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Reasonable Access: The Right to Development and Equality of Opportunity in Rural Canadian Healthcare

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Abstract

This study presents a literature synthesis that explores the complexities of the relationship between the Canadian healthcare system and the Right to Development in the context of equality of opportunity in rural Canada. The paper contends that the concept of ‘reasonable access’ within the Canada Health Act requires redefinition to secure equal opportunity and ensure a fair distribution of resources for all. Analyzing the notion of ‘reasonable access’ in the Canada Health Act, it becomes evident that merely removing financial barriers at the point of health care service is insufficient. Grounded in justice theory, this paper critically examines how the Canadian Health Act’s equality of opportunity and reasonable access provisions play out in rural settings, revealing that ethnic minorities face distinct geographic, cultural, and systemic barriers that call for targeted interventions. The analysis reveals that Canada has yet to fully align its healthcare policies with its international obligations under the Right to Health and the Right to Development, underscoring the need for more comprehensive reforms that address disparities in rural areas. The paper proposes an alternative approach to achieving equality of opportunity under the Act in both horizontal and vertical equity.

Keywords: right to development, reasonable access, Canada Health Act, rural healthcare, equity, social justice, horizontal equity, vertical equity

Accès raisonnable : Le droit au développement et à l'égalité des chances dans les soins de santé en milieu rural canadien

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Résumé

Cette étude présente une synthèse de la littérature explorant la complexité des liens entre le système de santé canadien et le droit au développement dans le contexte de l'égalité des chances en milieu rural canadien. L'article soutient que le concept d'« accès raisonnable » dans la Loi canadienne sur la santé doit être redéfini afin de garantir l'égalité des chances et une répartition équitable des ressources pour tous. L'analyse de la notion d'« accès raisonnable » dans la Loi canadienne révèle que la simple suppression des obstacles financiers au moment de la prestation des services de santé est insuffisante. Fondé sur la théorie de la justice, cet article examine de façon critique la mise en œuvre des dispositions de la Loi canadienne sur la santé relatives à l'égalité des chances et à l'accès raisonnable en milieu rural, révélant que les minorités ethniques sont confrontées à des obstacles géographiques, culturels et systémiques distincts qui nécessitent des interventions ciblées. L'analyse montre que le Canada n'a pas encore pleinement aligné ses politiques de santé avec ses obligations internationales en vertu du droit à la santé et du droit au développement, soulignant ainsi la nécessité de réformes plus globales pour lutter contre les inégalités en milieu rural. L'article propose une approche alternative pour atteindre l'égalité des chances en vertu de la Loi, en termes d'équité horizontale et verticale.

Mots-clés : droit au développement, accès raisonnable, Loi canadienne sur la santé, soins de santé en milieu rural, équité, justice sociale, équité horizontale, équité verticale

1.0 Introduction

Following the Canada Health Act (CHA), the primary objective of Canadian health care policy is to protect, promote, and restore residents' physical and mental well-being by ensuring 'reasonable access' to health services (Government of Canada, 1985). However, the legislation does not clearly define 'reasonable access,' leaving room for persistent barriers, particularly among marginalized groups. Birch and Abelson (1993) conceptualize reasonable access as "equal access for equal need", (Birch & Abelson, pp.632), an idea that aligns with egalitarian principles like Rawls' fair equality of opportunity and Daniels' interpretations of equitable resource distribution (Rawls 1971, 2001; Daniels, 1989). Additionally, Rawls' "Difference Principle" holds that inequalities in the distribution of resources are only justified if they benefit those who are least advantaged (Rawls, 1971, pp.75). In the context of healthcare, this means any variation in access must ultimately improve conditions for individuals experiencing the greatest inequities, further reinforcing the imperative of equity in health system design. This understanding is further supported by the United Nations General Assembly (1986) Right to Development, which recognizes health as a vital element of human progress. Rawls's Difference Principle expands on this by asserting that inequalities in the distribution of resources are only legitimate if they benefit the least advantaged groups (Mongin & Pivato, 2021). The maximin criterion underpins this principle, requiring that any resource allocation be judged preferable only if it raises the position of those worst off in society. Rawls supports this logic through both normative reasoning and his "original position" construct (Rawls, 1971, pp.17). In the context of healthcare, this approach requires that any disparities in access or outcomes be justified by tangible improvements for the most disadvantaged, thereby making equity central to the design and evaluation of health systems.

