

PALLIATIVE CARE: AN ENFORCEABLE CANADIAN HUMAN RIGHT?

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This article lays out a series of approaches for establishing an enforceable human right to palliative care in Canada. The article first examines international human rights instruments to which Canada is a signatory, and concludes that they offer limited assistance to palliative care advocates. The article then examines two promising *Charter* challenges. The first, based on section 15, argues that since palliative care is provided unevenly to those who require it, the equality provisions of the *Charter* could compel equitable provision of palliative care to Canadians with life-limiting illnesses. The second is based on section 7, and argues that failure to provide palliative care may impose an unacceptable level of psychological stress on those at the end of life. The article concludes with a look at the limitations of a *Charter* challenge, includ-

Cet article présente une série d'approches permettant d'établir un droit humain aux soins palliatifs au Canada. L'article examine d'abord des instruments internationaux relatifs aux droits de l'homme signés par le Canada et conclut qu'ils sont d'une aide limitée pour les militants des soins palliatifs. Ensuite, les auteurs s'attardent à deux contestations possibles fondées sur la *Charte*. La première, découlant de l'article 15, prétend qu'une disponibilité inégale aux soins palliatifs parmi ceux qui en ont besoin va à l'encontre du principe d'égalité qui forcerait donc à assurer une disponibilité équitable aux soins palliatifs pour les canadiens qui souffrent de maladies mortelles. La seconde se fonde sur l'article 7 de la *Charte* et indique que l'impossibilité de bénéficier des soins palliatifs peut entraîner des niveaux inacceptables de stress

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ing justification under section 1 of the *Charter*, and the lack of empirical evidence necessary to conclusively prove the arguments advanced under sections 15 and 7.

psychologique chez ceux qui se trouvent en fin de vie. L'article se termine avec un regard sur les limites d'une contestation fondée sur la *Charte*, incluant une justification selon l'article 1, ainsi que le manque de preuves empiriques nécessaires pour prouver les arguments fondés sur les articles 15 et 7 de manière concluante.

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Introduction

The relief of suffering is a goal common to both medicine and human rights,¹ and although as a global community we have been expressly seeking to identify palliative care as a human right for many years, it remains a largely unenforceable human right. The overarching reasons for this failure are numerous and include, among other things: (i) the difficulty in allocating scarce resources; (ii) disparities in health care delivery systems; (iii) the conceptual separation of end-of-life care from health care; (iv) a historic lack of consensus and training in the medical community regarding the core framework of end-of-life care; (v) the complexity in translating scientific evidence into policy and action; and finally, (vi) the absence of binding domestic legislation.

Palliative care aims to prevent and alleviate the pain and suffering of one of the world's most vulnerable groups—the dying. In 2002, the World Health Organization described palliative care as:

an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.²

¹ Margaret A Somerville, “Human Rights and Medicine: The Relief of Suffering” in Irwin Cotler & F Pearl Eliadis, eds, *International Human Rights Law: Theory and Practice* (Montréal: Canadian Human Rights Foundation, 1992) 505 at 506.

² World Health Organization, “WHO Definition of Palliative Care,” online: WHO <www.who.int/cancer/palliative/definition/en/> [WHO, “Definition”] (Palliative care has also been described by the WHO as simply, “end-of-life” care, delivered to people at the last stages of life and in progressive decline). Palliative end-of-life care is also known as “hospice palliative care,” that is, whole-person health care that “aims to relieve suffering and improve the quality of living and dying. Hospice palliative care strives to help patients and families address physical, psychological, social, spiritual and practical issues, and their associated expectations, needs, hopes, and fears; prepare for and manage self-determined life closure and the dying process; cope with loss and grief during the illness; and bereavement” (Canadian Hospice Palliative Care Association, “Hospice Palliative Care in Canada: A Brief to the Special Senate Committee on Aging” (Ottawa: CHPCA, 2007) at 2 [CHPCA, “Brief”]). The specific term “palliative care” emerged in the 1970s and is attributed to Canadian physician, surgeon, and academic, Balfour Mount (David Clark, “From Margins to Centre: A Review of the History of Palliative Care in Cancer” (2007) 8:5 *The Lancet Oncology* 430 at 434). See also Balfour Mount, “The Royal Victoria Palliative Care Service: A Canadian Experience” in

This definition reveals that palliative care embodies an integrated vision of health care, addressing more than just the physical symptoms of the patient experiencing the life-limiting illness.³ It acknowledges the relationship between physical and mental suffering, each of which is “capable of affecting the other.”⁴ Thus, it is whole-person care, seeking to prevent and relieve the full spectrum of the individual’s suffering and distress. It is also integrated care, the goal being to improve the individual’s quality of living as well as their quality of dying.⁵

In this paper, the terms “palliative care,” “hospice palliative care,” “palliative end-of-life care,” and “end-of-life care” are used interchangeably and in their broadest sense, meaning: whole-person health care aimed at relieving suffering and improving the quality of living and dying at the end of life. However, even though a number of definitions exist, there is among the health care providers “no common understanding of palliative care and end-of-life care and where each begins.”⁶

For the past two decades, advocates in the field of palliative care have been diligently piecing together the linkages, justifications, and foundations for establishing a human right to palliative care.⁷ The impetus to establish palliative care as a human right arises out of the reality that throughout the world, there

Dame Cicely Saunders & Robert Kastenbaum, eds, *Hospice Care on the International Scene* (New York: Springer, 1997).

³ Life-limiting illness can be described as a condition, illness, or disease that is eventually fatal, and the progress of which cannot be reversed by treatment. Life-limiting illness therefore includes “terminal” illness, “an illness in which, on the basis of the best available diagnostic criteria and in the light of available therapies, a reasonable estimation can be made prospectively and with a high probability that a person will die within a relatively short time” (Ronald Bayer et al, “The Care of the Terminally Ill: Morality and Economics” (1983) 309:24 *New Eng J Med* 1490 at 1491).

⁴ Clark, *supra* note 2 at 431.

⁵ CHPCA, “Brief”, *supra* note 2.

⁶ The Honourable Sharon Carstairs, *Raising the Bar: A Roadmap for the Future of Palliative Care in Canada* (Ottawa: Senate of Canada, 2010) at 24, online: Government of Canada <sen.parl.gc.ca/scarstairs/PalliativeCare/Raising%20the%20Bar%20June%202010%20(2).pdf> [Carstairs, *Raising the Bar*].

⁷ The genesis of this discussion is attributed to Margaret Somerville, a medical-law scholar at McGill University in Montréal: Frank Brennan, “Palliative Care as an International Human Right” (2007) 33:5 *Journal of Pain and Symptom Management* 494 at 494 [Brennan, “Palliative Care as Right”]. See also Somerville, *supra* note 1.

exist “wide disparities in the capacity, resources and infrastructure” devoted to the care of those suffering from life-limiting illnesses.⁸ Despite its expansive health care system, Canada is not immune to this issue. Within Canada, significant disparities with respect to access, quality, and delivery of palliative care also exist,⁹ provoking the need—the objective of this paper—to specifically consider whether an enforceable human right to palliative care exists under Canadian law.

The sense of urgency with respect to these disparities has intensified as medical headway continues to be made in our understanding of the required content of palliative care. For example, as alluded to above, within the palliative care community, there is a growing consensus that an integrated approach¹⁰ to the amelioration of pain and end-of-life distress must be taken into

⁸ Brennan, “Palliative Care as Right” *ibid* at 494. “In 2006, a detailed picture emerged from the first study to our knowledge ever to attempt an estimate of the global provision of palliative care. In total, 115 of the world’s 234 countries have established one or more hospice–palliative care services. However, only 35 (15%) of the 234 countries have achieved a measure of integration with other mainstream service providers together with wider policy recognition. Such a picture must be set against the stark realities of global need: 56 million deaths per year, with an estimated 60% who could benefit from some form of palliative care. Current provision of palliative care reaches only a tiny proportion of these patients, and the solution lies in better palliative care within mainstream health-care systems” (Clark *supra* note 2 at 436, citing Michael Wright et al, *Mapping Levels of Palliative Care Development: A Global View* (Lancaster: International Observatory on End of Life Care, 2006)).

⁹ The Honorable Sharon Carstairs, *Still Not There: Quality End-of-Life Care: A Progress Report* (Ottawa: Senate of Canada, 2005) at 1, online: Government of Canada <sen.parl.gc.ca/scarstairs/PalliativeCare/Still%20Not%20There%20June%202005.pdf> [Carstairs, *Still Not There*].

¹⁰ A multi-disciplinary, integrated approach to end-of-life care encompasses “psycho-social, existential and spiritual aspects of the patient’s experience” in addition to the technical aspects of symptom management. See Harvey Max Chochinov, “Dying, Dignity and New Horizons in Palliative End-of-Life Care” 56:2: CA: A Cancer Journal for Clinicians 84 at 84 [Chochinov, “New Horizons”]. Equally, the objective of palliative care is to enhance the patient’s quality of life and provide support systems using a team approach to address the needs of the patient and the patient’s family (WHO, *Definition, supra* note 2). For a similar view, expressed by Health Canada, see “Palliative and End-of-Life Care”, online: Health Canada <www.hc-sc.gc.ca/index-eng.php>. See also S Robin Cohen et al, “Existential Well-Being is an Important Determinant of Quality of Life: Evidence from the McGill Quality of Life Questionnaire” (1996) 77:3 Cancer 576; Tom A

account in order to address the full spectrum of suffering, including the ascendant obligation of all health care, the dignity of the individual.¹¹ The fact that the Canadian population is aging also underscores the necessity of responding to these disparities. By 2031, it is expected that approximately 25% of the Canadian population will be 65 years of age or older, and that 6.1% to 6.5% of the Canadian population will be 80 years or older.¹² And although senior citizens account for 75% of Canadian deaths per year, only 1 in 7 Canadians over the age of 75 is likely to go into some form of institutional care.¹³ The sense of urgency has become further heightened as many jurisdictions, including Canada, are currently debating the legalization of assisted suicide.¹⁴ Dis-

Hutchinson, Nora Hutchinson & Antonia Arnaert, "Whole Person Care: Encompassing the Two Faces of Medicine" (2009) 180:8 Canadian Medical Association Journal 845; L Marr, J Andrew Billings & David E Weissman, "Spirituality Training for Palliative Care Fellows" (2007) 10:1 Journal of Palliative Medicine 169; B Mount & M Kearney, "Healing and Palliative Care: Charting Our Way Forward" (2003) 17:8 Palliative Medicine 657.

¹¹ See generally Chochinov, "New Horizons" *ibid* at 84; Frank Brennan, "Dignity: A Unifying Concept for Palliative Care and Human Rights" [Brennan, "Dignity" on file with the *MJLH*]; Sylvia Patricia Duarte Enes, "An Exploration of Dignity in Palliative Care" (2003) 17:3 Palliative Medicine 263.

¹² Alain Bélanger et al, "Population Projections for Canada, Provinces and Territories: 2005-2031" at 50, online: Statistics Canada <www.statcan.gc.ca/pub/91-520-x/91-520-x2005001-eng.pdf>. See also Carstairs, *Raising the Bar*, *supra* note 6 (Seniors account for 75% of Canadian deaths per year and "almost 4 out of 5 people over the age of 65 have one chronic disease and about 70% have two or more progressive, life-limiting conditions" at 12-13).

¹³ Carstairs, *Raising the Bar*, *ibid* at 12. See also Senate Committee on Aging, *First Interim Report: Embracing the Challenge of Aging* (Ottawa: Senate of Canada, 2007) at 68, online: <www.parl.gc.ca/39/1/parlbus/commbus/senate/com-e/agei-e/rep-e/repintfeb07-e.pdf>.

¹⁴ In Canada, see e.g. Bill C-384, *An Act to amend the Criminal Code (right to die with dignity)*, 2nd Sess, 40th Parl, 2009 (defeated on second reading) as well as the more recent Québec hearings on euthanasia, assisted suicide, and dying with dignity commenced in September 2010. In South Australia, a recent private member's bill designed to allow voluntary euthanasia was tabled June 2010 but defeated at second reading (*Voluntary Euthanasia Bill 2010*, 23rd House of Assembly (first reading 24 June 2010), online: <www.legislation.sa.gov.au>). For recent UK developments, see especially *R (Purdy) v Director of Public Prosecutions*, [2009] UKHL 45, [2010] 1 AC 345. Prosecutorial guidelines regarding assisted suicide were changed as a result of this ruling: Director of Public Prosecutions, "Policy for Prosecutors in Respect of Cases of Encouraging or Assisting Suicide" (London:

parities raise a number of concerns here, including those related to the ability to provide patients with meaningful access and choice when seeking to alleviate their suffering and distress.¹⁵

At the international level, the main strategies for advancing palliative care as a human right have been to link palliative care to the more expressly recognized “right to health care,” as either a subset or extension thereof; or to link it conceptually, given its mandate, to international conventions that recognize the “dignity of the person.”¹⁶ Under these strategies, key progress has been made in mobilizing and sustaining the commitment towards establishing palliative care as a human right. Notwithstanding this critical progress, however, there are limits to these approaches. Perhaps the best known of these is the common difficulty of all internationally-recognized human rights: enforcement. In Canada, the ability to enforce international treaty rights is entirely dependent on Canadian domestic law. With respect to international human rights, specifically, Canada has tended *not* to implement targeted legislation, but rather has confirmed its commitments on the basis of existing Canadian legislation, policies, administrative measures, and programs.¹⁷ Thus, existing Canadian laws and norms, such as the *Canadian Charter of Rights and Freedoms*,¹⁸ as well as other legislation, human rights codes, and policies must be canvassed in order

Crown Prosecution Service, February 2010), online: CPS <www.cps.gov.uk/publications/prosecution/assisted_suicide_policy.html>.

¹⁵ For further discussion see Mary J Shariff, “The Dying Need Proper Care Before We Settle Assisted Suicide” (2010) 30:13 *The Lawyers Weekly* 5 at 5. See also Carstairs, *Raising the Bar*, *supra* note 6 (“However, palliative care offers the opportunity to manage symptoms, and provide physical, emotional, and spiritual support to the dying. Along with many of my Senate colleagues, I became convinced that before we could have a debate about euthanasia and assisted suicide in Canada we should be providing equitable access to quality, integrated palliative care. As a Committee, we were unanimous in our belief that what was needed was better care for the dying - better pain control, better training, and more research.” at 5); Mary J Shariff, “Navigating Assisted Death and End-of-Life Care” (2011) 183:6 *Canadian Medical Association Journal* 643 [Shariff, “Navigating Assisted Death”].

¹⁶ See discussion in Part II of this paper, *infra*.

¹⁷ See e.g. Elisabeth Eid & Hoori Hamboyan, “Implementation by Canada of its International Human Rights Treaty Obligations: Making Sense Out of the Nonsensical” in Oonagh E Fitzgerald, ed, *The Globalized Rule of Law: Relationships Between International and Domestic Law* (Toronto: Irwin Law, 2006) 449.

