Medicare and the Non-Insured Health Benefits and Interim Federal Health Programs: A Procedural Justice Analysis

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Procedural justice in health care goods and services allocation is a necessary, though likely insufficient, condition for a just health care system. Specific health care systems should accordingly be subject to procedural justice analyses. Norman Daniels and James E Sabin's accountability for reasonableness framework is one of the best accounts of procedural justice in the health care allocation context. This framework requires the public display of decisions and the reasons for health care allocation decisions ("publicity" or "transparency"), the use of publicly accepted or acceptable rationales in those decisions ("acceptance" or "acceptability"), and mechanisms for

La justice procédurale dans l'attribution des biens et services de soins de santé est une condition nécessaire, bien que probablement insuffisante, pour un système de soins de santé juste. Les systèmes de soins de santé spécifiques devraient donc être soumis à une analyse de leur justice procédurale. Le cadre d'analyse de responsabilisation de la raisonnabilité créé par Norman Daniels et James E Sabin est l'un des meilleurs exemples de justice procédurale dans le contexte de l'attribution des soins de santé. Celui-ci requiert l'affichage public des décisions d'attribution des soins de santé et de leurs motifs (« publicité » ou « transparence »), de l'utilisation de justifications

* Thank you to YY Brandon Chen, Julian Culp, Colleen Flood, Lisa Forman, Sophia Moreau, Sophie Nunnelley, Maxwell Smith, Lorraine Weinrib, and two anonymous reviewers for comments on earlier drafts and related works. Work on this article was conducted while I was a Senior Doctoral Fellow in the Comparative Program on Health and Society at the Munk School of Global Affairs and earlier drafts of some sections appear in the program's working paper series. Thank you also to the Lupina Foundation for funding the program, the other fellows in that program, and the Canadian Institutes of Health Research (CIHR) Training Program in Health Law, Ethics and Policy for feedback on work on the issues discussed above. I also acknowledge and appreciate funding from CIHR's Vanier Canada Graduate Scholarship program.

Citation: Michael Da Silva, "Medicare and the Non-Insured Health Benefits and Interim Federal Health Programs: A Procedural Justice Analysis" (2017) 10:2 McGill JL & Health 101.

Référence : Michael Da Silva, « Medicare and the Non-Insured Health Benefits and Interim Federal Health Programs: A Procedural Justice Analysis » (2017) 10 : 2 RD & santé McGill 101.

challenging and/or appealing the decisions ("reviewability"); it may also require legal protection of the fulfillment of the first three conditions ("regulation"). These conditions provide clear metrics for assessing nations' compliance with their framework account of procedural justice. This article accordingly applies that framework to three pillars of the Canadian health care system – Medicare, the Interim Federal Health Program, and the Non-Insured Health Benefits Program – to assess the extent to which Canada meets the demands of at least one influential account of procedural justice. It ultimately finds serious deficits in the publicity/transparency of the Canadian health care system, which makes it difficult to apply acceptability metrics, but identifies some progressive steps in better compliance with the publicity/transparency and reviewability components of the accountability for reasonableness framework. It also identifies non-drastic measures Canada can take to better achieve Daniels and Sabin's vision of procedural justice in health care allocation.

publiquement acceptées / acceptables dans ces décisions (« acceptation » ou « acceptabilité ») et des mécanismes de contestation et / ou d'appel des décisions (« révision ») ; il peut également exiger une protection juridique quant à l'accomplissement des trois premières conditions (« réglementation »). Ces conditions fournissent des paramètres clairs pour évaluer la conformité des nations à leur cadre de responsabilité de justice procédurale. Cet article applique donc ce cadre à trois piliers du système de santé canadien, soit l'assurance-maladie, le Programme fédéral de santé intérimaire, et le Programme des services de santé non assurés, pour évaluer dans quelle mesure le Canada répond aux exigences d'au moins un cas influent de justice procédurale. Il constate finalement de graves déficits dans la publicité et la transparence du système de soins de santé canadien, ce qui rend difficile l'application de mesures d'acceptabilité, mais identifie certaines étapes progressives pour mieux respecter les composantes de transparence et de révision du cadre de responsabilisation de la raisonnabilité. Il identifie également des mesures non-drastiques que le Canada peut prendre pour mieux réaliser la vision de Daniels et Sabin sur la justice procédurale dans l'attribution des soins de santé.

Introduction

Identifying the health care goods and services (henceforth, "health care goods") states should provide is notoriously difficult. While many agree that people ought to be able to access the health care goods they need, resource constraints entail a need for some form of rationing. An uncontroversial principle for identifying which goods and services should be prioritized remains elusive. Norman Daniels and James Sabin accordingly champion a procedural approach to identifying the health care goods that ought to be provided by the state.[1] A purely procedural understanding of health care justice may not account for all of its most important elements,[2] but their basic point about the need for procedural justice remains. The vast literature on Daniels and Sabin's framework for ensuring a fair process of selection is a helpful starting point for studying whether health care systems meet the demands of (at least one influential account of) procedural justice. Daniels and Sabin articulate their "accountability for reasonableness" (AFR) framework in several works.[3] Other authors apply Daniels and Sabin's indicia of fair processes to real world contexts. The resultant literature includes pieces that assess how the mainstream Canadian health care system, "Medicare," fares from an AFR perspective; still other works apply the AFR factors without directly appealing to that framework as part of related examinations of pro-

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1 Norman Daniels & James E Sabin, *Setting Limits Fairly: Learning to Share Resources for Health*, 2nd ed (New York: Oxford University Press, 2008) at 10 [Daniels & Sabin, *Setting Limits*] ("Justice requires limits to care, and the lack of consensus on principles of distribution means that we must develop an acceptable fair process for setting limits and learn how to apply that process in real-world situations").

2 See e.g. Richard Ashcroft, "Fair Process and the Redundancy of Bioethics: A Polemic" (2008) 1:1 Public Health Ethics 3; Mary B Mahowald, "Why Retreat to Procedural Justice?" (2001) 1:2 Am J Bioeth 25. In a recent work, I examine both the procedural and non-procedural dimensions of the purported "right" to health care: Michael Da Silva, "A Goal-Oriented Understanding of the Right to Health Care and Its Implications for Future Health Rights Litigation" (2016) 39:2 Dal LJ 377.

3 See e.g. Norman Daniels & James Sabin, "Limits to Health Care: Fair Procedures, Democratic Deliberation, and the Legitimacy Problem for Insurers" (1997) 26:4 Phil & Publ Aff 303 [Daniels & Sabin, "Limits"]; Norman Daniels & James Sabin, "The Ethics of Accountability in Managed Care Reform" (1998) 17:5 Health Affairs 50 [Daniels & Sabin, "The Ethics"]; Daniels & Sabin, *Setting Limits*, *supra* note 1, ch 4.

cedural justice in the Canadian health care system.[4] This work updates that research on Medicare's accountability for reasonableness bona fides in light of recent developments and provides additional facts and analysis. It also expands the analysis of the Canadian health care system's AFR by analyzing two group-specific health care programs that form part of the Canadian health care system: the refugee claimant-focused Interim Federal Health Program (IFHP) and the Aboriginal claimant-focused Non-Insured Health Benefits Program (NIHBP).[5]

My update begins with three Parts that provide basic information about AFR, the Canadian health care system, and why it is appropriate to assess the latter in light of the former. The next three Parts examine the extent to which Medicare, the IFHP, and the NIHBP include three components required by the AFR framework: public display of decisions and the reasons for those decisions, the use of publicly accepted/acceptable rationales

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4 See e.g. Doug Martin & Peter Singer, "A Strategy to Improve Priority Setting in Health Care Institutions" (2003) 11:1 Health Care Anal 59; Caroline Pitfield & Colleen M Flood, "Section 7 'Safety Valves': Appealing Wait Times within a One-Tier System" in Colleen M Flood, Kent Roach & Lorne Sossin, eds, *Access to Care, Access to Justice: The Legal Debate over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005) 477; Colleen M Flood, "Conclusion" in Colleen M Flood, ed, *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006) 449 at 451–53 [Flood, "Conclusion"]; Colleen M Flood & Michelle Zimmerman, "Judicious Choices: Health Care Resource Decisions and the Supreme Court of Canada" in Jocelyn Downie & Elaine Gibson, eds, *Health Law at the Supreme Court of Canada* (Toronto: Irwin Law, 2007) 25.

5 I should make two notes about terminology. First, the standard short form for the Non-Insured Health Benefits Program is "NIHB," but I use "NIHBP" for grammatical reasons. Second, as Constance MacIntosh notes, "[t]he term 'Aboriginal' is unique to Canada and Australia," may not reflect Aboriginal self-understanding, and could impose homogeneity at odds with facts: "Indigenous Peoples and Health Law and Policy: Responsibilities and Obligations" in Jocelyn Downie, Timothy Caulfield & Colleen M Flood, eds, *Canadian Health Law and Policy*, 4th ed (Toronto: LexisNexis, 2011) 575 at 578–89. "Aboriginal" is thus an imperfect term for comparative analyses and may be more broadly problematic. Given the use of the term in Canadian constitutional law, however, it has some value here. Even MacIntosh notes that the Constitution clearly states that the term "Aboriginal" "includes," but is not limited to, "Indians, Inuit and Métis" (*ibid*). It is thus a useful catch-all (though the fact that some powers are only discussed in terms of "Indians, Inuit and Métis" complicates the picture somewhat).

in those decisions, and mechanisms for challenging and/or appealing those decisions. I first confirm earlier work suggesting that Canada fails to provide (adequate) reasons for its Medicare decisions. I further demonstrate that even some appeal bodies are not bound to make the reasons for their decisions public. I argue that the online provision of reasons by some appeal bodies counts as an expansion of Canada's reason-giving component of AFR, but go on to note that the NIHBP is more transparent than Medicare or the IFHP. I then provide an original take on two different ways one can understand the publicly accepted/acceptable rationale criterion and argue that Canada's reason-giving deficiencies make it difficult to determine how Canada fares on either construal of the requirement (at least without engaging in potentially costly appeals). In the next Part, I provide an overview of the challenge/appeal mechanisms in Canada; I update the list of Canadian provinces with administrative appeal boards for health care allocation decisions found in some earlier publications and I add treatments of provincial ombudspersons and Aboriginal appeal mechanisms. A seventh Part provides an original take on the possible implications of this framework for Canada's progressive realization obligations. A conclusion follows. Ultimately, this updated and expanded analysis suggests that Canada should embark on substantial improvements in its realization of the first two components of AFR, but that Canada's score on the first metric is improving and its score on the third metric may be higher than earlier work suggests.

I. Accountability for Reasonableness and Procedural Justice in Health Care: An Overview

Daniels and Sabin advocate for the distribution of health care goods in conformity with the basic demands of political justice. Their approach rests on an argument of the following form:

> Premise 1: The distribution of health care goods is a concern of distributive justice.[6]
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> Premise 2: Authority for distributive justice vests in the public.

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[6] Daniels, at least, made this claim well before he developed the accountability for reasonableness framework with Sabin: Norman Daniels, *Just Health Care* (Cambridge, UK: Cambridge University Press, 1985) ch 3 [Daniels, *Health Care*].

> Premise 3: Authority for the distribution of health care goods vests in the public[7] (from Premises 1 and 2).
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> Premise 4: Where public authority is given to a representative body, such as the government, the representative body's decisions must still be responsive to the public entity from whom the body receives its delegated authority.
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> Premise 5: Distributive decisions about health care goods are made by some form of representative body.
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> Conclusion: Thus, distributive decisions with respect to health care goods must be responsive to the public (from Premises 3–5).

Daniels adopts Premise 1 because health care is required for fair equality of opportunity,[8] but it can just as easily be derived from the fact that health care goods are a bounded, valuable resource[9] and/or that there is a social obligation to meet people's health needs (and rationing is required to maximally meet these obligations).[10] Premise 2 follows from a complicated account of public authority that I cannot detail here.[11] Yet where Premise 2 is consistent with my claims about government authority above, it is granted for the sake of argument. Premise 5 is complicated by the fact that in practice many decisions are made by non-representative bodies, including authoritative rulers or their proxies. Yet, where one takes Premise 3 seriously, just health care decision making is only possible where the conditions in Premise 5 obtain; the only legitimate government or corporate authority for health care

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7 See e.g. Daniels & Sabin, "The Ethics", *supra* note 3 at 58.

8 See e.g. Daniels, *Health Care*, *supra* note 6 at 39–42; Daniels & Sabin, "Limits", *supra* note 3 at 311–12.

9 This point is suggested by Daniels & Sabin, *Setting Limits*, *supra* note 1 at 1–2.

10 Daniels and Sabin explicitly make this claim in Daniels & Sabin, "Limits", *supra* note 3 at 310–12.

11 It partly rests on claims about the conditions under which people will accept decisions made by others on their behalf. For example, Daniels and Sabin suggest that the public must view distributive decisions as legitimate and fair to accept them, but it is not strictly based on a consent-based model of authority (*ibid* at 304–06).

decision making is delegated authority. Thus, all health care decision making should be responsive to the public.[12]

Ideally, some universal principle would determine how distribution should take place, simplifying the action in the Conclusion. For instance, few would challenge the assertion that need is a good reason to prioritize certain goods. A principle whereby "all persons should receive the health care goods they need" is appealing in the goods and services prioritization context. Yet Daniels's earlier work suggests that even this uncontroversial principle is unlikely to solve the broader problem in light of the scarcity that requires us to prioritize goods and services in the first place. The principle leaves an important question open: "Even if we decide that access to health care should be based on need for services, which needs should we meet when we cannot meet all?"[13] Further principles need to be invoked to ensure fair distribution. One may, for instance, seek to prioritize goods in light of the values they promote.[14] Yet Daniels and Sabin's work suggests that even if health care allocation decisions were made on the basis of the best ethical principle we could conjure, this alone would not provide legitimacy to decisions on the basis of that principle. Political legitimacy for invoking that principle would still be required. There can be, and is, reasonable disagreement over many political concerns.[15] This reasonable disagreement arguably not only concerns the principles that determine how we ought to prioritize the distribution of certain goods, but also the status of values that could be used to justify new principles for the prioritization and distribution of health care goods, like "utility" and "equality", and how best to understand basic concepts underlying these principles, like "need" and "opportunity." Daniels and Sabin point to this "lack of consensus" on principles for decision making in the health care context.[16] There may also be a lack

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[12] This explains why they hold that their framework ought to prescribe principles for decision making by private entities as well, even though these entities arguably do not derive their authority from the public.

