

Litigating Innovation:
Health Care Policy and the Canadian Charter of Rights and Freedoms

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Is legal mobilization an effective instrument for policy innovation? This paper seeks to examine this question by studying the use of rights-based litigation in the context of publicly-funded health care. By focusing on a non-American case, the paper seeks to bring the techniques of comparative public law to understand the relationship among litigation, legal rules and social policy. In an ideal world, legal mobilization would succeed in establishing new legal rules desired by a social movement; those desired legal rules would generate positive policy consequences; and success would strengthen the movement. In the real world, however, these phenomena are often mutually exclusive. Legal mobilization may fail to establish desired legal rules, but positive policy consequences follow anyway; desired rules may emerge from the legal process, but have no impact on policy or social conditions; unsuccessful legal mobilization may nevertheless strengthen a movement by energizing members around particular causes; by contrast, successful mobilization may enervate a movement or energize a counter-movement. In essence, either legal mobilization is a “hollow hope” (Rosenberg 1991), or rights work as an instrument for shifting policy debate and empowering weaker groups (McCann 1994).

The use of rights-based litigation by advocates of health care policy reform in Canada provides a useful focus for evaluating these two possible scenarios for at least three reasons. First, health care is the single most important area of Canadian public policy. The delivery and financing of health care services is governed by the Canada Health Act, which requires that provinces provide equal access to publicly administered, comprehensive, universal, and portable health care coverage. Health care consumes about nine percent of GDP and is the largest single expenditure item in provincial budgets. Second, rights-based litigation is becoming an increasingly common phenomenon in the development of health care policy (Jackman 1995; Jackman 1995/96; Braen 2002; Jackman 2002; Greschner 2002; Manfredi & Maioni 2002). Key areas

already litigated under the Canadian Charter include physician supply management, medical practice regulation, hospital restructuring, and the regulation and provision of specific treatment and services. Finally, in June 2004 the Supreme Court of Canada heard oral arguments in two cases with potentially profound consequences for health care policy. The policy objective of the litigation in one case is to restrict the scope of public health care provision by challenging the constitutionality of legal prohibitions against the private provision of health care. By contrast, the objective of the litigation in the other case is to extend the range of funded services by establishing a constitutional obligation for provinces to fund an autism treatment as part of their health care policy.

These two cases—*Chaoulli v. Attorney-General of Quebec* (prohibition against private provision) and *Attorney-General of British Columbia v. Auton* (autism)—provide the substantive focus for our paper. Although both cases involve health care policy, they differ in two important ways. The *Chaoulli* case involves an individual litigant and seeks to restrict the scope of the public health care system. The *Auton* case involves a well-organized social movement seeking to extend the system's coverage. Both cases are nevertheless part of a growing trend toward litigating health care policy reform. Between 1982 and 2002 Canadian courts decided 37 cases involving judicial review of health care policy under the Canadian Charter of Rights and Freedoms (Manfredi & Maioni 2002; Greschner 2002), with eight of those cases decided at the Supreme Court level. Among the more important of these cases are decisions striking down the federal abortion law (*Morgentaler* 1988), modifying professional advertising regulations (*Rocket* 1990), upholding the criminal prohibition against assisted suicide (*Rodriguez* 1993), and establishing a constitutional right to sign language interpretation in the provision of health care services (*Eldridge* 1997). With the exception of *Morgentaler*, which established an entirely new abortion regime and resulted in the widespread use of private abortion clinics (Manfredi 2004: 181), the Supreme Court's health care decisions have operated at the margins of this crucial policy field. *Chaoulli* and *Auton* are different.

Chaoulli challenges the very existence of publicly provided health care, and *Auton* challenges the authority of provincial governments to determine which services are “medically necessary” and thus included within the public health care system.

We begin with a survey of the literature on legal mobilization, paying particular attention to the scholarly debate concerning its utility. We continue with sections on each of our case studies, which offer examples of two very different approaches to legal mobilization. The focus of these studies is on the reasons why policy advocates choose litigation, the development of litigation strategies and tactics, and the affect of litigation on legal rules and policy. We end by offering some tentative conclusions about what these case studies contribute to the general debate about legal mobilization as an instrument of policy innovation.