Despite the policy's stated objectives, Martin (2017) reveals that ethnic minorities in Canada's rural areas frequently encounter disparities in obtaining sufficient healthcare services, underscoring a persistent divide between the act's aspirations and on-the-ground realities. From an egalitarian standpoint, two core pillars illuminate what reasonable access should entail. First, ensuring equal access to healthcare is crucial for safeguarding each individual's fair share of opportunity embodied in Rawls' (1971, 2001) and the principle of fair equality of opportunity (Daniels, 1989). Second, the fair allocation of resources requires distributing essential assets such as hospitals, clinics, personnel, equipment, technology, funding, and supportive services and actively addressing barriers to reasonable access. This includes considering factors beyond geography, such as financial constraints, cultural and linguistic differences, transportation, digital divides, and discriminatory practices. Effective allocation therefore depends on both the availability of resources and the removal of systemic obstacles that may prevent certain communities from fully benefiting from them, reinforcing a broader commitment to equity and inclusion (Anahideh et al., 2022).

Health disparities are "a particular type of health difference closely linked with economic, social disadvantage" (Braveman, 2014, p.6). The World Health Organization describes these gaps as the uneven distribution of health outcomes and healthcare opportunities among different groups (WHO, 2022). This disparity is particularly evident in rural regions in developed nations, where the location of healthcare providers often does not align with population needs (Cox et al., 2023). In Canada, for example, although 21% of people live in rural areas, only a small

percentage of doctors and specialists practice there, leading to fewer healthcare resources and longer patient travel times (Liu et al., 2022). In the United States, economic challenges, such as insufficient public health coverage and geographic isolation, prevent nearly 30% of the region's population from accessing health services (Houghton et al., 2020). Additionally, social disadvantage reflects an individual's position in the societal hierarchy a status shaped by elements like racial/ethnic background (Braveman, 2014). Although the Right to Development (RtD) originally targeted inequalities in developing countries, its core principles emphasizing inclusive participation and equitable resource distribution apply equally to well-resourced liberal democracies, particularly where significant healthcare disparities persist.

In keeping with the view that everyone deserves a fair chance at achieving optimal health (Daniels, 2008), health equity underpins efforts to eliminate such disparities. Yet, these persistent gaps highlight the limitations of reasonable access in its current form particularly for rural Canadian and underserved communities under the Canadian CHA. Attaining equity requires working toward the highest possible health standards for all, with special attention to those most vulnerable due to social conditions (Gomez et al., 2021). From an egalitarian perspective, fair resource allocation and equal opportunity are vital for bridging the gaps that disproportionately affect marginalized groups (Nunes, 2021). The purpose of this paper is to analyze the CHA, specifically the term reasonable access within the Canadian healthcare system, to determine equality of opportunity and identify if Canada is fulfilling its commitment to the RtD, guided by the question: "To what extent do healthcare disparities exist in the Canadian health system, and how do these disparities impact the realization of the Right to Health among ethnic minorities in rural areas, reflecting Canada's commitment to the Right to Development?" This paper is organized into four main sections after the introduction to address this. Section 2 reviews the Canada Health Act and the principle of reasonable access. Section 3 examines healthcare disparities in Canada by exploring the overall healthcare law, the Canadian Charter of Rights and Freedoms interpretation, domestic healthcare legislation and policy impacts, and the role of the RtD in the healthcare system. Section 4 then questions whether Canada is fulfilling its commitment to the RtD. The conclusion summarizes the findings.

2.0 The Canada Health Act and Reasonable Access

The CHA establishes the core objective of Canadian healthcare policy: to protect, promote, and restore residents' physical and mental health by ensuring accessibility to health services without financial or other barriers (Government of Canada, 1985). Central to this mandate is the concept of 'reasonable access.' However, as highlighted by Birch and Abelson (1993) as well as Wellstood et al. (2006), the term reasonable access remains ambiguous, complicating its implementation and alignment with broader equity objectives. This analysis examines reasonable access from multiple perspectives: horizontal equity (ensuring equal treatment for equal needs by removing costs), vertical equity (allocating extra resources to populations with greater healthcare needs), non-financial barriers (geographical, cultural, and opportunity-related challenges), Aday and Andersen's (1974) framework of access (distinguishing potential from actual utilization), and broader social justice considerations (ensuring fairness and genuine equity beyond mere financial accessibility).