[13] Daniels, *Health Care*, *supra* note 6 at 15.

[14] Daniels's prioritization of the goods that are required for fair equality of opportunity arguably takes this form. See *ibid* at 49–50.

[15] Daniels alludes to this fact in his discussion of the facts of pluralism in Norman Daniels, "Accountability for Reasonableness: Establishing a Fair Process for Priority Setting is Easier than Agreeing on Principles" (2000) 321:7272 Brit Med J 1300 at 1300 [Daniels, "Accountability"].

[16] Daniels & Sabin, *Setting Limits*, *supra* note 1 at 2–4, 10, 204. See also Daniels

of consensus on the meaning of terms underlying those principles. These phenomena help explain Daniels and Sabin's affiliation of their work with the deliberative democracy model.[17] Representative decision makers must respond to the needs of a wide constituency that includes people with radically different views on health care allocation. Responsiveness accordingly entails engaging with people with a variety of views. Infrastructure may be required to ensure this responsiveness to real people occurs. Fulfilling their Conclusion's demands from the armchair is difficult.

In light of these concerns, Daniels and Sabin create further conditions for a fair process of distribution that is responsive to the public who maintain authority over decision making. The conditions necessary for these demands of distributive justice to be met fall under the title of "accountability for reasonableness." There are four basic conditions. The "Publicity Condition" requires that reasons for decisions be provided and that they be made public.[18] The "Relevancy Condition" requires that those reasons be relevant to health care decision making.[19] The "Revision and Appeals Condition" requires that decisions be subject to challenge and/or appeal and capable of revision in light of these challenges.[20] The "Regulative Condition" requires "some form of *regulation* to ensure that the other conditions are met."[21] The first three conditions require three metrics. In the most succinct statement of the necessary conditions of AFR, Daniels states that a health care process is fair only if it involves

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& Sabin, "Limits", *supra* note 3 at 306–07.

17 They do, however, suggest that their argument for accountability for reasonableness can succeed independently from a commitment to deliberative democracy: Daniels & Sabin, "Limits", *supra* note 3 at 307.

18 Daniels & Sabin, *Setting Limits*, *supra* note 1 at 11–12, 45.

19 *Ibid* at 12. It has also been referred to as the "Relevance Condition": *ibid* at 45, 169; Daniels & Sabin, "The Ethics", *supra* note 3 at 57. Per the formulation in "The Ethics," the ultimate rationales for decisions "must rest on evidence, reasons, and principles that all fair-minded parties (managers, clinicians, patients, and consumers in general) can agree are relevant to deciding how to meet the diverse needs of a covered population under necessary resource constraints" (*ibid*).

20 Daniels & Sabin, *Setting Limits*, *supra* note 1 at 45. This condition was originally just the "Appeals condition": Daniels & Sabin, "The Ethics", *supra* note 3 at 57.

21 Daniels & Sabin, *Setting Limits*, *supra* note 1 at 12, 45. This condition was once the "Enforcement condition": Daniels & Sabin, "The Ethics", *supra* note 3 at 57.

> transparency about the grounds for decisions; appeals to rationales that all can accept as relevant to meeting health needs fairly; and procedures for revising decisions in light of challenges to them. …
>
> Fair procedures must also be empirically feasible. They must involve practices that can be sustained and that connect well with the goals of various stakeholders in the many institutional settings where these decisions are made.[22]

To count as fair, in other words, a method for selecting what goods a given nation's health care system should provide ought to include:

(1) the public display of the product of, and reasons for, decision making ("publicity" or "transparency");

(2) the use of publicly accepted (or at least publicly acceptable) rationales in those decisions ("acceptance" or "acceptability"); and

(3) procedures for challenging and/or appealing the initial decisions ("reviewability").

For Daniels and Sabin, then, the responsiveness in the Conclusion has three components: decision makers must make decisions that the public would (and perhaps do) accept, make these decisions known to the public, and be open to public challenges to those decisions. These conditions are jointly supposed to provide conditions for fairness in health care decision-making processes. They also serve as metrics for measuring that fairness. One may look for these structural features of health care systems to assess whether they meet the demands of AFR. The Regulative Condition could then require legal protection thereof. One may label the requirement for the legal protection of (1)–(3) – for example, through binding legislation – "(4)."[23]

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[22] Daniels, "Accountability", *supra* note 15 at 1300.

[23] It is difficult to see how one can ensure that the first three conditions will be met without proper entrenchment. Yet Daniels does not make this claim and instead later states that the condition can be met by (4*) "voluntary or public recognition of the process" short of full legal protection: Norman Daniels, *Just Health: Meeting Health Needs Fairly* (Cambridge, UK: Cambridge University Press, 2008) at 119 [Daniels, *Just Health*]. I am not sure how to measure (4*) and thus stick to the blunt fact of (4) here. International human rights law prefers legislative entrenchment of social rights protections and thereby supports a

Now that the basic features of the AFR framework are clear, I can examine the extent to which this framework should and can be used to assess particular contexts. The AFR conditions were developed due to concerns about managed care organizations and framed as conditions on decision making for "insured patients."[24] Given the centrality of the notion of the public to Daniels and Sabin's view, it would be reasonable to think that their conditions are meant to apply primarily to public health insurance regimes, but managed care organizations are private entities, and the problem Daniels and Sabin identify is a universal one. Prioritization decisions must be made in all systems of health care delivery. This suggests that the AFR framework can be applied to a variety of contexts. Indeed, Daniels's later work on health justice not only expands the scope of his subject to include the social determinants of health, but also broadens the geographical scope of his inquiries.[25] The reasons listed in the following section suggest that the AFR framework can at least be applied to Canada. Further sections then apply the framework.

II. The Applicability of the Accountability For Reasonableness Framework to the Canadian Health Care System

Even if one holds that Canada's "public/tax-financed" health care system is not a traditional health insurance-based health care system,[26] there are at least three reasons why it is appropriate to apply the AFR framework to the Canadian health care system. If one quibbles with one of those reasons, I am hopeful that the other two will be sufficiently convincing. First, the

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requirement for (4). See e.g. *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 UNTS 3, art 2 (entered into force 3 January 1976) [*ICESCR*].

24 Daniels & Sabin, "Limits", *supra* note 3; Daniels & Sabin, "The Ethics", *supra* note 3.

25 See e.g. Daniels, *Just Health*, *supra* note 23 at ch 3–4 (examining the just distribution of the social determinants of health and its relationship with the AFR framework), 10 (examining AFR in developing countries with a primary focus on Mexico).

26 See Colleen M Flood & Aeyal Gross, "Introduction: Marrying Human Rights and Health Care Systems: Contexts for a Power to Improve Access and Equity" in Colleen M Flood & Aeyal Gross, eds, *The Right to Health at the Public/Private Divide: A Global Comparative Study* (New York: Cambridge University Press, 2014) [Flood & Gross, *The Right to Health*] 1 at 5.

framework is specifically tailored for the evaluation of the procedural fairness of health care systems in liberal states. The impetus for the framework is the aforementioned "lack of consensus" on principles for decision making that clearly arises in liberal states.[27] Daniels identifies the lack of consensus as a problem for "pluralist" states;[28] empirical research confirms that public opinion on social justice, including principles of distributive justice, varies.[29] The earliest in-depth application of AFR thus focused on the United States of America.[30] Similar disagreements exist in Canada. The persistent lack of unanimity on whether cosmetic dentistry or in vitro services ought to be publicly insured arguably stems from more fundamental disagreements about principles for decision making.[31] Canada's status as a liberal democracy, then, suggests that the Canadian health care system is the type of entity to which the AFR framework can be applied. Indeed, Canada was mentioned in the first article outlining the AFR framework.[32] This suggests that Daniels and Sabin's understanding of a health insurance-based regime is broad enough to include the Canadian health care system; even if this is an improper characterization of the Canadian health care system, Canada remains a liberal democracy.

Second, Canada's commitments to administrative justice and non-discrimination (as an aspect of administrative justice and as a standalone value) both imply that public decision making in Canada ought to be reasonable. Administrative justice demands that administrative decisions be made on the basis of reasons.[33] The AFR framework provides resources for assessing the extent to which these reasons are given in a particular context and

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27 Daniels & Sabin, *Setting Limits*, *supra* note 1 at 2–4, 10.

28 See e.g. Daniels, "Accountability", *supra* note 15 at 1300.

29 See e.g. Toril Aalberg, *Achieving Justice: Comparative Public Opinion on Income Distribution* (Leiden: Brill, 2003).

30 Daniels & Sabin, "The Ethics", *supra* note 3.

31 See e.g. Tom Blackwell, "'Huge' Demand for IVF Treatment in Ontario – Where it's Fully Funded – Has Wait Lists Stretching to 2018", *The National Post* (20 May 2016), online: <http://news.nationalpost.com/health/huge-demand-for-ivf-treatment-in-ontario-where-its-fully-funded-has-wait-lists-stretching-to-2018>; Carlos R Quiñonez & David Locker, "Canadian Opinions on Publicly Financed Dental Care" (2007) 98:6 Can J Public Health 495 at 496.

32 Daniels & Sabin, "Limits", *supra* note 3 at 308, 324, 334.

33 See e.g. the discussion of *Baker* found at 129, *below*.

provides metrics for assessing the extent to which decision makers are accountable for their commitment to this aspect of administrative justice. As Colleen M Flood points out, the AFR "factors map onto our understanding of the basic requirements for procedural fairness."[34] Non-discrimination, in turn, is a principle of Canadian law[35] and many international legal documents to which Canada is a party.[36] It also requires procedural safeguards for ensuring discriminatory reasons are barred from decision making. AFR can provide that bar. Where the Canadian health care system is in the domain of public administrative decision making and where Canada is committed to administrative justice and non-discrimination, it is appropriate to apply the AFR framework to that system.

Finally, the AFR framework provides good metrics for examining the extent to which the procedural elements of the international right to health care that Canada bound itself to realize are safeguarded. Canada is a signatory to several international covenants that recognize a "right to health."[37] One aspect of this right is a right to health care. The obligations this fact can and should impose upon Canada are contested. The international right to health care clearly requires some commitment to the provision of health care, but it can be difficult to identify what the content of this right should be. On the one hand, a right to all health care risks bankrupting those duty-bound to fulfill it.[38] On the other hand, a narrow scope for the right risks

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34 Flood, "Conclusion", *supra* note 4 at 451. As discussed at 129, *below*, the reason-giving requirements that mark Canada's commitment to transparency have been substantially constrained in the last decade. This does not change the fact that Canada is committed to the foundational norms of administrative justice, including transparency.

35 This norm is foundational for human rights legislation in every province and implied by the constitutional protection of equality in the *Canadian Charter of Rights and Freedoms*, s 15, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Charter*].

36 *International Convention on the Elimination of All Forms of Racial Discrimination*, 21 December 1965, 660 UNTS 195 (entered into force 4 January 1969) is just one of several examples.

37 The most famous example is *ICESCR*, *supra* note 23, art 12, which recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." Similar language appears in several documents.

38 Indeed, Colombia's domestic right to health care, restricted to a "minimum level of subsistence," arguably crippled their government: Alicia Ely Yamin, Oscar Parra-Vera & Camila Gianella, "Colombia: Judicial Protection of the

making it contentless. These are serious concerns for the substantive component of the right. There should, however, at least be a procedural dimension to the right. A right to a fairly administered system for identifying the content of the right in a given context arguably falls outside of international human rights law's aforementioned commitment to non-discrimination in decision making.[39] What "fairness" means here is contested. International human rights law does not provide an adequate metric for fulfilling this procedural dimension of international rights. I believe that Daniels and Sabin provide one of the better articulations of fairness and it can supplement the international framework that is already consistent with Daniels and Sabin's basic demands.

Of course, AFR may not perfectly mirror international norms and the fact of reasonable pluralism that grounds the framework may be unique to liberal societies, but, as Daniels and Sabin also note, limit setting is required in states with varying socioeconomic systems and health care delivery designs.[40] Where this problem is universal and international norms require procedural fairness, AFR's attempt to solve the problem for liberal societies by ensuring procedural justice may provide guidance in any context. I argue that there is also some substantive content to the right to health care elsewhere,[41] but the AFR framework can provide useful measures of the extent to which Canada's health care system meets the procedural demands that arguably form part of the international right.

Given the reasons for applying AFR to the Canadian health care system, it is unsurprising that there is some work on this topic already. Some of this work even appears in Daniels and Sabin's limited transnational analysis of

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Right to Health: An Elusive Promise?" in Alicia Ely Yamin & Siri Gloppen, eds, *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Cambridge, Mass: Harvard University Press, 2011) 103 at 121.

39 The commitment to non-discrimination is common throughout international human rights law. For instance, the *ICESCR*'s references to "equal and inalienable rights of all" and the rights of "everyone" (*supra* note 23, Preamble) are read as entailing equality and non-discrimination: Committee on Economic, Social and Cultural Rights, *General Comment No. 20: Non-Discrimination in Economic, Social and Cultural Rights*, UNESCOR, 42nd Sess, UN Doc E/C.12/GC/20 (2009) at para 3.

40 Daniels & Sabin, *Setting Limits*, *supra* note 1 at vii.

41 See e.g. Da Silva, *supra* note 2.

health care systems' AFR bona fides.[42] The existing literature provides a baseline for further analysis of the extent to which Canada comports with Daniels and Sabin's account of procedural justice in health care decision making. I am open to the possibility that other accounts of procedural justice may be equally applicable to the Canadian health care system so long as they can account for the demands of reasonable pluralism, administrative justice, and international human rights law. Yet the existing literature's provision of a baseline for comparison provides a practical reason to conduct further study on Canada's responsiveness to AFR norms where AFR is equally capable of accounting for reasonable pluralism, administrative justice, and international human rights law norms.

In this article, I update and expand upon the earlier research. To understand this broader analysis, however, one must first know some basic background information on the structure of the Canadian health care system. I provide it in the next Part.

III. The Canadian Health Care System: An Overview

The basic features of the Canadian health care system will likely be familiar to most readers of this text, so I will minimize the details here. I raise other points as necessary for the AFR analysis below. In Canada, health care is an area of "concurrent jurisdiction" between the federal government and the provincial governments.[43] "Health" and "health care" are not explicitly placed under the purview of either level of government in the original constitutional division of powers.[44] Provincial authority over hospitals, guaranteed in Section 92 of the Constitution,[45] and a federal spending power which is not explicitly mentioned in the text of the Constitution, but is instead "inferred" from a variety of other enumerated powers,[46] provide

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42 Daniels & Sabin, *Setting Limits*, *supra* note 1 at 180–84.

