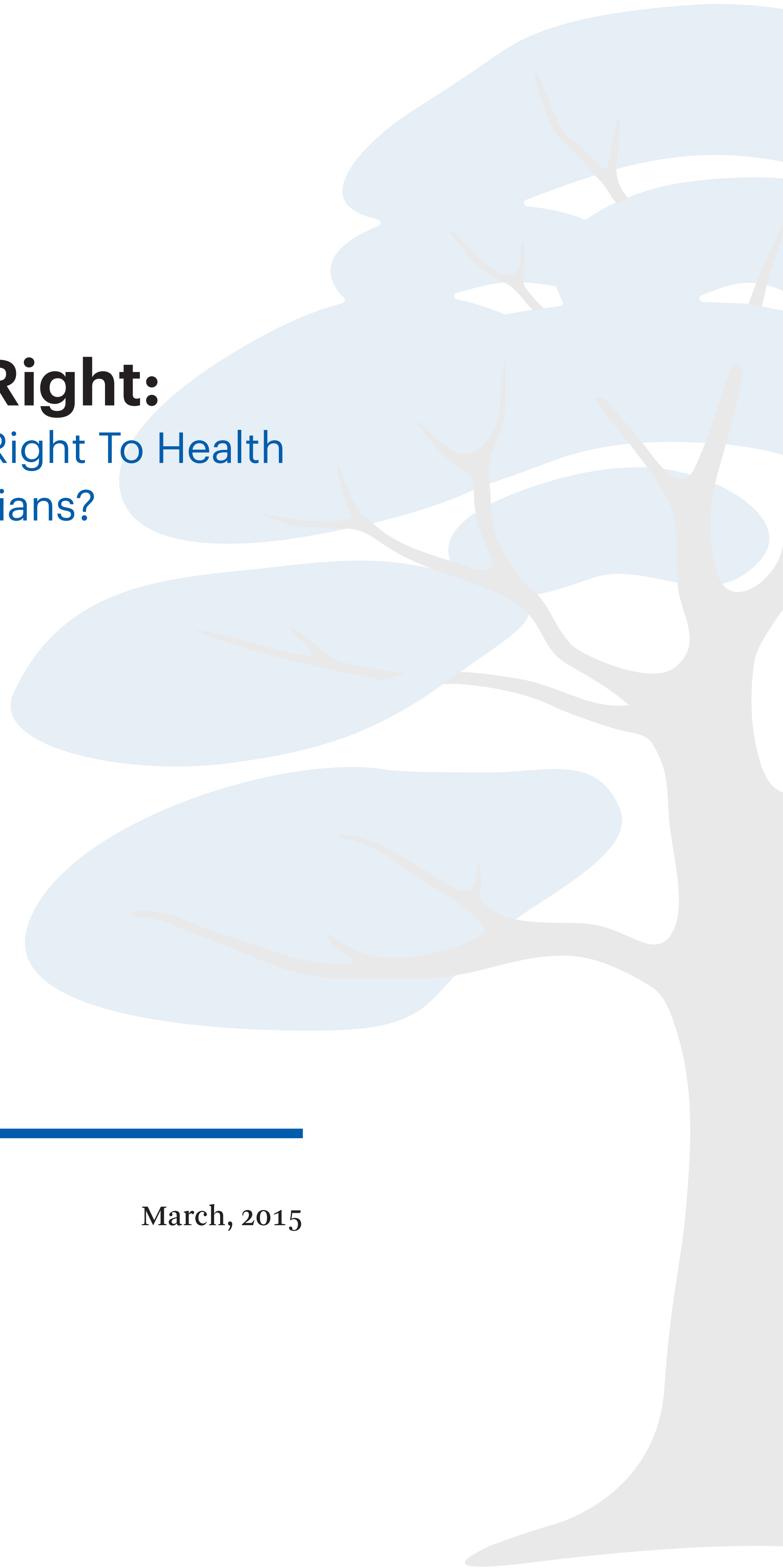

Getting It Right:
What Does The Right To Health Mean For Canadians?

By Vanessa Abban

Wellesley Institute
advancing urban health

March, 2015

The Wellesley Institute engages in research, policy and community mobilization to advance population health.

Author

Vanessa Abban

Acknowledgements

Thanks to Lisa Forman for her comments and guidance on an earlier version of this paper.

Any errors or omissions remain the responsibility of the author.

Copies of this paper can be downloaded from www.wellesleyinstitute.com.

