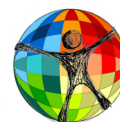


Approaches to Strengthening Access to Healthcare in a Rural British Columbian Context: Harnessing Voice and Lived-Experience

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ABSTRACT

Equitable accessibility and availability of health care services to rural communities is an internationally-acknowledged challenge. Barriers that rural citizens face when attempting to access care are typically physical, geographical and financial in nature. British Columbia is no stranger to this challenge, with rural and remote British Columbian communities often reporting a severe lack of access to local or nearby health care services, both primary and specialized in nature, requiring travel outside of the community to access care. This paper discusses the context and health care realities of rural communities in British Columbia, demonstrating the need for efforts to improve access to care for these areas. The paper then critiques legal strategies that have the potential to be used to strengthen access to care, such as implementing a right to health, interpretation of the Canadian Charter, and international commitments made by Canada regarding health protection. After discussing several of the issues that can arise in attempting to use such legal methods, including the risk of exclusion of community voice, the paper discusses extra-legal methods that allow for better and stronger participation from community members. Of particular importance is the potential for extra-legal methods to yield both public attention and advocacy efforts that have proven successful in causing much needed policy change in Canada's health care sphere. For there to ultimately be sustainable social change that improves the health care reality of British Columbia's rural communities, the Government of British Columbia needs to use a participatory approach informed by the lived-experiences and suggestions of its rural citizens.

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Introduction

Canada has made a commitment to provide healthcare to all of its citizens. As was stipulated in the *Canada Health Act* (CHA), the primary objective of Canadian healthcare policy is “to protect, promote, and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.”¹ In order to protect certain principles in the design and development of health policies and programs, the CHA states specific conditions that provincial and territorial governments are required to meet in their healthcare governance. Amongst these principles is the *accessibility* of healthcare delivery, a notion that is currently primarily understood in financial terms, as it requires that all Canadians have “reasonable access to insured services without charge or paying user fees”.²

Since the principle of accessibility entails access “free of financial or other barriers”,³ much of the focus remains on keeping care affordable by targeting what are mainly financial barriers. However, to Canadians, the idea that access to healthcare is to be based on need, rather than one’s ability to pay, is a defining value of our healthcare system.⁴ Further, the hurdles that Canadians have to overcome to access healthcare are not solely financial in nature. Canada’s rural populations, in particular, often face significant barriers that go beyond finances, including physical, geographical, and otherwise. As such, to ensure all Canadians, including those living in rural communities, are provided with the universal healthcare they are entitled to, the notion of accessibility needs to be understood as being more than

¹ Government of Canada, “Canada Health Act” (27 December 2018), online: <https://www.canada.ca/en/health-canada/services/health-care-system/canada-health-care-system-medicare/canada-health-act.html>.

² *Canada Health Act*, RSC 1985, c C-6, s 10 [CHA]. See also “Fact Sheet, FS-1, The Canada Health Act” (June 2000), online (pdf): *Canadian Nurses Association* <https://www.cna-aiic.ca/~media/cna/page-content/pdf-en/fs01_canada_health_act_june_2000_e.pdf>.

³ CHA, *supra* note 2 at s 12.

⁴ Danielle Martin et al, “Canada’s universal health-care system: achieving its potential” (2018) 391:10131 *Canada’s Global Leadership on Health* 1718 at 1718 [Martin].

simply financial, and efforts must be made to tackle the numerous non-financial barriers faced by rural Canadians.

This paper will discuss the context of rural Canada, focusing specifically on the healthcare realities of rural British Columbian communities. The paper will then explore and critique legal strategies with the potential to be used to strengthen access to care. After discussing the need for, and benefit of, approaches that better incorporate community voice, the paper will examine how extra-legal methods allow for stronger participation from community members, and have the potential to yield public attention and advocacy efforts that have proven successful in causing needed policy change in Canada's healthcare sphere. *This paper argues that ultimately, for there to be sustainable social change that can improve the healthcare reality of British Columbia (BC)'s rural communities, the Government of BC needs to take a participatory approach that is informed by the lived-experiences and suggestions of its rural citizens.*

Part I: The Issue of Access to Healthcare for Rural Canadian Communities

What is "Access"?

With financial barriers being the main focus of ensuring access to healthcare under the *CHA*, access is typically defined almost exclusively in terms of financial accessibility. In fact, the presence of user fees for services is often what is primarily considered as infringing on reasonable access to healthcare when assessing whether or not a province is meeting the accessibility requirement stipulated in the *CHA*, with less attention being given to non-monetary factors. Some authors have concluded that this exclusion implies "that service provision free at the point of delivery is a sufficient condition for "reasonable access" to services."⁵ Further to this point, some politicians and related commentators feel that the implementation of Canadian national health insurance alone has led to "equal access to care" and has

⁵ Stephen Birch & Julia Abelson, "Is reasonable access what we want? Implications of, and challenges to, current Canadian policy on equity in health care" (1993) 23:4 *International Journal of Health Services* 629 at 632 [Birch & Abelson].

been enough to “eliminate the pre-existing inequalities in the provision of healthcare.”⁶

Worryingly, this logic has led a former Minister of Health to claim that all Canadians have equal access to quality healthcare under the Canadian system, and has led federal health policy makers to move on to other issues regarding healthcare.⁷ However, as was eloquently stated by Birch and Abelson, “a system that is equitable in terms of producing equal access to services independent of income or ability to pay might be inequitable in terms of access to services according to need for those services.”⁸

As such, the definition and interpretation of the term “access” has attracted a significant amount of national debate amongst academics, policy makers, and consumers, which has led to conceptualizations that encompass a wide variety of themes.⁹ Access has been described to include availability, accessibility, and acceptability, defined as “a potential to utilise a service if required.” Having access to healthcare has also been explained to require “that there is an adequate supply of health services available.”¹⁰ Access incorporates a variety of important factors, including: geographic proximity to care; utilization of healthcare services; wait times for physician services or specialized care; travel time required to access care and convenience of getting to medical appointments¹¹; the number of physicians or hospital beds per capita¹²; and other markers of availability.

Despite the numerous different ideas circulating as to what comprises access, research on health services frequently employs the definition of access as being “the actual use of personal health services and everything that facilitates or impedes the use of

⁶ Birch & Abelson, *supra* note 5 at 629, 631.

⁷ *Ibid* at 631-632.

⁸ *Ibid* at 636.

⁹ *Ibid* at 631. See also Kathi Wilson & Mark W Rosenberg, “Accessibility and the Canadian health care system: squaring perceptions and realities” (2004) 67 *Health Policy* 137 at 138 [Wilson & Rosenberg].

¹⁰ Martin Gulliford et al, “What does ‘access to health care’ mean?” (2002) 7:3 *J Health Serv Res Policy* 186 at 186 [Gulliford].

¹¹ Wilson & Rosenberg, *supra* note 9.

¹² Gulliford, *supra* note 10 at 186.

personal health services".¹³ This definition is of particular interest for the purposes of this paper, as it allows for the contemplation of unique physical, non-monetary barriers that can impede access to care, such as those that may be at play in a vast country with a dispersed population, such as Canada.

What is the Situation in Canada?

