Socio-Economic Rights | Section I

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Providing Health Care but Receiving None in Return: An Expanded Right to Health Analysis of the Live-In Caregiver Program of Canada (1992-2014)

Introduction

Canada's robust universal, single-payer healthcare system has long made socio-economic rights (SER) advocates in the United States envious of our neighbors to the north. Fundamental human rights tenants echo in the Canadian Charter of Rights and Freedoms, including non-discrimination and individual freedom, yet the "right to health" has not been constitutionalized at the moment this essay was written.[1] While Canada has a strong track record of signing international human rights conventions and guaranteeing the right to health for permanent citizens, there remains a gap in the health rights of migrant workers, even in regular situations or formalized citizenship pathways. Ever-changing legal qualifications for permanent residency and arbitrary three-month waiting periods for healthcare coverage to come into effect make securing the right to health for even the most highly desirable workers—namely, healthcare workers in private households—a thorny task. The motto for Canada's paradoxical commitment to the socio-economic rights of migrant workers might be, as Toronto doctors Ritika Goel and Michaela Beder aptly articulate in the title of their medical journal op-ed, "Welcome to Canada…but don't get sick."[2]

This research paper will conduct an analysis of the right to health within the context of a notorious Canadian case study: the Live in Caregiver Program (LCP). A unique solution that was

[1] Maya Gunnarsson, "Constitutionalization of the Right to Health: A Pathway to Improved Health Outcomes?" *McGill Journal of Law and Health* (March 2019).
[2] Rikita Goel, and Michaela Beder, "Welcome to Canada ... but don't get sick," *Canadian Medical Association Journal*, (January 2012).

designed to facilitate pathways to citizenship for migrant domestic workers, as well as fill a dire need to supplement care work in the Canadian economy, became an exploitative transnational exchange of devalued and deskilled laborers. Through an expanded right to health analysis, this paper will tackle the multifaceted problems of the LCP's pitfalls, namely: policy willfully ignorant of the social determinants of health, systematic violations of the right to dignity, and failure to achieve non-discrimination and substantive equality in healthcare. In tracing the structural evolution of the LCP, this paper attempts to understand how a limited scope application of the right to health under international human rights law lacks the nuance and flexibility to hold countries to their socio-economic rights obligations.

Outlining the Right to Health Framework

In order to effectively analyze both the LCP and Canada's wider structural inability to fulfill its right to health obligations, it is crucial to establish a foundational comprehension of the right to health within the framework of international human rights law. This entails delving into the perspectives advocated by proponents of an extended right to health, as well as grasping the principles upheld by a human rights-based approach (HRBA) to healthcare.

The Right to Health in International Law

In unpacking the inherent actionable potential from an expanded right to health under human rights law, the ideal place to begin is in Article 12 of the International Covenant of Economic, Social, and Cultural Rights (ICESCR) itself. Canada, a signatory of the ICESCR since 1976, legally recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health,"[3] and, in keeping with the principle of progressive

[3] United Nations General Assembly, "International Covenant on Economic, Social and Cultural Rights." *UNGA Resolution 2200A (XXI)*, (19 Dec 1966): art 12(1).

realization in socio-economic rights positive obligations, agrees to take steps for the full realization of this right via "[t]he creation of conditions which would assure to all medical service and medical attention in the event of sickness."[4] The right to health depends on "the creation of conditions" to access medical services whenever and wherever they are needed, a conditionality which implies positive action on the part of the signatory to establish health infrastructure to meet the standards of its citizens.

Like many of the rights enshrined in the ICESCR, the Committee for Economic, Social and Cultural Rights (CESCR) has subsequently published two General Comments on the right to health for the guidance of parties in fulfilling their treaty obligations. "General Comment No. 14 on the Right to the Highest Attainable Standard of Health" was issued in 2000 and articulates two important developments regarding Article 12 of relevance to this paper. First, the Committee stresses the interdependency of the right to health to the realization of other fundamental human rights. Not only is the right to health *dependent on* other rights enumerated in the International Bill of Rights (namely "the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement"), but in the same breath, the Committee asserts that these aforementioned rights contain "integral components" which *depend on* the right to health.[5] In short, the full realization of the right to health cannot be achieved in a vacuum, since myriad socio-economic and political factors shape and are shaped by the individual's enjoyment of the highest standard of health.