At its core, the CHA emphasizes removing user fees to achieve free-at-the-point-of-service healthcare, primarily promoting horizontal equity by ensuring equal access for equal need (Birch & Abelson, 1993; Abatamarco et al., 2023). While this approach addresses economic equity and distributive justice, true equity in healthcare also requires attention to social, cultural, and systemic barriers. Focusing only on economic distribution may shape policy in ways that overlook these equally important dimensions of access. Horizontal equity is typically defined as “equal treatment for equal need.” Yet, the complexity arises in defining ‘need’ (Abatamarco et al., 2023). Some interpretations consider current health status, suggesting individuals with similar health conditions should receive equivalent care. Others argue for definitions based on potential health improvement or achieving equal health outcomes. Rawls’s Difference Principle adds another dimension, suggesting that those who have historically carried the greatest burdens may justifiably deserve greater shares of resources. Managing such allocations peacefully requires transparent criteria, inclusive decision-making, and policies that address historical disadvantage without generating new forms of resentment or inequity. Each interpretation results in distinctly different distributions of healthcare resources under the principle of horizontal equity. Birch and Abelson (1993), along with Wellstood et al. (2006), argue that genuine reasonable access must ensure care delivery aligns directly with individual needs. In rural contexts, need extends beyond immediate health conditions and includes factors like healthcare infrastructure availability. Urban residents typically enjoy sufficient healthcare services general practitioners, walk-in clinics, and specialized care while rural residents face amplified needs, but rather the obstacles to accessing care such as limited infrastructure, workforce shortages, and geographic isolation. While urban residents typically have sufficient service availability, rural residents experience higher barriers to access, making these obstacles a critical component of their healthcare needs. Thus, addressing horizontal equity in rural healthcare may necessitate adopting vertical equity principles, allocating additional resources to overcome geographic and infrastructural disadvantages, and ensuring rural residents have a fair chance to achieve optimal health outcomes (Abatamarco et al., 2023). Furthermore, Abatamarco et al. (2023) differentiate between fair and unfair disparities in healthcare utilization, noting that unjust disparities often stem from uncontrollable factors such as socio-economic status or geography. The CHA primarily achieves reasonable access by eliminating user fees and reinforcing horizontal equity. However, this narrow financial focus presumes that cost-free services automatically translate into equitable healthcare utilization a presumption challenged by ongoing non-financial barriers. Aday and Andersen (1974) distinguish between potential and actual healthcare access. ‘Having access’ indicates the potential to utilize health services, when necessary, while ‘gaining access’ represents actual engagement and service initiation (Reilly, 2021). Although CHA policies ensure potential access through cost elimination, they inadequately guarantee actual access. Non-financial factors such as geographical isolation, cultural differences, language barriers, and opportunity costs continue to restrict actual healthcare utilization despite financial barriers removal (Wellstood et al., 2006). Daniels (2008) emphasizes, achieving healthcare equity requires comprehensively addressing financial and non-financial barriers.

In the broader context of universal coverage, reasonable access significantly intersects with social justice, as it safeguards individuals’ fair share of opportunities by promoting health and normal functioning. Despite commitments to universal

healthcare, persistent disparities particularly among rural and marginalized groups illustrate that financial barrier removal alone cannot achieve equitable health outcomes. Furthermore, the CHA's lack of explicit definitions for 'access' and criteria for what constitutes 'reasonable' access limits its effectiveness. A comprehensive healthcare policy needs to incorporate both horizontal and vertical equity dimensions, ensuring theoretical availability and the practical realization of healthcare services tailored to specific community needs. Ultimately, redefining reasonable access within the CHA to include the elimination of financial barriers and the targeted allocation of additional resources aligns with the holistic vision of equality of opportunity for human development promoted by the RtD. A comprehensive healthcare policy needs to incorporate both horizontal and vertical equity dimensions, ensuring the theoretical availability of services and their practical realization in ways that address the specific types of healthcare needs faced by each community, as well as reducing barriers to access. This redefinition sets the foundation for addressing healthcare disparities comprehensively, as further discussed in the subsequent sections.

3.0 Healthcare Disparities in Canada

Health inequalities remain significant in Canada and have recently intensified (Government of Canada, 2024). CHA is designed to uphold, enhance, and renew public health by guaranteeing equitable access to essential healthcare services without financial or other restrictions, ensuring reasonable access to necessary healthcare services. The term reasonable access in CHA typically refers to access based on medical necessity, defined by the potential to improve, maintain, or recover health (Government of Canada, 2024). However, ambiguity remains about whether this refers strictly to the availability of services or actual utilization. Allin (2009) suggests that reasonable access should be interpreted as equitable utilization, allowing for empirical evaluation.

Despite this interpretation, significant gaps persist, with approximately 65% of Canadians benefiting from private supplemental health insurance provided primarily through employers, covering various secondary and tertiary healthcare services often involving copayments or deductibles (Martin et al., 2018). Another 11% rely on government-sponsored insurance plans, yet 25% to 33% of Canadians lack supplemental coverage, incurring out-of-pocket expenses for outpatient drugs and counselling services (Allin, 2009). This financial burden disproportionately impacts low-income Canadians, with households spending around \$450 annually out-of-pocket (Government of Canada, 2024). These gaps in supplemental insurance coverage highlight critical disparities in healthcare utilization and equity, emphasizing the need for expanded public healthcare coverage.

