

# THE FAILURE TO PROVIDE EQUITABLE PUBLIC HEALTH SERVICES IN BRITISH COLUMBIA AND THE CASE STUDY OF PHYSICIAN ASSISTANTS

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## Introduction

Law is an underutilized resource for public health interventions<sup>60</sup>. In 2002, after a sweeping probe of the Canadian healthcare system, Roy Romanow's very first recommendation was that "[a] new Canadian Health Covenant should be established as a common declaration of Canadians' and their governments' commitment to a universally accessible, publicly funded health care system.<sup>33</sup>" Because Canada is a developed nation which ensures reasonable access to all medically necessary health services, one would expect unmet healthcare needs to be rare, but this is not the case<sup>28</sup>. The healthcare environment features barriers which directly engage Canadians' rights to life and security of the person, as well as equality guarantees. It lacks human rights mechanisms for guaranteeing that healthcare decision-making accounts for Canada's international and constitutional obligations, which reveals an accountability breakdown<sup>50</sup>. This paper presents a picture of an impoverished philosophy of health care in Canada. Our system features weakly designed legal protections which cannot help manifest necessary public health interventions beyond the narrowest confines of 'medical necessity'. The case study used to illustrate this will be British Columbia's crisis in healthcare provision, coupled with the province's failure to regulate physician assistants despite persistent lobbying.

Since Confederation, health rights have lacked a clear constitutional or statutory presence in Canada. In dividing powers between the federal and provincial governments in the Constitution, health was not assigned to either level of government<sup>3</sup>. As such, both branches may still legislate about health, and the responsibility to remedy inadequacies in health provision does not fall to either branch. Consequently, as the Supreme Court noted in *Schneider*, "[h]ealth is not a matter which is subject to the specific

constitutional assignment but instead is an amorphous topic which can be addressed by valid federal or provincial legislation<sup>21,66</sup>.” The Royal Commission on Dominion-Provincial Relations of 1938 commented on this apparent oversight that the administration of public health was still in a primitive stage at Confederation. The governing assumption then was that health was a private matter to which the state should only intervene in emergencies<sup>21,66</sup>. My thesis is, in part, that Canadian healthcare governance still has this same impoverished view of public health, and still has not delineated clear and fulsome rights and responsibilities for health services provision.

Since 1984, the *Canada Health Act (CHA)* has governed the requirements of the provincial and federal branches in regulating healthcare provision<sup>1</sup>. It mandates that all medically necessary services are fully covered by the government. However, there is no definition of ‘medically necessary’ in the *CHA*, and what is deemed medically necessary is those services which need to be provided for the given province to receive full cash transfers from the federal government<sup>39</sup>. Provinces and territories under this scheme regulate public health through their provincial Acts and thus are funded virtually without federal constraint (53). As the Kirby Report notes, the *CHA* is a floor, not a ceiling<sup>29</sup>. The problem with regulating health provision this way is that no statutory incentive structure for government to provide anything more than the bear minimum mandated by the *CHA*. Further, since its passage, the federal government has not once withheld cash transfers from a provincial government because it was failing to comply with the *CHA*’s equity requirements<sup>42</sup>. In other words, provinces are under no statutory obligations whatsoever to create *good* public health regimes. So, this is, in part, a jurisdiction problem. The result is that little legal recourse is available when those services are provided in a way that does not meet the true healthcare needs of residents. The next section will examine BC, one jurisdiction where the accountability failure is particularly acute.

## **Waitlists and Unmet Healthcare Needs are a Crisis in British Columbia**

In BC, the wait between seeing a specialist and getting treatment has climbed from 5.6 weeks in 1993 to 10.6 weeks in 2016 – an 88 percent increase<sup>51</sup>. In a study from 2009, excessive wait time was the most commonly reported source of unmet healthcare needs<sup>56</sup>. Wait times for surgery are also on the rise in the province. Wait times for priority hip and knee replacement surgeries in the province are among the longest of the provinces and are getting worse<sup>31</sup>. For example, the proportion of BC patients who are receiving their knee replacements at the BC government-specified benchmark of six months was only 47 percent<sup>31</sup>. For British Columbians waiting for these services, this is a significant crisis.

