be collected by a government institution, unless it relates directly to an operating program or activity of the institution." Personal information includes that relating to the medical or employment history of the individual. JONES, DJ.: Selected Legal Issues, *op. cit*. Such FRA principles guide the collection and sharing of federal employee medical information concerning COVID.

FRAME 30

Canada's Private Sector Privacy Principles

Adopted under PIPEDA, (excerpts)

Principle 1 – Accountability: An organization is responsible for personal information under its control and shall designate an individual or individuals who are accountable for the organization's compliance with the following principles.

Principle 2 – Identifying Purposes: The purposes for which personal information is collected shall be identified by the organization at or before the time the information is collected.

Principle 3 – Consent: The knowledge and consent of the individual are required for the collection, use, or disclosure of personal information, except where inappropriate…. An organization should generally seek express consent when the information sought is likely to be considered sensitive…

Principle 4 – Limiting Collection: The collection of personal information shall be limited to that which is *necessary* for the purposes identified by the organization. Information shall be collected by fair and lawful means. Organizations shall not collect personal information indiscriminately.

Both the amount and the type of information collected shall be limited to that which is necessary to fulfil the purposes identified.

Principle 5 – Limiting Use, Disclosure & Retention: Personal information shall not be used or disclosed for purposes other than those for which it was collected, except with the consent of the individual or as required by law. Personal information shall be retained only as long as necessary for the fulfillment of those purposes.

Principle 6 – Accuracy: Personal information shall be as accurate, complete, and up-to-date as is necessary for the purposes for which it is to be used.

Principle 7 – Safeguards: Personal information shall be protected by security safeguards appropriate to the sensitivity of the information

Principle 8 – Openness: An organization shall make readily available to individuals specific information about its policies and practices relating to the management of personal information.

Principle 9 – Individual Access: Upon request, an individual shall be informed of the existence, use, and disclosure of his or her personal information and shall be given access to that information. An individual shall be able to challenge the accuracy and completeness of the information and have it amended as appropriate.

Principle 10 – Challenging Compliance: An individual shall be able to address a challenge concerning compliance with the above principles to the designated individual or individuals accountable for the organization's compliance.

Source: JONES, DJ & SHEPPARD, C. *Human Rights at Work: Mental Health Privacy & Equality in the Workplace*, (forthcoming 2022).

Of note for the health context is PIPEDA's proportionality principle implied in principle 7. It requires higher data protection for more sensitive personal information. Since identifiable personal health information is considered highly sensitive – partly because citizens consider it strictly confidential and partly because of the higher risks of stigmatization or discrimination – it is entitled to high data protection procedures.[258] Doing so is consistent with international norms and data principles flowing from the 1980s.[259]

[258] JONES D.J. & SHEPPARD C.: *Human Rights at Work: Mental Health Privacy & Equality in the Workplace*, (forthcoming 2022).

[259] *Ibid*. See also JONES, D.J. ET AL.: *Selected International Legal Norms in the Protection of Health Information in Health Research*, Canadian Institutes of Health Research/Public Works & Government Services Canada, Ottawa, 2001.

Beyond the federal sector, PIPEDA also applies in provinces or territories that fail to provide substantially equivalent private sector privacy protections. Some provinces has done so through general privacy laws or sectorial ones like those governing personal health information. In this context, Quebec has long been regarded as having amongst the most stringent privacy laws in North America. Quebec strengthened its private sector privacy law in 2021 – amongst other things – to heighten privacy breach reporting duties, require privacy impact assessments for cross-border transfers of data, and require regulated institutions to appoint privacy officers.[260] The province also recently proposed a new health data statute.[261] Such reforms align Quebec standards with the updated PIPEDA norms and the European Union's recent *General Data Protection Regulation*.[262]

How do such principles and practices apply concretely and coherently to instances when public health and safety collide with personal health information privacy and confidentiality? Such tensions and conflicts preceded and will continue long beyond specific Covid-19 pandemic challenges. For instance, for roughly a decade Supreme Court of Canada jurisprudence on drug or alcahol testing in dangerous workplaces has recognized the need, and high challenge, for justly reconciling an empolyer's duty to provide a safeworkplace with respect of employee's privacy rights. Doing so, it has reasoned, is more likely and aptly done through reasonable "for-cause" (e.g., post-incident) testing than by "universal random testing," because the latter may prove to be a disproportionate response.[263] To help identify, manage and resolve such conflicts, our comparative health and human rights law research has led us to propose a legal Health Information Privacy Framework (HIPFRA).[264] The HIPFRA affirms that affected institutions and professionals have important legal duties to preserve personal health information privacy and confidences, subject to narrow and precise exceptions: disclosure, authorized by express consent; required by legislation; authorized by a court; or required to address pressing, specific and overriding public interest or duties to others on the basis of objective necessity and proportionality.[265]

HIPFRA principles and exceptions help to elucidate and manage health information privacy in law and in practice. This is one conclusion of our ongoing project that studies health information privacy and equality in the workplace.[266] It confirms, for example, that Canadian federal transport law has long required airline pilots to undergo regular medical exams for fitness-for-work evaluations. Pilots thus typically sign consent or authorization forms that permit examining occupational health professionals to share with federal transport safety authorities and relevant results of required periodic medical examinations or medical interventions for the continued licensure of pilots. The medical reports remain confidential vis a vis the public. But the restricted disclosures – authorized by consent and by aeronautic regulations – help to balance and to advance public safety with limited infringements of health information privacy. Moreover, if individual health information is anonymized and

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260 Bill 64, *An Act to modernize legislative provisions as regards the protection of personal information*, 1st Sess, 42nd Leg, Quebec, 2021 (assented to 22 September 2021), SQ 2021, c 25. (enters into effect 2023).