Variations in healthcare inequities across provinces are driven by differences in healthcare funding, provider payment methods, public benefit comprehensiveness, service availability, and decentralization of authority (Allin, 2009). While universal coverage has aligned health service distribution with medical needs, disparities persist (Darrudi et al., 2022). Clarifying concepts, 'access to healthcare' refers to the potential to obtain health services, whereas 'utilization' indicates actual use (Aday & Andersen, 1974). Theoretical frameworks, notably Rawls's theory of justice, emphasize both fair equality of opportunity and the Difference Principle, which together seek to safeguard individual freedom while ensuring that any social and economic inequalities improve the situation of the least advantaged (Rawls, 1971).

Promoting equality of opportunity aligns with the RtD, a “comprehensive economic, social, cultural, and political process” aimed at improving overall well-being through active, meaningful participation and fair benefit distribution (Arjun, 2017). Thus, healthcare policies should incorporate individual participation supporting conditions essential for equitable development. Egalitarian healthcare opportunities commonly emphasize horizontal equity equal treatment for equal needs (Abatemarco et al., 2023; Wagstaff & van Doorslaer, 2000). However, healthcare utilization is influenced by both access conditions and personal preferences, making equal access alone insufficient to guarantee equitable outcomes. A refined egalitarian approach seeks to distinguish between inequalities resulting from uncontrollable circumstances and those stemming from individual choices, yet this distinction is often complicated by social and economic contexts that constrain what choices are truly available (Abatemarco et al., 2023). Fleurbaey and Schokkaert (2015, as cited in Cooper et al., 2023) stress that life outcomes should reflect personal effort more than uncontrollable factors.

Empirical studies reinforce these theoretical perspectives. For example, research from Northern Sweden reveals disparities in healthcare usage based on socioeconomic status, with wealthier individuals accessing more general practitioner services despite hospital utilization becoming more equal over time (San Sebastián et al., 2017). These findings highlight that active individual participation is crucial in addressing healthcare disparities effectively. In Canada, healthcare disparities are rooted in broader social, political, and economic disadvantages, particularly in rural areas where healthcare access is severely limited (Garasia & Doobs, 2019; Public Health Agency of Canada, 2018). Principles articulated by the Ontario Human Rights Commission and Canadian Human Rights Commission during the COVID-19 pandemic emphasize addressing social inequities, particularly for vulnerable groups (Mykhalovskiy et al., 2020). Notably, ethnic minorities experience significant disparities; for example, South Asian adults face diabetes rates 2.3 times higher, and Black adults 1.9 times higher compared to white adults (Public Health Agency of Canada, 2022). These inequities underline the necessity of targeted, rights-based public health strategies to mitigate disparities and achieve genuine healthcare equity. The persistence of these disparities demands a closer examination of Canada’s legal frameworks, explored further in the subsequent sections.

3.1 Canadian Healthcare Law and International Influence

This subsection explores how Canadian healthcare law integrates international human rights obligations, noting specific barriers due to federal-provincial jurisdictional dynamics.

Internationally stipulated economic, social, and cultural rights, such as the right to health, have limited direct enforceability within Canadian domestic legislation (Blouin, 2006). Although Canada has ratified international treaties like the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), these commitments primarily serve as interpretive aids rather than enforceable standards within domestic courts (Government of Canada, 2025). Canadian courts occasionally reference these international human rights instruments when interpreting domestic statutes and constitutional provisions such as the Charter of Rights and Freedoms, influencing legal outcomes indirectly (Canada Health Act, 1984).

The constrained domestic enforceability of international health rights disproportionately affects vulnerable groups, notably ethnic minorities residing in rural regions (Shadmi et al., 2020). This limited enforceability is partly due to Canada's federal structure, where healthcare jurisdiction predominantly rests with provincial and territorial governments (Caulfield & Von Tigerstrom, 2002). Consequently, federal oversight and consistency in adhering to international healthcare commitments face practical limitations, resulting in uneven application across regions. These jurisdictional constraints contribute significantly to health inequalities, as rural minority populations commonly encounter systemic barriers, including fewer healthcare facilities, limited availability of specialized medical services, and persistent socio-cultural biases within healthcare delivery. For newcomers in particular, unfamiliarity with the healthcare system and a lack of accessible information about available services can further impede access and exacerbate inequities (Bajgain et al., 2020).

