Health resource distribution in Canada has been criticized for being opaque and increasingly inequitable, with its disproportionate emphasis on curative over preventive care. Yet there has been relatively little scrutiny of priority-setting in publicly funded health care in Canada from bodies monitoring the international human right to health. Recently, however, domestic health governance on the one hand, and international health and human rights on the other, have converged around the promotion of evidence-based policy, accountability, transparency and participation as drivers of more equitable distribution of health care resources. This paper tracks the paths toward this convergence. The emphasis in health policy was largely driven by cost containment and service integration concerns, while democratic and institutional concerns around socio-economic rights protection are at the root of the health and human rights shift toward proceduralist approaches. This shared emphasis nonetheless opens new terrains of struggle for human rights approaches to health care distribution in Canada, around (i) managing indeterminacy in social determinants of health; (ii) addressing power imbalances that shape how health information is produced, communicated, and acted upon and (iii) the role of fundamental normative values that limit substantive policy around health.

La distribution des ressources en santé au Canada a été critiquée en raison de son caractère opaque et de plus en plus inéquitable, et de l’importance disproportionnée accordée aux soins curatifs par rapport aux mesures préventives. De plus, relativement peu d’études concernant les priorités établies en matière de services de santé publics au Canada ont été faites

1 “Almost every culture has a proverb, So long as you have your health. All over the world, people rank health as one of the greatest goods. Yet when it comes to decision-making and priority setting, health vanishes from the scene.” Jonathan Mann, cited in Alicia Ely Yamin, “Defining Questions: Situating Issues of Power in the Formulation of a Right to Health under International Law” (1996) 18 Hum Rts Q 398 at 407-408.

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par des organismes de contrôle du droit, reconnu dans des instruments internationaux, de tout être humain à la santé. Cela dit, récemment, la gouvernance nationale de la santé, d’une part, et le droit à la santé et les droits de la personne au niveau international, d’autre part, ont convergé et mis l’accent sur la nécessité de promouvoir des politiques fondées sur des données probantes, la responsabilisation, la transparence et la participation, facteurs qui sont aptes à assurer une distribution plus équitable des ressources en santé. Le document suit le cheminement vers cette convergence. Les politiques en matière de santé étaient largement fondées sur des préoccupations liées à la limitation des coûts et à l’intégration des services, alors que les préoccupations démocratiques et institutionnelles à l’égard de la protection des droits socio-économiques sont à l’origine du virage du droit à la santé et des droits de la personne vers des approches procéduralistes. Ces priorités communes ouvrent néanmoins la porte à de nouvelles luttes visant des approches axées sur les droits de la personne en ce qui a trait à la distribution des services de santé au Canada, luttes qui impliqueront les actions suivantes : (i) gérer l’indétermination dans les déterminants sociaux de la santé; (ii) corriger les déséquilibres de pouvoir qui déterminent la façon dont l’information en matière de santé est produite et communiquée et les réactions qu’elle entraîne, et (iii) éclaircir le rôle des valeurs normatives fondamentales qui limitent les politiques de fond en matière de santé.

I. INTRODUCTION

Despite Canada’s well-known tradition of publicly funded universal health care, concern about the equitable distribution of health care resources has grown. The Canada Health Act [CHA], passed in 1984, effectively ensured that hospital and physician services deemed medically necessary would be underwritten by a single government insurer and distributed on the basis of need and not ability to pay. This was achieved by a federal promise of dollar-for-dollar matched funds for provincial spending on covered services in exchange for a provincial promise that there would be no “user charges” by hospitals or “extra billing” by physicians for insured services. Although this “core of Medicare” has arguably remained intact, concern over the equitable distribution of health care resources in Canada has grown as governments struggle with delimiting the scope of services offered and as an increasing amount of health spending falls outside the scope of hospital and physician services. Yet human rights responses to this concern have been limited, both at the domestic and international level.

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2 See Canada Health Act, RSC 1985, c C-6 s 19-20. Furthermore, the establishment of a parallel private system was discouraged through prohibitions on, or disincentives toward private insurance for publicly insured services. See Colleen M Flood & Tom Archibald, “The Illegality of Private Health Care in Canada” (2001)164 Can Med Assoc J 825 [Flood & Archibald, “Illegality”].

3 Gregory Marchildon, Health Systems in Transition: Canada (Toronto: University of Toronto Press, 2006).
This paper argues that the lack of profound human rights scrutiny around the distribution of health care resources in Canada can be attributed in part to the opaque and poorly coordinated domestic spheres of authority for determining the funding, administration and delivery of services, but also the human right to health whose methodology remains deeply contested. Recent developments in health care governance in Canada, however, dovetailing with an emergent focus on governance and social determinants of health in human rights law, may open new doors for human rights scrutiny and the integration of rights-based approaches to questions of distribution of health-related goods and services.

II. LIMITED HUMAN RIGHTS SCRUTINY OF HEALTH RESOURCE DISTRIBUTION IN CANADA

This paper begins from the premise that the distribution of health care resources in Canada – whether public or not – is a question of significance from the perspective of international human rights. Canada is a signatory to the International Covenant on Economic, Social and Cultural Rights [ICESCR], which recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”

Article 12.2.d of the ICESCR requires all signatory states to take all steps necessary for the “creation of conditions which would assure to all medical service and medical attention in the event of sickness.” Article 2.1 enshrines the state’s duty of progressive realization: it must “take steps... to the maximum of its available resources, with a view to achieving progressively the full realization” of the rights in the ICESCR. Article 2.2 adds that the right to health is to be enjoyed “without discrimination”, and, in particular, without discrimination based on “social origin, property, birth or other status.”

The United Nations Committee on Economic, Social and Cultural Rights [CESCR] states, in its non-binding but influential General Comment No. 14 on the Right to the Highest Attainable Standard of Mental and Physical Health (General Comment No. 14) that states have a “core obligation” to, inter alia, “ensure rights of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable and marginalized groups” and “to ensure equitable distribution of all health facilities, goods and services”.

Yet health care distribution in Canada is arguably growing less equitable. Provinces have responded to perceived cost pressures on the system by limiting the scope of publicly-funded services, leading observers to question the opaque and physician-interest-driven processes for determining what is classified by provinces as medically necessary. The set of services that ultimately qualify has attracted criticism and litigation. Moreover, Canadians are relying increasingly

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4 International Covenant on Economic, Social and Cultural Rights, 16 December 1966, 993 UNTS 3 at art 12(1) [ICESCR].
5 Ibid at art 12.2.d.
6 Ibid at art 2.2.
7 UN Committee on Economic, Social and Cultural Rights [CESCR], General Comment No 14: The Right to the Highest Attainable Standard of Health (Art 12 of the Covenant), 11 August 2000, UN Doc E/C.12/2000/4 [General Comment No 14].
9 Cathy Fooks & Steven Lewis, Romanow and Beyond: A Primer on Health Reform Issues in
on services that fall outside the ambit of the *Canada Health Act*’s user fee ban, such as mental health care, palliative care, post-acute care, home care and pharmaceuticals. These non-CHA-covered health services are funded (or not) at provincial discretion. The related question about the relationship between health care services and social determinants of health has likewise been difficult to address within existing Canadian frameworks for the distribution of health-affecting resources, even as the right to health at the international level focuses increasingly on social and human rights determinants. In addition, wait times and other non-financial barriers to access have received increasing attention, particularly following a succession of reports that investigated the state of publicly-funded health care in Canada at the turn of the new millennium. Finally, an overarching concern in each of these areas is accountability: overlapping and unclear lines of responsibility for decisions affecting the provision of health services have made it difficult to determine whether decisions are achieving desired goals and who is responsible where they do not.

Non-governmental organizations have certainly raised concerns about coverage in their submissions to the CESCR. One NGO shadow report has noted

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10 See e.g. The Fyke Commission, *ibid* at 34 (discussing palliative care in the Canadian Health Care System); *Canada Health Action, ibid* (discussing post-acute care in the Canadian Health Care System); Fooks & Lewis, *ibid* at 9 (discussing pharmaceuticals and mental health care in the Canadian Health Care System).


12 See Carolyn Hughes Tuohy, “The Hedgehog and the Fox: Glouberman and Marmor on Towards a New Perspective on Health Policy” (2007) 2 Health Economics, Policy and Law 107 at 107. (Defining social determinants of health as “that broad set of socio-economic factors well beyond the purview of health care systems, strikingly correlated with socio-economic status, that influence the health of populations.”)


15 See The Canadian Council for Refugees, the Canadian Council for Churches, and the Inter-Church Committee for Refugees, *Draft Statement to the UN Committee on Economic, Social and Cultural Rights* (16 November 1998), online: Equality Rights <http://www.equality-
that the exclusion of prescription drugs, as well as dental and vision costs, from coverage under the public plan, in addition to provincial de-listing of hospital and physician services, together make health services unaffordable for those who lack the means to pay. Another has argued that the increasing reliance on private insurance and the lack of coverage of prescription drugs and physiotherapy has a disproportionate impact on First Nations people and people with disabilities. Another has expressed concerns about increasingly long waitlists in the public system.

The CESCR, however, has engaged only minimally with these concerns. In its 1993 Concluding Observations, the committee praised Canada’s high standard of health care and the accountability created through the Canada Health Act. In 1998, it recommended in general terms that federal and provincial arrangements be adjusted to make mental health care and home care available, and in 2006, it expressed concerns about health outcomes and access barriers faced by Aboriginal people, African Canadians, and homeless girls. But it has said nothing about systemic features of Canada’s health care system that might contribute to these outcomes and barriers. In fact, the CESCR had nothing but praise for Canada’s health care system as a whole.

The CESCR’s relative silence about growing inequalities in health resource distribution may result from the unwieldiness of the principle of non-retrogression, particularly in the context of a relatively well-developed single-payer health care system like Canada’s. The concept of non-retrogression, which represents an effort to concretize the duty of progressive realization, has been variously defined, and criticized as an “extremely crude and unsatisfactory yardstick” for

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17 rights.org/ngoun98/inter-church.htm> (noting “severe cutbacks” in health care for Canadians and permanent residents).


24 Ibid at para 8 (“The Committee notes with satisfaction the numerous health programmes conducted by the State Party, such as the 10-year Plan to Strengthen Health Care and the launch of the Public Health Agency”).

25 The principle is rarely carefully explored, and has been defined in numerous ways. General Comment No. 3, CESCR, Report on the Fifth Session, 1991, 5th Sess, Supp No 3, Annex III, UN
measuring compliance. The principle notably fails to address what it means to move backward and obscures the fact that progress may require old strategies to be abandoned and new strategies to be adopted in light of changing socio-economic circumstances. In the case of health care in a well-developed country like Canada, retrogression and progression cannot easily be disentangled. Indeed, critics of health care governance in Canada have complained that entrenched interests have blocked the abandonment of costly, antiquated treatments in favour of more cost-efficient ones.

The principle of non-retrogression is rendered even more difficult to apply in light of the Covenant’s purported neutrality as to mode of delivery. The CESCR has stated that the Covenant “neither requires nor precludes any particular form of government or economic system” and that it “cannot accurately be described as being predicated exclusively upon the need for, or the desirability of a socialist or capitalist system, or a mixed, centrally planned, or laissez-faire economy, or upon any other particular approach.”

This neutrality may explain why the principle of non-retrogression has been weakly applied. A representative example is the Committee’s response to extensive and unprecedented cutbacks in New Zealand’s social welfare programs in the early 1990s. The New Zealand government justified the cutbacks rather generally as part of a program to “reverse[e] economic decline and the growth of dependence on welfare.” Rather than declare the reforms retrogressive and a violation of the Covenant, or demand better justification from the country, the CESCR simply expressed concern that “recent extensive reforms may negatively affect the enjoyment” of economic, social and cultural rights (ESCRs), and urged the state to monitor those effects.

Doc E/1991/23 at para 9 [General Comment No. 3] at para 9 suggests that it imposes a strong justificatory burden on states that would take any “deliberately retrogressive measures”. See also Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, 22-26 January 1997 at para 14(e) (going somewhat further and declaring it a violation for states to “adopt any deliberately retrogressive measure that reduces the extent to which any right is guaranteed”); Siddiqur Osmani, “Globalization and the Human Rights Approach to Development” in Bård A. Andreassen & Stephen P. Marks, eds, Development as a Human Right: Legal, Political and Economic Dimensions (Cambridge, MA: Harvard School of Public Health, 2007) at 265 (understanding the principle to mean that “nobody should be allowed to suffer an absolute decline in the enjoyment of any right at any time” and that the principle “does not permit the level of enjoyment of any right to decline in comparison with the past”).


Ibid at 52-54.

