An Overview of the Canadian Health Care System: An International Human Rights Perspective

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Abstract
This paper begins with an overview of the Canadian health care system; particular attention is paid to physician and hospital services and the role of private health insurance. The paper then shifts focus to examine the international right to health, in particular the right to health as outlined in article 12 of the International Covenant on Economic, Social, and Cultural Rights. General Comment No. 14:The Right to the Highest Attainable Standard of Healthis relied on to help clarify the understanding of the obligations arising from article 12. The paper concludes with an analysis of how well the Canadian health care system fulfils article 12's obligations.

Key Words: Health Care; Public Health; Health Care System; International Right to Health; Canada

1. Introduction

Health and healthcare rarely seem to be far from most people's thoughts; it is a matter of personal concern and the subject of constant news coverage. Public criticism often centres on the long waiting times for medical tests and procedures and a general lack of funding for the health care system (Ontario Election, 2014; Caplan, 2014).Governments have to choose which medical services to provide while still meeting budgetary requirements; this makes immediate health care availability an unattainable goal. In Canada, government choices in health care are based on domestic policies; little, if any, attention is given to international law requirements. Despite the lack of domestic consideration, the understanding of the international right to health has grown.

The international right to health has been, in recent years, the subject of significant academic literature and growing recognition. Internationally, the right to health has been codified in various international documents and treaties, including the *International Covenant on Economic, Social and Cultural Rights (ICESCR)* (Erasmus, 2004, p. 252).This paper will explore how the Canadian health care system meets the

requirements of the international right to health as defined in the *ICESCR*. It will commence with an examination of the Canadian health care system before examining how the system fulfils the requirements found in the *ICESCR*.

2. The Canadian Health Care System

2.1 The *Canada Health Act*

Canada's health care system is based on the principle that "care should be allocated on the basis of need and not ability to pay." (Flood, Stabile &Tuohy, 2002, p. 300) Currently, the federal government's primary role in the health care system is governed by the *Canada Health Act (CHA)*.The primary objective of the *CHA* (1985, s 3) is "to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers". Since provinces have primary jurisdiction over health care (Jackman, 2000), the *CHA* does not establish a uniform national health care system. Rather, it establishes requirements that a provincial health insurance system must meet in order to be eligible for federal monies, these requirements are: universality, public administration, comprehensiveness, portability and accessibility (*CHA*, 1985).

Universality is considered the hallmark of the Canadian Medicare system (Choudhry, 1996).The provincial health care plan must provide all "medically necessary" hospital services and "medically required" physician services on identical terms and conditions to all residents (*CHA,* 1985, s 10; Health Canada, 2004; Flood &Choudhry, 2002, p. 8).Accessibility, which is closely associated with universality, is intended to ensure that individuals are able to access insured services unimpeded by extra costs or "other means" (such as discrimination and financial circumstances) (*CHA*, 1985, s 12; Health Canada, 2004).

Public administration requires that a public authority administer the provincial health insurance scheme on a non-profit basis; ultimate accountability must rest with the provincial government (*CHA*, s 8; Choudhry, 1996). The single-payer system, established by public administration, controls the costs of the medical services and allows for equitable access to the system (Romanow, 2002).

Comprehensiveness requires "the health care insurance plan of a province or territory must cover all insured health services provided by hospitals, physicians or dentists…" (*CHA*, s 9; Health Canada, 2004).Provided the province complies with *CHA*, the province ultimately decides what services to insure (Romanow, 2002).Given Canada's geographic size, portability is a key issue. Portability requires that a person who is moving to another province continues to be covered by his/her home province until the new province's health coverage begins (Health Canada, 2004; *CHA*, s 11; Farley, 2010; Gilmour, 2006, p 38-39).

The *CHA* also imposes two prohibitions on provinces. Extra billing, which is when the medical practitioner bills the patient an amount over what has already been paid to the practitioner for a health care service by the public system, is prohibited because it impedes a person's ability to access insured medical care (*CHA*, s 18; Health Canada, 2004).User fees, which include any "charge for an insured health service other than extra-billing" (*CHA*, s 19), are also prohibited because they are an impediment to public access to the health care system. Pursuant to sections 18 and 19 of the *CHA,* the provinces will be monetarily penalized for allowing either practice (Epps & Flood, 2002, p 752-753).

2.2 Who and What is Covered in the Public Health Care System?

All "province[s] must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions." (*CHA*, s 10)An insured person is defined as a resident of the province, other than a resident who has not yet satisfied the minimum period of residency in the province, a member of the Canadian Forces, the RCMP, or an imprisoned person detained in a penitentiary; the federal government provides health care services for these latter three groups (*CHA*, s 2; Health Canada Website).