261 Bill 19, *An Act respecting health and social services information and amending various legislative provisions*, 2nd Sess, 42nd Leg, Quebec, 2021.

262 See European Union, *Regulation (EU) 2016/679 of the European Parliament and of the Council of 27 April 2016 on the protection of natural persons with regard to the processing of personal data and on the free movement of such data, and repealing Directive 95/46/EC* (General Data Protection Regulation), [2016] OJ, L 119/1 (effective 2018) at para 51, online: http://data.europa.eu/eli/reg/2016/679/oj [*GDPR*].

263 See *Communications, Energy and Paperworkers Union of Canada, Local 30 v Irving Pulp & Paper, Ltd.*, 2013 SCC 34.

264 JONES & SHEPPARD: *Human Rights, op. cit.*

265 *Ibid*.

266 *Ibid*.

aggregated to provide a portrait of the incidence of a particular medical condition amongst pilots, the epidemiological portrait helps society to study, understand and address particular health conditions that may impact public safety. De-identification and anonymization of the reported data are proportionate procedures that apply the principle of a limiting health data collection to what is objectively necessary for the specific purposes; here, counting and studying cases.

Similarly, elements of HIPFRA help elucidate law and help guide and structure policy for reasonably balancing privacy and public health needs in the Covid era. For instance, in a recent case denying an injunction against a Canadian military vaccine mandate policy, the court found the mandate a reasonable invasion of individual privacy interests justified by overiding public health interests: *"…the impact that the CAF Vaccination Policy may have on a member's privacy interest is modest on its face and outweighed, in my view, by the public interest in protecting the readiness, health and safety of the Forces, the Defence Team and the public…"*[267] Such balancing should also inform effective contact tracing protocols, Covid case reporting for epidemiological data, or sharing one's vaccine status either voluntarily or as required by applicable public health law. Privacy Commissioners from across Canada have drawn on such reasoning in a pronouncement on Covid vaccine passports:

> *Vaccine passports must be developed and implemented in compliance with applicable privacy laws. They should also incorporate privacy best practices in order to achieve the highest level of privacy protection commensurate with the sensitivity of the personal health information that will be collected, used or disclosed. Above all, and in light of the significant privacy risks involved, the necessity, effectiveness and proportionality of vaccine passports must be established for each specific context in which they will be used.*[268]

IV.2.7. Other fundamental rights in conflict

The immediate foregoing sections in IV.2 have explored such fundamental freedoms as the right to physical integrity, liberty, security of person, mobility, and privacy. These echo and complement the discussion above, in section IV.2, of these and other rights in play from Canada's early Covid case law (e.g., freedom of religion and association, arbitrary detention), and our sampling of leading health and human rights (equality, cruel and unusual treatment) cases under the Canadian Charter in Part III, above. Conflicts between fundamental rights often express high value contests. Depending on how broadly one defines the right to health, one of its facets may sometimes conflicts with another facet. For instance, some of Canada's Covid litigation has sometimes pitted a collective right to public health protection (e.g., quarantine and vaccine requirements) against individual liberty, physical integrity, and autonomous health decisions. For government initiatives, some such conflicts will be resolved via the internal balancing requirements of sections 1 or 7 of the Canadian Charter; some, under the balancing of fundamental rights jurisprudence of the Supreme Court of Canada. For instance, in a case involving Charter conflicts between the accused's criminal justice right to access documentation essential to one's defense and an assault victim's equality and privacy rights in confidential medical records, the court urged a pragmatic and contextual approach:

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[267] *Neri*, *op. cit*. para. 62.

[268] OFFICE OF THE PRIVACY COMMISSIONER OF CANADA, "Privacy and COVID-19 Vaccine Passports: Joint Statement by Federal, Provincial and Territorial Privacy Commissioners", 19 May 2021, online: https://www.priv.gc.ca/en/opc-news/speeches/2021/s-d_20210519/.

FRAME 31

***SCC, 1999, R v Mills*, paras 61 and 63**

No single principle is absolute and capable of trumping the others; all must be defined in light of competing claims. As Lamer C.J. stated in Dagenais (...), "When the protected rights of two individuals come into conflict (…). Charter principles require a balance to be achieved that fully respects the importance of both sets of rights." This illustrates the importance of interpreting rights in a contextual manner (…).

