

The right to health in Canada

By Rhonda Ferguson*

Introduction

Canada is a country in North America with a population of over 33.7 million. It covers a large land area of about 9,093,507 sq km,¹ with most of the population residing in urban areas.² It is culturally and ethnically diverse, comprised primarily of people of British Isles origin (28%), French origin (23%), other European (15%), Amerindian (2%), Asian, African, Arab (6%), and mixed background (26%). According to the 2006 Census, 1,172,790 people self-identify as Aboriginal, which refers to, North American Indian (or First Nations people), Métis and Inuit.³ First Nations people account for 60% of the Aboriginal population, followed by Métis at 33%, and Inuit at 0.4%.⁴ The median age of Canadians is approximately 39.5 years, making it one of the youngest countries in the Organisation for Economic Co-operation and Development (OECD).⁵

According to statistics produced by the World Health Organization (WHO), Canadians appear to enjoy a relatively high standard of health, including a high life expectancy at birth (81 years compared to the global average of 68),⁶ low incidence of infectious disease (prevalence of tuberculosis is 3 per 100 000 people compared to the global average of 180 and prevalence of HIV is 4 per 1000 adults 15-49 years compared to the global average of 8)⁷ and extremely low under-five mortality rate (6 per 1000 live births compared to the global average of 65).⁸ Moreover, Canada's overall health system performance ranked 30 out of 191 WHO member countries listed in the WHO's health system performance ranking conducted in 1997.⁹ These figures, coupled with the country's high ranking position on the human development index

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CIA, "The World Fact Book, Canada," last modified February 1, 2011, <https://www.cia.gov/library/publications/the-world-factbook/geos/ca.html>

² Over two-thirds or 68.8% live in metropolitan areas. Statistics Canada, "Population and Demography," last modified October 27, 2010, <http://www.statcan.gc.ca/pub/11-402-x/2010000/chap/pop/pop-eng.htm>

³ Statistics Canada, "Aboriginal Peoples", accessed January 25, 2010, <http://www.statcan.gc.ca/cgi-bin/af-fdr.cgi?l=eng&loc=pdf/aboriginal-autochtones-eng.pdf&teng=Aboriginal%20peoples&tfra=Peuples%20autochtones>

⁴ *Ibid.*

⁵ *Supra* note 2.

⁶ World Health Organization, "Canada: Health Profile," 2008, <http://www.who.int/gho/countries/can.pdf>

⁷ *Ibid.*

⁸ *Ibid.*

⁹ World Health Organization, "World Health Report 2000, Health Systems: Improving Performance," 2000, p. 152, http://www.who.int/whr/2000/en/whr00_en.pdf

(Canada ranks 8th of 169 countries¹⁰) and an estimated 2008 GDP of 38,975 per capita (which makes it 7th among OECD countries¹¹) suggest that the country has the capacity and commitment to facilitate the enjoyment of the right to health for Canadians. However, because the individual is the holder of the right to health, one must look beyond averages to uncover who can be found at the extremes of these scales, unable to fully enjoy their right to health. Averages do not always provide a clear picture of the inequities and inequalities that may exist between areas and groups within the country, nor do they explain the relationship between socio-economic factors and health outcomes.

Furthermore, realization of the right to health entails more than the absence of illness and the willingness and capacity of the State to deliver care when illness arises; it encompasses consideration of the underlying determinants of health,¹² respect for the principals of equality and non-discrimination,¹³ certain standards of health care (availability, accessibility, acceptability and quality)¹⁴ and accountability and participation might be added to this list. It is also linked to the realization of other rights outlined in the International Bill of Rights,¹⁵ such as the right to food and to life. Moreover, governments, as primary duty-bearers, are obligated to not only refrain from actions that might impinge on the enjoyment of the right to health, but they must also take positive actions to ensure it; in other words, States have the obligation to respect, protect, and fulfill the right to health. It is with these considerations of the broader definition of the right to health, as elucidated in General Comment 14, that the following report proceeds.

In order to present a comprehensive – though not exhaustive - look at the extent to which the right to highest attainable standard of physical and mental health (right to health) is realized in Canada, this report employs a variety of measures developed internationally and nationally to look at both health and human rights, as well as data collected by international and national governments, agencies and non-governmental organizations. The report uses the list of illustrative indicators for the right to health developed by the United Nation’s Office of the High Commissioner on Human Rights (OHCHR), Millennium Development Goals (MDG) indicators, and other relevant indicators and databases to inform the assessment.

Legal Commitment to the Right to Health

International legally binding instruments

Canada’s commitment to the realization of the right to health is evidenced by its party status to a number of key instruments that include mention of the right to health directly or that include

¹⁰ United Nations Development Programme, “Human Development Report 2010,” *The Real Wealth of Nations: Pathways to Human Development*, 2010, p. 143, <http://hdr.undp.org/en/statistics/>

¹¹ Organisation for Economic Co-operation and Development., “Country Statistical Profiles 2010,” last modified 2010, <http://stats.oecd.org/index.aspx?queryid=23063>

¹² United Nations Committee on Economic, Social and Cultural Rights, “General Comment 14: The right to the highest attainable standard of health,” 11 August, 2000, para 4, [http://www.unhcr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En)

¹³ *Ibid.*, at para 3.

¹⁴ *Ibid.*, at para 12.

¹⁵ *Ibid.*, at para 3.

other rights or provisions that facilitate realization of the right to health. In 1977 Canada ratified what is perhaps the most central UN treaty in regard to the right to health, the International Covenant on Economic, Social and Cultural Rights (ICESCR), which explicitly lists health as a fundamental human right in Article 12. It has signed and ratified treaties that address specific populations, such as the International Convention on the Elimination of All Forms of Racial Discrimination (CERD) and Optional Protocol, the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) and Optional Protocol, the Convention on the Rights of Persons with Disabilities, and the Convention on the Rights of the Child (CRC) and Optional Protocol.

In addition to these, it is also a party to conventions that include relevant civil and political rights, such as the International Convention on Civil and Political Rights (ICCPR) and Optional Protocol related to abolition of the death penalty. For example, Articles 6, 7 and 8 of the ICCPR are directly related to health: the right to life, the right not to be subject to cruel, inhuman or degrading treatment or punishment, and the right not be held in slavery or servitude or to be required to perform forced or compulsory labour, respectively.¹⁶ Canada is also party to the Convention Against Torture, and other Cruel, Inhuman or Degrading Treatment or Punishment (CAT).

International non-binding instruments

Canada has accepted the Declaration of Alma Ata, the Constitution of the World Health Organization, the Declaration on the Right to Development,¹⁷ 25 conventions of the International Labour Organization (some of which are health-related), and it has endorsed the Standard Minimum Rules for the Treatment of Prisoners, and the Principles of Medical Ethics relevant to the Role of Health Personnel.

Regional legally-binding instruments

Canada is subject to the Inter-American Declaration on the Rights and Duties of Man¹⁸ through its membership in the Organization of American States. However, Canada has not ratified the American Convention on Human Rights, likely due to its inclusion of right to life provision that could prove detrimental to the rights of women in regard to abortion. Canada is therefore unable to ratify many of the Additional Protocols, including the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights.

For a full list of international treaties, declarations, norms as well as regional and national legislation relevant to the right to health to which Canada has agreed, consult Canada Treaty Information at <http://www.treaty-accord.gc.ca/search-recherche.asp?type=&page=TLA>.

¹⁶ United Nations International Covenant on Civil and Political Rights, 1966, <http://www2.ohchr.org/english/law/ccpr.htm>

¹⁷ However Canada has stated that it does not support a legally binding instrument on the right to development. See Submission in follow-up to HRC resolution 25/15 “The Right to development,” n.d., <http://www.ohchr.org/Documents/Issues/Development/Canada.pdf>

¹⁸ Although this Declaration was not originally a legally-binding document, the development of the Inter-American Commission on Human Rights instituted legal obligations with respect to the declaration.

Instruments Canada has not ratified

Despite its commitment to many of the key international treaties in which the right to health is mentioned, there remain a number of instruments to which Canada has not yet become Party. At the inaugural session of the Human Rights Council in 2006, Canada voted against the Draft Declaration on the Rights of Indigenous People, stating that while the country is committed to indigenous rights, it found some of the text problematic, including “parts of the text [that] are vague and ambiguous, leaving it open to different, and possibly competing, interpretations”.^{19,20} Nor has Canada ratified ILO Convention 169, which clearly outlines responsibilities of governments toward the health indigenous and tribal peoples. Furthermore, Canada has not yet signed the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, the Optional Protocol to the Convention on the Rights of Persons with Disabilities, the Optional Protocol to the Convention Against Torture, or the ILO’s Forced Labour Convention.

Implementing international human rights in the context of Canada

By entering into international, legally-binding human rights treaties, States’ Parties undertake to meet certain responsibilities and obligations in regard to the human rights contained therein. How a country incorporates international law into national law and how it can be used in domestic adjudication depends on the type of reception system²¹ the country has. Canada’s reception system has been described as a sort of hybrid of the monist and dualist systems:²² customary international law is incorporated into national law, but conventional international law must be implemented or adopted - some action must occur, it does not happen automatically.²³ Since international human rights law can be described as conventional international law, some kind of action must take place in order for it to take effect.

Human rights, health and adjudication in Canada

The right to health does not appear in the Canadian Charter of Rights and Freedoms, nor is it mentioned explicitly in any federal legislation. The Quebec Charter is the only human rights legislation in Canada that mentions economic and social rights,²⁴ though it does not specifically cite a right to health. However, in 2005, the Supreme Court of Canada examined whether the right to “life, liberty, and security of the person and the right not to be deprived thereof except in

¹⁹ Indian and Northern Affairs Canada, “Canada’s Position: Draft Declaration on the Rights of Indigenous Peoples,” last modified March 16, 2009, <http://www.ainc-inac.gc.ca/ap/ia/pubs/ddr/ddr-eng.asp>

²⁰ For a full discussion on Canada’s position on the United Nations Draft Declaration on the Rights of Indigenous Peoples, see Indian and Northern Affairs Canada, “Canada’s Position: United Nations Draft Declaration on the Rights of Indigenous Peoples,” last modified March 16, 2009, <http://www.ainc-inac.gc.ca/ap/ia/pubs/ddr/ddr-eng.asp>

²¹ A reception system, as defined by Gibran Van Ert “is a scheme of determining how rules of public international law are applied, considered, or set aside – in a word, received – into domestic law”. Gibran Van Ert., “Using Treaties in Canadian Courts,” in *The Canadian Yearbook of International Law*, vol. 38, ed. Don M. McRae (Canada: UBC Press, 2001), 3.

²² *Ibid.*

²³ *Ibid.*

²⁴ Bruce Porter, “A Right to health care in Canada Only if you can pay for it,” n.d., 2, http://www.srap.ca/publications/porter_a_right_to_healthcare_only_if_you_can_pay.pdf

accordance with the principles of fundamental justice” includes the right to adequate healthcare for the first time.²⁵

In *Chaoulli v. Quebec (Attorney General)*, appellants Dr. Jacques Chaoulli and George Zeliotis argued that legislation that prohibits private health care insurance from paying for services covered by public health care insurance schemes (which would presumably enable those able to pay for private insurance to access such care faster), violates the right to life, liberty and security of person under the Charter and/or the right to “life, and personal security, inviolability and freedom” as guaranteed under the Quebec Charter. They alleged that due to long waiting times for public health services in Quebec, this legislation prohibits people from accessing the care they need in a timely manner.

Three Supreme Court judges found that the legislation violated section 7 of the Canadian Charter; three found that it did not; and one judge did not rule on the Canadian Charter. In regard to the Quebec Charter, under which the judges reached a majority decision, four judges found that “in the context of unreasonable wait times for services, Quebec’s prohibition of private health insurance violated the right to life and personal security under the Quebec Charter” and that the “violation was not justified under the limitations clause in the Quebec Charter as demonstrating ‘a proper regard for democratic values, public order and the general well-being of the citizens of Quebec’”.²⁶ The right to health as outlined in the ICESCR was not invoked.

Prior to being brought to the Supreme Court, the case had been dismissed by the Superior Court and Court of Appeal. The Superior Court dismissed the case on the grounds that a violation of the right to life, liberty and security of person had occurred, but the legislation is justified “because it is in accordance with the principles of fundamental justice”, while the Court of Appeal also dismissed the case, with the three judges citing different reasons.