43 See e.g. *Carter v Canada (AG)*, 2015 SCC 5 at para 53, [2015] 1 SCR 331 [*Carter*].

44 *Constitution Act, 1867* (UK), 30 & 31 Vict, c 3, reprinted in RSC 1985, Appendix II, No 5, ss 91–92 [*1867*]. For further support for this interpretation, see Martha Jackman, "Constitutional Jurisdiction over Health in Canada" (2000) 8 Health LJ 95 at 110.

45 *1867*, *supra* note 44, s 92(7).

46 Jackman, *supra* note 44 at 97.

the concurrent jurisdiction required to establish the joint federal-provincial health care provision collaboration that frames the mainstream Canadian health care system.

This collaboration is primarily established by perhaps the most important example of federal action in the health care domain: the *Canada Health Act* (*CHA*).[47] The *CHA*, and the provincial and territorial statutes that operationalize it, are the primary legal foundations for Medicare, the "institutional core of Canada's health care system."[48] It sits at the centre of the mainstream Canadian health care system and the legal regulation thereof. It gives the federal government the power to transfer funds to the provinces for health care provision through provincial insurance regimes. To receive federal funding under the *CHA*, provinces must meet a variety of requirements, including the provision of certain "hospital services" and "physician services" (though provision and/or insured coverage of non-hospital dental services, prescriptions, and some other goods are specifically not required).[49] The definitions of these terms provide limits on the provinces' discretion on what services they insure. For the purposes of the *CHA*:

> "*hospital services*" means any of the following services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability…
>
> "*physician services*" means any medically required services rendered by medical practitioners[.][50]

To receive funding, then, the provinces must insure "medically necessary" or "medically required" services. This suggests that necessity and requirement are reasons provinces ought to consider when making distributive decisions. Yet "medically necessary" and "medically required" are undefined, leaving latitude on what to cover. Each province then has its own health insurance act, which spells out who gets to decide what "necessary" or "required"

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47 RSC 1985, c C-6 [*CHA*]. Jackman describes it as "a classic exercise of the federal spending power" (*supra* note 44 at 98).

48 William Lahey, "Medicare and the Law: Contours of an Evolving Relationship" in Downie, Caulfield & Flood, *supra* note 5, 1 at 1.

49 *CHA*, *supra* note 47, ss 2, 5, 7–12.

50 *Ibid*, s 2.

goods are insured in their respective health care systems. These decisions must be reasonable to comport with general administrative law principles and must not discriminate in their intent or effect as a matter of both constitutional law and human rights law, but the provinces can reach vastly different substantive outcomes in their decisions on what to cover. Provincial discretion on how to define "medically necessary" and "medically required" can even allow some World Health Organization (WHO)-identified essential medicines to go uncovered throughout a province.[51] Insulin is just one example of an essential medicine that "is not consistently funded" across the country.[52] Provincial discretion on *where* to cover services further limits coverage. The *CHA* only requires funding for medically necessary hospital services and medically required physician services. Provinces retain the discretion to not cover necessary or required services outside of the hospital or direct physician care.[53] Several WHO-identified essential medicines are commonly offered as prescription (e.g., lorazepam[54]) or over-the-counter (ibuprofen[55]) medicines.[56] Coverage of these goods is inconsistent. Funding for prescription drugs "varies from province to province."[57] Most over-the-counter drugs are not covered at all. Some provinces provide supplemental government prescription drug insurance.[58] Yet "access to prescription drugs

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51 For their complete list of essential medicines, see World Health Organization, *WHO Model List of Essential Medicines*, 19th ed (2015), online: <www.who.int/medicines/publications/essentialmedicines/en/> [WHO, *Essential Medicines*].

52 Flood, "Conclusion", *supra* note 4 at 449.

53 See e.g. Ontario's key provision on insured services which states that services are insured "only if they are provided in or by designated hospitals or health facilities" and "provided to insured persons in prescribed age groups" (*Health Insurance Act*, RSO 1990, c H.6, ss 11.2(3)–(4) [*HIA*, ON]).

54 WHO, *Essential Medicines*, *supra* note 51 at 5.

55 *Ibid* at 18.

56 One may debate whether certain over-the-counter items, like condoms, listed in WHO, *Essential Medicines*, *ibid* at 34, even constitute medicines, but a wide variety of prescription and over-the-counter WHO-identified essential goods are clearly medicinal.

57 Lahey, *supra* note 48 at 18.

58 Karin Phillips, Library of Parliament, "Catastrophic Drug Coverage in Canada" (Ottawa: Library of Parliament, 2016) at 8.

continues to depend on private means for many Canadians."[59] Essential goods may not even be covered in hospitals and physicians' care and no goods must be covered outside those contexts. Serious gaps in Medicare coverage and inconsistencies in coverage across the provinces result.

There are also a variety of federal health care programs for specific groups. The programs constitute health care sub-systems that combine with Medicare to form the Canadian health care "system." The Constitution grants the federal government authority over, and responsibility for, "Militia, Military and Naval Service, and Defence,"[60] "[t]he Establishment, Maintenance, and Management of Penitentiaries,"[61] "Indians, and Lands reserved for the Indians,"[62] and "Naturalization and Aliens."[63] The federal government exercises its consequent powers over the military, federal prisons, Aboriginals, and immigrants in the health care setting. While the provinces maintain jurisdiction over health care provision for most of these groups,[64] the federal government's spending power and powers over specific groups and locations justify several federal government health programs. Correctional Service Canada provides health care services to federal prisoners.[65] Veterans Affairs Canada provides health care benefits to some members of the armed forces and veterans.[66] In both cases, the programs

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59 Lahey, *supra* note 48 at 7. Coverage is better for certain populations, like senior citizens, in some jurisdictions, but this too varies from province to province.

60 *1867*, *supra* note 44, s 91(7).

61 *Ibid*, s 91(28).

62 *Ibid*, s 91(24). "Indians" here includes Métis. See *Daniels v Canada (Indian Affairs and Northern Development)*, 2016 SCC 12, 395 DLR (4th) 381.

63 *1867*, *supra* note 44, s 91(25).

64 Many immigrants, most Aboriginals, and all veterans are thus covered by Medicare. Some provinces even historically provided health care to refugee claimants but ceased doing so in the 1990s. See *Canadian Doctors for Refugee Care v Canada (AG)*, 2014 FC 651 at para 40, [2015] 2 FCR 267 [*Refugee Care*].

65 *Corrections and Conditional Release Act*, SC 1992, c 20, ss 85–89. For a critique of the Correctional Service Canada system aimed at the popular press, see Adam Miller, "Prison Health Care Inequality" (2013) 185:6 CMAJ E249.

66 See e.g. Veterans Affairs Canada, "Health Care Benefits (Treatment Benefits)", online: <www.veterans.gc.ca/eng/services/health/treatment-benefits> and its associated links for details.

fill gaps in Medicare coverage since Canadian Forces members and federal prisoners are barred from *CHA* coverage.[67] Citizenship and Immigration Canada likewise fills a gap in coverage by providing health care services to refugees, refugee claimants, and other new immigrants "seeking the protection of Canada" through, for instance, the IFHP.[68] The federal government also funds health care services on First Nations reserves and provides on-reserve services in some remote regions.[69] The First Nations and Inuit Health Branch of Health Canada then supplements Medicare through the NIHBP by providing health care services that are not insured by provincial insurance programs to both First Nations and Inuit (but not to Métis).[70] The scope of the federal government's responsibilities to these groups is contested. As Constance MacIntosh notes, "whether Canada has legal discretion to not address the health care needs of Indigenous peoples" is a

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67 *CHA*, *supra* note 47, s 2.

68 The phrase "individuals 'seeking the protection of Canada'" is used as a catch-all for refugees, refugee claimants, failed refugee claimants, positive Pre-removal Risk Assessment recipients, victims of human trafficking, persons granted permanent residency for policy or humanitarian reasons, or immigration detainees in *Refugee Care*, *supra* note 64 at paras 58–60. I adopt that phrasing here when referring to all IFHP claimants.

69 Health Canada, "Fact Sheet – First Nations and Inuit Health Branch" (2008), online: <www.hc-sc.gc.ca/ahc-asc/branch-dirgen/fnihb-dgspni/fact-fiche-eng.php> [HC, "Fact Sheet"]. For a broader list of Aboriginal health-related services funded by Aboriginal Affairs and Northern Development Canada or Health Canada, see The Jordan's Principle Working Group, *Without Denial, Denial, Delay, or Disruption: Ensuring First Nations Children's Access to Equitable Services through Jordan's Principle* (Ottawa: Assembly of First Nations, 2015) at 62. The federal government can also "authorize the use of [reserve] lands" for "Indian health projects" by virtue of the *Indian Act*, RSC 1985, c I-5, s 18(2). Section 73 of the *Indian Act* grants further authority to create regulations "to provide medical treatment and health services for Indians" (*ibid*, s 73(1)(g))." Per section 81, band council regulations must be consistent with those federal regulations (*ibid*, s 81(1)(a)).

70 MacIntosh, *supra* note 5 at 605; Health Canada, *Non-Insured Health Benefits Program: Annual Report 2014/2015*, by the First Nations and Inuit Branch (Ottawa: Health Canada, 2016) at 3 [*Annual Report 2014/2015*]. Whether the recent recognition of Métis as "Indians" for constitutional purposes in *Daniels*, *supra* note 62 will change anything about Métis NIHBP coverage remains to be seen.

live question.[71] Some Aboriginals can access a wider variety of goods and services using government funds than their non-Aboriginal counterparts (including pharmacy benefits and dental services) through the NIHBP.[72] Yet controversy over the nature of this program persists. As MacIntosh notes, "[i]n contrast to Canada's position that NIHB[P] is a discretionary policy-driven initiative, Indigenous organizations characterize the NIHB[P] … as a manifestation of Canada's lawful obligations to Indigenous Canadians emanating from treaty rights and the federal fiduciary obligation."[73] Other federal programs, such as the refugee-focused IFHP, face similar controversies.[74] Yet the federal government clearly believes it has the authority, if not the responsibility, to provide health care to the aforementioned groups.

Previous scholarship on Canada's compliance with the AFR framework focused on Medicare. This work expands on that analysis by focusing on some of the additional federal programs and analyzing how they contribute to Canada's compliance. I will focus on the IFHP and NIHBP. I take this focus due to the deep vulnerability of refugees, other immigrants seeking the protection of Canada, and Aboriginal Canadians, as well as the legal obligations Canada owes to these groups. The history of colonialism and forced migration, and continuing inequities between Aboriginals and other Canadians in economic and health outcomes, render many Aboriginals vulnerable. Refugees, in turn, are vulnerable by definition. Refugees and others seeking the protection of Canada were also forced to migrate. They come to Canada with no guarantee of legal status and often lack social and economic goods required to thrive here if they do attain legal status. Studying the IFHP and the NIHBP thus serves as a good proxy for Canada's commitment to vulnerable populations, which is also required by international human rights law.[75]

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71 MacIntosh, *supra* note 5 at 576.

72 See e.g. *ibid* at 605.

73 *Ibid* at 608.

74 The extent of the government's duties to persons under that program and whether the government can remove groups from coverage was, for instance, a central issue in *Refugee Care*, *supra* note 64. The issue of who must be covered by a program if it exists is clearly different from the issue of whether government must create a program. Yet both issues relate to the question of whether governments owe duties to provide programs to specific persons.

75 Relevant international human rights law documents here include *Convention on the Elimination of All Forms of Discrimination against Women,* 18 December 1979, 1249 UNTS 13 (entered into force 3 September 1981); *Convention*

Canada also owes duties to both groups. The federal government may owe duties to Aboriginals and refugees as a correlative of their constitutional powers. At minimum, the Constitution clearly entrenches Aboriginal treaty rights,[76] and in some cases, those treaty rights may include certain health care provision entitlements.[77] The government's fiduciary relationship with Aboriginal Canadians is well-established; fulfilling that fiduciary relationship arguably requires the provision of health care.[78] Canada owes duties to both Aboriginals and refugees under international law.[79] Of course, similar arguments can also be used to justify focusing on armed forces, veterans, federal prisoners, and perhaps even other classes of immigrants. Federal prisoners are also vulnerable.[80] Other immigrants can also be vulnerable

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on the Rights of Persons with Disabilities, 30 March 2007, 2515 UNTS 3, (entered into force 3 May 2008); Committee on the Rights of the Child, *General Comment No. 3: HIV/AIDS and the Rights of the Child*, UNCRCOR, 32nd Sess, UN Doc CRC/GC/2003/3 (2003) 1; Committee on the Elimination of Discrimination against Women, *General Recommendation No. 15: Avoidance of Discrimination against Women in National Strategies for the Prevention and Control of Acquired Immunodeficiency Syndrome (AIDS)*, UNCEDAWOR, 9th Sess, UN Doc A/45/38 (1990); Committee on the Elimination of Discrimination against Women, *General Recommendation No. 24: Article 12 of the Convention (Women and Health)*, UNCEDAWOR, 20th Sess, UN Doc A/54/38/Rev.1, ch I (1999). See also Da Silva, *supra* note 2 and my forthcoming doctoral dissertation, both of which cite these documents and others.

76 *Rights of the Aboriginal Peoples of Canada*, Part II of the *Constitution Act, 1982*, s 35(1), being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

77 MacIntosh, *supra* note 5 at 589–92.

78 *Ibid* at 576, 592–96.

79 Canada is a party to many agreements that include commitments to vulnerable groups. It is, specifically, a signatory to the *Convention Relating to the Status of Refugees*, 28 July 1951, 189 UNTS 137 (entered into force 22 April 1954) and adopted the *United Nations Declaration on the Rights of Indigenous Peoples*, GA Res 61/295, UNGAOR, 61st Sess, UN Doc A/RES/61/295 (2007).

80 There is, moreover, overlap between federal prisoners and the other groups. Aboriginal representation in prisons is notoriously high. The United Nations Human Rights Committee took issue with this state of affairs in 2015: Human Rights Committee, *Concluding Observations on the Sixth Periodic Report of Canada*, UNHRCOR, 114th Sess, UN Doc CCPR/C/CAN/CO/6 (2015) at para 18. Members of the armed forces and veterans face important health care concerns and can be rendered vulnerable by battle-related health concerns, such as post-traumatic stress disorder, but it is difficult to make the case that a member

when, for instance, their immigration status is tied to precarious work situations.[81] Canada owes duties to all three groups. Yet I can only examine a limited number of programs in any real depth in a limited space.