Flood, Tuohy, & Stabile, supra note 8. See also Lauchlan T Munro, “The ‘human rights-based approach to programming’: A contradiction in terms?” (Paper delivered at the University of Manchester Conference on “Winners and Losers from Rights-Based Approaches to Development”, 21-22 February 2005), online: <http://www.sed.man.ac.uk/research/events/conferences/documents/Winners%20and%20Losers-%20Papers/Munro.pdf> (calling non-retrogression a profoundly conservative concept for this reason).

General Comment No. 3, supra note 24 at para 8.


Ibid at para 18.
Finally, the continued influence of early “minimum core content” conceptions of ESCRs may appear to suggest that right to health has greater application in developing countries or countries with very rudimentary health care infrastructure. In its early work, the CESCR, reflecting prevailing academic views at the time, sought to cabin and clarify obligations in the ICESCR not only through the principle of non-retrogression, but also through a concept of a minimum core obligation linked primarily to subsistence-level need. Some theorists have doubted that anyone can properly define basic survival level needs, or that human dignity should be situated primarily at the level of what it takes to survive. Others have suggested a more flexible minimum core that would place different obligations on countries at different levels of development. In addition, the CESCR’s concept of the minimum core has evolved to include a number of more procedural obligations that extend beyond basic subsistence. Nonetheless, the idea that the primary role of ESCRs is to protect against the most severe cases of material deprivation has retained a persistent influence.

Whether difficulty lies with the concept of a minimum core, the challenges of progressive realization, or other factors, the fact remains that the human rights dimensions of health care distribution policies in developed countries have received less attention than health and human rights concerns in developing countries. Recently, however, the strategies, methodologies, and rhetoric employed to identify and remedy exclusions of marginalized groups and

34 See General Comment No. 3, supra note 24 at para 10 (“The Committee is of the view that a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon each State party. Thus, for example, a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or the most basic forms of education is, prima facie, failing to discharge its obligations under the Covenant”).
37 See General Comment No 14, supra note 7.
38 See e.g. David Bilchitz, *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights* (Oxford: Oxford University Press, 2007) at 179-180 (preferring a universal survival-based definition of the minimum core). See also Young, supra note 35 at 128-129 (discussing how the focus on survival-level need helps bridge the divide between ESCRs and the the better-established CPRs.)
individuals from social and state institutions have shifted. This shift is reflected prominently, though by no means exclusively, in developments in advocacy, monitoring, and academic writing concerning social and economic rights, including the right to health. Parallel developments in bioethics, health law, and policy emphasize a broadened field of health inquiry and increase the focus on social and structural determinants of health, evidence-based decision-making, and transparent and participatory approaches to norm-setting. The combined results of these changes set the stage for more meaningful human rights engagement with priority-setting in Canadian health care than has been evident to date.

III. HUMAN RIGHTS, HEALTH, AND A TURN TOWARD THE PROCEDURAL

The twenty-first century has been described as ushering in a changing vision of human rights, one that focuses less on detecting and remedying clear violations of pre-defined, universal and concrete rights and freedoms arising from overt government action, and instead places greater emphasis on the role of rights in “consolidating citizenship and democratic self governance.” Tara Melish describes, for example, how the “legalist and consumerist” modalities of the U.S. rights revolution of the 1960s and the “narrow and absolutist” methodologies of the international human rights movement are giving way to a “new, broader, more democratic understanding” of human rights law. This understanding remains grounded in the concept of human dignity, but instead of focusing on protecting citizens from a repressive state apparatus, it focuses on the meaningful engagement of the powerless in community-defined goals and priorities. It reflects a substantive fluidity and stronger emphasis on democratic processes. It may make more room for meaningful human rights based appraisals of systems – including, of course, health care systems – affecting social and economic rights.

The story of how and why ESCRs came to be understood as somehow less important, less meaningful, less “rights-like” by the human rights community provides a useful starting point for understanding this shift. Although ESCRs

39 See e.g. Norman Daniels & James Sabin, “The Ethics of Accountability in Managed Care Reform” (1998) 17 Health Affairs 50.
41 See Theodore Marmor, Fads in Medical Care Management and Policy (London: TSO, 2002) (canvassing themes – or “fads” in Marmor’s view – that have characterized health care reform across nations including: attempts to develop open and explicit criteria to inform the rationing of access to health care; calls for evidence-based decision-making about costs and efficacy in treatment; and the development of a broad “healthy public policy” agenda, embracing a wide range of social objectives within a framework of population health).
44 Ann Janette Rosga & Margaret L Satterthwaite, The Trust in Indicators: Measuring Human Rights (2009) 27 Berkeley J Int’l L 253 at 259 (“It is almost a cliche to say that economic, social
and civil and political rights [CPRs] enjoyed equal recognition within the *Universal Declaration of Human Rights* in 1948, there is little dispute that ESCRs have occupied the lesser place within the catalogue of human rights.

The original decision to create two treaties – the *International Covenant on Civil and Political Rights*, and the *International Covenant on Economic, Social and Cultural Rights [ICESCR]* – has been attributed to Cold War tensions. The Soviet states championed the cause of ESCRs, which they associated with the aims of the socialist society and western states asserted the priority of CPRs as the foundation of liberty and democracy. This conflict led to the creation of two separate instruments – the ICCPR and the ICESCR.

The rights in the two treaties are framed rather differently. The ICCPR provides that “no one shall be subjected to” violations of their civil and political rights, and the ICESCR is formulated in terms of states “recogniz[ing] the right of everyone to...” each of the enumerated rights. The rights enumerated in the ICESCR, unlike the rights in the ICCPR, also have the distinction of being limited by the principles of progressive realization and of resource availability set out in s. 2.1 of the ICESCR.

The General Assembly made clear that it did not intend to ascribe relative value to the two sets of rights through this separation. The existence of the two treaties, however, and their distinct framing, allowed “Western scholars and statesmen” to succeed in “[giving] priority to civil and political rights, emphasizing individual liberties [and promoting the view that] socio-economic right[s] were 'pseudorights'...” The International Law Commission [ILC] further entrenched the difference between the two sets of rights in its early draft articles on state responsibility, which classified rights as creating either “obligations of result” – which were understood as less strict since they allowed states to meet

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46 See United Nations High Commissioner for Human Rights, *Fact Sheet No. 16 (Rev. 1)*, The Committee on Economic, Social and Cultural Rights (July 1991), online: <http://www.ohchr.org/Docu-ments/Publications/FactSheet16rev.1en.pdf> [*Fact Sheet No 16*].
48 *International Covenant on Civil and Political Rights*, 16 December 1966, 999 UNTS 171 [ICCPR].
their obligations in any number of ways – and “obligations of conduct,” which set out more precisely what states were expected to do. Arguably, the ICESCR, to the extent that it “recognizes” rights toward which states are required to “take steps”, imposes the less strict kind of obligations of result.

Though the distinction has since been dropped from the ILC draft articles, the notion that the two treaties create different types of rights (with ESCRs more aspirational than legally binding) has been persistent. Viewed through this lens, for example, the CESCR’s claim of political neutrality as to how states meet their obligations, and its explicit acknowledgement of the need for local-level negotiation over the content of the rights, would place ESCRs squarely within the category of not-quite-rights – “development goals” perhaps – and therefore arguably of little importance within first-world countries. Although Cold War tensions eased in the 1970s, and despite continued affirmations of the interdependence and indivisibility of the full catalogue of rights, the perception of ESCRs as programmatic remains.

The continued marginalization of ESCRs has been further driven by the twentieth-century social and political contexts in which the rights came of age. The post-cold war period was characterized by transitions from authoritarian to liberal political systems. Conceptions of rights centred around protecting individuals politically targeted by repressive state apparatuses from assaults on liberty and bodily integrity. The human rights discourse became state-centric and absolutist, focused on liberties from state intervention. Human rights were understood to draw lines states were not to cross; they were a fixed set of rules for mandatory and uniform compliance. Within this vision, the differences between ESCRs and CPRs were exaggerated. CPRs, as rights that seek to protect against the overweening state, occupied a privileged place. Dignity-based claims that were the proper subject of local democratic processes and negotiation, either because they required consideration of competing resource needs, or varied


52 See Crawford, ibid at 22. See also PM Dupuy, “Reviewing the Difficulties of Codification: On Ago’s Classification of Obligations of Means and Obligations of Result in Relation to State Responsibility” (1999) 10 EJIL 371 (calling the distinction unhelpful).


54 General Comment No. 3, supra note 24 at para. 8: (stating that the principles of the ICESCR (“cannot accurately be described as being predicated exclusively upon the need for, or the desirability of a socialist or a capitalist system, or a mixed, centrally planned, or laisser-faire economy, or upon any other particular approach in question.”)

55 Sepúlveda Carmona, supra note 51 at 189.

56 Vienna Declaration and Programme of Action, 12 July 1993, UN Doc A/CONF.157/23 at s I(5).

between local contexts and cultures, were not viewed as “real” rights, or at least not ones that the international human rights movement should take up.\footnote{Neier, supra note 43; Kenneth Roth, “Defending Economic, Social and Cultural Rights: Practical Issues Faced by an International Human Rights Organization” (2004) 26 Hum Rts Q 63.}

The pertinence of the traditional vision of human rights – as negative rights designed to protect against the overweening state – has been called into question in a more globalized twenty-first century characterized by liberalizing governments, the increasing political power of transnational corporations, and decentralization of power and authority.\footnote{Alison Brysk & Gershon Shafir, People Out of Place: Globalization, Human Rights, and the Citizenship Gap (New York: Routledge, 2004); Jonathan Daniel Weiler, Human Rights in Russia: A Darker Side of Reform (Boulder, CO: Lynne Rienner, 2004) at 15; Steven R. Ratner, “Corporations and Human Rights: A Theory of Legal Responsibility” (2001) 111 Yale LJ 443.}

When power is less concentrated in states, and embedded within private or less institutionalized actors who may be acting beyond state reach or through its economic capture, the state-centric human rights paradigm loses currency as a means of protecting dignity, human agency, and citizenship.\footnote{Melish, supra note 42 at 73.} To address dignitary harms, marginalization, and abuses mediated through these changed vectors of power, rights are increasingly being reconceived not as substantive \textit{trumps} on local political processes and democratic choices, but rather as a set of \textit{tools} for guaranteeing that the voices and dignity-based interests of the poor and marginalized are heard and considered in the construction of the public agenda. Methodologies that seek to identify explicit state violations of fixed rules against individual rights claimants have not been abandoned. However, they have been supplemented by new sets of human rights strategies that focus on increasing accountability, transparency, and participation of rights holders (especially marginalized rights holders) in relation to state policies affecting human rights.\footnote{Elisabeth Martin, Marie-Pascale Pomey & Pierre-Gerlier Forest, “One Step Forward, One Step Back: Quebec’s 2003–04 Health and Social Services Regionalization Policy” (2010) 53 Canadian Public Administration 467 (explaining how NGOs concerned with poverty and inequality have recently adopted the mantle of human rights). See Melish, supra note 42 at 303 (citing the US-based Poor People’s Economic Human Rights Campaign). See also Scott Cummings & Louise G Trubek, “Globalizing Public Interest Law” (2008) 13 UCLA J Int’l L and Foreign Aff 1 (describing a “rule of law” movement relying on the language of human rights to “temper excesses of open markets with appropriate regulation and democratic rights”).}

The idea that states’ internal processes toward achieving treaty obligations are of human rights significance is, of course, not new.\footnote{Paul Hunt, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, UNGAOR, 2007, 4\textsuperscript{th} sess, UN Doc A/HRC/4/28 at paras 26 and 87 [Report of the Special Rapporteur, 2007] (stating that “traditional” human rights tools like “naming and shaming, letter writing campaigns, test cases, sloganizing and so on” may have “served the human rights community well” for a time, but that the complexities of the right to health require “additional methods, techniques, and skills” including benchmarks, indicators, and impact assessments). See also Jonathan Klaaren, “A Second Look at the South African Human Rights Commission, Access to Information, and the Promotion of Socioeconomic Rights” (2005) 27 Hum Rts Q 539 (suggesting a national model of socioeconomic rights protection based on participation, transparency, and a constitutional right of access to information).}

But early academic and institutional efforts to render ESCRs more meaningful sought to wrestle their

\begin{thebibliography}{99}
\item Melish, \textit{supra} note 42 at 73.
\item Paul Hunt, \textit{Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health}, UNGAOR, 2007, 4\textsuperscript{th} sess, UN Doc A/HRC/4/28 at paras 26 and 87 [\textit{Report of the Special Rapporteur, 2007}] (stating that “traditional” human rights tools like “naming and shaming, letter writing campaigns, test cases, sloganizing and so on” may have “served the human rights community well” for a time, but that the complexities of the right to health require “additional methods, techniques, and skills” including benchmarks, indicators, and impact assessments). See also Jonathan Klaaren, “A Second Look at the South African Human Rights Commission, Access to Information, and the Promotion of Socioeconomic Rights” (2005) 27 Hum Rts Q 539 (suggesting a national model of socioeconomic rights protection based on participation, transparency, and a constitutional right of access to information).
\item The \textit{ICESCR} itself requires states to “take steps” toward progressive realization of the rights. See \textit{ICESCR}, \textit{supra} note 4 at art 2.1.
\end{thebibliography}
content down to something more bounded, concrete and unchanging, to bring them in line with the traditional model. For example, in 1990 the CESCR introduced the idea of “minimum essential levels” of each right which would be immediately enforceable and not subject to vague limitations like progressive realization and maximum available resources. Similarly, Audrey Chapman has championed a “violations approach” to ESCRs, whereby she argued that monitoring bodies should focus on defining and identifying explicit violations of ESCRs by government actors, rather than attempt to assess progressive realization. The approach came under criticism from NGOs reluctant to abandon more aggressive enforcement of progressive realization. Yet, Chapman in those early years maintained her position largely because, in her view, there were insufficient tools and information to assess the fulfillment of the programmatic aspects of the right to health.