Equitable accessibility and availability of healthcare services for rural areas in a country with low population density and remote communities is a well-known challenge.¹⁴ With Canada in particular being a vast territory with very distributed populations, physical access to healthcare for rural communities is a challenge. While it cannot be dismissed that the implementation of the CHA and its resulting universal health insurance coverage has eliminated many of the financial barriers to accessing "appropriate, high quality healthcare," other barriers remain significant for rural Canadians, including physical and geographical barriers due in part to the size and dispersity of the country,¹⁵ as well as resulting issues regarding maldistribution of the healthcare workforce.

Populations in rural communities across Canada are growing, in part due to more affordable property and housing when compared to urban areas, as well as recently improved broadband access making life more sustainable in these areas.¹⁶ Nearly 20% of the Canadian population now lives in rural communities spread across 95% of the country. While these populations naturally require healthcare services, "the distribution of healthcare providers and resources does not mirror the need."

¹³ Lyn M Sibley & Jonathan P Weiner, "An evaluation of access to health care services along the rural-urban continuum in Canada" (2011) 11:20 BMC Health Services Research 1 at 2 [Sibley & Weiner].

¹⁴ Gillian Lewando Hundt et al, "The provision of accessible, acceptable health care in rural remote areas and the right to health: Bedouin in the North East region of Jordan" (2012) 74 Social Science & Medicine 36 at 42 [Hundt].

¹⁵ Sibley & Weiner, *supra* note 13.

¹⁶ "Rural challenges, national opportunity: Shaping the future of rural Canada" (2018) at 2, online (pdf): *Federation of Canadian Municipalities* <<https://fcm.ca/sites/default/files/documents/resources/report/rural-challenges-national-opportunities.pdf>> [FCM]. See also Department of Finance Canada, News Release, "More Canadians in Rural and Remote Communities to Access High-Speed Broadband Services" (15 March 2019), online: <https://www.fin.gc.ca/n19/19-020-eng.asp> [Department of Finance].

Only about 14% of family doctors, less than 3% of specialists, and similarly low numbers of nurses and other healthcare professionals, currently live in rural communities across Canada.¹⁷ Difficulties recruiting and retaining healthcare professionals in rural areas contributes to the maldistribution of healthcare providers, a known challenge for achieving universal healthcare coverage¹⁸ and an issue that is well-acknowledged by the *World Health Organization (WHO)*.¹⁹ In fact, Sibley and Weiner reported a gradient ranging from urban to increasingly rural, where markers of access to services, such as likeliness to have had a flu shot, use of specialist services, and continuity of primary care, decreased as communities became more rural.²⁰ They cited the maldistribution of physicians across the country as an explanation for why citizens of the most rural communities are likely to not have a regular family physician.²¹

As such, access to healthcare for rural communities is a challenge even in more advanced economic and social societies, like Canada. Despite the universality of healthcare insurance coverage, reduced access to care remains when comparing rural Canadian citizens to their urban counterparts.²² In fact, Canadians living in rural communities often report having to travel far distances to access “anything beyond the most basic forms of healthcare.”²³

A common saying, “If you’ve seen one rural town, you’ve seen one rural town.”²⁴ Rural realities vary greatly across

¹⁷ *Martin, supra* note 4 at 1724.

¹⁸ The Joint Learning Initiative, *Human Resources for Health: Overcoming the crisis* (Washington: Communications Development Incorporated, 2004) at 4 and 34. See also “Working together for health: The World Health Report 2006” (2006), online (pdf): *World Health Organization* <https://www.who.int/whr/2006/whr06_en.pdf?ua=1>. See also Lincoln C Chen, “Striking the right balance: health workforce retention in remote and rural areas” (2012) 88:323 *Bulletin of the World Health Organization* 323 at 323 [Chen].

¹⁹ *Chen, supra* note 18 at 323.

²⁰ *Sibley & Weiner, supra* note 13 at 5. Note that this distribution also decreased as communities became very urban.

²¹ *Ibid* at 7.

²² *Ibid* at 9.

²³ *Ibid*. See also *Martin, supra* note 4 at 1724.

²⁴ National Association of Development Organizations, *Featured Resources, “Vibrant Rural Communities Case Studies Series”* (10 December 2012), online: <https://www.nado.org/vibrant-rural-communities-case-study-series/>.

Canada, with rural communities being diverse in terms of population size, density, degree of remoteness, proximity to urban centres, and so on.²⁵ As a result of this variance, policies tackling rural access to healthcare cannot be developed with a “one-size-fits-all” approach. Therefore, despite rural access to care being an issue across Canada,²⁶ the remainder of this paper will be focused on the case of rural BC communities.

Part II: The Reality of Rural British Columbian Communities

What is Rural British Columbia?

Rural BC is not unlike other Canadian rural areas, with the presence of a strong divide between urban and rural areas.²⁷ Only about 5% of the province’s land is considered urban²⁸ containing approximately 60% of the population, with the remaining 40% being dispersed across the rest of the relatively large province.²⁹ With much variation existing between rural areas in BC, the development of rural communities that are closer to the urban centre of the province has been attributed primarily to “spillover growth” from the metropolitan population, while communities that are more rural can credit their development in large part to growing industries, such as produce, tourism, and others.³⁰

Lack of Local Physical Access to Healthcare

Healthcare provision to rural communities is an internationally-acknowledged challenge.³¹ BC is no stranger to this challenge, with the BC government having identified

²⁵ FCM, *supra* note 16 at 5.

²⁶ Martin, *supra* note 4 at 1726.

²⁷ Greg Halseth, Laura Ryser & Sean Markey, “British Columbia” in Sean Markey et al, eds, *Canadian Rural Revitalization Foundation: State of Rural Canada 2015* (Library and Archive Canada Cataloguing in Publication, 2015) 9 at 9 [Halseth].

²⁸ “Rural Health Services in BC: A Policy Framework to Provide a System of Quality Care” (2015) British Columbia Ministry of Health Cross Sector Policy Discussion Paper at 13 [Policy Framework].

²⁹ Halseth, *supra* note 27 at 9.

³⁰ *Ibid* at 10.

³¹ Hundt, *supra* note 14 at 323.

inadequate access to care as a provincial problem.³² Rural BC communities report a lack of access to local or nearby health care services, both primary and specialized in nature, requiring travel outside of the community to access care. Citizens often fear that the distances needed to be traveled to access care would be too long in the case of an emergency and can include traveling through dangerous road or weather conditions. Other reported difficulties are financial in nature, including the costs associated with needing to travel for care and the required accommodation outside of the community.³³

With rural BC being so diverse, many of the reported difficulties regarding needing to travel for care are specific to the demographics of the community, including high proportions of seniors facing increased difficulties traveling, or wide age ranges requiring the entire range of health care services. Further, the geographical reality of some communities makes traveling for care particularly difficult. Lastly, many difficulties unique to a lack of a specific care type are reported, including the consequences that arise from a lack of consistent, local primary care forcing patients to use emergency rooms for non-urgent issues, or a lack of maternity care causing families to need to leave the community weeks before their anticipated due date in order to give birth.³⁴

Consequences of Inadequate Access to Health Care in Rural Communities

A lack of adequate access to local health care in rural communities comes with many consequences. Geographic location is considered a determinant of health, in that those living in rural and remote communities across Canada typically exhibit poorer health status and reduced life expectancy compared to those living in city centres due in part to the effect geography has on creating disparities in access to health care.³⁵ *Statistics Canada*

³² *Policy Framework*, *supra* note 28 at 12.

