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DOUGLAS V INDEPENDENT LIVING CENTER: LITIGATING ACCESS TO PUBLICLY FUNDED HEALTH SERVICES IN THE UNITED STATES AND CANADA

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As health care costs grow, policy-makers face difficult trade-offs between competing demands in order to ensure health system sustainability. Government decisions limiting access to publicly funded health services have prompted a growing number of aggrieved citizens to turn to courts for redress. A recent case before the US Supreme Court asked whether Medicaid beneficiaries have a justiciable right to challenge state budget cuts impeding their access to health services. According to the claimants, cuts to provider reimbursement rates contravened federal conditions on Medicaid funding. Despite the different legal regimes and political structures in Canada and the US, legal claims relating to the accessibility of health services raise similar policy issues. In this paper, I discuss the tension between the judicial competence to adjudicate matters of complex social policy and the need for beneficiaries, who have little choice but to rely on the public system, to have mechanisms to hold governments accountable for their health policy decisions. I conclude that although judges should be reluctant to completely bar beneficiaries from seeking redress before the courts, they should show considerable deference to governmental policy choices in adjudicating the merits of these cases.

Alors que le coût des soins de santé augmente, le gouvernement se doit de faire des compromis entre plusieurs demandes concurrentes afin de maintenir la viabilité du système de santé. Les décisions gouvernementales visant à limiter l'accès au service de santé publique ont provoqué le mécontentement chez un nombre croissant de citoyens, qui se tournent maintenant vers le système judiciaire pour demander des réparations. Un cas récent demanda à la Cour suprême des États-Unis de se prononcer sur la possibilité des ayants droit de l'assurance médicale de contester les réductions budgétaires étatiques responsables compromettant leur accès au système de santé. Les plaignants soutiennent que ces réductions vont à l'encontre des préalables fédéraux du financement des soins de santé. Malgré les différences qui existent entre les juridictions et les institutions américaines et canadiennes, les demandes concernant l'accès aux soins de santé soulèvent des enjeux similaires. Dans cet article, j'examinerai les tensions entre la compétence judiciaire de statuer sur des sujets de politique sociale complexes et le besoin des bénéficiaires du système de santé, qui n'ont d'autre choix que de fier au système public, d'avoir droit à des mécanismes afin de rendre les gouvernements responsables de leurs decisions reli-

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ées à la santé. Je conclus que même si les juges se doivent d'être réticents avant d'exclure toute possibilité pour les bénéficiaires de soins d'aller chercher compensation devant les tribunaux, ils devraient démontrer une déférence considérable faces aux décisions gouvernementales lorsqu'il temps de trancher de tels cas.

Introduction

Given the proliferation of costly pharmaceuticals, sophisticated diagnostic technologies, and the aging population, policy-makers around the world are increasingly faced with difficult trade-offs between competing demands in order to ensure health system sustainability. Government decisions negatively affecting access to publicly funded health services have prompted a growing number of aggrieved citizens to turn to courts for redress. In this paper, I compare the responses of American and Canadian courts to legal claims challenging policies limiting access to health services in the context of public insurance programs.

A recent case before the US Supreme Court called upon the justices to determine whether Medicaid beneficiaries have a justiciable right to challenge state budget cuts impeding their access to health services. According to the claimants, cuts to provider reimbursement rates contravened federal conditions on Medicaid funding. When faced with similar questions, Canadian courts have determined that litigants cannot bring claims alleging a province breached the requirements of Canada's corresponding federal funding legislation, the *Canada Health Act*.[1] I argue that the denial of a private right of action is less problematic in Canada, due to the greater efficacy of political pressure in the context of a universal health insurance program and to the ability of plaintiffs to indirectly challenge government policies limiting access to publicly funded health services through other legal mechanisms, most notably the *Canadian Charter of Rights and Freedoms* and administrative law.

Despite the different legal regimes and political structures in Canada and the US, legal claims relating to the accessibility of health services raise similar policy issues. In what follows, I discuss the tension between the judicial competence to adjudicate matters of complex social policy and the need for beneficiaries, who have little choice but to rely on the public system, to have mechanisms to hold governments accountable for their health policy decisions. I conclude that although judges should be reluctant to completely bar beneficiaries from seeking redress before the courts, they should show considerable deference to governmental policy choices in adjudicating the merits of these cases.

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[1] RSC 1985, c C-6.