Newer interventions, advanced by human rights scholars and reflected in international institutions, emphasize the need to address, rather than avoid, the problems of progressive realization and gaps in information by requiring states to identify and attend to obstacles to assessing progressive realization as part of their international human rights obligations. This has been described as a move toward “monitoring-of-monitoring” or “managing accountability.”

Procedurally grounded human rights measures – such as human rights indicators, benchmarks, and impact assessments – are being developed so as to enhance arguably less substantive human rights principles like accountability, transparency, non-discrimination, democratic participation, and individual self-determination. They do not purport to give conclusive answers to questions

64 General Comment No. 3, supra note 24. See also Young, supra note 35.
66 See e.g. ibid. Although there are some aspects of the violations approach evident in comments of the CESCR (see e.g. General Comment No 14, supra note 7 at paras 30–31), the Committee has not shied away from suggesting novel methods for assessing progressive implementation. Chapman, “Violations Approach”, supra note 65 at 202.
68 See Rosga & Satterthwaite, supra note 44 at 275. See also Report of the Special Rapporteur, 2007, supra note 62 at para 87; General Comment No 14, supra note 7 at para 43(f) (requiring that states, as part of their minimum core obligations, set up and implement a national health plan; devise it using “participatory and transparent processes”; include methods such as indicators and benchmarks for measuring progress; all with particular attention to vulnerable or marginalized groups”); Young, supra note 35 at 116-118 (suggesting that theorists of economic and social rights should move away from substantive definition of the content of core rights and obligations and toward “concepts that facilitate rights’ content, operating as law”, including benchmarks, indicators, participatory processes, and justification requirements).
69 Rosga & Satterthwaite, supra note 44 at 259.
70 Melish, supra note 42 at 75.
71 See Joseph Raz, “Human Rights in the Emerging World Order” (2010) 1 Transnational Legal Theory 31 (describing the threefold role of human rights in the post-Cold War period as: “first... expressing the worth of all human beings; second... placing on the agenda concerns other than those of inter-governmental relations or big business profit; and third...empowering individuals
about how priorities should be set among competing objectives. 73 Rather, in addition to being valued norms in themselves, these principles are expected to drive progressive realization 74 by ensuring that decisions about priority setting are reasonable, transparent, informed by evidence, and take into account the needs of the most marginalized (as understood by the most marginalized). 75 The growing popularity of these tools – for ESCRs but also for CPRs 76 – suggests that human rights are relied upon increasingly for their values-driven and governance-enhancing function as opposed to any fixed normative content they might prescribe. 77 That is, deliberation-enhancing, accountability-oriented processes are used to create spaces of contestation – and to suggest values that might inform that contestation.

The history of the use of indicators for human rights monitoring by UN institutions reveals a developing orientation toward building up structures for internal accountability in service of the right to health. As early as 1990, Danilo Türk, Special Rapporteur on the Realization of Economic, Social and Cultural Rights, identified indicators as a potentially useful proxy for measuring the progressive realization of socio-economic rights, a “yardstick” that would provide a way of assessing progressive realization over time, developing core content, and facilitating comparisons of rights realization across countries with similar levels of

and voluntary associations in creating an additional channel for exerting influence and affecting the international order”, while expressing concerns about the institutional capacity and legitimacy of international institutions for the enforcement of rights to health and education). See similarly Brigitte I Hamm, “A Human Rights Approach to Development” (2001) 23 Hum Rts Q 1005; Mac Darrow & Amparo Thomas, “Power, Capture and Conflict: A Call for Human Rights Accountability in Development Cooperation” (2005) 27 Hum Rts Q 471 at 493 (noting that there can be normative or instrumental rationales for adopting human rights-based approaches to programming and development, but that instrumental conceptions “seem to be the most compelling”; noting also that “this rationale harnesses human rights ideas and energies in order to reach the excluded, or reinforces participatory approaches to situation assessment, empowering people as actors for their own development, strengthening institutions of governance and accountability, and so on”).

74 Ibid at para 27. See also Alicia Ely Yamin, “Defining Questions: Situating Issues of Power in the Formulation of a Right to Health under International Law” (1996) 18 Hum Rts Q 398 at 407 [Yamin, “Defining Questions”] (suggesting that the “distinction between instrumental and normative value of defining health as a human right collapses” when rights are understood to advance empowerment as both as goal and strategy).
76 Rosga & Satterthwaite, supra note 44 at 266 (showing how social scientists have measured and ranked countries performance in relation to CPRs, citing Charles Humana, World Human Rights Guide (London: Hutchison, 1983); Charles Humana, World Human Rights Guide (London: Hodder & Stoughton, 1986) Humana assigns percentage ratings to countries based on scores concerning forty CPRs, and ranking them “good, fair, poor or bad”) See also Kevin E Davis, Benedict Kingsbury & Sally Engle Merry, “Indicators as a Technology of Global Governance” 46 Law & Soc’y Rev (2012) 71 at 71-72 [Davis et al, “Indicators”] (discussing the direct and indirect roles played by indicators in decision-making by national and international institutions such as the World Bank.)
77 Cummings & Trubek, supra note 61.
socio-economic development. At that time, however, Türk was referring to traditional social and economic indicators: data sets developed by social scientists and economists around, for example, infant mortality for the right to health, or child literacy for the right to education. These are indicators of substantive health or education outcomes, which Chapman had rejected as insufficiently available or under-developed in order to help the ICESCR monitor progressive rights realization.

By 2006, the work of the UN Special Rapporteur on the Right to Health reflected a far broader concept of dignity-based right-to-health indicators. These indicators reflect processes, structures and institutions linked to health, in addition to health itself. For example, indicators now measure whether, as required by General Comment No. 14, states have adopted a national public health strategy that includes the right to health; whether the plan is formulated and monitored through the participation of “the most vulnerable and disadvantaged” individuals and groups; and whether there are effective internal monitoring and accountability mechanisms. Emphasis is placed on states’ duties to generate data in relation to indicators that are disaggregated to reflect contextual vulnerability and discrimination, and on state duties to monitor their own progress internally through indicator-based benchmarking.

Ideally, indicators move from being a tool for Committee-level assessment of states’ progressive realization to drivers of internal processes likely to drive realization of the right to health, by bringing to light discriminatory, arbitrary, or ineffective policies, and by requiring states to develop policy through the lens of human rights. Indicator-based monitoring is relied upon for opening up spaces for

78 Danilo Türk, The New International Economic Order and the Protection of Human Rights: Realization of Economic, Social and Cultural Rights, Progress Report, Prepared by Mr. Danilo Türk, Special Rapporteur, UNESCOR, UN Doc E/CN.4/Sub.2/1990/19 (1990) at para 7. See also Todd Landman, Studying Human Rights (New York: Routledge, 2006) at 90 (describing development indicators as “suitable proxy measures to capture the degree to which states are implementing [their human rights] obligations. For example, literacy rates and gender breakdown of educational attainment are seen as proxy measures of the right to education. . . .”).

79 See e.g. Türk, ibid at para 23. See also Davis et al, “Indicators” supra note 76 at 95-98 (discussing the genealogy, design and production of the Human Development Index, an indicator created in 1990 which combines health (measured by life expectancy), education (measured by literacy rates, and later schooling) and income (measured by GDP per capita, adjusted for purchasing power parity)).

80 Chapman, “Violations Approach”, supra note 65 at 33-34.

81 See Paul Hunt, Report of the Special Rapporteur on the right to the highest attainable standard of health to the Commissioner on Human Rights, UNGAOR, 2006, UN Doc E/CN.4/2006/48 [Report of the Special Rapporteur, 2006]. A recent effort to operationalize this model to evaluate the health systems of the full range of states sets out some 72 indicators. Many of these can be understood as outcome indicators, such as infant mortality rates and life expectancy, but many are better understood as requirements for domestic monitoring designed to leverage local political processes: the existence of a health plan, whether there is legal protection for participation of the marginalized within that health plan, and even transparency in national financing. See also Gunilla Backman et al, “Health Systems and the Right to Health: An Assessment of 194 Countries” (2008) 372 The Lancet 2047, 2057-2058.

82 General Comment No 14, supra note 7 at para 43.

83 Ibid at para 49(c).

84 Ibid at para 49(b).

85 Ibid at paras 34, 35 and 58.
civil society participation in generating systemic human rights-based reform at national and subnational levels.86

The recent attention to human rights impact assessments87 reflects a similar thrust. Human rights impact assessments appear to have been first advanced in the context of public health policy in relation to HIV/AIDS, on the view that public health programs needed to be structured along core principles of human rights and dignity if they were to effectively and legitimately address the epidemic. They have received the greatest attention, however, through John Ruggie’s mandate as Special Representative to the UN Secretary-General on business and human rights. In direct response to the limitations of more absolutist, narrow, and state-centric approaches to human rights outlined above,88 Ruggie rejects the idea of imposing a subset of international human rights obligations on corporations. Instead, he urges soft-law “due-diligence” obligations placed on private-sector actors to project potential human rights impacts of business projects to address governance gaps created by globalization. Under the proposed framework, companies would adopt human rights policies, integrate human rights throughout their organizations, conduct impact assessments in consultation with affected stakeholders, and monitor and track their own human rights performance, with a view toward sharing information and standardizing metrics for comparability.

Ruggie notes that corporate human rights abuse is most likely to take place in countries with the greatest governance challenges at the state level.89 He therefore emphasizes the need to reduce gaps in governance and information in relation to existing obligations.90 Thus, he suggests moving the human rights agenda beyond narrow, typically weak state institutions dedicated to their protection – presumably he means human rights tribunals and commissions – in order to ensure investigation of the human rights implications of choices within the full range of

See e.g. Alicia Ely Yamin, “The Future in the Mirror: Incorporating Strategies for the Defense and Promotion of Economic, Social and Cultural Rights into the Mainstream Human Rights Agenda” (2005) 27 Hum Rts Q 1200 at 1207 and 1212 (arguing that human rights organizations should move beyond identifying individual-level violations and instead collaborate with other disciplines like public health to use indicators in order to advocate in relation to structural and institutional factors in human rights and to create a “starting place for defining appropriate measures for governments to take toward progressive realization”) [Yamin, “Mirror”].

The human rights impact assessment has been described as a set of tools or methods designed to predict the likely effects of a program, policy, or project in order to inform and improve policy development. See e.g. Hunt and MacNaughton, supra note 75 at 8.


Ruggie, “Framework”, supra note 89 at 199-204.

Ibid at 192. Ruggie does not, of course, eschew traditional state duties to protect against human rights abuses within their territory through traditional human rights law enforcement.

See Ruggie, Report to the Secretary-General, supra note 89 at para 14.
government policy domains that shape business practice, such as commercial and investment policies, securities regulation, and corporate governance. The implication, very much in line with the mainstreaming approach he suggests for corporate human rights responsibility, is that state fidelity to human rights obligations can be understood as, in some contexts, a matter of degree, and will be enhanced by the ways in which states monitor compliance with those obligations internally.

There has been a renewed energy for human rights impact assessment for driving and monitoring governments’ obligations as a result of its increased profile in the corporate context. Even as they admit the novelty of the approach, Paul Hunt and Gillian MacNaughton go so far as to argue that human rights impact assessment is “highly recommended, if not required, [for states] to comply with [their] international human rights obligations to progressively realize human rights.” (emphasis added). Their suggested methodology, presented as a case study in relation to the right to health, draws on NGO-developed tools used to help governments and NGOs perform right to health impact assessments for a range of government programs, policies and projects.