The ruling is indicative of a general reluctance on the part of judges to rule in the area of economic, social and cultural rights, and the idea that certain activities of the State are beyond the jurisdiction of the courts, despite the fact that such activities can greatly affect enjoyment of rights. The ruling has been criticized for failing to further the enjoyment of a right to health for the poor:

*The majority simply ignores the plight of those who must, because of their circumstances, rely on publicly funded healthcare, and seems to assume that the court can play no role in ensuring that the state remedy any failures to provide adequate and timely health care to those in need.*²⁷

Essentially, the ruling in this case could serve to decrease enjoyment of the right to health, as enumerated in international human rights treaties, such as the ICESCR, and even the right to life, liberty and the security of person under the Charter if private insurance companies are allowed to provide for, what are otherwise, publicly-funded health care services, as resources would be diverted away from the public system, which most people depend.

²⁵ *Ibid.*, at 1.

²⁶ *Ibid.*, at 2.

²⁷ *Ibid.*, at 3.

Challenges in regard to the right to health in the Canadian context

To some extent Canada has taken these actions with regard to incorporating human rights into domestic legislation; for example, the Canadian Charter of Rights and Freedoms (hereafter referred to as “the Charter”) contains some of the rights outlined in the International Bill of Human Rights, particularly those outlined in the ICCPR, with fewer economic, social and cultural rights included. However, the right to health is not present in the Charter (discussed further in subsequent paragraphs).

To complicate matters, only the federal executive has the power to enter into an international treaty, yet some of the matters contained within international treaties fall under the legislative authority of the Canadian provinces and territories – legislative authority in Canada is divided between the federal and provincial governments according to Constitution Act 1867. As it happens, health and health care matters fall largely within the scope of provincial and territorial jurisdiction.²⁸ This means that while the federal government may enter into an international human rights treaty, it may not have legislative competency to enact necessary measures. With some international treaties, the federal government has used a “federal-state” clause, which means that applicability of the treaty provisions can be limited to select the provinces and territories (by doing this, the federal government avoids taking on full responsibility for sub-state compliance).²⁹ However, the federal-state clause cannot be used with the ICESCR³⁰ and therefore the state remains the primary duty-bearer and is responsible for enabling Canadians to enjoy their human rights, including the right to health, even though it falls primarily under provincial and territorial jurisdiction. This disconnect is remedied in part by the fact that the federal government has imposed conditions that the provinces and territories must meet in order to obtain federal funding, which will be discussed in the following section on national human rights mechanisms and the Canada Health Act.

National, provincial and territorial human rights mechanisms and the right to health

Canada has four main mechanisms that deal with human rights, they are: The Canadian Charter of Rights and Freedoms, the Canadian Human Rights Act, the Canadian Human Rights Commission and provincial and territorial human rights codes and legislation.³¹ The Canadian Human Rights Act and the Canadian Charter of Rights and Freedoms constitute the most important human rights legislation at the federal level while the Canadian Human Rights

²⁸ While provincial governments have jurisdiction over most matters pertaining to health care matters, the federal government holds some powers in the area of health and health care. For example, the federal government is responsible for public health matters such as quarantine, marine hospitals, and administering health care to First Nations peoples and military personnel. See Nola M. Ries, “Legal Foundations of Public Health in Canada,” in *Public Health Law & Policy in Canada* (2nd edition.), ed. Tracey M. Bailey, Timothy Caulfield, and Nola M. Ries (Canada: LexisNexis, 2008), 11

²⁹ Martha Jackman, “Women and the Canada Health and Social Transfer: Ensuring Gender Equality in federal welfare reform”, *Canadian Journal of Women and the Law*, 8(2) (1995): 22, footnote 81.

³⁰ *Ibid.*

³¹ There is also a Canadian Bill of Human Rights, which has become largely obsolete since the creation of the Charter.

Commission exists to administer human rights legislation and provincial codes outline the human rights of citizens relating to goods and services administered by the provincial government and areas not covered under federal jurisdiction.

The Charter is the central and perhaps most comprehensive piece of legislation pertaining to the rights and freedoms of Canadians; it is entrenched in the country's constitution and it is often invoked in human rights litigation in the country. However, as mentioned above, the right to health is not explicitly referenced in the Canadian Charter. Indeed, these documents focus heavily on civil and political rights with little mention of economic, social and cultural rights.

Provincial and territorial human rights legislation too fails to include mention of a right to health, with the exception of Quebec's Charter of Human Rights and Freedoms, which lists a right to a healthful environment: "Every person has a right to live in a healthful environment in which biodiversity is preserved, to the extent and according to the standards provided by law."³² Section 86 of the Quebec Charter also highlights the potential of affirmative action programs to promote health equity (among other things): "the object of an affirmative action program is to remedy the situation of persons belonging to groups discriminated against in employment, or in the sector of education or of health services and other services generally available to the public."³³

Other rights and their relationship with the right to health in the context of Canada

Although the purpose of this study is to assess the extent to which the right to health has been realized in the country, there are a number of other rights (most of which fall under the category of economic, social and cultural rights) that must be realized in order to enjoy the right to health. For example, the rights to housing, safe work, freedom from violence, a clean environment, food security, water and education are imperative to the realization of the right to health. Like the right to health, most of these entitlements are not explicitly recognized as human rights through human rights legislation in Canada, but it is clear that efforts are made to ensure Canadians have access to the preconditions for health – water, safe work, housing, food, education are all highly regulated goods and services. When an individual is unable to meet his or her basic needs, there are federal, provincial and municipal services available. Yet, without clear recognition of human rights in formal legislation stating the basic needs that must be met, people are unable to claim such things as entitlements. As has been noted and reiterated time and time again by the United Nations and the international community, all rights are inter-related, interdependent and indivisible; none can be realized in full without realization of the others. Given the importance of economic, social and cultural rights to many determinants of health, it is also necessary to consider the need for human rights legislation and policy in Canada to include reference to the things people need in order to achieve their best health, as well as a right to health.

Bill C-6: Canada Health Act

³² Quebec. Quebec Charter of Rights and Freedoms, R.S.Q., chapter C-12 , para.46, <http://www.cdpcj.qc.ca/en/commun/docs/charter.pdf>

³³ *Ibid.*, at para. 86.

Bill C-6, otherwise known as the Canada Health Act (CHA) was adopted in 1984 and represents the highest form of health law in Canada. Without referencing a right to health specifically, the CHA was founded on many shared principals. As one Virginia Leary points out:

For many observers, the Canadian health care system appears to be grounded in core elements of the right to health including the availability, accessibility, and acceptability of quality health goods, services and facilities, [however]... the terms “right to health” or “right to health care” are not mentioned explicitly in any of the documents establishing the Canadian health care system.³⁴

The CHA outlines the principals and conditions that must be met by each province and territory in order to receive funding from the federal government. The five criteria that must be met by the provinces and territories of Canada in order to receive federal government funding are as follows:

1. Public Administration: This principal contends “the health insurance plan of a province must be administered and operated on a non-profit basis by a public authority... [and that] the public authority must be subject to audit of its accounts and financial transactions...”³⁵
2. Comprehensiveness: “The health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists...”³⁶
3. Universality: “The health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions”³⁷
4. Portability: There must not be any “minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services...”³⁸
5. Accessibility: Among other things, this principal asserts that the health care insurance plan of a province “must provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons...”³⁹

What the act does not do, however, is *require* the government to make financial contributions to the provinces for health care.⁴⁰ Moreover, the act enables the federal government to provide

³⁴ Virginia Leary, “Health Care in Canada: Does a Health Care System Based on Shared Values Ensure Respect for the Right to Health?” In *Swiss Human Rights Book Vol. 3, Realizing the Right to Health*, ed. Andrew Clapham and Mary Robinson (Zurich: ruffer & rub, 2009), 473

³⁵ Canada Health Act, 1984, c. 6, s. 8., <http://laws.justice.gc.ca/PDF/Statute/C/C-6.pdf>

³⁶ *Ibid.*, at c.6 S.9.

³⁷ *Ibid.*, at c.6 s. 10.

³⁸ *Ibid.*, at c.6 s. 11.

³⁹ *Ibid.*, at c.6 s. 12.

⁴⁰ Dr. Bernard Dickens, “The Law’s Contribution to Sound Health Policy,” in *Do We Care? Renewing Canada’s commitment to Health Care*, ed. John Ralston Saul and Margaret J. Somerville (Canada: Merck Frosst Canada &

funding through monetary or tax transfer for care that is “medically necessary”⁴¹ for health, but neither “medically necessary” nor “health” are defined in the document. The value of listing health (and at the very least, health care) as a human right is that it translates needs into entitlements that cannot (or should not) be revoked. Although there is a strong health care system in Canada, which is valued by most Canadians and elected officials, without clear obligations on the part of the State, no entitlements can be claimed. This void underscores the importance of understanding health as a human right and need to include it in national legislation.

Health Financing

Total Health Care spending⁴²

Canada’s health system is funded by public and private sectors.⁴³ Public-sector funding refers to funding provided by federal, provincial and territorial, and municipal governments as well as workers’ compensation boards and social security programs.⁴⁴ Private-sector funding refers to health expenditures by households and private insurance firms.⁴⁵

The total health expenditure in Canada is expected to reach \$191.6 billion in 2010,⁴⁶ which is an increase from an estimated \$182.1 billion in 2009⁴⁷ and \$171.8 billion in 2008.⁴⁸ The total health expenditure per capita for 2010 is expected to be \$5,614 (which represents a growth rate of 4.0% from the estimated 2009 amount of \$5,397 and a growth rate of 4.7% from the confirmed 2008 amount of \$5,154).⁴⁹ However, when adjusted for inflation and for population changes, rates of increase are expected to be 1.6% in 2009 and 1.4% in 2010.⁵⁰

Total health care spending expressed as a percentage of GDP

Canada’s total health spending is among the highest in the world when expressed as a percentage of GDP.⁵¹ According to some estimates, between 1999 and 2006,⁵² Canada spent 9.7% of GDP on health, making it number 12 on the list of highest spenders on health care (as a percentage of GDP).⁵³ Total health care expenditure expressed as the country’s gross domestic product (GDP)

Co., 1999), 137

⁴¹ *Ibid.*

⁴² Estimates are in current dollars

⁴³ Canadian Institute for Health Information, “National Health Expenditure Trends, 1975 to 2010”, 2010, 15, http://secure.cihi.ca/cihiweb/products/NHEX_Trends_Report_2010_final_ENG_web.pdf

⁴⁴ *Ibid.*

⁴⁵ *Ibid.*

⁴⁶ *Ibid.*, at xi.

⁴⁷ *Ibid.*

⁴⁸ *Ibid.*

⁴⁹ *Ibid.*

⁵⁰ *Ibid.*

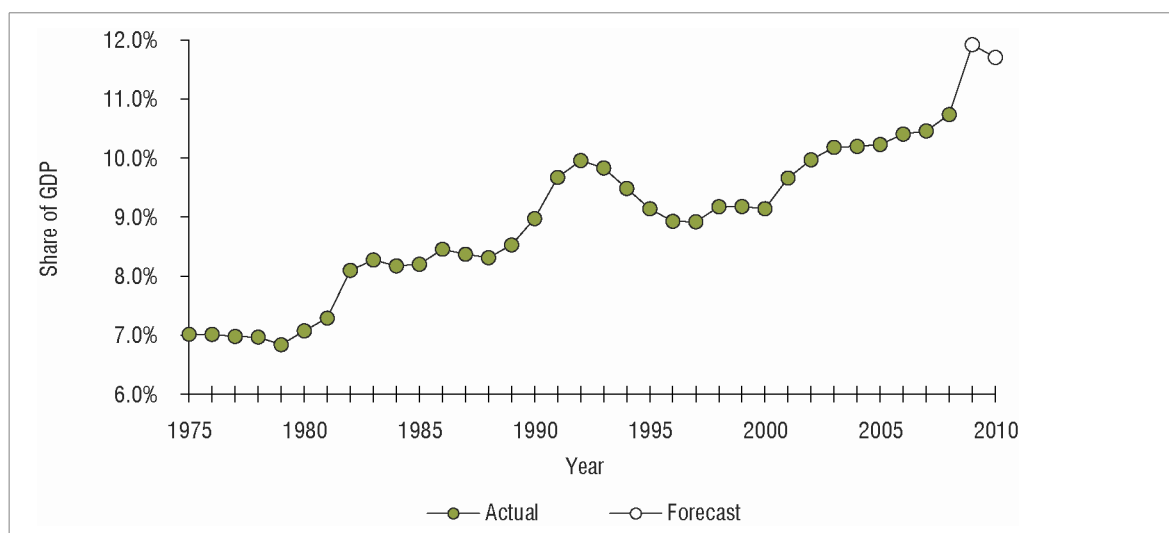
⁵¹ The Economist, “Pocket World in Figures,” 2009, http://www.economist.com/node/12758886?story_id=12758886

⁵² *Ibid.*

⁵³ *Ibid.*

is expected to reach 11.7% in 2010,⁵⁴ a decrease from 11.9% in 2009 and an increase 10.7% in 2008. It must be emphasized that these figures represents the sum of all healthcare expenditures, which includes out-of-pocket, public and private expenditures, and not merely government spending. Figure 1 below demonstrates the increase in total health spending as a percentage of the country's GDP between 1975 and 2010. Note that the forecasted spike in total expenditure as a percentage of the GDP for 2009 is more indicative of the economic downturn and decline in GDP⁵⁵ than it is greater health care spending.

