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Health resource rationing policy reform: re-thinking the role of the courts

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1 Introduction: how to meet health care demands fairly when we cannot meet all of them?

Health care spending is the largest expenditure for provincial budgets across Canada, ranging from 34.5% in Quebec to 44.6% in Nova Scotia.¹ Provincial health care budgets across Canada are estimated to continue to consume a larger proportion of the Canadian economy.² The current health care budget managed by the provincial governments has been suggested to be unsustainable.³ The reality is that the rationing of health care resources is inevitable and is complicatedly intertwined with balancing tradeoffs of budget sustainability with human rights and equality. Often, the executive branch of the government is placed into the position of making difficult and sometimes tragic decisions in managing the health care system and deciding the allocation of health funding.

On the topic of how a society should manage its health care resources, the discussion amongst scholars are shifting away from the traditional distributive principles, such as utilitarianism, egalitarianism, prioritarianism, and so on, to developing a more just process for the distribution of scarce health resources in a fair and accountable manner.⁴ American philosopher and health ethicist, Norman Daniels, proposed the theory of “procedural fairness” to address the problem of how a society could meet its health care demands fairly when it cannot practically meet all of them.^{5,6} According to this theory, the most justifiable approach in distributing scarce

¹ Barua et al., *The Sustainability of Health Care Spending in Canada*, Fraser Institute, published on May 31, 2016. Accessed from < <https://www.fraserinstitute.org/sites/default/files/sustainability-of-health-care-spending-in-canada.pdf> >. [Barua].

² *Ibid*, at page 7.

³ *Ibid*, at page ii.

⁴ Rumbold, Benedict, et al. "Universal Health Coverage, Priority Setting and the Human Right to Health." (2017).

⁵ Annette Rid, "Just health: meeting health needs fairly" (2008) Bulletin of the World Health Organization 86.8 : 653-653.

health care resources is to build a framework in which rationing decisions are made on an explicit and reasonable basis. The system that controls allocation of health care resources must adapt a mechanism of accountability for reasonableness, including evidence-based analysis of cost-effectiveness, openness of the decision-making process to the public, and a fair procedure allowing interested individuals to challenge the decisions.

Currently, the Supreme Court of Canada has shown reluctance in recognizing access to health care as a positive right under the constitution. What exact role should the court fulfill in order to assist health policy reform and create a more fair, just, and sustainable system to manage Canada's health care resources?

In this paper, I argue that instead of choosing between deferring to the government executive decision or asserting a strong judicial intervention, the Canadian judicial system should rather adapt a right-to-procedural-fairness approach in the context of access-to-healthcare litigations. In other words, rather than reviewing the substance of rationing decision outcomes, the judiciary should demand relevant government actors to demonstrate that health care rationing decisions were made in a framework that can withstand the scrutiny of accountability and reasonableness. I will provide evidence to support the notion that judicial demand of accountability for reasonableness from health authorities has contributed the establishment of a system that operates on a fairness principle proposed by Norman Daniels. By appropriately demanding the demonstration of accountability and reasonableness in the decision-making process for health resource allocations, the Canadian courts could play a pivotal role in transforming Canada's health care system into a more sustainable position.

⁶ Norman Daniels, *"Just health: meeting health needs fairly."* (2007) Cambridge University Press.

2 Lessons from abroad: the role of the English courts in the health rationing policy reform

Lessons from other nations, such as Brazil, indicate that an overly strong judicial intervention approach could make health systems less fair and less sustainable. Brazilian courts' strong willingness to strike down government executive decisions virtually divided the health system into two tiers: one for the selected individuals who had financial means to bring a legal challenge to obtain desired health service and another for the rest of the population. Certain rationing decisions are made not based on evidence of cost-effectiveness, but on the basis of their likelihood of avoiding or surviving potential legal challenges.^{7 8} With a focus on assessing the substantive outcome of a rationing decision, the overly strong judicial interventionist approach in access-to-health litigations could effectively result in the health system becoming less fair.

However, judicial interventions do not always produce similar outcome observed from Brazil. The changes in English case law and the resultant English health rationing policy reform provide a model of how courts could contribute to the transformation of the health system into a fairer state, while maintaining its budgetary sustainability.