The *Canada Health Act* requires that provincial health care insurance systems cover medically necessary hospital and physician services. Section 2 of the *CHA* defines hospital services as:

> …any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability, namely,
> (a) accommodation and meals at the standard or public ward level and preferred accommodation if medically required,
> (b) nursing services,
> (c) laboratory, radiological and other diagnostic procedures, together with the necessary interpretations,
> (d) drugs, biologicals and related preparations when administered in the hospital,
> (e) use of operating room, case room and anaesthetic facilities, including necessary equipment and supplies,
> (f) medical and surgical equipment and supplies,
> (g) use of radiotherapy facilities
> (h) use of physiotherapy facilities, and
> (i) services provided by persons who receive remuneration therefor from the hospital,
> but does not include services that are excluded by the regulations;

Physician services are defined in section 2 of the *CHA* as "any medically required services rendered by medical practitioners."Provincial First Ministers have discussed extending coverage to include home services and prescription drug coverage; however, most provinces do not cover these services (Flood, 2006).

With constantly evolving medical technology, provinces struggle to make decisions as to what should be covered as a "medically necessary" procedure under their health programs; the *CHA* does not provide guidance since it fails to define the term (Flood & Chen, 2010, p. 479; Hughes Tuohy, 2009).How provinces decide what health care services to fund depends on the category of the health service (Flood, 2006). Typically, provinces decide what is considered "medically necessary" physician services through negotiations with the provincial medical associations (Ries, 2006 (b), p. 47; Flood, Tuohy& Stabile 2002, p. 303-304). There are also various committees put in place to ensure that the technology, services and drugs covered by the health care plans are technologically sound (based on clinical evidence) and present good value for money for things such as pharmaceuticals and new technologies (*Ontario Drug Benefit Act*, 1990; Committee to Evaluate Drugs).

Despite the general approach followed by provinces, "it is difficult to articulate a principled definition of 'medically necessary' since what is medically necessary will fluctuate with the resources we have, our values, health care needs, and developments in technology." (Ries, 2006 (b), p. 47) Furthermore, given the scarce resources, it is impossible to fund all programs. In fact, recent trends show that many Canadian provinces are beginning to ration health care resources and are "deinsuring" previously covered health care services (Flood, Tuohy& Stabile, 2002, p. 304).

While the provinces are forced to choose which services to cover in their health care systems, individuals needing medical services will sometimes find that the services are not insured or are inadequately provided. Two provinces, Ontario and British Columbia have established administrative tribunals to "deal with claims that the respective provincial governments should be publicly funding particular treatments." (Flood, Tuohy& Stabile, 2002, p. 307)In addition, all provinces, with the exception of Prince Edward Island, have an Ombudsman that oversees the administration of government services, including health services (Forum of Canadian Ombudsman, 2014). Lastly, litigation over health care options remains a choice. In recent years there has been a substantial increase in litigation over healthcare related issues (*Cuthbertson v. Rasouli*, 2013; *Chaoulli v Quebec (Attorney General)*, 2005; *Edwardson v. St. Joseph's Healthcare Hamilton (St. Joseph's Hospital),* 2012; Flood & Chen, 2010, p. 480).

2.3 The Role of Private Health Insurance

Despite the fact that hospital and medical services are publicly funded under the Canadian health care system, significant areas of health care services are not typically covered by the public system (Flood, Tuohy& Stabile, 2002, p. 299). Health care services that are not normally covered include: pharmaceuticals that are not received as an in-patient hospital service; dental services; and home care services. Given the increase in home care and prescription drugs there has been an increase in the demand for private health insurance to cover these services (Canadian Institute for Health Information, 2010).

Provinces, historically, have limited or banned the use of duplicate private health insurance.Duplicate private insurance "offers cover for health services already included under public health insurance" (OECD Health Statistics, 2014). Some provinces have concluded that the CHA's universality and accessibility criteria support a ban on duplicate insurance (Flood & Archibald, 2001, p. 825); however, the *CHA* does not explicitly ban duplicate insurance. As a result, in some provinces, the only available private health insurance is supplementary-meaning the insurance covers medical treatment not available in the public system. Despite these restrictions, over 65% of the population has private health insurance (Canadian Institute for Health Information, 2010, pp. 16-19) and some people have fought for the right to purchase additional private health insurance.