As an extension of the principle of rights indivisibility, GC No. 14 explicitly states that the right to health "is not confined to the right to health care."[6] Although access to medical

[4] Ibid, art 12(1)(d).
[5] CESCR, "General Comment No. 14: The right to the highest attainable standard of health (art. 12)," (2000): para 3.
[6] Ibid, para 4.

services is explicit in the ICESCR's articulation of the steps to achieve the right to health in Article 12(2), the Committee explains that it is not enough for states parties to stop there. The Committee states: "On the contrary, the drafting history and the express wording of Article 12.2 acknowledge that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment."[7] The placement of social determinants within a spectrum for health rights' progressive realization, perhaps beyond the fulfillment of the right to medical care, contributes to a fundamental notion of what can be thought of as the "expanded" right to health under international human rights law.

An Expanded Interpretation of the Right to Health

The scholarly writings of Alicia Ely Yamin, an influential expert in human rights and public health praxis, argue an expansion of the right to health under human rights law. In parsing the language of the ICESCR and General Comment No. 14, Yamin proposes thorough analysis of underlying social determinants of health in normative oversight of health systems across the globe. Expressing a strong opinion about the spectrum of realizing health rights under SER law, Yamin writes that "social determinants are responsible directly and indirectly for a far greater proportion of health and ill-health than medical care."[8] According to Yamin's definition of social determinants as "the conditions in which people are born, grow, live, work and age," she reiterates that health rights are inextricable with the enjoyment of other human rights, "such as freedom of movement and information, and rights to education, housing and decent work."[9]

[7] CESCR, "General Comment No. 14: The right to the highest attainable standard of health (art. 12)," para 4.
[8] Alicia Ely Yamin, "Chapter 9: The Right to Health," *Research Handbook on Economic, Social and Cultural Rights as Human Rights* (Edward Elgar, 2020): 161.
[9] Ibid.

Yamin remarks that healthcare systems *themselves* are determinants of health and that the financing, resource allocation, regulation, and oversight of healthcare systems "are crucial to evaluating whether and how a state is protecting and promoting the right to health," emphasizing in particular "labor laws and [the] treatment of health workers, which [are] often neglected in health rights advocacy despite playing a significant role in the possibilities of realizing the right."[10] Yamin's claim that social determinants are even more critical to health than medical care will be central to the case study discussed in this paper, as the country of Canada has a large, albeit imperfect, nationalized healthcare system that seems to check all the boxes for human rights compliance.

Yamin goes on to defend a central aspect of the right to health that opens the lens of interpretation for activists even wider: the right to dignity. She argues that health rights contain a salient "moral importance" due to the "inextricable connection health has to a life of dignity."[11] Within the concept of dignity is an implied right to agency or full participation. Health is "essential to enable people to carry out their life plans," but it is "also difficult to imagine living a flourishing life […] without some basic preconditions for the enjoyment of health."[12] This conception has the potential to promote the right to health as a "super right" or a "gateway right," similar to the right to life in Article 6 of the International Covenant on Civil and Political Rights.[13] It is worth noting briefly that while the Canadian Charter of Rights and Freedoms enshrines a right to life in section 7, the Supreme Court of Canada decided not to interpret section 7 as including a constitutionalized right to health. Through cases such as *Chaoulli* and *Carter*, the Canadian Court "has favored an interpretation of sec. 7 that views the right to life in a

[10] Alicia Ely Yamin, "Chapter 9: The Right to Health," 161.
[11] Ibid, 160.
[12] Ibid, 160.
[13] United Nations General Assembly, "International Covenant on Civil and Political Rights," *UNGA resolution* 2200A (XXI). (16 Dec 1966): Art 12(1)(d).

strictly literal sense, meaning it is only engaged when there is a risk of death."[14] As a signatory of the ICESCR, Canada officially recognizes the international human right to health, but in refusing to ratify the Optional Protocol, Canada cannot be held judicially accountable for rights violations domestically or internationally.[15]