Legal Mobilization and Policy Innovation

The term legal mobilization refers to a host of related phenomena. It is a “process by which legal norms are invoked to regulate behavior” (Lempert 1976: 173); the translation of desires into demands “as an assertion of one's rights” (Zemens 1983: 700); or a “planned effort to influence the course of judicial policy development to achieve a particular policy goal” (Lawrence 1990: 40). Underlying particularly the third of these descriptions is the notion that litigation can be an effective instrument for social and political change. In general, the literature surrounding this idea has focused on three questions: Why do social movements litigate? Under what conditions is litigation successful in changing legal rules? To what extent do changes in legal rules affect the broader policy environment?

Choosing Litigation

The use of litigation as an instrument of socio-political reform traces its roots to the early twentieth century, when the National Consumers' League used litigation to advance the interests of working women and children in the United States (O'Connor &

Epstein 1984: 483). However, credit for the systematic development of this type of litigation usually goes to two groups: the American Civil Liberties Union (ACLU) and the National Association for the Advancement of Colored People (NAACP). Although both organizations oriented legal mobilization around a "leading case" approach (Scheingold 1974: 173), the NAACP initially took a more programmatic approach than did the ACLU (Rabin 1976: 221). Indeed, the NAACP explicitly developed "a strategic plan for cumulative litigation efforts aimed at achieving specified social objectives" (Rabin 1976: 216).

The NAACP turned to litigation because restrictive election laws and voting requirements, not to mention poverty and the legacy of slavery, ensured that African-Americans remained a "discrete and insular minority" (*Caroline Products* 1938: 152-53), unable to defend or advance their interests through normal democratic political participation. Thus, in 1915 the NAACP entered the judicial arena to defend the existing legal rights of African Americans, and in 1939 it established an independent Legal Defense and Education Fund (LDF) to undertake a systematic program of social reform through legal mobilization (Vose 1959: 39, 44). These legal struggles achieved important victories against restrictive property covenants and segregated education, and in favour of voting rights. The crowning achievement, of course, was the US Supreme Court's unanimous declaration in 1954 (*Brown v. Board of Education*) that segregated public education violates the constitutional guarantee of equal protection of the laws. Indeed, *Brown* has been credited with making judicial activism possible (Cover 1982: 1287-1316), and with being "such a moral supernova in civil liberties adjudication that it almost single handedly justifies the exercise" (Gold 1982: 108). To be sure, these victories required further legal and political action to become even partially effective, but the NAACP's apparent success came to define the method and potential of legal mobilization.

By the end of the 1960s, based to a large degree on the NAACP's experience, the conventional wisdom suggested that the principal reason for legal mobilization was political disadvantage. According to this theory, litigation occurs when groups are systematically blocked from other avenues of political change. However, by the middle of the 1970s this conventional wisdom was under attack. In perhaps the most widely cited article in the law and society literature, Marc Galanter argued that only repeat player (RP) litigants, with accumulated legal expertise and extensive legal resources, were likely to be successful in mobilizing the law programmatically to achieve long term objectives (Galanter 1974). Scholars identified other factors, such as diffuse financial support and longevity, as important in making litigation a feasible strategy (Scheppelle & Walker 1991: 161-68). It became apparent, in venturing "beyond the political disadvantage theory," that groups without political and economic resources were also unlikely to possess the legal resources necessary to sustain systematic litigation campaigns (Olson 1990). Indeed, even the NAACP had political resources in the form of financial support from philanthropic organizations and influential (or merely dedicated and hard-working) individuals with ties to the majority political community (Tushnet 1987: 2; Kluger 1975: 388-90). These observations suggested that legal mobilization, which appears superficially to be the exclusive province of political outsiders, actually belongs as much, and perhaps more, to political insiders (Brodie 2002).