As with human rights indicators, this methodology explicitly acknowledges the key roles of transparency, accountability, and participation of the most marginalized in driving progressive realization beyond the minimum core. Of course, human rights impact assessment requires policies to be evaluated against human rights norms. Moreover, as suggested above, Hunt and MacNaughton would require the processes of assessment themselves to be explicitly grounded in fundamental human rights principles. Thus, for example, equality and non-discrimination are not only external norms against which proposed policies are to be tested; they also require that impact analysis disaggregate information along marginalized group lines, and that poor and marginalized groups are given room to take part in transparent and accessible impact assessment processes.

This shift in emphasis toward processes of norm-generation is not limited to ESCRs. Commentators have relied on the diminishing importance of the difference between thresholds of “violation” and “fulfillment,” in order to argue

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95 Landman, supra note 78.
96 Hunt & MacNaughton, supra note 75 at 7.
98 Ibid at 33, stating: “A rights-based approach ... demands that the state take deliberate steps to progressively realize the right to health as expeditiously and effectively as possible. Impact assessment provides state with the methodology to do so” [emphasis added].
99 Ibid at 33 (citing the following general principles underlying rights-based approaches to impact assessment: (1) explicit human rights framework; (2) progressive realization; (3) equality and non-discrimination; (4) participation; (5) information; (6) accountability; and (7) interdependence of rights).
100 See e.g. Rosga & Satterthwaite, supra note 44 at 43 (noting that the rubric of “respect, protect, fulfill”, which was once thought to apply only to ESCRs, has been invoked in relation to CPRs as well). Similarly, the International Law Commission has dropped the distinction between
that neither set of rights can be understood simply as a set of clear substantive entitlements of individuals against states. So, for example, women’s rights to non-discrimination cannot be guaranteed simply through recognition and remedy of equality rights violations at the individual level, but must be understood in terms of women’s rights to equal participation in democratic and institutional processes, and rights to transparency and accountability in relation to that participation.

Nor is the shift in emphasis toward meaningful participation over substantive outcomes as a driver of progressive realization limited to the UN institutional actors and those who explicitly adopt their frameworks. Much critical right-to-health scholarship shares, but elaborates upon and refines the vision that human rights should primarily be understood in terms of locating responsibility and opening spaces for meaningful participation in determining health-affecting state policies through monitoring processes.

Alicia Ely Yamin, for example, emphasizes empowerment as an underlying theme in human rights, and suggests framing the right to health in terms of “the highest attainable standard of control over health.” (emphasis in original). She notes that poor health is “the product not only of human beings’ incomplete domination of nature, but of the domination of some people by others.” The central task of human rights and right to health activism is redefined as an exploratory one: “to discern the societal relations, combinations, and alignments of power that both produce and distribute disease...” She would therefore reject (perhaps provisionally) any normative account of an ideal health care regime, and focus instead on fleshing out the meaning of empowerment in context, and through collaboration with affected communities themselves.

In 1996, Yamin was skeptical of indicators as a process for achieving empowerment; she worried they render human rights monitoring too technocratic. By 2005, Yamin advocated that progressive realization could be

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103 See e.g. Hunt, Report of the Special Rapporteur, 2007, supra note 62; Hunt, Report of the Special Rapporteur, 2006, supra note 81; Hunt and MacNaughton, supra note 75; Backman and Hunt, supra note 75.

104 Yamin, “Defining Questions”, supra note 74 at 400.

105 Ibid at 402.

106 Ibid.

107 Ibid at 436 and 438.

108 Ibid at 406-407 (expressing the concern that indicators will render health status an objective, quantitative quality ... one more output to be produced.... [turning] human beings (and their behaviours) into one more input and thus the targets of incentive changes and objects of surveillance). See also Sally Engle Merry, “Measuring the World: Indicators, Human Rights and Global Governance” 52 Supp 3 Current Anthropology 2011 S83 for a thorough critique of indicators as a corporate form of thinking which grants authority to technical experts and replaces
driven by indicators, so long as those indicators remain contestable, not overly technocratic in that they include the qualitative, and are defined through the collaboration of human rights NGOs with other stakeholders including public health actors. AnnJannette Rosga and Margaret Satterthwaite likewise respond to concerns over the risks of indicators, with an emphasis on meaningful participation in creating a contestable set of indicators. They suggest that “indicators must be created that will measure the participation of the populace in decisions affecting both institutional design and policy priorities in the field of human rights,” and that “participation should ... extend to the process of designing and implementing indicators themselves.”

Under this developing model, the role of government is understood differently than in traditional rule-and-principle based approaches to human rights. The model promises to pry open spaces for democratic engagement by requiring states to account for their role in rights realization even when responsibility for outcomes is only partly or remotely within state control. This new emphasis casts human rights more as a framework set of tools for guaranteeing meaningful enfranchisement, grounded in principles linked to human dignity, rather than a set of substantive entitlements. It recognizes that lack of voice in democratic governance lies at the root of much human rights abuse. Under these newer models, government is no longer simply an object of human rights accountability, a potential human rights violator. It is also a “manager of accountability processes” between citizens and both state and private actors, increasingly recognized as implicated in human rights realization.

This new accountability-centred model, whereby public goods are scrutinized not (primarily) for their substantive distribution, but for whether processes for distribution comply with foundational human rights principles, holds a great deal of theoretical promise for human rights-based assessments of health systems in Canada. Generally, it diminishes the argument that CPRs and ESCRs are of fundamentally different natures, with ESCRs occupying the lower rung. Likewise, where states’ duties to self-monitor, disaggregate data, benchmark, and open up participation in policymaking occupy a more central place among their human rights obligations, the differences between “violations” and “minimum core” approaches on the one hand and progressive realization on the other diminish. Free of the need for universal substantive normativity, “immediately enforceable” ESCRs need not be restricted to the level of basic survival and can have greater resonance in a well-developed health care system. Insufficiently justifiable choices rooted in power, ignorance or stereotype cannot hide as easily behind privatized and disaggregated lines of responsibility and authority. Concerns about

political debate with technical expertise.

109 Yamin, “Mirror”, supra note 86 at 1210, stating: “If human rights groups are willing to work with other disciplines ... [indicators] can form the basis for the standard-setting work the human rights movement has successfully engaged in for years with respect to many civil and political rights issues, including prison conditions.”

110 Rosga & Satterthwaite, supra note 44 at 313-314. See also Davis et al, “Indicators,” supra note 76 at 88-89 (suggesting that some of the risks of reliance on indicators can be mitigated by making those indicators contestable).

111 Melish, supra note 42 at 74.

112 Ibid at 75.

113 See Young, supra note 35 at 166; and also Rosga & Satterthwaite, supra note 44 at 265.
transparency, accountability, and substantive distribution in Canadian health care – well-voiced in the political sphere – may be structured in concrete human rights terms.

Although the new emphasis on processes in human rights is relatively recent, its set of core themes is not. A number of authors have noted common intellectual underpinnings and features of the new conceptions of accountability and responsibility in human rights and new ideas about governance in the public sector (including health policy). That is, the driving themes in the “new human rights” – enhancing democratic governance through flexible norm-setting that responds to community-level needs, reliance on transparent, deliberative processes, evidence-based decision-making, and citizen participation – are closely paralleled in public policy, including health policy, literature in Canada and internationally. The emphasis has increased as resource constraints have put pressure on Canadian health care and raised concerns about accountability in the scope and distribution of publicly-funded services. The next section will examine the evolution of health governance in Canada along such lines, with a view to exploring how Canada might respond to the demands of the procedural dimensions of the human right to health, and to expose contextual challenges to this procedural project.

IV. GOVERNANCE AND ACCOUNTABILITY IN CANADIAN HEALTH CARE REFORM

As governments have taken an increasing role in rationing health care services, concerns about transparency and accountability have figured prominently in Canadian political, institutional and popular discussions around, and have driven recent reforms geared toward performance measurement and citizen participation. This section explains how reforms in Canadian health care came to be structured around transparency, accountability and citizen engagement with a view to determining whether the seeming parallels to these themes in health and human

rights suggest new opportunities for human rights scrutiny of health care distribution.

A. The Historical Disaggregation in Canadian Health Care

Concerns around accountability must be understood in the context of the overlapping and disaggregated institutional orders governing Canada’s health care system, and the incremental roles played by the federal and provincial governments in shaping the distribution of care. From its inception, the Medicare model was concerned with maintaining professional control over clinical decision-making, effectively leaving the scope and delivery of services to individual physician discretion. For this reason, it took a very long time before public values of any kind played a role in distribution of health care.

The professional dominance over the delivery and distribution of publicly funded health care in Canada stretches as far back as the nineteenth century. At this time, provincial governments, having constitutional responsibility for the administration and delivery of health care, began encouraging the distribution of hospital services based on need rather than ability to pay. They did so by requiring existing nonprofit municipal, charitable and religious hospitals to admit all patients on the basis of medical need in exchange for reimbursement and some regulatory oversight. Private for-profit hospitals did not qualify for the subsidy, and there were few state-owned and controlled hospitals at the time. By 1947, provinces began experimenting with government-funded hospital insurance to supplement largely employer-based private insurance plans: Saskatchewan implemented a plan to underwrite all medically necessary hospital stays, x-rays, laboratory services and some prescription drugs. British Columbia and Alberta soon followed suit, and after the federal government agreed to conditional cost-sharing in the mid-1950s, all ten provinces signed on.

In the early 1960s, following cost-sharing for universal insurance of necessary hospital services, Saskatchewan began to pioneer a similar scheme for physician services. Fearing incursions on professional autonomy, the physicians responded by going on strike for 23 days in 1962. Saskatchewan returned with a plan emphasizing physicians’ contractual autonomy, and physician autonomy remained an important feature in future negotiations over the form and content of Medicare. What is known today as Medicare was created in 1966 when, following recommendations from a Royal Commission Report on Health

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117 Colleen M Flood, Duncan Sinclair & Joanna Erdman, “Steering and Rowing in Health Care: The Devolution Option” (2004) 30 Queen’s LJ 156 at 172 (2004) (noting the noted the stubborn persistence of the view that government acts as “mere insurer, funding any care that a physician thinks is necessary,” even in the face of the government’s growing role.)

118 See e.g. The Charity Aid Act, Ontario Statutes, 1874, 37 Vict at ch 33.


120 For a historical overview, see Marchildon, supra note 3 at 19-25. For a richer history, see Carolyn Hughes Tuohy, Accidental Logics: The Dynamics of Change in the Health Care Arena in the United States, Britain, and Canada (New York: Oxford University Press, 1999) at 49 [Tuohy, Accidental Logics].

121 Tuohy, Accidental Logics, ibid at 53.

122 Ibid at 56.
Services, the federal government passed the Medical Care Act, designed to encourage the remaining provinces to introduce schemes like Saskatchewan’s. It established federal cost-sharing transfers to the provinces for medical care insurance schemes that met the criteria of universality, public administration, comprehensiveness and portability. The goal was to ensure that all Canadians had access to core hospital and physician services on the basis of need, rather than ability to pay. By 1972, all the provinces had signed on and a universal national health insurance plan was in place.

The CHA, passed in 1984, plugged some holes in the plan. It prohibited provinces from allowing “extra billing” by physicians and “user fees” charged by hospitals and clinics by deducting them dollar-for-dollar from the province’s share of the federal government transfer. In support of the prohibition on user fees and extra billing, the CHA also added a fifth funding condition to those mentioned above – accessibility. Finally, provinces either prohibited or created disincentives to private insurance for publicly insured hospital and physician services, in order to discourage the development of parallel private systems.

Thus, early models of Medicare, on their face, made no changes to the delivery of physician and hospital services, but simply underwrote a portion of what already existed. Distribution of covered hospital and physician services would remain determined by individual professional judgments about medical necessity. Other individual health services – home care, physical therapy, prescription drugs – could be funded and administered at provincial discretion, and provinces might require co-payment. Public health would likewise fall outside the CHA funding scheme. Provinces and territories could continue to regulate public health through provincial and territorial Public Health Acts and through specialized branches of each one’s ministry of health, and programs would be funded out of provincial and territorial budgets without federal constraint.

Under this basic structure, which remains in place today, Canada’s health system as a whole cannot fairly be described as nationalized, socialized, or a “command and control” system, nor can it fairly be described as comprehensive.