The evolution of British health care policy, in which the courts played an influential role, may offer Canada with a potential direction of moving forward with its health policy reform. Like any other publically funded health care system, the British National Health Services (NHS) must make difficult health funding allocation decisions as a part of its

⁷ Wang, Daniel. *"Right To Health Litigation In Brazil: The Problem And The Institutional Responses"* (2015) Human Rights LR. 15 (4): 617-641.

⁸ Ferraz, Octavio Luiz Motta. *"The right to health in the courts of Brazil: Worsening health inequities?"* (2009) Health and human rights 1: 33-45.

function.⁹ Historically, rationing decisions in the U.K. used to be made in a very implicit manner, i.e. patients were not informed of the economic reasons of denying their treatment¹⁰ and therefore, reasonableness of rationing decisions could not have been monitored. As a result, litigations were brought before the courts when treatments were denied. The evolution of British courts responses in addressing the issue of access to health could be systematically categorized into two eras: pre-*Child B* and post-*Child B* eras.¹¹ In the former, the British courts generally held a presumption of reasonableness in government executive decisions regarding allocation and management of health care funding. In the post-*Child B* era, the courts became increasingly demanding of the relevant government actor to demonstrate reasonableness in its decision making process.¹²

2.1 The pre-Child B era

R v Secretary of State for Social Services and Ors ex parte Hincks (1980) is a classic representation of the English courts' deferential approach. The Court simply affirmed that the government actor overseeing health care had no duty that could be enforced by the court for the provision of comprehensive health service simply due to limitations of available health resources. From hindsight, the court seemed to hold a presumption that government executives acted reasonably in reaching their allocation decisions. For the 15 years after, a series of litigations were decided based on the same principle in favour of the

⁹ Christopher Newdick, "Resource allocation in the National Health Service." (1997) *Am. JL & Med.* 23: 291.

¹⁰ Len Doyal, "The rationing debate. Rationing within the NHS should be explicit. The case for." (1997) *BMJ* 314.7087: 1114.

¹¹ Wei Liang Wang, Daniel. *Can litigation promote fairness in healthcare? The judicial review of rationing decisions in Brazil and England.* Diss. The London School of Economics and Political Science (LSE), 2013. [Wei]

¹² *Ibid*, at page 17.

health care authorities.¹³ In these decisions, the trend of courts' preference for exerting a minimal level of control over government's rationing decisions continued. When reviewing health care rationing decisions, courts would restrict their role from intervening government decisions, unless such decisions demonstrate obvious flaw and significant departure from community standard of reasonableness.¹⁴

2.2 The turning point – Child B

The English case law took a turn from its usual course in the High Court's decision in *R v Cambridge Health Authority, ex p B*, famously known as *Child B*.¹⁵ In this case, the 6-year old patient previously diagnosed with non-Hodgkin's lymphoma with an onset of acute myeloid leukemia was put on palliative care, as the doctors believed that further intensive treatments would not likely generate a response. The Child's family, through their own literature research and consultation with American doctors, believed that an additional course of intensive treatment, rather than palliative care, would be a more appropriate treatment strategy. The health authority decided not to fund such treatment due to a small likelihood of treatment success and a disproportionate loss of quality of life for the patient. The father of the patient took the health authority to court seeking judicial review to challenge the government's decision in denying the further intensive treatment.¹⁶ The High Court held that, amongst other things, the gravity of harm to the life of the child means the government needed to offer more explanation regarding the prioritization of its funding allocation decisions that consequently resulted in denying

¹³ *Ibid*, at page 124

¹⁴ *Ibid*, at page 116.

¹⁵ *R v Cambridge Health Authority, ex parte B* [1995] 2 All ER 129.

¹⁶ Chris Ham, "Tragic choices in health care: lessons from the *Child B* case." (1999) *BMJ* 319.7219: 1258.

the life-saving treatment.¹⁷ While affirming the health authority's statutorily delegated discretion in making funding decisions for medical service, the High Court's groundbreaking decision shifted the burden of proof to the government, demanding it to demonstrate objective reasonableness in its decision-making process.