Winning Cases

Whether seeking to press existing advantages, or mobilizing to overcome political disadvantage, organized group litigants face several strategic and tactical choices. The basic strategic choice is between direct sponsorship of test cases and participation as an *amicus curiae* (or intervener, to use Canadian terminology). Direct sponsorship maximizes control of litigation but is expensive; *amicus curiae* participation is less costly but provides far less control over the development of legal rules. From a strategic point of view, legal mobilization will be more successful to the extent that a social movement

exercises centralized control, brings cases in the proper sequence, and identifies favourable venues. The principal tactical decision is to identify “winnable” cases and arguments. The incremental character of judicial policymaking means that the ultimate legal objectives of a litigation campaign can only be achieved through the gradual development of discrete rules that eventually form the basis for a new, over-arching, legal doctrine. In practical terms, this means that cases involving the easiest legal questions must be identified and litigated first, before moving on to those raising more problematic issues. Factual clarity and sympathetic plaintiffs are also important factors in winning individual cases.

Policy Impact

The 1960s ideal of legal mobilization as an instrument for improving the position of the politically disadvantaged also began to fade as scholars questioned whether the achievements of groups like the NAACP were more apparent than real. As Stuart Scheingold observed, “two decades after the *Brown* decision, [Americans] are still struggling inconclusively with school desegregation.” According to Scheingold, the “continued vitality of litigation,” despite the unfulfilled promise of *Brown*, could “be read as a triumph of myth over reality” (Scheingold 1974: 95). In his view, litigation could produce social reform at best indirectly, by contributing to a broader process of political mobilization in which interests are activated, organized and realigned (Scheingold 1974: 131). Scheingold’s observations foreshadowed an important debate about legal mobilization between Gerald Rosenberg and Michael McCann, among others, during the 1990s. The debate opened with Rosenberg’s 1991 book, *The Hollow Hope*. Rosenberg examined six areas (civil rights, abortion and women’s rights, environment, reapportionment, and criminal law) and posed a very simple question: Did judicial decisions produce significant social reform? His findings were not optimistic, and he concluded that systematic institutional factors, including the limited nature of constitutional rights, limited judicial independence, and limited judicial implementation

capacity, made legal mobilization an exceptionally unreliable path to social reform (Rosenberg 1991: 10).¹

In 1992 Michael McCann described *The Hollow Hope* as “bold, compelling, and important,” yet ultimately unconvincing (McCann 1992: 720-21). Although McCann raised concerns about evidence, interpretation and conceptualization, he argued that Rosenberg’s approach missed the “constitutive capacity of law” in which “legal knowledge prefigures in part the symbolic terms of material relations and becomes a potential resource in ongoing struggles to refigure those relations” (McCann 1992: 733). McCann’s own study of legal mobilization and pay equity (McCann 1994) led him to conclude that legal mobilization provides important political payoffs, even in the absence of directly positive effects. In particular, the mobilization of rights discourse by marginalized groups, according to McCann, can be a source of empowerment that facilitates long-term improvement in their disadvantaged status (McCann 1994: 292). In his review *Rights at Work*, Rosenberg argued that McCann’s “de-centred” approach had missed important phenomena—such as union activism—that affected the degree of successful legal mobilization in the pay equity field (Rosenberg 1996: 448). According to Rosenberg, a close analysis of McCann’s findings actually supported the central thesis of *The Hollow Hope*, that “courts can help progressive forces, but only under conditions that both occur infrequently and are virtually determinative of change on their own” (Rosenberg 1996: 454).

One of the most important lessons of the McCann-Rosenberg debate is that measuring either the success or influence of legal mobilization is extremely difficult. Success is not a simple concept, nor is it identical to influence. Success can mean favorable outcomes in individual cases, or the development of desired legal doctrine. Yet even accomplishing these two difficult objectives does not guarantee achieving the broader socio-economic and political changes at which legal mobilization aims.

Moreover, case outcomes, doctrinal developments, and broader policy shifts may be entirely independent of group participation.

