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Mark Banyai

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Article abstract

Most of the Canadian population lives in urban settings where amenities, including rapid access to major hospitals and tertiary care, are readily available. However, a significant yet often overlooked segment of the population resides in remote areas, where daily life is markedly different, and accessing healthcare poses considerable challenges. As our society progresses toward truth and reconciliation with Canada's Indigenous peoples, it is crucial to reconsider and critically address the prevailing narrative surrounding remote living. In my interactions with non-Indigenous individuals living off reserves, many appear to view remote living as a personal choice, accepting that limited access to healthcare is an unavoidable consequence. However, I argue that Indigenous peoples were not — and still are not — offered a genuine “choice” regarding where they can live and, therefore, do not tacitly consent to reduced healthcare services.

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TÉMOIGNAGE / PERSPECTIVE

Does Living Remotely Imply Tacit Approval to Diminished Health Services?

Mark Banyai^a

Résumé

La majeure partie de la population canadienne vit dans des zones urbaines où les services, notamment l'accès rapide aux grands hôpitaux et aux soins tertiaires, sont facilement accessibles. Cependant, un segment important mais souvent négligé de la population réside dans des régions éloignées, où la vie quotidienne est sensiblement différente et où l'accès aux soins de santé pose des défis considérables. Alors que notre société progresse vers la vérité et la réconciliation avec les peuples Autochtones du Canada, il est essentiel de reconsidérer et d'aborder de manière critique le récit dominant concernant la vie dans les régions éloignées. Lors de mes échanges avec des personnes non autochtones vivant hors des réserves, beaucoup semblent considérer la vie en région éloignée comme un choix personnel, acceptant que l'accès limité aux soins de santé soit une conséquence inévitable. Cependant, je soutiens que les peuples autochtones n'ont pas eu — et n'ont toujours pas — de véritable « choix » quant à leur lieu de vie et que, par conséquent, ils ne consentent pas tacitement à une réduction des services de santé.

Mots-clés

soins de santé à distance, consentement éclairé, éthique biomédicale, vérité et réconciliation, population autochtone

Abstract

Most of the Canadian population lives in urban settings where amenities, including rapid access to major hospitals and tertiary care, are readily available. However, a significant yet often overlooked segment of the population resides in remote areas, where daily life is markedly different, and accessing healthcare poses considerable challenges. As our society progresses toward truth and reconciliation with Canada's Indigenous peoples, it is crucial to reconsider and critically address the prevailing narrative surrounding remote living. In my interactions with non-Indigenous individuals living off reserves, many appear to view remote living as a personal choice, accepting that limited access to healthcare is an unavoidable consequence. However, I argue that Indigenous peoples were not — and still are not — offered a genuine “choice” regarding where they can live and, therefore, do not tacitly consent to reduced healthcare services.

Keywords

remote healthcare, informed consent, biomedical ethics, truth and reconciliation, Indigenous population

Affiliations

^a Indigenous Services Canada, Ottawa, Ontario, Canada

Correspondance / Correspondence: Mark Banyai, mark.banyai@sac-isc.gc.ca

CURRENT PERSPECTIVES ON REMOTE LIVING

Imagine spending a week in an isolated cottage in the wilderness, far from traffic and surrounded by the quiet peace of nature. Now, imagine this is your daily reality. For some, this is life in the remote regions of Canada — whether by choice, obligation, or the circumstances of hereditary fortune. According to the 2021 Canadian census, approximately 40.6% of First Nations (1) live on reserves in isolated or semi-isolated regions across the country. While some may idealize these surroundings, the reality often sets in quickly after a few days. Picture life without a nearby grocery store, relying on hunting for subsistence, being hundreds or even thousands of kilometers from the nearest hospital, and enduring frequent power outages during long, harsh winters and insect-laden summers.

In 1876, the colonial British government introduced the Indian Act, asserting its responsibility to “civilize” the Indigenous population by imposing Eurocentric views and lifestyles. Over time, this led to the forced relocation of various nomadic peoples onto reserves, restricting their movement across ancestral territories. This displacement disrupted their self-sufficient ways, rendering them dependent on external provisions. Their culture underwent radical transformation, with ancestral practices, traditional dress, and language rapidly eroded.

Eventually, the British government imposed residential schools, delivering the final and most devastating blow to Indigenous populations. Children were forcibly taken from their families and placed in institutions where they were forbidden to speak their native languages and were indoctrinated with a strictly religious, Eurocentric education. The government pursued this policy with the stated goal of “killing the Indian in the child,” a strategy that nearly succeeded. The last Indian residential school, located in Rankin Inlet, Nunavut, closed as recently as 1997 (2). Since then, there has been a slow process of reconciliation and efforts to right the wrongs of the past. However, there are limits to what can be restored — certain dialects, along with their stories and cultural heritage, have been lost forever.