Additionally, despite Canada's commitments under international law to promote universal access to healthcare, provincial interpretations and implementations of the Canada Health Act often diverge. Provinces differ substantially in healthcare funding, resource allocation, and the comprehensiveness of covered services, reflecting varied policy priorities rather than a uniform adherence to international obligations (Allin, 2009). This variation underscores a critical challenge: achieving equitable healthcare access requires stronger federal mechanisms or collaborative frameworks that ensure provincial healthcare policies consistently align with Canada's international human rights commitments. Therefore, strengthening Canada's compliance with international health rights obligations necessitates more explicit legislative measures at both federal and provincial levels, robust accountability mechanisms, and explicit integration of international human rights standards into domestic healthcare laws and policies (Allin, 2009). Addressing these legislative gaps and jurisdictional barriers is crucial for mitigating healthcare disparities, particularly among marginalized and rural communities.

Internationally stipulated economic, social, and cultural rights, such as the right to health (RtH), find restricted application within Canadian legislation (Blouin, 2006). The courts, however, may reference these unimplemented international laws when interpreting domestic statutes and the Charter of Rights and Freedoms, impacting legal outcomes (Canada Health Act, 1985). The limited enforcement of international health rights in Canadian law particularly impacts minority populations in rural areas. Since these rights include ensuring equal access to healthcare without discrimination, the lack of robust execution can exacerbate health inequalities among these groups. Rural minorities often face barriers such as fewer healthcare facilities, less access to specialized care, and systemic biases (Bajgain et al., 2020), which are not sufficiently addressed due to the indirect influence and decentralized application of international treaties within Canada's federal structure. Given these persistent jurisdictional challenges and their implications for rural minority populations, the Canadian Charter of Rights and Freedoms emerge as a critical framework to address healthcare inequities, providing a legal basis for assessing Canada's domestic obligations toward equitable healthcare access.

3.2 Canadian Charter of Rights and Freedoms

The Canadian Charter of Rights and Freedoms is integral to safeguarding individual rights in healthcare. Section 7 of the Charter involves a two-step analysis to address

alleged violations (Caulfield & Von Tigerstrom, 2002): first, determining if there is an infringement on the rights to life, liberty, or security of the person; and second, if an infringement exists, assessing whether it aligns with the principles of fundamental justice. If it does not, a breach of section 7 is established, necessitating an additional assessment under section 15(1) to determine if there is a justifiable reason. Several sections of the Charter are pertinent to health issues and have been used as foundations for legal claims related to healthcare. For example, section 7 “guarantees a right to provide health care services” (Jackman, 2002, p. 6) and ensures a public healthcare system accessible to all populations without barriers that prevent vulnerable and marginalized groups from accessing services (Hogg, 1983). Furthermore, providing the active participation of ethnic communities and other groups facing significant health challenges in healthcare decision-making is crucial for improving health utilization and access to care (Canadian Human Rights Commission, 2010).

Section 15(1) of the Charter also impacts health by ensuring equality under the law, although not all differential impacts are recognized as discrimination (Caulfield & Von Tigerstrom, 2002). The Supreme Court of Canada’s test for section 15(1) violations focuses on identifying discrimination in laws that might affect minority groups in healthcare. This test questions whether laws create distinct disadvantages based on personal characteristics, fail to recognize existing societal disadvantages or perpetuate negative stereotypes. Consequently, systemic barriers may persist if unrecognized biases or structural inequalities are embedded within legislation or policy practices, thus failing to ensure equal dignity and respect as mandated by Section 15 of the Canadian Charter of Rights and Freedoms and affirmed in Supreme Court decisions (e.g., Canadian Charter of Rights and Freedoms, s. 15, 1982; Sangiuliano, 2022).

Section 15(1)’s application to healthcare access and needs in rural areas is also significant. Despite its aim to ensure legal equality, not all adverse effects are recognized as discrimination. However, the Supreme Court of Canada’s test for section 15(1) violations is crucial in assessing whether laws and policies inadvertently perpetuate healthcare disparities in rural settings. Rural areas, which often have a higher proportion of minority populations, face unique challenges due to geographic isolation and socio-economic factors. If the laws fail to recognize these collective challenges, they may contribute to systemic barriers that hinder equitable treatment, underscoring the need for nuanced policymaking. Given the Charter’s role in addressing systemic disparities, examining how domestic healthcare legislation and policies directly influence equitable healthcare access for marginalized communities is equally important.