However, the issues of unmet needs and wait times do not affect everyone equally. Though, in theory, everyone can access care in the single-payer system, the availability of care is shaped by socio-economic conditions. British Columbia has a problem with the provision of healthcare to marginalized peoples. For instance, one study found BC has among the highest level of reported unmet healthcare needs due to accessibility problems of the provinces<sup>51</sup>. In Canada, one’s health is shaped by where one lives or works. Aboriginal status, poverty, gender and disability are also all closely associated with significant health inequities in Canada<sup>48</sup>. Being a woman is an indicator that one is more likely to have a perceived unmet healthcare need<sup>28</sup>. The experience in the healthcare system of poor people is evidently much worse.

The bottom 33% of earners in Canada compared to the top 33% are 40% more likely to wait five days or more for an appointment with a physician<sup>61</sup>. One joint Canadian/United States survey found 17% of the bottom one-fifth of income-earners experienced an unmet healthcare need in the past year, as opposed to 9% of the wealthiest fifth<sup>28</sup>. Another study found that lower-income residents were more likely than their higher income counterparts to see general physicians, but were less likely, despite their poorer health, to be referred to a specialist<sup>28</sup>.

The issue is especially stark for rural populations. In his 2002 report, Roy Romanow wrote that there are serious concerns about timely access to services in rural and remote areas<sup>33</sup>. Though the *CHA* and BC's *Medicare Protection Act (4)* theoretically garner the same benefits for rural residents, as Health Canada's Special Advisor on Rural Health has remarked, "if there is two-tiered medicine in Canada, it's not rich and poor, it's urban versus rural"<sup>54</sup>. Not only is being rurally situated a social determinant of poorer health but on the healthcare service provision end, rural populations simply have fewer resources available to them. This is especially true in the case of British Columbia. Rural hospital closures and the trend toward centralization of healthcare provisions in BC have been impactful<sup>54</sup>. Shortages of medical professionals in these communities also result in poorer health outcomes<sup>54</sup>. Medical and supportive care can be inaccessible, unavailable, and unaffordable for cancer survivors living in rural northern communities, for instance,<sup>47</sup>. This lack of timely access to medical care results in frustrations, medical complications, and worse health outcomes for Northern rural cancer survivors<sup>47</sup>. Similarly, the availability of publicly funded treatment for opioid addiction – a public health emergency in the province – is much worse for rural areas of BC, especially the Northern and Interior regions<sup>52</sup>.

Aboriginal populations face a unique set of obstacles to accessing the equal quality of care in the BC medical system. Persistent inequalities in access to primary care for aboriginals is a severe health concern<sup>27</sup>. While BC has created a framework for addressing these health issues, their plan does not cover all Aboriginal populations, just First Nations<sup>58</sup>. Data suggests the non-urgent use of emergency departments is on the rise among aboriginal and otherwise marginalized populations<sup>27</sup>. This indicates these groups are using the ED in lieu of regular medical consultation and treatment. However, aboriginal people frequently report dissatisfying experiences at the ED because the services rendered did not fully meet their healthcare needs<sup>27</sup>. They also report various levels of discrimination and issues of dismissiveness toward their health problems<sup>27</sup>. Because of their high reliance on ED services "[a]ccess to appropriate, responsive primary health care services have been identified as critical to achieving overall improvements in health status among Aboriginal populations<sup>27</sup>".

Public calls to divert more resources into the healthcare system have been consistently loud in BC<sup>28</sup>. Healthcare already consumes more than 40% of provincial and territorial budgets in Canada<sup>37</sup>. More funding is not the answer; rather, it is a question of the apportionment of funding. A more equitable intervention will be mindful of the structural inequalities already in place, as more funding would likely just replicate existing inequalities.