³³ "An Investigation of Rural Citizen-Patient Priorities for Health Planning: Findings from the Rural Evidence Review Survey" (2019), online (pdf): Centre for Rural Health Research <<https://med-fom-crhr.sites.olt.ubc.ca/files/2019/09/RER-Survey-Findings-Summary-and-Map-August-2019-Final.pdf>> [RER Report].

³⁴ *Ibid.*

³⁵ Roy J Romanow, "Building on Values: The Future of Health Care in Canada" (2002) at 159, online (pdf): *Commission on the Future of Health Care in*

has reported that fewer Canadians living in rural regions rate their functional or overall health as being “excellent” or “very good”, and that Northern regions within Canada have more unmet health care needs compared to the national average.³⁶ Similarly, studies demonstrate that the health status of Canadians living in rural and remote parts of Canada is worse than those living in urban areas. A 2019 study demonstrated that preventable and treatable mortality rates are greatly affected by the geographic remoteness of a citizen, in that they are substantially higher in more remote areas as compared to in more easily accessible areas.³⁷ Of the many potential contributing factors for this phenomenon, studies report a community’s failure to provide emergency acute interventions in the “golden hour” of trauma,³⁸ increased wait times for care, delays in diagnosis due to difficulty accessing care and resulting effects on outcomes following care, community members avoiding seeking care,³⁹ and many others.

Apart from the direct impact on rural citizens, inadequate rural health care services have significant adverse effects on local economies and on the sustainability of rural communities. Rural community members report that a fear of lacking local health care services, or adequate access to services, would have a negative effect on the strength and vitality of their community.⁴⁰ Whether

Canada

<<https://qspace.library.queensu.ca/bitstream/handle/1974/6882/BuildingOnValues.pdf?sequence=5>>. See also “How Healthy Are Rural Canadians? An Assessment of Their Health Status and Health Determinants” (Sept 2006) at 50, online (pdf):

<https://secure.cihi.ca/free_products/rural_canadians_2006_report_e.pdf>.

³⁶ Verna Mitura & Ray D Bollman, “The Health of Rural Canadians: A Rural-Urban Comparison of Health Indicators” (2003) 4:6 Rural and Small Town Canada Analysis Bulletin 1 at 1.

³⁷ Rajendra Subedi, T Lawson Greenberg, & Shirin Roshanafshar, “Does geography matter in mortality? An analysis of potentially avoidable mortality by remoteness index in Canada” (2019) at 10, online (pdf):

<<https://www150.statcan.gc.ca/n1/en/pub/82-003-x/2019005/article/00001-eng.pdf?st=5Azaajmu>>.

³⁸ “Fact Sheet – Rural Health Care” (2 Nov 2006) at 2, online (pdf):

Newfoundland and Labrador Medical Association, <https://www.nlmn.ca/documents/document_39.pdf> [Fact Sheet – Rural Health Care].

³⁹ “Health Care in Canada 2009: A Decade in Review” (2009) at 64, online (pdf): Canadian Institute for Health Information,

<https://secure.cihi.ca/free_products/HCIC_2009_Web_e.pdf>.

⁴⁰ RER Report, *supra* note 33.

or not one can get reasonable access to healthcare affects peoples' choices as to whether to live in smaller communities. Without proper access to care, many rural Canadians are forced to relocate to urban centres.⁴¹

BC's Attempts to Improve Access to Healthcare for Rural Communities

As has been identified by the Ministry of Health of BC, the fact that much of the province of BC is rural "introduces unique challenges that must be addressed"⁴² as BC attempts to achieve its strategic vision to "systematically and opportunistically improve the health of the population through effective public health and healthy living strategies [...]"⁴³ The unique challenges that arise in attempting to adequately provide healthcare to rural communities in the province stem from multiple factors. First, populations of rural BC communities are said to often be "small, dispersed, and fluctuating [in population]".⁴⁴ Strikingly, much of the province has less than five residents per square kilometre of land. Further, BC has been described as "the most physically and biologically diverse region in Canada",⁴⁵ with its unique geography causing many communities to be particularly isolated, thus facing unique barriers to accessing care.⁴⁶ Lastly, issues regarding the recruitment and retention of healthcare providers in rural Canadian communities are not foreign to BC. The Ministry of Health of BC acknowledges that the challenges regarding appropriate access to healthcare in rural BC communities may be associated with poorer health outcomes and socioeconomic status for rural residents compared to those living in urban communities.

⁴¹ *Fact Sheet – Rural Health Care*, *supra* note 38.

⁴² *Policy Framework*, *supra* note 28 at 12.

⁴³ "B.C. Health System Strategy Implementation: A Collaborative and Focused Approach" (April 2014) at 3, online (pdf): *British Columbia Ministry of Health* <https://www.cchl-ccls.ca/document/1088/BC_Health_System_Strategy_Implementation.pdf>.

⁴⁴ *Policy Framework*, *supra* note 28 at 13.

⁴⁵ "Climate Change Publications: Introduction – British Columbia" (12 November 2015), online: *Natural Resources Canada* <<https://www.nrcan.gc.ca/environment/resources/publications/impacts-adaptation/reports/assessments/2008/ch8/10395>> [*Natural Resources Canada*].

⁴⁶ *Policy Framework*, *supra* note 28 at 13.

As such, strategies are being developed in BC to address this inadequate access.⁴⁷

Due to the uniqueness and diversity of rural communities in BC, strategies that have been taken by the BC Ministry of Health to meet the range of healthcare needs of rural communities have been varied, requiring innovation and creativity in order to meet the needs of the rural population, as well as flexibility and diversity in their implementation across communities. Approaches have ranged from changes to the structure of medical schools to promote rural curricula and the creation of rural medical campuses, to improving telecommunications networks in rural Canada⁴⁸ allowing for the implementation of telehealth models.⁴⁹ Some rural communities have even joined together to develop their own local strategies.⁵⁰ However, regardless of these efforts, rural communities continue to report improving access to healthcare as their main priority for healthcare.⁵¹

As can be seen from the strategies described above, while efforts are being made to improve access to care for rural BC communities, these efforts tend to be most informed by the fields of public health and medicine. Even in a policy framework developed by the BC Ministry of Health in 2015, recommendations touching only on health information management and technology, and the human resources behind the healthcare workforce, were put forward to strengthen current service delivery and capacity.⁵² With inadequate access to healthcare services for rural BC remaining an issue, the remainder of this paper will examine alternative strategies that can be utilized to strengthen local access to healthcare in the rural BC context.

⁴⁷ *Policy Framework*, *supra* note 28 at 13.

⁴⁸ *Department of Finance*, *supra* note 16.

⁴⁹ *Policy Framework*, *supra* note 28 at 38.

⁵⁰ "BC Rural Health Network", online: <<https://bcrhn.ca/>>.

⁵¹ *RER Report*, *supra* note 33.