In 2005, the Supreme Court of Canada ruled on a challenge to Quebec's prohibition on duplicate private health insurance. In *Chaoulli v Quebec*, the Court concluded that the prohibition on duplicate private health insurance was a violation of the *Québec Charter*; as a result such a prohibition was unlawful. Since the decision was ultimately based on Québec law, the decision only had immediate impact in Québec. In other provinces that prohibited private duplicate health insurance, the prohibitions remain in effect, although lawsuits challenging the prohibition have started (Flood & Chen, 2010). In 2006, the Québec government passed *An Act to Amend the Act respecting health services and social services*. This *Act*, now allows private health insurance for hip, knee and cataract procedures (*Health Insurance Act (Quebec);* Flood & Chen, 2010, p. 507; Premont, 2007, 2008). The new duplicative health insurance remains unpopular in Quebec

because the Supreme Court's decision does not guarantee that a person can access it (this means that barriers to purchase based on medical history can occur) (No one wants, 30 March 2009).

3. How the Canadian System Compares with International Human Rights Obligations

In the past 60 years, the concept of a right to health has been widely discussed and developed in international law (Erasmus, 2004). Article 12 of the *ICESCR*, the 'cornerstone protection of the right to health in international law,' (Hunt, 2003, ¶ 11) states:

> 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
> (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
> (b) The improvement of all aspects of environmental and industrial hygiene;
> (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
> (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Since 1989, the United Nations' Committee on Economic, Social and Cultural Rights (CESCR) has written General Comments on the rights listed in the *ICESCR*. These comments are not legally binding however Blake (2008) has argued that they have taken on a legislative orientation when interpreting socio-economic rights. In 2000, the CESCR issued *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, which deals with the scope and content of the right to health and is now considered to be the most authoritative interpretation of the content of the right to health. This paper will examine the content of the right to health as defined in article 12 of the *ICESCR* and detailed in *General Comment No. 14*.

3.1 The Right to Health

The right to health was originally defined as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (Constitution of the World Health Organization, 1946; Hunt, 1996, 2003;Toebes, 2006, p. 103) Today, the right to health is understood as a right to a number of freedoms and entitlements relevant to a person's health and it takes into account an individual's own biology and socio-economic preconditions as well as the states' available resources (*General Comment No. 14*, 2000, ¶ 9).

> The freedoms include the right to control one's health and body…and the right to be free from interference…[t]he entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable standard of health (*General Comment No. 14*, 2000, ¶ 8).

While the right to health does include 'timely and appropriate health care,' it also includes the right to health's underlying determinants. These underlying determinants include: "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" (*General Comment No. 14*, 2000, ¶ 11).

3.2 Article 12 of the *ICESCR*

In the *ICESCR,* article 12 is divided into two parts: the first part contains the general definition of the right to health and will form the primary focus of the paper; article 12.2 provides a list of examples of a state party's obligations under the right to health (*General Comment No. 14,* 2000, ¶ 7). Since Article 12.2 of the *ICESCR* only provides a list of examples, the content and meaning of these are, in general, self-evident (*General Comment No. 14*, 2000, ¶ 14-17; O'Connell, 2005, pp. 76-84).

According to General Comment 14, the right to health, as outlined in article 12.1 contains 'the following interrelated and essential elements': availability, accessibility, acceptability, and quality (*General Comment No. 14*, 2000, ¶ 12 (a)-(d)). These essential elements have been identified as a useful analytical tool to help determine the content of the right to health (Hunt, 2004, ¶ 41).

3.2.1. Availability

Availability means that "[f] unctioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party" (*General Comment No. 14*, 2000, ¶ 12(a)).The level of health care services that must be made available by the state varies from country to country; it depends on the level of development of a given state (*General Comment No. 14*, 2000, ¶ 12(a)).According to Brigit Toebes (1999, pp 665-667), the CESCR, through its analysis of country reports, has laid out clear indicators related to the availability of health care services. Namely, the CESCR examines the ratio of hospital beds and the number of nurses and doctors for a given population (Toebes, 1999, p 667). Additionally, availability means that an adequate number of hospitals, clinics and 'other health-related buildings' must be available in the state (*General Comment No. 14*, 2000, ¶12 (a); Hunt &Mesquita, 2006, 346).

Canada, compared with other OECD countries, has fewer doctors per capita; in 2013 (the most recent statistics available), there were only 2.4 physicians per 1000 population, compared with the OECD average of 3.2 physicians per 1000 population (OECD, 2013, p. 65). There are approximately 9.3 nurses per 1000 population (OECD, 2013, p. 79). The number of available hospital beds is declining in the country; in 2011 there were 2.9 hospital beds available per 1000 population compared to the OECD average of 5 (OECD, 2013, p. 91). With the decline in hospital beds, no increase in physician services and limited private health insurance for services covered in the public system, the provincial governments have resorted to rationing health care services through the use of waiting lists.

In Canada, wait times have been defined as:

> A wait time begins with the booking of a service, when the patient and the appropriate physician agree to a service and the patient is ready to receive it. The appropriate physician is one with the authority to determine the nature of the needed service. A wait time ends with the commencement of the service (Health Canada, 2006, p. 24).