The basic features of the IFHP are clear, but the program is, at best, only barely out of a period of transition. The IFHP is, fundamentally, a supplementary program that funds health care services for refugees and others seeking the protection of Canada who do not (yet) qualify for Medicare.[82] While successful refugee claimants secure eligibility for provincial health insurance, other claimants do not. Those uninsured by the provinces include refugees who have applied for refugee status but whose claims have not been heard; refugee applicants whose claim has been denied and are awaiting return to their country of origin; and – a variation on the latter theme – refugees whose claims have been denied but cannot be deported because their countries of origin are deemed insufficiently safe.[83] The IFHP is meant to fill this gap. Traditionally, the federal government chose which goods it would fund and set criteria for eligibility to receive them. The IFHP was originally intended to only provide emergency and essential health care.[84] Pre-2012 coverage for all qualified claimants was "comparable to that which

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of either group is vulnerable qua group member. This likewise (partly) explains why other non-Medicare systems, such as the workers' compensation regime, do not receive sustained analysis here.

81 For some issues with temporary worker programs, see e.g. Law Commission of Ontario, *Vulnerable Workers and Precarious Work* (Toronto: LCO, December 2012). Live-in caregivers who work in Canada for two years as part of the unique temporary foreign worker program should qualify for residency status yet they face lengthy delays in their applications, even after government promises to limit the backlog. See Nicholas Keung, "Foreign Caregivers Face Lengthy Wait for Permanent Status", *The Toronto Star* (21 July 2015), online: <www.thestar.com/news/immigration/2015/07/21/foreign-caregivers-face-lengthy-wait-for-permanent-status.html>. Students and temporary workers can fall under different health care coverage regimes beyond the scope of this work.

82 The IFHP predated Medicare (*Refugee Care*, *supra* note 64 at paras 35–38), but now plays this supplementary role.

83 The process for determining refugee status appears in *Immigration and Refugee Protection Act*, SC 2001, c 27 and its attendant regulations.

84 See Lisa A Merry et al, "Refugee Claimant Women and Barriers to Health and Social Services Post-Birth" (2011) 102:4 Can J Public Health 286 at 286.

Canadians receive through provincial health care plans"[85] and even covered some prescriptions, dental care, and psychological services that are not generally covered by Medicare.[86]

In 2012, the federal government attempted to restructure the IFHP and introduced different tiers of coverage,[87] beginning an ongoing period of transition. "Refugee claimants from non-[Designated Countries of Origin (DCOs)], refugees, successful [Pre-Removal Risk Assessment (PPRA)] applicants, most privately-sponsored refugees," and pre-2012 claimants received "Health Care Coverage," a tier that was supposed to be similar to Medicare and subject to the same gaps in essential coverage; yet they faced the further constraint that such services were only available if they were also "of an urgent or essential nature."[88] "[M]ost government-assisted refugees and some privately-sponsored refugees, as well as victims of human trafficking and some individuals admitted under a public policy or on humanitarian and compassionate grounds" received "Expanded Health Care Coverage," which was designed to fulfill further essential needs, including "translation services for health purposes," "laboratory, diagnostic and ambulance services," and "supplemental" services and products.[89] Persons from DCOs, such as Afghanistan, the war-torn state where Canadian Forces were recently deployed, were placed in a lower tier that only received the goods necessary to avoid a public health and safety emergency.[90] PPRA claimants were effectively removed from coverage. The restructuring changed how the program operated during the period that the changes were in force. Some studies suggest that patients, health care providers, and even

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85 Robert Vineberg, "Healthy Enough to Get In: The Evolution of Canadian Immigration Policy Related to Immigrant Health" (2015) 16:2 J Intl Migration & Integration 279 at 294.

86 *Ibid*. The IFHP explicitly provided coverage for "prenatal, contraception and obstetrical care; essential prescription medications; emergency dental treatments; and treatment and prevention of serious medical conditions" and other services were available with prior approval. See Merry et al, *supra* note 84 at 286.

87 *Order Respecting the Interim Federal Health Program, 2012,* PC 2012-433, (2012) C Gaz II [*Order Respecting the IFHP*].

88 *Ibid*, s 1; *Refugee Care*, *supra* note 64 at paras 61–79.

89 *Refugee Care*, *supra* note 64 at paras 67–68

90 *Order Respecting the IFHP*, *supra* note 87, ss 1, 4(3).

the IFHP's insurance provider lacked clarity on what was covered, leading health care providers to refuse care or charge fees and insurers to deny meritorious claims.[91] Yet, in a decision on the constitutional challenge to the restructuring, the Federal Court (FC) found that the cuts in coverage violated the Section 12 *Canadian Charter of Rights and Freedoms* right to be free from cruel and unusual treatment by "set[ting] out to make the lives of disadvantaged individuals even more difficult than they already are in an effort to force those who have sought the protection of this country to leave Canada more quickly, and to deter others from coming here" and, as a consequence, also "potentially [jeopardizing] the health, and indeed the very lives, of … innocent and vulnerable children."[92] The court also held that limiting the coverage of claimants from DCOs to services required for "Public Health or Public Safety" (PHPS) violated the Section 15 *Charter* right to equality and freedom from discrimination on the basis of national origin by risking the lives of those claimants and perpetuating the stereotype that they were "cheats."[93] Neither rights violation could be justified in a free and democratic society,[94] so Orders in Council instituting the changes were deemed to be of no force and effect.[95]

The federal government must operate within the structure of the Orders in Council creating the IFHP,[96] but it can make changes to the Orders in Council and its related regulations, including changes in coverage, with relative ease. It does not owe a duty of procedural fairness to the public

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91 Merry et al, *supra* note 84 at 288–89; Steve Barnes, "The Real Cost of Cutting the Interim Federal Health Program", (Toronto: Wellesley Institute, 2013) at 6. The Federal Court heard similar testimony, including reports that the administrative problems led to doctors requesting up-front payments from or refusing services to people who are qualified for particular services: *Refugee Care*, *supra* note 64 at paras 133–41.

92 *Charter*, s*upra* note 35, s 12; *Refugee Care*, *supra* note 64 at paras 689–91. Notably, some provinces expanded their insurance coverage for some immigrants or created new temporary coverage in the time between the Order in Council and the Federal Court decisions. See *ibid* at paras 257–63.

93 *Charte*r, *supra* note 35, s 15; *Refugee Care*, *supra* note 64 at paras 849–51.

94 *Refugee Care*, *supra* note 64 at para 1075.

95 *Ibid* at para 1116.

96 *Ibid* at para 52.

or any other relevant stakeholders before making changes;[97] there is, accordingly, no duty of consultation prior to decision making. The responses to the FC decision – specifically the changes to tiered coverage immediately after the decision and later restoration of the program to something resembling pre-2012 levels – exemplify that these changes can be made with relative speed and that this speed can maintain the threat of retrogression. They also highlight the fact that the IFHP's transition period is either ongoing or only recently ended. The FC decision limits the discretion of the federal government over who and what to cover under the IFHP, but the federal government initially did not respond to the FC decision by reinstituting the pre-2012 system. It maintained its tiered system of coverage. Top-level claimants in the 2015–2016 IFHP received essential goods available under Medicare, as well as supplemental and prescription coverage. Supplemental coverage provided funding for limited dental care, vision care, and psychological services.[98] Prescription drug coverage funded some medication that the WHO classifies as essential, but that Medicare does not cover outside of the hospital and physician services contexts, such as acetaminophen.[99] It did not fill all the gaps in Medicare coverage. Provincial Medicare formularies are (even now) largely used to set prescription drug coverage standards; the NIHBP formularies operate in the territories, but only 44 goods appear on the insurance provider's "IFHP Additional Drug Benefits" list.[100] Until recently, claimants enrolled in lower levels of the IFHP received even less coverage. After the election of a new, Liberal federal government in 2015, the federal government decided not to continue legal proceedings concerning the 2012 cuts and restored the IFHP to pre-2012 levels. Coverage for all eligible persons was restored to pre-2012 levels in April 2016. Groups of claimants are now differentiated by the length, rather than the content,

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97 See e.g. *ibid* at para 440.

98 Citizenship and Immigration Canada, "Interim Federal Health Program: Summary of Coverage" (2016), online: <www.cic.gc.ca/english/refugees/outside/summary-ifhp.asp>.

99 WHO, *Essential Medicines*, *supra* note 51 at 2 (referred to in the Model List of Essential Medicines as "paracetamol").

100 Blue Cross, "Benefit Structure Information" (2015), online: <www.medavie.bluecross.ca/cs/BlobServer?blobcol=urldata&blobtable=MungoBlobs&blobheadervalue2=abinary%3B+charset%3DUTF-8&blobheadername2=MDT-Type&blobkey=id&blobwhere=1187212198708&blobheader=application%2Fpdf>.

of their coverage.[101] Yet the threat of tiered coverage still remains. It was initially unclear whether the Liberal commitment to restore funding to the program would be joined by a decision to end tiered coverage. There is a nearby possible world where a new legal challenge to tiered coverage would be feasible. Continuing legal battles over the 2012 proposals and/or new legal battles over a different Liberal policy could have produced further changes to the IFHP. It is, in other words, legally easy to change IFHP coverage, but this ease can lead to retrogression and final determinations on the constitutionality of such changes by an apex court are still lacking.

The NIHBP, in turn, supplements provincial Medicare programs and federally-funded on-reserve services by insuring prescription and over-the-counter drugs, dental and vision care, "short-term crisis intervention mental health counselling," medical supplies and equipment, and medically-related transportation costs for members of registered First Nations and Inuit groups.[102] It provides this coverage as matter of last resort. If the goods are not otherwise covered by private health insurance, provincial plans, or other public programs, the NIHBP funds goods that Canadians outside the program would need to pay for out-of-pocket. As with Medicare and the IFHP, the NIHBP reimburses health care professionals for their services and patients are supposed to receive NIHBP-covered services for free at the point of service. The NIHBP's annual reports list criteria for the selection of the goods it will cover.[103] Every quarter, the program updates the list of drugs deemed necessary for the purposes of the NIHBP.[104] A 2016 version

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101 Citizenship and Immigration Canada, "Determine Your Eligibility – Interim Federal Health Program" (2016), online: <www.cic.gc.ca/english/refugees/outside/arriving-healthcare/individuals/apply-who.asp>.

102 See e.g. *Annual Report 2014/2015*, *supra* note 70 at 3; Health Canada, "Non-Insured Health Benefits for First Nations and Inuit" (2015), online: <www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/index-eng.php>. For the First Nations registration process, see *Indian Act*, *supra* note 69. While that act does not apply to Inuit or Métis, both are subject to similar registration processes.

103 *Annual Report 2014/2015*, *supra* note 70 at 3.

104 Canada, First Nations and Inuit Health Branch, "Non-Insured Health Benefits: Drug Benefit List 2016", (Ottawa: Health Canada, 2016) at iii [*DBL 2016*]; Health Canada, "Non-Insured Health Benefits – Reports and Publications" (2016), online: <www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/index-eng.php>.

includes, but is not limited to, antihistamines,[105] contraceptives,[106] gastrointestinal drugs,[107] hormones,[108] vitamins,[109] traditional "over-the-counter" drugs like the allergy medications Reactine and Claritin,[110] 33 antiretrovirals that are not covered by Medicare (five of which are only available to HIV patients and require prior approval),[111] antidepressants,[112] and antipsychotics.[113] The NIHBP explicitly excludes "anti-obesity drugs, household products, cosmetics, hair growth stimulants, and megavitamins."[114] People whose eligibility claims have been denied and those who seek to add goods to the list covered by the program face three levels of inter-departmental administrative appeal before judicial review of their challenges.[115] Disputes over "excluded goods" cannot be appealed.[116]

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105 *DBL 2016, supra* note 104 at 1.

106 *Ibid* at 99.

107 *Ibid* at 113.

108 *Ibid* at 123.

109 *Ibid* at 145.

110 *Ibid* at 1.

111 *Ibid* at 10–12.

112 *Ibid* at 76–82.

113 *Ibid* at 83–90.

114 This language appears in Health Canada, "Provider Guide for Pharmacy Benefits: Non-Insured Health Benefits" (2016), online: <www.hc-sc.gc.ca/fniah-spnia/pubs/nihb-ssna/_drug-med/2016-prov-fourn-guide/index-eng.php#a28>. See *DBL 2016, supra* note 104 at viii for the complete list of excluded goods.

115 An inter-departmental challenge begins with the Manager of the Pharmacy Policy Development Division or the Dental Policy Unit, before moving on to the Director, Benefit Management and Review Services Division, and ending with the Program's Director General. See Government of Canada, "Appealing a Decision under the Non-Insured Health Benefits Program" (2016), online: <www.healthycanadians.gc.ca/health-system-systeme-sante/services/non-insured-health-benefits-services-sante-non-assures/appealing-decision-faire-appel/index-eng.php>.

116 *DBL 2016*, *supra* note 104 at viii.

These broad structural features of the Canadian health care system do not tell the whole story of Canadian health care coverage and delivery or the legal regulation thereof. They do not, for instance, account for the complexities of the workers' compensation regime. The facts above nonetheless provide basic background necessary for analyzing the details of the system that are relevant to the AFR framework. It is now prudent to frame these details in light of the substantive demands of the AFR framework. As made clear in the following Part, Canada lacks (A) and it is difficult to determine the extent to which it fulfills (B). Canada thus clearly lacks (D) in all but the minimal sense of having a health care system that is legally regulated. I accordingly only focus on the extent to which Canada provides (A)–(C). I begin with (A).

IV. The Transparency Requirement: Reason-Giving in the Canadian Health Care System

In earlier work on this topic, Flood stated that Canada's Medicare regime does not follow the AFR framework.[117] Yet following the framework need not be an all-or-nothing affair. The legal system regulating Canada's health care system arguably does feature some of the structural features required by AFR. Canada's compliance with the AFR framework also appears to be improving, though it remains far from perfect. For instance, when Flood was doing her work, the provision of reasons was not one of the structural features provided by the Canadian health care system. Some headway has since been made in the public provision of reasons for health care coverage decisions. Yet, as discussed throughout this text, work remains to be done if Daniels and Sabin's call for AFR compliance is to be fully heeded.