One of the principal deficiencies of the legal mobilization literature is that it is based almost exclusively on the US experience. American scholars—or at least American political scientists—have been notoriously indifferent to the comparative study of law, courts, constitutionalism, and judicial behavior (Gibson, Caldeira, Baird 1998: 343).² Although this indifference is to some degree understandable, and has diminished in recent years, it means that the American understanding of the role of law and courts in policy development and implementation is perhaps less rich than it might otherwise be. At the same time, scholars outside the United States can also be faulted for not paying sufficient attention to this phenomenon in their own political systems. For example, although scholarly interest in litigation by organized groups in Canada dates back at least 50 years (Mallory 1954), existing studies have focused almost exclusively on litigation concerning gender equality and sexual orientation (Razack 1991; Morton 1992; Smith 1999; Hausegger 2000; Brodie 2002; Manfredi 2004). Moreover, there have been few systematic attempts to examine the policy impact of judicial decisions (Bogart 2002; Schneiderman & Sutherland 1997; Bogart 1994). These case studies thus seek to broaden the literature in two distinctive ways.

In order to organize our case studies, we adopt Cooper's model of remedial decree litigation, which consists of trigger, liability, remedy, and postdecree phases (Cooper 1988: 16-24). The trigger phase consists of both the general historical practices and specific triggering events that lead to the initiation of a case. The liability and remedy phases, in which rights violations are determined and remedies formulated to correct the violations, constitute the central components of remedial decree litigation. These phases may occur simultaneously or be the subject of separate proceedings. The final step in remedial decree litigation is the postdecree phase, during which remedies are implemented, evaluated and refined. This phase is characterized by interaction between

litigants and judges, with the degree of judicial involvement related to the extent of the constitutional violation, the organization capacity for change, and the surrounding political culture.

Reversal of Fortune: *Auton v. British Columbia*

Triggering Litigation

In 1987, Dr. O. Ivar Lovaas published the results of a study measuring the effects of a particular form of “early intensive behavioral intervention” (EIBI) for the treatment of autism (Lovaas 1987). The study reported that seventeen of nineteen children who received an average of forty hours per week of intensive individual therapeutic treatment demonstrated significant improvements in their social and communication skills. Moreover, nine of the children successfully completed first grade in regular classes and were no different from their peers with respect to IQ, adaptive skills, and emotional functioning. Six years later, Lovaas and two colleagues conducted a follow-up study, which suggested that the earlier treatment gains had been maintained and that eight of nine children were continuing to progress in regular classes without special support (McEachen, Smith and Lovaas 1993).

Because of the treatment’s apparent success, intensity (40 hours per week over two to three years), and cost (approximately \$50,000 annually), the Lovaas studies triggered the establishment of a continent-wide movement to secure private and public funding for EIBI that became known as Families for Early (or, in some cases, “Effective”) Autism Treatment (FEAT). Established in 1993 in northern California, the FEAT movement quickly spread across the United States and Canada. After engaging in individual advocacy for government funding of LAT for a year, Dr. Sabrina Freeman, a sociologist with an autistic daughter, founded a branch of FEAT in British Columbia in 1996 and became its executive director. Starting from the proposition that Lovaas Autism Treatment (LAT) “is an effective, scientifically supported treatment for young

children with the neurological disorder of autism,” FEAT BC’s position from the outset was that the BC government’s refusal to recognize LAT as a medically necessary service provided through the province’s health care system contravened “several laws designed to protect the rights of the disabled.”

Litigation was thus at the forefront of FEAT BC’s campaign to change the government’s policy toward LAT. Asserting that the “government of B.C. must recognize its legal obligation and financially support early, intensive and scientifically proven autism treatment for every child diagnosed with this condition,” it explicitly invited lawyers “who want to change the discriminatory health care system in Canada” to contact the organization. Referring to litigation in the United States, FEAT BC stressed that “the force of law must also be brought to bear in Canada” (<http://www.featbc.org>). Most relevantly, in August of 1996 a decision by the Alberta Court of Queen’s Bench held that “Lovaas-type programs” constituted a service for handicapped children within the meaning of the province’s Child Welfare Act and ordered the director of child welfare services to fund ninety percent of the therapy’s cost (*C.R.* 1996).