## Physician Assistants

This section will survey and evaluate the utility of a public health intervention: the accommodation of Physician Assistants (PAs) in the BC medical system. As a case study, this section will look at the failure of BC to facilitate physician assistants practicing in the province, despite lobbying efforts and several other provinces including Alberta, Manitoba and Ontario having undertaken this intervention already. If public health is the process of identifying the harms to health at a population level, and then seeking to remove them, then the harm at issue here is a crisis of unequal and untimely medical treatment, and the proposed intervention is the regulatory accommodation of PAs in BC. As Ries and Tigerstrom explain, once we identify a public health problem, the government can be called upon to enable choice and guide those choices through policy change<sup>65</sup>. It is this kind of intervention that this paper proposes and evaluates. In no way would this intervention be a ‘magic bullet’ which would fix all the woes of the healthcare system. Rather, this section seeks to establish that there is a good chance it would improve outcomes in some key areas of health service provision outlined above. The example of PAs simply serves to illustrate the weakness of health entitlements in BC and the failure of the right to health in Canada and its provinces. The purpose of this exercise is to show that, if Canada’s international, constitutional and statutory obligations vis-à-vis healthcare were taken seriously by lawmakers, they would take minimal steps to remedy the health crises described above. Considering the numerous benefits PAs could provide for the poor, rural and otherwise marginalized, the failure to bring them into BC shows a disregard for the medical needs of these groups. In other words, BC’s failure to take this step is a lens through which to demonstrate some of the shortcomings and gaps in the law’s equal provision of health care services and benefits.

PAs are medically trained professionals who operate within a practice scope determined by their supervising physician. Though Manitoba and Ontario each have hundreds of civilian PAs, BC does not currently have legislation or regulations which accommodate them into the provincial medical system<sup>30</sup>. Although they are parallel in “rank” to Nurse Practitioners, they differ in a couple of fundamental ways: first, PAs are educated in the medical school environment, while Nurse practitioners receive their education in established nursing modules. Secondly, while Nurse Practitioners operate independently and with a largely self-determined scope of practice, PAs work is flexible yet defined by the supervising physician’s practice. Thus, there is presumably little overlap between the two professions, and one does not render the other redundant.

It is significant that there is a consensus that integrating PAs into the medical system would improve not only wait times but other factors enumerated by the *CHA*: accessibility, comprehensiveness and universality are also potentially increased by the introduction of PAs. PAs allow doctors more time to spend with complex patients<sup>70</sup>, including marginalized folk. One American study found physician assistants had a large proportion practicing in rural communities, and in communities with a higher proportion of low income and minority residents<sup>45</sup>. This study concluded that PAs have a “greater propensity to care for underserved populations than do primary care physicians in other specialties<sup>45</sup>.” A Canadian study found PAs can help address service gaps including improved continuity care, access, equity and sustainability<sup>44</sup>. Importantly, PAs also have a powerful effect on re-admission rates – one study found those who received home visits from PAs showed a 25% decline in readmission rates<sup>62</sup>. In sum, PAs could have a profound

impact on poor rural populations with chronic health problems, as hospital readmission bears a significant social and personal cost to patients.

Though the question has not been empirically studied in BC due to the lack of PA integration into the public healthcare system, in 2005 the Canadian Orthopaedic Association found PAs allowed orthopedic surgeons to be freed up in their non-surgical activities. The result was greater patient surgery output and a reduction in waiting times<sup>24</sup>. One study found that PAs “saved” their supervising physicians approximately 204 hours per year<sup>25</sup>. They also found that “the double operating room model facilitated by PAs increased the surgical throughput of primary hip and knee replacements by 42%, and median wait times decreased from 44 weeks to 30 weeks compared with the preceding year<sup>25</sup>.” Another study found residents reported that PAs “significantly” improved their rotation and quality care<sup>38</sup>. Further, they decreased late discharges and increased early discharges, as well as decreased the resident’s workload<sup>38</sup>.