124 For an analysis of the meaning of these principles, see Colleen M Flood & Sujit Choudhry, “Modernizing the Canada Health Act” in Pierre-Gerlier Forest, Gregory Marchildon & Tom McIntosh, eds, The Governance of Health Care in Canada: The Romanow Papers, Volume 3 (Toronto: University of Toronto Press, 2004) 346 at 348.
125 Canada Health Act, supra note 2 at s 20.
126 Ibid at s 7.
128 Public health can be defined as the science and art of promoting health through broad population-level initiatives. See CEA Winslow, “The Untilled Fields of Public Health” (1920) 51 Science 23.
129 The federal government does, however, affect health policy through spending.
130 The “comprehensiveness” criterion at Section 7 of the CHA is largely defined out of meaning. Section 9 provides, “In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services...” See The Romanow Report, supra note 116 at 62-63 (noting that “This is not how the average person would define comprehensive... [but that d]espite this, comprehensiveness should be retained as a principle, not so much as a description of existing coverage under the Canada Health Act but as a continuing goal. It should be redefined to mean that, as financial resources permit and as the health care
Rather, it is more appropriately understood as a “single payer” system for a core set of universal public services, statutorily defined (at the outset and still) as hospital and physician services. The decision not to change the design of service delivery but rather to underwrite its costs meant that the scope of covered services would be driven neither by markets, nor hierarchy, but more by “collegiality” – the government “pays the bills and leaves those in medicine to practice their profession.”

But the passage of time brought new challenges and ideas around health and medical care that fundamentally tested the vision of Medicare rooted in the 1960s. Shifts in the governance of health care distribution in the last two decades have been shaped largely by two forces: concerns about cost containment, and the increasing importance of health interventions outside of hospital and physician services.

B. Costs and the Scope of Services: Redefining the Medicare Basket

From Medicare’s inception in the 1960s until the significant cuts of the 1990s, costs were kept in check largely without resort to restricting services available under the public plan. As discussed, a key part of the original single-payer bargain was that individual physicians maintained professional control over clinical decision-making. It was generally assumed that only medically necessary services would be billed to provincial plans, and that the definition of medical necessity could be managed at the doctor-patient level. Per-service fees were regulated according to “fee schedules” typically negotiated between provincial governments and provincial medical associations. These negotiations initially addressed the fee per physician service rather than the relative value of items listed on the fee schedule or the scope of services covered. Occasionally, there were additions or deletions from the fee schedule, generally at the initiative of medical associations with little substantive government involvement. Individual physicians, however, were largely permitted to determine who to treat, for how much, and how.

Costs from physicians’ services were primarily controlled by caps on billing or by legislative limits on the flow of physicians entering the profession or establishing themselves in a given province or area. At the hospital level, costs were constrained early on when provinces replaced fee-per-item payments with system changes, the definition of comprehensiveness (and of services insured under provincial plans) should continue to evolve”.

Carolyn Hughes Tuohy, “The Costs of Constraint and Prospects for Health Care Reform in Canada” (2002) 21 Health Affairs 32 at 35-36 (setting out three ways of understanding the “political icon” that is Canadian Medicare: a “traditional delivery system for physician and hospital services, underwritten by public funding”; “exclusive universal public financing of physician and hospital services”; and “exclusive universal public finance for a core set of services,” and arguing that each carries with it different prospects for reform, with the first conception being most restrictive, and the last being most liberal) (Tuohy, “Costs”).


Tuohy, Accidental Logics, supra note 120 at 205-206.

Ibid at 213.

Ibid at 205.

global budgets provided to each hospital. These budgets were based on historic spending, with increases driven mainly by provincial fiscal considerations. Occasionally, ministries of health, with input from professional associations, might negotiate with individual hospitals to fund new treatments on an ad hoc basis, but global budgets were considered relatively successful at keeping costs down. Government played a very limited role in determining which services were medically necessary as individual hospitals determined their own allocation of services within their budget.

By this point, the tradition of negotiation between the medical profession and provincial ministries of health was well entrenched, and health care in Canada could reasonably be described as “co-managed” between government and professional bodies. Government set broad budgetary parameters, and the medical profession determined distribution mainly at the point of care. Tuohy has called it “one of the puzzles of the Canadian case” that despite highly developed databases of both medical and hospital services generated through physician and hospital billing, there was little government involvement in monitoring or reviewing the mix, volume and distribution of hospital and physician services.

Evans and colleagues explain the state of affairs this way: Canadian public insurers (unlike, for example, private insurers in the United States) had no administrative overhead, no costs for estimating risk status to determine what to cover, and cheaper claims processing (not to mention marketing costs and shareholder premiums). Physicians, for their part, tended to express satisfaction with their level of clinical autonomy, avoiding problems like inadequate resources and rationing in the UK, and inadequate coverage and corporate dominance in the US. The trade-off was lower gross incomes.

But by the 1990s, significant financial pressures would come to bear on the Canadian health care system, creating a new climate for reform. In 1987, Canada had the second-highest level of per capita health spending in the world. An economic recession began in 1990. By 1993, federal and provincial deficits reached a record-breaking 65 billion Canadian dollars. The federal government responded by freezing social and health transfers, and in 1995, it actually cut transfers to the provinces for the first time. In this environment, real per capita

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137 Tuohy, *Accidental Logics*, supra note 120 at 212.
138 *Ibid* at 218.
139 See Marchildon, *supra* note 3 at 96.
141 Tuohy, *Accidental Logics*, supra note 120 at 231.
142 *Ibid* at 224-25.
144 *Ibid* at 232.
146 Tuohy, “Costs”, *supra* note 131 at 33.
147 Marchildon, *supra* note 3 at 106.
health spending declined sharply from 1992 to 1996. Then, rather suddenly, austerity was abandoned and spending rebounded quickly, so that spending in 2000 was actually 9 per cent higher than it had been in 1992, in 1995-adjusted dollars.\textsuperscript{148} Tuohy observes that the 30 billion dollars saved during the period of austerity came at a great political cost: federal-provincial wrangling over health care dollars and “an atmosphere of crisis that shook public confidence in the health care system and in government’s ability to manage it.”\textsuperscript{149} In the years to follow, in line with the tradition of professional-government co-managament, the scope of covered services would be adjusted through multiple provincial-level accommodations with professional bodies.

1. De-listing

A number of reforms resulted from the concerns over sustainability that dominated the 1990s. First, the concept of “de-listing” – i.e., limiting the scope of physician services covered under the fee schedule by deeming some to be “medically unnecessary” – began to gain popularity among members of the medical profession.\textsuperscript{150} De-listing, as a form of privatization, could both reduce government spending and provide physicians with extra income from non-insured items. Provincial governments and medical associations began more detailed and explicit negotiation over the coverage of specific items. In Ontario, for example, a Physician Services Committee [PSC] was established through a profession-government agreement in 1997, to assume primary responsibility for reviewing utilization of resources to determine which would be eligible for public coverage in accordance with undefined principles of “tightening” and “modernization.”\textsuperscript{151}

Along with the more prominent government role in determining the contents of the “Medicare basket” came public and academic concern about the processes of listing and de-listing services. Ontario’s PSC, for example, comprised of five members appointed by the Ontario Medical Association and five Ministry appointees, has been criticized for its lack of transparency, accountability, and public participation in relation to the principles and values that guide coverage determinations, and for these determinations themselves.\textsuperscript{152} Flood and Erdman note that although the original agreement between the Ministry and the profession establishing the PSC suggested an open process for listing and de-listing, in practice reasons for covering or denying coverage for particular services have tended not to be given, and processes for decision-making are closed. The public

\begin{itemize}
\item \textsuperscript{148} Tuohy, “Costs”, supra note 131 at 33-34.
\item \textsuperscript{149} Ibid at 34 (noting that “the proportion of Canadians in a cross-national survey, reporting the view that the health care system needed only minor changes, plunged from 56 percent to 20 percent between 1988 and 1998 and did not rebound with increased public investment”), citing Robert J Blendon et al., “Inequities In Health Care: A Five-Country Survey” (2002) 21 Health Affairs 182.
\item \textsuperscript{150} Tuohy, Accidental Logics, supra note 120 at 237.
\item \textsuperscript{151} Ontario Medical Association – Ministry of Health and Long Term Care Comprehensive Agreement 1997-2000 (December 1996), online: Ontario Medical Association <www.oma.org>.
\item \textsuperscript{152} Flood, Tuohy & Stabile, supra note 8 at 19.
\end{itemize}
is forced to rely on the Ministry to represent the larger public interest. There is little room in such approaches for stakeholder values to enter into funding determinations, or to be sure whether decisions were based on cost-benefit analysis in relation to health outcomes, political factors, or the interests of physician groups.

2. Early Hospital Restructuring: Experiments with Performance Measurement

In the hospital sector, provinces pursued twin avenues of reform in response to fiscal constraint: explicit cost-cutting through hospital closings and consolidations, and structural reorganization designed to integrate services across the health continuum, generally through the regionalization of health governance within provinces. These reforms ushered in a new focus on performance measurement and the coordination of health interventions that had previously been absent.

In one early response to cuts in hospitals’ global budgets in the 1990s, Ontario and Alberta experimented with “case-based funding formulas.” The idea was to project, for a given case, the expected costs of treating similar cases based on comparisons with peers, and then to measure the actual costs of treatment. In Ontario, institutions with average cost per weighted case below the mean of their peers would receive additional funding from an “equity fund” to bring them up to the group mean. In Alberta, funds would be redistributed from the less efficient “losers” to the more efficient “winners.” Case-based funding thus operated with the twin goals of rewarding efficiency and improving equity in the sense of giving each hospital its fair share of funding.

Although the projects raised concerns around hospitals “gaming” the system, and although the experiments were ultimately overshadowed by hospital restructuring efforts in the mid-1990s, they did elevate the prominence of certain themes in hospital resource allocation. First, they increased the perceived need for fair and transparent processes for funding, tied to performance. In Ontario, hospitals were satisfied with the collaborative policy approach for setting up case-based funding, resulting in greater acceptance of the policy, while actors in Alberta hospitals perceived a government “hidden agenda.” Second, hospitals accepted the idea that attention to outcomes and comparisons between groups were an important and fair way to determine appropriate allocations, even as they disputed the appropriateness of some comparators. But perhaps most importantly, these projects elevated the role of information-generation as a regulatory tool.

In both provinces, ministries of health used information generated through case-

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154 See e.g. Ontario Human Rights Commission & Hogan et al. v Ontario (Minister of Health and Long-Term Care) (2006), 58 CHRR D/317 (demonstrating judicial reluctance to address lack of transparency and consultation in decision to de-list gender reassignment surgery).
155 Vandna Bhatia, Susan West & Mita Giacomini, Equity in Case-Based Funding: A Case Study of Meanings and Messages in Hospital Funding Policy (Hamilton, ON: Centre for Health Economics and Policy Analysis - McMaster University, 1996).
156 Ibid at 42.
157 Ibid at 42-43.
based funding to establish provincial targets under hospital restructuring for expected resource use and utilization patterns.  

3. A Major Structural Shift: Regionalization

The most significant recent change in the management of hospital services came through regionalization, which has been described as “the most sweeping structural reform since Medicare had become a coast-to-coast program in 1971.” Regionalization can be understood broadly as the transfer of power and authority for health care policymaking and priority-setting to sub-provincial regional bodies -- so called Regional Health Authorities [RHAs] that are largely at arm’s length from government.

In the late 1980s and early 1990s, each province established a task force or commission of inquiry to deal with the new period of economic restraint. All reflected a similar set of general goals. Many were about efficiency: better health outcomes with less overall spending. Others addressed broader political concerns, such as increasing the accountability of decision-makers and enhancing citizen participation. Suggested directions for achieving those goals included a shift from institutionally-based to community-based care, a focus on a broader range of health determinants beyond the health care delivery system, making room for the representation of a variety of interests in the health field in health policy planning, and the integration of services across the continuum of care. Regionalization of health care was the favored structural approach for achieving these reforms, and was adopted from the late 1980s and through the 1990s in every province but Ontario (which finally adopted a form of regionalization in the mid-2000s).  