© Wellesley Institute 2015

10 Alcorn Ave, Suite 300
Toronto, ON, Canada M4V 3B2
416.972.1010
contact@wellesleyinstitute.com

TABLE OF CONTENTS

Introduction 1
Health Equity and the Right to Health 2
Defining Health Equity 2
History of the Right to Health 2
Defining the Right to Health 3
Canada's Progress on the Right to Health 4
National Public Health Strategy 5
Interim Federal Health Program 6
Achieving Health Equity Through a Rights Based Approach 7
Planning and Implementation 7
Monitoring and Evaluation 7
Box 1 - Elements of Good Practices Under a Human Rights Based Approach 8
Accountability 8
Participation 9
A Rights Based Approach to Health in Canada 9
Conclusion 10
References 11

Introduction

All Canadians have the right to health. This right is defined and protected by international human rights treaties that Canada has ratified, and yet good health in Canada is treated as a privilege instead of a right. As a privilege, health care is administered like any other social service, in part dependent on political will, with barriers to health care accepted as inherent system flaws. However, as a human right, the federal government is legally obligated to take positive action to ensure that all Canadians have equal opportunities to experience good health. To fulfil its obligation to uphold the right to health for everyone, the government must undertake a range of actions including adopting a rights based approach to health and health related policies and programs. A rights based approach does not require a sudden overhaul of a country's health care systems and policies, but instead calls for progress in line with a government's available resources and capabilities, to treat health as a right and not a privilege.

Human rights are part of Canada's moral fabric and international reputation. We stand by the values embedded in human rights such as equality, non-discrimination, and individual freedom. Many of these values are a part of the Canadian Charter of Rights and Freedoms, such as the rights to life, liberty and security of and freedom from discrimination. On the world stage, Canada is recognized as a defender of human rights and has been a consistent leader in this field. This commitment to human rights norms and principles makes it imperative for Canada to uphold its international legal responsibilities and duties to people within its borders.

The two main elements of the right to health are quality health care and action on the underlying determinants of health. While health care works to prevent and treat illness, protecting people's access to food, clothing, employment, and income, among other necessities, can secure overall health before health care is needed. The right to health does not and cannot guarantee that all people will be healthy, but rather declares that everyone must have access to opportunities to achieve good health. A rights based approach is a systemic framework that guides government action on health and fulfills its obligations to the right to health. The framing provided by a rights based approach defines governments as duty bearers with legal responsibilities to ensure good health for all people, and empowers people as rights holders who have the ability to make active claims (1, 2). This creates a stronger foundation to hold governments accountable to the right to health than arguments based exclusively on moral principles and social justice.

This paper examines how a rights based approach can advance health equity and reduce negative health outcomes experienced by vulnerable groups in Canada. It first identifies the right to health as an international legal norm and defines its key features and responsibilities. Next, it looks at Canada's progress on the right to health by examining two government policies that impact health. The third part outlines a rights based approach to health, by describing four key parts of the process. The final section provides recommendations for using a rights based approach to health and health related policies and programs in Canada. This paper aims to demonstrate that health is a right rather than a privilege and, as such, requires positive government action to ensure that all Canadians have equal enjoyment of the right and equal opportunities for good health.

Health Equity and the Right to Health

Defining Health Equity

In the early 1990s Margaret Whitehead published a seminal definition of health equity that continues to shape discussions on the topic: Health equity is "concerned with creating equal opportunities for health and with bringing health differentials down to the lowest level possible" (3). Health inequities, on the other hand, are "differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust" (3).

Building on Whitehead's definition and the work of others in the health equity field, Paula Braveman defines health disparities as "potentially avoidable differences in health (or in health risks that policy can influence) between groups of people who are more and less advantaged socially" (4).

Establishing the existence of health inequities requires comparing the health of those "worse off" with those "better off" in a society, and noting the differences. This must be done in a way that makes sense by considering who is affected and in what context. For example, the existence of respiratory problems is more likely for an elderly woman than for a fit teenager. However, higher trends of respiratory problems for teenagers living in poor quality housing compared to teenagers in adequate housing suggest health disparities that are unfair and avoidable. Health inequities are impacted by a person's social position, which can be determined by numerous factors such as wealth, racial/ethnic identity and power (4). Conversely, health inequities can contribute to the disempowerment of certain groups. Together these factors can result in skewed power relations that leave some populations underrepresented in health policies and programs. This can lead to social injustices and inequities that disproportionately affect vulnerable and marginalized groups and require remedies to provide equal access to good health.