FEAT BC secured strong legal representation from Christopher Hinkson, a partner in the Vancouver law firm of Harper, Grey, Easton. Founded in 1907, Harper, Grey, Easton is a relatively small (approximately 50 lawyers) firm specializing in civil litigation. Designated as one of the leading 500 lawyers in Canada by Lexpert, Hinkson’s practice includes medical malpractice, personal injury litigation, professional negligence, insurance, products liability and administrative law. From 1987 to 1995 he served as Vice Chairman/Director of the BC Medical Services Foundation. He is, in short, a highly experienced litigator with particular expertise in medical and health care issues, backed by a distinguished firm.

On March 30, 1998 FEAT BC issued a press release entitled “Malpractice in the B.C. Government,” which criticized the government for refusing to fund the “one effective treatment” for autism. On July 30, 1998 a number of families received a joint

letter from the deputy ministers of Education and Children and Families, informing them that the government was not “in a resource position” to fund LAT (*Auton* 2000: 58). Two weeks later, Connor Auton and his mother Michelle started class action proceedings on behalf of all children and their families who had been denied funding for LAT by the provincial government. Although the courts refused to certify the proceedings as a class action, the pleadings were amended to include three additional children and their parents, including Sabrina Freeman and her daughter Michelle Tamir. The petitioners sought a declaration from the court that the denial of funding for LAT contravened their constitutional rights under sections 7 and 15(1) of the Canadian Charter of Rights and Freedoms, and also sought an order of mandamus requiring that the government compensate them for the costs of LAT already incurred and for the future costs of treatment. Both parties agreed, however, that the liability and remedy issues could be dealt with in separate proceedings.

Liability Proceedings

The liability phase of proceedings consisted of a ten day trial before Madam Justice Marion Allan of the BC Supreme Court in April, 2000. The principal point of factual disagreement between the parties concerned the clinical effectiveness of LAT, which was the key issue underlying the legal claim that it should be considered “medically necessary.” The petitioners built their case in favour of LAT in two stages. Since all four children had received LAT at their parents’ expense, the first stage was to demonstrate that the treatment had made a difference in these specific cases. Although the government challenged the admissibility of physicians’ letters as evidence of progress under LAT, it did not dispute the parents’ own affidavits concerning improvements in behaviour and communication skills. Consequently, Justice Allan declared that she was “satisfied on the basis of admissible evidence that the infant petitioners made significant gains as a result of the Lovaas Autism Treatment they received” (*Auton* 2000: 60). The

petitioners' claims, of course, went further than this. They contended that their children's experience simply affirmed the results of the 1987 and 1993 studies, indicating that LAT "is a medically necessary service insofar as it significantly improves the condition of these children" (*Auton* 2000: 63-64).

While not vigorously disputing the claim of positive outcomes in these specific cases, the government did question the general scientific validity of the two Lovaas studies. The government argued that two methodological flaws seriously undermined the Lovaas studies: the absence of random assignment into experimental and control groups and the failure to replicate the study.³ In the government's view, these flaws made it impossible to derive any general conclusions about the effectiveness of LAT from these studies. At best, it argued, the treatment could be considered experimental. In support of this position, the government commissioned a study by the Office of Health Technology Assessment Services and Policy Research at the University of British Columbia. The study concluded that, "while many forms of intensive behavioural therapy clearly benefit children with autism, there is insufficient, scientifically-valid effectiveness evidence to establish a causal relationship between a particular program of intensive, behavioural treatment, and the achievement of 'normal functioning'." The study based this conclusion on two findings: (1) the existence of only one published report of a controlled clinical trial the results of which the scientific community was reluctant to accept; and (2) lack of corroboration by independent researchers. The report advised that "randomized trials of alternative early intensive treatment programs are ethical and feasible," and that such research "is required before effectiveness claims can form the basis of public funding decisions regarding alternative program options" (Bassett, Green & Kazanjian 2000: ix).