The problems here are clear. The reasons for decisions on what health care goods are covered in a given province are generally not publicly available. The committees charged with deciding what is covered under our health insurance regimes tend not to be explicitly required to provide reasons for their decisions, let alone make them public. For instance, Ontario legislation establishes rules for the composition of the Physician Services Committee, but does not indicate that the Committee needs to provide reasons for their actions under the legislation.[118] The only clear exception is that denial of particular claims for coverage by the General Manager of the

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[117] Flood, "Conclusion", *supra* note 4 at 452.

[118] *HIA*, ON, *supra* note 53, s 5.1.

health insurance regime must be reported to the Ministry of Health and the report must include an account of the grounds for that decision; these decisions do not explicitly need to be made public.[119] Even if one thinks that requiring reasons for every coverage decision on an item-by-item basis is too demanding, a system that fails to provide general reasons for decisions fails any reasonable reason-provision standard.

Even administrative appeal bodies are not always required to provide reasons for their decisions. There is a general rule of administrative law, dating back to the Supreme Court of Canada (SCC)'s decision in *Roncarelli v Duplessis* that administrative decisions cannot be arbitrary.[120] This arguably entails that at least some public decisions must be *based on* reasons. The circumstances in which these reasons must be made publicly available, however, are more limited. In *Baker v Canada (Minister of Citizenship and Immigration)* (*Baker*), the SCC famously stated that "in certain circumstances, the duty of procedural fairness will require the provision of a written explanation for a decision."[121] If one takes Daniels and Sabin's claims about the status of health care as a public good in the domain of distributive justice (namely, Premises 1 to 5 and the Conclusion above) seriously, the health insurance coverage context is arguably a context where the provision of written reasons for decisions ought to be required. It is thus heartening that the body charged with hearing appeals in Ontario, the Health Services Appeal and Review Board (HSARB), provides written reasons in several cases despite not being explicitly required to do so. Yet the fact that health care-related tribunals should provide reasons has not led Canadian courts to require those tribunals to do so. The circumstances addressed in *Baker* are limited and subsequent case law suggests that the requirement to give reasons may be exceptional rather than a wide-ranging duty for many Canadian tribunals, creating a distinction between the requirements of Canadian administrative law and Daniels and Sabin's framework.[122]

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119 *Ibid*, s 25.

120 [1959] SCR 121 at 140–42, 16 DLR (2d) 689.

121 [1999] 2 SCR 817 at 848, 174 DLR (4th) 193.

122 For an overview of the case law in which courts recognized and extended their own ability to supplement or introduce administrative reasoning where administrative decisions do not provide their own reasons, see Paul A Warchuk, "The Role of Administrative Reasons in Judicial Review: Adequacy & Reasonableness" (2016) 29 Can J Admin L & Prac 87 at 89–95.

In addition, impediments to the public display of appeal boards' reasons may remain after reason-giving conditions obtain. For instance, Flood and Michelle Zimmerman's work on the HSARB raises two potential problems: "The Boards' judgments are not online and appointments must be made to view the judgments archived in Toronto. Furthermore, because the judgments are not indexed, in order to locate a decision one needs to know the name and year of the case."[123] There may be impediments to accessing the written reasons for appeal decisions. Where access to these written decisions can be an indirect method for accessing reasons for administrative decisions, these may also be impediments to accessing the reasons for first instance decision making that are necessary for appeals.

Recent developments in the public display of appeal decisions suggest that Canada is making some strides in providing public reasons. Getting reasons from the initial decision makers in Ontario remains difficult, but access to the decisions of the aforementioned HSARB is improving. HSARB decisions are now indexed on the Canadian Legal Information Institute website, an online non-profit managed by the Federation of Law Societies of Canada. Initial indexing took place in 2010 and digitization of the backlog of decisions continues; one HSARB case dating back to 2002 was on the website by 22 January 2015 (though no further 2002 cases were added in the following year).[124] The site, which includes a search option, is also kept relatively up-to-date. Two 2015 decisions, one on a hearing request[125] and one substantive decision on a November 2014 hearing,[126] appeared within the first three weeks of the year. A later check-in on the timeliness of the posting of decisions, performed on 10 June 2016, unearthed two June 2016 decisions including a decision from a 3 June 2016 written hearing.[127] Quebec's main administrative tribunal, the Tribunal administratif du Québec (Administrative Tribunal of Québec), which is the site of first instance for insurance decision appeals, similarly maintains an online database of its decisions.[128]

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123 Flood & Zimmerman, *supra* note 4 at 35.

124 *VR v Ontario (Health Insurance Plan)*, 2002 CanLII 61089 (Ont HSARB).

125 *RS v Chirico*, 2015 CanLII 334 (Ont HSARB).

126 *MS v Ontario (Health Insurance Plan)*, 2015 CanLII 1390 (Ont HSARB).

127 *SH v Central East Community Care Access Centre*, 2016 CanLII 33704 (Ont HSARB); *MT v Mississauga Halton Community Care Access Centre*, 2016 CanLII 32347 (Ont HSARB).

128 La Société québécoise d'information juridique, "Trouver une décision", on-

While accessing the reasons for decisions about which services are covered remains difficult, a systematic review of accessible appeal decisions could provide some insight about which reasons decision makers rely on to decide what is covered under the health insurance regimes in at least two provinces. This indirect method falls short of the reason-giving requirement envisioned by Daniels and Sabin, which requires that the reasons for decisions create something analogous to case law.[129] However, it does constitute progress made since Flood et al wrote about the applicability of the AFR framework to the Canadian health care system.

Even where administrative appeal reasons are (or even must be) made public, appeals are an inefficient way to access reasons that ought to be provided as a matter of procedural justice prior to requesting a review. Human rights law tribunals have a history of long wait times. Ontario accordingly recently overhauled its human rights mechanisms to ensure greater accessibility.[130] Where a further judicial review is required to get reasons, this problem is even more pressing. The judicial review process can be time-consuming. In a recent decision, the SCC acknowledged that wait times for decisions in criminal cases have reached unacceptable lengths.[131] These delays, in turn, cause delays in civil and judicial review proceedings. Wait times remain long in all three contexts, creating frequent fodder for newspaper articles. General administrative law procedures can at least be less time-consuming. While waiting for a hearing may still prove onerous, some of these bodies take less time to provide reasons. For instance, while Ontario's appeal body for health care insurance decisions takes three months to provide written reasons, Alberta's equivalent body, the Appeal Panel, which has a more limited jurisdiction, is required to provide reasons within five

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line: <citoyens.soquij.qc.ca/>. The Manitoba Health Appeal Board does not post its decisions on its website ("The Manitoba Health Appeal Board", online: Government of Manitoba <www.gov.mb.ca/health/appealboard>) or on the Canadian Legal Information Institute website.

129 Daniels & Sabin, "Limits", *supra* note 3 at 327–28. Going to case law to get those reasons in the first place seems to get things backwards.

130 For a report on the recent reforms to the Ontario human rights system following widespread access problems, see Ontario Ministry of the Attorney General, *Report of the Human Rights Review 2012*, by Andrew Pinto (Toronto: Queen's Printer for Ontario, 2012).

131 *R v Jordan*, 2016 SCC 27, 398 DLR (4th) 381. In the case at issue, the accused had waited two and a half years for the completion of the preliminary inquiry from the moment he was charged: *ibid* at para 9.

days of the hearing.[132] Yet, even then, these procedures are an inefficient way to access reasons one should have as a matter of procedural justice and judicial review may be required to gain substantive outcomes.

The IFHP has arguably greater issues of transparency beyond those discussed above. The IFHP not only makes its decisions without adequate public consultation, but also fails to publish the reasons for its decisions. For instance, beyond the suggestion that pharmaceutical drugs at the lowest level of coverage are only available where they are necessary to "prevent or treat a disease posing a risk to public health or to treat a condition of public safety concern," the Summary of Benefits that listed the different levels of coverage in the post-FC decision interim program did not explain why the different levels existed or why particular groups of claimants fit into different levels of coverage.[133] The opacity of reasons for coverage is sometimes mirrored by opacity with regard to what goods are covered. When the federal government tried to implement the aforementioned budgetary cuts in 2012, doctors were unclear on which goods were still covered following the changes.[134] The government is transparent about its reasons for implementing the program. The stated purpose of the program is to provide "short term, interim medical care."[135] Yet this is, at best, a severely limited guide to understanding the reasons for why certain goods are covered. The stated purpose explains why certain long-term health interventions are not covered by the program. It does not explain how the government decides whether a particular good that can be provided on a short-term or interim basis is covered under the program. It also does not explain why certain long-term goods (like eyeglasses) were covered in higher tiers of the post-decision program or why different levels of coverage existed in the first place.

The federal government was transparent in its reasons for proposing changes to the program. It listed four reasons in its response to the aforementioned constitutional challenge to the government's attempted restructuring of the IFHP: (i) cost containment, (ii) public health and safety, (iii) the "integrity of Canada's refugee determination system and [deterrence

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132 Pitfield & Flood, *supra* note 4 at 493–94.

133 Citizenship and Immigration Canada, "Interim Federal Health Program: Summary of Benefits" (2015). The post-Federal Court decision interim program operated between 2014 and 2016: *ibid*.

134 *Refugee Care*, *supra* note 64 at paras 133–41.

135 *Ibid* at para 50.

of] its abuse," and (iv) "fairness to Canadians," which can be interpreted as a catch-all for the concern that immigrants receive greater coverage than Canadians receive under Medicare.[136] Yet this transparency did not save the proposed cuts. The FC found that (iv) was not a "pressing and substantial" objective in "the absence of any evidence that the pre-2012 IFHP was unfair to Canadians or that the 2012 IFHP is any fairer to Canadians," that the proposed changes were not rationally connected to (ii) or (iv), and finally, that the proposed cuts failed the minimal impairment and proportionality tests on any of the four objectives.[137] This example highlights the limits and potential value of transparency for health care justice in Canada. As the case, entitled C*anadian Doctors for Refugee Care v Canada (AG)*, makes clear, transparency cannot save a law or policy that conflicts with substantive Canadian law. The proposed cuts to the IFHP were inconsistent with substantive *Charter* provisions.[138] Where the reasons for infringing rights are unjustified, publicizing the reasons for violating those rights changes very little in terms of the outcome of a *Charter* challenge. However, this reason-giving still makes a small contribution to accountability for reasonableness and it may even advance health care justice broadly. Governmental transparency in this case made the inadequacy of the reasons for the decision clear, and thereby contributed to the long process of restoring the program to its previous non-tiered status. Yet full transparency in the IFHP is clearly lacking.

The NIHBP, by contrast, fares well on the transparency metric. The NIHBP's annual reports list the types of goods that are covered, set out guiding principles for the program (including principles guiding the selection of goods to be included in coverage), and state how much is spent providing selected goods and services.[139] While individuals must request the reports, I received copies within a week of requesting them, and summaries are available online. The 2014/2015 annual report includes examples of the guiding principles:

> • Benefits will be provided based on professional, medical or dental judgment, consistent with the best practices of health services delivery and evidence-based standards of care;

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136 See e.g. *ibid* at paras 53–56.

137 *Ibid* at paras 912–28, 938–1075.

138 *Ibid* at paras 1079–84.

139 See e.g. *Annual Report 2014/2015*, *supra* note 70 at 3, 27–70.

> • There will be national consistency with respect to mandatory benefits, equitable access and portability of benefits and services;
>
> • [And the NIHBP] will be managed in a sustainable and cost-effective manner.[140]

The NIHBP provides regular coverage updates online.[141] Complete annual drug benefit lists are also available online without a request and they provide more fine-grained reasons for coverage than the general NIHBP annual reports. To give a recent example, the NIHBP, Collaborative Emergency Centers, and Drugs and Therapeutics Advisory Committee balanced several factors in making listing decisions about changes to the Drug Benefit List, such as:

> • The needs of First Nations and Inuit clients;
>
> • Accumulated scientific and clinical research on currently-listed drugs;
>
> • Cost-benefit analysis;
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> • Availability of alternatives;
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> • Current health practices; and
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> • Policies and listings in provincial drug formularies.[142]

The Drug Benefit List also explains the process for the removal of goods from the program, including reasons for removal.[143] While the NIHBP does not explain each of its decisions about individual coverage, it does publish its decisions and the principles guiding its decision making.

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[140] *Ibid* at 3. These principles leave some room for professional discretion.

[141] Health Canada, "Non-Insured Health Benefits Program Update" (2016), online: <www.hc-sc.gc.ca/fniah-spnia/nihb-ssna/benefit-prestation/newsletter-bulletin-eng.php>.

[142] *DBL 2016*, *supra* note 104 at v.

[143] It lists clear criteria for the removal of goods and further policies and rules: *ibid* at vi–xi.

Decision making in the Canadian health care system, then, largely continues to be opaque. The NIHBP offers a notable exception to this general principle. Its regular, scheduled dissemination of decisions and reasons for decisions offer an example of best practices for improving transparency in other parts of the Canadian health care system.

V. The Public Acceptance/Acceptability Requirement: The Adequacy of Reasons for Decisions in the Canadian Health Care System

There are two ways of understanding the second requirement of AFR. It is difficult to determine how Canada fares on either interpretation. On one articulation of this requirement, AFR requires that "the grounds for decisions must be ones that fair-minded people *can* agree are relevant to meeting health care needs fairly under reasonable resource constraints."[144] Elsewhere, however, the Relevancy Condition is formulated such that decisions must be based on "evidence, reasons, and principles that *are* accepted" by fair-minded people.[145] Whether the reasons for decisions need to be accepted or merely acceptable is ambiguous. The lack of reason-giving in the Canadian health care system makes it difficult to determine whether the public accepts the reasons for health care decision making. If the public does not know why decisions are made, how can they decide whether they think those decisions were made for good reasons? Access to reasons seems to be a prerequisite for acceptance of reasons. The systematic review of all appeal decisions in Ontario and Québec suggested above could be helpful, but such a review is currently unavailable to the public and is beyond the scope of this article.

Direct evidence of how Canada fares is hard to identify if the acceptance of reasons understanding of this requirement is adopted. No public will ever accept all decisions made by a rationing body.[146] It is thus unsurprising that there are persistent demands to expand coverage. Demands for increased drug benefits and/or long-term care coverage are particularly persistent and

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144 Daniels & Sabin, *Setting Limits*, *supra* note 1 at 12 [emphasis added].

145 *Ibid* at 45 [emphasis added].