History of the Right to Health

Adopted in 1948 by the United Nations General Assembly, the Universal Declaration of Human Rights (UDHR) signalled international consensus on human rights norms, principles, standards and obligations (5). Although non-binding, the text remains the definitive document on human rights worldwide. It represents an international agreement on key morals and principles at a time of division between the Eastern and Western blocks and continues to be an important document for understanding the indivisibility, significance and universality of human rights (6). According to the Declaration, every person is born with human rights that cannot be violated or revoked, regardless of characteristics such as location, gender or age (7). As well, rights are all of equal importance so that one cannot be violated to fulfill another.

Article 25(1) of the UDHR says that everyone has the right to a standard of living adequate for health and well-being (8). Notably, this definition does not limit the right to health to health care access alone, but rather also includes other determinants of health (socio-economic or environmental factors that can impact one's health). The determinants identified in the Declaration include access to food, clothing, housing and medical care, as well as security in unemployment, sickness, old age and other circumstances beyond one's control (9).

In addition to the UDHR, the International Covenant on Economic and Social Rights (ICESCR) and the

International Covenant on Civil and Political Rights (ICCPR), both adopted by the UN General Assembly in 1966, comprise the International Bill of Human Rights.[1] On their own, international treaties are not binding on countries, meaning that a state cannot be held legally responsible to a treaty's provisions simply because it exists. Each country, also referred to as a state, must make the decision to sign a treaty (signalling its commitment) and then ratify it to become a state party, generally through discussion in parliament or the equivalent executive or legislative branch. Once a country ratifies a treaty, it enters into a legal agreement to uphold the treaty's provisions and any act to the contrary is a violation of this legal obligation (10).

Following the UDHR, the International Covenant on Economic, Social and Cultural Rights (ICESCR) also recognized and enshrined the right to health. Article 12 of the Covenant recognizes "the right of everyone to the highest attainable standard of physical and mental health," and identifies a range of steps to achieve this right, including healthy development of the child, prevention, control and treatment of diseases, and availability of medical care when people are sick (11). The principle of progressive realization, mentioned in Article 2.1 of the ICESCR, is also important to note. It means that a country is responsible to the right to health within the limitations of its available resources. Resultantly, UN Special Rapporteur to Health, Paul Hunt, said that greater progress on the right to health is expected of Canada due to its resource capabilities, compared to a country with fewer resources such as Chad (12).

Since the creation of the International Bill of Rights, the United Nations General Assembly has adopted a number of legally binding international documents that enshrine the right to health including the International Convention on the Elimination of Racial Discrimination (1965), the Convention on the Rights of the Child (1989), the Convention on the Elimination of all forms of Discrimination Against Women (1979) and the Convention on the Rights of Persons with Disabilities (2008). Each Convention emerged out of distinct contexts and therefore reflect norms and standards specific to their subject matter. The conventions are cumulatively important in that they reaffirm states' commitments and obligations to the right to health. They also develop this right in relation to the health needs of specific populations and impose legal requirements on state parties that ratify them.

Although ratifying states share a global legal commitment to realize the right to health, the documents listed above provide little direction or clarification of the obligations and entitlements of the right. As a result, the UN Committee on Economic, Social and Cultural Rights, the international body responsible for monitoring state parties' adherence to the ICESCR, published General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art.12) in 2000. The purpose of the General Comment was to provide greater clarity on the scope of the right to health, and the nature of the entitlements and obligations it imposes.

Defining the Right to Health

In General Comment 14 the Committee clarifies that the right to health does not equal the right to be healthy; it is impossible for the state to ensure that people will not contract illnesses or experience other

1 Unlike the UDHR, provisions found in the ICESCR and ICCPR can be legally binding.

forms of poor health. Instead, the concept of the right to health sets out freedoms and entitlements available to all people to ensure equal access to opportunities for good health. There are two dimensions to the right to health: first is the emphasis placed on health care to ensure good health and the second is the need for action on the underlying determinants of health (13). To uphold the right, there are three levels of obligations required of state parties: 1) respect: refrain from interfering with people's enjoyment of the right; 2) protect: prevent others from interfering with people's enjoyment of the right; and 3) fulfil: take action and adopt legislation to move toward the full realization of the right to health (13).