Figure 1: *Total Health Expenditure as a Percentage of Gross Domestic Product, Canada, 1975 to 2010*⁵⁶



Source: National Health Expenditure Database, Canadian Institute for Health Information

Health expenditure as compared with military spending

Health care expenditure as a percentage of the country's GDP is much higher than military expenditure as a percentage of GDP; for example, in 2009 military expenditure represented 1.5% of GDP,⁵⁷ while health care expenditure was 11.9% as noted above.

To view it another way, health care spending amounted to 18.1% of total government expenditure in 2007⁵⁸ (date for which the last comparable data could be found), while military spending accounted for 7.1%⁵⁹ of central government expenditure.

⁵⁴ *Supra* note 43 at xi.

⁵⁵ *Supra* note 43 at 20.

⁵⁶ *Supra* note 43 at 8.

⁵⁷ World Bank, "Military Expenditure (as % of GDP) Canada", last modified 2010, <http://search.worldbank.org/data?qterm=Canada+military+spending&language=EN&format=html>

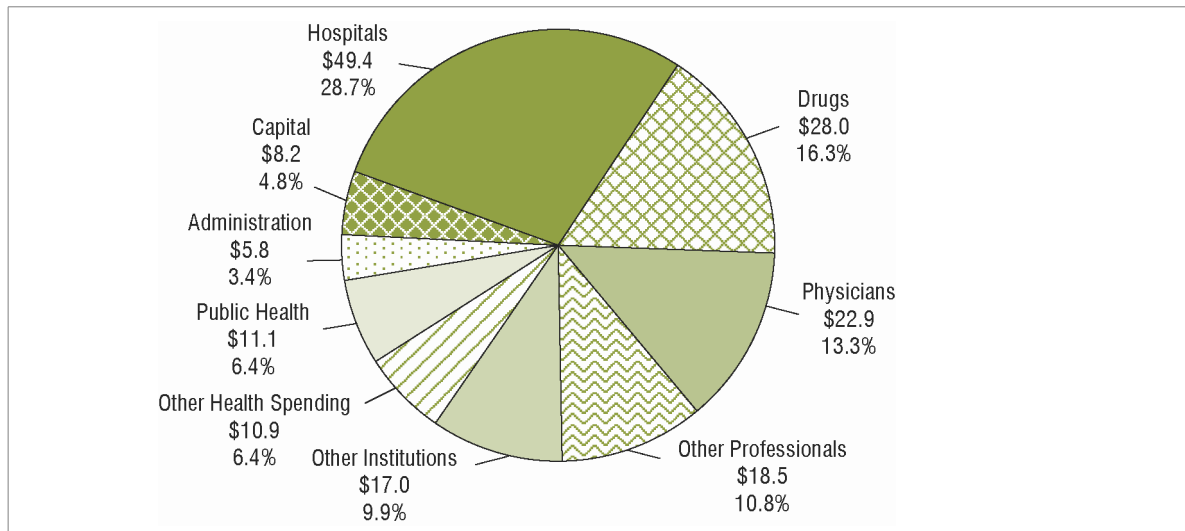
⁵⁸ World Bank, "Health Expenditure (as % of GDP) (Canada)", last modified 2010, <http://search.worldbank.org/data?>

[qterm=Canada+military+spending&language=EN&format=html&_topic_exact=Health](http://search.worldbank.org/data?qterm=Canada+military+spending&language=EN&format=html&_topic_exact=Health)

Breakdown of health care spending by area

According to the last report by the Canadian Institute for Health Information (CIHI), hospitals comprise the greatest percentage of total health expenditure at \$55.3 billion in 2010 (28.9% of total health care spending), followed by drugs at \$28 billion (16.3% of total health care spending) and physicians at \$26.3 billion (13.7% of total health care spending)⁶⁰. The following figure graph demonstrates the total health expenditure in Canada by use of funds:

Figure 2: *Total Health Expenditure by Use of Funds, Canada, 2008 (Billions of dollars and percentage of share)*⁶¹



Source : National Health Expenditure Database, Canadian Institute for Health Information

Health care spending by the federal government

The dollar amount of health care spending by the federal government has risen fairly consistently since the 1960's (from \$14,512 in 1961 to \$39,354 in 2006.)⁶² However, when expressed as a percentage of the GDP, it has fallen, particularly since the 1980's. The starkest contrast appears between the years of 1984 and 2006, wherein total federal government spending fell from 24.3% to 15.4% of GDP.⁶³ This indicates that changes in program spending by the federal government have not matched the rate of economic growth the country has experienced,⁶⁴ for example,

⁵⁹ World Bank. "Military Expenditure (% of central government expenditure) (2007)", last modified 2010, <http://search.worldbank.org/data?qterm=Canada+military+spending&language=EN&format=html>

⁶⁰ *Supra* note 43 at 16.

⁶¹ *Supra* note 43 at 17.

⁶² Canada, Department of Finance, "Fiscal Reference Tables, October 2003," Centre for the Study of Living Standards, www.fin.gc.ca/frt/2003/frt03_3.pdf as quoted in David Langille, "Follow the Money: How Business and Politics Define Our Health" in *Social Determinants of Health*, ed. Dennis Raphael (2nd ed.) (Toronto: Canadian Scholar's Press, 2009), p 306.

⁶³ *Ibid.*

⁶⁴ *Ibid.*

Canada's GDP per capita grew from \$14, 512 in 1961 to \$39,354 in 2006, while total federal government spending as a per cent of GDP decreased from 18.2 to 15.4.⁶⁵

Health care spending by provincial and territorial governments

In 2010, provincial and territorial governments spent an estimated \$3,663 per capita on health care,⁶⁶ though spending varies greatly from province to province and from province to territory. Age distribution, population density, geography, and differences in health care delivery all account for discrepancies in spending across the country.⁶⁷ The highest per capita spending can be seen in the territories (in northern Canada) due to “their large geographical areas and low population densities.”⁶⁸

Overall, in 2010 public sector financing accounts for 70.5% of health expenditure in Canada,⁶⁹ though the ratio of public to private sector health financing varies greatly from region to region; for example, public sector financing comprises 79% of financing in the territories and 67.4% in Ontario.⁷⁰

Private Health care spending

Private sector spending is comprised of three areas: household out-of-pocket expenditure, commercial and not-for-profit insurance expenditure and non-consumption expenditure⁷¹ (for example, hospital revenue from sources other than patients).⁷² In 2010, the private sector is expected to contribute 29.5% of total health expenditure⁷³ in the country. The private sector's share of health care expenditure as a percentage has remained fairly stable for over a decade. A major increase occurred after the recession of the early nineties, following which, governments were exercising fiscal restraint while “private-sector growth rates were considerably higher than the public sector rates... and, as a result, the private-sector share of total health expenditure increased to 29.9% by 1997”.⁷⁴

The dollar amount of private sector funding has increased significantly in recent decades: between 1998 and 2008, private health insurance expenditure per capita rose from \$139.4 to \$623.9; out-of-pocket health expenditure increased from \$277.5 to \$750.7; and non-consumption expenditure increased from \$60.7 to \$147.5.⁷⁵

⁶⁵ *Ibid.*

⁶⁶ *Supra* note 43, at 46.

⁶⁷ *Ibid.*

⁶⁸ *Ibid.*

⁶⁹ *Ibid.*

⁷⁰ *Ibid.*

⁷¹ *Ibid.*, at 27.

⁷² *Ibid.*

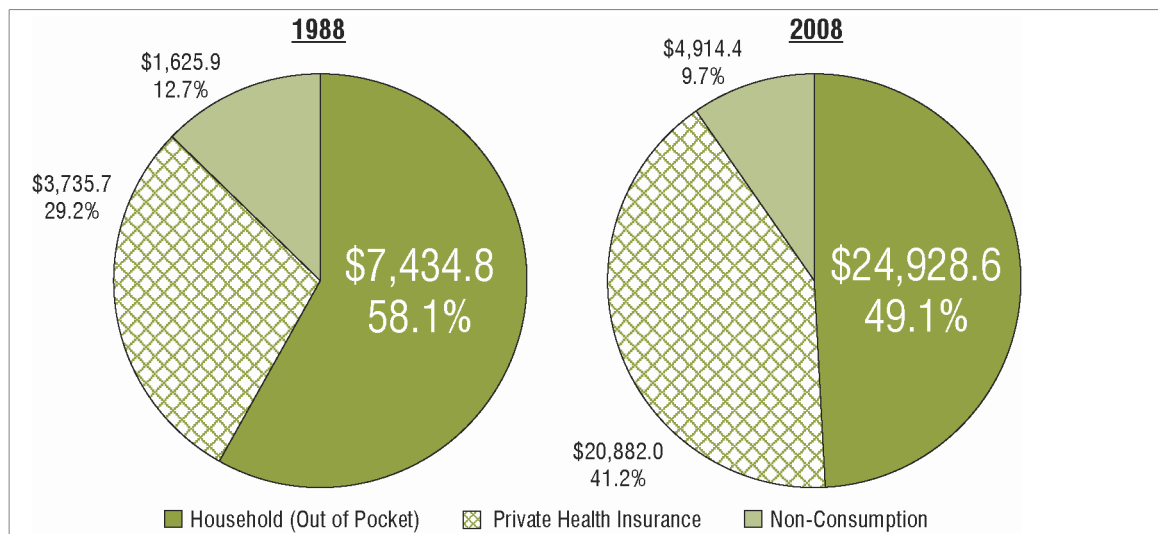
⁷³ *Ibid.*, at 23.

⁷⁴ *Ibid.*

⁷⁵ *Ibid.*, at 29.

As demonstrated in the graph below, despite constituting a smaller percentage of total health care expenditure in recent years, household spending in dollars has risen significantly over the past two decades.

Figure 3: *Distribution of Private Sector Health Expenditure by Source of Finance, Canada 1998 and 2008 (Millions of Dollars and Percentage Share)*⁷⁶



Source: National Health Expenditure Database, Canadian Institute for Health Information.

Population Health

Through examination of some commonly used measures of health, it is clear that Canadians enjoy a reasonably high level of health. In fact, Canada ranked 11th among 24 countries belonging to the Organization for Economic Co-operation and Development (OECD) in terms of overall health performance.⁷⁷ The ranking considered life expectancy, rates of death and disease, immunization rates, self-reported health and certain risk factors (such as rates of obesity).⁷⁸ In addition to this, Canada's health system overall was ranked 30th among 191 nations by the World Health Organization in its World Health Report 2000.⁷⁹

However on other measures, there appears to be a great deal of room for improvement: Canada ranked 23rd among 30 countries according to a Euro- Canada Health Consumer Index that incorporated measures of patient rights and information, waiting times for treatment, clinical outcomes, generosity of public health care systems and provision of pharmaceuticals.⁸⁰

⁷⁶ *Supra* note 43, at 13.

⁷⁷ Conference Board of Canada, "Healthy Provinces, Healthy Canadians: A Provincial Benchmarking Report," (Ottawa, Ont.: Conference Board of Canada, 2006), p.8, <http://www.conferenceboard.ca/documents.aspx?did=1533>.

⁷⁸ *Ibid.*, at 12.

⁷⁹ *Supra* note 9 at 152.