I. The US Legal Claim

The Medicaid program, which has 60 million low income beneficiaries,[2] fills a coverage gap left by the market-based system of health insurance allocation. Cost pressures are particularly acute within a countercyclical, income-tested program such as Medicaid, in which an economic downturn leaves governments with both a reduced tax base and an increased number of eligible beneficiaries. In 2008, the California government sought to address the state's "fiscal crisis" by cutting Medicaid provider reimbursement rates by 10%. Beneficiaries and providers responded by filing a legal claim alleging these rate cuts violated the federal equal access requirement.[3] According to this provision, in order to qualify for federal funding, a state Medicaid plan must "assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."[4] In other words, states must ensure provider reimbursement rates are sufficiently high that Medicaid beneficiaries have access to services that is comparable with other individuals (i.e., those insured under private plans and Medicare).

If a state wishes to amend its Medicaid plan, including provider reimbursement rates, it must seek the approval of the federal Department of Health and Human Services ("HHS"). Although HHS had not approved California's 2008 rate cuts, the state nevertheless proceeded with their implementation. In *Douglas v Independent Living Center*, the Ninth Circuit Court granted an injunction enjoining California from continuing with the rate cuts

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[2] Kaiser Commission on Medicaid and the Uninsured, "The Medicaid Program at a Glance", online: The Henry J Kaiser Family Foundation <www.kff.org/medicaid/upload/7235-05.pdf> at 1-3. Federal rules specify that to qualify for Medicaid, an individual must fall below a certain income level and be a member of an eligible group: children, pregnant women, adults with dependent children, people with disabilities, and senior citizens. Many states have expanded these criteria to cover additional beneficiaries. Medicaid covers a variety of services, including hospital services, physician services, laboratory services, and nursing home and home care services. In 2010, Medicaid spending was approximately $390 billion, with the federal government paying approximately 57% of those costs.

[3] See e.g. *Douglas v Independent Living Center*, 572 F 3d 644 (9th Cir 2009) [*Douglas* 2009]; *Independent Living Center of South California v Maxwell-Jolly*, 572 F 3d 644 (2009).

[4] 42 USC § 1396a(a)(30)(A).

pending the resolution of the litigation.[5] Last term, the US Supreme Court heard the California government's appeal from the Ninth Circuit decision.[6] This case was overshadowed by the attention garnered by another health care case heard during the same term, the constitutional challenge to the *Patient Protection and Affordable Care Act*.[7] However, *Douglas* called upon the Supreme Court to resolve the important issue of whether Medicaid beneficiaries and providers have a right to challenge state Medicaid policies and, more broadly, the scope of the Constitution's Supremacy Clause.

Historically, litigants have challenged state breaches of the equal access provision under § 1983 of the *Civil Rights Act*, which allows individuals to sue the government for deprivations of statutory rights. However, in 2002, in *Gonzaga University v Doe*,[8] the US Supreme Court narrowed the scope of this provision, finding that a plaintiff must first demonstrate congressional intent to create a legally enforceable right in order to succeed with a § 1983 claim. Most circuit courts have subsequently interpreted *Gonzaga* as precluding private enforcement of the equal access provision through § 1983, since nothing in the legislation suggests that Congress intended to create a privately enforceable right.[9]

Accordingly, the plaintiffs in *Douglas* pursued an alternative legal theory, arguing that because California's rate cuts were inconsistent with the federal equal access provision, they violated the Constitution's Supremacy Clause, which provides for the supremacy of federal laws over state laws.[10] The Supreme Court thus had to determine whether the Supremacy Clause provided an implied right of action to challenge state legislation, or whether the plaintiffs first had to prove the applicable legislation created a privately enforceable right. California argued that if the Court adopted the latter approach, the post-*Gonzaga* § 1983 jurisprudence dictated the claim should fail, due to the absence of congressional intent to create a cause of action in

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[5] *Supra* note 3.

[6] *Douglas v Independent Living Center of Southern California*, 132 US 1204 (2012) [*Douglas* 2012].

[7] *National Federation of Independent Business v Sebelius*, 132 US 2566 (2012) [*Sebelius*].

[8] 536 US 273 (2002) [*Gonzaga*].

[9] Nicole Huberfeld, "Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements" (2008) 42 UC Davis L Rev 413 at 426-57.

[10] *Douglas* 2009, *supra* note 3 at 649.

Medicaid legislation.[11] Following the Supreme Court's 1908 decision *Ex parte Young*,[12] numerous courts had assumed a freestanding right to invoke the Supremacy Clause to pre-empt state laws (independent of whether the relevant statute contained a private right of action), but California sought to challenge this assumption and to draw a distinction in the context of Congress' use of the Constitution's Spending Clause.[13]

Following oral arguments at the Supreme Court, but before the justices released their opinion, HHS retroactively approved several of the California plan's amendments and the state withdrew the remainder of the proposed changes.[14] The Court was then faced with the question of whether a Supremacy Clause claim could be maintained, given that the federal government had, in effect, affirmed that California's rate cuts did not violate federal law. Because this changed the circumstances of the plaintiffs' claim, the Supreme Court remanded the case to the Ninth Circuit, and the issue of whether beneficiaries can challenge state rate cuts under the Supremacy Clause remains unresolved. A judge may now conclude this case is more appropriately resolved through judicial review of the HHS decision to approve the plan amendments under the *Administrative Procedures Act*. Under this statute, courts would be required to give considerable deference to the agency's decision, with the applicable standard of review being whether the decision was "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law."[15]