The Fundamentals of a Human Rights-Based Approach (HRBA) to Health

Even if the right to health as it stands in Canada is not enforceable in the judicial sense, a human rights-based approach (HRBA) to designing, implementing, and monitoring national healthcare systems across states offers advantages to achieving the highest standard of health for all. Yamin asserts the "two principles that are widely agreed to characterize procedural aspects of an HRBA to health are non-discrimination/equality and participation/agency."[16] The human rights operation of turning "passive beneficiaries into active agents" who "participate meaningfully in the decisions that affect their well-being" is paramount in rethinking a top-down structured healthcare system.[17] While the most important decisions in healthcare policy are traditionally perceived to be technical matters, best left in the capable hands of experts, the HRBA to health stresses democratizing decision-making, to give social and ethical values as much weight and consideration as the relevant scientific evidence. Advocates of decentralizing government responsibility for health policy in favor of a more democratic model contest that: "If health sectors (and governments generally) are brought closer to the people they serve, the idea was that they would afford more opportunities for pluralistic voice, and therefore be more responsive."[18] The "moral importance" of the right to health underscores the fact that the

[14] Maya Gunnarsson, "Constitutionalization of the Right to Health: A Pathway to Improved Health Outcomes?"
[15] OHCHR, "OHCHR Dashboard," *Ohchr.org*, 2014.
[16] Alicia Ely Yamin, "Chapter 5: Beyond Charity: The Central Importance of Accountability," *Power, Suffering, and the Struggle for Dignity Human Rights Frameworks for Health and Why They Matter* (UPenn Press, 2016): 151.
[17] Ibid, 152.
[18] Ibid, 164.

actualization of the ICESCR's "highest attainable standard of physical and mental health" should involve giving the people the right to define this "standard" for themselves and governments following their lead—not vice versa.

The second fundamental principle of the HRBA to health is non-discrimination and the achievement of substantive equality. As the structural failings of national healthcare systems were exposed in light of the COVID-19 pandemic, Yamin argues that "what is most potentially transformative about addressing health as a right is that it forces us to re-evaluate the multiple layers of heterogeneity in our democratic institutions and broader democracies."[19] In other words, a HRBA to health can help us identify and condemn the ways that healthcare systems foster discrimination and reinforce hierarchies in society. While she situates her argument in political theories of democracy and consent of citizenship, Yamin is careful to assert that this model of healthcare governance does not therefore exclude non-legal citizens from an equal right to health. Yamin argues that all social citizens, regardless of permanent residency or citizenship status, "demonstrate their consent to membership in the nations to which they have immigrated" in many ways, such as through "working (often in 'necessary jobs, such as caretaking for the ill, that citizens abjure'); paying taxes; and engaging in volunteer work or political activism."[20] The HRBA to health emphasizes that, regardless of legal status in a particular country, the non-discrimination guarantees of socio-economic human rights law (per Article 2(2) of ICESCR) can be wielded in favor of those who are the most vulnerable to exclusion from the healthcare system for reasons of race, gender, disability, ethnicity, or citizenship status.

[19] Alicia Ely Yamin and Tara Boghosian, "Democracy and Health: Situating Health Rights within a Republic of Reasons," *19 Yale J. Health Pol' L. & Ethics* (2020): 106.
[20] Ibid.

The History of Canada's Citizenship Programs for Migrant Caregivers

To better understand the actualization of the human rights concepts discussed above, this section will explore the Live-in Caregiver Program in Canada using a right to health analysis to consider the ways in which official programmatic pathways to citizenship may lack in access to human rights and what they make up for with nationalization.

Domestic Work in Canada (pre-1992)

Long before the naissance of the Live-in Caregiver Program, 19th century Canadian employers of middle-class status hired domestic servants primarily from England as nannies or governesses, who were granted permanent resident (PR) status when they set foot on Canadian soil.[21] Domestic service was an unpopular line of work, as workers constantly suffered "low social status, unregulated hours, isolation and lack of independence."[22] While conditions of work were subpar, the demand for domestic workers outran the supply, and after World War II, the migration flow shifted from England to the Caribbean, primarily Jamaica and Barbados. Immigration programs such as the West Indian (re-named Caribbean) Domestic Scheme (1955-1966) contributed to the deskilling and devaluation of migrant domestic workers and were plagued by systemic racism against the majority Black women who made up the labor force of the program.[23] Colonial sentiments infiltrated national policy as "the Canadian government saw Caribbean 'servants' as the beneficiaries of Canadian 'generosity.'"[24] As beneficiaries of Global North benevolence, most workers "could only apply for PR after working for their employees for