2.3 The post Child-B era

The government's appeal eventually succeeded, as the court of appeal returned to the course established by jurisprudence that restrained the judiciary's involvement in deciding the allocation of the scarce health care resource. Notwithstanding the ultimate outcome in *Child B*, the High Court's decision in *Child B* had inspired courts in later cases to adapt a similar approach that questions accountability and reasonableness in the government's decision-making process for the allocation of health care funds. The courts refrained from disputing the health authority's expertise in making difficult rationing decisions. However, executive rationing decisions had to demonstrate procedural reasonableness in order to survive the scrutiny of judicial reviews.¹⁸ Most notably on the issue of public funding for gender reassignment surgery, the court in *R v North West Lancashire Health Authority, ex parte A and Others* struck down the health authority's refusal in denying the treatment.¹⁹ The government provided no evidence indicating the decision was made with assessment on the clinical need of the transsexual claimant and the relevant cost-benefit analysis. The court eventually ordered the government to reconsider its decision on the matter of funding gender reassignment surgeries.²⁰ Correspondingly, a rationing decision in refusing to fund a certain drug could survive the

¹⁷ Wei *supra* note 9, at page 127.

¹⁸ Wei *supra* note 9, at page 131..

¹⁹ *R v North West Lancashire Health Authority, ex parte A and Others* [1999] All ER (D) 911

²⁰ Wei *supra* note 9, at page 136.

scrutiny of judicial review if the government were able to demonstrate reasonableness in the decision-making procedure.²¹ In another case involving a transgender claimant, the government funded the initial gender-assignment surgery, but denied funding for the prosthetic breast implants. The government defended its decision in denying such “cosmetic” surgeries because of its low priority on the scale of medical necessity, as well as the potential unfairness that could arise as a number of women also had their requests denied. The reasoning provided by the government in this case eventually withstood the scrutiny of judicial review.^{22 23}

2.6 The dialogue between the courts and the governments

The dialogue between the judicial and executive branches of the British government played a central role in making the rationing decisions more explicitly reasonable. Courts often demanded the government to demonstrate the reasoning of its rationing decisions. Health authorities, in fear of potential lawsuits against their rationing decisions, were incentivized to institute an explicit mechanism to determine the allocation of its limited fund in a manner that is accountable for reasonableness.²⁴ Through the reform of institutionalizing the National Institute of Health and Care Excellence (NICE), the government had prioritized the need to establish a rationing procedure that is more fair and just.²⁵ It is reasonable to assume that NICE had brought the English health system into a relatively more stable equilibrium, in which the

²¹ *R v National Institute for Health and Clinical Excellence ex parte Bristol-Myers Squibb Pharmaceuticals Ltd* [2009] EWHC 2722.

²² *AC v Berkshire West PCT and the EHRC* (2010) 116 BMLR 125 (affirmed by CA, (2011) 119 BMLR 135 Civ 247).

²³ Christopher Newdick, "Health care rights and NHS rationing: Turning theory into practice." (2014) *Revista Portuguesa de Saúde Pública* 32.2 : 151-157.[Newdick].

²⁴ Wei *supra* note 9, at page 200.

²⁵ Wei *supra* note 9, at page 215.

government had become more reasonable in making the health rationing decisions, while the courts continued to defer to relevant government actor's expertise in making those decisions.²⁶ Under such system, this means that for the government, courts would refrain from getting in the way of its rationing decisions aimed at improving the sustainability of its health care budget and thus making government decisions more legitimized.

The outcome from the evolution of the English courts' role in overseeing the procedural reasonableness of government rationing decisions, from pre-*Child B* to post-*Child B* era, has helped transforming the system to become fairer and more just. The English health system is a step closer, relative to where it was, to achieving a status of "procedural fairness" to address the problem of how it could meet its health care demands fairly when it cannot practically meet all of them.²⁷

3 The Canadian justice system's current approach to access to health care litigations

The Supreme Court of Canada had struggled with its approaches in addressing constitutional challenges arising as a result of the scarce nature of health care resources (e.g. unreasonably long wait times and denial of certain treatments). Within a seven-month period, the court shifted from taking a deferential stance to government executive power, in *Auton v British Columbia*,²⁸ to asserting a strong judicial intervention by striking down

²⁶ Newdick, *supra* note 21.

²⁷ Wei *supra* note 9, at page 296.

²⁸ *Auton (Guardian ad litem of) v British Columbia (Attorney General)*, 2004 SCC 78, [2004] 3 SCR 657. [*Auton*].

the state monopoly in providing health care in Quebec, as seen in its landmark decision on *Chaoulli v Quebec*.²⁹

The appropriateness of imposing a positive right to access to healthcare has been an extensively debated topic amongst the Canadian legal academia community.³⁰ However, these two cases decided by the Supreme Court had clearly established that “[the] Charter does not confer a freestanding constitutional right to health care.”³¹ The overly deferential stance taken by the Supreme Court was widely criticized by legal scholars.