⁵² *Policy Framework*, *supra* note 28 at 19-38.

Part III: The Use of Legal Approaches to Strengthening Rural Access to Care in Canada

The issue of inadequate access to care is a significant concern that is to be taken seriously by the Government of BC, with several troublesome consequences. With BC having implemented initiatives to tackle this issue that are considered insufficient in the eyes of rural citizens, one must consider the use of alternative approaches to strengthen access to healthcare in the rural BC context. As was stated by the *Office of the High Commissioner for Human Rights*, in order to ensure citizens can fulfill their entitlement to the “enjoyment of the highest attainable standard of health conducive to living a life in dignity”, several complementary approaches are to be taken, including the adoption of legal instruments.⁵³ As such, this section of the current paper will focus on the potential use of legal approaches that can be taken to strengthen access to healthcare in Canada.

Implementing a Right to Health

The *Universal Declaration of Human Rights* recognized the right to health in 1948, stipulating in article 25 that “all human beings have the right to a healthy standard of living, medical treatment and assistance in case of illness.”⁵⁴ The right to health was consequently reaffirmed in several subsequent conventions,⁵⁵ and has been constitutionalized in the majority of the world’s countries’ constitutions, with 69% of states recognizing a right to healthcare.⁵⁶ The *WHO Constitution*, envisioning that “... the highest attainable standard of health [is] a fundamental right of every human being,” serves as a normative framework for the constitutionalized protection of health and access to healthcare in

⁵³ “CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health” (2000) at para 1, online (pdf): *Office of the High Commissioner for Human Rights*, <<https://www.refworld.org/pdfid/4538838d0.pdf>> [General Comment 14].

⁵⁴ *Universal Declaration of Human Rights*, 10 December 1948, UN art 25 [UNDHR].

⁵⁵ *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 2200A GA XXI art 12 (entered into force 3 January 1976) [ICESCR]. See also *Convention on the Rights of the Child*, 20 November 1989, 44 GA 25 (entered into force 2 September 1990).

⁵⁶ Courtney Jung, Ran Hirschl & Evan Rosevear, “Economic and Social Rights in National Constitutions” (2014) 62 Am J Comp L 1034 at 1054.

many countries, outlining a governmental responsibility to provide adequate health services to their population in order to achieve proper health.⁵⁷ Further, the right to health is acknowledged to be a fundamental aspect of our understanding of “a life in dignity” and of our internationally agreed human rights, such as rights to food, housing, work, education, and life, and is considered “inseparable or ‘indivisible’ from these other rights” in that it is indispensable for their exercise.⁵⁸ In fact, demonstrating their interrelatedness, these other rights are often considered to be underlying determinants of health.⁵⁹

Variations on the health rights constitutionalized across the world include rights to public health, health or medical care services, and overall health.⁶⁰ Important to acknowledge is the fact that while both the terms “right to health” and “right to healthcare” are included in different constitutions, the latter tends to be an aspect of the right to health, referring specifically to “curative, diagnostic, and preventative goods and services provided by medical, dental, allied health, and psychological professionals”.⁶¹ The WHO and the Office of the United Nations High Commissioner for Human Rights, aiming to consolidate the vast amount of initiatives and proposals as to what the right to health may or should mean, agreed that the right to health contains entitlements that include aspects of the right to healthcare, such as access to essential medicines, maternal, child, and reproductive health, equal and timely access to basic health services, amongst others.⁶² However, it has been suggested that the lack of consistency across nations regarding the protection of a right to health versus to healthcare, amongst other inconsistencies in the drafting of these rights, can result in vastly

⁵⁷ *Constitution of the World Health Organization*, 19-22 July 1946, WHO (entered into force 7 April 1948) [WHO Constitution].

⁵⁸ “The Right to Health: Fact Sheet No. 31” (June 2008), online (pdf): Officer of the United Nations High Commissioner for Human Rights, <<https://www.ohchr.org/Documents/Publications/Factsheet31.pdf>> [Right to Health Fact Sheet]. See also General Comment 14, *supra* note 53 at para 1-3.

⁵⁹ *Right to Health Fact Sheet*, *supra* note 58.

⁶⁰ Jody Heymann et al, “Constitutional rights to health, public health and medical care: The status of health protections in 191 countries” (2013) 8:6 *Global Public Health* 639 at 640.

⁶¹ Michael Da Silva, “The International Right to Health Care: A Legal and Moral Defence” (2018) 39:3 *Michigan Journal of International Law* 343 at 343.

⁶² *Right to Health Fact Sheet*, *supra* note 58 at 3-4.

different priorities for health planning and delivery at both community and national levels, consequently complicating enforcement.⁶³

With constitutional protection also varying in terms of specificity and focus in countries who have constitutionalized health rights, constitutionalizing a right to health has been found to come with little agreement as to what courts can do when governments are not acting in accordance with these rights.⁶⁴ As an example, a study was conducted comparing the legal impact of entrenching the right to health as a justiciable guarantee in two nations, Colombia and South Africa. In Colombia, the provision protecting a right to health was converted by the courts into a subjective, justiciable right, allowing any individual to bring an action forward for this fundamental right.⁶⁵ Resulting were high levels of adjudication, private litigation, and legal enforcement,⁶⁶ echoing with the concerns of skeptics of a right to health who argue that the entrenchment of health rights will lead not only to an expansion of judicial power, but also invitation for “incommensurable [...] claims”.⁶⁷ However, the researchers concluded that the legal impact of the right to health, not considering the health outcomes on the given populations, has taken a very different path in South Africa compared to Colombia. In the former, the right to health was framed in a way that supported provisional justiciability only allowing for judicial intervention in very specific health scenarios, ultimately leading to minimal litigation and persistence of health negotiations outside of courts.⁶⁸ The stark contrast between the consequences faced by these two countries demonstrates the care needed to be taken

⁶³ U Baxi, “The place of the human right to health and contemporary approaches to global justice: some impertinent interrogations” (2010) *Global Health and Human Rights: Legal and Philosophical Perspectives* at 12e27. See also Paul Farmer, “Challenging Orthodoxies: The Road Ahead for Health and Human Rights” (2008) 10:1 *Health and Human Rights* 5 at 5.

⁶⁴ Alana Klein, “Judging as Nudging: New Governance Approaches for the Enforcement of Constitutional Social and Economic Rights” (2008) 39:351 *Columbia Human Rights Law Review* 351 at 353 [Klein].

⁶⁵ Katharine G Young & Julieta Lemaitre, “The Comparative Fortunes of the Right to Health: Two Tales of Justiciability in Colombia and South Africa” (2013) 26 *Harvard Human Rights Journal* 179 at 180 [Young & Lemaitre].

⁶⁶ *Ibid* at 186-187.

⁶⁷ *Ibid* at 180.

⁶⁸ *Ibid* at 180, 210, and 216.

when a nation attempts to draft constitutional protections of health rights.