The use of waiting lists in Canada is increasingly common; one in five Canadians who required medical help encountered problems in accessing proper health care. (*Chaoulli v Quebec (Attorney General)*, 2005).

Health care service availability must operate within a fixed budget; as such, according to Abbing (2001, p. 58) "[w]ithin certain boundaries, waiting time is an acceptable tool for planning health care service

delivery." It is only when wait listed patients experience an exacerbation of their health problems as a result of waiting that the real problems associated with wait lists occur (*Chaoulli v Quebec (Attorney General)*, 2005).Both the government and the judiciary have reacted and implemented changes as a result of waiting lists. The Supreme Court, in *Chaoulli*(2005), struck down Québec's law that prohibited duplicate private health insurance. This decision may allow an individual to circumvent the public waiting lists by seeking private medical treatment (Premont, 2007, p. 56).While it may seem that allowing the purchase of private health insurance for publicly funded services will reduce the waiting lists in the public sector that is not always the case. Strong private health care systems do not inevitably lead to less wait times in the public system; in fact, the reverse is often the case; strong private health insurance systems can lead to longer waits in the public system (Flood & Sullivan, 2005, p. 142).

Besides the Court decision in *Chaoulli*, both the federal and provincial governments have introduced measures to alleviate wait times. In September 2004, the federal government announced that it would be increasing funding of provincial health care systems by an additional $5.5 billion to help reduce wait times for health care services; although current federal funding of health care is in state of flux (Department of Finance, 2010; Fekete, 2013). Additionally, in July 2005, the federal government appointed a Federal Advisor on Wait times; the Advisor was given a "mandate to undertake activities to ensure 'meaningful reductions in wait times' and to 'identify and continue to develop consensus on establishing comparable indicators and evidence based benchmarks'" (Health Canada, 2006, p. 19).

Furthermore, as part of the First Minister's *10-Year Action Plan to Strengthen Health Care*(2004), the provincial governments have also introduced new programs to help reduce wait times. The provincial governments identified five surgical areas of priority to reduce wait times and have attempted to develop policies around these areas (Ministry of Health Services British Columbia, 2014). Additionally, all provinces publicize the wait times at emergency rooms for physician consultations or surgical wait times; this keeps the public aware of the process and timeliness of potential health care services they may be trying to receive (Canadian Institute for Health Information, 2010 b).

While the Canadian government has comparable statistics to other OECD countries in relation to hospital beds and physician per population, concerns over availability of health care services remain. Canada rations access to health care services by using waiting lists. Canada has adopted several methods (a federal advisor on waitlists, increased funding, identification of key surgical areas and establishment of waitlist guidelines) in an attempt to control wait lists. Additionally, the Supreme Court of Canada has forced Québecto allow duplicate health insurance coverage and the province has developed a private health care insurance industry for certain surgeries. If Canada wishes to comply with Article 12 of the *ICESCR,* it needs to proceed cautiously with the methods it chooses to use to combat wait lists. The strengthening (or allowance) of private health care systems does not correlate with a reduction in wait times. Canada should continue to implement measures to decrease reliance on wait times, but it should do so cautiously to not further exacerbate the problem.

3.2.2. Acceptability

Acceptability is a second essential element of the right to health; it requires that facilities, goods and services are created and delivered in a manner that is culturally sensitive to the needs of the community (*General Comment No. 14*, 2000, ¶ 12 (c)). Essentially, all aspects of the right to health must take into

account an individual's cultural background, sex, and religion to ensure that all patients are treated in a culturally sensitive manner that best protects their human dignity (*General Comment No. 14*, 2000, ¶ 12(c)).

This can be a particular problem in Canada. In Canada, a nation that began with the recognition of two official languages and has a multitude of cultures (French, English and Aboriginal populations as well as many others), it may be difficult to find health care services that are culturally sensitive. Furthermore, cultural differences can also lead to miscommunication:

> [c]ommunication is an essential component of health care...[w]ithout adequate communication there is an increased risk of "miscommunication, misdiagnosis, inappropriate treatment, reduced patient comprehension and compliance, clinical inefficiency, decreased provider and patient satisfaction, malpractice injury, and death." (Health Canada, 2001, p. 19)

In Canada, "there is consensus from community level consultations and community-based surveys that many populations are less well served by the health system. This is attributed to "language barriers", "cultural barriers", lack of cultural sensitivity, or racism/ discrimination" (Taylor, 2012; Health Canada, 2001, p. 21). In 2001, a Health Canada report identified seven groups that experience problems in receiving appropriate health care because of cultural and/or language barriers: aboriginal peoples, immigrants and refugees, visible minorities, language minorities, persons of alternative sexual orientations, persons with disabilities and marginalized populations.