3.1 *Auton v British Columbia*: “prescribed by law”

Auton was a case involving parents of autistic children challenging the British Columbia government’s decision to deny funding for behavioral therapy. The Supreme Court agreed with the government’s position and held that the decision to deny funding did not infringe section 15(1) equality right under the Charter. The Court further affirmed its longstanding view on access to health care in Canada: the government is not obligated to meet all medical needs of the people.³² The legal academia community was greatly disappointed by the Supreme Court’s reluctance to intervene in government spending priorities.³³ While the government defendant had full discretion in deciding funding allocation, including denying funding, the Court’s could have been more active in demanding the government to demonstrate rationale in the setting of funding priorities. Instead, the court in *Auton* failed to probe the government for an explanation for the

²⁹ *Chaoulli v Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 SCR 791. [*Chaoulli*]

³⁰ Emmett Macfarlane, “*The Dilemma of Positive Rights: Access to Health Care and the Canadian Charter of Rights and Freedoms*,” *J of Canadian Studies* 48.3 (2014): 49-78.

³¹ *Chaoulli supra* note 29, at para 104.

³² *Auton, supra* note 28, at para 35.

³³ Natasha Bakht, “*Furthering an Economic/Social Right to Healthcare: The Failure of Auton v. British Columbia*,” (2005) *JL & Equal.* 4 : 241 [Bakht].

reasoning process and cost-effectiveness of its decision on funding allocation. Essentially, as long as the medical service is not prescribed by law, the Court would dismiss the claim without examining the rationale behind the decisions to qualify what service is (or is not) prescribed by law in the first place. The Court simply presumed the government's decision behind what is or is not "prescribed by law" was made in a reasonable and fair procedure. The Court has been criticized that it could have at least examined why and how autistic behavioral therapies were introduced in other provinces and British Columbia chose not to fund the same treatment.³⁴

3.2 Chaoulli v Quebec: continuing the reluctance in demanding reasonableness

Although the Supreme Court seemingly took a 180-degree turn in *Chaoulli* when it struck down the Quebec government's monopoly in operating the health insurance system, the Court was, in fact, reaffirming its tradition of asserting a minimal accountability requirement for the government in the way the health system is managed. In essence, McLachlin CJ's decision had asserted that section 7 of the *Charter* does not impose a duty upon the government to provide all medically necessary care, but only offers individuals the right to purchase private health insurance without being restricted by the government.³⁵ Professor Jackman viewed this as problematic,³⁶ citing the applicant's statement from *Toussaint v Canada (Attorney General)*:

"Unlike the patients considered in *Chaoulli*, who had the financial resources to purchase private healthcare insurance, the Applicant in the present case lives in poverty and is unable to pay for either private health

³⁴ *Ibid*, at page 254-255.

³⁵ *Chaoulli supra* note 29, at para 104

³⁶ Martha Jackman, "Charter Review as a Health Care Accountability Mechanism in Canada"(2010)." Health LJ 18: 1. [Jackman].

care or for private insurance. The remedy sought by more affluent applicants in *Chaoulli* would be entirely ineffective in vindicating the present Applicant's rights under s. 7."³⁷

Both majority and dissent in *Chaoulli* were criticized for their failure to suggest "any meaningful framework for government accountability in relation to access to health care, particularly for those unable to afford, or ineligible to obtain, private insurance or care."³⁸

In the dissenting opinion, Binnie and Lebel JJ asked:

"What, then, are constitutionally required "reasonable health services"? What is treatment "within a reasonable time"? What are the benchmarks? How short a waiting list is short enough? How many MRIs does the Constitution require?"³⁹

In the article titled "*A right to health care in Canada only if you can pay for it*", author Bruce Porter suggested that the above questions asked by the dissenting justices in rhetoric are in fact the very issues the court should call upon the government for answers, especially for the Canadians who do not have the financial resources to purchase additional private insurance should one day Canada adapt a nationwide two-tier public- and-private health system.⁴⁰ Rather than calling the *Chaoulli* decision "striking down" on the government, the alternative perspective offered by Bruce Porter suggests that the Court was in fact restating its previous refusal to demand the government to take reasonable measures to ensure fairness in the system for Canadians to access health care.

