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The Future of Health Law: How Can Law Meet Emerging Health Challenges?

Canadians have often prided themselves on having one of the best health-care systems in the world, but in recent years our system has fallen to the bottom of relevant international comparisons. Incremental attempts to improve the system have not resulted in significant improvements and the reality is that our most pressing challenges can be addressed only through ambitious, systemic reforms. For example, it is well established that Canada’s patchwork scheme for providing long-term care will not scale to meet growing needs as a quarter of the population enters retirement age over the next two decades.¹ As yet further examples, the Canadian “universal” system does not include essential services such as pharmaceuticals needed outside of hospital walls,² our present system fails to meet the needs of those living with mental illnesses,³ and there is a persistent gap between the health outcomes of Aboriginal peoples and other Canadians.⁴ Creative solutions are urgently needed as we face a perfect storm of outdated health system design, an aging population, provincial governments paying out over 50% of total revenues to health care, and aggressive court challenges from proponents of increased privatization.

In November 2015, the newly created University of Ottawa Centre for Health Law, Policy and Ethics brought together health law scholars from across Canada and abroad, including many colleagues from Dalhousie’s Health Law Institute, to analyze the role of law in meeting the plurality of challenges we face in the future. The vibrant papers presented at this 7th National Health Law Conference appear in this volume, along with forthcoming special editions of the *Alberta Law Review* and *McGill Journal of Law and Health* and a recent issue of the *Ottawa Law Review*.⁵ The four publications collectively illustrate the dynamic nature of health law and that Canadian researchers are at the forefront of this field. The papers in this specific journal span issues as diverse as global public health, the *Canada Health Act*,⁶ the right to health, and end-of-life services such as medical assistance in dying and palliative care. Despite this diversity, all these papers touch upon one of the most crucial issues faced by policy-makers—how should law evolve to meet future challenges in our health system and the future health needs of Canadians?

1 Michael Grignon & Nicole F Bernier, *Financing Long-Term Care in Canada* (Montreal: IRPP, 2012).

2 Steven G Morgan et al, “Estimated cost of universal public coverage of prescription drugs in Canada” (2015) 187:7 CMAJ 491.

3 Colleen M Flood & Bryan Thomas, “Fragmented Law & Fragmented Lives: Canada’s Mental Health Care System” in Jennifer A Chandler & Colleen Flood, eds, *Law and Mind: Mental Health Law and Policy in Canada* (Toronto: LexisNexis Canada, 2016) 29.

4 *Final Report of the Truth and Reconciliation Commission of Canada* (Montreal & Kingston: McGill-Queen’s University Press, 2015).

5 (2016) 47:2 *Ottawa L Rev*.

6 *Canada Health Act*, RSC 1985, c C-6.

One of the ways in which our system currently addresses health needs is by removing financial barriers to health care. Over the past few decades, patients have brought numerous claims before administrative tribunals and the courts seeking to expand the basket of insured services.⁷ In his contribution, Michael Da Silva analyzes competing views of what the right to health care *should* include by interrogating manifestations of the right in international law along with theoretical accounts of the right. From this, he has developed a set of metrics to assess realization of the right in different health care systems. A right to health must fulfill three goals: (1) creating and protecting a national health-care system, (2) ensuring universal access to the goods necessary for a dignified existence, and (3) ensuring procedural fairness in health-care allocation decisions. Applying those metrics to the Canadian system, we see there is a significant gap between what the right to health-care claims to be and what is actually delivered. Colleen M. Flood and Bryan Thomas’s paper picks up on these themes, and discusses the need to modernize the *Canada Health Act* so that the basket of publicly-funded goods and services evolves to meet the needs of Canadians. Locking in coverage for that which was important in the 1960s is not tenable in 2016. While Canada has universal public insurance for hospital and physician services, other services such as pharmaceuticals, long-term care, home care, and mental health are financed through a combination of out-of-pocket payments by patients, private insurance, and a patchwork of public programs—approximating the US system of multiple payers. As with Da Silva, Flood and Thomas claim that law can improve this situation by developing a process for re-evaluating and prioritizing publicly-insured services that is just, transparent, evidence-based, and sets appropriate priorities. Our present system, which provides universal, first dollar coverage for bunion removals for all Canadians but does not provide public funding for insulin in many cases, cannot be our future.