Canada has enacted various pieces of legislation to deal with some of these cultural and language barriers. For instance, the *Charter* guarantees "non-financial barriers which result in inequitable standards of care can be challenged" (Health Canada, 2001, p 51; *Eldridge v British Columbia*, 1997). Additionally, the Canadian government has passed the *Canadian Multiculturalism Act* of 1988. Section 3 (1) (c) of the *Multiculturalism Act* promised that the Government of Canada would "promote the full and equitable participation of individuals and communities of all origins in the continuing evolution and shaping of all aspects of Canadian society and assist them in the elimination of any barrier to such participation". Despite these legislative initiatives, it was not until 1997 that there was a large movement towards the removal of barriers in the health care system.

In 1998, a symposium called Removing Barriers: Inclusion, Diversity and Social Justice in Health Care, was held in Toronto; a second symposium followed in 2000, in Vancouver.

> Two specific actions were the direct result of the symposium: the Declaration on the Values in Health Care in Canada; and the request to the federal government for the establishment of a working group on diversity, inclusion and social justice. (Health Canada, 2001, p. 67)

While there is a wide recognition minorities face barriers to access, the government has yet to adopt a national patient charter. A patient's charter or bill of rights has been defined as "legislation enumerating and consolidating those patients' rights that exist at common law as well as rights from other sources...[it] would confer rights on users of all health care services (whether publicly funded or not…) and place corresponding obligations on providers of those services" (Flood & Epps, 2004, p. 517). Québec has adopted a patients' bill of rights, but such protection is not uniform across the country (*An Act Respecting Health Services and Social Services*, 1991).

While most Canadian citizens are not afforded rights under a patient's bill of rights, if they are treated in a culturally offensive manner during their health care treatment, several options are available to rectify the situation. Firstly, nine provinces have an Office of the Ombudsman that is allowed to hear complaints about its respective province's health care system. Additionally, a patient can also rely on the *Charter*; the *Charter* guarantees equality of access for Canadians to all government services (*Eldridge v British Columbia*, 1997).Finally, the person may also be able to obtain some relief from provincial human rights tribunals.

The Canadian government has an obligation to ensure that all aspects of its health care system are culturally acceptable to its citizens. Complaints procedures exist for problems in the health care system; furthermore, the *Charter* can apply to provincial health care systems. Such measures are an important start to ensure acceptability of health care services; nevertheless, Canada could further strengthen the acceptability requirement through the development of a national patient's charter. A patient's charter has many beneficial effects in the protection of health care rights (Flood & Epps, 2003-2004, p. 550-551; Vogel, 2010). Furthermore, Canada should ratify the Optional Protocol to the *ICESCR;* this would allow an individual, after he or she has exhausted the domestic courts and complaints procedures, the opportunity to pursue his or her claim at an international level (Melish, 2009).

3.2.3. Quality

A third essential attribute of the right to health is quality; it means that programs, health facilities or goods and services must be scientifically and medically sound and of good quality *(General Comment No. 14*, 2000, ¶ 12 (d)).Quality requirements include, amongst others: properly trained and skilled medical personnel (Toebes, 1999; *General Comment No. 3*, 1990) and scientifically approved medical procedures and treatment (*General Comment No. 14*, 2000, ¶ 12(d)).

In Canada, the licensing of health care professionals is a provincial matter (*Constitution Act 1867*). Each province has established a set of criteria for licensing doctors within its respective jurisdiction; this is left to the each provincial College of Physician and Surgeons. Accreditation of medical schools in Canada is primarily done through the Committee on Accreditation of Canadian Medical Schools in partnership with the Liaison Committee on Medical Education in the United States (The Royal College, 2014).

Publicly funded health care services vary between provinces; each province has programs to ensure that funded services meet technology standards and value for money. For instance, the Ontario government has established committees to review publicly funded drugs and treatments (Tuohy, 1999, p. 220).These committees consider, amongst other information, reports evaluating cost and medical effectiveness of the proposed new drug, therapy or treatment. Additionally, the committees also take into consideration such matters as access issues of vulnerable groups (Flood, 2006, p. 8).While the committees evaluate medical technology, other areas related to quality of health care service need to be improved.

In Canada, there are problems with a patient's continuity of care. Many patients, to meet their health care needs, have multiple doctors. Having multiple doctors can mean that individuals are not often reporting their entire medical history (this can include notes of previous medical procedures and tests); such a lack of easy follow-up on medical history can lead to problems with health care. There have been attempts to increase the use of telecommunications in patient health care with developments such as electronic health records; the use varies between doctors and privacy concerns need to be carefully considered (Rivkin-Haas,

2011; Wynia& Dunn, 2010). If properly used, electronic health records have an ability to improve the overall quality of the health care system. Canada should continue to research and implement such technology to ensure that the highest standard of health care is available to the public.