⁸⁰ Frontier Centre for Public Policy, "Euro-Canada Health Consumer Index 2008", 2008, p.2, <http://www.fcpp.org/pdf/ECHCI2008finalJanuary202008.pdf>

On other basic measures either directly related to or supportive of the right to health used by international organizations including the OHCHR and UNICEF, including access to clean and safe drinking water and excreta facilities, Canada scores quite high. In terms of immunization against preventable diseases, as of 2008, UNICEF noted that: 90% of children one year of age were vaccinated against polio, 97% received the DPT1 vaccine and 94% received the DPT3 vaccine, and 94% received the measles vaccine. In 2006 UNICEF also wrote that: 100 % of Canada's population is using improved drinking water sources (100% in urban areas, 99% in rural areas) and 100% of the population has access to improved sanitation facilities (100% urban and 99% rural).⁸¹

HIV/AIDS

The numbers presented here attempt to describe the situation of HIV and AIDS in Canada and have been retrieved from reports by Health Canada. Health Canada, in cooperation with provincial and municipal health organizations, collects data on HIV and AIDS infection rates across the country, as well as other information pertinent to understanding the transmission and treatment of the disease. However, the numbers reported do not accurately depict the prevalence and incidence of HIV and AIDS cases in Canada and the actual number of cases may be much higher.⁸² This is because the numbers here reflect only those cases that have been diagnosed and reported, when in fact many more people are infected with the virus but have not been tested.⁸³

In its last report on HIV and AIDS in Canada, 2009, the Public Health Agency of Canada estimated there were 65 000 people living with HIV and AIDS across the country in 2008, and 26% of these people were unaware that they had the virus.⁸⁴ The reported number of new infections in 2008 was 2,636, though it was estimated that the true number may lie somewhere between 2 300 and 4 300 new infections.⁸⁵ The number of reported new infections of HIV and AIDS in 2009 was 2,417 this is a decrease of 8.3% from new infections reported in 2008.⁸⁶ The highest proportions of these cases were reported by Ontario (41.9%), Quebec (21.4%), and British Columbia (14.0%).⁸⁷

The Public Health Agency of Canada noted that, since 2000, the greatest exposure categories for men and women are men having sex with men and heterosexual contact, respectively.⁸⁸ In 2009, men who have sex with men accounted for 41.8% of all positive HIV cases (of those with a known exposure category).⁸⁹ For women, intravenous drug use, other, and blood transfusions are listed as the second, third and fourth greatest exposure categories, respectively. For men, heterosexual contact, intravenous drug use, other, men having sex with men and intravenous

⁸¹ UNICEF, "At a Glance: Canada," last modified March 2, 2010, http://www.unicef.org/infobycountry/canada_statistics.html#0

⁸² Public Health Agency of Canada, "HIV and AIDS in Canada, Surveillance Report to December 31, 2009", p.1, <http://www.phac-aspc.gc.ca/aids-sida/publication/survreport/2009/dec/pdf/2009-Report-Rapport.pdf>

⁸³ *Ibid.*

⁸⁴ *Ibid.*

⁸⁵ *Ibid.*

⁸⁶ *Ibid.*, at 2.

⁸⁷ *Ibid.*

⁸⁸ *Ibid.*, at pages 3 and 4 respectively.

⁸⁹ *Ibid.*, at 3.

drug use, and blood transfusions are listed as the second to sixth greatest exposure categories, respectively.⁹⁰

The actual number of reported HIV cases decreased between 2008 and 2009, however the number of people living with HIV and AIDs has remained fairly consistent since 2000.⁹¹ However there were increases noted among specific groups, such as younger females, Aboriginals, and people over 40.⁹² However data on ethnicity and HIV is not always reported, some provinces and territories do not or have not in the past collected such information and therefore accurate comparisons between ethnic groups are difficult to make. Ontario and Quebec, Canada's two most populous provinces do not collect data on ethnicity and positive HIV test results.⁹³ In 2009, Caucasians accounted for 44.2 % of positive HIV test reports, followed by Aboriginals (Métis, Inuit, First Nations, and unspecified Aboriginal) at 33.3% and Black at 11.6%.⁹⁴

Canada has a wide variety of national and provincially based organizations dealing specifically with HIV and AIDS in Canada, in the form of resource centers, support groups, and health organizations,⁹⁵ some of which developed for specific populations, including Aboriginal groups and women. Moreover, the federal government has initiated several programs focusing on HIV/AIDS education, support, and care, such as Federal Initiative to Address HIV/AIDS,⁹⁶ which is guided by, among other things, the principle of partnership (between federal, provincial, territorial and municipal partnerships as well as partnership with the private sector, voluntary organizations and individuals). This is particularly worthy considering that a human rights-based approach to health care involves participation by individuals and groups from different areas of society.

HIV/AIDS education is commonplace in Canadian classrooms. The age and grade at which HIV/AIDS education is introduced to children varies between regions of the country. For example, some elementary schools introduce HIV/AIDS and related topics such as stigma and discrimination, while other schools do not mention the topic until much later and include less information during lessons.⁹⁷

Tuberculosis

While many Canadians believe that Tuberculosis has been eradicated from the country, new cases are reported each year. In 2008, 1,600 new active and re-treatment tuberculosis cases were reported (4.8 per 100,000), an increase of 1.5% from 1,577 cases reported in 2007.⁹⁸ British Columbia, Ontario and Quebec (the most populated provinces in the country) account for 69% of

⁹⁰ *Ibid.*, at 4.

⁹¹ *Ibid.*, at 15.

⁹² *Ibid.*, at 15

⁹³ *Ibid.*, at 32

⁹⁴ *Ibid.*, at 33

⁹⁵ The Body, the Complete HIV/AIDS Resource, "Canadian HIV/AIDS Organizations," http://www.thebody.com/index/hotlines/canadian_aso.html

⁹⁶ Public Health Agency of Canada. Federal, "Initiative to Address HIV/AIDS in Canada," n.p., last modified September 25, 2007, <http://www.phac-aspc.gc.ca/aids-sida/fi-if/>

⁹⁷ Canadian AIDS Society, "The Status of HIV/AIDS Education in Canada's Public Education Sector (March 2005), <http://www.cdnaids.ca/web/position.nsf/pages/cas-pp-0296>

these cases, however Nunavut experienced the highest rate of the disease at 184.4 per 100,000 – over 38 times the rate of the total Canadian population.⁹⁹

As noted earlier, Aboriginal peoples, and in particular, Inuit peoples, experience tuberculosis at a much higher rate than the total Canadian population. According to the Inuit Tapiriit Kanatami organization, the rate of tuberculosis among first nations and Inuit populations is 31 and 185 times higher, respectively, than that of Canadian-born, non-aboriginals.¹⁰⁰ In 2010, it was noted by the organization that the rate of tuberculosis among Inuit has doubled over the past four years.¹⁰¹ Gail Turner, chair of Inuit Tapiriit Kanatami's National Inuit Committee on Health, stated that “[i]t is unconscionable that these conditions exist in a country that boasts of having one of the lowest TB rates in the world.”¹⁰² Chief Angus Toulouse cited “overcrowded housing, poor nutrition and lack of access to health care” as important factors contributing to the disease among First Nations people.¹⁰³

Canada's major health care actors have recognized the importance of education efforts and continued research on the topic of tuberculosis. For example, the Tuberculosis Prevention and Control Program lead by the Public Health Agency of Canada has set a goal to reduce the incidence rate of TB in Canada to 3.6 per 100,000 by 2015”.¹⁰⁴ The Government of Canada has also collaborated with the Global Indigenous Stop TB Initiative in its attempt to reduce “the burden that [tuberculosis] has on Aboriginal peoples in Canada and around the world”.¹⁰⁵

Chronic and Non-communicable Disease

While not mentioned in the OHCHR's list of illustrative indicators for the right to health, chronic and non-communicable diseases (NCD) present a growing threat to the health of Canadians, with certain populations being affected disproportionately. Chronic diseases and NCD include diabetes, cancer and heart disease, among other things. These diseases contribute to morbidity and mortality rates more than any other diseases, and not only do they threaten the lives of those individuals and communities affected, they have created a greater demand for more expensive health care resources and some say, ultimately, threaten the quality of the country's health care system.

⁹⁸ Public Health Agency of Canada, “Tuberculosis in Canada 2008 (Pre-release).” 2008, p.5, <http://www.phac-aspc.gc.ca/tbpc-latb/pubs/tbcan08pre/pdf/tbcan2008pre-eng.pdf>

⁹⁹ *Ibid.*

¹⁰⁰ Inuit Tapiriit Kanatami, “Inuit TB rate doubles to 185 times the rate of Canadian-born non-aboriginals; First Nations rate 31 times higher,” March 10, 2010, <http://www.itk.ca/media-centre/media-releases/inuit-tb-rate-doubles-185-times-rate-canadian-born-non-aboriginals-first>

¹⁰¹ *Ibid.*

¹⁰² *Ibid.*

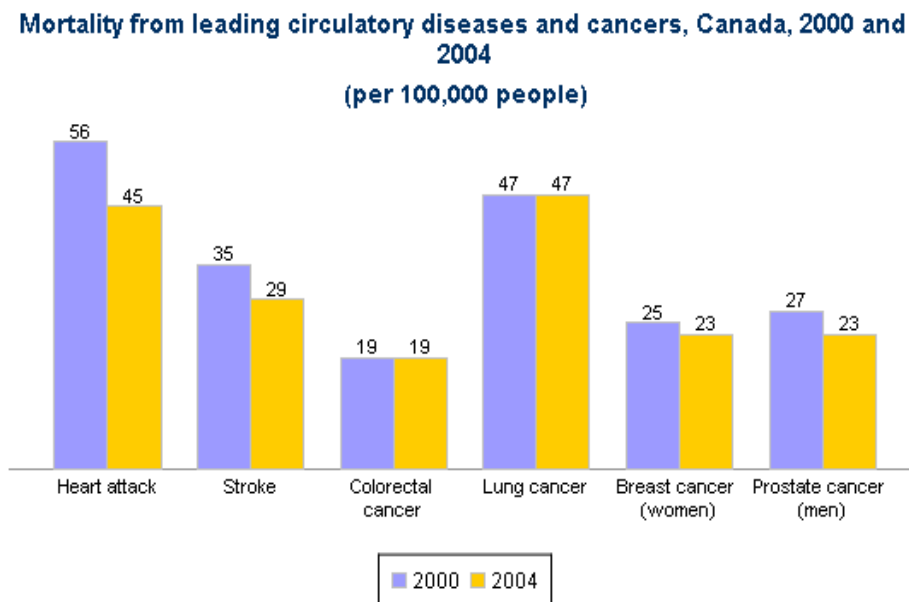
¹⁰³ *Supra* note 100.

¹⁰⁴ Health Canada, “National Tuberculosis Elimination Strategy,” <http://www.hc-sc.gc.ca/fniah-spnia/diseases-maladies/tuberculos/intro-eng.php>

¹⁰⁵ *Ibid.*

Canadians are most at risk of dying of circulatory system diseases and cancers.¹⁰⁶ Specifically, heart attack, stroke and lung cancer are the main causes of death.¹⁰⁷ The following chart shows mortality from leading diseases in Canada in 2000 and 2004.¹⁰⁸

Figure 4: *Mortality from leading circulatory diseases and cancers, Canada, 2000 and 2004 (per 100,000 people)*¹⁰⁹



Source: Statistics Canada. Mortality, by selected causes of death (ICD-10) and sex, Canada, provinces and territories, annual (age-standardized rate per 100,000 population) (CANSIM Table 102-0126). Ottawa: Statistics Canada, 2008.

Figure 5: *Mortality from leading circulatory diseases and cancers, by gender, 2004 (per 100,000 people)*¹¹⁰

¹⁰⁶ Human Resources and Skills Development Canada, “Indicators for Well-being in Canada; Health – Mortality from Leading Diseases,” <http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=5>

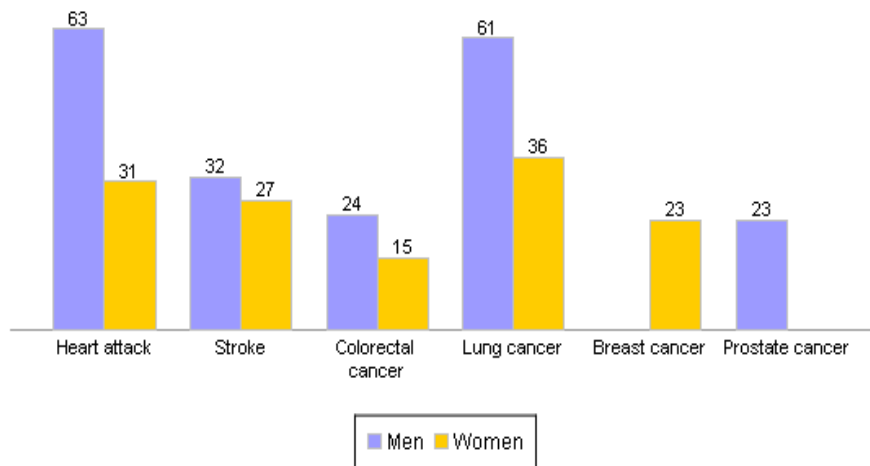
¹⁰⁷ *Ibid.*

¹⁰⁸ *Ibid.*

¹⁰⁹ Statistics Canada. Mortality, by selected causes of death (ICD-10) and sex, Canada, provinces and territories, annual (age-standardized rate per 100,000 population) (CANSIM Table 102-0126). (Ottawa: Statistics Canada, 2008) in Human Resources and Skills Development Canada, “Indicators for Well-being in Canada,” last modified February 3, 2011, <http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=5>

¹¹⁰ Statistics Canada. Mortality, by selected causes of death (ICD-10) and sex, Canada, provinces and territories, annual (age-standardized rate per 100,000 population) (CANSIM Table 102-0126). (Ottawa: Statistics Canada, 2008) in Human Resources and Skills Development Canada, “Indicators for Well-being in Canada,” last modified February 3, 2011, <http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=5>

**Mortality from leading circulatory diseases and cancers, by gender, 2004
(per 100,000 people)**



Source: Statistics Canada. Mortality, by selected causes of death (ICD-10) and sex, Canada, provinces and territories, annual (age-standardized rate per 100,000 population) (CANSIM Table 102-0126). Ottawa: Statistics Canada, 2008.