Studies indicate PAs could save the healthcare system money. In fact, at least in the American context, they were introduced to the healthcare system in response to a shortage of primary care physicians and rising healthcare costs in the United States in the 1960s<sup>46</sup> – they are tailor-made for this goal. A Conference Boards of Canada study found “under reasonable assumptions... adding physician assistants to the selected specialties of primary care, emergency care service, and orthopedics can generate cost savings to the [Canadian] health care system<sup>37</sup>”. When this study ran projections of PA cost savings from 2013 to 2017, operating under the conservative assumption PAs can substitute for 25% of physicians’ time in primary care, orthopedics and the ED, they found the cost savings would be \$22.4 million<sup>37</sup>. This is significant given that, as was discussed above, aboriginal peoples and other marginalized groups are increasingly using the ED as their primary method of care. The Commission on the Reform of Ontario’s Public Services agreed and recommended that “physicians should not perform tasks that could be done more efficiently and at a lower cost by physician assistants [and other non-physician clinicians]<sup>34</sup>”.

The BC government indicated its willingness to make regulatory accommodations for PAs in 2005; policy has not yet reflected this. In 2013, the British Columbia Medical Association [BCMA] released a statement imploring the BC government to regulate PAs and stating they supported the regulatory change “as one way to address the shortage of human health resources in the province<sup>64</sup>.” They also noted that the suitability of PAs to rural environments was a “necessary quality to match the extensive health care needs of rural populations<sup>64</sup>.” In 2015, a cross-sector policy paper released by the BC Ministry of Health noted that physician assistants could be valuable to the provincial healthcare system in their capacities of both role substitution and role delegation<sup>26</sup>. Despite the BCMA’s expressed desire to use PAs, they are still not employed in BC and are not a designated health profession under the *Health Professions Act*<sup>73</sup>.

It seems safe to conclude integrating PAs would help improve wait times and unmet healthcare needs at a low cost to the BC government in the long-term. Canada has administrative, international and constitutional obligations which all pertain to the provision of the base requirements for human health and livelihood. These commitments, alone or in combination, necessarily indicate Canadian healthcare providers (i.e. the provinces) need to take reasonable steps to meet the healthcare needs of residents. The accommodation of PAs into the healthcare system, for the reasons discussed above, is just one such a

reasonable step. The following sections outline the legal reasons why the BC healthcare system is left to function per the status quo.

## **The Failure of the Charter to Provide a Meaningful Right to Health**

The *Charter* does not provide a freestanding right to healthcare<sup>10</sup>, but sections 7 and 15 are the most fruitful ground under which right to health claims may be advanced. Despite the *Charter* guaranteeing the right to life and the right to equality for disabled persons, all *Charter*'s provisions for healthcare mandates is "where the government puts in place a scheme to provide health care, that scheme must comply with the *Charter*<sup>10,2</sup>." In most provinces including BC, the only recourse from a decision not to fund a given service or treatment is to seek relief from the courts through judicial review or *Charter* challenges<sup>40</sup>. For those readers unfamiliar, Section 7 relates to Life, Liberty, and Security of Person; Section 15 with Equality before and under the law and equal protection and benefit of the law.

### ***Section 7 Engages Health Rights but Does Not Provide Them***

Famously, it was in the *Chaoulli* decision that a 4-3 majority of the Supreme Court found that being deprived of access to timely surgery can trigger one's right to security of the person under s. 7<sup>10</sup>. Although the court was divided, all judges agreed on the basic principle that section 7 of the *Charter* applies to access to healthcare<sup>41</sup>. *Chaoulli* followed a line of cases such as the *BC Motor Vehicles* and *Gosselin* that had broadened the reach of section 7<sup>19</sup>. These cases made it clear that s. 7 is not limited to criminal offences but instead can extend to the nuances of physical and emotional distress, such as the distress caused by delays in procuring adequate medical treatment<sup>41</sup>. They are a clear expansion on the *Morgentaler* case, in which a slim majority of the SCC had decided criminal sanctions concerning the procurement of abortion services outside of a hospital violated s. 7<sup>18</sup>. *Chaoulli* took this right not to have one's health compromised by the state out of the confines of the criminal law<sup>68</sup>. 2011's *Insite* took this one step further, where McLachlin CJ held that "where the law creates a risk not just to the health but also the lives of the claimant [a violation of s. 7 is found]<sup>9</sup>." All of these decisions make it clear section 7 engages health rights, but it does not go so far as to provide them.