This issue is likely to reach the courts again, because budgetary concerns within state Medicaid plans will become increasingly acute over the next few years. In 2014, the *Patient Protection and Affordable Care Act*[16] will expand Medicaid eligibility to 133% of the poverty level.[17] While federal funds will

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[11] *Douglas* 2012, *supra* note 6 (Brief for the Petitioners, online: American Bar Association <www.americanbar.org/content/dam/aba/publishing/previewbriefs/Other_Brief_Updates/09-958_petitioner_douglas.authcheckdam.pdf> at 15-16) [*Douglas* Brief].

[12] 209 US 123 (1908).

[13] *Supra* note 11 at 18.

[14] See *Douglas* 2012, *supra* note 6 at 1206.

[15] 5 USC § 706(2)(a).

[16] Pub L No 111-148, 24 Stat 119 (2010).

[17] Benjamin D Sommers & Arnold M Epstein, "Why States Are So Miffed about Medicaid: Economics, Politics, and the 'Woodwork Effect'" (2011) 365 New Eng J Med 100 at 100. As with the Canadian Constitution, the Tenth Amendment

initially cover the entire cost of newly eligible individuals, this contribution will decrease over time for new beneficiaries.[18] Furthermore, states will only receive the traditional federal contribution (50–75%) for individuals who were eligible for Medicaid prior to the program's expansion.[19] In addition to the 16 million newly enrolled beneficiaries that have been projected,[20] more than nine million previously eligible individuals may now enroll in Medicaid due to new federally-mandated simplified application procedures, publicity respecting eligibility criteria, and the individual mandate to obtain health insurance.[21]

II. The Canadian Legal Claims

Similar to American Medicaid, Canadian Medicare is a co-operative federalism program, whereby provincial health insurance plans must meet certain conditions, including accessibility, in order to qualify for federal funding.[22] According to the *Canada Health Act*, a province's plan must satisfy four criteria in order to meet the accessibility requirement:

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permits the US federal government to impose conditions on federal funding. In *Sebelius*, *supra* note 7, a majority of the Supreme Court accepted the states' argument that it was coercive to make all federal Medicaid funding conditional on the expansion of eligibility, as the states had little choice but to accept the expansion, given that Medicaid is their largest source of federal funding (at 2604-05).

[18] Sommers & Epstein, *ibid* at 100.

[19] *Ibid*.

[20] Congressional Budget Office, *Reconciliation Act of 2010 (Final Health Care Legislation)* (HR Doc No 4872) (Washington, DC: US Congress, 20 March 2010) at 9 and Table 4. These figures assume states do not opt out of the Medicaid expansion, as permitted by the Supreme Court's recent finding in *Douglas*, *supra* note 6 at 2608.

[21] Sommers & Epstein, *supra* note 17 at 100-01. A majority of the US Supreme Court recently upheld the constitutionality of the individual mandate when faced with the question of whether it was a valid exercise of Congress' taxing power or of the Commerce Clause and Necessary and Proper Clause in *Sebelius*, *supra* note 7 at 2608.

[22] *Canada Health Act*, *supra* note 1, s 7. Similarly, the scope and legitimacy of the federal spending power has been a source of controversy and debate in both jurisdictions. See e.g. Andrew Petter, "The Myth of the Federal Spending Power Revisited" (2008-09) 34 Queen's LJ 163; Jeffrey T Renz, "What Spending Clause? (Or The President's Paramour): An Examination of the Views of

> (a) provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude … reasonable access to those services;
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> (b) provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province;
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> (c) provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists; and
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> (d) payment of amounts to hospitals … in respect of the cost of insured health services.[23]

In practice, provincial governments generally determine which physician and hospital services are insured, and the reimbursement rates for those services, through negotiations with provincial medical associations.

As Flood and Choudhry argue, "[f]or most Canadians, the [*Canada Health Act*] has become a document of near constitutional status, emblematic of Canadian values and a guarantee for all Canadians of the security of health insurance."[24] However, despite the public's perception of the *Act*, the courts have repeatedly held that it is merely a funding statute that does not confer privately enforceable rights. For example, in *Cameron v Nova Scotia (AG)*, the Nova Scotia Court of Appeal held that if provincial legislation "fails to meet the standards or objectives of the Canada Health Act, it does not follow that the appellants would be entitled to relief."[25] The Court went on to state that while "[f]ailure of a province to comply with the Canada Health Act

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Hamilton, Madison, and Story on Article I, Section 8, Clause I of the United States Constitution" (1999) 33:1 J Marshall L Rev 81.