158 *Ibid* at 43. See also Tuohy, *Accidental Logics*, supra note 120 at 213.
160 Flood, Sinclair & Erdman, “Steering and Rowing”, *supra* note 117 at 173. See also Lewis & Kouri, *ibid* at 14 (defining regionalization in Canada by four key features: each region occupies a sub-provincial territory; authority is devolved from provinces rather than self-created; regionalization consolidates authority previously distributed among many programs and communities; and each regional authority is responsible for a broad range of services, including things like community care, long-term residential care, acute hospital care, and often extending to other things like mental health and addictions, public health and health promotion).
161 For a summary, see Mhatre & Deber, *supra* note 145; Marchildon, *supra* note 3 at 115.
162 Tuohy, *Accidental Logics*, supra note 120 at 97.
Regionalization was expected to help in a number of ways. As discussed, government had begun funding health services largely by underwriting existing institutions and agencies – and in Saskatchewan, for example, those institutions amounted to 435 health boards for a population of only one million people drawing on government funds. Regionalization was expected to help in a number of ways. As discussed, government had begun funding health services largely by underwriting existing institutions and agencies – and in Saskatchewan, for example, those institutions amounted to 435 health boards for a population of only one million people drawing on government funds. Because funding was based mainly on historical practice, the system as a whole remained unresponsive to changing demands and circumstances. Consolidating accountability within regional health boards was expected to allow resources to move more fluidly in response to local needs. It was also expected to contribute to the vertical integration of services. Under existing arrangements, institutions had neither the ability nor the motivation to make rational decisions about deploying resources from one “silo” of care to another. Regionalization would allow home care to be proportionately expanded as hospital beds were reduced, for example; and a given “silo” would no longer benefit from offloading responsibilities to other actors represented in the regional health authority’s budget. It was envisioned that increased reporting of spending, projected and actual health outcomes and wait times – as would be necessary for re-distributing funding within regions – would result in more direct accountability to local citizens and make funding less conventionally politicized and dominated by professional interests. It would resolve what Flood and colleagues have called the conflict of interest problem arising when governments both manage health care distribution and set broad policy goals. Other ostensible benefits include promotion of evidence-based practices and increased spaces for public participation that come along with local participation, though the extent to which devolution by itself facilitates these results has been questioned. Finally, and less optimistically, regionalization can be understood as a way to contain discontent and conflict as service expectations seem increasingly to exceed what governments are prepared to pay for.

Unsurprisingly, regionalization has not fully lived up to its promise. The most oft-cited obstacle is the failure of most regions to situate full fiscal responsibility for all services within a given region. A broad conception of the social determinants of health would suggest that a very wide range of community services be included within the RHA budget. But even the two most important cost elements in a region’s existing health care system – remuneration for physicians and drug plans outside hospitals – have not been devolved to

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165 Lewis & Kouri, supra note 159 at 15.
166 Marchildon, supra note 3 at 107.
168 Lewis & Kouri, supra note 159 at 15-20.
170 See Lomas, supra note 132 at 819; Flood, Sinclair & Erdman, “Steering and Rowing”, ibid; and Lewis & Kouri, supra note 159 at 16.
171 Lomas, ibid at 818.
172 Flood, Sinclair & Erdman, “Steering and Rowing”, supra note 117 at 193; Lomas, supra note 132 at 823-824; Lewis & Kouri, supra note 159 at 20-23; and Moloughney, supra note 164.
174 Lewis & Kouri, supra note 159 at 25.
175 Ibid at 25.
regional authorities. Physician remuneration remains governed by professionprovince arrangements, and coverage of pharmaceuticals remains subject to technocratic cost-benefit analysis with little consideration of relationships with other services or public values. Community services and home care services have likewise tended not to be included in RHA authority. Lomas blames the long history of political accommodation for this situation.

In addition, the benefits of regionalization may be squandered through lack of RHA independence from provincial governments. Though the power held by RHAs varies from province to province, Flood and Archibald note a number of common constraints on RHA authority: members are appointed at pleasure and can be dismissed at any time; Ministers can issue binding directives to RHAs and withhold funds for non-compliance; Ministries retain the power to plan and fund additional services beyond those funded by the RHA; and RHAs cannot contract with private clinics nor make by-laws without Ministerial approval. Despite the rhetoric of devolution, many RHAs have in practice been subject to substantial provincial control. While there might be some place for provincial control—for example, should powerful local interests dominate RHA decision-making illegitimately—the potential benefits of regionalization are squandered when regionalization exists in name only.

In addition, the promise of needs-based funding has not been fully borne out. Some provinces have explicitly opted to maintain funding based on historical and political factors. In Ontario, commentators have blamed capture by medical interests with less to gain from investment in “upstream” factors like social determinants of health. In Newfoundland and Labrador, governments feared that technocratic needs assessment might limit the flexibility to assign funds based on concerns not reflected in the formula. And, as discussed further below, even where there have been official policies requiring each RHA to submit a plan documenting how it anticipates meeting the needs of its population, in most cases “this year’s plan is last year’s plan slightly twigged to reflect updated information.” Part of the problem may lie in the technical challenge of drawing up formulas for determining relative need that extend beyond age- and gender-adjusted population counts, and the (legitimate) fear that such formulas might become so complex as to shut out stakeholder participation. But the difficulties

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176 Ibid.
177 Lomas, supra note 132 at 820.
179 Lewis and Kouri, supra note 159 at 22, citing Denise Kouri, Kelly Chessie & Steven Lewis, *Regionalization: Where Has All the Power Gone? A Survey of Canadian Decision Makers in Health Care Regionalization* (Saskatoon: Canadian Centre for Analysis of Regionalization and Health, 2002) at 12.
180 McIntosh et al, supra note 163
181 Ibid at 57.
183 See e.g. McIntosh et al, supra note 163.
184 Hurley, supra note 182.
associated with implementing needs-based funding also suggest that it may be impossible to depoliticize allocation decisions within regions. Instead, regionalization and rationalization might be better understood not as de-politicizing but modifying the political environment in which the decisions are made. Regionalization and needs-based assessment may not ever have offered a complete technocratic solution to balancing a move away from hospital and physician based care and toward prevention, health promotion, and other upstream investments, much less to the broader problem of spending wisely and fairly. Instead, their promise lies in setting the stage for more transparent allocation, and, much like the new approach to human rights set out above, opening up new kinds of spaces for democratic accountability and participation beyond the ordinary political process. Understanding whether the ostensible shifts toward evidence-based distribution through regional consolidation have indeed opened up such new spaces, particularly for marginalized groups, in determining the distribution of health care resources in Canada requires an examination of the participation and accountability frameworks that have accompanied the move toward regionalized governance.

4. Participation and Accountability Frameworks

Regionalization both consolidated and devolved authority at once. As such, it traded off some opportunities for local participation in the multiple small boards of health care institutions for the promise of rationalization across institutions. The question is the extent to which regionalization has afforded opportunities for more meaningful accountability to citizens of the kind envisaged under new conceptions of the human right to health – opportunities for participation created through information-generation and new spaces for participation-enhancing deployment of that information.

Most RHA legislation provides only modestly for citizen involvement. Board members are appointed rather than elected, and only two provinces provide for community involvement in those appointments. The noteworthy example here is Quebec. In line with a far more developed participatory approach to regional health care governance, Quebec’s RHA legislation contains extensive provisions ensuring that boards represent numerous stakeholders: positions on the board are allotted to stakeholder groups including labour organizations, community organizations, medical professionals, and “socio-economic organizations.” The Minister fills these positions from lists provided by each group. Moreover, the lists and ultimate appointments must contain an equal number of men and women.

In most provinces, citizen participation is encouraged more through open RHA planning processes, consultation with legislatively-created community bodies, and

185 Ibid (stating that, in retrospect, the optimism around needs-based funding coupled with regionalization was unfounded, and that this “perhaps should have been obvious when one reflects how difficult reallocation is within fully integrated, hierarchical organizations, much less a regional health authority with far more muted power”).
186 See Flood and Archibald, Hamstrung, supra note 177 at 25.
187 See e.g. Nova Scotia Health Authorities Act, SNS 2000, c 6 at s 11; An Act Respecting Health and Social Services, RSQ, c S-4.2; Quebec Act Respecting Health and Social Services at s. 397.
188 Quebec Act Respecting Health and Social Services, ibid.
189 Ibid at s 397.0.1
RHA public reporting requirements. Legislation in most provinces requires that RHAs conduct regular open meetings where public reports are tabled and public submissions are heard. Duties to consult the public in devising annual health plans, however, are generally rarer: Quebec and New Brunswick are the only provinces requiring public consultation, and Quebec’s consultation requirements are far more specific.

The primary route for citizen participation in RHA planning is what Flood and Archibald call Community Health Councils—bodies created in RHA legislation and designed to act as liaisons between citizens and RHA boards. In some provinces, these bodies play a “very limited advisory role, acting as a kind of advocacy vehicle for citizens’ concerns”. In other jurisdictions, they are more powerful. For example, the Quebec CHC, known as the “people’s forum”, nominates RHA board members and, by law, plays an active role in devising RHA plans. Little appears to be known, however, about the extent to which participation through CHCs is meaningful as opposed to superficial. The most significant accountability-related achievement in regionalization is the explosion it generated in terms of improved transparency through reporting. Working within broad provincially-set parameters, RHAs must typically develop and publicize a regional plan setting out how they will meet their statutory obligations to provide for the health needs of the population. Legislation varies in the detail it requires of its plans: some of the more elaborate require RHAs to

190 See Flood & Archibald, Hamstrung, supra note 178 at 23.
191 Quebec Act Respecting Health and Social Services, supra note 187 at s 343.1; Regional Health Authorities Act, SNB 2002, c R-5.05 at s 33(1) [New Brunswick Regional Health Authorities Act]. This may be compared to other provincial legislation, in which duties to consult are framed permissively and subjectively: RHAs consult when they consider it appropriate with groups they see fit to consult with. See, for e.g., the Manitoba Regional Health Authorities Act, CCSM c R34 at s 24(2) [Manitoba Regional Health Authorities Act].
192 Flood & Archibald, Hamstrung, supra note 178 at 25.
193 Ibid at 25. See also Nova Scotia Health Authorities Act, supra note 187 at ss 45, 48 and 49; Health Authorities Act, RSBC 1996, c 180 [British Columbia Health Authorities Act]; Manitoba Regional Health Authorities Act, supra note 190 at s 32(1), whereby the mandate of the Manitoba District Health Advisory Council is very vaguely defined as “to advise and assist the board of the regional health authority”.
194 Quebec Act Respecting Health and Social Services, supra note 187 at ss 346.1 and 343.1.
195 Flood & Archibald, Hamstrung, supra note 178 at 27.
196 See e.g. New Brunswick Regional Health Authorities Act, supra note 191 at s 6(1) (setting out guidelines for the development of the provincial health plan); Regional Health Services Act, SS 2002, c R-8.2 at s 4 (affirming that the minister – i.e. the provincial government – is responsible for overall strategic direction, including, inter alia, the establishment of goals, objectives, performance measures and targets, and development of methodologies for resource allocation) [Saskatchewan Regional Health Services Act].
197 See e.g. New Brunswick Regional Health Authorities Act, supra note 190 at s 32(1); Health and Community Services Act, SNL 1995, c P-37.1 at ss 16 and 21(1) [Newfoundland and Labrador Health and Community Services Act]; Manitoba Regional Health Authorities Act, supra note 191 at ss 24(1) and 24(3); Saskatchewan Regional Health Services Act, ibid at s 51; Regional Health Authorities Act, RSA 2000, c R-10 at s 9(1) [Alberta Regional Health Authorities Act]; British Columbia Health Authorities Act, supra note 192 at s 5(1)(a). Quebec’s legislation requires RHAs to set out multi-year strategic plans supplemented by an annual “management and accountability agreement” negotiated between the provincial government and the RHA; Quebec Act Respecting Health and Social Services, supra note 187 at ss 346.1, 350, 385.1-385.3.
set out anticipated methods of measuring performance in the delivery and administration of health services.\textsuperscript{198}

As for the reporting requirements themselves, each RHA is statutorily required to report publicly on the extent to which its plans are met through some combination of financial reports, audited statements, and, most novel in this context, indicators of the health status of the population and the efficacy of the RHA basket of services.\textsuperscript{199} In addition, as permitted in most RHA legislation that places a premium on flexibility of objects and modes of assessment, RHAs increasingly negotiate additional accountability beyond what is explicitly set out in statutes through “performance agreements” with the provinces,\textsuperscript{200} followed by reports on progress toward achievement.\textsuperscript{201} The combined result has been a massive shift toward the use of targets or benchmarks, followed by statistical indicators on things like population health, service usage, wait times, and other aspects of system effectiveness.\textsuperscript{202} Flood and Archibald have described this as a “significant improvement on what provincial governments were historically prepared to divulge to citizens.”\textsuperscript{203}

Although regionalization addresses the distribution of only a part of health care in Canada, this move reconstructed the discourse around health care reform at all levels of government. It refocused the debate away from the spending itself and toward the importance of closer-to-the-ground decision-making, the use of

\textsuperscript{198} Flood, Sinclair & Erdman, “Steering and Rowing”, supra note 117 at 194. See e.g. New Brunswick Regional Health Authorities Act, supra note 191 at s 32(1); Alberta Regional Health Authorities Act, ibid at s 9(4)(a); Quebec Act Respecting Health and Social Services, supra note 187 at s 285.2(3).