146 In the American context, Daniels and Sabin acknowledge a worry that "the litigious public will accept no limits" on health care plans ("The Ethics", *supra* note 3 at 58).

politically salient today.[147] Constitutional challenges to the administration of health care provide examples of Canadians failing to accept policy-makers' decisions about health care rationing.[148] Unhappiness with coverage decisions also suggests an implicit issue with the reasons for those decisions (though one may also critique a decision on procedural grounds). Yet Canadian calls for greater coverage are rarely paired with calls to overhaul the Medicare decision-making procedures and there are few constitutional challenges raised relative to the number of insured Canadians. Both signs of a lack of acceptance of reasons may demonstrate pockets of discontent, rather than wholesale disagreement with the decision-making process or the reasons for decisions made within that process. The Canadian public's limited disagreements with the current system may simply exemplify the claim that no one will accept all rationing decisions, putting Canada on par with other countries. Yet it is also difficult to take the lack of widespread protest and/or challenges to the reasons for health care rationing decisions as being dispositive of whether Canadians accept those reasons. A lack of public anger could be emblematic of a lack of public awareness of the reasons for decisions, rather than public acceptance of those reasons. Relative silence should not be read as acceptance when one is gauging the acceptance of governmental decisions on a wide scale. Given the opacity of reasons provided for decisions made under the three programs listed above, lack of awareness is a likely explanation for the lack of public response to these decisions. We need better access to reasons to assess whether the public accepts them. Even a good survey on whether people accept reasons for decisions will require the provision of those reasons. The evidence for whether Canadians accept reasons for decisions is thus mixed, but the lack of response to some reasons may be better explained by a lack of awareness than acceptance.

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147 Newspaper articles on calls for increased coverage appear periodically. See e.g. Andre Picard, "Doctors' Orders: Expand Medical Coverage to Long-Term Care", *The Globe and Mail* (21 August 2007), online: <www.theglobeandmail.com/news/national/doctors-orders-expand-medical-coverage-to-long-term-care/article692138>.

148 The case law on this topic includes *Eldridge v British Columbia (AG)*, [1997] 3 SCR 624, 151 DLR (4th) 577 [*Eldridge*]; *Auton (Guardian ad litem of) v British Columbia (AG)*, 2004 SCC 78, [2004] 3 SCR 657 [*Auton*]; *Chaoulli v Quebec (AG)*, 2005 SCC 35, [2005] 1 SCR 791 [*Chaoulli*]; *Refugee Care*, *supra* note 64. Separate yet related case law focuses on decisions to criminalize health care goods: see e.g. *R v Morgentaler*, [1988] 1 SCR 30, 44 DLR (4th) 385; *Canada (AG) v PHS Community Services Society*, 2011 SCC 44, [2011] 3 SCR 134 [*Insite*]; *Carter*, *supra* note 43.

The hypothetical "acceptability" of reasons used to make decisions about Canadian health care distribution is similarly difficult to parse. Daniels and Sabin structure their analysis in terms of the views of "fair-minded people." Some further detail on their characteristics is necessary to perform the hypothetical agreement thought experiment. Daniels and Sabin's fair-minded people are "people who in principle seek to cooperate with others on terms they can justify to one another. … [They] seek reasons … they can accept as relevant to meeting consumers' or citizens' needs fairly under resource constraints."[149] This explanation is unhelpful if we do not know what reasons these fair-minded people are being asked to hypothetically accept. That information is lacking in Canada. In the abstract, it seems reasonable to assume that fair-minded persons could accept decisions made on the basis of what is "medically necessary" and "medically required." The aforementioned lack of protest against use of these terms in current reasoning provides (weak) evidence that Canadians not only could, but do accept those reasons in at least some cases (though, again, silence should not be read as acquiescence in this case). Yet the undefined status of those two terms means that they are, in practice, open to wide interpretation. On a wide enough interpretation, the phrases lack substantive content. Even the guiding principles on how to interpret these terms are generally undefined.[150] The threat of arbitrary decision making looms. In their original work on Canadian AFR, Flood and Zimmerman state that resource allocation "decision-making [in Canadian medicare] is generally opaque." Lack of transparency allows decision making on an *ad hoc,* politicized basis."[151] They suggest that the lack of transparency "allows for the possibility of self-interest or irrelevant considerations to guide these fundamental decisions."[152] In the absence of public reasons for decisions, it is unclear to what extent arbitrary decision making is made possible or actually allowed. Yet fair-minded individuals clearly would not accept arbitrary decision making. Such individuals are defined by their commitment to relevant reasons and arbitrary decisions are by definition not based on relevant reasons. If medical necessity is a proxy for political expediency, as Flood and Zimmerman worry, hypothetical agreement is unlikely.

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149 Daniels & Sabin, *Setting Limits*, *supra* note 1 at 44. Elsewhere, Daniels and Sabin suggest that fair-minded people seek cooperation on "mutually justifiable" terms ("The Ethics", *supra* note 3 at 51).

150 Flood & Zimmerman, *supra* note 4 at 30.

151 *Ibid* at 27.

152 *Ibid* at 30.

Even if decisions are in fact non-arbitrary, focus on the criteria of "medically necessary" and "medically required" alone do not get us far in the absence of substantive definitions for those terms. Decisions based on empty concepts may seem less problematic, but fair-minded individuals are still unlikely to accept that such decisions were fairly made. If evidence suggests that Canadians accept the reasons for health care rationing decisions, this could be evidence that current Canadians are insufficiently fair-minded. It is certainly the case that the reasons for decisions acquire some legitimacy from the fact of their being a product of fair legislative processes. The medical necessity and requirement criteria, for instance, are explicitly contained in the *CHA* and provincial Medicare implementation statutes. Yet fairly elected legislators can make decisions on the basis of inadequate reasons. Accepting that a government is a legitimate decision maker is not tantamount to accepting that all of its decisions are fair. Failing to object to longstanding practices of government, such as the use of the medical necessity and requirement criteria for Medicare decisions, does not necessarily constitute acceptance of such practices, particularly where details on how those criteria are understood in those practices are difficult to parse. Even when those decisions are sufficiently transparent as to make the decision-making process procedurally fair on one axis, transparent but unacceptable reasons are unreasonable and thus suggest that full procedural fairness is lacking. Moreover, even if citizens accept these poor reasons, this acceptance may be mistaken and fail to contribute to one of the interpretations of the acceptability criterion for accountability for reasonableness outlined above.

Ultimately, then, there is insufficient evidence to suggest that Canadians accept the reasons for decisions in the Canadian health care context and ample evidence that they lack access to sufficiently fine-grained parsing of those reasons to either actually or hypothetically accept them. Focusing on the IFHP does not improve Canada's score on this metric. Given the lack of transparency in the IFHP, it is difficult to even apply the accepted or acceptable reasons metrics to the program. While most would agree that the need for "short term, interim medical care" is an acceptable reason for government action, it is likely too vague a description to guide specific decisions on what to cover. It also does not explain what is covered at present. Given that the reasons for the proposed cuts to the program were both widely criticized by the public (who protested the cuts) and found to be inadequate to justify rights violations in a free and democratic society by the FC in the aforementioned *Refugee Care* case, it is clear that the reasons for those changes were not widely

accepted.[153] The reasons given by the federal government for the cuts could be *acceptable* reasons for government action in the abstract, but still likely did not justify the tiered system of coverage. For instance, positing cost-cutting as a justification for the cuts did not withstand critical scrutiny. Provincial governments and scholars both worried that any savings from the 2012 cuts to the program would result in downloading of costs to the provinces.[154] While the FC did not rule on whether the cuts would actually reduce costs – though they did hold that the cuts may "result in a reduction of costs *to the program*"[155] – there is evidence that when the cuts were in place, costs were downloaded to, for example, hospitals that continued to admit anyone who presented with an emergency.[156] This downloading raised serious questions about whether the proposed regime would be more cost-effective than the 2012 regime. There is, moreover, still no evidence that the 2012 program was unfair to Canadians or that the current program will lead to abuse of the system. It is unclear why some groups received basic and prescription coverage, some groups received basic coverage and PHPS prescription coverage, and some groups only received categories of PHPS coverage. Some categories tracked either vulnerability or some sense of desert. For instance, a less cynical view is that the IFHP prioritized pregnant women, children, and victims of human trafficking because they are the most vulnerable of the (already vulnerable) categories of refugees. Yet it may be that these categories were just a proxy for concerns related to desert. Perhaps there was an (unfounded) sense that these refugees were somehow less apt to abuse the system. The previous federal government's references to "bogus" refugee claimants in their justification of the cuts appeared to presume that claimants from DCOs were bogus in the absence of evidence to the contrary.[157]

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153 See e.g. "'Day of Action': Doctors, Activists Protest Refugee Health Care Cuts", *CTV News* (27 January 2017), online: <www.ctvnews.ca/canada/day-of-action-doctors-activists-protest-refugee-health-care-cuts-1.2423023>.

154 Barnes, *supra* note 91 at 8.

155 *Refugee Care*, *supra* note 64 at para 945.

156 Andrea Evans et al, "The Cost and Impact of the Interim Federal Health Program Cuts on Child Refugees in Canada" (2014) 9:5 PLoS ONE e96902 at 3; The PLOS ONE Staff, "Correction: The Cost and Impact of the Interim Federal Health Program Cuts on Child Refugees in Canada" (2014) 9:8 PLoS ONE e106198 (corrects an error in Table 2).

157 For use of the term "bogus" to justify the cuts, see *Refugee Care*, *supra* note 64 at para 56, citing the Minister of Citizenship and Immigration's spokesperson in 2012, soon after the changes came into force.

Even if one takes the less cynical view of these categories, the concerns regarding fairness and abuse did not explain all the different categories. For instance, if there was a concern that too many benefits would cause "bogus" claimants to come forward, why provide them with basic coverage while they awaited decisions on their claims? Public health and safety concerns likely explained why all claimants received PHPS coverage. Yet those concerns did not explain why some groups received *only* PHPS coverage between 2012 and 2016, particularly when preventative medicine, which falls under "basic" coverage, is often an effective means of preventing public health and safety emergencies. While the reasons for the 2012 cuts to the IFHP could theoretically have been acceptable reasons for government action, they could not have justified the tiered coverage that the previous federal government attempted to put in place.

The NIHBP again provides a minor exception to the story of Canadian failure under this aspect of AFR, but the program's small successes likely do not suggest best practices for producing acceptable or accepted reasons for decisions that can then be applied in other areas of the Canadian health care system. If one accepts that the aforementioned principles are acceptable reasons for the NIHBP's decisions, then the program also fares reasonably well on the acceptability-based public reason standard. Costs, the needs of relevant stakeholders, the use of scientific research, and attentiveness to relevant alternatives seem like acceptable reasons in the abstract. Yet the acceptability of these reasons for particular decisions will depend on context. As noted in my discussion of the IFHP, cost containment can be an unacceptable reason for failing to insure a good where there is insufficient evidence that, in so doing, program costs will in fact be reduced. It would thus also be helpful to know more about the particular scientific research on which the government bases its decisions in order to undertake a more fine-grained analysis of the acceptability of its reasons for decisions; bad science produces bad reasons for action. Despite these caveats, the broadly defined reasons for decision making in the NIHBP are ostensibly acceptable reasons in the abstract for health care allocation, so a more coarse-grained acceptability analysis counts in the program's favour. While the acceptability of reasons can be hard to define, the abstract acceptability of the NIHBP's reasons for drug coverage helps explain what is covered (providing a fit between reasons and actions that will support acceptance of both) and why the reasons are rarely challenged in courts or targeted by large protests. These facts suggest that the guiding reasons in the NIHBP are generally accepted. Greater Aboriginal input in deciding what will be covered would improve actual acceptance. Yet the NIHBP fares reasonably well on acceptability and acceptance-based public reason analyses at present. Given the high level of

generality of the principles and the contextual factors that determine whether the principles are actually accepted, it is unlikely that these reasons can easily be imported as reasons for decisions in other aspects of the Canadian health care system without further elaboration.

VI. The Reviewability Requirement: The Presence of Challenge/Appeal Procedures in the Canadian Health Care System

There are several challenge and appeal procedures related to the Canadian legal regulation of health care. One can challenge decisions on health care coverage and provision using constitutional law, human rights law, or general administrative law. The first two procedures can be summarized briefly. Sections 7 and 15 of the *Canadian Charter of Rights and Freedoms* protect rights to "life, liberty and security of the person" and "equality" respectively and allow for the challenge of any Canadian law.[158] Both sections have been used to challenge aspects of Canada's regulation of health care and even to demand provision of certain goods.[159] Section 12 of the *Charter* was also successfully invoked in the aforementioned challenge to the proposed cuts to the IFHP.[160] Every province also has a human rights tribunal.[161] If one feels that one has been discriminated against in the coverage or provision of health care, one can challenge the decision before the tribunal.[162]

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158 *Supra* note 35.

159 See e.g. *Eldridge*, *supra* note 148; *Auton*, *supra* note 148.

160 *Refugee Care*, *supra* note 64.

161 These are created by provincial human rights acts and their associated regulations. See e.g. Ontario's *Human Rights Code*, RSO 1990, c H.19, ss 35ff.

162 *Chaoulli*, *supra* note 148, is actually best understood as a provincial human rights case, though subsequent challenges highlight the quasi-constitutional status of Québec's human rights legislation to suggest that the case also has constitutional implications. See also *Waters v British Columbia (Ministry of Health Services)*, 2003 BCHRT 13, 46 CHRR D/139 [*Waters*]; *Newfoundland and Labrador v Sparkes*, 2004 NLSCTD 16, 131 ACWS (3d) 488 [*Sparkes*]; *Hogan v Ontario (Minister of Health and Long-Term Care)*, 2006 HRTO 32, 58 CHRR D/317; *Finan v Cosmetic Surgicentre (Toronto) Inc*, 2008 HRTO 47, 64 CHRR D/106; *Turnbull v British Columbia (Ministry of Health Services)*, 2011 BCHRT 324, [2011] BCHRTD No. 324 [*Turnbull*]; *XY v Ontario (Minister of Government and Consumer Services)*, 2012 HRTO 726, 74 CHRR D/331; *Refugee Care*, *supra* note 64.

Successful challenges require that one establish that one has been denied health care that is generally provided to others, that the denial is related to an enumerated ground, which human rights law is designed to protect (or an analogous ground), and that the government lacks a defence for the prima facie discriminatory denial of treatment.[163] These tribunal decisions are then themselves reviewable by courts.