[21] Lou Janssen Dangzalan, "The Evolution of Canada's Caregiver Program," *RAPPLER* (Aug 21, 2020).
[22] Marilyn Barber, "Domestic Service (Caregiving) in Canada," *The Canadian Encyclopedia: Historica Canada* (Feb 7, 2006; last ed. June 17, 2021).
[23] Dangzalan.
[24] Kwentong Bayan Collective, and Ethel Tungohan, "Poster #03: A Visual Timeline of Caregiving Work in Canada," 2.

one year."[25] Relative to their former European counterparts, Black domestic workers were viewed by the Canadian government as fungible and expendable, and often labeled as "non-preferred" by white private employers.[26] The conditions attached for Caribbean domestic workers were substantially less desirable, "including specific requirements with respect to education, civil status, and age; tests for pregnancy and diseases; wages inferior to those of other domestics; obligatory live-in service for at least one year; and a constant risk of deportation."[27]

In order to eradicate issues of racial preference in the CDS, Canada implemented a points-based immigration system in 1966 that classified types of work into different categories of "skill." Care work was relegated to "low-skill" occupation, and with the Non-Immigrant Employment Authorization Program (NIEAP) of 1973, the government made it nearly impossible to secure PR as a low-skilled migrant worker.[28] In response to the egregious hierarchization of labor, mostly along gendered and racial lines, the 1970 and 1980s in Canada were a time of discontent and mobilization of domestic care workers, whose "protests and activism shed light into exclusionary policies, as well as domestic abuse at the workplace."[29] Notably, in 1979, "seven Jamaican mothers" who came to Canada as domestic workers launched a successful citizenship campaign proclaiming that if domestic workers were "good enough to work," they were "good enough to stay."[30] The activism of the "seven Jamaican mothers" galvanized domestic workers from the Caribbean and the Philippines, and in 1981, amidst accusations of racial exploitation of migrant workers, Canada created the Foreign Domestic

[25] Kwentong Bayan Collective, and Ethel Tungohan, "Poster #03: A Visual Timeline of Caregiving Work in Canada," 2.
[26] Jarrah Hodge, "'Unskilled Labour': Canada's Live-in Caregiver Program," *Undercurrent* Volume III, No 2, (Sep 1 2006): 62.
[27] Sabaa A Khan, "From Labour of Love to Decent Work: Protecting the Human Rights of Migrant Caregivers in Canada," 26.
[28] Kwentong Bayan Collective, 2.
[29] Lou Janssen Dangzalan, "The Evolution of Canada's Caregiver Program."
[30] Kwentong, 2.

Movement Program (FDMP) which permanently established that after 24 months of working as a caregiver and establishing their "self-sufficiency,"[31] migrant workers would be able to apply for PR.[32] Within the next decade, approximately 30,000 Filipinos immigrated to Canada to labor in the care economy, and the FDMP was renamed the Live-in Caregiver Program in 1992.[33]

Right to Health Violations of the Live-in Caregiver Program (LCP)

At the time of its inception and early practice, the LCP was perceived by the international community as the culmination of Canada's efforts to regularize domestic work effectively and ethically. "While most nations have been reprimanded for their restrictive policies toward migrant domestic workers," legal scholar Sabaa Khan writes, "Canada's LCP has been commended by the UN Special rapporteur on the rights of migrants, and other nations have considered replicating the policy within their own borders."[34] While Khan acknowledges that access to the economic, social and political rights of citizenship is "a real—and rare" opportunity for migrant workers in the global economy, the project of Khan's study of the LCP is to investigate "whether the promise of eventual citizenship sewn into a labor migration policy actually improves the quality of employment generated by that policy."[35] With a focus on "quality" of employment, Khan takes a HRBA to the right to work for migrant caregivers that echoes the AAAQ framework of many CESCR General Comments.[36]

Under a strict definition of the right to health under international human rights law, qualitative studies and interviews of workers in the LCP on their workplace conditions reveal the

[31] Marilyn Barber, "Domestic Service (Caregiving) in Canada."
[32] Lou Janssen Dangzalan, "The Evolution of Canada's Caregiver Program," *RAPPLER* (Aug 21, 2020).
[33] Ibid.
[34] Sabaa A Khan, "From Labour of Love to Decent Work: Protecting the Human Rights of Migrant Caregivers in Canada," 24.
[35] Ibid, 25.
[36] CESCR, "General Comment No. 14: The right to the highest attainable standard of health (art. 12)," (2000): para 12.