Justice Allan was, to say the least, unimpressed by the report (*Auton* 2000: 66-67). She suggested that its authors had misled the court about whether the report had been subjected to external peer review before being filed as an exhibit in the proceedings; she

criticized the research team for not consulting health professionals supportive of LAT and for relying on a “single anecdotal comment” for a key finding; and she criticized the report for falsely asserting that Dr. Lovaas and his colleagues had claimed that LAT “cures” autism. In her view, the report added “little or nothing” to existing debates about the 1987 and 1993 studies and exhibited such “an obvious bias” towards the government’s position as to detract “significantly from its usefulness.” The only part of the report that she found valuable was its acknowledgment that “early intervention with behavioural treatment can help to alleviate autistic symptoms in many if not most autistic children.” Indeed, the expert witness testimony for both parties led her to conclude that there “are no effective competing treatments” for “those based on principles of ABA” (*Auton* 2000: 68). Moreover, she determined that “early intensive behavioural treatment” should be considered a “medically necessary service” under the terms of both provincial and federal legislation (*Auton* 2000: 75). She reached this conclusion by broadly defining a “medically necessary” service as “whatever cures or ameliorates illness” (*Auton* 2000: 75).

Having made this determination, and finding that British Columbia was not providing such treatment, Justice Allan turned her attention to whether this failure violated constitutionally guaranteed equality rights. Two prior Supreme Court of Canada decisions set the parameters of her discussion. First, in 1997 the Court had held in *Eldridge v. British Columbia* (1997) that British Columbia’s failure to provide a comprehensive system of publicly funded sign language interpretation for deaf patients denied those patients equal benefit of the law by limiting their ability to communicate effectively with health care practitioners. Second, in 1999 the Court had consolidated ten years of jurisprudence to set controlling principles for the application of equality rights. According to *Law v. Canada* (1999), the purpose of section 15(1) is “to prevent the violation of essential human dignity and freedom through the imposition of disadvantage, stereotyping, or political or social prejudice, and to promote a society in which all

persons enjoy equal recognition at law as human beings or as members of Canadian society, equally capable and equally deserving of concern, respect and consideration” (*Law* 1999: para. 51).

From *Eldridge*, Justice Allan determined that, “having created a universal medicare system of health benefits, the government is prohibited from conferring those benefits in a discriminatory manner.” From *Law*, she concluded that, by “failing to make appropriate accommodation for their health care needs” on the premise “that one cannot effectively treat autistic children,” the government was discriminating against such children by perpetuating a “misconceived stereotype” (*Auton* 2000: 80). She rejected the government’s claim that its decision was justified by—in fact, based on—a rational allocation of finite health care resources. Nevertheless, although she concluded that “the appropriate treatment is ABA or early intensive behavioural intervention” and that British Columbia “discriminates against the petitioners contrary to s.15(1) by failing to accommodate their disadvantaged position by providing effective treatment for autism” (*Auton* 2000: 85). Justice Allan agreed with the province that she did not have jurisdiction to make a specific order requiring the province to provide LAT. Instead, she invited counsel for both parties to make additional submissions on the precise nature of an appropriate remedy for the constitutional violation.

Although favorable to FEAT BC, the trial court’s liability finding was not without difficulty. First, the court arguably focused on the wrong principle of the Canada Health Act when it defined the issue in terms of universality (Greschner and Lewis 2003: 514). This principle is usually understood as requiring that all qualified provincial residents must receive insured services, not that all possible medical treatments be insured. Debates about the appropriate scope of insured services instead fall under the principle of comprehensiveness. Second, in broadening the definition of “medically necessary” the court departed from the Canada Health Act’s definition as encompassing services delivered in hospitals or by physicians (Greschner and Lewis 2003: 515). Moreover, the

court may have misinterpreted expert testimony in order to reach this broad definition. According to Justice Allan, the expert (Dr. Morris Barer) defined “medical treatment” as “whatever cures or ameliorates illness” (*Auton* 2000: 75). It is unclear, however, whether Dr. Barer considered “medical treatment” and “medically necessary service” as interchangeable terms.