### ***The Auton Decision, the Canada Health Act, and Medical Necessity***

In theory, the remedial objectives of s. 15 of the *Charter*, also known as the equality provision, provide a solid basis for challenging the failure of the BC government to ensure health policies reduce rather than worsen health inequalities<sup>48,2</sup>. However, this has not panned out in practice. The *Auton* decision has set a damaging precedent for the provision of equitable healthcare under s. 15. In *Auton*, the claimants

were parents of autistic children who sought to receive public funding for IBI/ABA treatment<sup>5</sup>. They sought a claim via section 15 of the *Charter*, alleging discrimination on the enumerated ground of disability. This therapy, though highly effective for the management of autism, is not typically administered by a physician.

The Court found this service fell outside the 'core' services guaranteed as medically necessary by the *CHA*. As discussed earlier, the *Canada Health Act (CHA)* provides that universal coverage is available for all interventions that are 'medically necessary.' They arrived at this decision for two reasons: First, 'core services' was defined as those administered by a physician – which is a very narrow definition considering physicians make up a small segment of the greater medical professional population. Secondly, the IBI/ABA treatment was relatively novel. The Court wrote: “[p]eople receiving well-established non-core therapies are not in the same position as people claiming relatively new non-core benefits” and “[f]unding may be legitimately denied or delayed because of uncertainty about a program and administrative difficulties related to its recognition and implementation<sup>5</sup>.” While it is true the purpose of the *CHA* “was never to fund every health service<sup>32</sup>,” the *CHA* mandates that provincial health insurance plans must satisfy five criteria: public administration, comprehensiveness, universality, portability and accessibility<sup>1</sup>. Thus it is difficult to see how such a narrow interpretation of 'medical necessity' under the *Act* can be justified. *Auton* went directly against the Supreme Court's earlier contention in *RJR Macdonald* that proving a *Charter* violation would not “require scientific demonstration” and that a violation could be made out through common sense<sup>20</sup>. Further, the Court at no point in *Auton* considered Canada's international obligations as described above. This demonstrates both an unwillingness of the Court to provide a fulsome and broad approach to the concept of medical necessity, and the inefficacy of international doctrine in Canadian courts.

As a precedent, *Auton* imposes an additional burden on historically disadvantaged groups seeking medical treatment because it re-entrenches existing social structures in the medical system. Martha Jackman had remarked that *Auton* was the moment when “formalism was typified” under s. 15 analysis<sup>48</sup>. Similarly, Bruce Porter has observed that in *Auton* the Supreme Court decided “the constitutionality of doing nothing to meet the needs of an extremely disadvantaged group in our society<sup>48</sup>. This right to do nothing is precisely the guiding logic behind British Columbia's failure to produce any meaningful policy response to excessive wait times and unmet healthcare needs. Thus it helps explain the province's failure to take steps such as regulating PAs.

This reluctance to provide equitable healthcare via S. 15 of the *Charter* is also partially explained by the cost of benefits. Historically, the SCC has been much more likely to find a violation of s. 15 when the remedy is affordable to the government. Cases litigated under s. 15 so often win based on their affordability that it appears questionable whether a litigant could ever win if the cost to government is too high, regardless of how strong the case of discrimination is<sup>55</sup>. The Court in *Auton* evidences this when they note that “the therapy is intensive and therefore expensive — between \$45,000 and \$60,000 per year” *per patient*<sup>5</sup>. This is an important contrast to *Eldridge*, where the service would supposedly only cost the government \$150,000 per year *overall*<sup>11</sup>. In *Eldridge*, discrimination contrary to section 15 of the *Charter* was successfully made out, and the service at issue was found to be medically necessary, even though ASL interpreters *are also not physicians*. La Forest wrote for the Court: “sign language interpretation is a ‘medically required’ service and hence a benefit under the *Act*<sup>11</sup>.” Later, the SCC in *NAPE* explicitly