macro and everyday violations of human rights. LCP caregivers possessed a grossly diminished right to health care, manifested "in part, through denied or delayed access to public health insurance and their exclusion from provincial occupational health and safety legislation."[37] Live-in caregivers under the program were "excluded from the protection of the *Loi sur les accidents du travail et les maladies professionnelles* (LATMP),"[38] and the position of migrant caregivers with pre-existing conditions was even more dire. For example, in Quebec, all immigrants and migrants, including those in the LCP, underwent "a waiting period, which lasts between two (2) to three (3) months during which they are not covered by the Quebec health insurance." In 2010, the employer became required to provide caregivers with coverage equivalent to national citizens during the waiting period, but there was no control mechanism to sanction this obligation and the interim coverage was dependent on the validity of the work permit (in the case of termination, therefore, the coverage would be lost).[39] The three-month waiting period in which migrant workers live and work in healthcare limbo is an example of the tradeoff that Khan problematizes in her research: three months of precarity in exchange for the possibility of permanent residency and all the rights and benefits it entails. It is a gamble that many migrants are willing to take, but very difficult to justify as policy from one of the richest countries in the world with a desperate need for workers in domestic care sectors.

Moreover, admittance into the LCP is not a guarantee for securing PR status at the end of the 24-month work period. In the early 2000s, after filing for permanent resident status in Canada, caregivers were required to undergo an exit medical exam, in addition to the exam they passed before entering the two-year program. In 2006, Juana Tejada, a Filipina caregiver in the

[37] Sabaa A Khan, "From Labour of Love to Decent Work: Protecting the Human Rights of Migrant Caregivers in Canada," 28.
[38] Elsa Galerand et al., "Domestic Labour and Exploitation: The Case of the Live-In Caregiver Program (LCP) in Canada," *SACPINAY Research Report* (January 2015): 23.
[39] Ibid, 22.

LCP, was declared "medically inadmissible" for permanent residency after her second medical exam found that she had a severe form of colon cancer.[40] Tejada's access to Alberta's provincial healthcare service was terminated in August 2007, and she moved to Toronto to live with her cousin and work as a caregiver for two families to pay for cancer treatment out-of-pocket. Backed by community and migrant rights groups, Tejada appealed her case in December, requesting an exemption on "humanitarian and compassionate grounds."[41] Citizenship and Immigration Canada (CIC) denied her application again, arguing that her health condition "might reasonably be expected to cause excessive demand on health and social services."[42] A month later, CIC acknowledged a "procedural error" on their end, reopened Tejada's case, formally exempted her from the medical examination requirement, and, at last, granted her permanent residency. After Tejada's passing, a 2010 amendment to the Immigration and Refugee Protection Act held that caregivers are no longer subject to a second medical examination in their PR applications. Under the "Juana Tejada Law," the Canadian government acknowledged the right to healthcare for migrant workers who had spent two years contributing to the care of Canadian citizens and the economy.[43]

Reforming the LCP under the Right to Dignity (2014-present)

Through the tireless activism of live-in caregivers and migrant rights lobbyists, stories like Tejada's captured national attention and pressured the Canadian government to restructure their pathway to citizenship programs for migrants in the domestic sector. Discrimination in healthcare as well as the right to decent work contributed to reforming the LCP, but the fundamental shift in policy (which occurred in 2014 and led to the dropping of the "Live-in"

[40] Ysh Cabana, "Juana Tejada," *The Canadian Encyclopedia: Historica Canada* (Sep 8, 2021).
[41] Ibid.
[42] Ibid.
[43] Ibid.

component) was disputed over migrant caregivers' right to dignity and privacy. According to a thorough fact-finding study conducted by McGill University on exploitation of workers in the LCP, there is a great disparity between the requirements of the LCP on paper and the reality of the everyday conditions caregivers face living in private households. While the CIC stipulates that employers must provide their caregiver with "private accommodation which ensures privacy, such as a private room with a lock on the door,"[44] regulation is neglectful and often indifferent to the dignity and privacy of (primarily female) migrant workers. Workers by and large had a room of their own, but some women responding to the McGill study reported having to share their room with children or guests of the employer.[45] Some women reported that their rooms served dual purposes in the household, such as storage space for the employer or as "the mandatory route in order to get to one of the freezers in the basement."[46]