Governments must ensure that health care systems are of good quality and that there are no unfair barriers to access for all people within their borders. According to General Comment No. 14 a good health care system must meet basic criteria: availability, accessibility, acceptability and quality. This document also speaks of progressive realization, meaning that states do not have to immediately overhaul their health care systems and policies at drastic costs, but can do so at a pace compatible with their resources and capabilities. There are a number of core obligations that must be upheld even as governments move toward the progressive realization of the right to health including, at a minimum, essential primary health care, food, housing, sanitation and drugs (13, 14).

A good health care system is an important part of good health. However, if it is uncoupled from work on the underlying determinants of health, good health care alone is insufficient to eliminate health inequities experienced by vulnerable groups. The determinants identified in General Comment No. 14 include food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment. The government must take deliberate action to enhance positive conditions and mitigate negative outcomes of these factors to ensure good health for all.

The right to health also acknowledges the interconnectedness and significance of all human rights. Paragraph 1 of General Comment 14 provides important framing for this notion, stating that "health is a fundamental human right indispensable for the exercise of other rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living life in dignity" (12). Likewise, Article 11 of the ICESCR and General Comment No. 14 outline the significance of rights and social conditions critical to health – such as the right to food, clothing and housing, and healthy environments – for people to fully access the right to health (11, 12). Therefore, it is important for the government to uphold and act on other human rights that support the objectives of the right to health. The right to health does not insulate people in a protective bubble that prevents poor health, but it does require a complex, multi-faceted approach to promote good health, eliminate conditions for poor health, and increase the availability of remedies for when poor health does occur.

Canada's Progress on the Right to Health

As a fundamental and universal human right, the opportunity to achieve good health shifts from being considered a privilege to an entitlement owed to all people equally. Canada has signed and ratified every international treaty relevant to the right to health and yet it has failed to create a systemic approach to advance the right for all people within its borders. Instead of being recognized as a formal legal right, health is typically discussed as a service or public good. The absence of national direction in Canada on the right to health means that the right is recognized on a case-by-case basis, dependent on individual policy

makers, government agendas, and court decisions. This creates an ad hoc approach that is inconsistent with the universal and inherent nature of human rights.

As a positive right, the right to health requires the state to take proactive measures to address systemic inequalities and ensure that all people have equal enjoyment of the right (13). This section looks at Canada's failure to embed the language and legal duties of the right to health into health policies and programs, and highlights inconsistencies in the Canada's fulfillment of its obligations under the right to health.

National Public Health Strategy

One of the core obligations outlined in General Comment No. 14 is for states to adopt and implement a national public health strategy and plan of action. The purpose of this strategy is to address health concerns of the entire population, based on evidence, with special attention paid to vulnerable or marginalized groups (5, 13). The creation of indicators and benchmarks is crucial to tracking progress on the right to health, and periodic reviews that are participatory and transparent are required to hold the government accountable. National health plans and strategies provide a framework for good health care systems compatible with the right to health. They also uphold states' responsibilities and obligations to international law (5, 13, 15, 16).

Canada does not currently have a national public health strategy and plan of action. As a result, Canada does not have a national framework to specify how it will fulfill its obligations to the right to health, nor pre-determined benchmarks and indicators to mark its progressive realization of the right to health.

The Canada Health Act (1985) is the closest piece of legislation that Canada has to a national health strategy and plan of action. The Act sets out the primary objectives and criteria for Canada's publicly funded insured health services and extended care services as carried out by the provinces and territories, and creates the Canada Health Transfer. Through the Canada Health Transfer, the Federal government makes cash contributions to provinces and territories to help fund their health care systems. To qualify for the Canada Health Transfer the health care insurance plan of each province and territory must satisfy the specific program criteria that set minimum standards and benchmarks for provincial health care systems and ensure uniformity nationwide.

In 2014 the Canada Health Accord, a 10-year negotiated agreement between the federal government and the provinces and territories that established funding standards, expired and the government did not negotiate a new agreement. This decision also altered the Canada Health Transfer. The new funding scheme introduced by the government provides per capita funding to the provinces, with annual increases based on the strength of the economy and no conditions attached to the funding (17). This means that the federal government has opted to not set standards for each provincial and territorial health care system. Without standards it is difficult to regulate adherence to human rights norms and principles necessary to limit barriers to good health. The elimination of the Health Accord also resulted in the disbandment of the Health Council of Canada, a non-profit organization that measured and reported progress made in Canada's health care system. The loss of the Health Council and elimination of national standards will make it more difficult to monitor the federal government's progress on improving health and provides fewer opportunities for accountability measures.