With the ghettoization of certain populations came significant healthcare inequalities. According to Diabetes Canada, an estimated 17.2% of Indigenous people living on reserves now suffer from diabetes, compared with 14% of non-Indigenous people (3). Additionally, Statistics Canada reports that “the rate of suicide among First Nations people (24.3 deaths per 100,000 person-years at risk) was three times higher than the rate among non-Indigenous people (8.0 deaths per 100,000 person-

years at risk). Among First Nations people living on reserve, the rate was about twice as high as that among those living off reserve” (4).

Many factors may contribute to these disparities, including genetics, loss of Indigenous lifestyles, diet, poor access to primary care, and inadequate mental health support (5,6). That said, throughout my career in remote locations across Canada, I have frequently encountered the argument that people living remotely “choose” to do so and are therefore subject to the consequences of their life choices. The belief persists that in Canada, individuals are free to move wherever they wish, and if their health suffers as a result of this choice, it is ultimately their responsibility.

I would like to approach this matter from a different perspective. Considering that Canada spans a vast geographical territory, it is understandable that not all health centres in remote regions can have the most up-to-date medical equipment available. But does living remotely automatically imply tacit consent to receiving decreased healthcare services? We should strive to better understand the reasons people choose to live in remote locations and explore how their health conditions can be improved while allowing them to remain where they wish to live. This discussion will examine the concept of tacit consent and its relevance to the specific conditions faced by Indigenous populations living in remote areas of Canada.

IS THERE TACIT CONSENT WHEN LIVING REMOTELY?

The notion of tacit consent, introduced by philosopher John Locke, is succinctly described in an article by Noah Busbee: “John Locke, who first put into writing the idea of tacit consent, explores the idea that obligations and duties both arise from and give rise to notions of consent. By receiving benefits from the state, one is therefore obliged to follow the laws of the state” (7). This means that individuals residing in a country or territory are subject to its laws and tacitly consent to follow them. When it comes to healthcare, a similar assumption could be made — individuals residing in isolated regions tacitly consent to having diminished or altered levels of healthcare because equipping and staffing a large hospital in every community is not feasible. At first glance, this argument seems logical. Canada is a vast country with a dispersed population, requiring universal healthcare to be provided to citizens who are few in number and widely scattered. Some regions are so remote that there are no roads — only forests or tundra stretching as far as the eye can see. Given these challenges, it might seem reasonable to conclude that providing the same level of healthcare to everyone is practically impossible. Consequently, one could argue that people living in remote areas tacitly accept the increased risks to their health. For instance, it is not feasible to have a computed tomography scanner in every village or a radiologist on standby to interpret the results. Serious illnesses, therefore, pose a significantly greater danger in remote regions than in urban centres.

I would argue that such a form of consent is only valid under certain preconditions. Although Locke himself did not make this explicit, philosopher John Simmons outlined specific conditions that must be met for tacit consent to be considered valid: “First, the person consenting must be aware that the situation calls for consent. Second, there must be a period of time when objections can be given. Third, that period of time ends. Fourth, there is ease or reasonableness for someone to object, and finally, there cannot be extremely detrimental consequences for objections. Only if all five conditions are met has one consented tacitly by remaining silent” (8).

Let us assume that most Canadians living in remote locations have de jure accepted these five points and, therefore, tacitly consented to them. However, I would like to emphasize that we are discussing most Canadians, not all Canadians — particularly not Indigenous Canadians. More specifically, because of historical inequities, it is important to remember that many Indigenous peoples were forcibly placed on reserves, fundamentally altering their way of life. Indigenous peoples were not even recognized as citizens until relatively recently in Canadian history. How could tacit consent be given when there was no meaningful dialogue between the two parties? The stronger military power — in this case, Britain — imposed laws and regulations by force.

Simmons’ five points of tacit consent have clearly not been met in this context, rendering Locke’s concept of tacit consent invalid. It is unreasonable to believe that any consent, tacit or otherwise, has been given in this specific case. Indigenous populations were not engaged in dialogue and have had almost no control over their territories for the past 400 years. We cannot assume that they have consented to living in isolated regions with diminished healthcare simply because they remain there. Often, they have little choice due to familial and financial constraints. While recent years have seen an opening of dialogue and efforts to improve health conditions on reserves, these steps are relatively recent and far from ideal. There remains a stark inequality in the healthcare distribution between northern and southern Canada. It would be inaccurate to claim that Indigenous peoples have consented to living under such conditions simply by staying where they are.