³⁷ *Toussaint v Canada (Attorney General)*, 2010 FC 810, 323 D.L.R. (4th) 338. (Memorandum of Argument at para. 27.)

³⁸ Jackman, *supra* note 33, at page 28.

³⁹ *Chaoulli* *supra* note 29, at para 163.

⁴⁰ Bruce Porter, "A Right to Health Care in Canada: Only If You Can Pay for It" (2005) 6 ESR Review: Economic and Social Rights in South Africa, 2005. Available at SSRN: <https://ssrn.com/abstract=2483372>

3.3 The continuing impact of *Auton* and *Chaoulli*

The strictly narrowed approach adapted by the Court in *Auton* and *Chaoulli* on the issue of access to health resembled the prevalence of deferential stance taken by the English courts in the pre-*Child B* era, before the government made the substantive leap in incorporating measures for accountability for reasonableness in its health resource rationing decision-making procedure, as discussed previously. Based on the recognition that the scope of service provided primarily falls under the discretion of the government, the impact of *Auton* and *Chaoulli* continued their influence in lower courts' access-to- health decisions several years after. *Auton* created a relatively bigger splash than *Chaoulli* due to its specific relevance to access-to-health claims.⁴¹

3.3.1 *Flora v Ontario Health Insurance Plan*

Flora is a case that came three years after *Auton* and *Chaoulli*. The plaintiff challenged the government's refusal to reimburse the expenditures of a life-saving surgery taken place in England. Mr. Flora was initially infected with hepatitis C virus from a blood transfusion in the 70s and was later diagnosed with an aggressive form of liver cancer that had a predicted survival of six to eight months, as he was not suitable to receive a liver transplant in Ontario. Mr. Flora subsequently received treatments in England. The decision to deny the request of reimbursement was later upheld by the Health Services Appeal and Review Board, Ontario Divisional Court, and Ontario Court of Appeal, as the courts repeatedly affirmed the notion that section 7 of the Charter does not impose any positive obligation on the government to provide health services.⁴² Mr. Flora was indeed able to, and did, purchase health services from abroad, free of any restrictions imposed by the Ontario government. In essence, the Court of

⁴¹ Cousins, Mel. "Health care and human rights after *Auton* and *Chaoulli*." (2009) McGill LJ 54 : 717.

⁴² *Flora v Ontario Health Insurance Plan*, 2008 ONCA 538, 91 OR (3d) 412; 295 DLR (4th) 309.

Appeal's decision strictly followed the majority views in *Auton* and *Chaoulli*: the judiciary will not intervene so long as the government does not impose a restriction on receiving health care through private means. In this case, Mr. Flora was fortunate to have sufficient financial resource to spend on the overseas treatment. However, had Mr. Flora not afford the surgery by himself, the outcome would have been fatal.

In the case at bar, the court failed to act as a guardian for the right-seekers and address the fundamental issue of whether the decision-making process was based on reasonableness. Such failure would undoubtedly have a more pronounced impact on the low-income right-seekers who do not have the financial means to afford such medical treatment like Mr. Flora did.

3.3.2 *Hogan v Ontario (Health and Long-Term Care)*

The Human Rights Tribunal of Ontario in *Hogan* dealt with a discrimination challenge against the Ontario government for defunding sex reassignment surgeries in 1998.⁴³ The majority gave the government the benefit of doubt by recognizing its legitimate jurisdiction in making rationing decisions. The Tribunal also recognized the pressing and substantive need in cutting sex reassignment surgery funding, amongst other medical services, in order to maintain the sustainability of the Ontario health system.⁴⁴ The majority decision resonated with the reasoning found in *Auton* and *Chaoulli*. The Human Rights Tribunal decided to adopt a deferential stance to the government's discretion in deciding the allocation of scarce health resources, without examining the reasonableness in the procedure that the government had taken to make such decision.

Interestingly, the facts presented in the case at bar along with the dissenting opinion of

⁴³ *Hogan v Ontario (Health and Long-Term Care)*, 2006, HRTO 32, 58 C.H.R.R. D/317.