¹⁸ *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B of the *Canada Act 1982* (UK), 1982, c 11 [Charter].

to ascertain whether an enforceable human right to palliative care actually exists in Canada.¹⁹

Another obstacle to advancing integrated palliative care as a subset of health care, is the conceptualization of palliative care as specialized care or “boutique care,”²⁰ a perspective that continues today.²¹ In Canada, this conceptualization is reflected in the structure of the *Canada Health Act*,²² which distinguishes between services that are “insured” (medically “necessary” or “required” care) and services considered “extended.”²³ As will be discussed later in this paper, palliative care generally falls into the latter category, meaning it does not attract federal support under the *CHA*.²⁴ Accordingly, with limited exceptions, responsibility for the delivery of palliative care falls mainly to the budgetary discretion of the provinces. Thus, palliative care delivery varies from province to province and the scope and quality of care lacks consistency.²⁵ Indeed, palliative care services are provided across a number of different settings, including via acute care, long-term care, or home care. While the majority of Canadians would prefer palliative home care—and indeed, to die at home—²⁶this is currently not a realistic expectation because 75% of deaths occur in hospitals and long-term care facilities.²⁷ Furthermore, as a result of “long-term care” falling to provincial or territorial governance, long-term care itself is fragmented. As described by Health Canada,

[a]cross the country, jurisdictions offer a different range of services and cost coverage. Consequently, there is little consistency across Canada in:

¹⁹ Eid & Hamboyan, *supra* note 17 at 455-456.

²⁰ Carstairs, *Still Not There*, *supra* note 9 at 13.

²¹ Clark, *supra* note 2 at 433.

²² *Canada Health Act*, RSC 1985, c C-6 [*CHA*].

²³ *Ibid* s 2.

²⁴ For more discussion see Part III.B of this paper.

²⁵ See *supra* note 7 and associated text. See also Canadian Institute for Health Information, *Health Care Use at the End of Life in Western Canada* (Ottawa: CIHI, 2007) at ch 3 and 5 [CIHI, *Western Canada*].

²⁶ World Health Organization, *The Solid Facts: Palliative Care* (Copenhagen: WHO Regional Office for Europe, 2004) at 16, online: <www.euro.who.int/__data/assets/pdf_file/0003/98418/E82931.pdf> [WHO, *Solid Facts*].

²⁷ CIHI, *Western Canada*, *supra* note 25 at 40.

- what facilities are called (e.g. nursing home, personal care facility, residential continuing care facility, etc.);
- the level or type of care offered and how it is measured; and
- how facilities are governed or who owns them.²⁸

The harsh reality is that 70% or more of Canadians currently do not have access to palliative care.²⁹ While part of this figure is attributable to the overarching jurisdictional issues, as described above, it is also attributable in part to a number of other critical factors, including: geographic remoteness,³⁰ ongoing institutional restructuring,³¹ eligibility requirements,³² federal jurisdiction over particular groups,³³ and point-of-entry into the health care system.³⁴

²⁸ Health Canada, “Long-Term Facilities-Based Care”, online: <www.hc-sc.gc.ca/hcs-sss/home-domicile/longdur/index-eng.php>.

²⁹ Carstairs, *Raising the Bar*, *supra* note 6 at 12.

³⁰ According to the Canadian Hospice Palliative Care Association, access to hospice palliative care services by Canadians living in remote/rural areas and those with disabilities is severely limited: CHPCA, “Hospice Palliative Care in Canada” (Ottawa, CHPCA 2004) online: <www.chpca.net/uploads/files/english/resource_doc_library/Fact_Sheet_HPC_in_Canada.pdf> [CHPCA, “Fact Sheet”]

³¹ Health care restructuring has reduced institutional care with more reliance on community-based agencies but with no proportionate increase in funding to these agencies. See CHPCA, “Fact Sheet,” *ibid*.

³² “Eligibility [for] home palliative/end-of-life care often requires a physician referral and a prognosis of death within a set time frame, usually six months. In some jurisdictions, clients must declare that they are no longer seeking curative treatment” (Health Council of Canada, *Home Care: A Background Paper* (Toronto: HCC, 2005) at 9 online: HCC <www.healthcouncilcanada.ca/docs/papers/2005/BkgrdHomecareENG.pdf>).

³³ See discussion in Carstairs, *Still Not There*, *supra* note 9 at 31-37 (For example, the federal government is responsible for delivery of health care, including palliative care, to: members of First Nations and Inuit communities, Canadian Forces personnel, veterans, members of the Royal Canadian Mounted Police, inmates in federal penitentiaries, and refugee claimants. Thus, access to palliative care can simply be a function of status or entitlement rather than need. That being said, accessibility of care is still not guaranteed, and it appears that it is only in the case of veterans that there is any semblance of coordinated palliative care services).

Furthermore, under a 2009 directive, federal inmates suffering from a terminal or chronic illnesses may be eligible for parole. While this is presumably aimed at providing an opportunity for release on compassionate grounds, it also can be seen

The bottom line is that most Canadians do not have access to palliative care; of those who do, the delivery and content of that care is inconsistent. In 2004 the “10-year Plan to Strengthen Canada” was published.³⁵ In the 10-year Plan, the First Ministers made certain commitments towards improving access to quality care for all Canadians. Many of these commitments directly impact end-of-life care and include: improving access to services based on need; first dollar support for home care services including “end-of-life care for case management, nursing, palliative-specific pharmaceuticals and personal care at the end of life”; and medical transportation for those who live in remote northern communities.³⁶ While the 10-year Plan is undoubtedly a step in the right direction, it really amounts to an increased federal role in funding provincial and territorial health care expenditures, leaving the Achilles heel of palliative care intact—that is, dependence on provincial/territorial discretion and the resulting variations in access, delivery, and content of palliative care.

This paper sets out to challenge the ongoing disparity by exploring the foundations for an argument for an enforceable human right to palliative care in Canada under the *Charter*. The objective of this paper is not to craft comprehensive *Charter* arguments. Rather, the main objective is to provide a starting point for discussion on a human right to palliative care in Canadian law.

Part I of this paper provides an overview of the international instruments being advanced to establish a human right to palliative care. In particular, the limitations of the international approach are more fully explored, particularly with respect to domestic enforcement. The section also includes an in-depth investigation of the concept of “dignity” as a potential means for advancing a right to palliative care, again exploring its weaknesses or limitations. In Part II we turn specifically to domestic Canadian law, especially the *Charter*, explor-

to promote early release in lieu of providing long-term palliative care within the federal prison system (Correctional Service of Canada, “Health Services” Commissioner’s Directive No 800 (Ottawa: CSC, 2009) at ss 1, 44-45, online: CSC <www.csc-scc.gc.ca/text/plcy/cdshtm/800-cde-eng.shtml>). For an introduction to this topic see Joseph O’Neill, Mohammad Akhter & Lucie Poliquin, “Terminally Ill Offenders: An International Dialogue” (2002) 9 *Journal of Correctional Health Care* 119.

³⁴ Discussed further in Parts III.C and III.D below.

³⁵ Health Canada, “A 10-year plan to strengthen Health Care” (2004), online: Health Canada <www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fimm-rpm/index-eng.php> [Health Canada, “10-year Plan”].

³⁶ *Ibid.* For discussion of additional initiatives and achievements that have been taken over the past number of years, see summary in Carstairs, *Raising the Bar*, *supra* note 6 at 15.

ing the grounds on which an enforceable right to palliative care might be established in Canada. After an overview of the *Canada Health Act*, the paper suggests that sections 7 and 15 of the *Charter* potentially provide a starting point for articulating an enforceable right to palliative care in Canada. In Part III, some limits of a *Charter* approach are addressed. The first of these is the internal limit on *Charter* rights, namely, justification under section 1. The second is an evidentiary limit to the establishment of a Canadian constitutional right to palliative care.

In the view of the authors, while research has clearly identified a need for integrated palliative end-of-life care in Canada, some of the critical elements needed to establish a constitutional right to palliative care still need to be supported by further study. Accordingly, the critical points to be taken from the discussion that follows are:

- *without* the domestic legal tools to enforce a right, a human right, such as palliative care, is largely illusory; and
- in the process of seeking out and applying the domestic legal tools to address perceived injustices, the scope of the right in question becomes better delineated, which in turn serves to illuminate the paths to legislative reform.

While not all countries have a constitutionally-entrenched *Charter*, as we do in Canada, we hope that from the discussion that follows, further paths and directions may emerge that will be of assistance in identifying palliative care as a legally-enforceable human right both in Canada and internationally.

I. Understanding the Limitations of International Human Rights Instruments

A. Palliative Care and the International Human Rights to Security, Equality, and Health

Human rights encompass the full range of standards derived from the United Nations *Universal Declaration of Human Rights*.³⁷ These rights are formalized in many international legal instruments, including covenants to which Canada is a signatory.³⁸ As described earlier, however, in order for in-

³⁷ *Universal Declaration of Human Rights*, GA Res 217(III), UN GAOR, 3d Sess, Supp No 13, UN Doc A/810 (1948) 71 [UDHR].

³⁸ *The International Covenant on Civil and Political Rights*, 19 December 1966, 999 UNTS 171 arts 2-21, Can TS 1976 No 47, 6 ILM 368 (entered into force 23 March 1976, accession by Canada 19 May 1976) [ICCPR]; UDHR, *ibid*. Political

ternational agreements to be binding within Canada, they have to be enshrined in domestic law either by statute or common law.³⁹ In other words, domestic law cannot be interpreted in such a way as to violate international commitments unless the domestic law at issue expressly requires that consequence.⁴⁰

There is no express human right to palliative care in any UN treaty.⁴¹ The World Health Organization (WHO), however, maintains that: “[a]ll people have a *right to receive high-quality care during serious illness and to a dignified death* free of overwhelming pain and in line with spiritual and religious needs.”⁴² The WHO points to the *UDHR*, in particular Article 25 thereof, to support this statement. Article 25 of the *UDHR* reads as follows:

Everyone has the *right to ... security* in the event of unemployment, *sickness, disability, widowhood, old age* or other lack of livelihood in circumstances beyond his [or her] control.⁴³

Article 1 of the *UDHR* has also been identified as relevant to establishing palliative care as a human right. Article 1 reads:

All human beings are born *free and equal in dignity and rights*. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.⁴⁴

and civil rights, including rights to: liberty and security; equality before and under the law; freedom of expression, conscience, and movement; and freedom from mistreatment and arbitrary detention, are all reflected by arts 3, 9-10, 13, 19 of the *UDHR* and are incorporated into *ICCPR*. Economic, social, and cultural rights including rights to: economic and social security; work and adequate standard of living; health; education; and leisure are reflected in arts 22-27 of the *UDHR* and are incorporated into the *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 UNTS 3, (entered into force 3 January 1976) [*ICESCR*].

³⁹ *R v Hape*, 2007 SCC 26, [2007] 2 SCR 292.

⁴⁰ See generally Gerald Heckman “The Role of International Human Rights Norms in Administrative Law” in Colleen M Flood & Lorne Sossin, eds, *Administrative Law in Context* (Toronto: Edmond Montgomery, 2008) 318.

⁴¹ See Brennan, “Palliative Care as Right” *supra* note 7 at 495. Compare Liz Gwyther, Frank Brennan & Richard Harding, “Advancing Palliative Care as a Human Right” (2009) 38 *Journal of Pain and Symptom Management* 767 at 769-770 [Gwyther, Brennan & Harding, “Advancing Palliative Care”].

⁴² WHO, *Solid Facts*, *supra* note 26 at 16 [emphasis added].

⁴³ *UDHR*, *supra* note 37 art 25 [emphasis added].

⁴⁴ *Ibid* [emphasis added]. See also *ibid* art 25.1 which states: “Everyone has the right to a standard of living adequate for the health of himself and of his family ...”

The WHO underscores that the notions of fairness, equality, and equity in the *UDHR* require that established standards of palliative care (such as those developed for cancer care) be offered to all people with similar health needs.⁴⁵

In addition to the *UDHR*, a human right to palliative care has also been argued to be a component or subset of an overall international human right to health.⁴⁶ For example, the *ICESCR* states:

12(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;

12(2) The steps to be taken by the States Parties to ... achieve the *full realization* of this right shall include those necessary for:

...

(d) The creation of conditions *which would assure to all* medical service and medical attention in the event of sickness.⁴⁷

In a General Comment, the UN Committee on Economic, Social and Cultural Rights—the body responsible for supervising government compliance with the *ICESCR*—included palliative care as part of states’ obligation to respect the right to health. It did so by describing how states must refrain from, among other things, denying or limiting equal access to palliative health services.⁴⁸

⁴⁵ WHO, *Solid Facts*, *supra* note 26 at 16.

⁴⁶ See Brennan, “Palliative Care as Right” *supra* note 7 at 495. See also Council of Europe, Committee of Ministers, *Recommendation on the organisation of palliative care*, REC (2003) 24 (which stated *inter alia*, that palliative care is “an inalienable element of a citizen’s right to health care” at 2); Senate, Subcommittee to Update *Of Life and Death, Quality End-of-Life Care: The Right Of Every Canadian* (Ottawa: Senate of Canada, 2000) online: <www.parl.gc.ca/36/2/parlbus/commbus/senate/Com-e/upda-e/rep-e/repfinjun00-e.htm> [2000 *Senate Report*] (recommending that end-of-life care should emerge from the current health care restructuring as a “core service available to all Canadians” at 5.C).

⁴⁷ *ICESCR*, *supra* note 38 art 12 [emphasis added].

⁴⁸ General Comment No 14 issued by the Committee of the *ICESCR* states: “In particular, States are under the obligation to *respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventative, curative and palliative health services” (Committee on Economic, Social and Cultural Rights, *General Comment 14: The right to the highest attainable standard of health*, ESC, 22nd Sess, UN Doc E/C.12/2000/4, (2000) at para 34 [empha-

There are also a number of specialized or regional covenants and treaties that contain provisions that may further strengthen the right to palliative care as a subset of the right to health care. Examples of instruments that mandate equitable access to available health care services include instruments with respect to the rights of the child,⁴⁹ racial discrimination,⁵⁰ and discrimination against women.⁵¹ For the groups covered by these instruments, it may be possible to argue that the equitable right to health care *necessarily includes* certain positive rights related to palliative care.

The assertion of a positive right to palliative care under these international instruments, however, is highly problematic because of an overall lack of legal tools for enforcement. This seems to be the case notwithstanding the emergent global consensus about the precise content of a government's obligations with respect to palliative care (such as equitable access to and delivery of palliative care as a core component of health care⁵²). While international instruments assist with documenting human rights violations and establish avenues for complaints to the governing human rights body, these review-type options do not

sis in the original]). See also Gwyther, Brennan & Harding, "Advancing Palliative Care," *supra* note 41.

⁴⁹ *Convention on the Rights of the Child*, GA Res 44/45, UN GAOR, 44th Sess, Supp No 49, UN Doc A/44/49 (1989) 167 art 24.

⁵⁰ See *The International Convention on the Elimination of All Forms of Racial Discrimination*, GA Res 2106 (XX), UN GAOR, 21 December 1965, 660 UNTS 195 art 5(e)(iv) [ICERD].