Beyond issues regarding drafting of health rights is the fact that studies have found that a nation's commitment to health is not necessarily related to whether a constitutionalized right to health exists.⁶⁹ Contrary to what one may think, not having constitutionalized this right does not leave citizens without health rights enforcement, as other avenues exist. For example, while it may be surprising to many that Canada has not explicitly constitutionalized health rights, the *CHA* has been said to be a statutory or regulatory attempt to give meaning to a right to health, by defining in law the type and extent of treatment that any health service should provide. Once the content of economic, social, or cultural (ESC) rights have been defined in statute, as is the case in Canada through the *CHA*, it is said that the perception that they do not offer a basis for judicial adjudication due to their not being constitutionalized becomes weaker. As such, regardless of not having a right to health in the Canadian constitution, judges will, in many cases, still decide whether the acts or omissions of the authorities in the case at hand break the statutory duties in place.⁷⁰

Interpretation of the Canadian Charter of Rights and Freedoms

Where, in some jurisdictions, effective adjudication of ESC rights is limited or non-existent, the indirect protection of ESC rights has been made possible through the judicial application of duties deriving from civil and political rights, where those duties are closely interrelated with ESC rights obligations.⁷¹ As such, duties arising out of ESC rights can be justiciable, even if procedural limitations require violations to be translated in terms of civil and political rights. The protection of the right to health can be seen as a direct example of this in many nations, where judicial protection is often achieved in different legal systems through the

⁶⁹ Eleanor D Kinney & Brian Alexander Clark, "Provisions for Health and Health Care in the Constitutions of the Countries of the World" (2004) 37:2 Cornell International Law Journal 285 at 287.

⁷⁰ "Courts and the Legal Enforcement of Economic, Social and Cultural Rights" (2008) at 17, online (pdf): *International Commission of Jurists*, <<https://www.refworld.org/pdfid/4a7840562.pdf>> [*International Commission of Jurists*].

⁷¹ *Ibid* at 65.

right to life and the right to be free from torture or cruel and unusual treatment, amongst other civil and political rights.⁷²

Given that Canada does not have a constitutionalized right to health, the *Canadian Charter of Rights and Freedoms* (the *Charter*), despite being said to be primarily concerned with the protection of political and civil rights, contains provisions that have been interpreted to provide avenues for the protection of ESC rights.⁷³ Of particular interest, although not the only avenue, section 7 of the *Charter*, regarding the right to life, liberty, and security of the person,⁷⁴ has been interpreted in cases that can be seen as being health-protective.⁷⁵

However, skeptics to this approach highlight a limitation that exists as a result of the fact that not all aspects of ESC rights can be framed in terms of civil and political rights.⁷⁶ Further, more recent Canadian decisions involving interpretation of *Charter* provisions have been said to be at variance with the protection of socio-economic rights.⁷⁷ For the most part, failure to provide a socio-economic good, such as healthcare, is not currently explicitly acknowledged as being an infringement or violation of the right to life, liberty, or security of the person, as per section 7. While it has been suggested that earlier *Supreme Court of Canada* (SCC) decisions can be seen as attempting to keep the possibility open for section 7 to be interpreted as protecting certain positive rights,⁷⁸ in more recent cases involving contemplation of section 7 in the context of a right to healthcare, the SCC has stipulated that the *Charter* “does not confer a

⁷² *International Commission of Jurists*, *supra* note 70 at 66.

⁷³ Martha Jackman, “From National Standards to Justiciable Rights: Enforcing International Social and Economic Guarantees Through Charter of Rights Review” (1999) 14 *Journal of Law and Social Policy* 69 at 79.

⁷⁴ *Canadian Charter of Rights and Freedoms*, s 7, Part I of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

⁷⁵ Canada, Senate Canada, *The Health of Canadians – the Federal Role*, vol 6 (The Standing Senate Committee on Social Affairs, Science and Technology, 2002) at Ch. 5 – Timely Access to Health Care. See also *R v Morgentaler*, [1988] 1 SCR 30 [Morgentaler]. See also *Canada (Attorney General) v PHS Community Services Society*, [2011] 3 SCR 134 [PHS].

⁷⁶ *International Commission of Jurists*, *supra* note 70 at 17.

⁷⁷ Paul O’Connell, “The Death of Socio-Economic Rights” (2011) 74:4 *The Modern Law Review* 532 at 544 [O’Connell].

⁷⁸ *Ibid.*

freestanding constitutional right to healthcare.”⁷⁹ Further, the Court has said “one day s. 7 may be interpreted to include positive obligations,” inferring that the corresponding duties do not currently involve more than non-interference.

It can be argued it may be time that Canada begins expanding their interpretation of these rights to include positive obligations regarding healthcare provision. However, for the time being, providing hope for those wishing to see section 7 as a mechanism for protecting the health of the public is the fact that the SCC has nonetheless tended to use this section in their reasoning in cases ending in health-protective holdings, despite not inferring any ensuing positive obligations. For example, in *R v. Morgantaler*, the Court used section 7 to decriminalize access to or provision of a healthcare good, being abortion services. The SCC held that the mandatory certification procedure created by section 251 of the *Criminal Code of Canada*,⁸⁰ requiring all physicians performing abortions to first obtain a specific type of certificate, created such severe delays to receiving an abortion that women were put at risk of physical and psychological harm, constituting an “infringement on the purely physical aspect of the individual’s right to security of the person.”⁸¹ Similarly, in *Canada (Attorney General) v. PHS Community Services Society*, the SCC held that laws prohibiting possession of controlled substances, and subsequent failure on the part of the Minister of Health to provide a legislated exemption to these laws for a government-sanctioned safe injection facility, violated and limited section 7 rights, in that these acts prevent injection drug users from accessing the health services offered by the safe injection site, “threatening their health and indeed their lives.”⁸²

While it has to be understood that the court in *Morgantaler* did not declare a constitutional right to abortion or freedom of choice, nor in *PHS* did they create a positive right for injection drug users to have access to care in safe injection sites, these cases should be seen as a willingness of Canadian courts to use the

⁷⁹ *Chaoulli v Québec*, [2005] 1 SCR 791, 2005 SCC 35 at para 104.

⁸⁰ *Criminal Code*, RSC 1985, c C-46, s 251.

⁸¹ *Morgantaler*, *supra* note 75 at 31.

⁸² *PHS*, *supra* note 75 at 139.

Charter in a health-protective manner, by preventing infringements on the health of the Canadian public.

International Commitments Made by Canada Regarding Health Protection

International human rights law clearly recognizes a right to health, in that “every country in the world has accepted that human rights are universal and is bound by at least one treaty containing a provision on the right to health”.⁸³ Canada has bound itself to realize the international right to health through the ratification of several international instruments.⁸⁴ Amongst other agreements, Canada is one of the many signatories of the *Constitution of the WHO*,⁸⁵ and the 1948 *Universal Declaration of Human Rights*,⁸⁶ both of which contain provisions recognizing the right to health as a human right of all individuals. Importantly, Canada has also signed and ratified the 1966 *International Covenant on Economic, Social and Cultural Rights (ICESCR)*. Famously, article 12.1 of the *ICESCR* describes that states party to the covenant recognize “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,” followed by article 12.2 which enumerates a number of steps that are to be taken “to achieve the full realization of this right.”⁸⁷

A nation’s commitment to health-protecting international treaties, such as the *ICESCR*, has been used internationally by courts to reaffirm the constitutional status of the right to health, as well as by researchers to explore the extent to which the right to health set out in these treaties can serve as a framework to assess current levels of provision of healthcare services. In *Etcheverry, Roberto Eduardo v. Omint Sociedad Anónima y Servicios*, the *Corte Suprema de Justicia de la Nación Argentina* stressed that duties to protect the right to health arise from international human

⁸³ Stephen Marks, “The emergence and scope of the human right to health” (2013) at 23, online (pdf): *Harvard Library* <<https://dash.harvard.edu/bitstream/handle/1/29429086/Ch%201-%20%20Marks-%20Emergence%20and%20Scope%20of%20the%20RTH-Final%20rev.pdf?sequence=1&isAllowed=y>>.

