
THINK PAPER

I. The Right to Palliative Care in Canada

A) *What is Palliative Care?*

Palliative care, also known as end-of-life care, is administered to terminal patients and the elderly. The care is designed to minimize pain and maximize comfort for individuals who have been diagnosed with a life-threatening illness or who are in the advanced stages of life. Rather than focusing on curing the individual's condition, the care focuses on maintain his or her quality of life.

Palliative care provides medical services but it also focuses on “[p]roviding comfort and dignity for those with a life-limiting or terminal illness and their families” (McMaster Health Forum, pg 2). Palliative care uses a holistic approach which includes pain and symptom management, social, psychological, emotional and spiritual support (McMaster Health Forum, pg 3). It also includes support for the individual's caregivers where appropriate. Research shows that palliative care is essential and should be provided as soon as an individual is diagnosed with a serious illness. It is not meant solely for those who are in the final stages of life (McMaster Health Forum, pg 3).

The benefits of palliative care are numerous. Having quality end-of-life care can lead to a better quality of life, longer lives, greater involvement in treatment decisions and often results in fewer hospitalizations (McMaster Health Forum, pg 4). Further, the support it can provide for caregivers is invaluable.

Given Canada's aging population, access to palliative care is becoming increasingly important.

B) *Canada's Health Care System*

The two-tiered legislative approach to health care in Canada results in inconsistent availability of palliative care services. Both the Federal and Provincial levels of government fund health care services. The Provincial governments receive money from the Federal Government via the Canada Health Transfer payments.

In 2002, the Federal Government endorsed the Canadian Strategy on Palliative and End-of-Life Care. This was abandoned in 2007. In 2012, The Way Forward program was introduced and purported to create a national framework for palliative care services. In March 2015, a final report was produced which described the benefits inherent in an integrated approach to palliative care. The report states that a “system-wide shift” is required to achieve integrated palliative care. This shift would facilitate an understanding that palliative care is an extension of health care rather than a form of boutique care only required for some individuals. The

Report acknowledges that dying is a part of living, and this should be reflected in our health care system.

CHA

The two-tiered legislative approach to health care is established by the *Canada Health Act*, RSC, 1985, c. C-6 (*CHA*). Palliative care is not specifically mentioned in the *CHA*. However, it falls under the “extended health care services” definition which includes “nursing home intermediate care service, adult residential care service, home care service and ambulatory health care service” (section 2). This is distinct from “insured services” which only covers hospital and physician services (section 2). Hospital and physician services are defined to be the “medically required/necessary” services provided in hospitals, or by physicians respectively. Physicians are further defined to be those that are legally entitled to practice medicine. Given the range of care providers involved in palliative care, many would not fall into the category of physician services.

Section 3 of the *CHA* declares “that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers”. This section falls short of establishing a right to any minimum standard of health care. However, it does demonstrate the Canadian approach to health care which focuses on “cure” rather than “care” (for more information on this see: Henteleff, Shariff & MacPherson, “Palliative Care: An Enforceable Canadian Human Right?” (2011) *McGill Journal of Law and Health* 5(1) at p 150).

The *CHA* places the onus on provinces to determine if and how it will fund palliative care services. Because palliative care falls under the provincial purview of health care services, the country does not have a consistent approach to delivery and availability of services or funding at a local level.

In Ontario, the province provides health care services under the *Health Insurance Act*, RSO 1990, c. H.6. The specific services funded under this legislation are laid out in the regulations. However, palliative care is not considered a “core” medical service such as and therefore, does not have its own budget. This leaves palliative care programs at the mercy of budget cuts within the regions that the care is administered.

C) Current Access to Palliative Care in Canada

Palliative Care in Canada is available in many different settings including hospitals, long-term care facilities, hospices and in-home care. Providers of palliative care often include, doctors, nurses, pharmacists, social workers, other health care professionals such as occupational therapists and spiritual counselors. Despite the variety of settings, acquiring quality and affordable care is incredibly challenging because of the two-tiered legislative approach.

Palliative care experts report that palliative care is required in 90% of all deaths (McMaster Health Forum, pg 6). Despite this, reports estimate that “the health system is currently unable to provide palliative care to 70% of those in need” (McMaster Health Forum, pg 6).