⁵¹ *Convention on the Elimination of All Forms of Discrimination against Women*, 18 December 1979, 1249 UNTS 13 arts 11.1(f), 12, Can TS 1982 no 31 (entered into force 3 September 1981) [CEDAW]. For an in-depth discussion see Frank Brennan, Liz Gwyther & Richard Harding, "Palliative Care as a Human Right" (Open Society Institute Public Health Program, 2008) at 23-26, online: <www.soros.org/initiatives/health/focus/ipci/articles_publications/publications/pc_humanright_20080101> [Brennan, Gwyther & Harding, "Palliative Care as a Human Right"]. See also Liz Gwyther, Jonathan Cohen & Tamar Ezer, "Introduction to Human Rights and Palliative Care" in *Legal Aspects of Palliative Care* (Pine-lands: Hospice Palliative Care Association of South Africa, 2009) at 7, online: <www.lrc.org.za/booklets/1014-2009-legal-aspects-of-palliative-care>.

⁵² Committee on Economic, Social and Cultural Rights, *supra* note 47 at para 19. The *Declaration* comments on a right to health as one of the "core obligations" regardless of resource availability. See also Gwyther, Brennan & Harding, "Advancing Palliative Care," *supra* note 41.

provide the means to enforce governmental obligations, should the government fail to carry them out.⁵³

Furthermore, as expressly acknowledged in the *ICESCR*, the ability to realize rights, including the right to health care, is ultimately dependent on the availability of resources, which varies from jurisdiction to jurisdiction.⁵⁴ Under the *ICESCR*, for example, government compliance with the right to health is “aspirational” only, and rights are to be achieved over time, based on the resource availability of respective signatory nations.⁵⁵

Even if one were able to successfully argue that the *ICESCR*—or any other international instrument, for that matter—guaranteed a right to health care and therefore a right to palliative care, the *Charter*, as mentioned earlier, does not expressly guarantee a right to health care. Thus, the Canadian government is unlikely to recognize any right to health care, palliative care included, unless it has been grounded somewhere in Canadian domestic law.

B. Palliative Care and the International Human Right to Dignity

While ... every human rights violation involves a violation of human dignity, I do not agree that every violation of human dignity involves a violation of human rights.⁵⁶

The notion of “dignity,”⁵⁷ a critically important and powerful cornerstone of palliative care,⁵⁸ has also been asserted as a potential legal foundation for

⁵³ For further discussion, see the Ontario, Ministry of the Attorney General, *The Protection of Social and Economic Rights: A Comparative Study* (Toronto: MAG, 1991).

⁵⁴ *ICESCR*, *supra* note 38 art 2(1), 2(3).

⁵⁵ See Brennan, Gwyther & Harding, “Palliative Care as a Human Right,” *supra* note 51 at 22-23.

⁵⁶ Brian Orend, *Human Rights: Concept and Context* (Peterborough: Broadview Press, 2002) at 88. For further discussion on difficulty in connecting dignity as an intrinsic right to a human right see Brennan, “Dignity,” *supra* note 11. See also Brennan, Gwyther & Harding, “Palliative Care as a Human Right,” *ibid* at 19-35.

⁵⁷ For a definition of dignity see *Québec (Public Curator) v Syndicat national des employés de l'hôpital St-Ferdinand*, [1996] 3 SCR 211 at 256, L'Heureux-Dubé J (referring to dignity in s 4 of the Québec *Charter* she writes “I believe that section 4 of the Charter addresses interferences with the fundamental attributes of a human being which violate the respect to which every person is entitled simply because he or she is a human being and the respect that a person owes to himself or

establishing a human right to health care.⁵⁹ Indeed, clinical palliative care models and international human rights instruments share the language of “dignity.” Thus, dignity appears to provide a logical conduit for establishing palliative care as a human right. However, to assert dignity as the foundation for a legally-enforceable human right to palliative care requires that the term be capable of legal interpretation and definition. Despite the fact that the term dignity is cited in a number of human-rights proclamations,⁶⁰ including the *UDHR*,⁶¹ these instruments provide no definition of dignity, nor has dignity been “authoritatively interpreted or applied by any of the competent, inde-

herself” interestingly, the Québec *Charter* has a specific section referring to “dignity” as a right—in contrast to the Canadian *Charter*).

See also Dr Gro Harlem Brundtland, former Director-General of the World Health Organization, “Health, Dignity and Human Rights” (Keynote address at 7th Conference of European Health Ministers in Oslo, Norway, 12 June 2003), online: World Health Organization <www.who.int/dg/brundtland/speeches/2003/conference_european_healthministers/en/> (she states “at the root of the concern for equality and freedom from discrimination in human rights thinking and practice, lies the notion of human dignity: the equal and inherent value of every human being.”). See e.g. *UDHR*, *supra* note 37 at Preamble. Accord *ICESCR*, *supra* note 38 at Preamble; *ICCPR*, *supra* note 38 at Preamble; *ICERD*, *supra* note 50 at Preamble; *CEDAW*, *supra* note 51 at Preamble. Many of the international human rights instruments explicitly state that the respective right described therein is derived from the inherent dignity of the human person.

⁵⁸ See generally David Morrison, “The Protection and Promotion of Human Rights and Dignity for Cancer Patients: An IPOS Responsibility” (Presidential Symposium on Psycho-Oncology and Palliative Care as a Human Right, delivered at the IPOS 11th World Congress of Psycho-Oncology, Vienna, 25 June 2009), online: <www.strathmor.com/assets/pdf/0906-PresidentialSymposium.pdf>; Harvey Max Chochinov, “Dignity and the Essence of Medicine: The A, B, C and D of Dignity Conserving Care” (2007) 334 *Brit Med J* 184 [Chochinov, “Dignity, Essence of Medicine”].

⁵⁹ See Brennan, “Dignity” *supra* note 11. See also Council of Europe, PA, 1999 Ordinary Sess (Third Part), *Protection of the Human Rights and Dignity of the Terminally Ill and the Dying*, Texts Adopted Rec 1418, V/99 Gazette Parliamentary Assembly 11 (s 1 of this document states: “The vocation of the Council of Europe is to protect the dignity of all human beings and the rights which stem therefrom”; s 5 states: “The obligation to respect and to protect the dignity of a terminally ill or dying person derives from the inviolability of human dignity in all stages of life”).

⁶⁰ See discussion in Brennan, Gwyther & Harding, “Palliative Care as a Human Right,” *supra* note 1 at 34.

⁶¹ See *UDHR*, *supra* note 37 art 1.

pendent, international institutions.”⁶² The law has not defined dignity; hence, dignity is rooted “outside the jurisprudence”⁶³ and, as described by Morrison, is, simply, “pre-legal.”⁶⁴ As will be clarified below, despite the fact that there are no legally binding definitions of “human dignity” in the jurisprudence, there is no doubt that the concept has played a key role in Canadian constitutional law, as laid down by the Supreme Court of Canada in the late 20th century. While the Court has recently stepped away from using this concept as definitive, this is a relatively recent development. Only the passage of time will tell us whether or not this constitutes a permanent shift in emphasis.

Additionally, it is important to note that the *Charter* does not explicitly mention “dignity”⁶⁵ and, furthermore, that the Supreme Court of Canada no longer requires a claimant to show an affront to dignity in order to prove infringement of the *Charter*’s equality provision.⁶⁶ According to the Supreme Court, dignity had “proven to be an *additional* burden on equality claimants, rather than the philosophical enhancement it was intended to be.”⁶⁷ While it might be said that dignity forms part of the essence of the *Charter*, it is, for the

⁶² Bartha Maria Knoppers, *Human Dignity and Genetic Heritage: A Study Paper Prepared for the Law Reform Commission of Canada Protection of Life Series* (Ottawa: Law Reform Commission, 1991) at 23; see also Brennan, “Dignity,” *supra* note 11.

⁶³ Morrison, *supra* note 58 at 2.

⁶⁴ *Ibid* at 2.

⁶⁵ While it is no longer a required element for proving a violation of equality rights under s 15 of the *Charter*, the notion of dignity is considered to be subsumed into the express *Charter* guarantees. See the discussion of dignity in *Rodriguez v British Columbia (AG)*, [1993] 3 SCR 519 (in both the majority reasons of Sopinka J and the dissenting reasons of McLachlin J). See also *Bou Malhab v Diffusion Métromédia*, 2011 SCC 9 (“Since good reputation is related to dignity, it is also tied to the rights protected by the *Canadian Charter*” at para 18).

⁶⁶ *R v Kapp*, 2009 SCC 41, [2008] 2 SCR 483 [*Kapp*]. See also Mary C Hurley, “Charter Equality Rights: Interpretation of Section 15 in Supreme Court of Canada Decisions” (Ottawa: Library of Parliament, 2007) online: <www.parl.gc.ca/information/library/PRBpubs/bp402-e.htm> (“The claimant’s burden of establishing section 15 infringement does not oblige her or him to adduce evidence of violation of human dignity or freedom; the fact that a distinction in treatment is based on one or more section 15 grounds will often be sufficient to establish such an infringement in that it will be apparent, through judicial notice and logic, that the distinction is discriminatory” at 8).

⁶⁷ *Kapp*, *ibid* at para 22, McLachlin CJC & Abella J [emphasis in original].

above reasons, not an efficient means to advance a legal right to palliative care under the *Charter*.⁶⁸

That being said, dignity is used in many international human rights instruments, and the Supreme Court has mandated that Canadian courts should, in making their decisions, take these instruments into account when Canada is a signatory.⁶⁹ This is the case even when these instruments have not yet been given the full force of law domestically.⁷⁰

As described by the Supreme Court in *Baker v Canada*:

the values reflected in international human rights law may help inform the contextual approach to statutory interpretation and review.⁷¹

⁶⁸ In its preamble, the *Canadian Bill of Rights*, SC 1960, c 44, reprinted in RSC 1985, App III, states that the Parliament of Canada affirms that “the Canadian Nation is founded upon principles that acknowledge the supremacy of God, the dignity and worth of the human person and the position of the family in a society of free men and free institutions.” Therefore, the *Bill of Rights* might be used to support arguments that dignity is a right, and that dignity includes the right to health care which in turn includes a right to end-of-life care. Indeed, the federal Senate Committee in its 2000 report on end-of-life care points to the *Bill of Rights* to assert that human dignity and worth “compel” the provision of excellent end-of-life care (2000 *Senate Report*, *supra* note 46 at 5). Yet reliance on the *Bill of Rights* to assert a right to palliative care is problematic for a number of reasons, too numerous to be fully canvassed herein. Perhaps the most relevant of these for this paper is that the *Bill of Rights* applies only to the federal government, while delivery of health care is mainly within provincial jurisdiction, and thus not subject to the *Bill of Rights*. For further discussion see Peter W Hogg, *Constitutional Law* (Toronto: Carswell Legal, 2010) at ch 34.3(b), ch 35.

⁶⁹ The terms of the rights covenants (and any decisions rendered under them by an international human-rights committee) are relevant to interpretation of the *Charter* pursuant to a principle that statutes should be interpreted in conformity with international law as far as is possible. For further discussion see Ruth Sullivan, *Sullivan on the Construction of Statutes*, 5th ed (Markham: LexisNexis Canada, 2008) at 537-549.

⁷⁰ See *Health Services and Support – Facilities Subsector Bargaining Association v British Columbia*, 2007 SCC 27 at paras 20, 69, [2007] 2 SCR 391, 283 DLR (4th) 40. See also *Baker v Canada (Minister of Citizenship and Immigration)*, [1999] 2 SCR 817 at 860-862, 174 DLR (4th) 193 [*Baker*]; *Slaight Communications v Davidson*, [1989] 1 SCR 1038 at 1056-1057, 59 DLR (4th) 416 [*Slaight Communications*].

⁷¹ *Baker*, *ibid* at 861.

Again, however, the term “dignity,” even when articulated by ratified international instruments, is simply neither legally rigorous enough, nor, arguably, required to support a constitutional right to palliative care in Canada. This is not to say that dignity is wholly irrelevant, particularly given Canada’s international commitments, including those in the “International Bill of Rights.”⁷² But dignity itself (or an affront to dignity) does not justify or establish a legally-enforceable right to palliative care. It is therefore asserted herein that advancing a right to palliative care on the basis of the concept of dignity is not required in Canada.⁷³

Furthermore, while the *ICCPR*, for example, contemplates rights similar to those of the *Charter*, a protocol to the *ICCPR*, of which Canada is a party, requires that individuals claiming a violation of rights under the protocol first exhaust all available domestic remedies before petitioning the Human Rights Committee of the United Nations.⁷⁴ Thus, the *Charter* is necessarily where we begin our substantive discussion.

II. Potential *Charter* Arguments

A. Overview

The authors have identified two possible approaches that may help to establish a legally enforceable human right to palliative care under the *Charter*.⁷⁵ A first approach attempts to establish that there is indeed a legal right to health

⁷² *UNDHR*, *supra* note 37 at Preamble, arts 1, 22 ; *ICCPR*, *supra* note 38 at Preamble, art 10(1); *ICESCR*, *supra* note 38 at Preamble. The *UDHR*, *ICCPR* and *ICESCR* together are understood as “The International Bill of Human Rights.”

⁷³ The authors however should not be understood as in any way dismissing the significance of “dignity” in conceptualizing the substance of palliative care (and health care generally) or the critical importance of approaches aimed at elucidating the potential of dignity in advancing a human right to palliative care.

⁷⁴ *ICCPR*, *supra* note 38 at art 41(c); *Optional Protocol to International Covenant on Civil and Political Rights*, 16 December 1966, 999 UNTS 302 at art 2 (entered into force 23 March 1976, accession by Canada 19 May 1976). For further discussion see Hogg, *Constitutional Law*, *supra* note 68 at ch 36.9(c). In addition, the signatory government must also be a signatory to the protocol in order for such petition to be made.

⁷⁵ It is important to reiterate that the review provided here is not intended to be comprehensive. While there are additional initiatives being undertaken at the federal and provincial levels to increase and support palliative and end-of-life care, (see e.g. the 10-year Plan *supra* note 35) the focus of this review is to establish some foundation for an argument in favour of a *constitutional right* to palliative care.

care in Canada, which includes palliative care in the provision of core health care services, by arguing that the omission of palliative care constitutes a breach of section 7 *Charter* guarantees.

A second approach offers a more direct path, in that it does not rely on having to first establish a legal right to health care. Rather, this second approach involves only the consideration of how existing health care legislation pertaining to palliative care operates to violate section 15 *Charter* guarantees. There is no positive right to a minimum standard of health care in Canada (this is discussed in more detail below); thus, the argument required to establish a constitutional right to palliative care under the second approach must demonstrate either that there is an violation of *Charter* rights in the delivery of extended care, or that certain distinctions between insured care and non-insured (i.e. extended) care made in the *CHA* are in violation of *Charter* rights.