(...) The conflict is resolved by considering conflicting rights in the factual context of each particular case.[269]

IV.3. Exceptions and reasons that would justify giving primacy to the right to health over other conflicting fundamental rights (free speech/religion; privacy; health discrimination)

Conflicts between the right to health and other fundamental rights and freedoms have been discussed above in our review of leading Charter health and human right cases (Part IV), in the review of Canada's early Covid cases law (s. IV.8), and in the detailed review of of physical integrity and privacy (ss. V.2.5-2.6). Those analyses indicate that when government or institutional health measures collide with fundamental rights or freedoms – like the right to physical integrity, decisional medical autonomy, equality, privacy or freedom of worship – those measures must be demonstrably justified within applicable doctrinal requirements and exceptions or by necessity. If so, the measures are more likely to be given primacy. Jurisprudential elements from those analyses suggest a general legal inquiry or framework for assessing whether an intervention is likely justified. It consists of five questions:

(i) How does the intervention engage or infringe a fundamental freedom or right?

(ii) What is the statutory or other legal basis and purpose of the intervention? Does it respect applicable statutes, and does it target a pressing and substantial goal?

(iii) Is its scope and breath non-arbitrary and objectively reasonable (e.g., it is rationally based on scientific evidence)?

(iv) Will less invasive means achieve the public health goal?

(v) Is the intervention thus objectively necessary and proportionate?

Both prior to and during the pandemic, courts have upheld or invalidated health measures depending whether they were reasonable, arbitrary or objectively necessary. Of course, the balancing and objective necessity inquiry may tilt, depending on the evidence and context. Canada's Covid case law, for example, indicates that if the scientific evidence from a Covid wave shows high risks of contagion and severe illness, courts are likely to be more deferential to expertise on the necessity of invasive measures. If another Covid wave shows consistently moderate contagion with moderate or minimal risks of significant harm, courts are likely to invoke the proportionality test to require commensurate moderation of measures, to give more breathing space to fundamental freedoms.

Finally, it should be noted that whether we judge that the "right to health" has advanced also depends on how we define the right – that is, what facet of a right to health is engaged under question (i) of the inquiry? An invasive public health measure that justifiably infringes religious freedom, for example, may advance the health protection right to health. As well, if a court invalidates an unjustifiably discriminatory measure that excludes citizens from employment

[269] *R v Mills*, [1999] 3 SCR 668, paras 61 and 63.

because of attitudinal prejudice on mental health, then we may conclude the ruling advances the equality right to health.

IV.4. 'Grey areas' with regard to the right to health

The foregoing review of diverse and evolving facets of Canada's right to health helps identify important legal uncertainties or lingering ambiguities on relevant definitions, rights, duties, and standards. Such grey areas pose challenges and questions, for today and for the future. Here is a sampling.

Right to Timely Care: Part III and section IV.2., above, demonstrate that the fundamental Charter right to life, liberty and security of the person and the right to equality have removed criminal law, public law, and government policy impediments to medically necessary health services (e.g., medical treatment, abortion, addiction therapy). What is the scope, the depth, and the limits of such fundamental rights in affording a positive right to medically necessary care?

Medical Assistance in Dying: Will Canada's eligibility requirements for participating in its MAID regime expand to include minors? If so, what procedural standards best protect vulnerable persons from potential abuse?

Environmental Health: To what extent does the Canadian Charter, federal environmental law, antidiscrimination law, afford citizens the right to be free from dangerous chemicals, toxic pollutants, contaminated soil, air pollution and other major impediments to a healthy environment?

Citizen Petitions & Reparations: Under what circumstances and grounds, may citizens legally compel government and institutions to take affirmative health measures, like funding a medical procedure, publishing health data, instituting objective health protection standards, re-imposing effective public health mandates?

International Standards: To what extent will international human rights norms continue to nudge, guide or even mandate standards and duties to enable and fulfil the right to health?

Repairing the Past: Recent court judgments and recent legal actions have sought to repair historic health and human rights violations in such domains as wrongful government experimentation on inmates,[270] non-consensual sterilization of Indigenous women,[271] systemic discrimination impacting Indigenous children.[272] What other measures should join compensation, public reports, and apologies, to best enable society to promote public accountability, repair injury and prevent future harms, right wrongs, and otherwise advance reparative justice?

IV.5. Abuse of the right to health

The legal doctrine of an "abuse of rights" has gained some recognition in international law and in civil law jurisdictions. In Canada, it has thus found some expression in corners of Quebec civil law. It remains an open question of how, if at all, the doctrine would apply in the Quebec or Canadian human rights context. Since our focus is on Canadian federal law, an analysis of it lies beyond the scope of the study.

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[270] *Barker v Barker*, 2020 ON SC 3746.

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V. Conclusion

This study has explored Canada's right to largely under Canadian federal law. It offers a few basic conclusions.

First, Canada offers no sole, clear and authoritative legal source for the definition, scope, and application of a right to health. The Canadian Constitution's silence on “health”, however, does not obscure the role of Charter jurisprudence as a transformative, if not revolutionary, source of health-related human rights over the last four decades. Even before Canada's modern human rights revolution, federal quarantine and drug safety laws have served the ancient role of societal public health protection. The absence of a sole legal source for Canada's right to health means that the right flows from diverse, multiple legal sources. Canada's right to health is thus multi-sourced—from Charter, statutory, international common and civil law sources.

Second, the study also suggests that a veritable constellation of related rights flows from diverse legal sources, to structure – like a crystal prism – different faces or facets of Canada's right to health. Visually, Canada's right to health may be seen as a prism of rights. Such correlative rights do not emerge simultaneously. Different aspects of the right to health are evolving – from aspirational conceptions toward full legal development with clear duties and standards. The right to physical and mental integrity, the right to universal health insurance, and a right to healthy housing, a right to participate in the advances of science, do not enjoy similar recognition under Canadian law, even as each continues to evolve.