Canada’s aging population is leading to a shift in health needs, with an increased emphasis on one’s experience at the end of life. Quebec has been at the forefront of these issues, being the first province to regulate medical assistance in dying (MAiD). In her contribution to this volume, Michelle Giroux explores Quebec’s legislative approach, which recasts the balance between sanctity of life and autonomy. She describes the province’s statutory scheme, such as the limits on who qualifies for MAiD and the process that must be followed in carrying out such a request, with a view to informing similar debates occurring in other provinces. Quebec’s law conceptualizes MAiD as part of a continuum of end-of-life care, which includes other care options such as palliative care. Jocelyn Downie, a world leader on the issue of MAiD, similarly looks beyond the Supreme Court’s decision in *Carter*⁸

7 See e.g. *Eldridge v British Columbia (Attorney General)*, [1997] 3 SCR 624; *Auton (Guardian ad litem of) v British Columbia (Attorney General)*, 2004 SCC 78.

8 *Carter v Canada (Attorney General)*, 2015 SCC 5.

and the federal government's legislative response to explore other types of end-of-life care "that have long lived in the shadows of physician-assisted death." She highlights concerns that legal uncertainty is leading providers to deny palliative sedation (combined with withholding or withdrawal of artificial hydration and nutrition) on contestable grounds and, conversely, to provide patients with this service without consent. Uncertainty is similarly leading to some patients being given oral hydration and nutrition despite an advance directive to the contrary. Downie argues that in order to provide better care for the dying, policy-makers must now provide legal clarity around these end-of-life services. Chidi Oguamanam also speaks to the future of end-of-life care and emphasizes that to meet the health needs of Canadians, our laws, policies, and health care providers must take into account our diverse cultural make-up. He examines the regulatory structure surrounding the transition from medical futility to palliative care and the role that ethnicity, beliefs, values, and religion should play in that process.

Just as palliative care represents a departure from the traditional emphasis on curing illness, the purview of public health shifts the focus from treating patients to disease prevention. One of the greatest public health challenges facing Canada and the world is the rising epidemic of obesity. Barbara von Tigerstrom analyzes the present regulatory environment, pointing to consumer protection laws as a tool for mitigating the public health impact of obesity and diet-related chronic diseases. She highlights the synergies between consumer protection and public health methodologies, and argues that efforts to strengthen consumer protection laws could reinforce public health goals such as the reduction of obesity. While the other papers in this volume challenge whether the Canadian health-care system adequately addresses our health needs, for example, through its focus on hospital and physician services and curative rather than palliative or preventive care, Lawrence Gostin, a world-renowned leader in public health law, explores health needs at a global level. He argues that reductions in morbidity and mortality are not robust indicators of success, unless these benefits are equitably distributed. In order to move away from a situation in which we achieve high levels of global public health but still lag in justice, he argues that policy makers must implement universal basic health-care services, population-level strategies to prevent disease (such as clean water and sanitation) and, perhaps most importantly, socio-economic policies (such as access to education, housing and employment) targeting the social determinants of health.

Although the "Future of Health Law" theme is forward-looking, this conference was also a time to reflect on past accomplishments. As the finale event for the Canadian Institutes of Health Research (CIHR) Training Program in Health Law, Ethics and Policy, this event was a celebration of how far health law has come as a field, and of the close-knit Canadian health law community. Over the past 13 years, the CIHR Training Program

provided funding for 134 students pursuing graduate studies in health law across Canada. Alumni have gone on to influence health policy in positions in federal and provincial ministries of health, academia, various health organizations, and private practice. Several contributors to this volume are either graduates (Michael Da Silva, Lorian Hardcastle, and Chidi Oguamanam) or founders (Jocelyn Downie and Colleen M. Flood) of the Training Program.

Despite the many challenges faced by the Canadian health-care system, 2016 represented the 50th anniversary of the *Medical Care Act*,⁹ which established our national program for universal health insurance. While Medicare responded to health needs by removing income-related barriers to hospital and physician services, the papers in this publication focus on how best to respond to the future health needs of our population. It is our hope that the CIHR Training Program laid the foundation for health law to continue to flourish and that its alumni will generate the evidence necessary to aid policy-makers in meeting the health needs of Canadians over the next 50 years and beyond.

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9 *Medical Care Act*, SC 1966, c 64.