[23] *Supra* note 1, s 12.

[24] Colleen M Flood & Sujit Choudhry, "Strengthening the Foundations: Modernizing the Canada Health Act" in Tom McIntosh, Pierre-Gerlier Forest & Gregory P Marchildon, eds, *The Governance of Health Care in Canada*: *The Romanow Papers*, vol 3 (Toronto: University of Toronto Press, 2004) 346 at 346. The authors also argue that "to view the CHA as simply a dry and dusty spending statute, whereby the federal government transfers funds to provinces that comply with certain conditions, belies the importance of the CHA in the hearts and minds of Canadians" (at 346).

[25] (1999), 204 NSR (2d) 1 at para 97, 177 DLR (4th) 611 (NSCA).

may result in the Government of Canada imposing a financial penalty on the province … [this is] a political, not a justiciable issue."[26]

III. The Policy Issues

In both Canada and the US, legal challenges to health service accessibility raise several significant policy issues. In the first part of this section, I discuss the importance of an available mechanism through which beneficiaries can hold state or provincial governments accountable for their health policy decisions. In particular, I address three accountability mechanisms: federal enforcement, political pressure, and recourse to the courts. In the second part of this section, I argue that legal accountability must be balanced against a countervailing policy concern—the judiciary's institutional competence to adjudicate matters of complex social policy. I conclude that while judges should be reluctant to completely foreclose a private right to challenge government decisions, they should show considerable deference to the state's policy choices in adjudicating the merits of these claims.

A. The Importance of Accountability

Recipients of both Canadian Medicare and US Medicaid have little choice but to rely on their respective governments to provide reasonable access to health services. In the US, this reliance is a function of the inability of beneficiaries to afford private health insurance or to pay for care out-of-pocket. In Canada, reliance is government-mandated, as provinces have implemented a variety of prohibitions and disincentives to prevent or limit the privatization of health care services and the development of duplicate private insurance,[27] thereby creating a state monopoly over most hospital and physician services. Because of these regulations, generally only those individuals who are wealthy enough to travel outside of Canada and pay for health ser-

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[26] *Ibid* at para 97. See also *Brown v British Columbia (AG)* (1997), 41 BCLR (3d) 265, 73 ACWS (3d) 163 (BCSC); *Lexogest Inc v Manitoba (AG)* (1993), 101 DLR (4th) 523, 85 Man R (2d) 8 (Man CA); *Canadian Union of Public Employees v Canada (Minister of Health)*, 2004 FC 1334 at para 44, 244 DLR (4th) 175.

[27] For a discussion of these legislative provisions, see Colleen M Flood & Tom Archibald, "The Illegality of Private Health Care in Canada" (2001) 164:6 Can Med Assoc J 825. Duplicate private insurance covers services already insured within the public plan. This can be contrasted with supplementary private insurance, which covers services not included in the public plan (such as dental or optometry services or pharmaceuticals received outside of hospitals).

vices entirely out-of-pocket have an alternative to the public system. This reliance on government necessitates there be mechanisms in place by which the state can be held accountable when the public program fails to provide a reasonable standard of care.

The intergovernmental nature of both countries' public health insurance programs has the potential to facilitate accountability, with the central government acting as a check on state or provincial policies. Indeed, in *Douglas*, the California government argued that the appropriate remedy for breaches of the equal access requirement was federal enforcement rather than litigation by private parties.[28] But despite this position, and although HHS arguably has greater institutional competence than the judiciary to assess the adequacy of health service accessibility, California disregarded the requisite federal approval process in implementing its rate cuts, a fact attracting the criticism of Justice Kagan during oral arguments before the Supreme Court. Specifically, she (somewhat rhetorically) asked the Attorney General of California whether the state "end-ran the administrative process" by implementing the regulations and new rates "before [it] submitted them to HHS, and continued them in effect while HHS was considering them, and [then] continued them in effect to the extent that [it was] allowed to do so by the injunction, even after HHS disapproved them."[29]

In this case, California was clearly far more responsive to judicial sanctions than to the threat of federal enforcement. It is uncertain whether there would have been any meaningful HHS review of California's rate cuts in the absence of an available legal mechanism for beneficiaries to compel such a review, particularly given the federal government's history of lax enforcement against state governments. Instead, HHS has preferred to concentrate its enforcement efforts on the compliance of providers with fraud and abuse laws.[30] Furthermore, even if the federal government had taken enforcement action against California by withholding funds for the state's failure to comply with Medicaid's legislative requirements, this blunt remedy could have further impeded beneficiary access to health services by shrinking an already strained state Medicaid budget. During oral arguments in *Douglas*, Justice

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[28] *Douglas* Brief, *supra* note 11 at 16.