John Rawls, in his critique on distributive justice, offers counterarguments to the concept of tacit consent and further develops the notion of consent. Although not explicitly discussing tacit consent, Rawls’ original position argues that consent from a party is only valid if its fundamental principles are agreed upon behind a veil of ignorance. This concept (9), otherwise known as the “original position”, exemplifies how we should perceive consent and address the plight of those who are worst off, thereby emphasizing rights, freedoms, and equality, without sacrificing the most vulnerable. As an example, imagine taking all Canadian citizens and performing a societal “reshuffling.” Now imagine these citizens have their memories erased and are tasked with redesigning their communities, political systems, and population distribution, all from a neutral standpoint. As philosopher Michael Sandel explains in his book *Justice* (10), referring to Rawls: “What principles we, as rational self-interested persons, would choose, if we found ourselves in this position?” (p.141). Rawls concludes that we would not choose

utilitarianism. After all, we would not want to be born into an impoverished family with limited opportunities for upward mobility, leaving us unable to access the education and skills needed to improve our lives — that is, perpetuating minimal utility and ongoing poverty. Likewise, we would not choose libertarianism. Such economies often result in significant disparities between the rich and poor, with limited opportunities for upward mobility or improvement. Instead, Rawls suggests that in most cases, we would opt for an egalitarian social welfare structure. This structure would ensure that even the least well-off socially or medically would have access to essential services, such as healthcare, at no cost to them.

Now, we turn our attention to the topic at hand: whether there is a form of tacit consent when living in remote communities. Over the past decade, healthcare in northern isolated communities has improved significantly with the advent of telehealth and the simplification of bureaucratic processes, making healthcare more geographically accessible than ever. While everyone would prefer to have the best possible healthcare, for a certain percentage of the population, leaving their communities is not a feasible option because of family obligations, financial constraints, social networks, and other factors. For many Canadians, the choice to leave their communities is more an illusion than a genuine possibility. If someone were given the option to move to a larger city to access better healthcare, doing so would mean leaving behind their entire identity and history. It can therefore be argued that this is not a real choice and does not reflect genuine consent to living in remote locations. Instead, this situation resembles being forced to choose between two undesirable options: accepting diminished health services or abandoning a significant part of one's identity.

We can observe that with the ongoing dialogue between governments and Indigenous communities, progress is being made toward meeting the five criteria for tacit consent outlined by Simmons. However, we are not there yet. First, Indigenous peoples living in remote areas are not fully consenting to their living conditions because they have only partial control over the management of their lands. Second, while objections to inadequate healthcare are being raised and sometimes addressed by the government and regional authorities, these efforts remain inconsistent. Third, consent to living in remote areas cannot be easily revoked because leaving comes at a great individual cost. Fourth, objections to diminished healthcare are inadequately addressed due to limited financial and human resources. Finally, those who do not consent to living in remote areas often cannot relocate because of familial, financial, or social constraints, leaving them unable to avoid the detrimental effects of their circumstances.

Given that several of these criteria remain unmet, I argue that true consent has not been given to living in remote conditions with reduced access to healthcare. Recognizing this, it becomes imperative to shift the current healthcare narrative in Canada to better address the specific needs of remote communities. By doing so, we can work toward ensuring improved healthcare access for those who are, in terms of healthcare distribution, among the worst off.

WHAT CAN WE DO DIFFERENTLY?

I have sought to establish that the criteria for tacit consent have not been met for those living remotely, particularly for Indigenous populations in Canada. Providing healthcare to remote locations is undeniably challenging, and people in these circumstances face significant healthcare discrepancies that must be addressed by medical authorities. Indigenous populations have not consented to poor living conditions, and we must strive to better understand the realities of all Canadians, not just those in urban areas. A deeper understanding of the living conditions in remote regions is essential to fostering a more thorough and informed dialogue with all Canadians. It is unethical to assume that all citizens living remotely have freedom of movement and that living in such areas is purely a “choice.” Uprooting oneself carries significant social and psychological ramifications. Our focus should be on improving access to healthcare without revisiting the colonial practice of uprooting populations “for their own good.” Improving healthcare access in remote regions does not necessarily mean providing a computed tomography scanner in every community. Instead, we should prioritize easy access to primary healthcare, rapid access to culturally sensitive mental health services, efficient medical evacuations when necessary, access to clean drinking water for all, and more. If we, as a society, are committed to reconciliation, we must not only recognize the regional differences and challenges faced by a large portion of our citizens living outside urban areas, but also address these issues in a timely and effective manner.

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None to declare

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