

Section 7 of the *Charter*: A Constitutional Right to Health Care? Don't Hold Your Breath

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Introduction

Access to health care services within a publicly funded system, what we know as Medicare, is of undeniable importance to Canadians.¹ In its recent report, the Commission on the Future of Health Care in Canada stressed the value Canadians place on Medicare and described access to public health care as a “right of citizenship.”² As governments grapple with the challenge of sustaining the Medicare system financially while meeting growing demands for services, individuals and groups seem increasingly willing to turn to litigation under the *Canadian Charter of Rights and Freedoms*³ to challenge government decisions to exclude certain services from the roster of publicly funded health care.

In this brief paper, I consider whether the Supreme Court of Canada is likely to interpret s. 7 of the *Charter*, the provision that guarantees rights to life, liberty and security of the person, as imposing a positive obligation on government to fund specific health care services.⁴ I begin with a short overview of arguments typically offered against and for the proposition that s. 7 encompasses positive rights claims. I then review several key cases in which courts have considered the application of s. 7 in a health care context. Finally, I analyse the impact of the Supreme Court's recent decision in *Gosselin v. Québec*,⁵ where the majority ruled s. 7 does not compel the state to provide a minimum level of social assistance, on claims to a right to publicly funded health care. Ultimately, I conclude the Court is unlikely to expand the interpretation of s. 7 to include claims to health care and, even if it does, the challenge would then lie in defining the scope of that right.

The Debate between Negative and Positive Rights

Section 7 of the *Charter* provides that “[e]veryone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with principles of fundamental justice.” Breaches of s. 7 may be justified under s. 1 of the *Charter*, which “guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.”

The debate about whether s. 7 encompasses a right to health care tends to turn on a distinction between negative and positive rights.⁶ Proponents of the negative rights theory argue s. 7 protects an individual's right to be left alone and guards against state action that impinges on one's personal autonomy and integrity.⁷ On this account, s. 7 does not encompass economic and social claims that depend on positive state intervention. Others argue the rights to life, liberty and security of the person are hollow unless the state bears some obligation to assure conditions in which individuals may enjoy those rights.⁸ In regard to a s. 7 claim to health care, Martha Jackman argues, “In practical terms, a right to life and to security of the person is meaningless without access to health care, both in a preventive sense, and in the event of acute illness.”⁹

The question boils down to this: is the state's proper place to leave its citizens alone to enjoy the rights they have or is the state actively to provide goods and services so citizens may enjoy rights? Timothy Christian sums up the distinction as follows:

A negative right is thus the absence of coercion which impairs enjoyment of the right. It is to be contrasted with a positive right which would require the actual provision of the matter to which there is a right. An example will make the distinction clear. The *Charter* guarantees the right to life. Does this mean that the *Charter* is a barrier protecting everyone against state deprivation of their life, or does it mean that there is a positive obligation on the state to provide the goods and services necessary for the sustenance of life? Is it a statement of civil liberties or a manifesto of social welfare benefits?¹⁰

Although the distinction between negative and positive rights has been criticized as outdated and artificial,¹¹ its influence on judicial reasoning is undeniable, as I discuss below.

Judicial Interpretation of Section 7 in the Health Care Context

To date, Canadian courts have rejected the argument that s. 7 imposes a positive obligation on governments to fund specific health care services. Rather, courts have interpreted s. 7 as protecting an individual's right to make fundamental health care decisions free from undue state interference, especially threat of criminal sanction.¹² Cases like *R. v. Morgentaler*,¹³ *Rodriguez v. British Columbia*,¹⁴ and *R. v. Parker*¹⁵ clearly invoke negative conceptions of s. 7 rights. In each of these cases, the claimants challenged government intrusion (in the form of criminal prohibitions regarding abortion, assisted suicide and marijuana possession) into their lives and argued individuals have a sphere of autonomy in which government should not interfere. In *Morgentaler*, this sphere related to women's reproductive choices; in *Rodriguez*, to decisions about controlling the timing and manner of one's death; and, in *Parker*, to medicinal use of marijuana to control a disease.