In either case, the authors suggest that there are certain *Charter* rights and principles that can support a right to palliative care under Canadian constitutional law.⁷⁶ Again, the goal here is not to set out detailed *Charter* arguments. Rather, the authors wish to encourage the discourse to develop these complex arguments by illuminating *Charter* rights and cases relevant to the delivery of palliative care in Canada. These rights and cases can, in turn, be used to challenge legislation and policies that appear to thwart equal and meaningful access to quality end-of-life care. As written by the late Tommy Douglas, former premier of Saskatchewan and champion of public health care:

When we began to plan Medicare, we pointed out that it would be in two phases. The first phase would be to remove the financial barrier between those giving the service and those receiving it. The second phase would be to reorganize and revamp the delivery system—and, of course, that's the big item; it's the big thing we haven't done yet.⁷⁷

According to the authors, this second phase should include the realization of palliative end-of-life care as an enforceable right.

⁷⁶ In the pages that immediately follow, the authors' focus primarily on the second argument because of the availability of empirical evidence that can be used to support such an argument. This is not to say that the first argument is without merit. This is explored to a certain extent (given the empirical limitations) under the heading "Care versus Cure" in Part III.D(4) below.

⁷⁷ Interview of Michael B Decter, former Deputy Minister of Health, The Atkinson Letter (10 January 1997) online: Atkinson Foundation <www.atkinsonfoundation.ca/publications/health4.htm> (Decter cites Tommy Douglas' writings).

B. The Canada Health Act

Before we can consider *Charter* arguments, we must first determine whether there is a right to accessible health care in Canada, and, if so, the scope of that right. Put another way, what is the nature of the legislative framework securing the legal right to health care in Canada? As Sharon Sholzberg-Gray, former president of the Canadian Healthcare Association, wrote:

Universal access to needed healthcare services is regarded as a core value of Canadians and a measure of equality of citizenship. In Canada, we have done much more than simply talk about the idea that accessibility to healthcare is a public good; we have made it the law of the land.⁷⁸

The *CHA* is the foundation of the publicly funded health care system in Canada.⁷⁹ According to the *CHA*, the primary objective of Canadian health policy is:

to protect, promote and restore the physical and mental well-being of residents in Canada and to *facilitate reasonable access* to health services without financial or other barriers.⁸⁰

The phrase “facilitate reasonable access” is important. It is *not* the object of the *CHA* to establish a positive right to a minimal standard of health care, except to the extent that care, as a service, is considered medically required or necessary (as discussed below). Indeed, the function of the *CHA* is to establish the criteria and conditions that must be met by the provinces and territories in order to qualify for the federal cash contribution under the Canada Health and Social Transfer.⁸¹ To this end, the *CHA*’s main objective is to ensure that all eligible residents of Canada have reasonable access to quality health care—that is, without financial or other barriers.⁸²

Not all health care, however, is covered. As mentioned above, the *CHA* distinguishes between insured health services and what are described as “ex-

⁷⁸ Sharon Sholzberg-Gray, “Accessible Health Care as a Human Right” (1999/2000) 11:2 NJCL 273 at 274.

⁷⁹ *CHA*, *supra* note 22. The *CHA* was passed in 1984, replacing the *Hospital Insurance and Diagnostic Services Act*, RSC 1957, c 28 and the *Medical Care Act*, RSC 1970, c M-8.

⁸⁰ *CHA*, *ibid* s 3 [emphasis added].

⁸¹ *Ibid* ss 4-7.

⁸² *Ibid* s 3.

tended” services. Only insured health services are subject to the “reasonable accessibility” criteria.⁸³ These services are further subject to the additional four criteria of public administration,⁸⁴ comprehensiveness,⁸⁵ universality,⁸⁶ and portability,⁸⁷ which, together, comprise what are known as the “five principles” of the *CHA*. These criteria (along with two conditions)⁸⁸ must be met by the provinces and territories in order for them to qualify for federal funding.⁸⁹

Accordingly, under the *CHA* there is a right to insured health services and reasonable access to those services, but not to extended services. Insured health services include hospital services, physician services, and surgical-dental services provided to insured persons.⁹⁰ In all cases, insured services are those considered medically “necessary” or “required.”⁹¹ Despite the importance of these words, in terms of identifying those services that are subject to the five principles, the statute does not specifically define them. The result has been that medically required physician services “are generally determined

⁸³ *Ibid* s 12 (which states that provinces must provide insured persons with uniform and reasonable access to insured health services).

⁸⁴ *Ibid* s 8 (sets out that provincial health care insurance plans must be administered and operated on a non-profit basis by a public authority).

⁸⁵ *Ibid* s 9 (which stipulates that provincial plans must insure all insured health services provided by hospitals, medical practitioners or dentists).

⁸⁶ *Ibid* s 10 (which demands that all residents in the province have access to insured services on uniform terms and conditions).

⁸⁷ *Ibid* s 11 (which requires that provinces pay for insured health services for residents -typically persons who have lived in the province for three months or longer-when temporarily absent from the province or Canada as well as pay amounts for insured health services provided in another province).

⁸⁸ *Ibid* s 13 (under s 13, the provincial governments are required provide any information required by the Minister and give recognition to any federal transfers in their respective public and promotional documents).

⁸⁹ *Ibid* s 7.

⁹⁰ *Ibid* s 2 (“insured health services” means hospital services, physician services and surgical-dental services provided to insured persons, but does not include any health services that a person is entitled to and eligible for under any other Act of Parliament or under any Act of the legislature of a province that relates to workers’ or workmen’s compensation.”)

⁹¹ *Ibid* s 2 (the interpretation section of the *CHA*, and in particular the definitions of “health care insurance plan,” “hospital services,” “insured health services,” and “surgical-dental service”).

by physicians in conjunction with their provincial and territorial health insurance plans.”⁹²

Extended health services are described in the *CHA* as services including: (i) nursing home intermediate care; (ii) adult residential care service; (iii) home care service; and (iv) ambulatory health care service.⁹³ Although the *CHA* refers to regulations that are supposed to assist in specifically defining “extended health care services,” no such regulation has yet been created by the federal government.⁹⁴ Extended health services therefore tend to encompass a broader “continuum of care” (which includes services such as access to pharmaceuticals outside of the hospital setting, home and community care, long-term care, and palliative care) and are generally not considered medically “necessary” or “required.”⁹⁵ Thus, these services are not protected under the *CHA*’s five principles and the *CHA* does not require the provinces and territories to provide funding for these extended services. Instead, it is up to the individual provincial and territorial governments to determine whether and how they will fund extended care.⁹⁶ Only “the four western provinces ... have designated palliative care as a [provincial] core service,” while the remaining six provinces and the three territories have not yet done so.⁹⁷

The delivery, accessibility, and content of palliative end-of-life care are thus a function of provincial and territorial discretion, and, as described above, significant disparities exist across Canada. Under this framework, the dispari-

⁹² Health Canada, *Canada Health Act: Annual Report 2008-2009* (Ottawa: Health Canada) at 3 online: Health Canada <www.hc-sc.gc.ca/hcss/alt_formats/pdf/pubs/cha-ics/2209-cha-ics-ar-ra/chaar-ralcs-09-eng.pdf>.

⁹³ *CHA*, *supra* note 22 at s 2.

⁹⁴ See *ibid*, s 2 definition of “extended health care services”.

⁹⁵ See Sholzberg-Gray, *supra* note 78 at 284. For a description of medically necessary see *Auton (Guardian ad litem of) v British Columbia (AG)*, 2002 BCCA 538 at paras 36-40, 220 DLR (4th) 411. The Court of Appeal’s judgment would be reversed on other grounds, 2004 SCC 78, [2004] 3 SCR 657, 245 DLR (4th) 1 [*Auton* cited to SCR].

⁹⁶ *Auton, ibid*, McLachlin CJC (“... the medicare scheme ... envisions ... core physician-provided benefits plus non-core benefits at the discretion of the Province” at paras 43-44).

⁹⁷ See the Honourable Sharon Carstairs, “Motion Urging Government to Provide Long-term End-of-life Care” in Debates of the Senate (Hansard), 39th Parl, 1st Sess, No 143:5 (25 April 2006) at 84 [Carstairs, “Motion”].

ties only stand to increase, given shifting demographics⁹⁸ and increased demand by an expanding and aging population.⁹⁹

C. Section 15

Having described the general regulatory framework that establishes palliative care as extended care, as well as having provided certain facts and data to illustrate that disparities in the delivery of palliative care exist in Canada, the discussion now turns expressly to the *Charter*, commencing with section 15. This discussion begins by looking at one example that readily illustrates the inequalities of access to palliative care—namely, cancer care. The authors acknowledge and applaud the efforts of pioneers of palliative care, many of whom were and still are focused primarily on cancer care. The question here, however, is not whether noble and valuable work has been done in cancer care; indeed, the authors want to make it clear that this work is not being criticized. The issue of concern to the authors is whether a constitutional argument can be made to support palliative care as an enforceable right in Canada based on the unequal provision of palliative care to patients who are not suffering from cancer. These legal arguments are not aimed at diminishing care for cancer patients or the work of those employed in this crucial field.

The purpose of this Part is to establish at least *some* of the factual bases that might be used to assert a breach of rights under section 15 of the *Charter*. Once this factual foundation has been laid, we turn to relevant *Charter* cases and set out some of the arguments that may help to establish an enforceable right to care, with the caveat that further empirical evidence is essential to founding a strong *Charter* argument.

⁹⁸ See text accompanying note 13, *supra*. See also Senate, Special Senate Committee on Aging, *Canada's Aging Population: Seizing the Opportunity* (Ottawa: Senate of Canada, 2009) at 5 (Chair: Hon Sharon Carstairs) [Senate, *Canada's Aging Population*]; Canada, *Commission on the Future of Health Care, Building on Values: The Future of Health Care in Canada: Final Report* (Ottawa: Government of Canada Publications, 2002) at 20-23, online: Depository Services Program <<http://dsp-psd.pwgsc.gc.ca/Collection/CP32-85-2002E.pdf>> [*Romanow Commission Report*].

⁹⁹ See generally *Romanow Commission Report*, *ibid*. Some increased demands include: home adaptations; increased support and maintenance to facilitate aging in place; culturally-appropriate long-term care services; and comparable access to medication across all forms of insurance (public or private). See also Jeff Berryman, "Up in Smoke: What Role Should Litigation Play in Funding Canada's Health Care?" (2004) 12 Health LJ 125.

1. The Connection to Cancer Care

The development of many palliative care practices has historically arisen mainly out of cancer research, treatment, and care.¹⁰⁰ Such is largely still the case today. The palliative care initiatives taken in cancer care provide an excellent basis upon which to build a legal case for the expansion of those services. One way this can be accomplished is by demonstrating a disparity in care between those whose palliative care needs are cancer-related and those whose palliative care needs arise for other reasons.

Of Canadians who access hospice palliative care, 90% have cancer-related conditions, even though cancer-related deaths make up only one quarter of all deaths in Canada.¹⁰¹ Similarly, a recent government report states that up to 85% of palliative care patients in Ontario have cancer.¹⁰² These numbers demonstrate an emerging reality of disproportionate access and suggest unequal treatment of those who are suffering from non-cancer life-limiting conditions, such as Chronic Obstructive Pulmonary Disorder, neuromuscular degenerative conditions, cirrhosis, or congestive heart failure. Of course, there will likely be other groups for whom there is unequal access, but the authors do not have the empirical data to make those arguments at this time.

The authors turn to evidence from Alberta as one illustration of the arbitrariness of the current delivery system for palliative care in Canada.¹⁰³ Alberta

¹⁰⁰ See Derek Doyle et al, *Oxford Textbook of Palliative Medicine* (Oxford: Oxford University Press, 2004) (citing several explanations why most palliative programs offer care mainly to cancer patients and their families). See also WHO, *Solid Facts*, *supra* note 26 at 7, 9, 12; Clark, *supra* note 3; CIHI, *Western Canada*, *supra* note 25 (suggesting that palliative care is more likely to be received “when death is somewhat more predictable, as in the case of cancer” at 82).

¹⁰¹ See *2000 Senate Report*, *supra* note 47 at Part I.A. For similar statistics from Western Canada see CIHI *supra* note 25 at 59, 66, 78, 82.

¹⁰² See Cancer Care Ontario, “Palliative and End-of-Life Care,” online: CCO <www.cancercare.on.ca/cms/One.aspx?portalId=14473&pageId=15001>.

¹⁰³ A similar framework appears to be in place in Manitoba. See e.g. *CancerCare Manitoba Act*, RSM 1987, c C20, CCSM c C20, s 7. CancerCare Manitoba describes how palliative care is included in home care and sets out the eligibility requirements, see CancerCare Manitoba, “Home Care” online: CCM <www.cancercare.mb.ca/home/patients_and_family/patient_and_family_support_services/home_care/>. Compare Cancer Care Ontario, “Palliative Care Program” online: CCO <www.cancercare.on.ca/cms/one.aspx?pageId=8706>. See also Saskatchewan’s *The Cancer Agency Act*, SS 2006, c C-1.1 (“The Lieutenant Governor in Council may make regulations: ... (i) establishing eligibility requirements

was chosen because empirical data from this jurisdiction was readily accessible. As we will see, the apparent arbitrariness in palliative care provision is not remedied by federal government involvement.

In 1998, the Alberta Cancer Board created the Palliative Care Network Initiative to work toward providing equitable access to palliative care for Albertans “living with or affected by” cancer.¹⁰⁴ In February 2001, the Canadian Strategy for Cancer Control and Palliative Care Working Group issued a report that affirmed that palliative care is a fundamental component of cancer control.¹⁰⁵ It recommended that palliative care delivery within cancer care and other health care delivery systems be better integrated.¹⁰⁶ Later, in December 2003, a second national initiative, the Primary Health Care Transition Fund, allocated \$4,317,000 to the Alberta Cancer Board (as lead and partner organization) for the creation of the Pallium Integrated Care Capacity Building Initiative.¹⁰⁷

Like other Western Canadian provinces, Alberta addresses palliative care as part of its core services.¹⁰⁸ In 2008, Alberta Health Services issued a report that indicated that palliative care outside of cancer care is not as strong as within cancer specialities, stating that the Palliative and End of Life Care Institute “will bring added value if it creates comprehensive, integrated initiatives that meet the needs of cancer and non-cancer patients and address resource inequalities ... Health care practitioners must forge ahead and remove barriers [rather]

for persons to receive cancer care services or other services from the agency” s 20(i)); *Cancer Agency Regulations*, RRS c C-1.1, Reg 1, ss 4(1)-(2).

¹⁰⁴ Alberta Cancer Board, *The Alberta Cancer Board Hospice Palliative Care Network: Provincial Framework*, by Marie-Josée Paquin (Edmonton: Alberta Cancer Board, 2003) at 5, online: www.cancerboard.ab.ca/maco/pdf/hpcn_prov_framework_04-12-28.pdf [Alberta Cancer Board, *Palliative Care Network*].

¹⁰⁵ See Silvana Luciani & Neil J Berman, “Canadian Strategy for Cancer Control” 21:1 *Chronic Diseases in Canada* 23.