[29] *Douglas v Independent Living Center* (3 Oct 2011), Washington 09-958 (USSC), online: USSC <www.supremecourt.gov/oral_arguments/argument_transcripts/09-958.pdf> at 6 [*Douglas* Oral Argument Transcript].

[30] Abigail R Moncreiff, "The Supreme Court's Assault on Litigation: Why (and How) It Might Be Good for Health Law" (2010) 90 BUL Rev 2323 at 2341.

Ginsburg referred to this as a "very drastic remedy … [that would] hurt the people that Medicaid was meant to benefit."[31]

Until recently, HHS had failed to provide standards or methods for measuring equal access. Nor had it implemented clear state reporting requirements, set out a plan to improve accessibility, or amassed evidence respecting the effect of state policies on beneficiary access to health services.[32] Federal enforcement of the equal access provision would have been difficult, given the unclear definition of equal access and the absence of methods for measuring access to health services. Although HHS has recently drafted a rule addressing accessibility, Rosenbaum characterizes it as "a model of inaction" that is primarily "an information-gathering exercise."[33] State governments must now submit one year of access data if provider rate cuts "could result in access issues," but a state could unilaterally determine its rate reductions would not raise access issues and therefore not submit this data to HHS.[34] This could actually result in less federal scrutiny than the previous status quo, as the federal government may now only examine the rate cuts state governments bring to its attention.

Like its American counterpart, Health Canada can withhold funding for non-compliance with the *Canada Health Act*. It too has been criticized for its

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[31] *Douglas* Oral Argument Transcript, *supra* note 29 at 5. Although beyond the scope of this paper, a case heard by the US Supreme Court on 8 January 2013 may address the ability of the federal government to enforce conditions on states in the context of spending legislation. In *Delia v EMA*, 133 S Ct 99, 184 L Ed 2d 646, a case challenging North Carolina's lien on tort recoveries for the purposes of recovering Medicaid expenditures, Texas and 10 other states filed an amicus brief arguing that even if state law is inconsistent with the federal legislation governing Medicaid, *supra* note 4, the law is not pre-empted. Although the *Act* gives the Secretary of Health and Human Services discretion to withhold only a portion of federal reimbursement from a non-compliant state, Texas argued that a state may, without violating any federal law, merely accept the reduced funding while continuing to participate in the Medicaid program. *Delia v EMA*, Brief for Texas, Alabama, Georgia, Hawaii, Idaho, Indiana, Michigan, Nebraska, New Mexico, Ohio and South Carolina in Support of Petitioner, online: American Bar Association <www.americanbar.org/content/dam/aba/publications/supreme_court_preview/briefs/12-98_pet_amcu_texas-alabama-etal.authcheckdam.pdf>.

[32] Sara Rosenbaum, "Medicaid and Access to Health Care – A Proposal for Continued Inaction?" (2011) 365 New Eng J Med 102 at 103.

[33] *Ibid*.

[34] *Ibid*.

similarly permissive approach to provincial breaches of the *Act* and its lack of meaningful guidance with regard to federal funding conditions. For example, Choudhry characterizes "the federal government's non-enforcement of the *CHA* … [and] the failure of political actors and the academic community to highlight the federal government's abdication of its responsibilities … [as] a national embarrassment."[35] However, unlike in the US system, where there may be more opportunity for the federal government to act as an accountability mechanism to review state health policies, the Canadian federal government's cash contribution to provincial health budgets may be insufficient to incentivize compliance with conditions of the *Act*, even if Health Canada were to amplify its enforcement efforts. While Medicare was initially predicated on a federal/provincial cost-sharing arrangement, the federal government subsequently shifted to a combination of smaller transfer payments and tax points.[36] This leaves provinces to make up the budgetary shortfall in an extremely expensive program that is so popular among the public that it would likely be politically infeasible to limit or abandon it. As Roy Romanow, the former premier of Saskatchewan and head of a major federal commission on Medicare argues, "the relative size of the federal transfer compared to the provincial cost of delivering health services has become a dominant and disruptive theme of contemporary intergovernmental relations in Canada."[37]

Although both the Canadian and American federal governments do little to enhance the accountability of provinces or states for their health programs, beneficiaries themselves may exert political pressure to catalyze health policy change. However, Medicaid's low reimbursement rates and other access

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[35] Sujit Choudhry, "Bill 11, the Canada Health Act and the Social Union: The Need for Institutions" (2000) 38 Osgoode Hall LJ 39 at 57.