More recently, individuals and groups have attempted to use the *Charter* to claim a right of access to specific health care services; *Cameron v. Nova Scotia*¹⁶ and *Auton v. British Columbia*¹⁷ are two key examples. The prevailing judicial attitude toward this type of s. 7 claim was revealed in

Cameron, a case in which an infertile couple sought government funding for costly fertility treatments under ss. 7 and 15 of the *Charter*. The case turned on s. 15, the equality rights provision, and the trial judge dismissed the s. 7 claim quite summarily, agreeing with the government's submission that "finding the public funding of particular medical services to be considered an element of the right to life, liberty or security of person would expand the parameters of judicial review, well beyond its present scope."¹⁸

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In *Auton*, children with autism and their parents made ss. 7 and 15 claims seeking government funding for a particular form of treatment for autism referred to as early intensive behavioural intervention. Without appropriate therapy, children with autism may suffer many harms: self-injurious behav-

our; inability to communicate effectively with those around them; social isolation and stigmatization; and a likelihood of institutionalization in adulthood. As a result of this poor prognosis, the claimants argued the British Columbia government's refusal to fund early intervention therapy deprived the children of their constitutional rights to liberty and security of the person.

The trial judge found a violation of s. 15 that could not be justified under s. 1 and declined to deal with the claimants' s. 7 argument. The appeal also turned on s. 15, but Justice Saunders of the B.C. Court of Appeal offered her comments on the application of s. 7 to the facts of the case:

When the *Charter* was first presented considerable debate ensued as to whether it could apply to provide a positive entitlement to health care. In my view, in the context of this case, it does not. The impugned measure does not impinge on the right to life. Jurisprudence to date suggests that the right to liberty concerns physical liberty or "an irreducible sphere of personal autonomy," circumstances which do not result from the funding and treatment decision at issue in this case. And while there may be room for debate as to whether the right to security of the person may be infringed in circumstances such as are here presented, I consider that the underinclusiveness of the health system, even as it relates to children, would not violate a principle of fundamental justice.¹⁹

The Impact of *Gosselin v. Québec*

As *Cameron* and *Auton* show, courts have been reluctant to address s. 7 claims that challenge government decisions to deny public funding for specific health care services. The Supreme Court's recent decision in *Gosselin v. Québec* suggests this trend is likely to continue and it seems unlikely a majority of the Court will expand the scope of s. 7 to include a right to government-funded health care services.²⁰

Gosselin involved a class action against the Province of Québec challenging the government's decision to reduce welfare benefits for certain categories of recipients. The claimants alleged this reduction violated their rights to life and security of the person under s. 7 because it brought their income to a level at which they could not obtain the necessities for life.²¹ The trial judge dismissed the action on the basis that the rights claimed were economic in nature and therefore not protected under s. 7.²² As the following passage indicates, the judge's reasoning turned on the contest between negative and positive liberties:

There is a difference between, on one hand, economic and social rights that depend on active intervention and use of important State resources, and on the other, civil and political rights that depend only on recourse to political and judicial institutions regardless of a State's level of development.²³

Similarly, the majority of the Supreme Court of Canada dismissed the s. 7 claim.²⁴ Chief Justice McLachlin ruled s. 7 does not encompass a "right to a level of social assistance sufficient to meet basic needs"²⁵ for two key reasons:

(1) because "the dominant strand of jurisprudence on s. 7 sees its purpose as guarding against certain kinds of deprivations of life, liberty and security of the person, namely, those that occur as a result of an individual's interaction with the justice system and its administration"²⁶ and

(2) "[n]othing in the jurisprudence thus far suggests that s. 7 places a positive obligation on the state to ensure that each person enjoys life, liberty or security of the person. Rather s. 7 has been interpreted as restricting the state's ability to deprive people of these."²⁷

While the majority in *Gosselin* rejected the s. 7 claim, McLachlin C.J. noted the issue of whether s. 7 can apply outside the administration of justice remains an unanswered question and stated "[o]ne day s. 7 may be interpreted to include positive obligations. I leave open the possibility that a positive obligation to sustain life, liberty, or security of the person may be made out in special circumstances."²⁸

In her dissent, Arbour J. (with whom L'Heureux-Dubé J. concurred) held s. 7 includes a "positive dimension," and "[f]ew would dispute that an advanced modern welfare state like Canada has a positive moral obligation to protect the life, liberty and security of its citizens."²⁹ She conceded that "[t]here is considerably less agreement, however, as to whether this positive moral obligation translates into a legal one."³⁰ Nonetheless, Arbour J. held s. 7 encompasses a right to assistance from the state to meet "basic needs of subsistence."³¹