Interim Federal Health Program

In 2012, the Federal government made cuts to the Interim Federal Health Program (IFHP). The IFHP offers limited coverage of health-care services for refugees, refugee claimants and certain other groups. The changes made in 2012 created varying levels of health care coverage for different groups and left some people without coverage at all (18). The removal of health coverage for refugees and refugee claimants resulted in health-related disadvantages and avoidable negative health impacts for an already vulnerable population (18). For example, a health equity impact assessment analyzing the policy change noted that women and children were particularly vulnerable to physical and emotional abuse when they experienced barriers to primary care and had limited use of critical care even in medical emergencies (19). There is also evidence that changes to the IFHP affected pregnant women's access to adequate care due to confusion surrounding who retained health coverage after the cuts (20).

Despite the legal obligation imposed by international human rights, they are not directly enforceable by Canadian law (21). In other words, the Canadian judicial system cannot find the government guilty of violating the right to health. However, the courts are still important for accountability to the right to health. Domestic courts can interpret the Canadian Charter of Rights and Freedoms and domestic laws that uphold the right to health and Canada's international legal obligations (21).

In 2014 a Federal Court case was brought against the Minister of Citizenship and Immigration. It was supported by various non-governmental organizations and affected individuals in response to changes to the IFHP (22). Ultimately, Justice Mactavish rejected changes to the IFHP as unconstitutional and stated that the policy was inconsistent with sections 12 (freedom from cruel and unusual punishment) and 15 (right to equality and freedom from discrimination) of the Charter of Rights and Freedoms (22). This decision gave the government four months to effectively reverse the policy changes and the IFHP was partially restored in November 2014 – a restoration that proponents in the case argue does not meet the Court's requirements. The federal government continues to frame health coverage for refugee populations in Canada as a privilege instead of a right, using the language of "genuine" versus "bogus" refugees to define who is entitled to health care (23). The government is appealing the court decision in an effort to reverse it (23).

The courts can play a crucial role in enforcing the right to health within domestic jurisdictions (24). However, there are certain limitations that constrain the ability of litigation to fully uphold the right to health. Namely, the judicial process relies on individuals to come forward when their rights have been denied. Furthermore, obstacles that are embedded in the legal system may deter possible claimants from stepping forward (e.g., costs and lack of information) (25). Also, reliance on the courts to uphold the right to health will result in an ad hoc approach in which case-by-case decision making neglects to address deeper system changes that are needed. Therefore the judiciary, while effective in some cases, is only one tool in a box of possible accountability measures (25).

Achieving Health Equity Through a Rights Based Approach

The right to health is embedded in a number of signed and ratified international treaties. As a result, state parties are obligated to uphold a series of legal responsibilities that advance the right for all people. Additionally, the right empowers people and communities to actively claim their rights by giving them entitlements (specific things they claim) and legal documents and treaties to give authority to their claims.

A rights based approach to health works toward the systematic realization of the right to health and health related rights, and empowers people to participate in making decisions that affect their health (16, 24, 26, 27). The approach also considers human rights norms and principles (e.g. non-discrimination, participation and accountability) in the development, implementation and evaluation of health and health related policies, goods and services (28). Central to a rights based approach is the attention paid to marginalized and vulnerable communities and their health outcomes resulting from health and health related policies or programs. The approach regards health inequities as a social injustice and offers solutions to re-balance power to improve the health of socially disadvantaged populations (2).

The following section briefly describes the four elements of a rights based approach and how they can work to advance the right to health. Additionally, Box 1 lists good practices under a rights-based approach as outlined by the United National Population Fund. These practices were written for a rights based approach to development but can be adapted to meet the requirements of the right to health.

Planning and Implementation

A human rights based approach to health requires policy makers to consider and embed human rights principles in the development and implementation of health and health related policies and programs. The creation of policies and programs requires a focus on the elements of a good health care system (availability, accessibility, acceptability and quality), positive action on the underlying determinants of health, and clear consideration of how the policy or program can contribute to achieving these goals. Decisions made around planning and implementation of policies and programs require consideration of the direct and indirect effects of social marginalization, disadvantage, vulnerability and discrimination (29). When a policy or program is implemented, targeted attention is needed to ensure that groups who are often overlooked are aware of the new policy or program, and of their entitlements.