[36] For a discussion of the federal government's shifting financial commitment to Medicare, see Steven Lewis et al, "The Future of Health Care in Canada" (2001) 323 Brit Med J 926 at 926. The authors note that by 1995, through some negotiated and some unilateral changes, the federal government's 50% contribution was reduced to 16% (according to the provinces) or 32% including tax points (according to the federal government). The transfer payment portion of the federal contribution was grouped together with other social programs (post-secondary education and welfare) in the Canadian Health and Social Transfer, but these programs have since been disaggregated into the Canada Health Transfer and the Canada Social Transfer.

[37] Commission on the Future of Health Care in Canada, *Building on Values: The Future of Healthcare in Canada – Final Report*, by Roy J Romanow (Ottawa: CFHCC, 2002) at 5.

barriers suggest vulnerable beneficiaries lack the political power to motivate state governments to maintain robust Medicaid programs. For example, American physicians argue that they are deterred from accepting Medicaid patients by the fact that both Medicare and private insurance reimbursement rates are higher,[38] and providers frequently report losing money when treating Medicaid recipients.[39] In one widely-reported case that attracted the media's attention, a twelve-year-old Medicaid beneficiary who was unable to access dental care died of brain sepsis after infection spread from an abscessed tooth. Although the tooth extraction would have cost only US$80, the efforts to treat his infection (including two surgeries and over six weeks of hospitalization) were estimated at over US$250,000. At the time, only 900 of the state's 5,500 dentists accepted Medicaid patients, and it took months, and dozens of phone calls, to find a dentist who would accept a Medicaid patient.[40] Financial deterrents to treating Medicaid beneficiaries are extremely concerning, as they may exacerbate existing health disparities linked to income. California's across-the-board budgetary cuts were particularly problematic, as they affected all health services equally, with no regard to the cost or efficacy of particular services, nor to especially acute access concerns for certain types of services or within certain segments of the population.

Although Canadian courts have not permitted individuals to privately enforce the provisions of the *Canada Health Act* against the provinces, this may present less of an accountability concern in the Canadian context, due to the comparative potential for beneficiaries to exert political pressure. In contrast to the US, the universal nature of Canada's health care system means that those with low incomes are not relegated to a separate health insurance plan that politicians consequently have little incentive to adequately resource.[41] It remains to be seen whether expanding Medicaid to cover an addi-

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[38] Stephen Zuckerman, Aimee F Williams & Karen E Stockley, "Trends in Medicaid Physician Fees, 2003–2008" (2009) 28:3 Health Affairs 510. See also Sandra L Decker, "In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help" (2012) 31:8 Health Affairs 1673.

[39] Mark A Rothstein, "Who Will Treat Medicaid and Uninsured Patients? Retired Providers Can Help" (2011) 39:1 JL Med & Ethics 91 at 92.

[40] Mary Otto, "For Want of a Dentist", *The Washington Post* (28 February 2007), online: Washington Post – The Breaking News Blog <www.washingtonpost.com/wp-dyn/content/article/2007/02/27/AR2007022702116.html>.

[41] Aboriginal health is a notable exception. Due to shared provincial/federal jurisdiction, aboriginal people, in some ways, are relegated to their own health program and have thus far lacked the political capital to compel governments to

tional 25 million individuals[42] will improve the political clout of beneficiaries, thereby narrowing the gap between their access to health services and that of privately insured individuals and US Medicare recipients. If the expansion does indeed enhance the political power of beneficiaries, this may provide support for Canadian critics of increased privatization who have suggested that a two-tier health care system could erode popular support for a robust public health care system.[43]

In addition to the deficient federal enforcement efforts and limited political accountability afflicting Medicaid, there are few legal mechanisms available for reviewing policies affecting the accessibility of health services. Although beneficiaries may have recourse to judicial review when HHS approves or denies a state's proposed Medicaid plan amendments, *Douglas* illustrates that states may fail to submit amendments for approval altogether or disregard the federal government's disapproval of proposed amendments. By contrast, although Canadian litigants have been unable to invoke the provisions of the *Canada Health Act* to challenge provincial health policies, they have successfully advanced grievances relating to health service accessibility through other legal arguments. For example, claimants have alleged that the government's failure to fund particular health services constituted discrimination in contravention of section 15 of the *Charter*[44] and provincial human rights legislation.[45] Plaintiffs have also invoked section 7 of the *Charter*, arguing that government restrictions on the availability of private insurance, coupled with long wait times, violate the right to life, liberty, and security of the person.[46] Other individuals have brought claims alleging that long wait

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provide adequate health services. For a summary of the laws and policies affecting aboriginal health in Canada, see Constance MacIntosh, "Indigenous Peoples and Health Law and Policy: Responsibilities and Obligations" in Jocelyn Downie, Timothy Caulfield & Colleen M Flood, eds, *Canadian Health Law and Policy*, 4th ed (Markham, Ont: LexisNexis, 2011) 575.

[42] *Supra* notes 20 and 21.