⁴⁴ *Ibid*, at paras 103-105.

the Tribunal highly resembled that of the majority decision discussed in the English case of *A and others*, as mentioned previously in this paper. The dissent assessed the decision-making process and found no evidence to indicate that delisting sex reassignment surgery was made based on “social, political or economic factors as normally befits Cabinet decisions.”⁴⁵ Unfortunately, such reasoning was only found in the dissent.

The overly deferential stance taken by the Supreme Court had a lasting impact on the lower court decisions. Most Canadian courts displayed significant restraint on the topic of judicial activism. Since so few of the section 7 and section 15 decisions had required demonstration of procedural fairness, the provincial governments have rarely been probed by the courts regarding the process in which difficult and sometimes tragic rationing decisions were made.⁴⁶ As shown in the discussion on the English case laws, a judicial review on procedural fairness and inquiries on reasonableness of government’s decision-making process would contribute to advancing the health rationing system towards a fairer and more just state.

4 The Canadian health system needs the court to demand demonstration of procedural reasonableness

The bigger danger of such deferential approach taken by the Supreme Court, as seen in the two high profile cases *Auton* and *Chaoulli*, is the potential of sending an unintended signal to the government suggesting that the court will not intervene in health resource allocation decisions as long as such decisions are budgetary allotment by nature. This can be problematic as the current form of our health system has been criticized for being the product of “an accumulation of historical decisions (and non-decisions) often unlinked by any discernible

⁴⁵ *Ibid*, at paras 382-383.

⁴⁶ Jackman, *supra* note 33 at page 20.

guiding rationale.”^{47 48}

4.1 The need of improvement: accountability in the rationing of funding for physician service in Ontario

In Canada, the legal definition of the term “medically necessary” determines which services are funded by the government. This very term also carries a great deal of weight in the eyes of the courts, as they have chosen an overly deferential stance to the governments and their decisions on choosing what is and is not “medically necessary.” Unfortunately, it has been suggested that the definition of “medically necessary” was not made based on factual evidence. In a three-year research program funded by the Canadian Health Services Research Foundation, Professor Flood and colleagues studied the rationing of medical services and how rationing decisions were made in Canada. Regarding how rationing decisions were made for the funding of physician services in Ontario, Professor Flood’s study found the following:

“... the Byzantine process for determining what physician services are publicly funded in the province of Ontario reveals decisions are a result of negotiations between the provincial government and the medical association which acts as the bargaining agent for physicians in Ontario. The negotiations are over the level of tariffs for each medical service. Thus the schedule of tariffs becomes the list of services that are publicly funded and defined as ‘medically necessary.’ So the concept of ‘medical necessity’ does not drive the determination of what is or is not publicly funded. Rather it is a label that is applied *ex post* labor negotiations.”^{49 50}

Professor Flood’s findings were published in the mid-2000s and may not be reflective of today’s health system *status quo*. In my research, no additional literature was found to

⁴⁷ Bakht *supra* note 30, at page 256.

⁴⁸ Donna Greschner & Steven Lewis, "Auton and Evidence-Based Decision- Making: Medicare in the Courts" (2003) 82 Can Bar Rev at page 531.

⁴⁹ Colleen Flood. "Just Medicare: the role of Canadian courts in determining health care rights and access." The Journal of Law, Medicine & Ethics 33.4 (2005): 669-680.

⁵⁰ Colleen Flood, Joanna Erdman. "The Boundaries of Medicare: Tensions in the Dual Role of Ontario's Physician Services Review Committee." Health LJ 12 (2004): 1.

answer the question of whether any changes had been introduced to the negotiation process for physician services funding decisions. However, a search of recent reports from provincial Auditor Generals indicated that there is a huge room for improvement in terms of accountability to reasonableness in the Canadian health system's resource rationing process.