Monitoring and Evaluation

Once policies and programs have been implemented it is necessary to monitor their impact through data collection and to evaluate their outcomes. Some examples of monitoring and evaluation techniques are the development of indicators and benchmarks, use of impact assessments, and collection of disaggregated data (30). There are three different categories of indicators useful to a rights based approach: structural, process, and outcome. These categories measure impact at different stages of a policy or program process and allow for constant updating of government action. A rights based approach can incorporate human rights measures within existing impact assessments (e.g. Health Equity Impact Assessments) or use its own impact assessments (e.g. Human Rights Impact Assessments) to monitor progress. It is important to collect disaggregated data of key characteristics (e.g. socio-economic status, sex and age) to understand

what is happening within groups and to develop appropriate programs to meet the needs of specific groups (31). Disaggregated data also permits comparisons across identity groups in order to show whether health trends are average or if they reflect inequities or discrimination (13). This is a non-exhaustive description of monitoring and evaluation tactics and each policy and program must carefully consider its goals and objectives to create an appropriate and reflective strategy.

Box 1 - Elements of Good Practices Under a Human Rights Based Approach

- Programs identify the realization of human rights as ultimate goals of development.
- People are recognized as key actors in their own development, rather than passive recipients of commodities and services.
- Participation is both a means and a goal.
- Strategies are empowering, not disempowering.
- Both outcomes and processes are monitored and evaluated.
- Programs focus on marginalized and excluded groups.
- The development process is locally owned.
- Programs aim to reduce disparities and empower those left behind.
- Situation analysis is used to identify immediate, underlying and root causes of development problems.
- Analysis includes all stakeholders, including the capacities of the state as the main duty-bearer and the role of other non-state actors.
- Human Rights standards guide the formulation of measurable goals, targets and indicators in programming.
- National accountability systems need to be strengthened with a view to ensure independent review of government performance and access to remedies for aggrieved individuals.
- Strategic partnerships are developed and sustained.

Source: United Nations Population Fund. The human rights-based approach. 2010 [cited 2015 March 12]; Available from: http://www.unfpa.org/human-rights-based-approach.

Accountability

Accountability measures are necessary at national and local levels to effectively hold governments accountable. Helen Potts suggests that some accountability measures could include “judicial procedures, national human rights institutions, health commissioners, democratically elected local health councils, public hearings, patients’ committees, and impact assessments” (32). Non-state actors and affected populations have two courses of action they can take to ensure accountability for the right to health: call attention to the government’s failure to respect, protect and fulfill the right to health and possibly seek restitution or remedies in the process, or engage in constructive accountability which moves beyond blame and punishment. Constructive accountability recognizes and encourages further action on what the state does well while calling for revisions and remedies where failure occurs (32-34). This is a more

inclusive and cooperative understanding of accountability that focuses on dialogue and engagement of policy and decision makers and stakeholders to improve health policies and programs.

Participation

A rights based approach requires that states empower people most impacted by existing health inequities (2). This means that people must have the freedom to participate in decision making that affects them and can also expect government action to actively uphold their right (e.g. creation of health care systems) (7, 13). The significance of the right lies in the opportunities and processes that it can construct to help people achieve good health. Inclusion of marginalized groups requires building the capacities of communities, civil society organizations and government staff, and creating open environments to promote participation (33). For example, people may need to be paid for their time or changes to the way information is treated may be required, in order to encourage and create safe spaces (33). People must also have access to information to make decisions, claim quality services, monitor progressive realization, hold those responsible to account, and engage in other forms of effective participation (35).

A Rights Based Approach to Health in Canada

Although a rights based approach to health requires the buy-in and engagement of various state and non-state actors, the core obligations of the right to health lie with Canada's federal government as the signatory to ratified treaties. As such, recommendations for a rights based approach that reduces health inequities for all Canadians must focus on what the federal government can do, within its available powers and resource capabilities, to affect change and uphold the right. A rights based approach demands the consideration of human rights norms and principles in all health and health related policies and programs. The following recommendations suggest what this framework should look like in Canada.

Firstly, as part of the requirements of General Comment No. 14, **the federal government must create a national public health strategy and plan of action to move towards progressive realization of the right to health**. This must be a targeted plan to ensure that health care systems meet minimum requirements and standards. This plan must be developed based on epidemiological evidence and a participatory and transparent process (13). It also requires clear, measurable benchmarks and indicators to track progress on the health of vulnerable populations (13). As part of this strategy, the federal government should return quality conditions to the Canada Health Transfers as the transfers offer key policy levers to influence provincial health care systems. Moreover, a national health strategy should include equity indicators to ensure that health inequities are reduced and eventually eliminated.