Obesity

In 2009, about 18% of Canadians over the age of 18, self-reported height and weight measurements that put them in the body mass index (BMI) category of “obese”. Higher obesity rates were reported by both men and women between 2003 and 2009; obesity rates among men rose from 16% to 19%, and among women, from 15% to 17%.¹¹¹ While obesity is not an illness in itself, it is related to a number of diseases such as diabetes and heart disease.

Child Health

Canadian children enjoy a high life expectancy and good health.¹¹² Moreover, Canadian children experience comparatively low rates of disease and disability.¹¹³ As noted above, the vast majority of children are immunized against preventable disease such as measles, whooping cough and polio.

Infant mortality is a common measure of the level of development and health of a country. The OHCHR uses infant and under-five mortality rates as an indicator for the right to health. Infant mortality refers to the number of infants who die in the first year of life.¹¹⁴ In 2006 in Canada

¹¹¹ Statistics Canada, “Canadian Community Health Survey,” 2009, <http://www.statcan.gc.ca/daily-quotidien/100615/dq100615b-eng.htm>

¹¹² Public Health Agency of Canada, “The Chief Public Health Officer’s Report on the State of Public Health in Canada 2009: Chapter 3 The health of Canadian Children,” 2009, <http://www.phac-aspc.gc.ca/cphorsphc-respcacsp/2009/fr-rc/cphorsphc-respcacsp06-eng.php#c3-3>

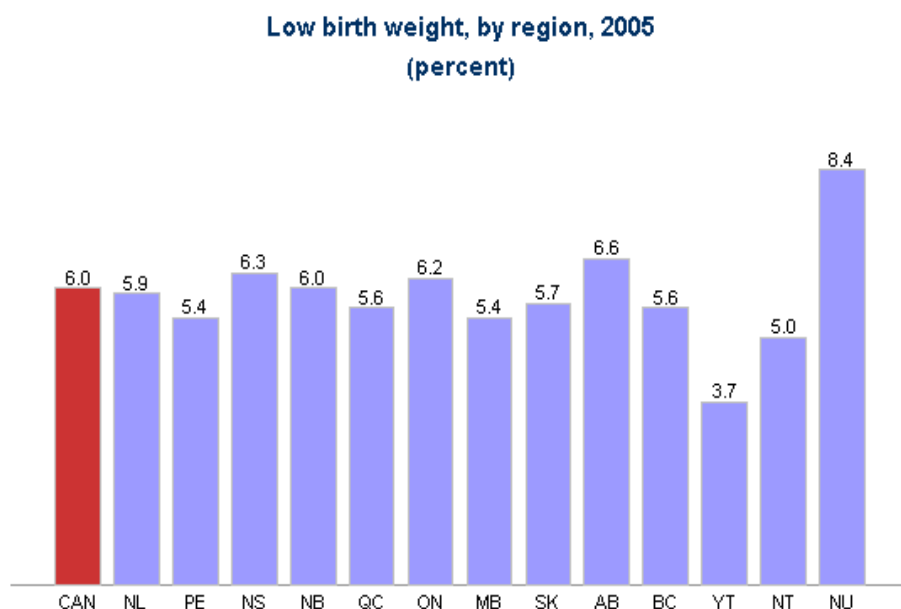
¹¹³ *Ibid.*

¹¹⁴ Human Resources and Skills Development Canada, “Indicators for Well-being in Canada: Health – Infant mortality,” last modified February 3, 2011, <http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=2>

this number was 5.0 per 1,000 live births.¹¹⁵ However 2005 statistics show how rates vary considerable across regions: for example the rate of infant mortality in Nunavut is nearly double that of the Canadian average at 10 per 1,000 live births.

Low birth weight is another common measure employed internationally. The OHCHR lists low birth-weight as an outcome indicator for the right to health. Between 2004 and 2005 Canada had the lowest proportion of low birth-weight babies among G7 countries, with 6.0% of infants in Canada born at low birth weight in 2005.¹¹⁶ Again, this rate varies considerably across regions as depicted in the following chart.

Figure 6: Low birth weight, by region, 2005 (percent¹¹⁷)



Source: Statistics Canada. Live birth, by birth weight (less than 2,500 grams) and sex, Canada, provinces and territories, annual (CANSIM Table 102-4509). Ottawa, Statistics Canada, 2008.

In 2004 it was reported that, for children aged 1 to 11, the rate of mortality due to intentional or unintentional injury was 4.9 per 100, 000; the rate of mortality due to malignant cancers was 2.7 per 100,000; and the rate of mortality due to congenital malformations, deformations and chromosomal abnormalities was 1.4 per 100,000.¹¹⁸

Overall, Canada has achieved significant decreases in child mortality rates caused by intentional or unintentional injuries. Between 1971 and 1975, Canada had the fourth highest child injury mortality rates among OECD countries, at 27.8 deaths per 100,000.¹¹⁹ Today, that rate is 9.7 per

¹¹⁵ *Supra* note 112.

¹¹⁶ Human Resources and Skills Development Canada, “Indicators for Well-being in Canada: Health – Low Birth Weight,” last modified February 3, 2011, <http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=4>

¹¹⁷ Statistics Canada, “Live birth, by birth weight (less than 2,500 grams) and sex, Canada, provinces and territories, annual,” (Ottawa: Statistics Canada, 2008) in Human Resources and Skills Development Canada, “Indicators for Well-being in Canada,” last modified February 3, 2011, <http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=5>.

¹¹⁸ *Supra* note 112.

¹¹⁹ *Ibid.*

100,000. While Canada is still among the bottom ten countries, with the highest child injury mortality rates among OECD countries, it has improved significantly on this measure. Still, injury is the leading cause of morbidity and disability for children.¹²⁰ In 2005 it was reported that 15% of hospitalizations of children under 12 years were the result of injury.¹²¹ However, data collected by the 2002/03 First Nations Regional Longitudinal Health Study found that 18% of First Nations children required medical care for injury.¹²² Moreover, aboriginal children experience higher rates of unintentional injuries and deaths resulting from drowning and other causes.¹²³

Ill health and disease affecting children include: being overweight (16.9 % of the children aged 2 to 11 years), asthma (15.6 % of children aged 4 to 11 years), obesity (7.4% of children aged 2 to 11), and cancer (15 new cases per 100,000 children aged 0 to 14).¹²⁴ In terms of mental illness and behavioral issues, 2004-2005 reported data (listed as self, parent or other) shows that 14.7% of children aged exhibit “high levels of emotional and/or anxiety problems”.¹²⁵ For that same time period, 14.2 % of children aged 2 to 5 years exhibit “high levels of physical aggression, opposition and/or conduct disorder”.¹²⁶ Very few Canadian children contract vaccine preventable diseases such as measles (0.4 cases per 100,000 for 2004-2005).¹²⁷

With regards to mental health, it is estimated that up to 15% of Canadian children and youth are affected by a mental illness.^{128,129} For First Nations children up to the age of 11, this number climbs to 29% .¹³⁰

Women’s Health

Looking only at the measure of life expectancy, it may appear that women are healthier, or perhaps that they are able to enjoy their right to health even more so than Canadian men. However a look at a variety of other indicators, and considering policies and practices, it becomes clear that this may not necessarily be true. In 2005 men and women self-reported similar levels of health, though slight differences can be seen between men and women who rated their health as “excellent” (21% of men and 23% of women) and also between men and women who rated their health as “fair or poor” (11% of men and 12% of women) ;¹³¹ similar trends can be seen in self-reporting on mental health.¹³²

¹²⁰ *Ibid.*

¹²¹ *Ibid.*

¹²² *Supra* note 112.

¹²³ *Ibid.*

¹²⁴ *Ibid.*

¹²⁵ *Ibid.*

¹²⁶ *Ibid.*

¹²⁷ *Ibid.*

¹²⁸“ Mental illnesses are characterized by alteration in thinking, mood or behavior — or any combinations thereof — associated with some significant distress and impaired functioning. Mental illnesses take many forms, including mood disorders, schizophrenia, anxiety disorders, personality disorders, eating disorders and addictions such as substance dependence and gambling” in *Supra* note 111.

¹²⁹ *Supra* note 112.

¹³⁰ *Ibid.*

¹³¹ Human Resources and Skills Development Canada, “Indicators of Well-being in Canada, Health – Self rated health,” last modified February 3, 2011, <http://www4.hrsdc.gc.ca/.3ndic.1t.4r@-eng.jsp?iid=10>

¹³² *Ibid.*

Maternal Mortality

Maternal mortality in Canada is among the lowest in the world at 5.5 per 100,000 live births in 2002–2004.¹³³ And according to UNICEF, the maternal mortality ratio in 2005 and lifetime risk of maternal death in Canada is 1 in 11000.¹³⁴ According to UNICEF 97% of births were attended by a skilled attendant between 2003 and 2008.¹³⁵

Abortion

In 2005, 96,815 abortions were performed in Canada.¹³⁶ Abortion in Canada is legal and has been considered a legal right since 1988.¹³⁷ The Canada Health Act guarantees access to medical services, of which abortion is considered. However, access to abortions varies across regions; for example, abortion services were unavailable in Prince Edward Island at the time of writing, and the province of New Brunswick will not pay for abortions outside publicly funded facilities¹³⁸ (therefore it will not pay for abortions performed in abortion clinics).

Violence Against Women

In 2006, Statistics Canada stated “Violence against women is a persistent and ongoing problem in Canada and around the world. It affects women’s social and economic equality, physical and mental health, well-being and economic security”.¹³⁹ Data from 2004 show that approximately 7% of women (and 6% of men) in a long-term relationship (married or common law) have experienced abuse at the hands of their partner at some point over the previous five years.¹⁴⁰ This number is down from 8% of women in 1999.¹⁴¹

Women are also more likely to experience severe forms of violence from men than men experience from women. In 2004, “twice as many women than men were beaten by their partners and four times as many were choked; 16% of women who were victimized by a spouse were sexually assaulted, and; twice as many female as male victims of spousal assault reported chronic, ongoing assaults (10 or more)”.¹⁴²

¹³³ Statistics Canada, “Canadian Perinatal Health Report 2008 Edition,p.30, ” <http://www.phac-aspc.gc.ca/publicat/2008/cphr-rspsc/pdf/overview-apercu-eng.pdf>

¹³⁴ UNICEF, “At a Glance: Canada,” last modified March 2, 2010, http://www.unicef.org/infobycountry/canada_statistics.html#0

¹³⁵ *Ibid.*

¹³⁶ Statistics Canada, “Induced Abortion Statistics,” last modified May 21, 2008, <http://www.statcan.gc.ca/pub/82-223-x/2008000/5202129-eng.htm>

¹³⁷ Abortion Rights Coalition of Canada, “Position Paper #15, How to get an abortion in Canada,” February 2006, p.1, <http://www.arcc-cdac.ca/postionpapers/15-How-To-Get-an-Abortion-in-Canada.pdf>

¹³⁸ National Abortion Federation, “Access to Abortion in Canada,” 2010 <http://www.prochoice.org/canada/access.html>

¹³⁹ Statistics Canada, “Measuring Violence Against Women, Statistical Trends 2006,” p. 7, <http://www.uregina.ca/resolve/PDFs/Women%20and%20violence.pdf>

¹⁴⁰ *Ibid.*, at 16-17.

¹⁴¹ *Ibid.*, at 17.

¹⁴² *Ibid.*, at 19.