The Question that Remains

In view of its decision in *Gosselin*, how might the Supreme Court respond to a s. 7 claim for access to state-funded health care services? Would a need for certain health care services constitute the "special circumstances" that, according to McLachlin C.J., would warrant an expanded interpretation of s. 7? On the more generous interpretation of s. 7 offered by Arbour J., would governments be obliged to fund particular therapies? Turning back to the *Cameron* and *Auton* examples, it seems likely the facts and interests at play in *Cameron* (a professional couple seeking fertility treatment to fulfill a desire to have a biologically related child) may not be sufficiently compelling to warrant imposing a constitutional obligation on government to fund the treatment. However, the facts in *Auton* are certainly more sympathetic. The trial judge alluded to this when she stated "autism is a disability so severe and comprehensive that it affects all aspects of [the children's] lives. Their core medical need is for treatment that will permit them to break out of their isolation."³² Yet, despite the fact the case involved a vulnerable group (children), a devastating disability (autism), and evidence of a promising therapy (early behavioural intervention), the British Columbia courts were unwilling to recognize the s. 7 claim. If these seemingly compelling circumstances are not sufficient to trigger s. 7, it is difficult to think of facts that would warrant an extension of s. 7 doctrine to compel governments to fund specific health care services.

Although Arbour J. advocates a broader interpretation of the constitutional right to life, liberty and security of the person,

even her reasoning in *Gosselin* may not hold much promise for those who believe s. 7 ought to include a positive right to publicly funded health care services. Throughout her analysis, she refers to “the most basic positive protection of life and security,”³³ the “basic means of subsistence”³⁴ and “one’s basic health.”³⁵ In my view, this scope of positive s. 7 protection is very narrow and would apply to only a limited category of health care services.

Ultimately, the implications of the Supreme Court’s ruling in *Gosselin* to s. 7 claims for access to publicly funded health care are somewhat problematic. First, if the basis of a s. 7 claim to health care services is to assure a reasonable standard of health for all persons, then any arguments regarding a s. 7 right to health care should apply *a fortiori* to a right to a minimum level of economic security.³⁶ Public health practitioners have long pointed to evidence that poverty is a more fundamental cause of ill health than lack of access to health care.³⁷ Angus Deaton states the correlation clearly:

Poorer people die younger and are sicker than richer people; indeed, mortality and morbidity rates are inversely related to many correlates of socioeconomic status such as income, wealth, income and social class. economic deprivation is strongly related to ill health.³⁸

So, from a health care advocacy perspective, the Court’s rejection of the claim in *Gosselin* does not bode well for the use of s. 7 litigation to address fundamental social determinants of health.

Second, from a legal perspective, if the Court were to rule s. 7 protects a positive right of access to state-funded health care services, the content of that right would likely be quite difficult to define. In *Gosselin*, while Arbour J. was quite comfortable in asserting the existence of positive rights under s. 7, she recognized the difficulty in defining the scope of such rights:

The ostensible difficulty here is the general assertion that positive claims against the state for the provision of certain needs are not justiciable because deciding such claims would require courts to dictate to the state how it should allocate scarce resources, a role for which they are not institutionally competent.

One can in principle answer the question of whether a *Charter* right exists — in this case, to a level of welfare sufficient to meet one’s basic

needs — without addressing how much expenditure by the state is necessary in order to secure that right. It is only the latter question that is, properly speaking, non-justiciable.

Of course, in practice it will often be the case that merely knowing whether the right exists is of little assistance to the claimant. For, unless we also know what is required, or how much expenditure is needed in order to safeguard the right, it will usually be difficult to know whether the right has been violated.³⁹

Arbour J. purported to resolve this concern by stating “[t]his Court need not enter into the arena of determining what would satisfy such a ‘basic’ level of welfare because that determination has already been made by the legislature, which is itself the competent authority to make it.”⁴⁰ The Québec government had established a minimum monthly welfare benefit for single adults of \$466, but the claimants received less than that amount, so the case came before the Supreme Court “on the basis that the government failed to provide a level of assistance that, according to its own standards, was necessary to meet”⁴¹ basic necessities.