Third, as such, the Canadian experience accords with a broad, multifaceted, dynamic right to health structured on diverse fronts over time by complementary and interactive synergistic dignitary rights. Some facets and rights are conspicuous; others more obscure. Thus, if Canada's right to health encompasses a right to health care, it also transcends it. It does so in synergy with other health-related human rights, like the right to informational privacy, liberty and security of the person, equal access to heath services, and the right to health protection. A right to a healthy environment remains on the horizon. Canadian law thus advances related rights and facets of a right to health in diverse contexts. As such diverse health-related rights advance, a robust and more developed and coherent right to health seems likely to emerge.

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  Le rôle des cours constitutionnelles dans la gouvernance à plusieurs niveaux - États-Unis d'Amérique : la Cour suprême, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), novembre 2016, VI et 46 pp., référence PE 593.503 (French translation with added comments);

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II. Judicial remedies for individuals before the highest jurisdictions

- **Belgium**: BEHRENDT, CH.: *Recours des particuliers devant les plus hautes juridictions, une perspective de droit comparé - Belgique*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), octobre 2017, V et 38 pp., référence PE 608.732;
- **Canada**: POIRIER, J.:
  Recours des particuliers devant les plus hautes juridictions, une perspective de droit comparé - Canada, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), octobre 2017, VIII et 73 pp., référence PE 608.733 (original French version);

  Legal Proceedings available to Individuals before the Highest Courts: A Comparative Law Perspective - Canada, Comparative Law Library Unit, European Parliamentary Research Service (EPRS), October 2017, X and 80 pp., reference PE 608.733 (English translation);
- **Council of Europe**: PÉREZ DE LOS COBOS ORIHUEL, F.: *Los recursos de los particulares ante las más altas jurisdicciones, una perspectiva de Derecho Comparado - Consejo de Europa: Tribunal Europeo de Derechos Humanos*, Unidad Biblioteca de Derecho Comparado, Servicios de Estudios Parlamentarios (EPRS), octubre 2017, VI y 51 pp., referencia PE 608.734;
- **European Union**: SALVATORE, V.: *I ricorsi individuali dinanzi alle più alte giurisdizioni, una prospettiva di diritto comparato - UE: Corte di giustizia dell'Unione europea*, Unità Biblioteca di diritto comparato, Servizio Ricerca del Parlamento europeo (EPRS), ottobre 2017, VI e 39 pp., referenza PE 608.742;
- **Germany**: SCHÖNDORF-HAUBOLD, B.: *Rechtsbehelfe des Einzelnen bei den höchsten gerichtlichen Instanzen: eine Perspektive der Rechtsvergleichung - Deutschland*, Bibliothek für Vergleichendes Recht, Wissenschaftlicher Dienst des Europäischen Parlaments (EPRS), Oktober 2017, X und 65 S., Referenz PE 608.735;
- **Italy**: LUCIANI, M.: *I ricorsi individuali dinanzi alle più alte giurisdizioni. Una prospettiva di diritto comparato - Italia*, Unità Biblioteca di diritto comparato, Servizio Ricerca del Parlamento europeo (EPRS), ottobre 2017, VIII e 31 pp., referenza PE 608.736;
- **Spain**: GONZÁLEZ-TREVIJANO SÁNCHEZ, P.: *Los recursos de los particulares ante las más altas jurisdicciones, una perspectiva de Derecho Comparado - España*, Unidad Biblioteca de Derecho Comparado, Servicios de Estudios Parlamentarios (EPRS), octubre 2017, VIII y 52 pp., referencia PE 608.737;
- **Switzerland**: DE ROSSA, F.: *Recours des particuliers devant les plus hautes juridictions, une perspective de droit comparé - Suisse*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), octobre 2017, VIII et 58 pp., référence PE 608.738;
- **United Kingdom**: CRAM, I.: *Judicial remedies for individuals before the highest jurisdictions, a Comparative Law perspective - The United Kingdom*, Comparative Law Library Unit, European Parliamentary Research Service (EPRS), October 2017, VIII and 50 pp., reference PE 608.746;
- **United States**: ACOSTA, L.: *Judicial remedies for individuals before the highest jurisdictions, a Comparative Law perspective - United States of America*, Comparative Law Library Unit, European Parliamentary Research Service (EPRS), October 2017, VIII and 33 pp., reference PE 608.743.