Aboriginal women and men report higher rates of violence than non-aboriginal women or men, with aboriginal women experiencing the most violence: 24% of women and 18% for men reported experiencing spousal violence in the previous five years.¹⁴³

Aboriginal Health

Aboriginal population and conceptions of health

According to Canada's 2006 census (most recent census for which data is available), 1,172,790 people self-identified as Aboriginal.¹⁴⁴ In Canada, "Aboriginal" refers to North American Indian (First Nations people), Métis and Inuit.¹⁴⁵ The census identified approximately 698,025 North American Indians, 389,780 Métis, and 50,480 Inuit.¹⁴⁶ These and other socio-legal categories of Aboriginal peoples have been constructed by the Canadian Government, largely for legislative and policy purposes,¹⁴⁷ though have been criticized as having "little or no correlation with culturally meaningful groupings".¹⁴⁸ Despite such criticism, however, these categories are used to inform health programming, services, and delivery to Aboriginal peoples.¹⁴⁹

Given that the Aboriginal population in Canada is diverse and comprised of many unique groups of people, it seems almost futile to attempt to define how Aboriginal peoples collectively conceive of "health". However, in an attempt to do just that, the Royal Commission on Aboriginal Peoples proposed the following holistic notion of "health":

*For a person to be healthy, [he or she] must be adequately fed, be educated, have access to medical facilities, have access to spiritual comfort, live in a warm and comfortable house with clean water and safe sewage disposal, be secure in cultural identity, have an opportunity to excel in meaningful endeavor, and so on. These are not separate needs; they are all aspects of the whole.*¹⁵⁰

Likewise, the National Aboriginal Health Organization stated, "health is generally not seen as separate and distinct from other aspects of life, and engages with physical, mental, emotional, social and spiritual factors".¹⁵¹ According to the Cree peoples of Canada, "such elements are not

¹⁴³ *Ibid.*, at 64.

¹⁴⁴ Statistics Canada, "Population Counts," 2010, last modified June 21, 2010, <http://www.statcan.gc.ca/pub/89-645-x/2010001/count-pop-denombrement-eng.htm>

¹⁴⁵ *Ibid.*

¹⁴⁶ Statistics Canada, "Aboriginal identity population by age groups, median age and sex, 2006 counts for both sexes, for Canada, provinces and territories - 20% sample data," last modified June 10, 2010, [http://www12.statcan.ca/census-recensement/2006/dp-pd/hlt/97-558/pages/page.cfm?](http://www12.statcan.ca/census-recensement/2006/dp-pd/hlt/97-558/pages/page.cfm?Lang=E&Geo=PR&Code=01&Table=1&Data=Count&Sex=1&Age=1&StartRec=1&Sort=2&Display=Page)

¹⁴⁷ Constance MacIntosh, "The Intersection of Aboriginal Public Health with Canadian Law and Policy," in *Public Health Law & Policy in Canada*, 2nd Edition, ed. Tracey M. Bailey, Timothy Caulfield, and Nola M. Ries (Canada: LexusNexus, 2008), 397.

¹⁴⁸ *Ibid.*

¹⁴⁹ *Ibid.*

¹⁵⁰ Canada, Royal Commission on Aboriginal Peoples, "Report of the Royal Commission on Aboriginal Peoples: Volume 3 Gathering Strength" (Ottawa: Minister of Supply Services, 1996), 206.

¹⁵¹ *Supra* note 147, at 399.

arranged in a hierarchy of human needs but as equally important and necessary components of ‘being alive well’.¹⁵² These sentiments are not far from the definition of health proposed by the WHO: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”.¹⁵³

Health Care and Aboriginal Populations

“Registered Indians” or “Status Indians” refer to members of the First Nations who meet certain criteria in accordance with the Canada’s Indian Act and can therefore be registered with Indian and Northern Affairs Canada (INAC). Aboriginal people on INAC’s list of Registered Indians are entitled to federally administered health benefits such as vision and dental care among other things and on top of provincial health care schemes. However, about 30 per cent of self-identifying Aboriginals are not recognized under the Indian Act (and therefore do not have access to such benefits) either because they do not meet the strict criteria employed by the Act or because they have chosen not to apply.¹⁵⁴ The criteria used in the Indian Act to grant status as a Registered Indian has been widely criticized for its exclusionary and even sexist provisions. For example, until 1985, Status was granted according to paternity, which meant that if a Status woman married a non-Status man, she would lose her Status and her children would be unable to apply.¹⁵⁵ Conversely, non-Status women who married Status men were able gain Status. In 1985 bill C-31 was passed in attempt to rectify these discriminatory provisions as well as other legislation that required Aboriginal people to “denounce their status in law if they wished to obtain the right to vote, to serve in the military or to train for certain professions such as medicine or law”.¹⁵⁶

Inuit and Métis are also excluded from registration under the Indian Act and therefore do not qualify for the same health care benefits provided by the federal government as do Registered Indians. However, despite the fact that Inuit are unable to register under the Indian Act, they are eligible for some federal health programs specifically designed for Inuit people.

Access to Health Care – Inuit

According to a report by the Royal Commission on the Future of Health Care in Canada (hereafter referred to as the Romanow Report), Inuit people “...may face challenges in accessing the health care system”. The Aboriginal Peoples Survey conducted in 2006 showed that Inuit were far less likely than the total Canadian population to have seen or talked on the phone with a doctor in the year leading up to the survey (this includes family doctor and specialists).¹⁵⁷

¹⁵² N. Adelson, ““Being Alive Well”: Health and the Politics of Cree Well-Being.” (Toronto: University of Toronto Press) as quoted in The Canadian Institute for Health information, “Population Health Initiative, 2004,” 2004, p. 78, http://secure.cihi.ca/cihiweb/products/IHC2004rev_e.pdf

¹⁵³ World Health Organization, preamble to the “Constitution of the World Health Organization”, http://www.who.int/governance/eb/who_constitution_en.pdf .

¹⁵⁴ *Supra* note 147 at 397.

¹⁵⁵ *Ibid.*

¹⁵⁶ *Ibid.*

¹⁵⁷ Statistics Canada, “Aboriginal Peoples Survey 2006: Inuit Health and Social Conditions,” 2006, last modified December 3, 2008, <http://www.statcan.gc.ca/pub/89-637-x/89-637-x2008001-eng.htm>

According to the survey, 56% of Inuit adults had contact with a doctor over the year, compared to 79% of the total Canadian population.^{158,159}

These discrepancies may be attributed to the fact that most of the Inuit population resides in Northern Canada, where transportation and telecommunications infrastructure is not as well developed as it is in other parts of the country, weather is more extreme, and there are fewer hospitals. For example, none of the 52 Inuit communities have year-round road access and only some have hospitals.¹⁶⁰ This means that while communities without hospitals have health centers with nurses, Inuit must be flown to other communities to access care from physicians or medical specialists - and flights are subject to weather conditions.¹⁶¹ Another barrier Inuit face is that some do not speak English and require translation services.¹⁶²

Access to Health Care - Métis

According to the 2006 Aboriginal Peoples Survey, Métis adults were less likely to have a family doctor than the total Canadian population (81% compared to 86%),¹⁶³ and it was reported that Métis adults were approximately as likely as the total Canadian population to state that “in the last year there was a time when they needed health care but did not receive it” (11% compared to 12%).¹⁶⁴ “Long wait times” was listed as the most common reason (23%) for not receiving care by Métis.¹⁶⁵ In addition to conventional health care, about 32% of Métis stated, “traditional medicines or wellness practices were available in their community”.¹⁶⁶

Aboriginal Health

Though Canada, through various agencies and organizations, collects an impressive amount of data on the health of its general population, there has been criticism of the availability of information on the health of Aboriginal peoples, particularly Métis peoples. The use of different methods of data collection, lack of collaboration and coordination between governments (provincial and federal) may contribute to the difficulty of rigorous comparisons between the health statuses of the Aboriginal population to that of the non-aboriginal population on some measures. Data on the health of Aboriginal populations excluded from the Indian Act (i.e., non-status) is perhaps the most absent. The Health Council of Canada stated in 2005 that:

[T]he life expectancy of the Métis is unknown as are rates for infant mortality, low birth weight, and types of cancer that most commonly cause death in the Métis population. Other major mortality causes are unknown ... The rate and type of communicable

¹⁵⁸ This figure was calculated after age standardization.

¹⁵⁹ *Supra* note 157.

¹⁶⁰ *Ibid.*

¹⁶¹ *Supra* note 157.

¹⁶² *Ibid.*

¹⁶³ Statistics Canada, “Overall Health of the Métis Population: Fact Sheet,” 2006, last modified February 19, 2009, <http://www.statcan.gc.ca/pub/89-637-x/2009006/art/art1-eng.htm>

¹⁶⁴ *Ibid.*

¹⁶⁵ *Ibid.*

¹⁶⁶ *Ibid.*

*diseases affecting the Métis are also unknown, with the exception of some data on HIV/AIDS.*¹⁶⁷

From the data that is available, it is clear that despite provincial and federal health care schemes available to some Aboriginals, many groups continue to experience disproportionate levels of ill-health and disease. In fact, in 2003, the National Advisory Committee on SARS and Public Health referred to the disparity between the health status of Aboriginal populations and the non-Aboriginal population as “a national disgrace”.¹⁶⁸ Some basic indicators - life expectancy at birth, infant mortality, and communicable diseases (discussed later) - demonstrate that First Nations and Inuit populations do not enjoy the same level of health as the non-Aboriginal population in Canada.

A 2004 study by the Canadian Population Health Initiative showed that the life expectancy of Status First Nations women is five years lower than that of Canadian women, and the life expectancy of Status First Nations men is seven years lower than that of Canadian men.¹⁶⁹ This gap is even more pronounced between Inuit peoples and the total Canadian population: the life expectancy of Inuit Women is 12 years lower than Canadians women and for Inuit men, it is eight years lower.¹⁷⁰ First Nations and Inuit peoples also experience far higher rates of infant mortality: Infant mortality per 1,000 live births is 5.3 for the total Canadian population, 8.0 for First Nations peoples, and 15 for Inuit peoples. Emerging statistics show that the disparities between some groups are even more alarming: The rate of tuberculosis among Inuit peoples is 186 times that of Canadian-born non-Aboriginal.¹⁷¹

Suicide and injury rates for Status First Nations and Inuit Peoples are also significantly higher than those of the non-aboriginal population:¹⁷² Status First Nations peoples have a suicide rate twice as high as the Canadian population (28 compared to 13 per 100,000 respectively) and Inuit peoples have a rate six times higher than that of the Canadian population (79 per 100,000). Looking at deaths caused by injury, First Nations peoples are four times more likely to die from injury than the total Canadian population.¹⁷³

It is clear that the Status First Nations populations do not enjoy the same level of health as the non-Aboriginal population. The disparities between the health status of Non-status Aboriginals and other populations may be similarly troubling, though comparative data for some measures cannot be located. The large amount of resources put into provincial and federal health care schemes suggests that it is not the availability of health care that is at the root cause of such

¹⁶⁷ Prairie Women’s Health Centre of Excellence and British Columbia Centre of Excellence for Women’s Health, “Aboriginal Maternal and Infant Health in Canada: Review of On-Reserve Programming,” 2009, 7, http://www.pwhce.ca/pdf/AborigMaternal_programmes.pdf

¹⁶⁸ National Advisory Committee on SARS and Public Health, “Learning from SARS: Renewal of Public Health in Canada,” (Ottawa: Health Canada, 2003), p. 79, <http://www.phac-aspc.gc.ca/publicat/sars-sras/pdf/sars-e.pdf>

¹⁶⁹ Canadian Population Health Initiative, “Improving the Health of Canadians,” (Ottawa: Canadian Institute for Health Information, 2004), 83.

¹⁷⁰ *Ibid.*

¹⁷¹ Bill Curry, “Aboriginals in Canada face ‘Third World’-level risk of tuberculosis,” 2010, <http://www.theglobeandmail.com/news/national/aboriginals-in-canada-face-third-world-level-risk-of-tuberculosis/article1496790/>

¹⁷² *Supra* note 147 at 401.