General (non-human rights) administrative law avenues require a more lengthy discussion. Flood and Zimmerman only list Ontario, Alberta, and British Columbia (BC) as provinces with "administrative tribunals to which the citizens thereof can bring … an application to review a decision not to publicly fund a service or a treatment" and briefly mention that Québec's "Tribunal administrati[f] du Québec hears appeals concerning health treatment or service coverage."[164] This list is arguably under-inclusive. Ontario, Québec, and Alberta maintain appeal mechanisms for (at least some) health insurance decisions. In Ontario, "[a]n insured person who has made a claim for payment for insured services may appeal a decision of the General Manager refusing the claim or reducing the amount so claimed to an amount less than the amount payable by the Plan."[165] In Québec, "[a]n insured person or person eligible for a plan or program … who believes he has been wronged by a decision of the [Régie de l'assurance maladie du Québec] may apply for a review of the decision" at the Tribunal administratif du Québec.[166] Under Alberta regulations, there is a limited right of review of one's request for out-of-country provision of services not available in Canada.[167] Yet other provinces also allow for limited administrative appeals. The Manitoba Health Appeal Board has the power to hear appeals on several

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163 These criteria can be established by reading the requirements for prima facie discrimination in *Moore v British Columbia (Education)*, 2012 SCC 61 at para 33, [2012] 3 SCR 360 [*Moore*] together with the defence requirement in *Ontario (Human Rights Commission) v Simpsons-Sears Ltd*, [1985] 2 SCR 536 at 558–59, 23 DLR (4th) 321 and transposing them into the health care context. While *Moore* only interprets a single provincial human rights act, the structural similarities between all Canadian human rights acts suggests that this test applies in all provinces.

164 Flood & Zimmerman, *supra* note 4 at 34.

165 *HIA*, ON, *supra* note 53, s 20(1)(b).

166 *Health Insurance Act*, CQLR c A-29, s 18.1 [*HIA*, QC].

167 *Out-of-Country Health Services Regulation*, Alta Reg 78/2006, s 2 [*Out-of-Country*].

grounds, including appeals by those who have been "denied entitlement to a benefit under [*The Health Services Insurance Act*] or the regulations,"[168] and New Brunswick regulations charge the Insured Services Appeal Committee with "advis[ing] the Minister on appeals by persons on matters in dispute or disagreement with respect to … refusal of a claim for payment for entitled services or reduction of the amount so claimed."[169] These provinces suggest that Canada fares better on AFR's challenge/appeal component than previously thought.[170]

In nearly every case, administrative decisions can then be reviewed by courts. For instance, Ontario explicitly states that people making challenges under their system have a right of appeal to the Divisional Court after an HSARB decision.[171] In Manitoba, the statute outlining the powers of its equivalent review board does not explicitly refer to a right of review at court, but it is also not barred.[172] Albertan laws are generally silent on how Albertan appeal mechanisms work.[173] There is, then, an extra level of possible challenge before the judicial level in several Canadian provinces and none of these challenges preclude further review at court.[174] This also counts

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168 *Health Services Insurance Act*, RSM 1987, c H35, CCSM c H35, s 10(1)(b) [*HSIA*].

169 NB Reg 84-20, s 33.01(2)(b).

170 Nova Scotia took steps to recognize an appeal board, but has not yet established one. The *Insured Health Services Act*, SNS 2012, c 44 (4th Sess), ss 39–51, would establish the Insured Health Services Appeal Board and outline its powers relative to other judicial appeal bodies, but since it has only been enacted and not proclaimed, the statute has not come into force.

171 *HIA*, ON, *supra* note 53, s 24(1).

172 *HSIA*, *supra* note 168.

173 See e.g. *Alberta Health Care Insurance Act*, RSA 2000, c A-20; *Out-of-Country*, *supra* note 167.

174 There are no references to review or appeal mechanisms for would-be patients in the health insurance acts of Newfoundland and Labrador (*Medical Care Insurance Act, 1999*, SNL 1999, c M-5.1), Nova Scotia (*Health Services and Insurance Act*, RSNS 1989, c 197), Prince Edward Island (*Health Services Act*, RSPEI 1988, c H-1.6), Saskatchewan (*The Saskatchewan Medical Care Insurance Act*, RSS 1978, c S-29) or the territories (*Health Care Insurance Plan Ac*t, RSY 2002, c 107; *Hospital Insurance and Health and Social Services Administration Act*, RSNWT 1988, c T-3). In Québec, arbitration is required for disputes arising from "an agreement" (i.e., "an agreement with the repre-

in favour of Canada's challenge/appeal score. No legislation bars judicial review of IFHP decisions. Judicial review of NIHBP decisions is theoretically possible if internal review procedures are exhausted.

Ombudspersons provide another example of an administrative entity to whom one can formally challenge health care allocation decisions.[175] The existence of this avenue for challenging and reviewing government decisions contributes to the Canadian health care system's reviewability. Ombudspersons come in two relevant forms: general ombudspersons and health care-specific ombudspersons. First, every province except Prince Edward Island has legislation enabling ombudspersons to hear complaints concerning government action and work to resolve outstanding issues.[176] These general ombudspersons can then make recommendations to different entities about how to resolve the issue. They possess different levels of jurisdiction over health care,[177] but ombudspersons with adequate jurisdiction may provide a limited tool for securing or expanding entitlements. While ombudspersons lack authority to enforce their recommendations, some have high compliance rates with their decisions; the Québec Ombudsman claims 97% of its recommendations are approved.[178] Second, Québec and

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sentative organizations of any class of health professionals"), but this does not explicitly preclude judicial review of decisions that do not involve or fall under an "agreement" (*HIA*, QC, *supra* note 166, ss 1, 19, 54ff).

175 For an example focused primarily on Québec, see Catherine Régis, "The Accountability Challenge in Health Care: The Contribution of a Health Ombudsman" (2014) 4:1 J of Arbitration & Mediation 87.

176 *Ombudsman Act*, RSA 2000, c O-8 [*OA*, AB]; *Ombudsperson Act*, RSBC 1996, c 340 [*OA*, BC]; *Ombudsman Act*, RSM 1987, c O45, CCSM c O45 [*OA*, MB]*; Ombudsman Act*, RSNB 1973, c O-5 [*OA*, NB]; *Citizens' Representative Act*, SNL 2001, c C-14.1 [*CRA*]*; Ombudsman Act*, RSNS 1989, c 327 [*OA*, NS]; *Ombudsman Act*, RSO 1990, c O.6 [*OA*, ON]; *Public Protector Act*, CQLR c P-32 [*Public Protector*]; *The Ombudsman Act*, *2012*, SS 2012, c O-3.2 [*OA*, SK]. Yukon also recognizes an ombudsman: *Ombudsman Act*, RSY 2002, c 163 [*OA*, YT].

177 See e.g. *Public Protector*, *supra* note 176, s 13; *OA*, SK, *supra* note 176, s 14; *OA*, AB, *supra* note 176, ss 12, 12.1, 28(3); *OA*, BC, *supra* note 176*,* Schedule; *OA*, NB, *supra* note 176*,* Schedule A; *OA*, YT, *supra* note 176, ss 18, 20; *CRA*, *supra* note 176, Schedule; *OA*, NS, *supra* note 176, s 1; *OA*, ON, *supra* note 176, s 14; *OA*, MB, *supra* note 176, ss 15, 22.

178 Le Protecteur du Citoyen, "Roles and Mandates" (2016), online: <https://protecteurducitoyen.qc.ca/en/about-us/role-and-mandates>.

Alberta recognize health care-specific ombudspersons who are granted the authority to discharge legislative "patients' bills of rights" (that also exist in jurisdictions without ombudspersons).[179] These bills consolidate existing rights and sometimes grant additional rights. In Québec and Alberta, they can ground complaints about the public health care systems.[180] In Québec, at least, the ombudsperson is then duty-bound to make recommendations to specific governmental entities (e.g., ministries, bureaucratic administrators, and governments themselves) as to how to protect the bill's enumerated rights, though the ombudsperson lacks the authority to provide this protection on his or her own.[181] Some scholars suggest that the presence of "an economical, easily accessible and independent complaints process," which can amount to an ombudsperson, is necessary for the patients' bill of rights

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[179] See *Act Respecting Health Services and Social Services*, CQLR c S-4.2; *Act Respecting the Health and Social Services Ombudsman*, CQLR c P-31.1, s 7 [*Health Ombudsman Act*]; *Alberta Health Act*, SA 2010, c A-19.5, s 2 [*AHA*]; *Health Advocate Regulation*, Alta Reg 49/2014, ss 1, 2, 4 [*HAR*]. The "patients' bill of rights" language is not uniform across jurisdictions. It is nonetheless a useful catch-all for related terms such as "patients' charter," and is accordingly viewed as equivalent in, e.g., Mark Ammann & Tracey Bailey, "Alberta's Patient Charter: Is It a Course Worth Charting?" (2011) 19:2 Health L Rev 17; Colleen M Flood & Kathryn May, "A Patient Charter of Rights: How to Avoid a Toothless Tiger and Achieve System Improvement" (2012) 184:14 CMAJ 1583. For an earlier article addressing these bodies, which uses the "bill of rights" language, see Colleen M Flood & Tracey Epps, "Waiting for Health Care: What Role for a Patients' Bill of Rights?" (2004) 49:3 McGill LJ 515.

[180] *AHA, supra* note 179; *Health Ombudsman Act, supra* note 179, s 7; *HAR*, *supra* note 179, s 4.

[181] *Health Ombudsman Act*, *supra* note 179, ss 7, 20, 24; Flood & May write that patients' bill of rights, which are also recognized in non-Canadian jurisdictions, "do not generally grant formal legal rights. … [T]hey can act as a catalyst through which to resolve individual patient concerns quickly and economically" (*supra* note 179 at 1583). On this reading, new rights established in a patients' bill of rights are mere aspirations. One could alternatively understand them as moral rights that are legally recognized, but are not legally enforceable. This would explain why Nova Scotia passed legislation recognizing aspirational ideals *rather than* a patients' bill of rights: Ammann & Bailey, *supra* note 179 at 20. Governments may alternatively see patients' bills of rights as legally enforceable even if they do not create entities to enforce them, which would create incoherence between rights recognized in, and duties imposed by, the bills. There would be formal legal recognition of the rights, without the corresponding duties.

to have teeth,[182] but health care-specific ombudspersons and patients' bills of rights could exist without one another.[183] Other provinces could soon follow Québec and Alberta by creating new fora for lodging complaints. For instance, while Ontario's past attempts to establish a patients' bill of rights and to create an entity to protect those rights failed,[184] past failure is not necessarily an indicator of future failure.[185] There are signs that similar legislation could be enacted in Ontario in the near future. Long-term care residents in Ontario already possess a codified set of rights established by the provincial *Long-Term Care Homes Act, 2007*.[186] In late 2015, Ontario appointed its first patients' ombudsperson under 2014 amendments to the *Excellent Care for All Act, 2010*.[187] This development potentially presages legislative recognition of patients' rights outside the long-term care setting.[188] The addition of new health care ombudspersons will further increase Canada's health care reviewability, even if their limited powers mean that they cannot ensure actual revisions of government decisions on their own and thus do not perfectly fulfill the reviewability criterion envisioned by Daniels and Sabin.

Constitutional law, human rights law, and the general (non-human rights) administrative law of several provinces, then, allow for challenges

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182 Flood & May, *supra* note 179 at 1583.

183 Indeed, Québec's patients' bill of rights existed before the Health and Social Services Ombudsman was established, and the bill was originally enforced by another entity: Ammann & Bailey, *supra* note 179 at 19. See also *ibid* at 21–23, which accordingly distinguishes questions concerning whether a patients' bill of rights should exist from questions concerning whether an entity should be created to enforce it.

184 *Ibid* at 20 (stating that there have been three attempts by government to create an Ontario patients' bill of rights).

185 An Albertan bill of rights proposal in 1998 failed before the modern bill was recognized in 2010: Bill 201, *Alberta Patients' Bill of Rights*, 2nd Sess, 24th Leg, Alberta, 1998.

186 SO 2007, c 8, s 3.

187 SO 2010, c 14, ss 13.1–13.7, as amended by *Public Sector and MPP Accountability and Transparency Act, 2014,* SO 2014, c 13, Schedule 5.

188 As discussed in notes 181 and 183, recognition of an ombudsperson does not necessarily lead to recognition of a bill; these legal tools can be separated. For instance, BC invokes the language of the "patients' bill of rights" in a regulation, but the text does not grant specific rights or create an entity to protect them: *Patients' Bill of Rights Regulation*, BC Reg 37/2010.

or appeals, or both, of health care allocation decisions. To fulfill the AFR conditions, these mechanisms must allow for the revision of challenged decisions. This is formally available under all of the challenge and review mechanisms listed here. Whether these mechanisms are an effective means of challenging decisions that actually lead to the revision of decisions is a further concern. Daniels and Sabin do not explicitly require substantive revision at any level, but their framework seems to imply that revisions ought to take place. A reviewability criterion without any prospect of effecting change is of little value; without such a criterion, it is difficult to see how AFR can fulfill its promise of ensuring the type of representativeness health care justice demands as captured, for example, by Premise 4 above. There is reason to question the extent to which Canadian mechanisms result in real change. Successful constitutional claims in the health care domain are rare at best.[189] The mechanisms available under general administrative law faces similar concerns. Flood and Zimmerman only identified one "successful substantive administrative law challenge in health rationing" and that case merely secured reimbursement for the provision of a specific health care good.[190] Ombudspersons rely on governments' political will to enforce their

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189 A right to sign language interpretation in a hospital setting was recognized in *Eldridge*, *supra* note 148. Yet there is some debate about whether this constitutes a health care service. As Colleen M Flood notes, access to the service is minimal throughout much of Canada even after *Eldridge*: "Litigating Health Rights in Canada: A White Knight for Equity?" in Flood & Gross, *The Right to Health*, *supra* note 26, 79 at 89–90. Challenges to criminal prohibitions on health care goods or services did meet with some success in *Morgentaler*, *supra* note 148; *Insite*, *supra* note 148; and *Carter*, *supra* note 43. Refraining from criminalizing access to health care services is not the same as guaranteeing the right to have a health care good covered by public health insurance, but most other health rights-based litigation brought before the Supreme Court of Canada has not resulted in a court-mandated entitlement. Lower court decisions have not been any more promising. The Federal Court of Appeal (*Toussaint v Canada (AG)*, 2011 FCA 213 at paras 77–80, [2013] 1 FCR 374, leave to appeal to SCC refused, 34446 (5 April 2012) [*Toussaint*]; *Covarrubias v Canada (Minister of Citizenship and Immigration)*, 2006 FCA 365 at paras 33–37, [2007] 3 FCR 169), the Federal Court (*Refugee Care*, *supra* note 64 at para 571), and the Ontario Court of Appeal (*Flora v Ontario (Health Insurance Plan, General Manager)*, 2008 ONCA 538 at paras 105–08, 295 DLR (4th) 309) have all stated that there is no positive right to have a particular medical service covered under a health insurance regime or to otherwise have the government provide a particular health care service.