III. Right to respect for private life

- **Belgium**: BEHRENDT, CH.: *Le droit au respect de la vie privée : les défis digitaux, une perspective de droit comparé - Belgique*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), octobre 2018, VI et 32 pp., référence PE 628.304;
- **Canada**: MOYSE, P.-E.: *Le droit au respect de la vie privée : les défis digitaux, une perspective de droit comparé - Canada*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), octobre 2018, VIII et 67 pp., référence PE 628.292;
- **Council of Europe**: PÉREZ DE LOS COBOS ORIHUEL, F.: *El derecho al respeto de la vida privada: los retos digitales, una perspectiva de Derecho comparado - Consejo de Europa*, Unidad Biblioteca de Derecho Comparado, Servicios de Estudios Parlamentarios (EPRS), octubre 2018, VI y 53 pp., referencia PE 628.261;
- **European Union**: SALVATORE, V.: *Il diritto al rispetto della vita privata: le sfide digitali, una prospettiva di diritto comparato - Unione europea*, Unità Biblioteca di diritto comparato, Servizio Ricerca del Parlamento europeo (EPRS), ottobre 2018, VI e 39 pp., referenza PE 628.243;
- **France**: PONTHOREAU, M.-C.: *Le droit au respect de la vie privée : les défis digitaux, une perspective de droit comparé - France*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), octobre 2018, VIII et 34 pp., référence PE 628.241;
- **Germany**: SCHÖNDORF-HAUBOLD, B.: *Das Recht auf Achtung des Privatlebens – Problemstellungen im Digitalbereich, eine rechtsvergleichende Perspektive: Deutschland*, Bibliothek für Vergleichendes Recht, Wissenschaftlicher Dienst des Europäischen Parlaments (EPRS), Oktober 2018, X und 94 S., Referenz PE 628.285;
- **Italy**: LUCIANI, M.: *Il diritto al rispetto della vita privata: le sfide digitali, una prospettiva di diritto comparato - Italia*, Unità Biblioteca di diritto comparato, Servizio Ricerca del Parlamento europeo (EPRS), ottobre 2018, VIII e 46 pp., referenza PE 628.259;
- **Spain**: GONZÁLEZ-TREVIJANO SÁNCHEZ, P.: *El derecho al respeto de la vida privada: los retos digitales, una perspectiva de Derecho comparado - España*, Unidad Biblioteca de Derecho Comparado, Servicios de Estudios Parlamentarios (EPRS), octubre 2018, VIII y 58 pp., referencia PE 628.260;
- **Switzerland**: MÉTILLE, S.: *Le droit au respect de la vie privée : les défis digitaux, une perspective de droit comparé - Suisse*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), octobre 2018, VIII et 57 pp., référence PE 628.242;
- **United Kingdom**: CRAM, I.: *The right to respect for private life: digital challenges, a Comparative-Law perspective - The United Kingdom*, Comparative Law Library Unit, European Parliamentary Research Service (EPRS), October 2018, X and 38 pp., reference PE 628.249;
- **United States**: ACOSTA, L.: *The right to respect for private life: digital challenges, a Comparative-Law perspective - The United States*, Comparative Law Library Unit, European Parliamentary Research Service (EPRS), October 2018, VIII and 35 pp., reference PE 628.240.

IV. Freedom of expression

- **Belgium**: BEHRENDT, CH.: *Liberté d'expression, une perspective de droit comparé - Belgique*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), octobre 2019, VI et 42 pp., référence PE 642.243;
- **Canada**: MOYSE, P.-E.: *Liberté d'expression, une perspective de droit comparé - Canada*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), octobre 2019, VI et 71 pp., référence PE 642.244;
- **Council of Europe**: ZILLER, J.: *Liberté d'expression, une perspective de droit comparé - Conseil de l'Europe*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), octobre 2019, VI et 64 pp., référence PE 642.268;
- **European Union**: SALVATORE, V.: *La libertà di espressione, una prospettiva di diritto comparato - Unione europea*, Unità Biblioteca di diritto comparato, Servizio Ricerca del Parlamento europeo (EPRS), novembre 2019, VI e 40 pp., referenza PE 644.172;
- **France**: PONTHOREAU, M.-C.: *Liberté d'expression, une perspective de droit comparé - France*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), octobre 2019, VI et 43 pp., référence PE 642.245;
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- **Italy**: LUCIANI, M.: *La libertà di espressione, una prospettiva di diritto comparato - Italia*, Unità Biblioteca di diritto comparato, Servizio Ricerca del Parlamento europeo (EPRS), ottobre 2019, VIII e 55 pp., referenza PE 642.242;
- **Peru**: ESPINOSA-SALDAÑA BARRERA, E.: *La libertad de expresión, una perspectiva de Derecho Comparado - Perú*, Unidad Biblioteca de Derecho Comparado, Servicios de Estudios Parlamentarios (EPRS), noviembre 2019, VI y 43 pp., referencia PE 644.176;
- **Spain**: GONZÁLEZ-TREVIJANO SÁNCHEZ, P.: *La libertad de expresión, una perspectiva de Derecho Comparado - España*, Unidad Biblioteca de Derecho Comparado, Servicios de Estudios Parlamentarios (EPRS), octubre 2019, VIII y 56 pp., referencia PE 642.241;
- **Switzerland**: COTTIER, B.: *Liberté d'expression, une perspective de droit comparé - Suisse*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), octobre 2019, VIII et 39 pp., référence PE 642.262;
- **United Kingdom**: CRAM, I.: *Freedom of expression, a Comparative-Law perspective - The United Kingdom*, Comparative Law Library Unit, European Parliamentary Research Service (EPRS), October 2019, VI and 53 pp., reference PE 642.263;
- **United States**: VELENCHUK, T.: *Freedom of expression, a Comparative Law perspective - The United States*, Comparative Law Library Unit, European Parliamentary Research Service (EPRS), October 2019, X and 48 pp., reference PE 642.246.