⁸⁴ *ICESCR*, *supra* note 55.

⁸⁵ *WHO Constitution*, *supra* note 57.

⁸⁶ *UNDHR*, *supra* note 54 at art 25.

⁸⁷ *ICESCR*, *supra* note 55.

rights treaties, creating “a social pledge” to citizens.⁸⁸ Similarly, article 12 of the *ICESCR* has been used as a framework for assessing the current availability, accessibility, and acceptability of healthcare provision to rural communities in other countries.⁸⁹

In *General Comment 14*, when the *United Nations* elaborated and interpreted article 12 of the *ICESCR*, comments of interest to rural communities were made. Paragraphs 14 and 18 specifically address the right to healthcare services that are available and accessible, with express mention of rural settings. Further, physical accessibility was defined in this document as “within safe physical reach for all sections of the population”⁹⁰, applying to communities that are likely to be more distant from care. However, worryingly, in a Government of Canada report, when the Government of BC was asked to speak to the key measures they have adopted to implement article 12 of the *ICESCR* from 2005-2009, no mention was made of any steps taken to ensure the physical accessibility defined in the Covenant for the province’s rural communities.⁹¹ Similarly, in review processes such as the *Universal Periodic Review*, where States are asked to declare the actions they take to improve human rights issues in their countries and to fulfill their human rights obligations, Canada has not spoken to any human rights issues regarding access to healthcare for its rural communities.⁹² Not surprisingly, rural BC residents continue to face difficulties accessing medical care. As such, despite Canada having adopted these international agreements, the evidence shows that their incorporation into healthcare provision practices in rural Canada seems to be limited, demonstrating the potential weakness of these types of commitments.

⁸⁸ *Etcheverry, Roberto Eduardo v. Omint Sociedad Anónima y Servicios*, [2001] Corte Suprema de Justicia de la Nación Argentina (Argentina).

⁸⁹ *Hundt*, *supra* note 14 at 323 at 37.

⁹⁰ *General Comment 14*, *supra* note 53 at para 12.

⁹¹ Canada, *International Covenant on Economic, Social and Cultural Rights: Sixth Report of Canada* (Minister of Public Works and Government Services of Canada, 2013) at 28-32 [*Canada ICESCR Report*].

⁹² “Universal Periodic Review” (2019), online: *United Nations Human Rights Council* <<https://www.ohchr.org/EN/HRBodies/UPR/Pages/UPRMain.aspx>>.

Why Not Use Legal Approaches for Rural Canada?

Apart from the issues specific to each of the legal approaches discussed in the previous sections, Canadians attempting to use legal avenues to strengthen access to healthcare services for rural communities are likely to face other barriers and fundamental issues. First, in contemplating permitting legal claims to be made in this context, one must think of the role Canadian society is prepared to allow the judiciary to play in our nation. In a country like Canada with such a stark view on separation of powers, constitutionalizing ESC rights and consequentially making courts the venue to enforce these rights could “take courts too far outside their legitimate role in a constitutional democracy”.⁹³ Further, socio-legal scholars have argued that approaching access to healthcare through legal frameworks and rights-based approached turns “health [into] a matter of justice”, and “enables the relabelling of ‘problems’ as ‘violations’”.⁹⁴

More practically, suggesting rural communities litigate in order to have the protection of their health enforced raises issues concerning access to justice, including the high cost and reported increasing length of litigation in Canada,⁹⁵ as well as barriers due to literacy and language, physical and mental disabilities, racial discrimination, education levels, and a lack of information on the legal system.⁹⁶ A study was conducted in Norway examining the conditions under which litigation is likely to be most effective in creating social change. With the voicing of rights claims being identified as a crucial first step for citizens seeking redress through a legal system, the study unveiled that marginalized litigants are likely to face numerous barriers in expressing their voice beyond the practical or resource barriers listed above, such as distrust and fear towards the legal system, a feeling of cultural distance, and

⁹³ Klein, *supra* note 64 at 358.

⁹⁴ AE Yamin, “Will we take suffering seriously? Reflections on what applying a human rights framework to health means and why should we care” (2008) 10:1 Health Hum Rights at 46 and 48.

⁹⁵ “2018 National Litigation Report” (2018) at 5, online (pdf): Grant Thornton, <<https://www.granthornton.ca/globalassets/1.-member-firms/canada/insights/pdfs/2018-litigation-report.pdf>>.

⁹⁶ Amanda Dodge, “Access to Justice Metrics Informed by the Voices of Marginalized Community Members: Themes, Definitions and Recommendations Arising from Community Consultations” (2013) at 2-3, online (pdf): Canadian Bar Association’s Access to Justice Committee, <http://www.cba.org/CBA/cle/PDF/JUST13_Paper_Dodge.pdf> [Dodge].

past experiences in the legal system. Specifically, the author explained that there are numerous barriers that need to be overcome for social rights claims to emerge from marginalized groups and then be translated into language that is appropriate for litigation:

“First, [marginalized groups] need to have an understanding of the situation they experience as violating their rights and be aware that legal remedies may exist; they must also be able to identify their grievance in a way that is sufficiently explicit to provide the basis for litigation, as well as identify who to blame – who bears moral and legal responsibility for the situation that constitutes the rights violation. And they must be able to mobilise the legal resources to transform their grievances into legal claims that the system will accept.”⁹⁷

Further, a report was produced from interviews conducted with marginalized Canadians attempting to access justice through the use of the Canadian legal system, where many respondents made comments along the lines of “Unless you have [a lot] of money, you cannot access justice.”⁹⁸ The results included in this report conveyed a strong belief on the part of citizens that their human rights are being eroded due to a lack of access to justice. As a result of barriers impeding their access to justice, the vast majority of the community members in the report acknowledged that they were afforded rights and protections by the law, but felt that these rights and protections were neither accessible nor honoured, and that accountability was unenforceable upon those responsible for the rights violations.⁹⁹

In addition to the above critique of legal approaches for social change that is centred around access to justice issues, an investigation of litigation as a strategy for advancing social rights for marginalized groups reported a skepticism amongst academics regarding the effectiveness of courts in creating social

⁹⁷ Siri Gloppen, “Public Interest Litigation, Social Rights and Social Policy” (Paper delivered at the World Bank Conference, New Frontiers of Social Policy: Development in a Globalizing World, 12-15 December 2005) [unpublished] at 8 [Gloppen].

⁹⁸ Dodge, *supra* note 96 at 1-2.