Canada has tried to develop programs that ensure the quality of its health care system. Practitioners are subject to licensing standards and procedures are carefully evaluated before they are listed for coverage under the public health system. Canada must seek to improve the overall quality of its health care system, programs such electronic health records, which helps facilitate quality of care for a patient should be implemented. The development and use of electronic health programs is important for the quality of the health care system and the Canadian government should continue to support these programs.

3.2.4 Accessibility

Accessibility has four sub-components: physical accessibility, economic accessibility, information accessibility and non-discrimination (*General Comment No. 14*, 2000, ¶ 12 (b)).

Physical Accessibility

Physical accessibility means that the facilities, goods and services must be within physical reach of the entire population (*General Comment No. 14*, 2000, ¶ 12 (b)(ii)).Particular emphasis is placed on physical accessibility for marginalized or vulnerable groups, including: women, elderly, ethnic minorities and persons with disabilities and rural patients (*General Comment No. 14*, 2000, ¶ 12 (b)(ii)). As Toebes (1999) explains the CESCR is particularly concerned with rural areas and believes that state parties should adopt measures that encourage doctors and nurses to establish practice in rural areas. State parties must attempt to ensure that there is not an imbalance between urban and rural areas when it comes to accessing services related to the right to health (Toebes, 1999, p. 669).

The Canadian government has a system that provides public health care to all citizens regardless of social status, health status, and other factors. Despite the universal nature of the Canadian health care system, there are problems with accessibility of health care services. Physical accessibility for persons with disabilities and physical accessibility for rural Canadians are the two major concerns that will be addressed.

Physical accessibility to health care services is a significant concern for persons with disabilities; if an individual is unable to access the building, the health care services themselves are also inaccessible. Under Article 12 of the *ICESCR*, a state must ensure that buildings and health care facilities and services are physically accessible to persons with disabilities; this requirement has also been included in the *Convention on the Rights of Persons with Disabilities,* to which Canada is a party. In terms of guaranteeing physical accessibility for persons with disability, the province of Ontario has enacted legislation ensuring physical access to government buildings and public facilities for persons with disabilities (*Accessibility for Ontarians with Disabilities Act 2005).* Additionally, the rights of persons with disabilities are also protected through both federal and provincial human rights codes. Despite these laws, their lack of enforcement still causes accessibility problems (Smith, 2009). Thus, despite having laws in place to ensure accessibility to buildings and public services for persons with disabilities, the failure to enforce these laws means that Canada is not complying with its international obligations.

Other aspects of physical accessibility are also problematic. These problems can be tied directly to the nature of the Canadian geography. Given the enormous size of the country, there are rural areas with sparse

population (Laurent, 2002); individuals living in these areas still require health care. In general, "rural Canadians have higher death rates, higher infant mortality rates, and shorter life expectancies than do urban Canadians" (Laurent, 2002, p. 2)

Canada has established an office of Rural Health to deal with the health care needs of rural Canadians. Despite this government agency, access to health care is still problematic in rural areas. At present, over 22% of the Canadian population lives in rural areas yet only 10.1% of Canadian physicians practice in a rural area (Society of Rural Physicians Canada, 2014). Furthermore, the distance to access health care services is on the rise for rural residents; more than 2/3 of rural residents live 100 km away from their closest physician (Laurent, 2002, p. 8).

Aware of this growing problem, provinces and territories have adopted numerous approaches to address the rural health care problem; including tuition waivers and financial incentives. These provincial initiatives have been highly successful (Physician Supply Still Growing Faster, 2012). Additionally, telehealth services can help remove physical barriers to health by allowing rural residents to receive care through the adoption of modern telecommunication services. The Society of Rural Physicians (retrieved November 30, 2014) has recognized the success of provincial initiatives but has called on the federal government to develop more national initiatives.

Physical Accessibility requires both the ability for a patient to physically access a building, and the equipment, facilities and services in it, and for equitable distribution of health care services between rural and metropolitan areas. For the former requirement, Canada has domestic legislation in place to ensure that disabled Canadians are able to access medical facilities; although enforcement of these laws is lacking. Recently, Canada strengthened these guarantees with the adoption of the UN *Convention on the Rights of Persons with Disabilities*; however, it has yet to sign and ratify its optional protocol. The Optional-Protocol is the enforcement mechanism for the *Convention on the Rights of the Persons with Disabilities.* Canada should ratify the optional protocol to further strengthen the protection for persons with disabilities.