V. Ratification of international treaties

- **Belgium**: BEHRENDT, CH.: *La ratification des traités internationaux, une perspective de droit comparé - Belgique*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), mars 2020, VI et 44 pp., référence PE 646.197;
- **Canada**: PROVOST, R.: *La ratification des traités internationaux, une perspective de droit comparé - Canada*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), février 2018, VI et 34 pp., référence PE 633.186;
- **France**: PONTHOREAU, M.-C.: *La ratification des traités internationaux, une perspective de droit comparé - France*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), juin 2019, VI et 61 pp., référence PE 637.963;
- **Germany**: GRAF VON KIELMANSEGG, S.:
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- **Italy**: CAFARO, S.: *La ratifica dei trattati internazionali, una prospettiva di diritto comparato - Italia*, Unità Biblioteca di diritto comparato, Servizio Ricerca del Parlamento europeo (EPRS), luglio 2018, VIII e 42 pp., referenza PE 625.128;
- **Morocco**: BERRAMDANE, A.: *La ratification des traités internationaux, une perspective de droit comparé - Maroc*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), décembre 2018, VIII et 52 pp., référence PE 630.337;
- **Portugal**: SALVAÇÃO BARRETO, P.: *A ratificação de tratados internacionais, uma perspectiva de direito comparado - Portugal*, Unidade Biblioteca de Direito Comparado, Serviços de Estudos do Parlamento Europeu (EPRS), novembro 2018, VIII e 33 pp., referência PE 630.294;
- **Spain**: FERNÁNDEZ DE CASADEVANTE ROMANI, C.: *La ratificación de los tratados internacionales, una perspectiva de Derecho Comparado - España*, Unidad Biblioteca de Derecho Comparado, Servicios de Estudios Parlamentarios (EPRS), septiembre 2021, VIII y 80 pp., referencia PE 698.044;
- **Switzerland**: DE ROSSA, F.: *La ratification des traités internationaux, une perspective de droit comparé - Suisse*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), mars 2018, VI et 35 pp., référence PE 614.719 ;
- **United States**: WINSTON, A.M.: *Ratification of international treaties, a Comparative Law perspective - United States of America*, Comparative Law Library Unit, European Parliamentary Research Service (EPRS), July 2020, VIII and 44 pp., reference PE 652.013.

VI. Principles of equality and non-discrimination

- **Austria**: VAŠEK, M.:
  Die Grundsätze der Gleichheit und der Nichtdiskriminierung, eine rechtsvergleichende Perspektive – Österreich, Bibliothek für Vergleichendes Recht, Wissenschaftlicher Dienst des Europäischen Parlaments (EPRS), Oktober 2020, VIII und 44 S., Referenz PE 659.277 (original German version);

  Les principes d'égalité et de non-discrimination, une perspective de droit comparé - Allemagne, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), mars 2022, XIV et 111 pp., référence PE 729.295 (French translation with added comments);
- **Belgium**: BEHRENDT, CH.: *Les principes d'égalité et non-discrimination, une perspective de droit comparé - Belgique*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), février 2021, VIII et 44 pp., référence PE 679.087;
- **Canada**: SHEPPARD, C.:
  The principles of equality and non-discrimination, a Comparative Law perspective - Canada, Comparative Law Library Unit, European Parliamentary Research Service (EPRS), November 2020, VIII and 64 pp., reference PE 659.362 (original English version);

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- **Chile**: GARCÍA PINO, G.: *Los principios de igualdad y no discriminación, una perspectiva de Derecho Comparado - Chile*, Unidad Biblioteca de Derecho Comparado, Servicios de Estudios Parlamentarios (EPRS), marzo 2021, VIII y 120 pp., referencia PE 690.533;
- **Council of Europe**: ZILLER, J.: *Les principes d'égalité et de non-discrimination, une perspective de droit comparé - Conseil de l'Europe*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), octobre 2020, VIII et 72 pp., référence PE 659.276;
- **European Union**: SALVATORE, V.: *I principi di uguaglianza e non discriminazione, una prospettiva di diritto comparato - Unione europea*, Unità Biblioteca di diritto comparato, Servizio Ricerca del Parlamento europeo (EPRS), gennaio 2021, VIII e 61 pp., referenza PE 679.060;
- **France**: PONTHOREAU, M.-C.:
  Les principes d'égalité et non-discrimination, une perspective de droit comparé - France, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), janvier 2021, VIII et 44 pp., référence PE 679.061;

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- **Germany**: REIMER, F.:
  Die Grundsätze der Gleichheit und der Nichtdiskriminierung, eine rechtsvergleichende Perspektive - Deutschland, Bibliothek für Vergleichendes Recht, Wissenschaftlicher Dienst des Europäischen Parlaments (EPRS), Oktober 2020, XIV und 77 S., Referenz PE 659.305;