3.3 Domestic Healthcare Legislation and Policy Impacts

This subsection critically assesses Canada’s domestic healthcare policies and their direct impacts on disparities, highlighting current coverage schemes’ limitations and consequences, particularly for marginalized groups in rural areas. The Canadian federal government bears international accountability for complying with treaty obligations in healthcare; however, practical jurisdiction lies with the provincial governments, limiting federal oversight in ensuring treaty fulfilment (Jackman, 2002). While there is broad agreement that health ought to be safeguarded as a human right, there is less consensus on the specific obligations this imposes on governments. Jackman stated that Romanow stresses in the *Future of Health Care in Canada* that

Canadians consider “equal and timely access to medically necessary health care services based on need as a right of citizenship, not a privilege of status or wealth” (Jackman, 2010, pp.71; Commission on the Future of Health Care in Canada, 2002). Canadian legislative measures align with both international human rights, particularly the right to optimal health under the ICESCR and domestic laws in the Charter to ensure healthcare access based on need (Caulfield & Von Tigerstrom, 2002). However, increasing recognition exists of shortcomings in Canada’s publicly funded healthcare system, especially for impoverished populations and those with mental health issues (Caulfield & Von Tigerstrom, 2002). Moreover, persistent service deficits and long wait times challenge the principle that healthcare access should rely solely on need. Therefore, the following section delves into how the Canadian Charter of Rights and Freedoms interprets and shapes these obligations, providing a legal framework for addressing the system’s shortcomings.

Declarations of commitment to equality are common within Canadian legal and political institutions, yet genuine equality, particularly in healthcare, remains elusive (Ries, 2006). Public healthcare laws established by federal and provincial governments in Canada outline a notably limited coverage scheme; not all treatments are included. This limitation can infringe upon equality rights by reducing opportunities to scrutinize potentially discriminatory distribution of healthcare resources. The existing structure of Canada’s healthcare system, by excluding specific treatments from public coverage, fails to address the distinct needs of disadvantaged groups, particularly minorities in rural areas (Ahmed et al., 2016). This shortfall results in disparities in health outcomes, where those in greatest need may not receive the necessary care due to lack of coverage. Building on this legal foundation, the following subsection analyzes how key provisions of the Canadian Charter of Rights and Freedoms shape legal interpretations and practical implications for healthcare equity.

Despite Canada’s robust healthcare system, challenges persist, particularly for rural and marginalized populations (Martin, 2017). Studies indicate that these groups face disproportionate health burdens, with higher mortality rates and more severe complications from chronic conditions (Martin, 2017; Rural Ontario Municipal Association, 2024). Historical and ongoing inequities further exacerbate these issues, as seen in the limited access to culturally appropriate care for Indigenous communities (Nguyen et al., 2020) and the barriers encountered by recent immigrants and ethnic minorities (Kalich et al., 2016). These challenges underscore that a uniform policy approach is insufficient. Merely proclaiming universal coverage does not equate to genuinely equitable access. The CHA does not account for how high-need groups might require more targeted resources. This gap undermines a principle central to the RtD, the obligation of states to ensure that development here, manifested through healthcare benefits everyone, not just the socially or geographically advantaged (United Nations General Assembly, 1986). Present empirical findings on healthcare utilization patterns, highlighting studies demonstrating concrete examples of existing disparities across regions and socio-economic groups.

3.4 Empirical Evidence of Healthcare Inequities

Empirical studies provide concrete evidence of healthcare disparities across Canada, underscoring how factors like income, education, and regional differences affect healthcare utilization and access. Empirical research reveals further dimensions of

healthcare inequities in Canada. Evidence shows that healthcare utilization in some sectors and provinces skews toward individuals with higher income and education levels, demonstrating a “pro-rich” distribution (Zhang & Chen, 2024, p.9). Conversely, lower-income populations often underutilize healthcare services, even though direct costs for many services have primarily been removed (Ahmed et al., 2016). Most studies have analyzed the utilization of general practitioners, specialists, hospitals, and, occasionally, dental services separately. They generally model initial patient engagement with healthcare professionals independently from subsequent service usage a two-stage method reflecting that while initial contact is typically patient-initiated, ongoing treatment or follow-up is more provider-driven (Ahmed et al., 2016).

Studies in 2023 indicated that urban public health services protect rural migrant women's health rights and boost their fertility intentions by enhancing health status and urban settlement, especially for those with lower income or shorter urban residency (Jiang & Huang, 2023; Dunlop et al., 2000). However, when analyses were performed across self-reported health categories, income factors remained nonsignificant. Better-educated individuals in “excellent” health tended to use more physician services, potentially due to a greater propensity for preventive care. The study also noted regional differences, such as in Ontario and British Columbia residents had a higher probability of visiting family physicians and made more visits than those in the Atlantic provinces (Allin, 2009; Dunlop et al., 2000).