In addition to sharing their space, many women in the LCP reported "disturbances" and "intrusions" into their bedrooms by employers or family members.[47] The extent of the violations of caregivers' privacy is disturbing:

> "The intrusion of the employers in the rooms constitutes a recurrent practice. One woman reports having once found her room turned upside down. She later learned that the employer's spouse had organised an evening during which her guests disguised themselves with her clothes. Another woman knows her employer regularly enters her room when she is not there. The vast majority is convinced that their employers enter their room in their absence."[48]

Recalling Alicia Yamin's emphasis on the power of social determinants on the realization of the expanded right to health, it is accurate and important to understand these attacks on the dignity and privacy of migrant caregivers as violations of the "super right" to health. The discomfort of

[44] Jarrah Hodge, "'Unskilled Labour': Canada's Live-in Caregiver Program," 63.
[45] Elsa Galerand et al., "Domestic Labour and Exploitation: The Case of the Live-In Caregiver Program (LCP) in Canada," 12.
[46] Ibid.
[47] Ibid, 13.
[48] Ibid.

living in a permeable space under constant control and surveillance of one's employer, took an enormous toll on the mental health of caregivers in the LCP. Female caregivers in the McGill study reported feeling "unhappy, depressed, humiliated, lost, degraded and disillusioned," and one woman was quoted as feeling "like an insect."[49] Another worker admitted to having "very low self-esteem"; another that she is led by her treatment at work to feel "as if she is the property of her employers."[50] Combined with the physical and mental exhaustion of live-in caregiver work that almost all (26 out of 23) women interviewed admitted is the worst part of their work, many of the caregivers go right to bed after their work ends, crying and "asking themselves why they are doing this job."[51]

Reports of these abuses, as well as sexual and physical violence, led the Harper government to remove the live-in requirement in 2014, and the LCP became the CP.[52] The new CP made three improvements to the design and structure of the LCP. First, living-in became optional for caregivers, open to "negotiation" between employer and employee (however, the terms on which migrant workers are freely agreeing to live-in remains dubious).[53] The second change was to prescreen applicants to see if they qualify for permanent residency before work permits are issued. Prescreening was intended to lessen "heartaches of a broken promise of PR," but the downside is "a longer processing time since the PR background checks are conducted at the beginning."[54] The third formal change in the CP is that work permits are no longer "employer-specific," chaining caregivers to potentially abusive workplace situations. Permits are

[49] Elsa Galerand et al., "Domestic Labour and Exploitation: The Case of the Live-In Caregiver Program (LCP) in Canada," 15.
[50] Ibid.
[51] Ibid, 23.
[52] Lou Janssen Dangzalan, "The Evolution of Canada's Caregiver Program."
[53] Jill Hanley et al., "Does Canada 'Care' about Migrant Caregivers?: Implications under the Reformed Caregiver Program," *Canadian Ethnic Studies* 49, no. 2 (2017): 127.
[54] Dangzalan.

now "occupation-specific" along two tracks, "one recognized as more skilled ('Caring for People with High Medical Needs Pathway') and one as less skilled ('Caring for Children Pathway')."[55] Many of these policy shifts seem to have been informed by a human-rights based approach to the right to work, so that caregivers have increased agency and decision-making power in the conditions of their employment and living situation. But the HRBA to the reformed Caregiver Program woefully lacks an axis of non-discrimination for migrant workers, given the socio-economic and political vulnerability that migrant workers have under Canadian law.

Beyond the Case Study: Lessons, Strategies, and Proposals for the Path Forward

The CP Within Broader Structures of Health Inequity

Many medical professionals in Canada who cherish their country's universal, single-payer healthcare system have denounced the mandatory three-month waiting period for health coverage for all foreign arrivals and called for its abolition.[56] They argue that the waiting period does not make sense from a public health standpoint, and, due to the "healthy immigrant effect," it would cost less to provide coverage for recent arrivals than it does to cover their "Canadian-born peers."[57] Indeed, from a human rights perspective as well, the three-month waiting period for immigrants is at odds with the CESCR General Comment No. 20, which specifies that "everyone" is entitled to the principles of non-discrimination and equality in socio-economic rights, not just nationals.[58]

However, even if the three-month waiting period and other formal rights-exceptions against migrants are abolished, an intersectional framework of substantive equality shows us that