In Ontario, the Ministry of Health and Long-Term Care is responsible for funding palliative care and does so through Local Health Integration Networks which include hospitals, Community Care Access Centres, hospices and long-term care homes (Attorney General of Ontario (“AGO”) Report, pg 281, Appendix 1). In 2014, the Auditor General of Ontario reported that “most of Ontario’s publicly funded palliative-care services are used by cancer patients” (AGO Report, at pg 262). The Report further cited that 60% of deaths occur in hospitals despite the fact that many of these deaths are “not sudden and could have been planned to occur elsewhere” (AGO Report, pg 264). Further, research indicates that palliative care is more cost-effective than hospital care. The daily average cost of a hospice, palliative care bed is roughly \$460 per day compared to the \$1,100 per day expense of a hospital bed (AGO Report, at pg 265).

D) Palliative Care as an International Right

Internationally, the right to palliative care is gaining momentum. The *International Covenant on Economic, Social and Cultural Rights* at article 12, lists that individuals have a right to the “highest attainable standard of physical and mental health. This is echoed by the *International Covenant on Civil and Political Rights* at article 7 which articulates the right to be free from “cruel, inhuman or degrading treatment”.

Recently, the international community has renewed the drive for access to palliative care. In 2014, the World Health Organization issued a resolution titled: “Strengthening of palliative care as a component of integrated treatment within the continuum of care” (see: http://apps.who.int/gb/ebwha/pdf_files/EB134/B134_R7-en.pdf). The Resolution stated that “palliative care is an ethical responsibility of health systems” and urged member states to ensure palliative care is available and accessible.

In other jurisdictions, palliative care has been framed as an extension of the right to health care and less frequently an extension of the “dignity of the person”. The European Union provides an example of this.

E) Law

Canada’s shortcomings in the provision of palliative care can be challenged under two different sections of the *Canadian Charter of Rights and Freedoms*.

i.) Section 7

Section 7 of the *Charter* contains the right to life, liberty and security of the person in accordance with the principles of fundamental justice. To establish a violation of section 7, a claimant must demonstrate that they have suffered an endangerment of their life, liberty or security of person, and that this deprivation was not in accordance with the principles of fundamental justice.

Life is interpreted by the Courts based on the usual and ordinary meaning of the term. In *Chaoulli v Quebec (Attorney General)*, 2005 SCC 35, the Court held that the restriction on attaining private health care insurance, combined with prolonged wait times at hospitals, was endangering the lives of Quebecers. While that case involved an economic right; the right to private health insurance, the lack of the right endangered the complainants’ life (at para 45).

The Supreme Court of Canada recognized in *New Brunswick (Minister of Health and Community Services) v G(J)*, [1999] 3 SCR 46 that the security of the person includes “both the physical and psychological integrity of the individual”. If stress reaches a sufficient level, it could be worthy of section 7 protection. The Court articulated that “state action must have a serious and profound effect on a person’s psychological integrity . . . [it] must be greater than ordinary stress or anxiety” (at 77-78). In *Rodriguez v British Columbia (Attorney General)*, [1993] 3 SCR 519 at p 589, the Court stated that the security of the person is infringed if the state’s actions impose suffering upon the individual.

Statistics demonstrate that a lack of access to palliative care can result in a quicker, more stressful death. The diagnosis of a life-limiting illness is stressful enough. The thought of having to face the illness without adequate access to pain and symptom management and social and psychological support, would only exacerbate this stress. Without this type of support, individuals are left with few options. Those who can privately fund palliative care may choose to do so. Others, who lack the means, may choose to resort to the incoming physician assisted suicide option. Stress that rises to the level where an individual is compelled to consider ending their life certainly endangers both the life and security of the person. Thus the current access to palliative care in Canada endangers both the life and security of Canadians.

This endangerment is only tolerable if it is in accordance with the principles of fundamental justice. The most applicable principle of fundamental justice in this case is arbitrariness. The Court in *Chaoulli* at paras 130-31, held that “[a] law is arbitrary where it ‘bears no relation to, or is inconsistent with, the objective that lies behind [it].’” The Court stated that this requires consideration for the state interest and societal concern (at paras 130-31).

The *CHA* is the impugned law in the case of access to palliative care. A complainant would have to demonstrate that access to palliative care is inconsistent with the objectives stated within the legislation. As cited above, the *CHA*’s stated objective is to “protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers” (section 2). Rather than protecting and promoting the mental health and well-being of Canadian residents, the inadequate and inconsistent funding and access to palliative care is endangering the lives and security of persons. Regarding consideration for state interest and societal concern, as everyone will die, and the great majority of people (90%) will benefit from the provision of palliative care, the consideration would weigh in favour of societal concern regarding access to palliative care.