¹⁷³ *Supra* note 169 at 82.

issues (although accessibility, acceptability and quality may be issues). Instead, the ability for many Aboriginal peoples to enjoy their “highest attainable standard of health” is perhaps most hindered by a variety of socio-economic factors, including, poor living conditions, poverty, lack of access to meaningful employment, pollution/contaminated environment, etc. Factors at the institutional level may be at play as well: the divisions of powers and responsibilities between federal and provincial governments may contribute to a lack of coordination and collaboration, allowing for gaps in coverage of people and health care issues. MacIntosh suggests that the division of powers as set out in the Constitution Act, 1867 is problematic because it mandates the federal government with jurisdiction over “Indians and lands reserved for Indians”, while the provinces are responsible for most health care matters (with the exception of some constitutionally mandated issues).¹⁷⁴ Moreover, the health care available to Non-status Aboriginals is also of concern, as providing the unique care and programs that some populations might require may be challenging for the provinces in terms of both financial and professional resources, especially in remote communities.¹⁷⁵

Prisoner Health

According to a statistic produced by the Elizabeth Fry Society for 2000, Canada has one of the highest incarceration rates in the world, with young people being four times as likely as adults to be imprisoned.¹⁷⁶

Prisoners in Canada identify health care as their greatest concern.¹⁷⁷ Federal offenders are not covered under the Canada Health Act, the highest piece of health care legislation in the Country, nor are they covered under provincial health care systems and Health Canada.¹⁷⁸ According to section 86 (1) of the Corrections and Conditional Release Act, the Correctional Service of Canada (CSC) is responsible for the provision of health care for inmates serving in federal penitentiaries: “The Service shall provide every inmate with... essential health care;¹⁷⁹ and ... reasonable access to non-essential mental health care¹⁸⁰ that will contribute to the inmate’s rehabilitation and successful reintegration into the community.”¹⁸¹ As for the quality of care prisoners receive, it is stated in the Act that health care, “shall conform to professionally accepted standards”.¹⁸²

¹⁷⁴ *Supra* note 147 at 403.

¹⁷⁵ *Supra* note 147 at 403.

¹⁷⁶ Elizabeth Fry Society of Canada, “Fact Sheet: The Human and Fiscal Costs of Prison,” n.d., <http://www.efsmanitoba.org/Facts-Sheet.page>

¹⁷⁷ Howard Sapers, “Annual Report of the Correctional Investigator, 2006-2007,” (Ottawa: Minister of Public Works and Government Services Canada, 2007), 37. As quoted in *Supra* note 175.

¹⁷⁸ The Correctional Investigator Canada, “Annual Report of the Office of the Correctional Investigator 2009 – 2010,” p.10, 2010, <http://www.oci-bec.gc.ca/rpt/pdf/annrpt/annrpt20092010-eng.pdf>

¹⁷⁹ “health care” means medical care, dental care and mental health care, provided by registered health care professionals

¹⁸⁰ “mental health care” means the care of a disorder of thought, mood, perception, orientation or memory that significantly impairs judgment, behavior, the capacity to recognize reality or the ability to meet the ordinary demands of life

¹⁸¹ Corrections and Conditional Release Act, S.C. 1992, c. 20, <http://www.canlii.org/en/ca/laws/stat/sc-1992-c-20/latest/sc-1992-c-20.html>

¹⁸² *Ibid.*

As of 2006, over half (52%) of CSC health care sites providing care to inmates failed accreditation, while another 38% were accredited with conditions.¹⁸³ The “two key factors that prevented accreditation were the inadequacy of the existing clinical governance structure and the absence of continuing professional education and training for health care staff.”¹⁸⁴

Communicable Disease

Prisoners tend to be disproportionately affected by a variety of illnesses, having become ill or contracted disease either before incarceration or after. It is estimated by CSC that inmates are generally 20 times more likely to have contracted the Hepatitis C virus (HCV); 10 times more likely to have contracted HIV, and; at least twice as likely to have suffered from a mental disorder.¹⁸⁵ Other estimates suggest that rates of HCV among prisoners are 30 to 40 times higher than in the general population.¹⁸⁶ Across Canada, the rates for both HIV and HCV are much higher for female prisoners than for male prisoners.¹⁸⁷

Data collected through the CSC Infectious Disease Surveillance System show that in 2006, 4.49% of women in federal penitentiaries are HIV positive, an increase of 1.65 percentage points from 2.84% reported in 2005, but a slight decrease from 5% reported in 2000.¹⁸⁸ Changes in the annual percentage of HIV positive male inmates in federal penitentiaries have been less dramatic: from 1.6% in 2000 to 1.54% in 2006, with the greatest increase occurring in 2002 when 1.99% of the male population in federal penitentiaries was reported HIV positive.¹⁸⁹

Between 2000 and 2006, the percentage of female inmates in federal penitentiaries with the Hepatitis C virus (HCV) decreased from 42.4% to 36.0%, while the percentage of males with HCV increased 7.6 percentage points during that same time period, from 19.7% to 27.3%.¹⁹⁰

There is a higher percentage of individuals that engage in HIV and HCV risk activities, such as intravenous drug use, in prisons than in the general society. In Canadian society intravenous drug users and sex workers experience higher rates of HIV/AIDS and Hepatitis, and this trend is apparent in Canadian prisons as well. Although, because there is a higher concentration of intravenous drug users and sex workers in prison than there is in the population outside of prison, there is also a higher concentration of illnesses linked to these activities, such as HIV and HCV in prison.

¹⁸³ Elizabeth Fry, “Health and Mental Health,” fact sheet, n.d., p.2, <http://www.elizabethfry.ca/eweek2010e/pdf/Health%20and%20Mental%20Health.pdf>

¹⁸⁴ *Ibid.*

¹⁸⁵ Correctional Service Canada, “Quick Facts: Health Services Sector,” last modified June 25, 2010, <http://www.csc-scc.gc.ca/text/pblct/qf/15-eng.shtml>

¹⁸⁶ *Supra* note 178 at 22.

¹⁸⁷ *Supra* note 183.

¹⁸⁸ Correctional Service Canada, “Public Health in Federal Corrections, Infectious Disease Surveillance Update,” last modified April 7, 2009, http://www.csc-scc.gc.ca/text/pblct/hsbulletin/2008/no1/vol6_no1_9-eng.shtml

¹⁸⁹ *Ibid.*

¹⁹⁰ *Ibid.*

Harm reduction initiatives, such as needle exchange programs, have not yet been introduced to in Canadian prisons, despite evidence suggestion that such measures can decrease the spread of HIV and HCV.¹⁹¹

Mental health

The following was noted by prison ombudsman Howard Sapers in his 2009-2010 report:

*As a society, we are criminalizing, incarcerating and warehousing the mentally disordered in large and alarming numbers. The needs of mentally ill people are unfortunately not always being met in the community health and social welfare systems. As a result, the mentally ill are increasingly becoming deeply entangled in the criminal justice system.*¹⁹²

He went on to say that the number of prisoners with serious mental health issues “continues to grow” and that “the prevalence rate of mental illness in the offender population far exceeds that of general society”.¹⁹³ Moreover, it is estimated that approximately 90% of female inmates engage in substance use and, due to decreasing availability of community-based addiction and counseling services, prison is increasingly used as a substitute for treatment centers.¹⁹⁴

Female inmates are three times more likely to suffer from depression than their male counterparts¹⁹⁵ and they are also more likely to engage in self-harm practices.¹⁹⁶ Many female inmates have been victims of abuse at some point throughout their life, which affects their mental health.¹⁹⁷ Self-harming practices, such as self-mutilation, are often used as a means of coping with the stress of incarceration¹⁹⁸ [which may be compounded by past life events such as abuse or addiction].

In 2007, prison ombudsman wrote that the CSC failed to meet its obligation to provide “essential mental health care and reasonable access to non-essential mental health care in accordance with professionally accepted standards”,¹⁹⁹ as per s. 86(1) the Corrections and Conditional Release Act. Sapers noted that between 1997 and 2007, the number of prisoners suffering from mental illness doubled, “yet the level of non-punitive mental health services for prisoners, especially those in specialized psychiatric hospitals...remained the same or diminished”.²⁰⁰

Efforts on the part of the prison system to provide adequate mental health care have been made—as evidenced by new initiatives, mental health training for prison workers, and stated priorities in

¹⁹¹ *Supra* note 183.

¹⁹² *Supra* note 178 at 6.

¹⁹³ *Ibid.*, 10.

¹⁹⁴ *Supra* note 183.

¹⁹⁵ *Ibid.*

¹⁹⁶ *Ibid.*

¹⁹⁷ *Ibid.*

¹⁹⁸ *Ibid.*

¹⁹⁹ *Ibid.*

²⁰⁰ *Ibid.*

regard to the recruitment of mental health professionals²⁰¹ - however, the fact remains that prisons are understaffed in terms of mental health care professionals.²⁰²

Solitary Confinement

International human rights actors have urged governments to limit their use of solitary confinement in terms of both frequency and duration and the United Nations Human Rights Committee has even suggested that the practice can amount to a violation of international law.²⁰³ Despite growing controversy, the use of solitary confinement is increasing in Canadian prisons.²⁰⁴ According to the Prison Ombudsman:

*[T]he number and duration of instances of segregation is increasing in federal correctional institutions. In some maximum-security institutions, as much as a third of the population can be on segregation status. The average number of accumulated days in segregation is 95. The long-term segregation population (over 120 days) is growing, and... [c]lose to 40% of inmates spent more than 60 days in segregation.*²⁰⁵

It is estimated by some experts that, while in solitary confinement, up to 90% of prisoners may experience negative symptoms such as “insomnia, confusion, feelings of hopelessness and despair, hallucinations, distorted perceptions and psychosis”.²⁰⁶ Despite suggestions that solitary confinement should never be used on mentally ill prisoners,²⁰⁷ when considering the number of mentally ill people housed in Canadian prisons and the frequency with which the practice is used, one can deduce that it is likely that mentally ill patients are subject to the practice.

Inmate deaths, suicide, violence, and self-injury

In 2005/6, 182 prisoners died while under the supervision of the criminal justice system.²⁰⁸ Data collected between 2003 and 2004 shows that there were 142 federal inmate deaths over this time period and 128 during the 2001 and 2002 time-period.²⁰⁹ For federal inmate deaths over the period of 2003/4: 19 deaths were the result of inmate suicide; 11 were the result of murder; 1 was the result of legal intervention (for example killed legally by authorities during hostage taking attempt); 101 deaths were listed as “other”, which refers to natural causes, overdoses and accidental deaths; and 1 was unknown.²¹⁰

²⁰¹ Correctional Service Canada, “Response of the Correctional Service of Canada to the 37th Annual Report of the Correctional Investigator 2009 – 2010, last modified November 5, 2011, <http://www.csc-scc.gc.ca/text/pblct/ci09-10/index-eng.shtml>

²⁰² *Supra* note 178 at 11.

²⁰³ *Ibid.*

²⁰⁴ Canadian Civil Liberties Association, “Solitary Confinement is not a mental health treatment program,” 2011, <http://ccla.org/our-work/national-security/solitary-confinement-2/>

²⁰⁵ *Supra* note 178 at 14.

²⁰⁶ *Supra* note 178 at 13.

²⁰⁷ *Supra* note 178 at 14.

²⁰⁸ Prison Justice, “Facts and Statistics,” n.d., http://www.prisonjustice.ca/politics/facts_stats.html

²⁰⁹ Statistics Canada, “Adult Correctional Services in Canada 2003/2004,” (Catalogue no. 85-211-XIE), 2005, p. 48, <http://www.statcan.gc.ca/pub/85-211-x/85-211-x2004000-eng.pdf>

²¹⁰ *Ibid.*

In 2007, a study on inmate deaths released by the Office of the Correctional Investigator found that some deaths may have been preventable “through improved risk assessments, more vigorous preventative measures, and more competent and timely responses by CSC staff”.²¹¹ The report listed “delayed response to medical emergencies, assessment of pre-suicide indicators, availability of medical resources, lack of information-sharing between clinical and front-line staff, and care and custody of offenders with mental health problems”²¹² as issues to be improved upon.

In recent years, one particular inmate death has been the subject of much debate and investigation, that of Ashley Smith. The 19-year-old died in hospital from self-initiated asphyxiation²¹³ performed in her segregated cell as guards watched under orders not to intervene.²¹⁴ Leading up to her death, Smith had spent nearly a year in segregation while in the federal system, during which time she did not receive a proper mental health assessment (despite 168 self-harm incidents throughout her custody).²¹⁵ She may have also suffered abuse by a correctional officer who has been charged with assaulting her six months prior to her death.²¹⁶ Prison ombudsman Howard Sapers called her death “preventable” and “tragic” and stated that Smith “did not receive the care, treatment and support that Canadians expect from the [CSC]”.²¹⁷

It has also been noted that suicide is a particularly troubling issue for female inmates, with some experts suggesting that approximately half of female federal inmates demonstrate suicidal behavior.²¹⁸ Data released in 2007 show that the statistics for inmates of maximum security prisons are even more staggering: 71% of women and 21% of men in maximum-security prisons had attempted suicide.²¹⁹

Environmental Health

The state of the environment is a determinant of health;²²⁰ the ill-health effects of climate change and environmental contamination are increasingly recognized around the world, and this is also true in Canada.

Water

²¹¹ Office of the Correctional Investigator, “Backgrounder: Correctional Investigator's Assessment of the Correctional Service of Canada’s Progress in Responding to Deaths in Custody,” last modified September 7, 2010, <http://www.oci-bec.gc.ca/rpt/oth-aut/oth-aut20100908info-eng.aspx>

²¹² *Ibid.*

²¹³ CBC Report, “Death of Ashley Smith preventable concludes report,” 2008, as quoted in *supra* note 207.