Unfortunately, this attempt at resolving the problem of judicial competence to adjudicate matters of resource allocation is not particularly helpful and results in a positive right under s. 7 that may largely be devoid of clear meaning, particularly when applied in the health care context. According to the *Canada Health Act*⁴² and provincial health insurance statutes,⁴³ governments will fund “medically necessary” health care services, however, these statutes do not define what constitutes a medically necessary service and this becomes a matter of provincial policy-making. However, if a claimant asserts a right to health care under s. 7 of the *Charter*, the response based on Arbour J.’s reasoning is as follows: s. 7 encompasses a positive right to health care where necessary for basic protection of life and security. Courts are not institutionally competent to determine the scope of that right but Canadian governments (through the *Canada Health Act* and provincial health insurance legislation) have defined the scope as coverage for medically necessary services. So, in adjudicating a s. 7 claim, courts are merely assessing whether governments have met their own commitments to provide medically necessary health care for their citizens. However, since medical necessity is not defined, courts are right back into “[q]uestions of resource allocation [that] typically involve delicate matters of policy,”⁴⁴ matters which Arbour J. seems to say are not justiciable. The result is a frustrating degree of circularity.

Conclusion

The prospects seem dim that the Supreme Court of Canada will recognize a positive right to publicly funded health care services under s. 7 of the *Charter*. Even if the Court broadens the application of s. 7 in this manner, I suspect the content of the right would be so vague or so attenuated as to offer little to fulfill the hopes of those who view s. 7 litigation as a means to expand the scope of our Medicare system by challenging government decisions to restrict health care funding.

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1. Indeed, a March 2003 public opinion poll found that a majority of respondents (78%) cited Medicare as the most prominent symbol of Canadian identity. Medicare outranked hockey, a surprising fact considering the poll was conducted during Stanley Cup playoff season. See Dennis Buecker "Medicare tops the flag, anthem and hockey as national icon; Queen last" *Canadian Press* (3 April 2003).
2. Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada* (Canada, 2002) at xvi.
3. *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [*Charter*].
4. Litigants may also argue s. 15 of the *Charter*, the equality guarantee, protects a right to access health care services. However, an analysis of s. 15 claims in the health care context is beyond the scope of this paper. For a brief commentary on this issue, see Greschner, *infra* note 12.
5. (2002) 221 D.L.R. (4th) 257, aff'g [1999] R.J.Q. 1033 (C.A.), [1992] R.J.Q. 1647 (S.C.) [*Gosselin*].
6. For a fuller discussion of philosophical perspectives on a right to health care and the contest between negative and positive rights claims, see e.g. Tamara Friesen, "The Right to Health Care" (2001) 9 *Health L.J.* 205.
7. See e.g. Karen Selick, "Rights and Wrongs in the Canadian Charter" in Anthony A. Peacock, ed., *Rethinking the Constitution: Perspectives on Canadian Constitutional Reform, Interpretation, and Theory* (Don Mills, Ont.: Oxford University Press Canada, 1996) 103; Richard A. Epstein, *Mortal Peril: Our Inalienable Right to Health Care?* (Reading, Mass.: Addison-Wesley, 1997), esp. ch. 2, "Practical Obstacles to Positive Rights."; and John Richards, "William Schabas v. Cordelia" (2000) 11 *N.J.C.L.* 247.
8. See e.g. John D. Whyte, "Fundamental Justice: The Scope and Application of Section 7 of the Charter" (1983) 13 *Man. L.J.* 455, where he states, at 474; "[a]ssuming that the *Charter* is dedicated to granting rights over matters of fundamental importance, 'security of the person' will include conditions necessary for life such as food and shelter."
9. Martha Jackman, "The Regulation of Private Health Care Under the *Canada Health Act* and the *Canadian Charter*," [1995] 6:2 *Const. Forum* 54 at 56.
10. Timothy J. Christian, "Section 7 of the Charter of Rights and Freedoms: Constraints on State Action" (1984) 22 *Alta. L.Rev.* 222 at 227.
11. See e.g. Martha Jackman, "What's Wrong With Social and Economic Rights?" (2000) 11 *N.J.C.L.* 235 where she states, at 242:

Many classical rights, such as the right to vote, the right to fair trial, freedom of expression and of association, do not come into existence automatically upon their recognition, but rather are dependent on concerted state regulation and action, rather than on the absence of state compulsion or control. It is therefore simplistic to suggest recognition and respect for classical rights imposes no corresponding obligation to act, or negligible costs only, on the state.
12. For further discussion of this issue, see e.g. Donna Greschner, "How Will the Charter of Rights and Freedoms and Evolving Jurisprudence Affect Health Care Costs?" Discussion Paper No. 20 (Commission on the Future of Health Care in Canada, September 2002) and Martha Jackman, "The Implications of Section 7 of the *Charter* for Health Care Spending in Canada" Discussion Paper No. 31 (Commission on the Future of Health Care in Canada, October 2002). Both available online at <<http://www.healthcarecommission.com>> under "Resources/Research."
13. [1988] 1 *S.C.R.* 30 [*Morgentaler*]. *Morgentaler* involved a s. 7 challenge to the *Criminal Code* provisions that criminalized abortion unless certain requirements were met. Specifically, the impugned provision required a woman seeking an abortion to appear before a three-member therapeutic abortion committee, obtain a certificate authorizing the abortion and, finally, find a physician other than one on the committee to perform the abortion. Because of this process, many women faced significant delays in