In *Chaoulli*, the Court found that the way the province had chosen to distribute resources was arbitrary thus violating section 7. The same analysis and conclusion applies in the case of palliative care. While access to palliative care services occurs at a provincial level, the categorization of palliative care as an extended service rather than an insured service is not based on meaningful criteria. Palliative care is deemed to be medically necessary by many medical professionals. Yet, in the *CHA*, it is not classified as such. There is no meaningful reason for this distinction and thus the inadequate resource distribution for such services.

Further support for the argument that the lack of access to palliative care violates section 7 of the *Charter*, can be found in the recent case of *Carter v Canada*, 2015 SCC 5. The Supreme Court of Canada has held that Canadians should have access to physician assisted death. It

would be arbitrary to support and publicly fund medical services that lead to death, without providing the same funding and access to services that aim to prolong life or at least manage pain and suffering. Adequate access to palliative care is even more imperative in the wake of the *Carter* decision.

ii) Section 15

Section 15 protects the right to equality. It states that:

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability

The Courts have repeatedly stated that this section deals with substantive equality (*Andrews v Law Society of British Columbia* [1989], 1 SCR 143 at 165). The Supreme Court of Canada in *Law v Canada*, [1999] 1 SCR 497 held that a section 15 analysis should consist of an examination of:

- a. Whether an impugned law or policy distinguishes between groups of people on the basis of personal characteristics, or fails to consider a group's already disadvantaged place in society thus resulting in differential treatment;
- b. Whether the differential treatment can be linked to one of the enumerated grounds; and
- c. Whether the differential treatment discriminates against a group by imposing a burden or withholding of a benefit.

As stated above, palliative care falls under the "extended health care services" designation in the *CHA*. This classification of relegates it to a second class standing. Rather than being covered as an "insured service", palliative care is listed as an extraneous type of care. This discriminates against disabled and aged individuals. Currently, the *CHA*'s classification of palliative care distinguishes between the medical needs of the elderly or people life-threatening disabilities, and the needs of the young and healthy.

Whereas young and healthy individuals can access more medically necessary insured medical services, those with life-threatening illnesses or disabilities or those who are at an advanced age, cannot access the type of care that they require. Once diagnosed, these individuals require support and medical services in the form of palliative care. The lack of access to this type of care perpetuates their already disadvantaged position in society.

This differential treatment is linked to the enumerated grounds of both disability and age. The *CHA* is withholding the benefit of quality and affordable care suited to the specific needs of the disabled and aged.

Eldridge v British Columbia (Attorney General), [1997] 3 SCR 624 established the principle that if the government is going to provide a service, it must do so without discriminating. In *Eldridge*, the Court held that the failure to provide sign language interpreters was discriminatory. The current approach to funding medical services is under-inclusive. Only

medically necessary services are funded, while those aimed at providing care, are not funded. This distinction disproportionately impacts the aged and those with disabilities. Current research is supporting a shift in thinking of palliative care as being medically necessary. If it is understood as a medically necessary service, then the failure to provide for it would be a violation of section 15 rights.

This principle is bolstered by *Auton (Guardian ad litem of) v British Columbia (Attorney General)*, 2004 SCC 78. *Auton* involved a mother, trying to get funding to cover a new autism treatment for her infant son (at para 1). The issue in *Auton* revolved around the distinction between core and non-core services. The case focused on whether discrimination arose because of the denial of a “medically necessary service to a disadvantaged group while providing medically necessary services for others. Thus the benefit claimed . . . [was] funding for all medically required treatment” (at para 30). However, the Government had not offered this benefit and therefore *Auton* was distinguished from *Eldridge* on the basis that it involved “access to a benefit that the law has not conferred” (*Auton* at para 38).

Alternatively, the *CHA* could be challenged based on section 4 of the *CHA*. Section 4 states that “the purpose of this Act is to establish criteria and conditions in respect of insured health services and extended health care services provided under provincial law that must be met before a full cash contribution can be made”. The key considerations for eligibility are “public administration, comprehensiveness, universality, portability and accessibility” (*CHA*, section 7). If it could be shown that the palliative care is not meeting those requirements and yet the Government is providing funding for this extended service regardless, then it could be said that the Government is applying this law in an unequal manner.