established governmental financial concerns can alone be sufficient to justify a *Charter* violation under section 1 in the right circumstances<sup>16</sup>. There the Supreme Court acknowledged the cost of averting *Charter* violations should be weighed against “the scale of the financial challenge confronting the government” when deciding whether or not government action is demonstrably justified for section 1<sup>16</sup>. Former Justice Rothstein revealed some of the Court’s thinking when he wrote that “[w]hether or not one likes it, cost may be a relevant practical consideration in a section 1 defence of an under-inclusive social benefit program<sup>67</sup>.”

*Auton* and its fallout speak to a major issue with the efficacy of the *Charter* for healthcare litigation: that Courts tend to give more deference to the legislature when dealing with a complex social issue<sup>8</sup>. Notwithstanding *Chaoulli* the Supreme Court has historically been hesitant to interfere with legislative choices on how to regulate healthcare services. For instance, in the context of examining whether a legislative provision was justified per s. 1 of the *Charter*, the Chief Justice wrote that deference is appropriate in adjudging complex social problems due to inherent uncertainty<sup>8</sup>. Similarly, in *M v H* the majority stressed: “the importance of deference to the policy choices of the legislature” in demonstrating that a section 15 violation was justified per s. 1<sup>14</sup>. There the Court concluded that “[a]s a general matter, the role of the legislature demands deference from the courts to those types of policy decisions that the legislature is best placed to make<sup>14</sup>.”

This record does not bode well for the vision of substantive equality under section 15 of the *Charter*. Ultimately, *Auton* has had a chilling effect on s. 15 claims of this nature<sup>35</sup>. Despite Romanow’s recommendation that the government should develop programs and services which recognize the health care needs of “women, visible minorities, people with disabilities, and new Canadians,<sup>33</sup>” courts have since relied on *Auton* to deny effective and required treatments to claimants. For instance, in *Ali*, the Federal Court of Appeal relied on *Auton* to deny fibromyalgia patients reimbursement<sup>39</sup> for their vitamins and supplements<sup>6</sup>. As a precedent, *Auton* empowers the courts to take a conservative approach to the provision of medical benefits, even for profoundly disadvantaged groups. What this approach does is “to ignore that it is precisely where discretion and prerogative are exercised that discrimination is most likely to occur<sup>39</sup>.” *Auton* suggests the government’s obligations to remedy the positions of disadvantaged groups is not “a freestanding commitment to provide any specific service that might improve [their status].” Government inaction to the provision of health benefits both reflects and perpetuates discrimination<sup>48</sup>. At least in part, this helps explain why the BC government does not take even the most straightforward of steps to improve the provision of health services for equity-seeking groups.

Given the weak protections afforded by the *CHA* and the Court’s decision to interpret medical necessity in an extremely narrow manner, there is no legal instrument through which British Columbians can demand interventions to the status quo of public health. Petitioning the government to allow medical practitioners who could improve health outcomes for poor, rural and marginalized peoples to practice in the province, namely PAs, is left as a purely political exercise. Because the *Charter* takes a narrow, negative rights-approach to the provision of healthcare services, it will rarely find a governmental obligation to provide residents with basic services. This judicial closed-mindedness is an enormous pitfall. The problem for PAs then is if we choose to define medically necessary services as those administered by a physician, nothing PAs – or any other of the many essential non-physician health professions – do could ever be

considered medically necessary. Thus, there is no financial or legal incentive for BC to create a more equitable healthcare sector by welcoming medical professionals who can better serve marginal populations.