[43] See e.g. Carolyn Tuohy, Mark Stabile & Colleen M Flood, "How Does Private Finance Affect Public Health Care Systems? Marshaling the Evidence from OECD Countries" (2004) 29:3 J Health Pol 359 at 387-90.

[44] See e.g. *Eldridge v British Columbia (AG)*, [1997] 3 SCR 624, 151 DLR (4th) 577 [*Eldridge*]. But see *Auton (Guardian* ad litem *of) v British Columbia (AG)*, 2004 SCC 78, [2004] 3 SCR 657.

[45] See e.g. *Hogan v Ontario (Minister of Health and Long-Term Care)*, 2006 HRTO 32, [2006] OHRTD no 34 (QL). But see *Armstrong v British Columbia (Ministry of Health)*, 2010 BCCA 56, 2 BCLR (5th) 290.

[46] *Chaoulli v Quebec (AG)*, 2005 SCC 35, [2005] 1 SCR 791 [*Chaoulli*].

times in the public system compelled them to obtain health services outside of Canada, for which they are entitled to reimbursement.[47] Plaintiffs have also framed claims in tort law, alleging that governmental negligence led to unreasonably long waits for health care services.[48]

B. Balancing Accountability Against Concern for Institutional Competence

Although courts serve the important functions of protecting vulnerable beneficiaries and acting as a mechanism to enhance governmental accountability, these considerations must be balanced against the countervailing concern regarding the judiciary's competence to adjudicate complex matters of social policy. An intricate web of variables influences health sector decision making, including the availability of resources (temporal, monetary, and human), public and media pressure, provider and interest group advocacy, bureaucratic self-interest, political factors (for example, the timing of the next election), and technical and often contradictory scientific and policy evidence. As Cohen and Smith argue, "the state is likely to be involved in polycentric disputes in which the determination of any particular factor or issue involves the simultaneous adjustment of numerous other factors and issues, and affects the interests of numerous individual and collective interests."[49]

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[47] See e.g. *Stein c Tribunal administratif du Québec*, [1999] RJQ 2416 (Qc Sup Ct (Civ Div)). But see *Flora v Ontario (Health Insurance Plan, General Manager)*, 2008 ONCA 538, 91 OR (3d) 412.

[48] See e.g. *Cilinger c Québec (PG)*, [2004] RJQ 2943, 135 ACWS (3d) 775 (Qc CA), leave to appeal to SCC refused, 30703 (December 31, 2004) and *Mitchell (Litigation Administrator of) v Ontario* (2004), 71 OR (3d) 571, 242 DLR (4th) 560 (Ont Sup Ct). Although most of these claims have failed to survive a motion to strike or class certification motion, see *Heaslip Estate v Mansfield Ski Club Inc*, 2009 ONCA 594, 96 OR (3d) 401, in which a boy died waiting for an emergency transfer to a hospital after air ambulance operators failed to follow a policy addressing the prioritization of urgent cases. The Ontario Court of Appeal refused to strike this claim on the basis that the government did not owe a duty of care. I discuss these tort cases in greater detail in Lorian Hardcastle, "Government Tort Liability for Negligence in the Health Sector: A Critique of the Canadian Jurisprudence" (2012) 37:2 Queen's LJ 525. Specifically, I argue that the Canadian judiciary's restrictive approach to health sector tort claims may present its own accountability concerns, as only particular types of claims are captured by the *Charter* or administrative law.

[49] David Cohen & JC Smith, "Entitlement and the Body Politic: Rethinking Negligence in Public Law" (1986) 64:1 Can Bar Rev 1 at 8.

Judges must account for the complexity of the health system by according government policy choices an appropriate degree of deference.

In the pre-*Gonzaga* § 1983 Medicaid jurisprudence, state courts diverged on whether to adopt what I characterize as a substantive or a procedural approach to adjudicating breaches of the equal access provision. Those that adopted a substantive approach focused primarily on the rates of provider participation in Medicaid and beneficiary health service utilization as indicia of accessibility.[50] However, these numbers are contingent upon a host of factors independent of reimbursement rates. For example, low-income Medicaid recipients may have difficulty accessing transportation or childcare in order to attend health care appointments, there may be physician shortages in low-income communities, educational or cultural barriers may deter particular groups from seeking health care services, and providers may be reluctant to accept Medicaid patients due to higher rates of co-morbidities and lower patient compliance (stemming from reasons such as an inability to fill prescriptions or attend follow-up appointments). Even in universal health care systems such as Canada's, there is evidence to suggest that after adjustment for disease prevalence, lower income may be associated with reduced health service utilization.[51] It is crucial that policy-makers conduct research to determine the causes and effects of inequitable access to health services and craft solutions to mitigate this disparity However, it is problematic for courts to take on this role themselves by making legal determinations hinging on the complex array of variables affecting service utilization.