obtaining abortion services, particularly in areas outside large urban centres. The majority of the Supreme Court (Dickson C.J., Lamer, Beetz, Estey and Wilson JJ.) held the *Criminal Code* provision violated s. 7 of the *Charter* and could not be justified under s. 1. (McIntyre and LaForest JJ. dissented and found no breach of s. 7). The judges who found a breach of s. 7 held that “security of the person” under s. 7 protected a woman’s physical and mental integrity from serious state interference in the criminal law context.

14. [1993] 3 S.C.R. 519 [*Rodriguez*]. Sue Rodriguez challenged the constitutionality of the *Criminal Code* prohibition against assisted suicide. Ms. Rodriguez had amyotrophic lateral sclerosis (commonly known as Lou Gehrig’s disease), a fatal disease that progressively robs a person of basic physical capacities and she wanted to have the ability to end her life when her suffering became intolerable. However, when that time came, she would physically be unable to commit suicide without assistance and wanted a physician to help her to die, but any physician who aided her risked criminal sanction. Ms. Rodriguez sought an order, based on ss. 7, 12 (the prohibition against cruel and unusual punishment) and 15 of the *Charter*, declaring unconstitutional the *Criminal Code* prohibition against assisted suicide. In respect of s. 7, Ms. Rodriguez argued the impugned law deprived her of the right to live the last of her life in dignity and the right to be free from state interference in making fundamental decisions about her life or, more precisely, about her death. In a narrow majority, the Supreme Court of Canada dismissed Ms. Rodriguez’s claim. (Sopinka, LaForest, Gonthier, Iacobucci and Major JJ. constituted the majority. Lamer C.J., L’Heureux-Dubé, Cory and McLachlin JJ. dissented.) Sopinka J., writing for the majority, held that though the *Criminal Code* prohibition abridged Ms. Rodriguez’s right to security of the person under s. 7, that infringement accorded with principles of fundamental justice. With regard to the nature of the interest captured by the right to security of the person under s. 7, Sopinka J. stated, at 588:

There is no question then, that personal autonomy, at least with respect to the right to make choices concerning one’s own body, control over one’s physical and psychological integrity, and basic human dignity are encompassed within security of the person, at least to the extent of freedom from criminal prohibitions which interfere with these.

15. (2000), 49 O.R. (3d) 481 (C.A.) [*Parker*]. *Parker* involved a challenge to provisions of the federal *Controlled Drugs and Substances Act* (formerly the *Narcotic Control Act*) that prohibited possession of marijuana. Mr. Parker suffered from a severe form of epilepsy and grew marijuana for his own use to control his seizures. Upon being charged with possession of marijuana, an offence punishable by imprisonment, Mr. Parker argued the offence provisions violated his rights under s. 7 of the *Charter* because he faced criminal sanction for using marijuana to meet a medical need. The Ontario Court of Appeal held Mr. Parker’s rights to liberty and security of the person were violated by the untenable choice between safeguarding his health and risking imprisonment. With respect to the content of the right to liberty in s. 7, the Court stated the threat of prosecution and imprisonment under the impugned legislation engaged Mr. Parker’s liberty interests. In the circumstances of this case, the Court held the risk of deprivation of liberty was not in accordance with principles of fundamental justice, nor could it be justified under s. 1. Regarding the right to security of the person, the Court reiterated language from *Morgentaler* to the effect that state interference with an individual’s physical and psychological integrity violates security of the person. Further, the Court emphasized, at para. 97, that “[d]eprivation by means of a criminal sanction of access to medication reasonably required for the treatment of a medical condition that threatens life or health also constitutes a deprivation of security of the person.”
16. (1999), 177 D.L.R. (4th) 611 (N.S.C.A.), aff’d (1999), 172 N.S.R. (2d) 227 (S.C.), leave to appeal to S.C.C. refused, [1999] S.C.C.A. No. 531 (QL) [*Cameron*].
17. (2000), 78 B.C.L.R. (3d) 55 (S.C.), aff’d (2002) 6 B.C.L.R. (4th) 201 (C.A.), leave to appeal to S.C.C. granted, [2002] S.C.C.A. No. 510 (QL) [*Auton*].
18. N.S.S.C. decision, *supra* note 16 at para. 160. The claimants did not pursue their s. 7 argument on appeal.
19. B.C.C.A. decision, *supra* note 17 at para. 37 [internal citations omitted].
20. On May 15, 2003, the Supreme Court of Canada granted leave to appeal in *Auton*; however, the Court may well confine its ruling to s. 15 and leave the s. 7 issue regarding access to health care for another day.
21. The claimants also alleged the welfare scheme violated s. 15 of the *Charter* and s. 45 of the Québec *Charter of Human Rights and Freedoms*, R.S.Q., c. C-12, which provides for a right to “measures of financial assistance and to social measures provided for by law, susceptible of ensuring such person an acceptable standard of living.”