Access to health care services for rural Canadians is also problematic. Canada has a large land mass and pockets of isolated communities; it is difficult to establish health care centres in these areas. While provincial initiatives have had some success, a more comprehensive national response is needed in order to address the CESCR's concern about health care accessibility in rural areas (Society of Rural Physicians, 2014; Toebes, 1999, p. 667).

Economic Accessibility

General Comment 14 states that "payment for health care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether publicly or privately provided, are affordable for all…" (*General Comment No. 14,* 2000, ¶12(b)).There is no explicit violation of the right to health by having privatized or privately funded services. Nonetheless, part of the economic accessibility entails that any privatization of health care services "does not constitute a threat to the affordability" of such services (Toebes, 1999, p. 666).Economic accessibility refers to health care services, whether public or privately funded, being affordable to all (*General Comment No. 14*, 2000, ¶ 12(b)). The Canadian system, which is based on the principle of allocating health care services based on need, funds both physician and hospital services; the remaining health care service are not covered in the public system.

Important services such as pharmaceuticals, home-care and experimental treatments are not typically covered by the public health care system; these services can be covered by private health insurance. If an individual cannot access private health insurance he or she may be unable to afford to access these services (Health Canada, 2001, p. 13). In fact, "[i]nequities in provision of non-insured services, which include dental services, vision correction, prescription drugs and counselling or mental health services, have been highlighted as an area of growing concern" (Health Canada, 2001, p. 13).Moreover, the demand for these types of health care services is increasing. (CLHIA Report on Long-Term Care Policy, 2012; Health Canada, 2001).

The government of Canada has to ensure that citizens can access these important features of the health care system both within the publicly funded system and in the private system. If duplicate private health insurance becomes prevalent, Canada may have to consider some of the options put in place in Australia (such as community rating or subsidization programs) to ensure more equitable access to private health insurance and thus areas of health services not covered in the public system (*Private Health Insurance Act*, 2007; Private Health Insurance-Glossary of Commonly Used Terms, 2014).

Information Accessibility

Information accessibility means that individuals must be able to "seek, receive and impart information and ideas concerning health issues" (*General Comment No. 14,* 2000, ¶ 12). Individuals should be given all the information necessary to make an informed decision about their health. This means a patient should be able to obtain information on his/her medical diagnosis or treatment plan (Hunt, 2005, ¶ 46 (b)). This right must be balanced against patient privacy rights (*General Comment No. 14*, 2000, ¶12 (b)).

Aside from covering the cost of doctor consultations in the public system, the Canadian and provincial governments have been involved in the development of information technology and accessibility. In 2001, the Canada Health Infoway was established to "achieve the desired future state of information technology for the Canadian health care system" (Health Canada, 2006, p. 41). While each province is at different stages of the development of health information technology, a common feature has arisen: the creation of electronic health records and the digitizing process of collecting health information from patients (Office of the Auditor General, 2010; Ries, 2006 (a), p. 684; Rozenblum et al., 2011). Despite the initial development of these tools, they are still being grossly underused. For instance, electronic health records (EHRs) are used by approximately 36% of practising physicians; that means the majority of physicians rely on paper records which drastically reduces the portability of a patient's health history (Rozenblum et al., 2011, p. E82; Office of the Auditor General, 2010). This lack of portability can impact the standard and continuity of care that the patient receives.

In addition to electronic medical records, all provinces have also created telehealth services (Canada Health Infoway, 2011). Studies have shown that these services are beneficial to patients (RabeSmolensky, 2003; Ciemens, 2009).Telehealth

> is defined as the delivery of health related services and information via telecommunications technologies. Clinical uses of telehealth technologies refers to: transmission of medical images for diagnosis; groups or individuals exchanging health services or education live via videoconferences; transmission of medical date for diagnosis or disease management; health advice by telephone. Non-clinical uses

> of tele-health technologies include: distance education including continuing medical education, grand rounds, and patient education; administrative uses including meeting among telehealth networks, supervision, and presentations; research (Canada Health Infoway, 2011, p. 44-45).

Information accessibility requires that a government develop and provide the means for a patient to obtain information regarding health issues. Through the increased development of electronic communications and services, Canada has designed programs that allow individuals to do so. Furthermore, both the provinces and federal government have tried to protect patient privacy interest with the implementation of health information specific privacy legislation (Fact Sheet, 2014). The Canadian and provincial government should encourage physicians to use electronic health records and telehealth services. Both can be vital information tools for not only the patient but also the treating physician.

Non-Discrimination

The last component of accessibility is non-discrimination (*General Comment No. 14*, 2000, ¶ para 12 (b)(i)).All facilities, goods and services related to health must be made available to all members of the public "without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status" (*General Comment No. 20*, 2009 ¶ 2).The CESCR has identified groups that can be covered by the other status classification, it includes: age, disability, health status (including HIV status), and economic and social situation (including poverty) (*General Comment No. 20,* 2009, ¶28-35).Discrimination must be immediately eradicated from all health care services; failure to do is a violation of the right (*General Comment No. 3,* 1990; Hunt, 2004, ¶40).The next paragraphs will examine potential grounds of discrimination in Canada's health care system.