Secondly, **the federal government should create a rights-based framework that is applied to all new policies and programs**. A rights based approach stresses consideration of human rights norms and principles in all health and health related policies and programs (2, 15, 36). Canada does not have a clear process or framework that considers human rights when planning, implementing and monitoring government policies and programs. Such a framework might stipulate that policy proposals must clearly identify marginalized groups that could be disproportionately affected, as well as address barriers and enhance positive policy/program elements, with targets and indicators to measure progress toward health equity and human rights goals. The same consideration must be made for other human rights norms and principles, including

participation, universality, indivisibility and interconnectedness of other rights.

Thirdly, **the right to health should be codified in domestic legislation**. Canada has been instructed many times to incorporate the right into domestic legislation by the Committee on Economic, Social and Cultural Rights and other treaty monitoring bodies. Currently, the federal government can only be found in violation of the right to health by international bodies. Alternatively, domestic groups that want to access the right to health must do so using different language consistent with the Charter of Rights and Freedoms, as was done in the IFHP court case. Additionally, other levels of government, most notably provincial and territorial governments, cannot be held accountable to the right to health since the international obligation is held by the state. The inclusion of the right to health in Canadian legislation would protect vulnerable groups by providing domestic legal authority and remedies to violations of the right (14, 37).

Finally, **strategies should be put in place to ensure state level action on each of the underlying determinants of health**. In addition to a good health care system, General Comment No. 14 lists access to essential and nutritious food, access to basic shelter, housing and sanitation, and access to essential drugs as core obligations of the state. The federal government has consistently taken action to remove itself from work on the determinants of health. Successive federal governments have downloaded responsibility for social goods and services (e.g. housing) to other levels of government with little attention paid to ensuring that these goods and services are well-resourced or delivering equitable access to the conditions that determine good health. NGOs and individuals have already made calls for a national PharmaCare Plan and national housing strategy in Canada.[2] Following through with such plans, in addition to other strategies on the underlying determinants of health (e.g. poverty and food security strategies), is important for upholding the right to health and reducing health inequities.

Conclusion

The right to health reframes our understanding of health. Access to good health is not a government service to be provided when convenient or cost-effective, but rather is a universal and inalienable right that legally requires action. A rights based approach creates a framework that ensures consistent consideration of human rights in all health and health related policies and programs.

As a state party to every treaty relevant to the right to health, Canada has legal duties and obligations to uphold the right. The recommendations in this paper suggest ways in which the federal government can consider creating a rights based approach that addresses health inequities experienced by vulnerable and marginalized populations. Equipped with the knowledge of the right to health and what it entails, Canadians can hold their government accountable to its legal obligations and require positive action to eliminate barriers to good health for everyone.

2 For example, the Canadian Health Coalition unites multiple national organizations to advocate for universal PharmaCare in Canada.

References

1. Office of the United Nations High Commissioner for Human Rights. Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality. Human Rights Council 2012.
2. Yamin AE. Suffering and powerlessness: the significance of promoting participation in rights-based approaches to health. Health and Human Rights. 2009;11(1):5-22.
3. Whitehead M. The concepts and principles of equity and health. Health Promotion International. 1991;6(3):217-28.
4. Braveman P. Health disparities and health equity: Concepts and measurement. Annual Review of Public Health. 2006;27:167-94.
5. Backman G, Hunt P, M Jur RK, Jaramillo-Strouss C, Fikre BM, Rumble C, et al. Health systems and the right to health: an assessment of 194 countries. The Lancet. 2008;372:2047-85.
6. United Nations. The Universal Declarataion of Human Rights: History of the document. [cited 2015 Jan 27]; Available from: http://www.un.org/en/documents/udhr/history.shtml.
7. United Nations Population Fund. Human Rights Principles. 2005 [cited 2015 March 12]; Available from: http://www.unfpa.org/resources/human-rights-principles.
8. UNICEF. Intorduction to the Convention on the Rights of the Child. [cited 2015 Jan 27]; Available from: http://www.unicef.org/crc/files/Definitions.pdf.
9. United Nations. The Universal Declaration of Human Rights. [cited 2015 Jan 27]; Available from: http://www.un.org/en/documents/udhr/index.shtml.
10. World Health Organization. Health impact assessment: The determinants of health. [cited 2015 Jan 27]; Available from: http://www.who.int/hia/evidence/doh/en/.
11. United Nations General Assembly. International Covenant on Economic, Social and Cultural Rights. 1966 Dec 16. United Nations, Treaty Series, vol. 993, p. 3.
12. UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant). 2000 Aug 11.
13. Porter B, Jackman M. International human rights and strategies to address homelessness and poverty in Canada: Making the connection. Social Rights Advocacy Centre, 2011.
14. Hunt P. Missed opportunities: human rights and the Commission on Social Determinants of Health. Global Health Promotion. 2009;16(1):36-41.
15. MacNaughton G, Hunt P. Health impact assessment: the contribution of the right to the highest attainable standard of health. Public Health. 2009;123(4):302-5.
16. Hunt P. Promotion and protection of all human rights, civil, political, economic, social and cultural rights: Report of the Sepcial Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt. Human Rights Council 2008.
17. United National Population Fund, Harvard School of Public Health. A human-rights based approach to programming 2010.
18. Gruskin S, Bogecho D, Ferguson L. 'Rights-based approaches' to health policies and programs: articulations, ambiguities, and assessment. Journal of Public Health Policy. 2010;31(2):129-45.