An additional argument could be made that the Federal and Provincial Governments are not allocating resources for extended services in a non-discriminatory way. For example, the Federal Government provides specific funding for the Partnership Against Cancer. This Partnership is receiving \$241 million from Health Canada over five years ending in 2017. While the Partnership addresses many aspects of cancer treatment, care and research, its mandate does include the entire spectrum of cancer-care, thus palliative care. By providing this funding for palliative care for individuals with cancer, the Government is failing to account for the needs of individuals with other life-threatening illnesses. One article reported that “[o]f Canadians who access hospice palliative care, 90% have cancer-related conditions, even though cancer-related deaths make up only one quarter of all deaths in Canada” (Henteleff et al, pg 131).

The Court’s decision in *Nova Scotia (Worker’s Compensation Board) v Martin* 2003 SCC 54 at para 5, is particularly helpful for this argument. In that case, workers compensation legislation provided coverage for several disabilities; chronic pain was not one of them (at para 5). Therefore, where the government provides funding for some palliative care services, the limitations on who these services are provided to, could be argued as being discriminatory. However, this could be argued to be a special program that has the object of “amelioration of conditions of [a] disadvantaged . . . groups” (section 15(2), *Charter*).

F) Section 1 Defences

Section 1 of the *Charter* provides that the rights contained within the Charter can be limited in accordance with a democratic and just society. In order to justify a limitation on a *Charter* right, the government would have to pass the Oakes Test.

In *R v Oakes*, [1986] 1 SCR 103, the Supreme Court of Canada articulated the test for section 1 justifications. The test requires that the limit be prescribed by law. In this case, the law would be the *CHA*. The test also requires that the impugned legislation have a pressing and substantial purpose (at para 69).

The other components of the test evaluate proportionality by considering:

- A) A rational connection between the impugned law and the right being violated;
- B) Minimal impairment on the right infringed; and
- C) Salutary and deleterious effects are proportionate (at para 70).

In this case, it would be difficult for the Government to satisfy this test. While the *CHA* has a pressing and substantial purpose, as it protects Canada's health care system, the proportionality part of the test would fail. The harm caused by the unequal allocation of resources under the *CHA* is not proportionate to the benefits provided. Further, there appears to be no rational connection between the lack of funding for palliative care and the *CHA* division of palliative care to extended services. This is applicable for violations to both section 7 and 15 of the *Charter*. The benefits rendered by the *CHA* do not proportionately impact an individual's section 7 and section 15 rights.

The evidence demonstrates that this does not minimally impair the rights to life, security of the person or equality. While the Government might point to the fact that other provinces have better and more established palliative care programs, the Court in *Chaoulli* stated that pursuing medical services in other provinces "is clearly not a solution for the system's deficiencies" (at para 44). Further the Court stated that obtaining care outside of the province, was "case-specific and is limited to crisis situations" (*Chaoulli*, at para 44). Palliative care is not a crisis situation. Further, requiring an individual to pursue quality and affordable palliative care outside of their province of residence goes against the basic tenants of palliative care. Instead of providing supportive services to guide a person medically and psychologically through the last stages of their lives, pursuit of palliative care outside of one's home province would uproot and disturb this process. The fact that 70% of Canadians cannot access palliative care demonstrates that this right is more than minimally impaired.

Finally, the current approach to palliative care in Canada results in deleterious effects such as expedited deaths and increased psychological stress prior to death. While the *CHA* results in some salutary effects for individuals with certain diagnoses, these do not outweigh the deleterious effects caused by this legislative scheme. The failure to provide palliative care as an extension of regularly funded health care services cannot be saved by section 1 of the *Charter*.

Resources

Timeline of Palliative Care changes in Canada: <http://www.hc-sc.gc.ca/hcs-sss/palliat/support-soutien/chronolog-eng.php>

McMaster Health Forum: <https://www.mcmasterhealthforum.org/docs/default-source/Product-Documents/citizen-briefs/access-to-palliative-care-in-ontario-cb.pdf?sfvrsn=2>

The Way Forward: <http://www.hpcintegration.ca/media/60044/TWF-framework-doc-Eng-2015-final-April1.pdf>

AGO report: http://www.auditor.on.ca/en/reports_en/en14/308en14.pdf