⁹⁹ *Ibid* at 2-4.

change, even in countries the author described as having “reasonably strong and well-functioning legal systems”.¹⁰⁰ The author highlighted the important difference that should be considered between litigation success and social success, with litigation success being defined as a narrow success in the sense of winning cases, whereas social success is defined as the broader success of changing social policy.¹⁰¹ Further, she explained how the most effective social rights litigation in terms of winning cases is not always the most effective in actually shaping social policy, and that beneficial impact on policy is dependent on social movements and organizations that engage in broader strategies of social and political mobilization.¹⁰² This thought echoes with the argument that law should be used as part of a “larger organizing campaign”, where the goal is to advance organizing efforts in creating social change, rather than winning a lawsuit.¹⁰³

Lastly, and perhaps most importantly, is the risk of excluding community voice when relying too heavily on legal methods to address social change. As was previously discussed, rural living is a particularly unique reality, distinct not only from living in urban centres, but also distinct between communities. With BC being described as “the most physically and biologically diverse region in Canada”¹⁰⁴, barriers faced by communities are bound to be equally diverse. Shin Imai argues that an important part of “lawyering for social justice” is working directly with the communities themselves, as he cautions against believing one’s self to be an expert on the injustice faced by a community before even consulting with the community.¹⁰⁵ Using legal methods to achieve social change within communities risks allowing for too large a role for legal professionals,¹⁰⁶ which can lead to reducing participation of community members, and as a result, exclusion of community voice.

¹⁰⁰ *Gloppen*, *supra* note 97 at 2.

¹⁰¹ *Ibid* at 3.

¹⁰² *Ibid* at 1 and 33.

¹⁰³ Orly Lobel, “The Paradox of Extralegal Activism: Critical Legal Consciousness and Transformative Politics” (2007) 120:4 *Harvard Law Review* 937 at 960 [Lobel].

¹⁰⁴ *Natural Resources Canada*, *supra* note 45.

¹⁰⁵ Shin Imai, “A Counter-Pedagogy for Social Justice: Core Skills for Community-Based Lawyering” (2002) 9.1 *Clinical Law Review* 195 at 195 and 201.

¹⁰⁶ *Lobel*, *supra* note 103 at 961.

As such, with the issues and barriers that Canadian communities could face in attempting to use legal approaches to improve their access to care, and with the likely ensuing exclusion of their participation and voice, it is perhaps time to accept that the use of the law in solving this social injustice is not the approach to take for rural Canada.

Part IV: Extra-Legal Methods and the Inclusion of Community Voice

Why is the Inclusion of Community Voice Important?

In a province with strong and flourishing rural communities, healthcare policy development nonetheless tends to be envisioned only within the boundaries of urban Vancouver and Victoria. This urban-focused approach has resulted in “a significant reduction in the eyes and ears that the provincial government has on the ground across [rural] BC”.¹⁰⁷ However, considered most successful in addressing human rights issues are collective efforts, which include close connections with communities, groups, and individuals faced with the social injustice at hand.¹⁰⁸ Authors have suggested that “we need to listen [to] and understand what people in [communities] have to say about opportunities and challenges [they face]”, and that this can be done through implementing more “place-based”-informed approaches to policy development.¹⁰⁹

Further supporting the need for greater efforts towards including communities is the fact that Canada has an obligation to work with communities to ensure their participation in healthcare planning, and has taken steps towards ensuring this duty is documented nationally. In *UN General Comment 14*, elaborating on article 12 of the *ICESCR*, it is stipulated that “promoting health must involve effective community action in setting priorities, making decisions, planning, implementing, and evaluating strategies to achieve better health”.¹¹⁰ Similarly, the *WHO* and

¹⁰⁷ Halseth, *supra* note 27 at 9.

¹⁰⁸ Barbora Bukovská, “Perpetrating Good: Unintended Consequences of International Human Rights Advocacy” (2008) 5:9 *International Journal on Human Rights* 7 at 8.

¹⁰⁹ Halseth, *supra* note 27 at 13.

¹¹⁰ *General Comment 14*, *supra* note 53 at para 54.

the Office of the United Nations High Commission for Human Rights, in elaborating on the right to health, have stipulated that the international right to health, which Canada is a signatory to, includes participation of the population in decision-making as it relates to health at both the community and national level.¹¹¹ The WHO further explains that in order to display good governance in the process of public health law reform, countries should integrate the principle of “participation” into their reform processes.¹¹² These duties are also reflected within Canada, where guidelines on public engagement in *Health Canada* and the *Public Health Agency of Canada* highlight the importance the Canadian government sees in providing opportunities for citizens to participate in decision-making processes.¹¹³ In assessing their commitment to the ICESCR, the Government of BC reported their recognition of the fundamental importance of community solutions and approaches when working to change the health status of First Nations people in the province,¹¹⁴ demonstrating an awareness of the necessity for community participation. However, the province sadly has not yet done so in the rural BC context.

Extra-Legal Methods Better Incorporate Community Voice, and Lead to Positive Change

Given the importance of incorporating the voice of patient-citizens from rural communities, methods that better allow for this inclusion need to be considered. In fact, many extra-legal methods show an understanding of the great value of community participation. Orly Lobel speaks of the dangers of reliance on specialized legal knowledge, and how moving away from the role of “lawyer” and more to an extra-legal role of “organizer” can minimize this reliance.¹¹⁵ Lobel further suggests the “Law and Organizing” approach in creating social change, which rejects

¹¹¹ *Right to Health Fact Sheet*, *supra* note 58 at 4.

¹¹² Roger Magnusson, “Advancing the right to health: the vital role of law” (16 January 2017) at 73, online (pdf): World Health Organization, <<https://www.who.int/healthsystems/topics/health-law/chapter5.pdf>>.

¹¹³ “Guidelines on Public Engagement 2019” (November 2019) at 1, online (pdf): Health Canada and the Public Health Agency of Canada, <<https://www.canada.ca/content/dam/hc-sc/healthy-canadians/migration/publications/health-system-systeme-sante/guidelines-public-engagement-publique-lignes-directrice/alt/HCPHAC%20Guidelines%20on%20Public%20Engagement%202019.pdf>>.

¹¹⁴ *Canada ICESCR Report*, *supra* note 91 at 41.

¹¹⁵ Lobel, *supra* note 103 at 961.

the use of law in exchange for lawyers working with community members to seek local, non-legal solutions to social injustices being faced by marginalized groups.¹¹⁶

Extra-legal methods that have shown recent success in Canada include those that highlight personal stories from patient-citizens in order to raise public awareness and harness advocacy efforts. Quebec has demonstrated a positive example of how public attention brought to a health-related public issue applied sufficient pressure on authorities to create a much-needed policy. A no-escort practice that was in place in Quebec for decades did not permit extra passengers, beyond the patient themselves, to board the emergency plane during medical evacuations from northern Quebec communities into larger cities, such as Montreal and Quebec City. Outraged, pediatricians from Quebec called for a change in this practice, doing so by illustrating personal experiences from affected families and patients, as well as from healthcare providers describing the severely negative effects of forcing child patients to travel alone.¹¹⁷

"A young girl wakes up in the Montreal Children's Hospital, fearful and alone. She tries to escape and return home."