\textsuperscript{199} In Alberta, annual reports must contain audited financial information, senior management and board remuneration, and “other performance information required by regulation”: Alberta Regional Health Authorities Act, supra note 197 at ss 9(4)(a) and 14(2)(b). Manitoba legislation specifies that annual reports shall contain, in addition to financial statements, the health services provided, their costs, and a “report respecting the health status of the population and the effectiveness of the health services provided or funded by the regional health authority”: Manitoba Regional Health Authorities Act, supra note 197 at s 38(2). In Nova Scotia, the legislation is more open-ended: district health authorities are required to provide financial statements and “such information as is required by the Minister for the purpose of monitoring and evaluation of the quality, accessibility and comprehensiveness of health services”: Nova Scotia Health Authorities Act, supra note 187 at s 21(1)(c).

\textsuperscript{200} Saskatchewan Regional Health Services Act, supra note 196 at s 54(2); British Columbia Health Authorities Act, supra note 193 at s 7(2); Newfoundland and Labrador Health and Community Services Act, supra note 197 at s 24.

\textsuperscript{201} For a discussion of performance agreements as a tool to allow governments to set the course of agencies’ work without micromanaging, see Mark Considine, “The End of the Line? Accountable Governance in the Age of Networks, Partnerships, and Joined-Up Services” (2002) 15 Governance 21 at 22. Quebec’s legislation explicitly requires the use of performance agreements and consequent reporting: Quebec Act Respecting Health and Social Services, supra note 187 at s 385.7.

\textsuperscript{202} The British Columbia Ministry of Health Services describes the purpose of reports pursuant to performance agreements as “an opportunity to compare the performance of health authorities relative to each other, Ministry expectations, and to provide the public with ongoing information on the impact of redesign on patient services”: Report on Health Authority Performance Agreements 2002/2003 (2003): online, British Columbia Ministry of Health Services <http://www.health.gov.bc.ca/soc-sec/pdf/haagrement0203.pdf>.

\textsuperscript{203} Flood and Archibald, Hamstrung, supra note 178 at 25.

\textsuperscript{204} Ibid at 25. See Manitoba Regional Health Authorities Act, supra note 191 at s 38(2); Quebec Act Respecting Health and Social Services, supra note 187 at s 346.
comparable indicators, benchmarks set based on scientific evidence, effectiveness at the local level, and public consultation. These values are explicitly reflected, for example, in the 2004 “Ten-Year Plan to Strengthen Health Care in Canada”, in which the federal, provincial, and territorial first ministers (i.e., the Prime Minister and the Premiers of each province) agreed to address issues around access to health care and wait times in key health areas. In addition, the move toward provincial regionalization prompted the federal government to consolidate Statistics Canada with a number of other health data management infrastructures, so as to establish the Canadian Institute of Health Information, which “has grown into one of the world’s premier health information agencies with extensive databases on health spending, services and human resources”.

The move toward evidence-based, accountable, and more inclusive policymaking, however, is hardly the adoption of a human rights-based approach to health care distribution. The following section will evaluate the extent to which commonalities between human rights and health governance developments described in the last two sections of this paper opens up new terrains of struggle and opportunity for human rights based approaches to resource allocation related to health care in Canada.

V. APPRAISAL: HARMONY AND DISSONANCE IN HUMAN RIGHTS AND HEALTH GOVERNANCE

Changes to Canada’s systems of health care governance in the last two decades share a number of common features with procedural approaches to the right to health discussed in Part IV. Regionalization is neither necessary nor sufficient for equitable, non-discriminatory, transparent, participatory, progressive decisions about which health and related services to provide, nor does regionalization itself ensure, for example, that those services are available, accessible, acceptable, and of good quality. Nonetheless, the move toward regionalization, accompanied as it has been by preoccupations over ensuring accountability, participation, and evidence-based policy, appears friendly to new conceptions of human rights and the right to health described above. Like the human rights approaches, it begins by recognizing the disproportionate emphasis on curative over social and structural determinants of health. It seeks to dis-entrench structures that support an anachronistic reliance on curative models, and move away from arbitrary, inefficient, and ineffective allocation decisions by coordinating services and opening up priority-setting to flexible, transparent, accountable, and participatory local-level decision-making. Participation is sought through representative local

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206 Marchildon, supra note 3 at 109.

207 See e.g. Lomas, supra note 132 at 819. See also Hunt and Backman, supra note 75 at 42-50.

208 Hunt & Backman, ibid at 47-48.
boards and public reporting. Transparency and accountability are likewise pursued through public plans for progress toward legislatively-bounded goals, mandatory reporting including indicators, benchmarks, and comparative data indicating progress toward those benchmarks. Through orchestration – including comparison of targets and means of achieving progress toward those targets – it might promote continual improvement by revealing progress over time.

At the same time, context is important. Canada’s new institutions for managing health care distribution were not designed as, nor do they fully reflect, a proceduralist, participation-oriented, human rights-based approach to determining distribution of health care resources in Canada. Politically, these changes were motivated by concerns about service integration, cost containment, and communicating accountability to an increasingly dissatisfied public. They were justified publicly with reference to their value for citizen engagement, but their capacity for citizen engagement in practice has been criticized. Conceptually, they draw more on changing ideas about regulatory law that have become prominent since the early 1990s, known collectively as “new governance”, than they do on human rights.

New governance, which has been described as a “darling child” of regulators and academics, is usually understood as an alternative set of organizing principles that emerged in response to criticisms of the bureaucratic command-and-control regulatory model that dominated most Western welfare states since the New Deal. Lester Salamon suggests that it has become the dominant model of modern government. While this field is diverse, its general orientation can be understood by noting a few key organizing tenets. There is a preference for situating decision-making close to the community level. Fixed rules, imposed hierarchically, are abandoned in order to allow local administrators to direct their own actions through goal-directed measures combined with performance indicators. The collaboration and participation of all stakeholders, including non-state actors, is sought. According to new governance approaches, this collaboration is expected both to improve decision-making and to retain the

209 Lomas, supra note 132 (noting the empowerment rhetoric that came along with regionalization, but doubting whether community participation was ever necessary to the central vision of regionalization, and suggesting that empowerment was bound to take a backseat to cost-cutting goals).
212 Melish, supra note 42 at 31.
213 Lobel, supra note 210 at 357. But see Amy J Cohen, “Governance Legalism: Hayek and Sabel on Reason and Rules, Organization and Law” (2010) 2010 Wis L Rev 357 at 378 (asserting that that “new governance emerged as much as a response to deregulation and privatization as to socialist planning”).
215 For a thorough summary, see Lobel, supra note 210.
216 Ibid at 345.
democratic legitimacy lost through the loosening of government authority, by providing information through performance indicators and protecting opportunities for input. Incentives, including pressure from stakeholders armed with performance evaluation, are expected to generate the adoption of best practices and the continual improvement of progress toward agreed-upon goals.

Some underlying instincts of the new governance models are clearly reflected in developments in models of Canadian health care, and, as discussed above, in many of the elements in the move toward procedurally-based conceptions of human rights. But the change in Canada has been a partial one, and it does not conform to all the key prescriptions of either model. Canada’s program of regionalization, even with its focus on transparency, accountability, and participation, might better be described as “new governance-esque.” Moreover, numerous critics of the proceduralist turn in social and economic rights are concerned that this represents a step backward for human rights, as substantive benefits and protections are being traded for nebulous procedural rights and information that may or may not be successfully deployed.

With reference to a number of key ongoing tensions within and between new governance and new proceduralist conceptions of the right to health, the following sections will evaluate the extent to which the shift in health care administration in Canada meets, challenges, and informs the shift toward proceduralism in the right to health. It concludes that the common focus on driving equitable distribution through meaningful participation opens up space for human rights actors to press for better democratic governance in Canada’s regionalized health care governance. This, however, requires human rights actors to develop their own conceptions of meaningful participation in the context of new governance-oriented health policy.

A. Wholism, Managing Complexity, and Social Determinants of Health

Perhaps the most common critique of Canada’s move toward regionalization is that it is not comprehensive enough. New governance seeks to “push control further into organizational structures, inscribing it in systems that can be audited.” In parallel, human rights actors have emphasized the need to move away from overly curative models of health, consistent with the CESCR’s

217 Ibid at 371-404.
218 Cohen, supra note 213 at 379.
221 Hunt & Backman, supra note 75 at 42 (defining the integrative project of human rights in the following terms: “As a recent WHO publication observes, health systems and services are mainly focused on disease rather than on the person as a whole, whose body and mind are linked and who needs to be treated with dignity and respect... [Therefore] health care and health systems must embrace a more holistic, people-centered approach”). See also Norman Daniels, “Equity and Health: Toward a Broader Bioethics Agenda” (2006) 36 The Hastings Center Report 22 (suggesting that the human right to health can and should drive resources away from curative approaches and toward social determinants of health).
requirement of equitable resource allocation and its emphasis on social determinants. Regionalized governance promises to facilitate the movement of resources “upstream” by placing allocation decisions in a context where the relative importance of social determinants and preventative measures can be fairly weighed and re-weighed against competing demands in relation to measurable health-related outcomes.

Yet only a small portion of health-affecting areas have been devolved to regional or local authorities for rationalization and integration through ostensibly open, participatory, accountability-oriented governance. The most obvious gap is authority over physician services and pharmaceuticals, two areas that are dominated by powerful private interests. The maintenance in some provinces of separate funding streams and governance structures for mental health and addictions, public health, and health promotion - not to mention the only limited coordination in some regions with community and social services - raises similar concerns. A regionalized project that is purportedly dedicated to allocating resources where they are most needed to improve health outcomes should be able to accommodate moving resources across the fullest possible range of determinants of those outcomes.

Ensuring equitable distribution and adopting a national health plan that is evidence-based and addresses the health concerns of the whole population are core obligations. Regionalized decision-making is, of course, not the only way to achieve the rationalization of health care resources, and nothing in the ICESCR, General Comment 14, or scholarly interpretations of the international human right to health prescribes the level at which allocation decisions are to be taken. However, to the extent that regionalized governance organized along principles of transparent, participatory, and evidence-based allocation, benchmarked and measured in relation to locally-set goals, purports to drive that reallocation, the exclusion of key areas of physician services and pharmaceuticals is unfortunate.

The shift in governance across Canada, however, may be in its infancy. From a human rights perspective, limited regionalization might be understood as a step

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222 See General Comment No 14, supra note 7 at para 52 (identifying as violations both misallocation and failure to take steps such as identification of indicators and benchmarks).

223 Ibid at para 11 (emphasizing the importance of underlying determinants of health in addition to curative health care).

224 Lewis & Kouri, supra note 159 at 14.

225 General Comment No 14, supra note 7 at paras 43(e)(f).

226 Ibid (emphasizing the importance of participatory decision-making at community, national and international levels, but without going so far as to prescribe levels at which allocation decisions are made).

227 In Quebec’s case, perhaps it is in its adolescence. Quebec first began its regionalization process in 1988; by 2004, Quebec’s regionalized system explicitly adopted an upstream-oriented population health approach with the goal of “managing a continuum of interventions aimed at developing and maintaining the population’s health and optimizing individuals’ personal and social autonomy,” in part by seeking to “reduce social inequalities which constitute an obstacle to well-being and health”. See David Levine, “A Healthcare Revolution: Quebec’s New Model of Healthcare” (2005) 8 Healthcare Quarterly 38 at 39-40. Placing authority for priority-setting squarely outside of provincial government, Quebec’s most recent iteration of the regional model further devolves authority to local Health and Social Service Centres “to conduct an inventory of all health-affecting resources in a region currently and to analyze gaps across the continuum of care” and to allocate budgetary resources locally.
in a state’s progressive path toward more comprehensive rationalization. Moreover, faithful understanding of social determinants suggests that their discovery can only be understood as a constant process that evolves as cultures and societies change.

There is of course a risk of overextending the scope of what health authorities are required to consider. This is a key criticism of the social determinants of health model. The more factors go into reports, indicators, and benchmarks, the greater the risk that the spaces opened for democratic participation will be too complex for stakeholders to navigate.\(^\text{228}\) However, the concern – both from the perspectives of the right to health and a commitment to equity in health resource distribution – is that the historic focus on funding hospital and physician services operates at the expense of social determinants, affecting the marginalized the most. Placing social determinants on a level deliberative playing field may be the best way to ensure that the process of identifying and ranking determinants (even as they remain potentially boundless) against traditional health services becomes possible. A regionalized model that is at least capable of expanding to address a full range of factors affecting health would thus institutionally accommodate the shared key insight of new governance and of the proceduralist orientation in right to health: that there is an “unknowingness” that prevents any regulator or norm-consolidator from taking into account all relevant considerations,\(^\text{229}\) and yet, alongside it, a duty to seek out and better understand those considerations.