Publicly insured health care services are available to all Canadian citizens regardless of health, poverty, age, gender, race, etc. Nonetheless, certain groups, including Aboriginal Canadians, new immigrants, racial minorities, language minorities, poor people and persons with disabilities do not have equal availability or access to health care services (Jackman, 2007, p. 113).In Canada,

> discrimination in health care context is often indirect and systemic. Indirect discrimination occurs when "exactly the same services are provided to everybody (so that they appear fair) but when for cultural, religious, linguistic or other reasons it is not possible for members of one or more black and minority ethnic groups to benefit equally from them (Ontario Human Rights Commission, 2004).

This type of discrimination is closely tied to the notion of culturally sensitive health care services. The United Nations has stated that adverse effect discrimination (indirect discrimination) is discrimination and it needs to be immediately eliminated from the health care system; the Supreme Court of Canada has also recognized adverse effect discrimination as a type of prohibited discrimination (*General Comment No. 20*, 2009, ¶ 8; *Egan v Canada*, 1995).

In addition to problems related to adverse effect discrimination, not all health care services and facilities are publicly available. There is a thriving private insurance system in Canada for services not covered by the public health care system. Private sector insurance could result indirect discrimination based on poverty or health status (Health Canada, 2004; Flood &Choudhry, 2002, p. 8).The federal government should closely

monitor the private health insurance system and consider some of the regulations (such as community rating) that have been implemented in Australia in order to eradicate discrimination from the private health care system (Private Health Insurance, 2014).

In Canada, there is significant protection against discrimination. The federal and provincial governments have enacted human rights statutes that can offer protection from discrimination in the both the public and private sector. Additionally, the *Charter of Rights and Freedoms* stipulates, in section 15, that government laws, programs, or actions cannot discriminate on the basis of a set list of enumerated or analogous grounds (*Eldridge v British Columbia*, 1997). While the *Charter* and human rights statutes can be used to combat discriminatory practices or effects in the health care system, not all forms of discrimination are legally recognized; for instance, poverty or social status, cannot form the basis of a discrimination claim under the *Charter* (*Gosselin v Quebec (Attorney General)*, 2002).Canada should adopt the internationally recognized grounds of discrimination in order to fulfil its obligations under the *ICESCR*.

4. Conclusion

In the Canadian health care system, the provincial government controls the implementation of health care services; this is generally done in compliance with the federal government's requirements under the *CHA*. The federal government, for its part, contributes to the funding of the health care system and has enacted the *CHA,* which establishes basic requirements for publicly funded health insurance. One of the core principles of the *CHA* is that access to health care services should made on the basis of need, not on the ability to pay (Romanow, 2002). As such, physician and hospital services are publicly funded and are available to all Canadians regardless of race, age, health status, etc. Despite this, there are areas of the Canadian system that need to be improved in order to comply with the obligations arising under the article 12 of the *ICESCR*.

While the public system is meant to be non-discriminatory, sectors of the Canadian population are subject to adverse treatment. There are large portions of minorities in Canada that do not have equal access or equal benefit of the health care system. From Canada's Aboriginal population, to poor, disabled or rural Canadians, not everyone receives the same access and quality of treatment under the system. The Canadian government needs to address these issues; discrimination in the health care system needs to be immediately eradicated.

Furthermore, waiting lists continue the plague the system. In recent years, the provincial and federal government have contributed significant funds to combat this problem and have adopted numerous initiatives to lessen the wait time. More still needs to be done and the introduction of private health insurance may not prove to be the best solution to combat the problem. The Canadian and provincial governments need to proceed cautiously.

Moreover, the public health care system is not exhaustive; in fact, large sectors of the health care system are not covered in the public system. This means that if an individual wants access to services such as out of hospital pharmaceuticals, home care services, or dental services, he or she will have to pay for them. In Canada, there is a thriving private sector health insurance industry that provides coverage of these sectors of the industry. Individuals who cannot afford, or are too ill, to purchase private coverage or who do not receive private insurance benefits through their employment, may be unable to afford these services and thus will be denied access to important health care services. It was the original intention of the government not

to create a two-tiered health care system; this is a potential risk. Canada will have to ensure access to services or to private health insurance; without it, a two-tiered system could develop.

Health care in Canada is quite complex. At present, despite some common needs that are prevalent across most of the Western world (particularly funding issues), the Canadian system has significant strengths and has many provisions and attributes that comply with Article 12 of the *ICESCR*.

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