Section 15 of the *Charter* is often said to be a better candidate than s. 7 for the provision of positive rights. Because the text reads in positive language, specifying “every individual has **the right to** the equal protection and equal benefit of the law,” it is the *Charter*’s best bet for positive rights<sup>2</sup>. However, the SCC has limited the expansiveness to positive rights under this provision. In *Eldridge*, the Supreme Court refused to comment on whether s. 15 places a positive obligation on the government to ameliorate pre-existing disadvantage, and instead reiterated that “once the state does provide a benefit, it is obliged to do so in a non-discriminatory manner<sup>11</sup>.” Given that *Eldridge* has repeatedly been called the “high watermark” for s. 15 cases, that the Court there refused to declare s. 15 contains fully positive obligations for the government speaks volumes about the fate of positive rights under the *Charter*. There may be some room for optimism about s. 15 litigation in the future, however. While in the past, section 15 claimants always had to show they were denied a benefit the appropriate comparator group was receiving – which proved to be a high hurdle to pass – the most recent s. 15 tests from *Taypotat* re-affirmed that this will no longer be a necessary element of the legal test<sup>13</sup>. In other words, demanding non-discriminatory provision of benefits through s. 15 might be easier for claimants going forward.

## The Future of Positive Rights Under the Charter

For the right to health to be meaningful at all, it must be construed to contain positive rights which can mandate state action. Otherwise, it is merely an empty vessel. A focus on equality instead of entitlements could provide a reasonable path forward for the *Charter*<sup>57</sup>. Though s. 15 is beleaguered, there is room for optimism about the expansion of substantive relief and positive rights to be had for s. 7. The good news is that the SCC has rejected an originalist interpretation of the provision: as Lamer J argued in *BC Motor Vehicles*, to hold s. 7 to the original framers’ meaning would cause *Charter* rights to be “frozen in time to the moment of adoption with little or no possibility of growth, development and adjustment to changing societal needs<sup>19</sup>.”

Indeed, while proposals that socioeconomic rights could be inherent in s. 7 were initially rejected, there have been occasional hints in the form of dissents and lower court decisions that the Supreme Court may one day recognize poverty as a condition which triggers section 7 protection in some circumstances. While in *Gosselin* the majority of the Supreme Court passed up a fantastic opportunity to provide either a fulsome approach to positive rights under the *Charter* or at least a coherent philosophy of it, the Court there refused to outright deny the existence of positive rights under s. 7. There the majority of the Court rejected a claim that below-subsistence level social assistance rates for youth violated a positive right to life and security of the person founded under s. 7. McLachlin CJC for the majority wrote that the issue before them was not whether s. 7 has ever or would ever create positive rights, but rather whether it did in those particular circumstances. Unfortunately, they found it did not<sup>12</sup>. However, the Chief Justice wrote in obiter that s. 7 one day “may be interpreted to include positive obligations” and reiterated it “would be a mistake to regard s. 7 as frozen<sup>12</sup>.” We should also look to Arbour J’s strong dissent in that case. She wrote that the barriers to finding positive obligations under the *Charter* are less substantial than conventional wisdom assumes.

“This Court has never ruled, nor does the language of the *Charter* itself require, that we must reject any positive claim against the state,” she wrote, adding: “the language and structure of the *Charter* — and of s. 7 in particular — actually compel it”<sup>12</sup>. Justice Arbour offers a powerful sentiment for the equitable provision of healthcare which calls on us to bear in mind yesterday’s dissent might be tomorrow’s majority.

## Conclusion

The most appropriate and effective method for improving overall population health status is to improve the health of the lowest socio-economic groups and “reductions in health inequalities require reductions in material and social inequalities.”<sup>48</sup> Under this approach, it is virtually pointless to tweak the existing public healthcare scheme, and the only answer is broad-sweeping structural change. PAs are not a magic bullet. The magic bullet, if there is one, is for Canadian courts to take their legal obligations under international law seriously and provide the highest attainable standard of health. Barring that, Canadian courts should take a broad and purposive approach to *Charter* interpretation. That approach should recognize our Constitution is a ‘living tree’ which evolves with time. It needs to evolve to provide the health equity which is inherent in the rights to life, liberty and security of the person, as well as equality. The failure for BC to elect even the most straightforward of public health interventions – integrating more health professionals into the public system – speaks to how far away the status quo is from an equitable legal approach.

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