  Les principes d'égalité et de non-discrimination, une perspective de droit comparé - Allemagne, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), mars 2022, XIV et 111 pp., référence PE E 729.295 (French translation with added comments and update);
- **Italy**: LUCIANI, M.: *I princìpi di eguaglianza e di non discriminazione, una prospettiva di diritto comparato - Italia*, Unità Biblioteca di diritto comparato, Servizio Ricerca del Parlamento europeo (EPRS), ottobre 2020, X e 71 pp., referenza PE 659.298;
- **Peru**: ESPINOSA-SALDAÑA BARRERA, E.: *Los principios de igualdad y no discriminación, una perspectiva de Derecho Comparado - Perú*, Unidad Biblioteca de Derecho Comparado, Servicios de Estudios Parlamentarios (EPRS), diciembre 2020, VIII y 64 pp., referencia PE 659.380;
- **Spain**: GONZÁLEZ-TREVIJANO SÁNCHEZ, P.: *Los principios de igualdad y no discriminación, una perspectiva de Derecho Comparado - España*, Unidad Biblioteca de Derecho Comparado, Servicios de Estudios Parlamentarios (EPRS), octubre 2020, VIII y 104 pp., referencia PE 659.297;
- **Switzerland**: FREI, N.:
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- **United States**: OSBORNE, E.L.:
  The principles of equality and non-discrimination, a Comparative Law perspective - United States of America, Comparative Law Library Unit, European Parliamentary Research Service (EPRS), March 2021, XII and 83 pp., reference PE 689.375 (original English version);

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VII. Right to health

- **Argentina**: DÍAZ RICCI, S.: *El derecho a la salud, una perspectiva de Derecho Comparado - Argentina*, Unidad Biblioteca de Derecho Comparado, Servicios de Estudios Parlamentarios (EPRS), noviembre 2021, XVIII y 134 pp., referencia PE 698.814;

- **Austria**: WIMMER, A.: *Das Recht auf Gesundheit, eine rechtsvergleichende Perspektive - Österreich*, Bibliothek für Vergleichendes Recht, Wissenschaftlicher Dienst des Europäischen Parlaments (EPRS), April 2022, XI und 70 S., Referenz PE 729.394

- **Belgium**: BEHRENDT, C.; *Le droit à la santé une perspective de Droit comparé - Belgique*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), mars 2022, IX et 74 pp., référence PE 729.344 ;

- **Council of Europe**: ZILLER, J.: *Le droit à la santé, une perspective de droit comparé - Conseil de l'Europe*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), septembre 2021, VIII et 67 pp., référence PE 698.030;

- **European Union**: SALVATORE, V.: *Il diritto alla salute, una prospettiva di diritto comparato - Unione europea*, Unità Biblioteca di diritto comparato, Servizio Ricerca del Parlamento europeo (EPRS), dicembre 2021, X e 68 pp., referenza PE 698.827;

- **France**: PONTHOREAU, M.-C.: *Le droit à la santé, une perspective de droit comparé - France*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), octobre 2021, X et 66 pp., référence PE 698.755;

- **Germany**: REIMER, F.: *Das Recht auf Gesundheit, eine rechtsvergleichende Perspektive - Deutschland*, Bibliothek für Vergleichendes Recht, Wissenschaftlicher Dienst des Europäischen Parlaments (EPRS), Oktober 2021, XIV und 81 S., Referenz PE 698.770;

- **Italy**: LUCIANI, M.: *Il diritto alla salute, una prospettiva di diritto comparato - Italia*, Unità Biblioteca di diritto comparato, Servizio Ricerca del Parlamento europeo (EPRS), gennaio 2022, XII e 85 pp., referenza PE 698.893;

- **Mexico**: FERRER MAC-GREGOR POISOT, E.: *El derecho a la salud, una perspectiva de Derecho Comparado - México*, Unidad Biblioteca de Derecho Comparado, Servicios de Estudios Parlamentarios (EPRS), enero 2022, X y 116 pp., referencia PE 698.899;

- **Spain**: GONZÁLEZ-TREVIJANO SÁNCHEZ, P.: *El derecho a la salud, una perspectiva de Derecho Comparado - España*, Unidad Biblioteca de Derecho Comparado, Servicios de Estudios Parlamentarios (EPRS), noviembre 2021, X y 89 pp., referencia PE 698.810;

- **Switzerland**: DUPONT, A.S., BURGAT, S., HOTZ, S. et LÉVY, M. : *Le droit à la santé, une perspective de droit comparé - Suisse*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), Mai 2022, XVI et 126 pp., référence PE 729.419

- **United Sates**: MARTIN, J.W.: *Right to health, a Comparative Law perspective - United States of America*, Comparative Law Library Unit, European Parliamentary Research Service (EPRS), May 2022, XI and 74 pp., reference PE 729.407.

VIII. Law of exception (legal bases for anti-COVID-19 measures)

- **Belgium**: BOUHON, M., JOUSTEN, A., MINY, X.: *Droit d'exception, une perspective de droit comparé - Belgique : Entre absence d'état d'exception, pouvoirs de police et pouvoirs spéciaux*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), avril 2021, X et 161 pp., référence PE 690.581;
- **France**: ZILLER, J.: *Droit d'exception, une perspective de droit comparé - France : lois d'urgence pour faire face à l'épidémie de Covid-19*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), mai 2021 (mise à jour du 1er juin 2021), X et 105 pp., référence PE 690.624;
- **Germany**: SCHÄFER, B.:
  Das Recht des Ausnahmezustands im Rechtsvergleich - Deutschland: Ungenutztes Notstandsrecht und Integration des Ausnahmefalls in das einfache Recht, Bibliothek für Vergleichendes Recht, Wissenschaftlicher Dienst des Europäischen Parlaments (EPRS), mai 2020, IV und 35 S., Referenz PE 651.938 (original German version);