¹⁰⁶ See Alberta Cancer Board, *supra* note 104. See also discussion in Carstairs, *Still Not There*, *supra* note 9 at 38.

¹⁰⁷ See Health Canada, “Pallium Integrated Care Capacity Building Initiative” (2006) online: [www.apps.hc-sc.gc.ca/hcs-sss/phctf-fassp.nsf/lkAttachments/7952E21AB29242288525728F006C5DCE/\\$File/15E_SUM_PalliumCare.pdf](http://www.apps.hc-sc.gc.ca/hcs-sss/phctf-fassp.nsf/lkAttachments/7952E21AB29242288525728F006C5DCE/$File/15E_SUM_PalliumCare.pdf) [Health Canada, “Pallium”].

¹⁰⁸ See Carstairs, “Motion” *supra* note 97 at 84.

than hinder the extension of palliative care beyond cancer.”¹⁰⁹ Some of the commentary it gathered is particularly revealing of the disparities:

One informant passionately spoke about her patients and serving their palliative care needs. She stated the central intake system is not working for them, that the needs of her patients are not being met by the program as it stands and that defining palliative care pertains more to cancer patients than anything.

...

Another informant spoke about liaising with the hospital consult team for inpatients and said, there are “*no palliative care physicians that we can refer our outpatients to*” the “[RPCP] *that’s for cancer patients, they don’t deal with [our] patients,*” we “*can’t draw on them for a resource right now.*” She stated it would be very beneficial if they had a palliative care physician in her specialty as a backup for outpatients.

...

Medical consultation and referral is often a barrier to patients accessing palliative care services. Physicians are not referring their patients to the palliative care program because there is uncertainty of what palliative care is about, what role palliative care plays as it exists today, resulting in specialties being “*somewhat narrow in their focus of palliative care.*”¹¹⁰

Based on the foregoing, a preliminary observation might be made. Outside of the funding transferred pursuant to the *CHA*, the federal government, under a national initiative, has provided funding to support what is technically an extended service. The province controlling the funding is already providing that extended service (palliative care) as a provincial core service, yet the funding is directed only to a select group—namely, patients with cancer. As queried by Sandra McKinnon, is palliative care “just for cancer patients?”¹¹¹

¹⁰⁹ Alberta Health Services & Caritas Health Group, *The Palliative & End of Life Care Institute: A Summary Report of Findings From Key Informant Interviews and Two Additional Focus Group Sessions* (August–October 2008) at 1-2, online: Palliative.org <www.palliative.org/KI_Summary_Report_FINAL.pdf>.

¹¹⁰ *Ibid* at 10-11 [emphasis added].

¹¹¹ Sandra McKinnon, “Palliative Care: Just for Cancer Patients?” online: Palliative.org <www.palliative.org/PC/ClinicalInfo/Editorials/PCJustForCancerPatients.html>. See also CIHI, *Western Canada supra* note 25 (“As cancer patients become increasingly likely to have access to appropriate care at the end of life, an-

The above provides but a few examples of government laws, policies, and actions that may be discriminatory in terms of the delivery of palliative care. Further, there is no shortage of anecdotal discussion about unequal access to, and delivery of, palliative care across Canada. In the authors' view, however, more detailed research and analyses are needed regarding how the more than 430 palliative care programs and services are structured and delivered.¹¹² More research is also needed regarding the extent to which these palliative care programs and services meet the needs of those who require them. Such data would clarify the basis upon which a *Charter* argument in favour of a right to palliative care could be made. Regardless, the authors believe that the foregoing account establishes sufficient factual basis to proceed with an examination of potential *Charter* arguments for enforcing a legal right to palliative care on the basis of section 15.

Before turning to the case law, another observation should be made. There is little doubt that the government is providing a publicly-funded benefit (end-of-life care) to some and not to others. Whether you receive that benefit appears to be dependent on whether you are, for example, an in-patient or an out-patient, a veteran or an inmate, a cancer sufferer or a patient with chronic renal failure. Regardless of root cause, at the end of life the treatment needed is the same: care, compassion, and the alleviation of pain, psychosocial, and existential suffering.¹¹³

2. Equitable and Meaningful Access: The *Eldridge* and *Auton* Cases

Subsection 15(1) *Charter* provides:

Every individual is equal before and under the law and has the right to equal protection and 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.¹¹⁴

Section 15 provides that where a person interacts with the law, that person must be granted *substantive* equality. In other words, sometimes treating two

other huge challenge now awaits: the delivery of expert palliative care to those with non-malignant disease" at 82); *Romanow Commission Report*, supra note 98 at 182; Clark, supra note 2 at 437.

¹¹² See Carstairs, *Still Not There*, supra note 9 at 1.

¹¹³ See generally Chochinov, "New Horizons," supra note 10; Chochinov, "Dignity, Essence of Medicine," supra note 58.

¹¹⁴ *Supra* note 18 at s 15(1).

people identically is not equality. For example, a government program might require that a person be on the second floor of a building in order to access it. The rule treats everyone the same: everyone must be on the second floor. If there is no elevator, however, people requiring a wheelchair cannot access the program. There is thus an inequality in the program's delivery.

Hence, once the state provides a benefit to the public, it is obligated to do so in a non-discriminatory manner. The government must take measures to ensure that disadvantaged groups are able to benefit equally from government services. The equality rights under section 15 can therefore be seen to create positive human rights obligations once the government has already entered the field. The following cases establish this principle.

Eldridge v British Columbia

The *Eldridge*¹¹⁵ case involved a challenge to the non-provision of sign-language interpreters to deaf persons seeking hospital medical services—namely, physician-delivered consultation and maternity care. The claimants argued that this omission by the hospital was in breach of the equality guarantee under section 15 of the *Charter*. The Supreme Court of Canada unanimously held that since hospital services were funded through the *Medical and Health Care Services Act*,¹¹⁶ the hospital was implementing a government program. The *Charter* therefore applied, and the Province of British Columbia was obligated to provide translators to the deaf to ensure equal access to the core health benefits provided under the British Columbian scheme. In failing to provide translation services for the deaf, the Province had effectively denied to a particular group a benefit that was provided to the general population.

In a subsequent decision, *Auton (Guardian ad litem of) v British Columbia (AG)*, the Supreme Court focused on the distinction between “core” benefits

¹¹⁵ *Eldridge v British Columbia*, [1997] 3 SCR 624 [*Eldridge*]. The first ruling on s 15 by the Supreme Court of Canada was issued in *Andrews v Law Society of British Columbia*, [1989] 1 SCR 143, 56 DLR (4th) 1 [*Andrews*]. This case articulated the framework for the interpretation of s 15 equality rights cases which is to be applied in subsequent determinations on s 15 violations by lower courts. The framework was to a certain extent reformulated in *Law v Canada (Minister of Employment and Immigration)*, [1999] 1 SCR 497, 170 DLR (4th) 1, to underscore a “heightened focus on human dignity.” See also discussion in Hurley, *supra* note 66.

¹¹⁶ SBC 1992, c 76, as amended by *Medicare Protection Act*, RSBC 1996, c 286.

already available to everyone under the provincial health care scheme and “non-core” services.

Auton (Guardian ad litem of) v British Columbia (AG)

The *Auton*¹¹⁷ case involved a challenge relating to a service that was not covered under the public health insurance scheme and thus addressed the “comprehensiveness” criterion under the *CHA*. In *Auton*, a behavioural treatment for pre-school aged children with autism (known as Intensive Behavioural Intervention or IBI) was not funded by the provincial scheme. Other programs for autistic children between the ages of three and six, however, were funded provincially. The decision to deny funding to IBI was in part due to the emergent nature of the treatment, which was only beginning to be recognized as desirable, as well as fiscal imperatives. The issue was therefore whether section 15 required the provincial health insurance scheme to include all services that might improve an illness or condition.

In accordance with *CHA* requirements, complete funding was only available under British Columbia’s legislation for medical services considered to be core services. The provincial plan did not fully fund non-core services involving other health practitioners, despite the fact that they might be considered medically necessary or required.

According to the Supreme Court, the claimants did not establish unequal treatment under section 15(1), since they did not show that they failed to receive a benefit that the law was providing.¹¹⁸ This is the key distinction between *Auton* and *Eldridge*. In *Eldridge*, the service being provided was provided to everyone; thus, equal access to core services (physician and hospital services) was required—the benefit-granting law had to be applied in a non-discriminatory fashion. By contrast, *Auton* was concerned with “access to a benefit that the law has not conferred”; there was no denial of access to core benefits.¹¹⁹ That being said, however, the court went on to explore, *inter alia*, the following two questions: (i) what of the non-core services for autistic children that were receiving funding? (ii) could they form a basis for demonstrating discrimination on the part of the government?

The Court stated that it is an “anticipated feature of the legislative scheme” that not all services will be covered and, accordingly, the exclusion of a non-

¹¹⁷ *Auton*, *supra* note 95.

¹¹⁸ *Ibid* at paras 27-47.

¹¹⁹ *Ibid* at para 38 [emphasis in the original].

core service from coverage is not an adverse distinction based on an enumerated ground.¹²⁰ If it were otherwise held, it would “effectively amend the Medicare scheme and extend benefits beyond what it envisions: core physician-provided benefits plus non-core benefits at the discretion of the Province.”¹²¹ Accordingly, equality does not require the government to eliminate or ameliorate all pre-existing disadvantages or create a new benefit or program for an individual or group.¹²² Section 15 is not intended to eliminate all distinctions in law, only those that are discriminatory.¹²³

3. Section 15 as Applied to Palliative Care

The *Auton* case demonstrates the great difficulty of using equitable access arguments as a basis for extending a service when the government is providing that service on the basis of a discretionary policy, as opposed to on the basis of legislation. As mentioned earlier, the *Charter* does not require a government to fund extended services. However, once any level of government (federal, provincial or territorial) enters into this arena and covers the cost of certain extended services, those services must be provided in a non-discriminatory manner.¹²⁴

The *Auton* decision may appear, at first, to constitute a very large hurdle because of the difficulties that are bound to be encountered in trying to extend funding for palliative care, as if it were a core service. While there is increasing support for the position that palliative care should be included as an insured service under the *CHA*,¹²⁵ and, indeed, certain provinces do assert that it is a core provincial service on the basis of a discretionary policy, legislatively we are not yet there.¹²⁶

¹²⁰ *Ibid* at para 43.

¹²¹ *Ibid* at para 44.

¹²² See Robert E Charney & Zachary S Green, “*Auton* and *Chaoulli*: Who Decides the Future of Health Care in Canada?” (2005/2006) 19 NJCL 263 at 271.

¹²³ Hurley, *supra* note 66 at 2 (discussing *Andrews*).

¹²⁴ *Ibid*.

¹²⁵ See Senate, *End-of-Life Care*, *supra* note 46 at 30-31. See Carstairs, *Still Not There*, *supra* note 10 at 3. See *Romanow Commission Report*, *supra* note 98 at xxxi, 63, 172.

¹²⁶ Provincial governments (such as Manitoba and Alberta) have identified palliative care as a core service and palliative care is paid for out the provincial budget without a federal cash contribution. Nonetheless, the authors have already indicated that the delivery is at best uneven (depending in large part on the root cause of the

Unlike the treatment in *Auton*, however, palliative care is not a new or emergent treatment.¹²⁷ Indeed, “[p]alliative care has matured over recent years, with little doubt that end-of-life care providers are better positioned to address various sources of symptom distress than ever before.”¹²⁸ Both best practices¹²⁹ and empirically-derived models of palliative care have been developed.¹³⁰ Palliative end-of-life care cannot be considered a therapy “fresh off the drawing board,”¹³¹ and is thus distinguishable from IBI in *Auton*. It has had the benefit of years of development, improvement, refinement, and research.¹³²

The established practice of palliative end-of-life care is an important consideration because in *Auton*, the relevance of the discussion surrounding IBI as an emergent technology did not concern clinical effectiveness or the desirability of funding. Rather, it concerned the “appropriateness of the comparator group used in the *Charter* section 15 analysis.”¹³³ As described by the Court, “[p]eople receiving well-established non-core therapies are not in the same position as people claiming relatively new non-core benefits.”¹³⁴ We agree with this distinction.

In the view of the authors, the Court is indicating that established non-core therapies may be treated differently than emergent non-core benefits, such as those sought in *Auton*. Palliative care is clearly well established, and those who would claim a right to non-core palliative care are claiming precisely *the same type of care* as those who are actually receiving funded non-core palliative care.

need for care, such as cancer). This apparent arbitrariness in itself justifies a s 15 challenge. Again, more empirical and statistical information is required.

¹²⁷ See also Doyle, *supra* note 100.

¹²⁸ Chochinov, “New Horizons,” *supra* note 10 at 84.

¹²⁹ See e.g. the establishment of the Best Practices and Quality Care Working Group in 2002, which since 2003 has been working with Accreditation Canada to influence hospice palliative care accreditation standards across Canada. See also Frank D Ferris et al, *A Model to Guide Hospice Palliative Care: Based on National Principles and Norms of Practice* (Ottawa: Canadian Hospice Palliative Care Association, 2002), online: CHPCA <www.chpca.net/uploads/files/english/resource_doc_library/model_to_guide_hpc/A+Model+to+Guide+Hospice+Palliative+Care+2002-URLUpdate-August2005.pdf>.

¹³⁰ See Chochinov, “New Horizons,” *supra* note 10 at 92-93.

¹³¹ Charney & Green, *supra* note 122 at 273.

¹³² See Chochinov, “New Horizons,” *supra* note 10 at 84.

¹³³ Charney & Green, *supra* note 122 at 273.

¹³⁴ *Auton*, *supra* note 95 at para 55.

To be clear, the argument made here is not aimed at transforming non-core services into core services. This was the argument made in *Auton* and it was rejected: there is no “right” to non-core benefits. Here, however, the suggestion is that once the government has exercised its discretion to provide specific non-core services, these non-core services should be provided in a non-discriminatory manner. In the case of palliative care, policy decisions have been made to provide services to a group that is suffering from a particular life-limiting condition, namely, cancer. In order to not be discriminatory, those who suffer equally from other life-limiting conditions (and thus have an equal need for end-of-life care) should be entitled to the same government benefit. The root cause of the suffering should be irrelevant, otherwise discrimination is present.¹³⁵

In *Auton*, therapy A was a funded non-core therapy for autism. The plaintiffs believed that the failure to fund therapy B for autism was discriminatory. However, the Court was clear that the funding of therapy A did not make a refusal to provide funding for therapy B discriminatory. In other words, the same root cause was treatable via two different therapies, A and B, the latter of which was emergent. In the case of palliative care, we have the same therapy, A, but two (or more) different root causes, Y and Z. The argument is that one therapy, therapy A, must not be funded on a basis that discriminates between root causes Y and Z. Furthermore, the emergent nature of the therapy at issue in *Auton* was a key factor in the court decision. Palliative care is an established branch of medicine. For these reasons, *Auton* is not directly applicable.