"A toddler, flown to the hospital without his parents from northern Quebec, falls from a bassinet in the emergency room."¹¹⁸

These are amongst the stories these advocating physicians highlighted, in order to bring the public's attention to this harmful on-going medical practice.¹¹⁹ The positive outcome of these efforts, occurring entirely independently of legal efforts, was the Minister of Health of Quebec succumbing to the public pressure that ensued, creating a new policy barring the no-escort practice and allowing sick children who need to be airlifted from northern

¹¹⁶ *Lobel*, *supra* note 103 at 959.

¹¹⁷ Benjamin Shingler, "Quebec policy leaves Indigenous children anxious and alone on medical flights, doctors say", *CBC News* (24 Jan 2018), online: <<https://www.cbc.ca/news/canada/montreal/quebec-emergency-care-flight-inuk-1.4501194>>.

¹¹⁸ *Ibid.*

¹¹⁹ *Ibid.*

Quebec for emergency medical treatment to be accompanied by either a parent or a guardian.¹²⁰

It is not to say that legal methods that can incorporate community voice do not exist. However, of the results of these legal methods, those that are most quickly and directly beneficial to the communities themselves can often be attributed to the public attention, advocacy, and social pressure resulting from the use of the legal method, rather than any legal ramification itself. For example, a positive outcome of using the right to health is said to be the power it adds to campaigning and advocating for social change, and the fact that it can push important health issues higher up in international and national agendas.¹²¹ Similarly, the case study below demonstrates how the earliest-produced positive outcome of a human rights inquiry into the state of healthcare services was the public attention brought to the issue at hand.

Case Study: Human Rights Inquiry on Emergency Healthcare

A human rights inquiry on the state of emergency healthcare in Northern Ireland was run by the *Northern Ireland Human Rights Commission*, to investigate the extent to which the Northern Ireland government and public authorities “respect, protect, and fulfill” the human rights of citizens seeking emergency care. Despite the human rights inquiry being legal in nature, with assessments drawn to Northern Ireland’s adherence with the *ICESCR* and other applicable health-related statutes and case law, the inquiry included a strong focus on public participation. Evidence was taken from interviews conducted with ministers, health and public health departments and organizations, healthcare providers, and most importantly, those on the receiving end of the healthcare service at hand, being patients and their families.¹²² However,

¹²⁰ Charlie Fidelman, “Quebec ends ‘cruel’ air ambulance policy of separating kids from parents”, *Montreal Gazette* (5 July 2018), online: <<https://montrealgazette.com/news/quebec-ends-cruel-air-ambulance-policy-of-separating-kids-from-parents>>.

¹²¹ Gunilla Backmann, et al, “Health systems and the right to health: an assessment of 194 countries” (2008) 372 *Lancet* 2047 at 2048.

¹²² “Human Rights Inquiry: Emergency Health Care” (2015), online (pdf): *Northern Ireland Human Rights Commission*, <https://www.nihrc.org/uploads/publications/NIHRC_Emergency_Healthcare_Report.pdf> [Northern Ireland Inquiry].

not only is this method uncommon in being the first human rights inquiry in the world to be undertaken on healthcare in emergency departments, it also required a tremendous amount of effort and resources, spanning a relatively long period of time and requiring the participation of many professionals and involved authorities, as well as large time commitments from those wishing to vindicate their rights.¹²³

Of particular benefit was the fact that this inquiry drew the public's attention to this pressing human rights issue.¹²⁴ While no evidence of systemic violations of human rights were found, the results of the inquiry were said to demonstrate inhumane and degrading cases of inadequate access to and treatment within emergency care facilities, and were consequently shared among numerous news outlets.¹²⁵

The public attention drawn to the issues in the state of emergency care in Northern Ireland is arguably the most beneficial result of this inquiry to date. However, importantly, it is one that can be directly achieved without large human rights inquiries and the issues that come with using legal methods, but rather through the use of extra-legal methods that highlight community voice by sharing patient-citizens' stories and personal experiences.

Conclusion

To return to the saying, "If you've seen one rural town, you've seen one rural town",¹²⁶ there are many rural realities that

¹²³ "Human Rights Inquiry: Emergency Healthcare", online: Northern Ireland Human Rights Commission <<https://www.nihrc.org/Publication/detail/human-rights-inquiry-emergency-healthcare>>.

¹²⁴ Northern Ireland Inquiry, *supra* note 122.

¹²⁵ "Human rights concern over A&E care", *Belfast Telegraph* (27 May 2015), online: <<https://www.belfasttelegraph.co.uk/news/northern-ireland/human-rights-concern-over-ae-care-31256970.html>>. See also Marie-Louise Connolly, "NI emergency health care inquiry finds 'degrading' cases", *BBC News* (27 May 2015), online: <<https://www.bbc.com/news/uk-northern-ireland-32888240>>.

¹²⁶ Brett Schwartz, "Vibrant Rural Community Case Studies Series" (10 December 2012), online: *National Association of Development Organizations* <<https://www.nado.org/vibrant-rural-communities-case-study-series/>>.

constitute non-metropolitan BC,¹²⁷ with each community facing unique barriers that impede their access to care. As was suggested by Gulliford, “the availability of services, and barriers to access, have to be considered in the context of the differing perspectives, health needs and material and cultural settings” of the diverse communities at hand.¹²⁸ To best grasp these distinct rural perspectives that will better inform policy, approaches need to involve meaningful inclusion and participation of rural communities to allow for the incorporation of their voice, needs, and priorities.

If given the opportunity to be involved in discussions on how to strengthen the state of their access to care, rural BC community members have much to share, including both methods to minimize the effects of needing to travel for care, as well as methods to increase local capacity. Examples of specific recommendations from rural communities have included creating walk-in clinics or community health centres to reduce reliance on emergency services, increasing spots in rural medical schools and prioritizing training local rural students, and periodic visits to the community from traveling providers, amongst many others.¹²⁹ Their perspectives are informed by their lived-experience as patient-citizens within rural communities, and are thus of great benefit to the development of sustainable and realistic health policy. However, this advantage would be lost should methods be used that do not allow for the inclusion of community voice. Further, with barriers to care and thus solutions being unique to each rural community, the importance of community-informed and -tailored methods of “place-based” policy development is demonstrated.¹³⁰

Rural BC community members understand that instating the entire range of health services within their communities to meet all of their healthcare needs locally, including, for example, specialist care, is unfeasible. Instead, this paper recommends that to strengthen rural access to healthcare, the Government of BC take a participatory approach, harnessing the voice and perspective of rural communities to create citizen-informed, sustainable social

¹²⁷ *Halseth, supra* note 27 at 13.

¹²⁸ *Gulliford, supra* note 10 at 186.

¹²⁹ *RER Report, supra* note 33.

¹³⁰ *Halseth, supra* note 27 at 13.

change. This paper concludes that extra-legal methods not only avoid the limitations and barriers that come with the use of legal methods in inciting social change, but also allow for the necessary inclusion of the perspectives, needs, and priorities of rural community members. Importantly, strategies that incorporate community voice also come with the greatest potential for raising public awareness on the current inadequate state of healthcare in rural BC. This paper ends with the hope that should Canadians be made aware of the sad healthcare realities being faced by rural communities within their own country, they will join the fight in advocating for social change for their rural counterparts.

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