  Le droit d'exception, une perspective de droit comparé - Allemagne : non-utilisation du droit d'exception en faveur de l'application du droit ordinaire, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), mai 2020, IV et 38 pp., référence PE 651.938 (French translation with added comments);
- **Italy**: ALIBRANDI, A.: *Il diritto di eccezione: una prospettiva di diritto comparato - Italia: stato di emergenza*, Unità Biblioteca di diritto comparato, Servizio Ricerca del Parlamento europeo (EPRS), giugno 2020, VIII e 49 pp., referenza PE 651.983;
- **Spain**: LECUMBERRI BEASCOA, G.:
  El Derecho de excepción, una perspectiva de Derecho Comparado - España: estado de alarma, Unidad Biblioteca de Derecho Comparado, Servicios de Estudios Parlamentarios (EPRS), abril 2020, II y 19 pp., referencia PE 649.366 (original Spanish version);

  Das Notstandsrecht, eine rechtsvergleichende Perspektive - Spanien: Alarmzustand, Bibliothek für Vergleichendes Recht, Wissenschaftlicher Dienst des Europäischen Parlaments (EPRS), April 2020, II und 20 S., Referenz PE 649.366 (German translation with added comments);

  Le droit d'exception, une perspective de droit comparé - Espagne : état d'alerte, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), avril 2020, II et 19 pp., référence PE 649.366 (French translation);

  Il diritto di eccezione, una prospettiva di diritto comparato - Spagna: stato di allarme, Unità Biblioteca di diritto comparato, Servizio Ricerca del Parlamento europeo (EPRS), aprile 2020, II e 20 pp., referenza PE 649.366 (Italian translation with added comments);

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IX. Other topics

- **Copyright Law**: AA. VV.: *Copyright Law in the EU: Salient features of copyright law across the EU Member States*, Comparative Law Library Unit, European Parliamentary Research Service (EPRS), June 2018, VIII and 409 pp., reference PE 625.126;
- **Supreme Court of the United States: appointment of judges**: DÍEZ PARRA, I.: *La nomination des juges de la Cour Suprême des États-Unis*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), septembre 2020, 10 pp., référence PE 652.103.

- **Selected case law:**
  COMPARATIVE LAW LIBRARY UNIT: *Better Law-Making – Selected case law*, Comparative Law Library Unit, European Parliamentary Research Service (EPRS), January 2017, 5 pp;

  COMPARATIVE LAW LIBRARY UNIT: *Rule of law – Selected case law*, Comparative Law Library Unit, European Parliamentary Research Service (EPRS), March 2017, 15 pp, reference PE 599.338;

  MICHAELSEN, F. and DÍEZ PARRA, I. (coord.): *Accession of the EU to the ECHR – Selected publications & case law*, Comparative Law Library Unit, European Parliamentary Research Service (EPRS), July 2017, 7 pp, reference PE 607.299.

- **Selected publications:**
  COMPARATIVE LAW LIBRARY UNIT: *Better Law-Making – Selected publications*, Comparative Law Library Unit, European Parliamentary Research Service (EPRS), January 2017, 9 pp;

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  DIMBOUR, C. and DÍEZ PARRA, I. (dir.): *Sélection de publications en droit comparé : Juridictions constitutionnelles : fondamentaux*, Unité Bibliothèque de droit comparé, Service de recherche du Parlement européen (EPRS), février 2020, 35 pp., référence PE 646.175.

This study forms part of a larger Comparative Law project which seeks to present the right to health in a broad range of legal systems around the world. After analyzing applicable constitutional sources, federal legislation and leading case law, the definition and content, scope and limits, and evolution of Canada's right to health are explored.

The subject of this study is the Canadian legal system.

This study begins with an overview of selected historic dangers to Canada's health, challenges of the Covid-19 pandemic, and how such historic tragedies help contextualize and nurture national health needs and duties towards emergence of a right to health. It then explores leading constitutional, statutory and jurisprudential developments at the confluence of health law and human rights as sources of a right to health. While a right to health is not expressly enumerated in the Canadian Constitution, diverse fundamental rights of the Canadian Charter of Rights and Freedoms have been significant drivers of access to medically necessary services and a protectorate of health-related values. Many such rights have proved pivotal in Canada's early Covid litigation. As well, federal human rights law, federal legislation on health services and national public health and safety regulations, underscore the vital role that such laws play in accessing, protecting and promoting human health. The document concludes with an exploration of the contours of the right to health – its definitions, scope and breadth, and its interface with fundamental rights to liberty, security of the person, equality, bodily integrity, privacy, etc. Such Charter rights have reformed Canadian law on abortion, euthanasia, health information privacy, solitary confinement. The study suggests that Canada's right to health encompasses and transcends access to health care. The right is not static; but, dynamic and iterative. It continues to evolve on a spectrum from a narrow right to health services, to a right to health protection, towards a broader right to determinants of health. The right draws on and synergizes with correlative, health-related dignitary rights. Together, they comprise facets of a right to health in diverse contexts. As they advance, a more robust and developed right to health seems likely to emerge in Canadian law.

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