4.2 Ontario Auditor General Report, 2016: the Government needs to improve its assessment of the cost-effectiveness of physician service fee budget

In the recent *Annual Report* from the Ontario Auditor General, the Ontario Ministry of Health and Long-Term Care's spending on physician billing was audited. In the 2015/16 fiscal year, Ontario spent \$11.59 billion on physician services, which increased by 20% from the 2009/10 fiscal year. Ontario physicians are amongst the highest paid in the country. With the newly implemented patient-enrolment models, which are found to be more costly than the fee-for-service model, the Ministry has yet to define quality of care necessary for evaluation of the cost-effectiveness analysis.⁵¹

Regarding the health care funding spent on specialist fees, the Ministry had no information to assess the reasonableness for the large variances in fee-for-service payments within the same specialty (i.e. ophthalmologists near the high-end of pay range received on average \$1.27 million each, which is \$710,000 higher than the average payment of \$553, 000 received by ophthalmologists in the mid-range). Regarding the reports of many anomalous physicians billings, the government had not implemented any measures to address or investigate the issue and had minimal success in controlling the billing for excessive testing (i.e. excessive preoperative testing for low risk cardiac procedures). Overall, the *Annual*

⁵¹ Bonnie Lysyk, "Annual Report 2016: Chapter 3 Ministry of Health and Long-Term Care – Physician Billion" (2016) 1: Office of the Auditor General of Ontario, 551- 567

Report found that the government had a lack of control over the cost-effectiveness of its health care budget.⁵²

4.3 British Columbia government's awareness of the cost-effectiveness for money spent on physician service

In 2014, the British Columbia Auditor General published its report on the "Oversight of Physician Service."⁵³ The Auditor General examined the economics of the British Columbia provincial health system and found that the cost of physician services in 2011/12 totaled 9% of the overall provincial budget, amounting to over 3.6 billion dollars. Due to the great burden of physician service cost on British Columbia's limited provincial budget and its sustainability, the Auditor General emphasized the importance of having the government make health budget allotment decisions based on cost-effective analysis in order to achieve optimum level of value for money.⁵⁴

The audit report focused on examining the quality and cost-effectiveness of services provided by the fee-for-service model and Alternative Payment Program, which represented the two largest physician funding sources in British Columbia. The audit concluded that "[overall], Government does not know if physician services are high- quality and offering good value for the money spent. This calls into question Government's ability to make informed decisions regarding physician services."⁵⁵ More specifically, the British Columbia provincial government did not have a comprehensive system for the assessment and management of physician service performance. Also, the government could not demonstrate the cost-effectiveness of the money spent on physician compensation.

⁵² *Ibid*, at page 567.

⁵³ Russ Jones, "*Oversight of Physician Services*", (2014), Office of the Auditor General of British Columbia.

⁵⁴ *Ibid*, at page 5.

⁵⁵ *Ibid*, at page 5.

4.4 Room for improvement to bring more accountability in provincial health funding allotment

Under the *Canada Health Act*, the Federal Government transfers payments to the provincial governments for the provision of universal health care services to residents across Canada.⁵⁶ Ultimately, the provincial governments are at the position of making specific budget allotment decisions (i.e. adding or delisting medical services).⁵⁷ ⁵⁸ Therefore, the accountability for reasonableness in provincial governments health spending decisions is especially important in ensuring fairness and justice in the health rationing decisions. Evidence of how physician services are negotiated and the government's lack of awareness of the cost-effectiveness of its health spending suggest that Canada's health system requires a better mechanism for the decision-making process to incorporate more elements of evidence-based approach and reasonableness. The sustainability of the provincial health budget could make a huge impact on whether certain services are provided to the patients in need. As we have seen in the Human Rights Tribunal decision in *Hogan*, amongst many other court decisions, the sustainability of the provincial health budget can be used as the trump card to deny access-to-health claims. The important question is whether patients should continue to unfairly carry the burden of maintaining the sustainability of the health system, rather than requiring the government to make reasonable budget allotment decisions based on cost-effectiveness analyses.

Evidence provided in this section begs the courts to consider reforming its approach in assessing health-rationing claims. Similar to reform adapted by the English courts in the post-*Child B* era, the Canadians courts should reconsider its current deferential approach,

⁵⁶ *Canada Health Act*, RSC, 1985, cC 6.

⁵⁷ Sujit Choudhry, "The Enforcement of the *Canada Health Act*." McGill LJ 41 (1995): 461.

⁵⁸ Gregory Marchildon, "The three dimensions of universal Medicare in Canada." (2014) Canadian Pub Admin 57.3: 362-382.

and start demanding the state to demonstrate the procedure it has taken to arrive at the conclusion of denying funding for a certain medical service.