22. In *Irwin Toy Ltd. v. Québec (Attorney General)*, [1989] 1 S.C.R. 927 at 1003, the Supreme Court of Canada rejected the notion that s. 7 protects “economic rights as generally encompassed by the term ‘property’.”
23. Q.S.C. decision, *supra* note 5 at para. 213 [translated by author].
24. McLachlin C.J., Gonthier, Iacobucci, Major, Bastarache, Binnie and LeBel JJ. found no s. 7 breach. L’Heureux-Dubé and Arbour JJ. found a s. 7 violation that was not justifiable under s. 1.
25. *Supra* note 5 at para. 76.
26. *Ibid* at para. 77 [internal citation omitted].
27. *Ibid* at para. 81.
28. *Ibid* at paras. 82 & 83.
29. *Ibid* at para. 308.
30. *Ibid*.
31. *Ibid* at para. 311.
32. B.C.S.C. decision, *supra* note 17 at para. 134.
33. *Supra* note 5 at para. 309.
34. *Ibid* at paras. 309 & 332.
35. *Ibid* at para. 311.
36. Joel Bakan makes a similar point in *Just Words: Constitutional Rights and Social Wrongs* (Toronto: University of Toronto Press, 1997). He states, at 139:

All the proposals for a social right to health place on the state an obligation to ensure that all Canadians have access to health care. They say nothing, however, about the social determinants of ill health, particularly the unequal social relations that have much to do with why and to whom illness happens.
37. See e.g. Michael Marmot, “The Influence of Income on Health: Views of an Epidemiologist” (2002) 21:2 *Health Affairs* 31; John W. Lynch, George A. Kaplan & Sarah J. Shema, “Cumulative Impact of Sustained Economic Hardship on Physical, Cognitive, Psychological, and Social Functioning” (1997) 337 *New Engl. J. Med.* 1889; and Marcia Angell, “Privilege and Health: What is the Connection?” Editorial (1993) 329 *New Eng. J. Med.* 126.
38. Angus Deaton, “Policy Implications of the Gradient of Health and Wealth” (2002) 21:2 *Health Affairs* 13 at 13.
39. *Supra* note 5 at paras. 330, 332-33.
40. *Ibid* at para. 333.
41. *Ibid* at para. 334.
42. R.S.C. 1985, c. C-6. The *Canada Health Act (CHA)* sets out five criteria the provinces must meet in order to receive a full financial contribution from the federal government for health care. These criteria are: public administration, comprehensiveness, universality, portability and accessibility (see s. 7). The criterion of

comprehensiveness is linked with medical necessity and s. 9 of the *CHA* states:

In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists, and where the law of the province so permits, similar or additional services rendered by other health care practitioners.

The *CHA* defines “insured health services” to mean “hospital services, physician services and surgical-dental services provided to insured persons” (see s. 2). In turn, hospital services” are defined as specific listed services that “are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability” and “physician services” are “any medically required services rendered by medical practitioners” (see s. 2). The *CHA* does not define the terms “medically necessary” or “medically required.”

43. For example, the British Columbia *Medicare Protection Act*, R.S.B.C. 1996, c. 286, insures “medically required services” (s. 1). In Alberta, the *Health Care Insurance Act*, R.S.A. 2000, c. A-20 defines “insured services” as “all services provided by physicians that are medically required” (s. 1). Under the Ontario *Health Insurance Act*, R.S.O, 1990, c. H.6, “insured services” include “medically necessary services rendered by physicians” (s. 11.2). The terms “medically necessary” or “medical required” are not defined.
44. *Supra* note 5 at para. 331.