[55] Dangzalan; Hanley, 127.
[56] Rikita Goel, and Michaela Beder, "Welcome to Canada ... but don't get sick."
[57] Ibid.
[58] UN Committee on Economic, Social and Cultural Rights (CESCR), "General comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights)," (July 2009): para 3.

female migrant workers (such as those who comprise over 90% of the Caregiver Program[59]) will still experience severe health disparities, which infringe on their right to health. Sabaa Khan insists upon the fact that, even after receiving permanent resident status, "economic and social insecurities continue to plague live-in caregivers" due to the "secondary policy barriers" to health they cannot circumvent.[60] Barriers such as "ineligibility for public services, social isolation, racism within the health system, and employment conditions" make it much harder for migrant women of color to access health services and protect their physical and mental health.[61] The legal liminality of migrant workers is not the only obstacle to the full realization of their right to health; rather, their liminality intersects with "a range of factors which heighten vulnerability to health risks and long-term consequences, such as precarious employment status, poverty and/or dependency, racialized status and limited social integration."[62] For all migrant workers, regardless of gender, "many workers do not report a health problem for fear of immediate repatriation to their home country, and when they do report it, it is not quickly addressed."[63] And even when these workers pursue treatment, they face multiple barriers to receiving adequate care, including long work hours, lack of independent transportation to clinics, long wait times, and language barriers.[64] Studies show that migrant women "often experience more intensely these language and cultural barriers, as compared to immigrants in other categories."[65] Identifying and lowering these secondary policy barriers to healthcare for migrant

[59] Sabaa A Khan, "From Labour of Love to Decent Work: Protecting the Human Rights of Migrant Caregivers in Canada," 29.
[60] Ibid, 30; Jaqueline Oxman-Martinezet et al., "Intersection of Canadian Policy Parameters Affecting Women with Precarious Immigration Status: A Baseline for Understanding Barriers to Health," *Journal of Immigrant Health* 7 (2005): 254.
[61] Ibid, 250.
[62] Jenna Hennebry et al., "Out of the Loop: (In)access to Health Care for Migrant Workers in Canada," *Int. Migration & Integration* 17 (2016): 524.
[63] Ibid, 529.
[64] Ibid, 530.
[65] Oxman-Martinez et al., 255.

women of color in the care sector is crucial to the complete realization of the human right to "the highest attainable standard of physical and mental health."

Constitutionalizing the Right to Health

Acquiring a deep understanding of the expanded right to health under international human rights law with a HRBA to dignity and non-discrimination is merely the first step to fulfill the lofty goals set forth in the ICESCR. The LCP of Canada is a prime case study to trace the fault lines in even the best nationalized healthcare systems, but in order to do more than lip service to the universal right to health, Canada must constitutionalize the right to health in its domestic law to be held accountable by its citizens. Human rights have long been embedded in Canada's moral fabric, and Canada has signed and ratified almost "every international treaty relevant to the right to health" (the Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families is the noteworthy exception).[66] Despite this, Canada has yet "to create a systemic approach to advance the right for all people within its borders," and health is typically discussed as a "service or public good" rather than a justiciable right.[67]

Opponents of constitutionalizing the right to health argue that it has the potential to negatively impact the country's overall health. Citing Brazil as an example, they claim that "providing constitutional protections to health rights leads to middle-class and wealthy individuals using the courts to ensure access to costly, non-critical treatments, which takes money away from providing care to the most vulnerable in society."[68] While judicial enforcement through individual lawsuits is one way of entrenching the right to health in constitutions, a second method "involves the judiciary ordering broader changes to national

[66] Vanessa Abban, "Getting It Right: What Does the Right to Health Mean for Canadians?," *Toronto: Wellesley Institute* (2015): 4.
[67] Ibid.
[68] Maya Gunnarsson, "Constitutionalization of the Right to Health: A Pathway to Improved Health Outcomes?"

health policies."[69] A broader approach to changing health care in Canada to guarantee non-discrimination can look to South African and Indian courts for normative guidance.[70] Above all, a constitutionalized right to health contains significant potential for socio-economic rights activists in Canada to decide what their government must do to respect, protect, and fulfill the health rights of *every* social citizen, no matter which step on the pathway to citizenship they might be standing on. And from that point on, Canadian courts and citizens will be empowered to decide just how expansive the right to health can really be.

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