5 Discussion

This paper presented a brief overview of the steps taken by the English courts that have assisted the United Kingdom's health policy reform by adjusting the degree and manner of judicial deference to government health rationing decisions. The English courts had found the delicate balance by refraining from making substantive decisions regarding the funding of medical services. The courts demanded the government to demonstrate procedural reasonableness as a part of the judicial review. Such legal reform taken by the English courts had contributed to incentivizing the government to adapt a system that makes health resource rationing decisions based on an explicitly reasonable principle. The lesson provided by analyzing the dialogue between the English courts and their government counterpart offers a potential glimpse into how the fairness of the Canadian health resource rationing system could be improved.

5.1 Putting things into Canadian perspective

In Canada, the judicial branch of the government serves the important role of overseeing the executive government's decision that may infringe Charter-guaranteed rights.⁵⁹ In the context of health care rationing, governments are in the position of considering the medical needs of every person living under their jurisdiction. Generally, the judiciary should respect the governments' experience and expertise in making its scarce resource allocation decisions. However, governments are susceptible to the complicated interests of politics and can

⁵⁹ Dodek et al., *"Public Law Public Law: Cases, Commentary, and Analysis."* 3rd Edition. Emond Publishing, at page 15.

sometimes be influenced to shift away its focus from the common good.⁶⁰ Especially in the context of health care, where government decisions can have grave impacts on the lives of affected individuals, courts should hold governments accountable to a high standard of reasonableness. Unlike the elected legislature or the executive branch of the government, the only mandate in the judicial system is justice itself. As said by Abella J in her keynote speech to the 1999 Constitutional Cases Conference, “[Courts] accountable less to the public's opinions and more to the public interest.”⁶¹ Through the means of impartiality and justification based on reasons, Canadian courts can certainly require governments to demonstrate accountability for reasonableness in their health rationing decisions.

In different levels of the Canadian justice system, from Human Rights Tribunal to the Court of Appeal and the Supreme Court of Canada, the deferential approach adapted in *Hogan, Flora, Auton and Chaoulli* represent the current prevalent trend of the judiciary. Such approach is not helpful to promoting accountability in the health system as the government executives and decision makers are not required to be held accountable for demonstrating reasonableness in their decision-making process.

5.2 Respecting the boundary of separation of power does not necessarily equate to allowing the government to act unreasonably

This paper does not seek to undermine the rationale for courts to execute judicial reviews regarding health-rationing decisions with great caution. The reality in the Brazilian health system is a great lesson for courts everywhere else to refrain from adapting such an overly strong judicial interventionist approach. Courts should not overstep their boundaries and

⁶⁰ Bakht *supra* note 33, at page 254.

⁶¹ Rosalie Abella, *the Judicial Role in a Democratic State*. Keynote Address Osgoode Hall Law School York University April 7, 2000. 1999 Constitutional Cases Conference. Accessed from < <http://www.ontariocourts.ca/coa/en/ps/speeches/judicialrole.htm> >.

assume themselves in the role of policy-makers. However, this does not mean letting the government run with its money without supervision. As Deschamps J had expressed in *Chaoulli*, “[deference] cannot lead the judicial branch to abdicate its role in favour of the legislative branch or the executive branch.”⁶² The court is the right forum for complicated political debates when the fundamental rights and interests are at stake.⁶³

This paper discussed the evidence indicative of the Canadian health systems’ need to improve accountability for reasonableness (e.g. the way physician services were negotiated in Ontario and the lack of cost-effective analysis for the money spent by the provincial government). With the data indicating the unsustainable nature of the provincial health care budgets,⁶⁴ Canada needs a more effective and fairer system to make those difficult but necessary health resource rationing decisions.

As seen from the evolution of case law in the U.K. from pre-*Child B* to post-*Child B* era, Canadian courts could play a pivotal role in promoting the provincial governments to reform their health rationing policy. This does not mean that such proposed judicial activism is sufficient to produce the desired effect. The proposed reform in judicial oversight of executive action could certainly provide a kick-start to promote the government moving to the right direction. As Canadian courts begin probing the governments on the reasoning process that have lead them to arrive at their final conclusion on denying a certain treatment, the government decision-makers would have more incentives to develop a health resource rationing system with improved accountability for reasonableness, which are essential in establishing a fairer and more just health care system.

⁶² *Chaoulli supra* note 29, at para 87.

⁶³ *Chaoulli supra* note 29, at para 87-89.

⁶⁴ Barua *supra* note 1, at page ii.