In contrast to this substantive approach, courts adopting a procedural approach to equal access before *Gonzaga* inquired whether a state considered the requisite factors set out in Medicaid legislation (efficiency, economy, and equality of care) and whether the government conducted research to estimate the effect of proposed rate cuts on beneficiaries' access to services. In other words, judges examined the process the state undertook in setting provider reimbursement rates and the factors it weighed in making this decision. In *Douglas*, the California courts favoured this procedural approach, focusing their criticisms on the state's failure to conduct cost studies to analyse the anticipated effects of the rate cuts. Judicial scrutiny of the state's rate-setting process arguably falls more squarely within the institutional competence of

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[50] Sean Jessee, "Fulfilling the Promise of the Medicaid Act: Why the Equal Access Clause Creates Privately Enforceable Rights" (2009) 58:3 Emory LJ 791.

[51] Mark Lemstra et al, "High Health Care Utilization and Costs Associated with Lower Socio-Economic Health Status: Results from a Linked Dataset" (2009) 100:3 Can J Public Health 180.

the courts than does a judicial attempt to analyse health service utilization and provider reimbursement data.

Canadian courts have similarly struggled with the appropriate degree of deference to accord governmental policy decisions. For example, in *Chaoulli*, a challenge to limits on the availability of private health insurance, a majority of the Supreme Court of Canada stated that "[t]he fact that the matter is complex, contentious or laden with social values does not mean that the courts can abdicate the responsibility vested in them by our Constitution."[52] In contrast, the dissenting justices questioned the ability of the courts to define "the scope and nature of 'reasonable' health services," concluding that "[t]he public cannot know, nor can judges or governments know, how much health care is 'reasonable' enough to satisfy [the *Charter*.] … It is to be hoped that we will know it when we see it."[53]

As with their American counterparts, Canadian judges have sometimes focused primarily on the procedure employed by policy-makers, granting greater deference when the decision making process was fair and deliberate and the government weighed the appropriate considerations. For example, in *Eldridge*, a challenge to British Columbia's refusal to fund sign language interpretation services for individuals receiving insured health services, the Supreme Court of Canada was critical of the Ministry of Health's ad hoc decision making process. Specifically, the Court noted that the initial request to fund interpreter services "was declined out of hand"[54] and that the $150,000 program was characterized as a "strain" on available resources, even though it would consume only 0.0025% of the provincial health care budget.[55] By contrast, in *Armstrong v British Columbia (Ministry of Health)*, the BC Human Rights Tribunal accepted the government's refusal to fund prostate cancer screening services. In that decision, which was affirmed by the Court of Appeal, the plaintiff alleged that the government's failure to these services constituted discrimination because it insured screening for cancers affecting the female reproductive system. In concluding that the complaint was not justified, the Tribunal cited the extensive scientific evidence and expert tes-

[52] *Supra* note 46 at para 107.

[53] *Ibid* at para 163.

[54] *Supra* note 44 at para 4.

[55] *Ibid* at para 87.

timony respecting the efficacy and cost of a screening program the government relied on in making its decision.[56]

Conclusion

In light of mounting cost pressures, policy-makers will increasingly be called upon to make difficult choices between competing demands in order to ensure health system sustainability. Although courts should not act as a barrier to necessary cost-containment measures, judicial scrutiny of government policies is a critical component of health sector accountability, particularly for programs like Canadian Medicare and US Medicaid, in which beneficiaries have little alternative but to rely on the government. In the US, *Douglas* has left open the question of whether Medicaid recipients and providers have a private right of action to challenge state budget cuts, the ultimate resolution of which may have profound implications for beneficiaries, who lack the ability to exert political pressure and have limited other recourse against budget cuts, particularly given the climate of lax federal enforcement.

The evolving American jurisprudence in this area will prove interesting for a Canadian audience. Of particular importance will be the judicial approach to reviewing governmental health policy choices, specifically whether courts adopt a substantive approach to equal access or instead focus on ensuring that states employ a fair, deliberate, and evidence-based decision making process. If judicial scrutiny leads to improved state government decision making, this jurisprudence may legitimize the role of courts in facilitating health sector accountability. This may, in turn, motivate Canadian courts to amplify their own scrutiny of government decisions. In addition, if the US jurisprudence prompts increased federal enforcement or oversight of Medicaid, Health Canada may be similarly motivated to take a more active role in setting standards to meet the conditions of the *Canada Health Act* or, perhaps, to enforce the numerous ongoing breaches of the *Act*.[57]

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[56] 2008 BCHRT 19 (available on CanLII), 62 CHRR D/1, aff'd *supra* note 45.

[57] For a discussion of the numerous unenforced breaches of the *Canada Health Act*, see Choudhry, *supra* note 35.