Research on utilization among specific populations highlights that while detailed insights are provided for narrowly defined subgroups, these findings cannot be generalized to the broader population. Limited availability of specialized healthcare services and prolonged wait times often worsen cardiac conditions among Rural, Remote, and Northern Communities (RRNC) residents, sometimes necessitating invasive procedures such as percutaneous coronary interventions or coronary artery bypass surgeries (Alaeddine, 2024). Van Doorslaer and Jones (2003) as cited in (Grignon et al., 2023) analyzed health inequities in Canada using data from over 107,000 individuals in the 2001 Canadian Community Health Survey. Their findings indicate that doctor visits did not show significant income-related inequities once adjusted for health needs, suggesting that visits were primarily determined by medical necessity. However, wealthier individuals were more likely to have any doctor visits and, in particular, to consult general practitioners even after adjusting for health status. Lower-income individuals tended to have more frequent visits when GP services were accessed.

In contrast, specialist and dental care usage demonstrated a pronounced “pro-rich” bias, while hospital care was more common among lower-income populations. This quantifies the extent of healthcare inequities and highlights income, education, and regional differences as key contributing factors. Here, the focus shifts to domestic healthcare legislation and policy, critically assessing their direct impacts on disparities, especially for marginalized and rural communities. The following subsection analyses how the RtD framework could serve as an overarching guide for comprehensively addressing these disparities.

3.5 Right to Development and Canadian Healthcare System

The RtD is integral in shaping equitable healthcare systems by emphasizing health as a fundamental component of human development. According to the Declaration on the Right to Development (DRTD), states are obliged to create conditions that

enable individuals and populations to participate actively, contribute to, and benefit from development, underscoring equitable access to essential resources such as healthcare (United Nations General Assembly, 1986). This commitment aligns with several prominent international human rights instruments addressing health concerns extensively. For instance, Article 25 of the Universal Declaration of Human Rights (UDHR) guarantees everyone the right to an adequate standard of living necessary for health and well-being (United Nations, 1948). Similarly, Article 12 of the ICESCR establishes the entitlement to the highest attainable standard of physical and mental health (United Nations, 1966).

Philosophically, the principles of healthcare justice articulated by John Rawls's theory of distributive justice advocate that social and economic inequalities must benefit the least advantaged, such as those in rural and marginalized communities (Rawls, 2017). Norman Daniels extends these ideas, emphasizing health as critical for fair equality of opportunity. He argues that health disparities diminish individual well-being and undermine societal fairness, insisting that public health policies should mitigate these inequalities and support everyone's ability to pursue life goals equally (Daniels, 2008).

Integrating the RtD within Canada's healthcare policies requires viewing health beyond merely medical services, recognizing it as essential for broader social and economic participation. Despite Canada's robust healthcare infrastructure, rural and minority populations continue to experience significant disparities, including higher mortality rates and greater complications from chronic conditions, compounded by limited access to culturally appropriate and specialized healthcare services (Martin, 2017; Rural Ontario Municipal Association, 2024). Therefore, redefining reasonable access within Canadian healthcare to include the removal of financial barriers and targeted resource allocation aligns with the holistic vision of the RtD, promoting equitable development and meaningful participation for all individuals. Although the RtD framework was initially conceptualized to address inequalities in developing countries, its core principles remain universally applicable, emphasizing equitable participation and resource allocation within healthcare systems, including those of developed nations like Canada (Piron, 2002). Implementing RtD in a liberal, federally decentralized healthcare system such as Canada's involves aligning policy and governance structures with international human rights standards, which promotes transparency, accountability, and participatory decision-making, essential for addressing systemic healthcare disparities (Jackman, 2002; Forman, 2015). The following section investigates how Canada's healthcare policies and practices measure against its commitments under the RtD framework.

4.0 Is Canada's Commitment to the Right to Development and Right to Health?

Canada has explicitly committed to upholding the RtD and the RtH by ratifying significant international human rights treaties, notably the Vienna Declaration (Vienna Declaration, 1993; Government of Canada, 2025). These frameworks mandate the equitable distribution of healthcare resources and require states to actively ensure non-discrimination, transparency, and meaningful participation in healthcare governance.

The nation has further demonstrated a commitment to global health policy initiatives, such as the Ottawa Charter for Health Promotion and the influential Lalonde Report, which emphasize addressing the social determinants of health

(Bourgeault et al., 2015; Marchildon et al., 2021). Specific programs, particularly those targeting Indigenous populations like First Nations and Inuit communities, also illustrate tangible efforts toward equitable access (Marchildon et al., 2021). Despite these efforts, significant gaps remain between Canada's international commitments and practical outcomes within its healthcare system.