B. Hard and Soft Tools in Support of Participation

Both new governance and human rights approaches place heavy emphasis on participation as a driver of more responsive allocation decisions in health care. But participation in Canadian RHAs has been weak. Processes themselves may not create room for meaningful participation, as when unidirectional flows of information (typically from professionals to citizens) have stood in place of real deliberative exchange,\(^\text{230}\) or when the information presented was too technical or rushed through for participants to understand.\(^\text{231}\) Moreover, there is little evidence that citizen deliberators are actually listened to. Abelson has noted:

> The limited experiences with deliberative methods in the health sector, to date, have suggested that the outcomes of deliberations


\(^{229}\) Flood & Archibald, \textit{Hamstrung, supra note 178} at 28 (noting that in the context of RHA reporting “intelligibility is a problem. Clearly RHAs have incentives to portray performance in the most positive light, and the results are often lengthy, obtuse documents that contain, but do not effectively communicate to the public, key facts about performance”). See also Gräinne de Búrca, “New Governance and Experimentalism: An Introduction” (2010) 2010 Wis L Rev 227 at 233-235 (suggesting that experimentalist/new governance projects are most likely to be successful when interdependence across policymaking sites is strong, and proposing that governance systems adopt “the broadest possible degree of stakeholder participation compatible with effective decision-making...” (emphasis added)).

\(^{230}\) Cohen, \textit{supra note 213} at 361.


\(^{232}\) \textit{Ibid.}\n
are rarely, if ever, binding, and are often heavily ‘managed’ […] by the health authority. Evaluations of deliberative processes in the health sector have identified concerns among public participants about what, if anything, would be done with their representations.233

A related concern has been expressed over devolution in form rather than substance. To the extent that RHAs fail to operate independent of ministries, regionalization remains a hierarchically engineered exercise that does not live up to the promises of genuinely participatory, collaborative, reflexive governance. From a human rights perspective, central organization is not by itself a problem. However, local-level participation that is rendered anemic by regional authorities lacking the ability to translate data into policy change undermines the promise that accountable, transparent governance that prioritizes the participation of the most vulnerable will ensure that the interests of the powerful do not dominate the policy agenda.234 At worst, devolution in form only might shield government health rationing – with its history of domination by entrenched interests – under an illusion of democratic legitimacy provided by participatory approaches.

Emerging proceduralist approaches – both in human rights and new governance – will need to develop concepts of transparency and participation that address the risk that half-measures may result in window dressing instead of real governance innovation. Despite new governance’s rejection of rule-based adjudicatory processes, it is friendly toward judicially ensured rights of participation, transparency, and information.235 New human rights approaches rely on genuine participation in order to translate elusive, arguably “soft law” concepts like progressive realization into meaningful, concrete, and firm legal obligations.236

Some problems can be addressed with improvements in the design of consultations. Efforts might be made to develop indicators of “real” rather than “sham” participation. Consultation requirements contained in RHA legislation may be clarified, and failures to adhere may be addressed via administrative review.237

233 Ibid at 247.
234 See General Comment No 14, supra note 7 at art 54 (“The right of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral component of any policy, programme or strategy developed to discharge governmental obligations under article 12. Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people's participation is secured by States”). See also Hunt & MacNaughton, supra note 75 at 2049 (describing General Comment No 14 as requiring “opportunities for as much participation as possible in health-related decision-making”).
235 Lomas, supra note 132.
237 Hunt & Backman, supra note 75 at 50.
238 But see Hospital Employees’ Union v Health Authorities (British Columbia) (2003), 2003 BCSC 778 at para 93 (acknowledging that legislation required open board meetings, finding a violation, but refusing to issue a formal declaration of the violation on the basis that it might “adversely impact on contracts that the boards entered into with innocent third parties”).
A more troubling problem, however, is addressing power differences among participants. Left unassisted, those with the fewest resources are the least able to participate. Unstructured participation might result in certain citizen voices being disproportionately heard. Expensive autism treatment may generate more support than inexpensive needle-exchange programs, for example.

New governance scholars are divided about how to respond to power differences in deliberation. Recently, some have been prepared to explore the possibility that traditional top-down normativity might interact with, or frame, new governance approaches. These scholars have been more likely to embrace hybridity with traditional substantive norms and structures when this is a necessary precondition for democratic deliberation; for example, when they make up for power imbalances and distributional justice problems getting in the way of meaningful participation. Thus, governance theories that are said to underlie the new Canadian health governance project may be open to measures designed to seek out and support the participation of the most vulnerable and marginalized in deliberation.

A commitment to real participatory deliberation requires attention to the full range of barriers to participation, however, and these are potentially endless. In response, the human rights approach will draw from its own rich and morally ambitious tradition, including its capabilities-based definitions of poverty that seek to understand and to respond to all the factors that stand in the way of meaningful self-governance. Unlike new governance, which is generally hesitant about substantive normativity, the recent human rights embrace of new governance conceptions comes in the context of broad normative commitments, many of which are more completely defined than the progressive realization of the right to health. Indeed, through the concepts of the interdependence and indivisibility of human rights, a participatory human rights approach acknowledges that processes are embedded within contexts of inequality and dignitary harm, and offers a framework for addressing such contexts. The tension between the normative orientation of new governance and that of human rights will play out on this terrain; human rights actors will be challenged to increase the extent to which efforts toward power equalization figures in new governance approaches.

240 Eric Fombonne, “The Prevalence of Autism” (2003) 289 Journal of the American Medical Association 87 at 89 (“I[ronically, what has triggered substantial social policy changes in autism appears to have little connection with the state of the evidence.... [F]urther consideration should be given to how and to why the least evidence-based claims have achieved impressive changes in funding policy”).
244 Article 5 of the Vienna Declaration states, “All human rights are universal, indivisible, interdependent, and interrelated”. See supra note 56.
C. Values  
Accountability mechanisms contained within RHA legislation and associated ministerial requirements and performance agreements are required to serve provincially-set objectives, operating within the framework of the *Canada Health Act*. Human rights, or even fundamental rights of equal access to health services, are not usually set out in RHA legislation; rather, RHA goals tend to be at once vaguely and narrowly defined as protection and promotion of health, responsiveness of health services to need, and coordination.

What distinguishes the human rights project generally from the new governance project is its prior commitment to an explicit set of substantive norms grounded in a broad, integrated, dignity-based human rights framework. So, for example, when human rights bodies turn toward proceduralism, they urge the use not only of *health* indicators, but of *right-to-health* indicators; they turn health impact assessments into *right to health* impact assessments. The human rights project sets out particular ideas about how participation and deliberation should be conducted (the CESCR suggests special attention to the most vulnerable). It sets parameters for how indicators should be selected (again, the CESCR suggests attention to the most vulnerable groups, including women, children, adolescents, the elderly, and people with disabilities). As to substantive responses, human rights approaches assume a connection between health and, among other things, the availability of clean water, adequate sanitation, nutritious food, adequate shelter, education, a safe environment, availability of health-related information, freedom from discrimination outside of health care distribution, and access to rights-based adjudication of claims for violation of the right to health.

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245 See e.g. *Alberta Regional Health Authorities Act*, supra note 197 at s 5; *Manitoba Regional Health Authorities Act*, supra note 191 at s 23(2)(h). The exception here is Quebec, whose legislation reflects broad normativity centered around equitable distribution of services, ensuring autonomy, addressing marginalization, and individual rights. See *Quebec Act Respecting Health and Social Services*, supra note 187 (stating at s. 1 that the object of the Act at s 1 is to “maintain and improve the physical, mental and social capacity of persons to act in their community and to carry out the roles they intend to assume in a manner which is acceptable to themselves and to the groups to which they belong”; requiring, at ss 3(6)(7) that the provincial-level health plan focus on, *inter alia*, “reducing the impact of problems which threaten the stability, fulfillment or autonomy of users” and “attaining comparable standards of health and welfare in the various strata of the population and in the various regions”; setting guidelines for management of services at s 3, including that “(1) the person requiring services is the reason for the very existence of those services; (2) respect for the user and recognition of his rights and freedoms must inspire every act performed in his regard; (3) the user must be treated, in every intervention, with courtesy, fairness and understanding, and with respect for his dignity, autonomy, needs and safety; (4) the user must, as far as possible, play an active role in the care and services which concern him;...”

246 See supra notes 81-85 and accompanying text (illustrating the distinction between health indicators and right to health indicators); see also Hunt & MacNaughton, *supra* note 75 (illustrating the distinction between health impact assessments and right to health impact assessment).

247 *General Comment No 14, supra* note 7 at para 43(f).

248 *Ibid* at para 49(c).

249 See Hunt & Backman, *supra* note 75 at 44.

250 See generally *ibid*. 
The question of whether and how deliberative processes can and should serve pre-defined normative ends has troubled new governance scholars. In general, governance approaches show a reluctance to “pick winners” in terms of policy choices, based on the idea that policy solutions should be selected through deliberative processes themselves. The theory is that deliberative approaches are preferable precisely because what best promotes health (or human dignity in relation to health) is elusive. In this way, they would appear hostile to the rich framework of predetermined values set out by the CESCR and some right to health scholars, though they might be more amenable to the very broadly framed goals contained in the ICESCR itself.

However, the differences between the theories of governance reflected in Canadian health care regionalization and the health and human rights perspective may, at the moment, be somewhat smaller than they seem. Recall that the substantive content of the right beyond the minimum core has been, until recently, relatively underdeveloped, and that the determinacy of normative features residing within the substantive core has likewise been called into question. New procedurally-oriented human rights approaches are willing to leave a significant amount to the deliberative sphere when it comes to issues of distribution; this is unsurprising given the general reluctance among human rights monitors to engage in questions of distribution and to determine the content of progressive realization prior to its reliance on deliberative approaches. Compared to distribution determined historically and/or by relatively opaque accommodation with medical professionals, proceduralist approaches to progressive priority-setting may be understood, like new governance, as a “reason-seeking, indeed law-seeking project.”

New governance scholars are unlikely to go so far as to suggest that particular normative outcomes – say, equitable, state-underwritten provision of the full range of health care services – ought to be imposed at the outset. This suggests that if new governance approaches (or new-governance-esque approaches), like regionalization, are to succeed in redistributing health care across the continuum in accordance with need and not ability to pay, such a normative commitment will need to be found within individual and community participants through the deliberative process.

Roy Romanow, in his report, stated “[I]n their discussions with me, Canadians have been clear that they still strongly support the core values on which our health care system is premised – equity, fairness and solidarity. These values are tied to their understanding of citizenship.” To the extent that this sentiment drives experiments geared toward better horizontal integration of health care resources, for example, transparency, participation, and accountability may drive the human rights goal of equitable distribution. Should human rights values in relation to progressive realization crystallize and separate from those concepts of progressive realization embraced by participants in new governance projects, however, the

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251 Cohen, supra note 213 at 382-387.
252 Ibid at 383.
253 Ibid.
254 Cohen, supra note 213.
255 The Romanow Report, supra note 116 at xvi.
goals of human rights and new governance might fail to align. In that event, human rights actors, advocates, and monitors might retreat from their reliance on processes and return toward more traditional approaches that rely on ex ante substantive normativity. As Vincent Greason and Lucie Lamarche, deeply skeptical of data-oriented governance as a driver of human rights realization express:

[H]uman rights and social justice activists have to pay more attention to new public management strategies as well as to the numerous evaluation and benchmarking devices made available for the purpose of public decision making. We may have to temporarily depart from litigation in order to come back to it better informed...

VI. CONCLUSION

The common turn toward enhanced democratic participation in human rights and health care governance presents promise as well as challenges. It gives traction, without deciding, to the need to extend health care beyond “core obligations” and toward social determinants, beyond hospital and physician services and toward “upstream” services that are increasingly relied upon by Canadians but often excluded from coverage. More ambitiously, it locates the denial of the right to health and equitable distribution squarely in the disenfranchisement and disempowerment of citizens from control over what affects their bodies; it delegitimizes professional and market capture of health-affecting policy. It also creates new challenges for human rights actors responding to changes in Canadian health care administration that purport to democratize, beyond ordinary political processes, the distribution of health care resources. This common embrace of participation, transparency and accountability need not necessarily undermine the human rights commitment to dignity-based self-realization. It does, however, renew the challenge to human rights actors to develop and offer methods to ensure that purportedly democracy-enhancing governance processes deliver what they promise.

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256 One could imagine such a result in relation to, say, funding for palliative care, should deliberative processes disproportionately value life-extending treatments over end-of-life care. See e.g. Frank Brennan, “Palliative Care as an International Human Right” (2007) 33 Journal of Pain Symptom Management 494.

257 Supra note 219 at 20.