190 *Supra* note 4 at 52–53, citing *Stein v Québec (Régie de l'assurance-maladie)*, [1999] RJQ 2416, AZ-99021819 (Azimut) (Sup Ct).

recommendations; they cannot ensure substantive changes on their own. Finally, human rights law presents a mixed bag. As Nola M Ries makes clear,[191] it has successfully been used as a channel to obtain reimbursement for otherwise uninsured goods,[192] to ensure that professionals provide goods on a non-discriminatory basis,[193] and to reduce wait times.[194] However, it is not always a successful avenue.[195] Fully evaluating the potential efficacy of these three legal review mechanisms is beyond the scope of this article. Nevertheless, their existence counts in favour of Canada's legal regulation of health care on the original formulation of the AFR framework.

The IFHP does not appear to have a specific appeal process but, as noted above, it does not attempt to preclude judicial review. One can, for instance, go directly to the FC for judicial review of a denial of coverage and can invoke administrative and constitutional law arguments in one's challenge.[196] All of the aforementioned legal tools should be available to IFHP claimants and most of the same caveats about the effectiveness of these tools apply. IFHP decisions rarely lead to judicial cases.[197] The aforementioned challenge to the proposed 2012 changes, however, suggests that constitutional law can be used to make substantive changes to the IFHP. While the IFHP lacks specific review procedures and general coverage decisions rarely receive judicial review, then, the major instance of judicial review of IFHP policies, *Refugee Care*,[198] suggests that there are other powerful legal tools for challenging decisions made about the program.

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191 "Charter Challenges" in Downie, Caulfield & Flood, *supra* note 5 at 634–35.

192 *Waters*, *supra* note 162.

193 *Korn v Potter* (1996), 134 DLR (4th) 437 (BCSC), 22 BCLR (3d) 163.

194 *Sparkes*, *supra* note 162.

195 See e.g. *Turnbull*, *supra* note 162 (just one of many examples of failed claims for health care coverage under human rights law).

196 This process was famously followed by Nell Toussaint, though she ultimately lost her challenge before the Federal Court and the Federal Court of Appeal: *Toussaint*, *supra* note 189.

197 E.g., a 28 January 2016 Westlaw search for "Interim Federal Health" only unearthed 22 judicial, board, or tribunal decisions, several of which were different level decisions in the same cases.

198 *Supra* note 64.

The NIHBP also does not bar judicial review of its decisions, but the requirement that individual claimants exhaust inter-departmental administrative appeal channels before requesting judicial review may delay access to judicial proceedings. This would be acceptable if the issues raised were resolved without requiring judicial review and thus without the use of limited judicial resources. Yet this internal appeals process may also delay resolution of an issue that does warrant judicial review. As with the IFHP, very few cases make it to judicial review and only a small number of those cases concern individual claimants challenging coverage.[199] This suggests that the substantive reviewability of the NIHBP, namely the ability of appeals and challenges brought by individuals to effect substantive changes in the program, may be limited. Challenges to the implementation of the program, on the other hand, may not require initial inter-departmental appeals. Service providers could, in theory, challenge the implementation of the program before human rights tribunals and requested judicial review of those decisions. Yet a sucessful challenge, such as the aforementioned challenge to the government's proposed changes to the IFHP in *Refugee Care*, is absent in the NIHBP context. The bar on appeals of decisions about excluded goods also undermines the reviewability of the NIHBP by precluding review of the absence of coverage of essential vaccines and other goods.[200]

Ultimately, then, there are review or challenge procedures throughout the Canadian health care system. The value of these procedures for securing actual substantive changes to initial decisions is, however, limited. I examine the relative merits of review versus challenge procedures as mechanisms for expanding health care entitlements in greater detail elsewhere.[201] For now, it suffices to note that constitutional law has been (admittedly rarely) successfully used to make changes in the Medicare and IFHP contexts, human rights law has a mixed history in the Medicare and NIHBP contexts, and general administrative law has a limited history of success. Challenge

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199 A Westlaw search for cases mentioning the "Non-Insured Health Benefits Program" on 28 January 2016 only identified 25. Even a search that did not require exact phrasing (omitted quotation marks) only returned 72 judicial cases and 41 board or tribunal decisions, many of which involved insurance agencies rather than individual claimants. A search for "NIHB" only unearthed seven board or tribunal decisions, and 11 judicial decisions.

200 *DBL 2016*, *supra* note 104 at viii.

201 See the chapter of my forthcoming doctoral dissertation devoted to administrative law: Michael Da Silva, *Realizing the 'Right' to Health Care in Canada* (SJD Thesis, University of Toronto, 2017) ch 7 [unpublished].

and review mechanisms are nominally available, but they may not result in substantive changes.

VII. The Right to Health Care and Progressive Realization: A Further Concern

If one believes that the AFR framework can be a useful mechanism for analyzing the international right to health care, then the AFR conditions can also serve as metrics for determining the extent to which states are meeting the procedural goals of the right to health care. International human rights law does not oblige states to comply with AFR as developed by Daniels and Sabin, but AFR may provide insight as to how to track what those international obligations ought to achieve. I conclude this piece by examining how this could be the case for the "progressive realization" component of the international right to health care.

The international right to health care requires that states progressively realize components of the right to health care.[202] The *Universal Declaration of Human Rights* calls on "every individual and every organ of society" to take "progressive measures, national and international, to secure … universal and effective recognition" of human rights and freedoms.[203] The *International Covenant on Economic, Social and Cultural Rights*, in turn, requires that parties "take steps" towards fulfilling social rights recognized in the *Covenant* "with a view to achieving progressively [their] full realization."[204] This means that states that cannot fulfill all their duties immediately (due, for example, to resource constraints) must fulfill more of their duties over time. Once they take these steps and fulfill these demands, moreover, they cannot cease fulfilling their obligations. International human rights law explicitly states that one cannot be "deliberately retrogressive"

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202 As noted at 113–14, *above*, international human rights law recognizes a broader right to health. An international right to health care can be carved out of that broader right by focusing on provisions related to health care goods and services, rather than the social determinants of health. As a component of the broader right to health, the international right to health care shares many features of the broader right. The "progressive realization" component is just one example.

203 GA Res 217A (III), UNGAOR, 3rd Sess, Supp No 13, UN Doc A/810 (1948), Preamble.

204 *ICESCR*, *supra* note 23, art 2.

in one's realization of the right to health care.[205] When combined with the AFR framework, this progressive realization framework allows for a useful way of analyzing the extent to which states are meeting the procedural components of the right to health care. If one takes the procedural justice and progressive realization components of the international law right to health care seriously, the addition of a procedural safeguard or review/appeal mechanism demanded by the AFR framework contributes to nations' right to health care achievements. The elimination of a safeguard or review/appeal mechanism ought to count against it. This understanding allows for further analysis of the Canadian health care system and the legal regulation thereof.

Procedurally progressive measures in the legal regulation of Canada's health care system can be identified. Alberta's creation of a health care ombudsperson and patients' bill of rights increases reviewability. Ontario's recognition of a health ombudsperson does the same, even in the absence of a patients' bill of rights. The additional online fora for reading Ontario and Québec's health care appeal decisions mentioned above are progressive steps towards transparency that have been taken since Flood and Zimmerman conducted their earlier work on the Canadian health care system's procedural fairness. Still, as the foregoing made clear, the provision of public reasons for original decisions about which health care goods are covered needs to be made mandatory before the progressive realization of accountability for reasonableness measures can be considered to have reached a point where we can properly gauge acceptability. Where the publicity condition is unfulfilled and the acceptability criterion consequently cannot be properly studied, Canada has yet to make sufficient progress in its fulfillment of the AFR conditions to even complete the AFR analysis. Canada is doing better, but further work needs to be done.

The history of deliberate retrogression in the Canadian context also concerns procedural aspects of Medicare. The recent history of Medicare does not offer many instances of substantive deliberate retrogression. Groups of people are not frequently removed from coverage without warrant. Large-scale cutbacks in the list of insured goods are rare. Deliberate retrogression in the provision of procedural protections is more common. For instance,

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[205] *Committee on Economic, Social and Cultural Rights: Report on the Twenty-Second, Twenty-Third and Twenty-Fourth Sessions*, UNCESCR, 22–24th Sess, Annex, Agenda Item 4, UN Doc E/2001/22 (2001) 128 at 139.

the HSARB's jurisdiction was limited in recent years.[206] This minimized its ability to secure procedural justice in health care, and has made it more difficult for people to use the board to secure or expand their health care entitlements. This deliberate retrogression in procedural fairness thus serves as a bar to increased access to goods. The most striking violation of the progressive realization of the procedural aspect of the right to health care, however, is the seeming disappearance of BC's administrative appeal body for health insurance coverage and provision. In their original work on the Canadian health care system's accountability for reasonableness, Flood and Zimmerman identified BC as one of the few provinces that allowed for an appeal of health care insurance decisions.[207] Yet BC's relevant legislation no longer outlines the powers of any appeal body, including the Medical and Health Care Services Appeal Board (MCSAB) highlighted by Flood and Zimmerman.[208] The BC Ministry of Health's online list of "Colleges, Boards and Commissions" highlights the Medical Services Commission, the first instance decision maker, and 11 related boards, but does not list the MCSAB or any other board that fulfills all of its previous functions.[209] The

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206 *Ministry of Health and Long-Term Care Appeal and Review Boards Act*, *1998*, SO 1998, c 18, Schedule H, s 6(1), 6(3). HSARB now accepts a bar on its ability to consider constitutional issues: *EH v Ontario (Health Insurance Plan),* 2011 CanLII 67509 at paras 10–12 (Ont HSARB).

207 Flood & Zimmerman, *supra* note 4 at 34.

208 *Ibid*; *Medicare Protection Act*, RSBC 1996, c 286, ss 41–44, 45.1 [*MPA*]. See also *Hospital Insurance Act*, RSBC 1996, c 204. There is a reference to "each former member of" that board in a list of persons "engaged in the administration" of the *MPA*, but this is one of the only legal recognitions of the board and reference to it is made in the past tense (*ibid*, s 49). Appeals to the province's Supreme Court remain possible.

209 British Columbia has several appeal bodies related to professional regulation and certification for eligibility under particular allocation regimes, but the only body listed by the province that specifically addresses insured benefits is the Medical Services Commission, a first instance decision maker. Per the province:

> The Medical Services Commission (MSC) manages the Medical Services Plan … in accordance with the Medicare Protection Act and Regulations. … The responsibilities of the MSC are two-fold: to ensure that all B.C. residents have reasonable access to medical care and to manage the provision and payment of medical services in an effective and cost-efficient manner ("Medical Services Commission" (2016), online: <www2.

MCSAB no longer maintains a website and it appears to no longer exist. At best, it is no longer publicly promoted. This suggests deliberate retrogression in procedural fairness in a Canadian province. There may be good reasons to disband the Board (or to remove its presence online), but these reasons are at least partially offset by the resulting reduction of accountability for reasonableness. Luckily, the addition of new ombudspersons in Canada should serve as progress in this arena and at least partially offset this diminished reviewability.

IFHP and NIHBP processes, by contrast, are largely stable. There are some signs of minor procedural progress in the NIHBP's transparency. Since 2012, it has published an online newsletter for clients that is "intended to inform them about their coverage … as well as updates and changes to NIHB[P] policy and benefit information."[210] A new price file, which explains how the program applies to incontinence-related goods, also tries

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gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/colleges-boards-and-commissions/medical-services-commission>).

The listed boards are the Hospital Appeal Board, the Community Care and Assisted Living Appeal Board, the Patient Care Quality Review Boards, and the Health Professions Review Board. The website also provides a link to information on the Health Sector Agencies, Boards & Commissions Appointee Remuneration: British Columbia, "Colleges, Boards and Commissions" (2016), online: <www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/colleges-boards-and-commissions>. The Patient Care Quality Review Boards can hear appeals and challenges related to

> (i) the delivery of, or the failure to deliver, health care;
>
> (ii) the quality of health care delivered;
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> (iii) the delivery of, or the failure to deliver, a service relating to health care;
>
> (iv) the quality of any service relating to health care (*Patient Care Quality Review Board Act*, SBC 2008, c 35, s 1).

However, these challenges concern the decisions and actions of regional health authorities, not the Medical Services Commission: *ibid*, s 4(1)(a)(i). The Patient Care Quality Review Board should improve BC's challenge score, but it does not replace the Medical and Health Care Services Review Board function as an *appeal* mechanism.

210 Health Canada, *Non-Insured Health Benefits Program: First Nations and Inuit Health Branch Annual Report 2012/2013* (Ottawa: Health Canada, 2013) at 94.

to make the NIHBP more transparent to health care providers.[211] The procedural components of the NIHBP and the IFHP otherwise remain stable (despite the recent largescale substantive changes to the latter).

Conclusion

The AFR framework provides useful tools for analyzing the extent to which states are ensuring that their health care system and the legal regulation thereof are meeting the procedural requirements of distributive justice. Unfortunately, in three major components of the Canadian health care system, many decisions about which goods individuals are entitled to obtain are made on the basis of reasons that are either shielded from public view or unacceptably vague. Canadian health care thus fails one of the tests for AFR compliance: the public provision of reasons for decisions. This makes it difficult to determine whether Canada meets the second requirement, namely that decisions be made on the basis of publicly accepted or acceptable reasons. Canada's many appeal mechanisms, including mechanisms not identified in earlier research, provide some insight into the reasons decisions are made by forcing governments to make their reasons public. Those mechanisms thus further count in favour of Canada's ability to ensure that the nation's health care system, and the legal regulation thereof, comports with the demands of AFR by increasing its reviewability. The removal of an appeal mechanism from one province suggests a step backwards in meeting the demands of distributive justice in this area, but new ombudspersons help offset this loss in reviewability. These additions, considered along with additional online fora for Medicare appeal mechanisms, raise hope that Canada recognizes a need for greater provision of information in this area and will progressively come to provide the transparency in decision making that AFR demands.

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211 *Ibid* at 93.