Persistent disparities highlight shortcomings, particularly concerning healthcare delivery to underserved populations. Rural communities experience chronic shortages of healthcare professionals and infrastructure, substantially limiting equitable access (Marchildon et al., 2021). Additionally, the absence of formal national policies integrating nurse-led primary care exacerbates the gap between Urban and rural healthcare availability. Moreover, despite international obligations emphasizing participatory rights in healthcare, Canada has yet to establish a national patient charter of rights, limiting citizens' involvement in health-related decision-making processes and undermining principles of participatory governance outlined by the RtD (United Nations General Assembly, 1986).

Transparency is another critical issue impeding Canada's realization of its international healthcare commitments. Health Canada provides reporting on the Canada Health Act's administration; however, clarity concerning the comprehensive coverage of health services remains insufficient (Marchildon et al., 2021). Such transparency gaps complicate assessments of equitable healthcare provision and resource allocation, hindering accountability and effective governance aligned with international human rights standards. Furthermore, ethnic minorities and immigrants continue to experience discriminatory barriers within Canada's healthcare system, notably communication difficulties, limited culturally tailored care, and uneven service delivery (Tsai & Ghahari, 2023). These issues directly conflict with Canada's commitments under international conventions, such as those expressed at Habitat II and the World Conference against Racism, where Canada pledged enhanced support for vulnerable communities (Oneka et al., 2017; Tsai & Ghahari, 2023).

Critically, the Canadian Charter of Rights and Freedoms does not explicitly guarantee a comprehensive 'right to health,' although jurisprudence has recognized that international human rights standards inform national justice principles (Jackman, 2002). This creates a partial and somewhat ambiguous domestic interpretation of the RtH, limiting effective recourse and accountability for marginalized groups facing significant healthcare challenges. Given these identified disparities and shortcomings, it is evident that Canada's current healthcare practices only partially fulfil its international RtD and RtH obligations. Achieving full compliance requires a strategic shift toward policies explicitly promoting vertical equity, enhanced transparency, and active citizen participation. Aligning healthcare resources to address the needs of marginalized and geographically isolated populations is essential. This alignment meets Canada's treaty obligations and promotes genuine equality of opportunity, allowing all individuals to achieve optimal health and full societal participation.

5.0 Conclusion

The analysis demonstrates that despite Canada's stated commitment to reasonable access within the CHA, significant healthcare disparities persist, particularly affecting ethnic minorities in rural areas. These disparities reflect systemic limitations in both policy and practice, notably the ambiguous legislative definition of reasonable access, insufficiently tailored resource allocation, and gaps in

culturally competent care. To effectively mitigate rural healthcare disparities through legislation, several key measures should be enacted:

1. **Reframe “Reasonable Access”:** Legislative clarity is essential. The CHA should explicitly incorporate vertical equity principles, acknowledging the greater needs of rural and marginalized communities by mandating additional resources and specialized infrastructure.
2. **Enhance Federal-Provincial Accountability:** Strengthening legislative frameworks to ensure provinces adhere to equitable standards, consistent with international human rights commitments such as the RtD, will foster uniformity and fairness across Canada's healthcare system.
3. **Mandate Culturally Competent Care:** Legislative requirements for healthcare providers to undertake comprehensive, sustained cultural competency training will address systemic biases and improve trust and healthcare utilization among ethnic minorities.
4. **Expand Targeted Resource Allocation:** Policies should specifically allocate funds for infrastructure, including mobile clinics, telehealth services, translation and interpretation services, and incentive programs for healthcare professionals to practice in rural areas.

Unique barriers in rural communities amplify health disparities and demand targeted legislative action under the RtD framework. First, geographic isolation impedes equitable resource distribution: rural populations often lack reliable transport and digital infrastructure, limiting their participation in essential health services. Second, the shortage of healthcare professionals further compounds this inequity. When culturally competent providers are scarce, minority groups face longer wait times and less culturally informed care, undermining RtD's non-discrimination and participation principles. When culturally competent professionals are few and far between, minority groups experience systemic discrimination that contradicts RtD's principles of non-discrimination and participation. Third, social and cultural isolation in homogenous rural settings can foster stigma and exclusion, undermining meaningful community engagement. Finally, legislative frameworks that mandate community outreach, culturally sensitive programming, and the active involvement of minority voices directly uphold RtD's tenets of non-discrimination and genuine participation. Explicitly embedding these principles in legislation and practice will enable Canada to better fulfill its commitments to the Right to Development, promote genuine equality of opportunity, and ensure all individuals regardless of geography, ethnicity, or social status have access to the highest attainable standard of health.

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