A second, and perhaps stronger, section 15 argument also presents itself. The federal government has provided funding in certain circumstances to assist cancer-based palliative care initiatives.¹³⁶ Nonetheless, palliative care is typically perceived as extended care because of the operation of the *CHA*. This statute sets out that only medically “necessary” or “required” services are “insured” services for the purposes of the cash transfer. This terminology of “necessary” or “required” is not fully defined in the legislation, apparently in order to permit the exercise of discretion by the provinces in determining coverage under their provincial health insurance plans. Outside of the in-patient setting, most palliative care will not be federally insured care (under the *CHA*) because it falls into that broader category of extended care, leaving it to provincial discretion.

¹³⁵ See *Nova Scotia (Workers' Compensation Board) v Martin*, 2003 SCC 54, [2003] 2 SCR 504 [*Martin*]. The case is discussed in further detail under sub-part (2) below.

¹³⁶ Health Canada, “Pallium,” *supra* note 107.

This begs the question, why is it that palliative care is not, for the most part, considered medically “necessary” or “required” under the *CHA*? This is not a new question. In fact, the concern as to what exactly is “medically necessary” has been present since the formation of the public health care system in Canada in the 1960s and was reconsidered when the *CHA* was created in the 1980s.¹³⁷ Part of the answer is that palliative care is specialized care necessarily delivered by a team of health professionals, as opposed to care delivered solely by physicians. There is more to palliative care than medical assistance.¹³⁸

The other part of this answer, however, lies in the translation of health care via the *CHA* into an “illness-oriented hospital-dominated health system”¹³⁹ with a *cure* focus. Indeed, a study undertaken in Alberta in 2001 indicated that 52% of hospital stays that ended in death were not “treatment intensive,” meaning that very little was done in terms of surgery or major diagnostic procedures.¹⁴⁰ This study and others indicate that when a patient is dying, or a terminal diagnosis is made, resource expenditures on that particular patient are reduced.¹⁴¹ Dying requires care, but not cure, and it is only cure-focussed care that tends to be insured under the *CHA*.

Section 15 requires not only that there be an enumerated ground (dealt with below), but also that there be a comparison between one group receiving government benefits and the group which is asserting a constitutional right to those same or similar benefits.¹⁴² In this case, when one compares those who have conditions that are curable to those whose conditions are life-limiting, the distinction is quite stark. In other words, the treatment of those who can be “cured” is generally funded through the *CHA*, while those who cannot be cured are generally left without the benefit of the *CHA* and its five principles: accessibility, public administration, comprehensiveness, universality, and portability.

¹³⁷ See Donna Wilson, “Medically Necessary? The Case for Fully Funded End-of-Life Care” (2002) 10:3 Health Law Review 3 at 3.

¹³⁸ Brenda Gibson, “Volunteers, Doctors Take Palliative Care Into the Community” (1995) 153:3 Canadian Medical Association Journal 331 at 331.

¹³⁹ Wilson, *supra* note 137 at 3.

¹⁴⁰ *Ibid* at 4.

¹⁴¹ *Ibid* at 4.

¹⁴² *Hodge v Canada (Minister of Human Resources Development)*, 2004 SCC 65 at paras 17-23, [2004] 3 SCR 357.

In the view of the authors, this care versus cure distinction is also relevant when discussing section 7. We therefore return to this debate in the context of our section 7 discussion in Part II.D(4). In the section below, we discuss the final element of a section 15 challenge—namely, an enumerated or analogous ground.

4. The Enumerated Ground: Discrimination by Virtue of Disability

Proceeding with the first section 15 argument, identified above, one of the key elements of a section 15 challenge is that there must not only be discrimination against the citizen, but this discrimination must also be based on either (i) one of the grounds specifically enumerated in the section (race, national or ethnic origin, colour, religion, sex, age, or mental or physical disability), or (ii) a ground analogous¹⁴³ to those enumerated.

Disability is a ground of prohibited discrimination pursuant to section 15. The use of the word “disability” recognizes that whatever the cause of the impairment, the disability is the loss of a level of functioning that is considered normal¹⁴⁴ and thus includes illness. While the inclusion of disability in section 15 can be concerned with distinctions between persons who have disabilities and those who do not, it can also be used to ensure non-discrimination between groups with different disabilities. Just as “family status” encompasses a variety of relationships (including those who are married, single, with children, and so on),¹⁴⁵ so does disability encompass a variety of different groups. Thus, there can be discrimination between groups of persons with different disabilities.

Long-term care is generally perceived as a form of extended care and is therefore not subject to the universality and accessibility guarantees under the

¹⁴³ Examples of analogous ground are citizenship (see *Andrews*, *supra* note 115) and sexual orientation (see *Vriend v Alberta*, [1998] 1 SCR 493, 156 DLR (4th) 385 [*Vriend* cited to SCR]).

¹⁴⁴ The World Health Organization’s *International Classification of Functioning, Disability and Health* defines disability as “the outcome or result of a complex relationship between an individual’s health condition and personal factors, and of the external factors that represent the circumstances in which the individual lives” World Health Organization, *International Classification of Functioning, Disability and Health, Short Version* (Geneva: WHO Publications, 2001) at 23.

¹⁴⁵ See *B v Ontario (Human Rights Commission)*, 2002 SCC 66, [2002] 3 SCR 403 at paras 38-39, 53-57 (while *B v Ontario* was not a *Charter* challenge, many of the principles espoused in this case could be applied in *Charter* litigation).

CHA.¹⁴⁶ Yet, when they form part of cancer-care, in many provinces, long-term care and palliative care are available and covered by public insurance.¹⁴⁷ Factually, there is no distinction between the need for palliative care arising out of a cancer-based illness, on the one hand, and other life-limiting illnesses on the other. All palliative care requires the management of pain and suffering.¹⁴⁸ Thus, under the operation of the federal *CHA*, in conjunction with provincial cancer-care legislation and activities occasionally funded in part by the federal Parliament, palliative care is being provided for certain individuals and not for others. This is a form of discrimination between disabilities. By favouring one root cause of impairment over another, there can be little doubt that a distinction has been made between cancer and other conditions that require palliative care and that this distinction is based on an enumerated ground.

Because benefits are being granted to a particular group based on fortuitous circumstances, it is, arguably, not open to government to limit benefits for others who are suffering from precisely the same circumstances, on the basis of a different disabling condition. This is a denial of equal benefit under the law.

Indeed, the Supreme Court had the opportunity to consider discrimination between disabilities in a 2003 case, *Nova Scotia (Worker's Compensation Board) v Martin*.¹⁴⁹ In *Martin*, two individuals who suffered from chronic pain challenged legislation that excluded them from coverage under the regular workers' compensation system. The appellants argued that the legislation discriminated against them on the basis of disability and denied them equal benefit under the law and, as such, infringed section 15(1) of the *Charter*. In finding that section 15(1) had been infringed, the Supreme Court stated:

By entirely excluding chronic pain from the application of the general compensation provisions of the Act and limiting the applicable benefits to a four-week Functional Restoration Program for workers injured after February 1, 1996, the Act and the FRP Regulations clearly impose differential treatment upon injured

¹⁴⁶ See *CHA*, *supra* note 22, s 2 which defines "extended health care services" as: "the following services, as more particularly defined in the regulations, provided for residents of a province, namely, (a) nursing home intermediate care service, (b) adult residential care service, (c) home care service, and (d) ambulatory health care service." See generally Sholzberg-Gray, *supra* note 78.

¹⁴⁷ See discussion at II.B above.

¹⁴⁸ See generally Chochinov, "New Horizons," *supra* note 10. See also *Romanow Commission Report*, *supra* note 98 at 183.

¹⁴⁹ *Martin*, *supra* note 35.

workers suffering from chronic pain on the basis of the nature of their physical disability, an enumerated ground under s. 15(1) of the *Charter*. *In the context of the Act, and given the nature of chronic pain, this differential treatment is discriminatory. It is discriminatory because it does not correspond to the actual needs and circumstances of injured workers suffering from chronic pain, who are deprived of any individual assessment of their needs and circumstances. Such workers are, instead, subject to uniform, limited benefits based on their presumed characteristics as a group. The scheme also ignores the needs of those workers who, despite treatment, remain permanently disabled by chronic pain ... The challenged provisions clearly violate s. 15(1) of the Charter.*¹⁵⁰

With respect to palliative care delivery and access, we do not have a piece of legislation that we can specifically point to as a breach of section 15, making our task particularly challenging. As a general proposition, the *Charter* does not impose positive duties to act.¹⁵¹ The authors nonetheless argue that the decisions of the federal and provincial governments, having chosen to enter into the domain of palliative care by providing funding for palliative care services, are subject to the *Charter*, including the obligation to cover everyone, who, under section 15, has a constitutional right to be included.¹⁵² Cancer care provides one example where end-of-life care is being delivered on an unequal footing and may therefore provide the basis for a valid *Charter* argument to provide palliative care to all who require it.¹⁵³

Of course, this raises the question of what remedy would be appropriate, assuming a section 15 breach is found. If the fault lies not with legislation (as might very well be the case with respect to palliative care delivery and access), but rather with the exercise of discretionary power, the remedy might only be a simple issuance of a declaration and an instruction to government to remedy the situation.¹⁵⁴ However, whatever the remedy, an authoritative statement by the Supreme Court as to the existence of a constitutional right to palliative care

¹⁵⁰ *Ibid* at para 5 [emphasis added].

¹⁵¹ See *Vriend*, *supra* note 143 at 532-536.

¹⁵² *Ibid*.

¹⁵³ See comments by Sholzberg-Gray, *supra* note 7878.

¹⁵⁴ On this point see the discussion of the adequacy of a declaratory remedy in *Little Sisters Book and Art Emporium v Canada (Minister of Justice)*, 2000 SCC 69, [2000] 2 SCR 1120 [*Little Sisters*].

may spur government action to provide the care that many need, but which they may not be receiving under the current system.

D. Section 7 of the Charter

Section 15 is not the only route to judicial recognition of a constitutional right to palliative care. Section 7 of the *Charter* may also be useful in achieving this objective. Section 7 provides as follows: “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.”¹⁵⁵

The case law has developed a two-pronged analysis with respect to section 7. First, the claimant must show that there is a real or impending deprivation of one of the following guarantees: (i) life; (ii) liberty; or (iii) security of the person. Second, it must be shown that the deprivation is not in accordance with the principles of fundamental justice.¹⁵⁶ The question here, then, is whether reasonable arguments may be advanced on both prongs, suggesting that section 7 has been infringed due to the failure of the federal and provincial governments to provide meaningful, universal palliative care coverage, pursuant to the *CHA* and provincial health care plans. In the view of the authors, the answer to this question is in the affirmative.

1. Violation of Security of the Person

The security of the person involves protection of “both the physical and psychological integrity of the individual.”¹⁵⁷ Sufficient psychological stress placed on an individual will constitute an affront to the security of the person.¹⁵⁸ Not every stress, however, is sufficient for section 7 protection: “the ordinary stresses and anxieties that a person of reasonable sensibility would suffer as a result of government action” will not be protected by section 7.¹⁵⁹ The majority in the *G (J)* decision explains:

¹⁵⁵ *Charter*, *supra* note 18 s 7.

¹⁵⁶ See *Reference re Section 94(2) of the Motor Vehicle Act (BC)*, [1985] 2 SCR 486 at 500-504 [*Motor Vehicle Reference*].

¹⁵⁷ *New Brunswick (Minister of Health and Community Services) v G (J)*, [1999] 3 SCR 46 at 76-77, Lamer CJC, and at para 116, L’Heureux-Dubé J, concurring [*G (J)*].

¹⁵⁸ *Ibid* at 77-78, Lamer CJC.

¹⁵⁹ *Ibid* at 77, Lamer CJC.

For a restriction of security of the person to be made out, then, the impugned state action must have a *serious and profound effect on a person's psychological integrity*. The effects of the state interference must be assessed objectively, with a view to their impact on the psychological integrity of a person of reasonable sensibility. This need not rise to the level of nervous shock or psychiatric illness, but *must be greater than ordinary stress or anxiety*.¹⁶⁰

Those seeking palliative care are already under the psychological stress of dealing with a life-limiting illness. They are in the vulnerable position of being unable to manage their care needs and pain without significant social, medical, or pharmaceutical intervention. Because the federal scheme that operates to classify the majority of palliative care services places them outside of insured care,¹⁶¹ the government adds a significant amount of stress to the lives of those who are already under extraordinary strain.

Without access to integrated palliative care, many people with life-limiting illnesses will potentially be faced with a dilemma: live out their remaining days in pain and suffering (including spiritual and existential suffering), without the care that would relieve their suffering and feelings of being a burden to others, or consider ways to end their suffering by hastening death or committing suicide.¹⁶² While some may suggest that there is no direct evidence of this dilemma, the authors believe that current empirical data appears to support this linkage.¹⁶³ As described by Dr Harvey Chochinov:

¹⁶⁰ *Ibid* at 77-78, Lamer CJC [emphasis added].

¹⁶¹ See Sholzberg-Gray, *supra* note 7878 at 284.

¹⁶² For further discussion of the relationship between desire for hastened death and palliative care, see Chochinov, "New Horizons," *supra* note 10; Deborah Dudgeon, "Excellent Palliative Care, Not Euthanasia" in Barney Sneiderman & Joseph M Kaufert, eds, *Euthanasia in the Netherlands* (Winnipeg: The Legal Research Institute, 1994) 81 at 81-85.

¹⁶³ "Over the last decade, much work has been done to establish the incidence and prevalence of psychiatric issues among patients nearing death. For example, [the prevalence of] anxiety disorders in terminally ill cancer and AIDS patients ranges from 15% to 28%, with some studies indicating a higher prevalence of mixed anxiety and depressive symptoms in cancer patients rather than anxiety alone. The prevalence of anxiety appears to increase with advancing disease and mounting deterioration in the patient's physical status. As patients become sicker, their anxiety may include fears about the disease process, the clinical course, possible treatment outcomes, and death ... Although screening strategies as simple as ask-

More ubiquitous aspects of suffering—including psychological, existential, or spiritual distress—are not necessarily well understood or researched, nor do they necessarily engender a well-considered response. Distress of this kind may express itself as an overwhelming sense of hopelessness, existential or spiritual angst; loss of sense of dignity; sensing oneself a burden to others; or a waning of one's will to live and a growing desire for death or wish to no longer carry on living.

...

Among patients with life-threatening illness, sensing oneself as a burden to others seems to be an important theme related to quality of life, optimal palliative care, and maintenance of dignity at the end of life. Personal or individual autonomy—especially in Western society—is often conflated with the notion of being a whole person, so that dependency can be seen or experienced as threatening the integrity of personhood itself. Therefore a bad death is frequently characterized by “feeling a burden to others” and is often invoked in matters pertaining to suicide or requests for hastened death among patients with advanced disease.¹⁶⁴

ing the patient if they are depressed ‘most of the time’ have shown good diagnostic sensitivity and specificity, depression continues to be overlooked among patients who are terminally ill. This further adds to their burden of suffering and undermines their quality of life” (Chochinov, “New Horizons” *supra* note 10 at 86). See also LJ Materstvedt et al, “Euthanasia and Physician-Assisted Suicide: A View From an EAPC Ethics Task Force” (2003) 17:2 *Palliative Medicine* 97; Marije L van der Lee et al, “Euthanasia and Depression: A Prospective Cohort Study Among Terminally Ill Cancer Patients” (2005) 23:27 *Journal of Clinical Oncology* 6607 (An empirical discussion on connections between terminal illness and depression in terminally ill cancer patients and explicit requests for assisted suicide).