²¹⁴ CBC, “Ashley Smith Inquest Broadened,” 2010, <http://www.cbc.ca/canada/story/2010/11/12/ashley-smith.html>

²¹⁵ CBC Report, “Death of Ashley Smith preventable concludes report,” 2008, as quoted in *supra* note 207.

²¹⁶ *Ibid.*

²¹⁷ *Ibid.*

²¹⁸ Cherami Wichmann, Ralph Serin, Jeffrey Abracen, Research Branch Correctional Service Canada, “Women offenders who engage in self-harm: a comparative study,” 2002, p.2., http://dsp-psd.pwgsc.gc.ca/collections/collection_2010/scc-csc/PS83-3-123-eng.pdf

²¹⁹ *Supra* note 183.

²²⁰ *Supra* note 147 at 407.

Access to clean water is a basic indicator used by the OHCHR to assess realization of the right to health. In Canada drinking water falls under federal-provincial jurisdiction with cooperation of municipalities and agencies. The majority of Canadians have access to potable water and the quality of the treated water entering Canadian homes is generally very good. In fact, the country's drinking water is considered among the safest in the world.²²¹ Health Canada is active in international water quality research and is considered a World Health Organization/Pan American Health Organization Collaborating Centre for Water Quality.²²² Canada has also participated in the development of WHO guidelines for drinking water.²²³

Despite its high standards for water quality, there have been isolated cases of waterborne diseases entering drinking water. In these cases, communities are advised to boil water, however some people have reported becoming ill and in a few cases, people have died as a result of contaminated drinking water. For example, in 2000 over 2,300 people became ill and seven people died as the result of drinking water contaminated with E. coli, which was provided by a municipal well in Walkerton, Ontario.²²⁴

Aboriginal peoples are far less likely to be able to access to safe drinking water: in 2006, approximately 12% of reserve communities were under orders or advisories to boil water any point in time,²²⁵ while 50 communities remained under advisory for over a year, and seven for at least five years.²²⁶ These figures represent improvements in Aboriginal access to safe drinking water from the 1991 levels, when "24% of homes located on reserves did not have drinkable water".²²⁷ However, the security of safe water access for Aboriginal communities remains problematic: studies performed by Indian and Northern Affairs Canada in 2001 and 2003 indicated that about "75% of reserve communities were at risk of their water treatment facilities failing due to facility conditions".²²⁸

Country food

The term "country food" refers to "mammals, fish, birds, and plants that are locally harvested from wild stock".²²⁹ Though access to safe foods is not listed as an indicator for the right to health, the quality of food one consumes undoubtedly impacts health. Moreover, certain foods, plants and herbs have special medicinal significance for some Aboriginal groups. General Comment 14 notes that "the vital medicinal plants, animals and minerals necessary to the full enjoyment of health of indigenous peoples should [...] be protected."²³⁰

²²¹ Health Canada, "Environmental and Workplace Health – Health Canada Tap Water Survey," last modified August 21, 2009, http://www.hc-sc.gc.ca/ewh-semt/water-eau/drink-potab/tap_water-eau_robinet-eng.php

²²² *Ibid.*

²²³ *Ibid.*

²²⁴ Jamie Benidickson, "Public Health and Environmental Protection in Canada," in *Public Health Law & Policy in Canada* (2nd edition.), ed. Tracey M. Bailey, Timothy Caulfield, and Nola Mr. Ries (Canada: LexisNexis, 2008), 454.

²²⁵ *Supra* note 147 at 415.

²²⁶ *Ibid.*

²²⁷ *Ibid.*

²²⁸ *Ibid.*

²²⁹ *Supra* note 147 at 418.

²³⁰ *Supra* note 12.

Considering that the vast majority of Aboriginals residing in the Arctic (91%) consume traditional foods, or “country foods” from the wild,²³¹ the quality and contamination of such food is relevant to any discussion of the right to health for Aboriginal peoples in Canada. The two most problematic types of contaminants found in country foods in the Arctic are persistent organic pollutants (POPs) (for example, PCBs and DDT) and heavy metals.²³² Prenatal exposure to contaminants such as mercury, perhaps consumed through country foods, pose specific neurobehavioral risks.²³³ Population samples taken in two areas in Northern Canada showed that up to 80% of pregnant women in one area and 68% of pregnant women exceeded safe levels of mercury in their blood.²³⁴ Moreover, about 50% of pregnant women in select areas of the North had PCB levels above the “level of concern” proposed by Health Canada.²³⁵ In a speech given by the President of the Inuit Circumpolar Conference Canada, the following was stated on behalf of Canadian Arctic Indigenous Peoples Against POPs:

[T]he food which for generations nourished us and keeps us whole physically and spiritually, is now poisoning us.... The environment is our supermarket...As we put babies to our breasts we feed them a noxious chemical cocktail that foreshadows neurological disorders, cancers, kidney failure, and reproductive dysfunction. That Inuit mothers – far from areas where POPs are manufactured and used, have to think twice before breast-feeding their infants is surely a wake-up call to the world.²³⁶

Industrial pollution

Higher than average rates of certain illnesses and diseases self-reported by residents in and around Sarnia, Ontario are suspected by some to be linked to pollution from the petrochemical industry in the area. Approximately 40% of Canada’s petrochemical industry is situated in Sarnia.²³⁷ A survey conducted in 2006, by the Aamjiwnaang Environment Committee found that members of the Aamjiwnaang First Nation reserve, located just south of Sarnia experienced alarming rates of respiratory illness and discomfort: About 40 % of band members surveyed used an inhaler, and 17% of adults and 22% of children self-reported suffering from asthma.²³⁸ Moreover, among other things, 39% of women surveyed self-reported experiencing still-birth or miscarriage; 16 % of adults and 27% of children self reported experiencing skin rashes and conditions; and 26 % of adults reported experiencing severe and chronic headaches.²³⁹ There is also concern over the perceived decline in male births, while further research is needed to confirm this trend, “an assessment of the sex ratios in the reserve revealed that the significant ongoing decrease in the proportion of male live births began in the early 1990s and continued

²³¹ *Supra* note 147 at 418.

²³² *Supra* note 147 at 419.

²³³ *Supra* note 147 at 420.

²³⁴ *Ibid.*

²³⁵ *Ibid.*

²³⁶ Sheila Watt-Cloutier, President of the Inuit Circumpolar Conference reproduced in *supra* note 147 at 420 and Government of Canada, Canada at the WSSD, “Sustainable Development: A Canadian Perspective,” 2003, http://www.wssd.gc.ca/canada_at_wssd/canadian_perspective/pg056_e.cfm and

²³⁷ Elaine MacDonald and Sarah Rang, EcoJustice, “Exposing Canada’s Chemical Valley An Investigation of Cumulative Air Pollution Emissions in the Sarnia, Ontario Area,” 2007, p.8, <http://www.ecojustice.ca/publications/reports/report-exposing-canadas-chemical-valley/attachment>

²³⁸ *Ibid.*

²³⁹ *Ibid.*, at 9.

through 2003” when that particular study ended.²⁴⁰

International Aid

The OHCHR’s list of illustrative indicators for the right to health includes the indicator, “[n]et official development assistance for health sector received/provided as a proportion of public expenditure on health/gross national income (GNI)”. Canada does not receive aid, however this indicator can be used from a human rights perspective to determine the extent to which developed countries, in this case Canada, comply with their international obligations and responsibilities in regard to the human right to health. Considering that both the ICESCR and the Declaration on the Right to Development include provisions for international co-operation for the purpose of realizing the rights listed therein, States’ Parties have responsibilities, and in some cases, obligations toward citizens of other countries

Article 2 (1) of the ICESCR states:

Each State Party...undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

Article 4 (1) of the Declaration on the Right to Development states:

States have the duty to take steps, individually and collectively, to formulate international development policies with a view to facilitating the full realization of the right to development.

In this light, monetary and other forms of aid, and knowledge and technology sharing are imperative to the realization of the right to health in developing countries. Historically Canada has been among the largest contributors of development assistance, though its contributions still do not reach 0.7% of GNI, as has been recommended by the United Nations.²⁴¹

Since 2000 Canadian official development assistance (ODA) spending has increased from \$2.6 billion in 2000–2001 to \$4.2 billion in 2006–2007 to \$4.73 billion in 2008 (USD), making Canada the 9th largest donor in terms of net amount and 16th largest donor in terms of ODA as a proportion of GNI (0.32%).²⁴²

Other accounts suggest that for 2008/09, Canadian Federal Government Departments dispersed 4,854.25 million dollars in ODA, the largest portion of which was dispersed by the Canadian

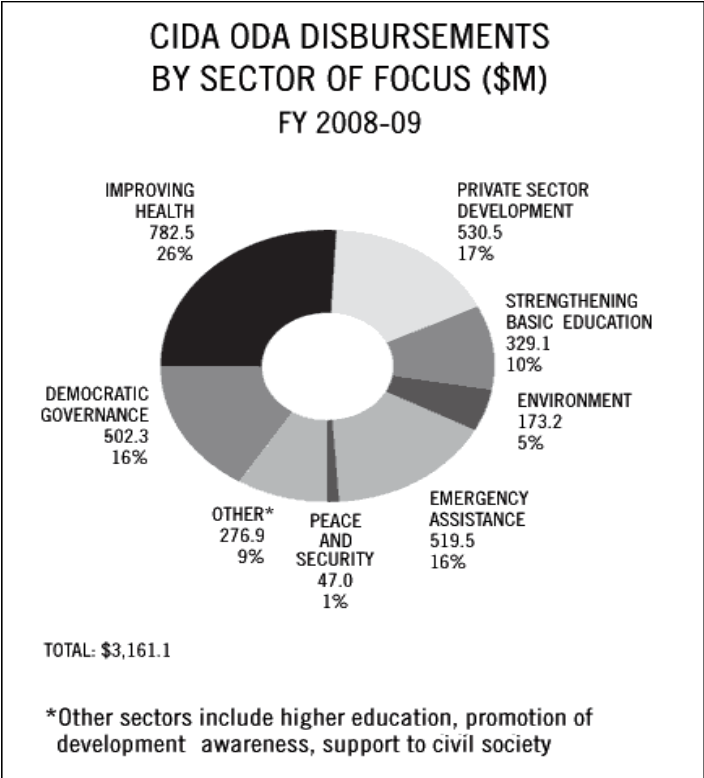
²⁴⁰ *Ibid.*, at 9.

²⁴¹ Jennifer Paul, Marcus Pistor, International Affairs, Trade and Finance Division, “Official Development Assistance Spending,” (PRB 07-10E), May 13, 2009, <http://www2.parl.gc.ca/content/LOP/ResearchPublications/prb0710-e.htm#intlassistance>

²⁴² *Ibid.*

International Development Agency (CIDA) (\$3,575,190,000).²⁴³ Of CIDA’s official development assistance disbursements for 2008-09, 26% went toward “improving health”, as depicted in the graph below from CIDA.²⁴⁴

Figure 6: Details Of CIDA's Official Development Assistance by Sectors²⁴⁵



Source: CIDA

Conclusion

Canada has shown a strong commitment to the right to health through its acceptance of numerous key international treaties and agreements, including the ICESCR and through its successful fulfillment of obligations to respect and protect. It has implemented a variety of measures to ensure that most Canadians enjoy a high standard of health and have access to adequate, acceptable, accessible and quality health care. Although it has yet to enshrine the right to health in national legislation, the underlying values of the right to health are generally applied

²⁴³ Canadian International Development Agency, “Report to Parliament on the Government of Canada’s Official Development Assistance – 2008–2009.,” <http://www.acdi-cida.gc.ca/acdi-cida/ACDI-CIDA.nsf/eng/NAT-9288209-GGP#coda>

²⁴⁴ *Ibid.*

²⁴⁵ *Supra* note 242.

to health policy in the country. Moreover Canada has committed to devoting a large amount of resources into health promotion and care.

Despite the relatively high level of respect and protection afforded to the right to health of most people, some groups within the population continue to experience illness and disease disproportionately: Aboriginal populations suffer from higher rates of illness and disease on nearly all measures. Moreover, health care services are less accessible to groups residing in the Northern and remote areas of the country. Geographical and financial constraints account for some of these issues, but the other issues, including poverty, job insecurity, lack of safe and adequate housing, also play a large role in determining health and illness. Therefore in order to increase health equity and fulfill its obligation in regard to the right, the Canadian government, the primary duty-bearer, must do more to address the social determinants of health, particularly for Aboriginal peoples.