19. Forman L. Making the case for human rights in global health education, research and policy. Canadian Journal of Public Health. 2011;102(3):207-9.
20. Rioux M. The right to health: human rights approaches to health In: Raphael D, Bryant T, Rioux M, editors. Staying alive: Critical perspectives on health, illness, and health care. Toronto Canadian Scholars Press Inc; 2006.
21. Gruskin S, Ahmed S, Bogecho D, Ferguson L, Hanefeld J, Maccarthy S, et al. Human rights in health systems frameworks: what is there, what is missing and why does it matter? Global Public Health. 2012;7(4):337-51.
22. Chapman AR. The social determinants of health, health equity, and human rights. Health and Human Rights. 2010;12(2):17-30.
23. Government of Manitoba. Budget paper D: Update on major transfer arrangements 2012.
24. Canadian Healthcare Association. Changes to the Interim Federal Health Program: Position statement. 2012.
25. Barnes S. The real cost of cutting refugee health benefits: A health equity impact assessment. Wellesley Institute, 2012.
26. Marwah S. Refugee health care cuts in Canada: System level costs, risks and responses. Wellesley Institute, 2014.
27. Canadian Doctors For Refugee Care v. Canada (Attorney general). Federal Court; 2014.
28. Payton L. Federal government to appeal ruling reversing 'cruel' cuts to refugee health. CBC News. 2014.
29. Forman L. A rights-based approach to global health policy. In: Brown G, Yamey G, Wamala S, editors. The Handbook of Global Health Policy. West Sussex: Wiley-Blackwell; 2014. p. 459-82.
30. Rasanathan K, Norenhag J, Valentine N. Realizing human rights-based approaches for action on the social determinants of health. Health and Human Rights. 2010;12(2):49-59.
31. London L. What is a human-rights based approach to health and does it matter? Health and Human Rights. 2008;10(1):65-80.
32. Tarantola D, Gruskin S. Human rights approach to public health policy. In: Heggenhougen K, Quah S, editors. International Encylopedia of Public Health. San Diego2008. p. 477-86.
33. Braveman P, Gruskin S. Poverty, equity, human rights and health. World Health Organization, 2003.
34. United Nations Population Fund. A Human Rights-Based Approach to Programming: Practical Implementation Manual and Training Materials. 2010.
35. Hunt P, Backman G. Health systems and the right to the highest attainable standard of health. Health and Human Rights. 2008;10(1):81-92.
36. Potts H. Accountability and the right to the highest attainable standard of health. University of Essex Human Rights Centre, 2008.
37. Freedman LP, Waldman RJ, Pinho Hd, Wirth ME. Who's got the power? Transforming health systems for women and children. UN Millennium Project 2005, Task Force on Child Health and Maternal Health, 2005.
38. Yamin AE. Toward transformative accountability: Applying a rights-based approach to fulfill maternal health obligations. International Jounral on Human Rights 2010;7(12):95-121.
39. States OoA. Inter-American Commission on Human Rights: Petition and Case System. 2011 [cited 2015 Jan 27]; Available from: http://www.oas.org/en/iachr/mandate/petitions.asp.

40. Inter-American Commission on Human Rights. Missing and murdered Indigenous women in British Columbia, Canada. Organization of American States 2014.