¹⁶⁴ Chochinov “New Horizons,” *supra* note 10 at 86-87 (“According to reports from family members of patients who had died after having previously expressed a wish for hastened death, 58% to 94% were distressed about being a burden to others. Physicians who had been asked to assist with death-hastening measures indicated that patients’ concerns about being a burden to others was a motivating factor in 41% to 75% of requests. Among dying patients who actually killed themselves, feeling a sense of burden to others was almost universal. Data from Oregon indicates that 63% of patients who received a hastened death under that state’s Death with Dignity Act had expressed a strong sense of having become a significant burden to their family, friends, or caregivers. The authors further report that this motivation for death-hastening practices is becoming more prominent over time” at 91).

There can be little doubt that the general exclusion of palliative care from insured services under the *CHA*, which shifts the obligation to provincial discretion, means that governments are adding to the psychological stress of those who require such care. The effect is surely greater than the “ordinary” stress of life, as articulated by the Supreme Court of Canada.

When appropriate palliative care is provided, additional options become available to the person suffering from the life-limiting illness. At minimum, the person’s physical pain can be managed regardless of his or her financial circumstances. Spiritual and existential pain can also be addressed: the person can “not only be made to feel more comfortable, but more broadly, provided with comfort” in accordance with current palliative care best practices.¹⁶⁵ When a person is comforted in these ways, suicide may be a less prevalent alternative.¹⁶⁶ Unremitting pain and suffering that cannot be relieved can be a pre-condition to a desire for death-hastening practices.¹⁶⁷ That the decision to shorten one’s life can be influenced by a lack of access to appropriate palliative care options cannot be ignored.¹⁶⁸

These realities may also support an argument that the section 7 “life” interest is also engaged. Current empirical evidence regarding the physical and psychological suffering at the end of life, some of which has been described above, suggests that a failure to provide access to palliative care in accordance with current best practices may increase the likelihood of the loss of life and therefore infringes the “life” interest under section 7. In *Chaoulli*, four of the seven justices held that the “life” interest under section 7 became engaged even though there was no statistical evidence to prove that people had actually died as a result of the government policy at issue.¹⁶⁹ On the balance, the “life” interest under section 7 may not be as clearly engaged as the “security of the

¹⁶⁵ Chochinov, “New Horizons,” *supra* note 10 at 84.

¹⁶⁶ See e.g. LJ Materstvedt et al, *supra* note 136 at 65.

¹⁶⁷ *Ibid.* See also van der Lee et al, *supra* note 163; Carstairs, *Raising the Bar*, *supra* note 6 (“As one physician said in a written brief, ‘The antithesis to deliberate ending of life is good palliative care’” at 13).

¹⁶⁸ For additional arguments on how obligations under the *ICESCR* require prioritizing the palliative care agenda over the assisted suicide agenda see Shariff, “Navigating Assisted Death” *supra* note 15.

¹⁶⁹ *Chaoulli v Québec (AG)*, 2005 SCC 35 at para 112, [2005] 1 SCR 791, McLachlin CJC & Major J [*Chaoulli*] (Bastarache J concurring). See also *Chaoulli* at paras 37-38, 40-42, Deschamps J (holding that the Canadian *Charter* and *Québec Charter* protect the right to “life” in the same way, and that the *Québec Charter*’s right to life was infringed by wait lists even without strong proof of mortality).

person” interest. Regardless, the engagement of either will be sufficient to allow the argument to proceed to the next stage of the analysis.

Note that the authors are arguing that the general exclusion of palliative care from insured services under the *CHA* constitutes interference with security of the person. This could be somewhat problematic because it might be interpreted as simply state inaction, whereas the law requires actual state action or interference with security to constitute infringement of section 7. However, it might, in turn, be argued that the decision to place palliative care outside of insured services was not merely inaction, but a specific policy choice, engaging section 7 rights. Thus, the task that remains is to seek out and identify examples of state action in the delivery of and access to palliative care that increases the psychological stress of those who have life-limiting conditions.

2. Violation of the Principles of Fundamental Justice

It is well established that the principles of fundamental justice are found in “the basic tenets of our legal system”¹⁷⁰ and that one of these principles is lack of arbitrariness.¹⁷¹ As Chief Justice McLachlin and Justice Major explained:

A law is arbitrary where “it bears no relation to, or is inconsistent with, the objective that lies behind [it].” To determine whether this is the case, it is necessary to consider the state interest and societal concerns that the provision is meant to reflect.

In order not to be arbitrary, the limit on life, liberty and security requires not only a theoretical connection between the limit and the legislative goal, but a real connection on the facts. The onus of showing lack of connection in this sense rests with the claimant. The question in every case is whether the measure is arbitrary in the sense of bearing no real relation to the goal and hence being manifestly unfair. The more serious the impingement on the person’s liberty and security, the more clear must be the connection. Where *the individual’s very life may be at stake, the reasonable person would expect a clear connection, in theory and in fact, between the measure that puts life at risk and the legislative goals.*¹⁷²

The authors have already addressed how the individual’s very life may be at stake by virtue of the non-provision of palliative care options to all those who

¹⁷⁰ *Motor Vehicle Reference*, *supra* note 156.

¹⁷¹ *Chaoulli*, *supra* note 169 at para 125, McLachlin CJC & Major J.

¹⁷² *Ibid* at paras 130-131 [emphasis added].

need them. Based on the wording adopted by some justices in *Chaoulli*, this might be sufficient, but additional elements should also be considered.

Access to publicly funded palliative care can be seen as arbitrary in the sense that access to insured palliative care services is, arguably, not based on meaningful criteria. For example, as discussed above, the vast majority of government spending on palliative care at both the federal and provincial levels appears, in many cases, to be connected to a particular diagnosis—namely, cancer—as opposed to the need for palliative care itself. While the authors stress that they are not challenging the importance of or need for palliative care in cancer-related treatment, it is a legitimate legal task to explore whether the apparent exclusion of other diagnoses from fully funded palliative options is arbitrary.

3. The Interplay between Sections 7 and 15

While each *Charter* right is to be judged individually, they are not entirely independent of one another. In the case of palliative care, the values that underlie section 15 can influence the analysis under section 7. In the concurring opinion of Justice L'Heureux-Dubé in *G(J)*, the learned justice chose to specifically address the connection between sections 7 and 15 of the *Charter*, writing:

Thus, in considering the s. 7 rights at issue, and the principles of fundamental justice that apply in this situation, it is important to ensure that the analysis takes into account the principles and purposes of the equality guarantee in promoting the equal benefit of the law and ensuring that the law responds to the needs of those disadvantaged individuals and groups whose protection is at the heart of s. 15. *The rights in s. 7 must be interpreted through the lens of ss. 15 and 28, to recognize the importance of ensuring that our interpretation of the Constitution responds to the realities and needs of all members of society.*¹⁷³

The authors take this to mean that, where the violation of the rights protected by section 7 (life, liberty, or security of the person) would have a disproportionate impact on those groups protected by the equality guarantee found in subsection 15(1), a careful analysis of the relationship between principles of fundamental justice, on the one hand, and the importance of equality, on the other, is required.

¹⁷³ *G(J)*, *supra* note 157 at para 115 [emphasis added].

One means of linking section 7 to section 15 is to consider precisely *where* health care money is being spent. As explained by the Supreme Court: “The *Charter* does not confer a freestanding constitutional right to health care. However, where the government puts in place a scheme to provide health care, that scheme must comply with the *Charter*.”¹⁷⁴ There is no constitutional requirement to provide health care, according to the Supreme Court. Yet, *if* the government introduces a program, that program must be provided in accordance with all constitutional guarantees. Equality is only genuine where it is substantive, as opposed to formal, in nature.¹⁷⁵ One can judge the substantive equality of a health program only in the broader context of the operation of that program. If it is indeed the case that an exceptionally large percentage of government money spent on palliative care goes to addressing a particular disease—namely, cancer—then the distribution of resources could be deemed arbitrary in the sense used by all the justices in *Chaoulli*. Furthermore, an unreasonable waiting list is sufficient to trigger arbitrariness in a law designed to deliver reasonable access to health care. This was found to be the case in *Chaoulli* by Chief Justice McLachlin and Justice Major:

The primary objective of the *Canada Health Act*, R.S.C. 1985, c. C-6, 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” (s. 3). By imposing exclusivity and then failing to provide public health care of a reasonable standard within a reasonable time, the government creates circumstances that trigger the application of s. 7 of the *Charter*.¹⁷⁶

4. Care versus Cure

Additional arbitrariness in access and delivery lies in the differential treatment of those who have disabilities that are relatively temporary in nature and those who have disabilities that are unlikely to improve during their lifetimes, that is, those with life-limiting illnesses. This might be described as a “care” versus “cure” distinction, which appears to exist in many areas of medical practice where it is thought that only curative measures are medically relevant,

¹⁷⁴ See *Chaoulli*, *supra* note 169, McLachlin CJC & Major J, at para 104 [emphasis added].

¹⁷⁵ *Andrews*, *supra* note 115.

¹⁷⁶ See *Chaoulli*, *supra* note 169 at para 105 [underlining in original; italics added].

notwithstanding issues of pain control.¹⁷⁷ This distinction was discussed earlier with reference to section 15. Indeed, the language of the *CHA*, “to *protect, promote and restore* the physical and mental well-being of residents of Canada,”¹⁷⁸ is clearly focused on preventing and curing threats to well-being as opposed to providing care to those whose illnesses are beyond the point at which a cure may be reasonably expected.

The difficulty with this approach is that it ignores the social model of disability. While the “cure” focus is perhaps understandable, given the biomedical orientation of the *CHA*,¹⁷⁹ most people knowledgeable in the field of disability studies view disability not as a matter of medical pathology, but as a matter of social construction.¹⁸⁰ For example, a person who uses a wheelchair for mobility is, according to the social model of disability, not disabled merely as a result of the medical condition. Rather, the disability is a result of the fact that the built environment has far too many structures that cannot accommodate the needs of those who use wheelchairs for mobility.¹⁸¹ From this perspective, there is little doubt that people who require palliative care are disabled to the extent that their ability to interact in society is severely hampered. Because there is no chance to medically improve or protect the health of the patient, however, this social reality does not enter into the equation. In other words, a “cure” interpretation of the *CHA* is arguably a violation of section 15 of the

¹⁷⁷ For example, “Palliative care has matured over recent years, with little doubt that end-of-life care providers are better positioned to address various sources of symptom distress than ever before. It is also clear that the distinction between somatic distress and psychological or spiritual disquietude becomes less clear and increasingly entangled as death draws near. Yet, there is an inclination for care providers to parse these out, focusing on those things that seem within our grasp to attenuate, while neglecting those we sense are beyond reach” (Chochinov, “New Horizons,” *supra* note 10 at 84).

¹⁷⁸ *CHA*, *supra* note 22 s 3 [emphasis added].

¹⁷⁹ In the biomedical model of disability, there is a focus on the pathology or disease that “creates” an inability to carry out normal functions. For example, with a person who has a mobility impairment, the disability is a result of the pathology of the condition that is the medical “cause” of the inability at issue.

¹⁸⁰ Jerome E Bickenbach, *Physical Disability and Social Policy* (Toronto: University of Toronto Press, 1993) at 136-149.

¹⁸¹ While this is not necessarily the forum in which to make this argument, the authors believe that constitutional guarantees require a broader view of disability. After all, the rights under the *Charter* are to be construed purposively. See e.g. *R v Big M Drug Mart*, [1985] 1 SCR 295, 60 AR 161, 18 DLR (4th) 321.

Charter. Indeed, it intimates that there exists a systemic denial of rights at the very foundation of the health care system in Canada.

What should replace the “cure” perspective? Quite simply, access to health care should be determined on the basis of need. If caring for the person is as important as curing the person,¹⁸² palliative care should fall within the definition of “insured services” under the *CHA* and, in fact, justice demands it.

The authors do not advance this argument lightly, given that resource allocation decisions must be made on a daily basis. In *Chaoulli*, the possibility of instructing the government to deploy more financial resources was clearly a concern even for the justices who believed that *Charter* rights had been unjustifiably infringed:

The appellants *do not seek an order that the government spend more money on health care*, nor do they seek an order that waiting times for treatment under the public health care scheme be reduced. They only seek a ruling that because delays in the public system place their health and security at risk, they should be allowed to take out insurance to permit them to access private services.¹⁸³

The authors understand and respect the concern espoused in this paragraph. Nonetheless, an appreciation of the right of government to determine its spending priorities should rarely be used to undermine the fundamental values of Canadian society. The *Charter* represents some of the core values of what it means to be Canadian. If Canadian society is willing to abandon those values in favour of economic considerations, what Canadian societal values will remain?

Notwithstanding the rhetorical nature of this question, two responses to this fiscal concern present themselves. First, where access to health care is concerned, the Supreme Court of Canada has ruled that the *Charter* mandates funding for services that the relevant statutory framework would not otherwise provide, as was the case in *Eldridge*. Therefore, the approach offered within this paper is not without precedent. While the class of people in that case (those in need of sign-language interpretation) was more limited as a class than

¹⁸² See Chochinov, “Psychiatry and Terminal Illness,” (2000) 45:2 Canadian Journal of Psychiatry 143 at 143 (regarding the need for a care focus of the patient and how a cure-oriented focus is too narrow).

¹⁸³ *Chaoulli*, *supra* note 169, McLachlin CJC & Major J at para 103 [emphasis added].

those needing palliative care, the impact of the refusal to recognize this right is just as severe.

As mentioned earlier, the Supreme Court has already indicated that the possibility of death necessitates a more careful examination of the content of the principles of fundamental justice to ensure that a proper balance is achieved within the section 7 analysis. By extension, the general reluctance of the courts to force governments to spend money via constitutional imperative should be carefully examined where the refusal to prescribe spending could result in increasing suffering, to the point of potentially hastening death.

The authors acknowledge that this answer may be unpalatable to a court that is made to rule on a request for recognition of a constitutional right to palliative care. In such a case, there is an alternative argument: the constitutional right to palliative care does not demand that government spend more money on palliative care. Rather, the right demands that when money is spent on palliative care, that money must be spent in a non-discriminatory way. In the view of the authors, the interaction of sections 15 and 7 of the *Charter* may justify such a determination.

III. Limitations

A. Section 1

As described above, the government may be able to establish that the violation of a *Charter* protected right is permissible or “justified” under section 1. The framework for the justification of *prima facie* violations of constitutionally protected rights under the *Charter* was established by the Supreme Court in *R v Oakes*.¹⁸⁴ There are three stages to this analysis.

The first stage is whether the proposed limit is “prescribed by law.” In the case of palliative care, there is no question that the distinctions made by or pursuant to the *CHA* are prescribed by law and present an intelligible standard to the public. However, if government action or policy is at the whim of a government official, and not mandated by statute, regulation, or the common law, it is not “prescribed by law” for the purposes of section 1 and such an infringement cannot be justified.¹⁸⁵

¹⁸⁴ *R v Oakes*, [1986] 1 SCR 103 [*Oakes*]. The *Oakes* test was later refined by: *Dagenais v Canadian Broadcasting Corporation*, [1994] 3 SCR 835; *RJR-Macdonald Inc v Canada (AG)*, [1995] 3 SCR 199.

¹⁸⁵ See *Little Sisters*, *supra* note 154 at paras 141, 145-146, 222-224. See also *Irwin Toy Ltd v Québec (AG)*, [1989] 1 SCR 927.

The second stage of the analysis is whether the objectives sought to be achieved by government through the law are “pressing and substantial.” At this stage, the court requires that the government show that the law’s objectives are sufficiently important to warrant overriding what are otherwise constitutionally protected rights.

If the objective is deemed sufficiently important at the second stage of analysis, the third stage of analysis proceeds to examine whether the government has chosen means proportional to the objective. This third stage may be viewed as having three sub-stages. The first of these sub-stages demands that the government demonstrate a *rational connection* between the objective and the means sought to achieve it. The second sub-stage involves proof of *minimal impairment*: whether the government has chosen a method of achieving its objective that can be reasonably said to impair the constitutionally protected right as little as possible. The third sub-stage is an assessment of proportionality. Here, the courts weigh both the salutary (positive) and deleterious (negative) effects of the government measure to determine whether the negative effect on the constitutionally-protected right is justified, given the positive effects of the law or of the measure chosen. As was established in *Chaoulli*, where the life of a citizen is at issue, the onus on the government is a heavy one. It should never be easy for the government to justify placing the lives of citizens at risk through legislative indifference.

Is there a justification for depriving one’s constitutionally-guaranteed rights to equality under sections 7 and 15 in the context of palliative care? The authors believe there is not. It is true that government funding priorities are important and may even be important enough to constitute a pressing and substantial objective for the purposes of the *Oakes* analysis.¹⁸⁶ However, even assuming a funding crisis, the consequences of such a crisis should not be borne disproportionately by some of the most vulnerable members of our society. Of the approximately 15% of Canadians receiving palliative care,¹⁸⁷ 90% have accessed this care through cancer-care.¹⁸⁸ If there were ever a clearer argument for a lack of proportionality under the *Charter*, in the view of the authors, it is difficult to conceive of it.

¹⁸⁶ See *Newfoundland (Treasury Board) v NAPE*, [2004] 3 SCR 381 (the Court held that a financial crisis to the public purse was sufficient for s 1 purposes. However, the Court was clear that, first, this would be rare, at para 72; second, financial reasons *alone* will never constitute a s 1 justification, at paras 69-71) [*NAPE*].

¹⁸⁷ Carstairs, “Motion,” *supra* note 96 at 83.

¹⁸⁸ See *2000 Senate Report*, *supra* note 46 at Part I.A; CHPCA “Fact Sheet”, *supra* note 30.

Section 1 has never been successfully invoked after a violation of section 7 has been found by the court, though the Supreme Court has recognized that, at least in theory, it is still a possibility.¹⁸⁹ In the absence of case law from which analogies might be drawn, it is difficult to conceive of an argument that governments could advance to justify the violation of section 7 pursuant to the *Oakes* test.¹⁹⁰ Once a basic tenet of the justice system has been violated by the government, it should be reasonably difficult (and thus relatively rare) for the government to show that a free and democratic society would allow the law to be enforced notwithstanding the violation. For example, an economic justification—that is, the argument that a right to palliative care would be too expensive and hamper government spending priorities—can be dealt with by defining the right carefully.¹⁹¹ Furthermore, it is difficult to show that the government’s choice to focus on “cure” over “care” minimally impairs the right at issue, when that constitutional right would be better protected if the government had not made the statutory choice in the first place.

To extend the section 1 analysis beyond the foregoing would enlarge this paper beyond its intended scope. If a right to palliative care is argued in court, the applicant will have to present empirical data on palliative care access and delivery in the Canadian health care system, requiring more work on all fronts. This leads us to our next point.

B. Lack of Empirical Data and Other Considerations

In advancing the legal right to palliative care, more empirical analysis must be done. Given the current lack of data, we can only conclude somewhat anecdotally that palliative care is not as integral a part of health care as it should be.¹⁹² For the purposes of advancing an argument for the enforcement of palliative care as a legal right, further research is essential. There is an insufficient empirical foundation, for example, to state categorically whether decisions about appropriate palliative end-of-life care are being made for economic reasons, as opposed to being made in the best interests of the person requiring care.

¹⁸⁹ See Hogg, *Constitutional Law*, *supra* note 68 at ch 47.3.

¹⁹⁰ *Oakes*, *supra* note 184.

¹⁹¹ See *Martin*, *supra* note 135 (“[B]udgetary considerations in and of themselves cannot justify violating a *Charter* right, although they may be relevant in determining the appropriate degree of deference to governmental choices based on a non-financial objective” at para 6). See also *NAPE*, *supra* note 186.

¹⁹² See discussion in Part III.B, *supra*.

It is also important to point out that advancing palliative care access and delivery does not rest on collecting data generated solely from the formal health care system. There are strong arguments in support of the notion that people requiring palliative care should receive integrated end-of-life care in their own homes and among their loved ones.¹⁹³ Not only is there good reason for this from the patient's perspective, but also from the government's economic perspective, as it is purportedly less expensive to provide palliative care in the home than in institutional settings.¹⁹⁴ However, this raises the following question: even if having palliative care among loved ones is preferable, are those who require it receiving the support they need?¹⁹⁵ A decision regarding the best form of palliative care should not necessarily be based on the shortage of hospital beds, or the existence of a caring relative at home. Instead, it should be the result of an assessment regarding the best interests of the person requiring care. Also to be considered are the interests of the individuals responsible for the provision of care at home, namely, adult children and the spouses of those requiring care, among others.

In order to proceed with a *Charter* argument, much more empirical data is needed, including qualitative research, as well as dissemination of that re-

¹⁹³ WHO, *Solid Facts*, *supra* note 26 (“[m]ost studies have found that around 75% of respondents would prefer to die at home” at 16). See also *Romanow Commission Report*, *supra* note 98 at 182 (80% of Canadians prefer to die at home); CHPCA, “Fact Sheet” *supra* note 31 at 1-3.

¹⁹⁴ See Senate, *Canada's Aging Population*, *supra* note 98 at 167-168, which states: “[t]he evidence supports home care as a cost-effective substitute for residential long-term care. Departmentally, the average residential care facility cost for community care is approximately one quarter of the average cost for priority access beds available on a contracted basis.” However, the report continued by noting that palliative care in the home has undesirable consequences for women and low income-earners: “[w]omen bear a disproportionate share of the informal caregiving work. While roughly equal numbers of men and women aged 45 to 65 are involved in informal caregiving, women are more likely to be high intensity caregivers” (Senate, *Canada's Aging Population*, *supra* note 98 at 117). See also discussion in Charmaine Spencer & Ann Soden, “A Softly Greying Nation: Law, Ageing and Policy in Canada” (2007) 2 *Journal of International Aging, Law and Policy* 1 at 22-25.

¹⁹⁵ For a summary of statistics concerning informal and family caregivers see CHPCA, “Fact Sheet,” *supra* note 30; See also discussion in Valerie A Crooks & Allison Williams, “An Evaluation of Canada's Compassionate Care Benefit from a Family Caregiver's Perspective at End of Life” (2008) 7:14 *BMC Palliative Care*.

search across platforms related to medicine, aging, and other life-course issues.¹⁹⁶

Conclusion

Trying to establish palliative care as an enforceable human right involves many obstacles. Efforts are being made to ground palliative end-of-life care as an enforceable right under certain international instruments that recognize rights to security, equality, and health, as well as the right to dignity. However, international treaties and documents are difficult to enforce in the absence of domestic legislation—a situation that prevails in Canada. Furthermore, the term dignity itself seems to elude categorical definition for legal purposes.

The need for Canadian palliative care services is increasing, although a significant portion of the populace cannot access them. To add to the confusion, while the majority of health care is delivered by the provincial and territorial governments, health care for some groups (such as current and former military personnel, Aboriginal persons, and federal prisoners) is the constitutional responsibility of the federal government. This has resulted in wide variations in the availability, quality, and delivery of palliative care across the country. Further increasing these variations, the preliminary evidence indicates that much of the government-funded palliative care hinges on a cancer diagnosis. Regardless of the source of the need for palliative-care services, the need for those services is the same. Care, compassion, and the alleviation of pain, and psychosocial and existential suffering, are all needed by those approaching the end of life, regardless of the underlying condition that necessitates palliative care.

In Canada, the *Charter* is the primary constitutional instrument whose jurisprudence addresses these issues. While there is also no express mention of palliative care—or even health, for that matter—in the *Charter*, some of the express protections contained therein may be broad enough to include constitutional protection for those in need of palliative care. In this paper, the authors have relied specifically on the *Charter* to put forward an argument that palliative care is a human right in Canada. In particular, sections 7 and 15 of the *Charter* are potential means of demonstrating the violation of a constitutional right to palliative care in Canada. There are two ways to demonstrate the right to palliative care. The first is by demonstrating a right to health care, and then showing that palliative care falls within that right to health care. The second

¹⁹⁶ Of course, there may be still other questions related to standing, evidentiary issues and more that are not mentioned here. To attempt to even list all of these potential issues would be beyond the scope of this paper.

approach is not based on a right to health care, but rather on the unequal delivery of health care services in Canada.

To summarize the first *Charter* argument: section 15 protects everyone from laws that draw discriminatory distinctions between those who receive a benefit from the law and those who do not. Legitimate distinctions are permitted; discrimination is not. The *Eldridge* case establishes that unequal access caused by the application of a law that provides a benefit can be discriminatory. Although the *Auton* case may appear, at first, to be contrary to the position advanced here, in the view of the authors, *Auton* presents a very different set of circumstances than would a challenge to the current palliative care regime in Canada. In *Auton*, the argument was that extended services should be treated as core services. If accepted, this would have eliminated extended services altogether, and treated every service as a core service. The argument made here is more nuanced, in that the argument relies on (among other things) the differential impact of the delivery of palliative care in order to make a finding of discrimination. Therefore, an argument can be made that equitable and meaningful access to palliative care is constitutionally mandated by section 15.

In addition to proof of discrimination itself, it must also be shown that the discrimination is on a ground enumerated in section 15, or one analogous thereto. Disability (either mental or physical) is one such enumerated ground. People with life-limiting illnesses are coping with suffering and this affects their activities of daily living; there is therefore a proven disability. There is jurisprudence suggesting that differentiation between disabilities in the provision of government support is discriminatory within the meaning of section 15. This suggests that a jurisprudential basis may exist to improve the availability of palliative end-of-life care through a constitutional challenge based on the *Charter's* equality guarantee.

Furthermore, section 7 of the *Charter* could also be used to support a constitutional challenge. The right to security of the person is engaged because failure to provide adequate palliative care causes severe psychological stress, and the Supreme Court has previously ruled that serious and profound psychological stress is a violation of security of the person. Given that lack of integrated palliative care may also hasten the death of the person suffering from a life-limiting illness, this may also be sufficient to engage the right to life as guaranteed by section 7. If either interest is engaged, this challenge will pass the first stage of the section 7 analysis.

The second step of proving a *prima facie* section 7 violation is to show that the violation is not in accordance with the principles of fundamental justice. A measure cannot be in accordance with the principles of fundamental justice when it is arbitrary. Arbitrariness can be found: (i) when a person's life is put

at risk, and there is no clear connection between the measure chosen and the legislative goals; or (ii) the funding decision is not based on relevant criteria. There is also jurisprudence to show that where the “security of the person interest” is engaged, and the measure would have a disproportionate impact on groups whose equality before the law is guaranteed by section 15, courts should be quite concerned with ensuring that the principles of fundamental justice are applied in a manner consistent with the equality guarantee.

Finally, there can be little doubt that the *Canada Health Act* is focused on curing illnesses. However, this relies on the biomedical definition of disability and ignores the contemporary social model of disablement. Through this oversight, the *CHA* fails to respect equality requirements. In terms of resource allocation, the Supreme Court has held that a constitutional guarantee (notably section 15) can require the provision of a service that, under the statute as passed, was not to be provided. Therefore, governmental spending priorities are *not* an absolute bar to finding that there is a constitutional requirement for the provision of palliative care services. At the very least, the spending priorities of government cannot be discriminatory in nature.

Of course, there can be limits on the scope of the right to palliative care put forward in this paper. The most obvious source of such a limit would be section 1 of the *Charter*. However, the onus would be on the government to justify such limitations. More empirical data is required to obtain a complete picture of the current palliative care delivery system in Canada and, importantly, on the impact of that system on different segments of the Canadian population. Similarly, the impact of changes to palliative care delivery on other government priorities may require further study, both by those who seek to advance the existence of this right and by the government that may seek to define its scope.

Although the focus of this paper has been the *Charter*, this is not the only possible avenue of enforcing human rights, including one to palliative care in Canada. Other Canadian human-rights legislation¹⁹⁷ could provide alternative bases for asserting such a right. Furthermore, the interpretation of human-rights legislation may be influenced by international human rights instruments to which Canada is a signatory. Therefore, notwithstanding our argument that international palliative care developments may not be relevant to establishing a

¹⁹⁷ All provinces and territories, as well as the Federal Government, have adopted human rights codes or other legislation. See e.g. *Canadian Human Rights Act*, SC 1976-77, c 33, s 2, reprinted in RSC 1985, c H-6; Québec’s *Charter of human rights and freedoms*, *supra* note 61; *The Saskatchewan Human Rights Code*, SS 1979, c S-24.1; *The Yukon Territories’ Human Rights Act*, RSY 2002, c 116.

Canadian human right to palliative care, the principle of recognition of international obligations might be argued by some to represent a “floor” of rights and protections. At minimum, the existence of these international obligations, along with domestic human rights legislation and codes, provide additional incentive and opportunity to explore and reinvigorate initiatives with respect to a right to equal and meaningful access to palliative care.

The authors believe that the impact of international instruments and domestic human rights legislation deserve robust analysis independent of *Charter* considerations. In order to keep this paper within manageable bounds for both the authors and the reader, a detailed analysis of the non-constitutional legislative framework for the protection of human rights must be left to another day.

In the end, this paper offers one approach which, if adopted, might alter the parameters under which palliative care is made available to Canadians. It is the hope of the authors that this article will stimulate debate on this important issue, among policy-makers, academics, families, caregivers, and the general public. With time and effort on the part of all concerned, better solutions may be found to ensure that end-of-life care needs can be met in a way that affirms the relief of suffering as a defining element of Canadian human rights.