Remedy Phase

The remedy proceedings took place in November, 2000, and Justice Allan rendered her judgment in February, 2001 (*Auton* 2001). Part of these proceedings concerned the province’s initial efforts to comply with the liability ruling. Specifically, it had established the Provincial Centre for Autism and Related Disorders (P-CARD) to provide province-wide services, including EIBI, for at least twenty hours per week to all diagnosed autistic children less than six years of age by 2003. The petitioners objected to this program because of its age restrictions, limited number of treatment hours, and failure to include LAT. Justice Allan approached these objections cautiously, noting that the case “raises significant public policy issues as to the respective roles of the judiciary and the legislature.” “The issues raised by the petitioners,” she continued, “underscore the difficulties inherent in a process where the Court’s finding of unconstitutionality is designed to change governmental behaviour.” Recognizing the importance of judicial review, Justice Allan nevertheless held that “the judiciary cannot dictate what treatment programmes should or should not be implemented, nor can it dictate how limited financial resources should be allocated.” She was unwilling to characterize the government’s compliance efforts as reluctant, negative or intransigent (*Auton* 2001: para. 26, 27, 30). In her view, it was too early to judge the efficacy of the P-CARD program, and therefore premature “to make an order of mandamus” (*Auton* 2001: para. 45). The result was a three part remedy declaring a denial of equality rights, directing the Crown to

fund early intensive behavioral therapy for children with autism, and awarding the adult petitioners in the case \$20,000 in monetary damages.

Postdecree Phase

From Justice Allan's courtroom, the case moved to the British Columbia Court of Appeal, where the government appealed the liability declaration and the petitioners cross-appealed on the treatment and damages issues (*Auton* 2002). The appellate court unanimously rejected the government's appeal, holding that "the failure of the health care administrators of the Province to consider the individual needs of the infant complainants by funding treatment is a statement that their mental disability is less worthy of assistance than the transitory medical problems of others" and signaled that "the community was less interested in their plight than the plight of other children needing medical care and adults needing mental health therapy" (*Auton* 2002: para. 51). The court also rejected the petitioners' cross-appeal against Justice Allan's decision not to require funding for LAT specifically, agreeing with her conclusion that it was not the only effective form of EIBI that autistic children could receive (*Auton* 2002: para. 83-84). It similarly rejected their cross-appeal against her refusal to require treatment beyond the age of six. Although accepting "that the efficacy of treatment is unlikely to end at the crisp attainment of school age," the appellate court held that "issues of funding programs for children of school age may involve additional considerations not before the Court, either in evidence or submissions" (*Auton* 2002: para. 90). However, the court did direct that disputes about the duration of treatment be decided on a case-by-case basis in an appropriate dispute resolution process or in trial court proceedings, thus in principle expanding Justice Allan's remedy to include children over the age of six. The cross-appeal was successful with respect to the specific children involved in the original proceedings. Although the court was unwilling to impose a general policy on LAT or duration of treatment, it found that the children named in the original complaint were "entitled to government funded

treatment in the nature of that which they have been receiving...to continue until the medical view is that no further significant benefit in alleviating the autistic condition can reasonably be expected from a continuation of treatment” (*Auton* 2002: para. 92).

The province reacted to its appellate court loss in two ways. Most obviously, it applied for leave to appeal to the Supreme Court, which the Court granted on May 15, 2003. Less obviously, it sought to restrict the appellate court’s ruling to the four children named as parties. Not surprisingly, twenty-three families who had been part of the original class action application, and who had remained background participants in the *Auton* litigation, objected to the province’s action. They filed a petition in the British Columbia Supreme Court claiming the same remedy as the named *Auton* litigants, including monetary damages (*Anderson* 2003). With the exception of monetary damages, the court agreed with these families and held that they, too, should receive government funded LAT until such time as it was no longer medically beneficial.

On June 9, 2004, the Supreme Court of Canada heard oral arguments in *Auton*. The case’s broad importance was evident in the fact that it attracted nineteen interveners, including ten governments (Canada, New Brunswick, Manitoba, Quebec, Ontario, Alberta, Saskatchewan, Newfoundland and Labrador, Prince Edward Island, Nova Scotia), eight organizations (Canadian Association for Community Living, Council of Canadians With Disabilities, Women’s Legal Education and Action Fund, DisAbled Women’s Network, Autism Society Canada, Families for Effective Autism Treatment of Alberta Foundation, Friends of Children with Autism, Families for Early Autism Treatment of Ontario), and one individual. Not surprisingly, the governments were all concerned about the case’s implications for their capacity to set health care funding priorities. By contrast, the non-governmental organization interveners all urged the Court to uphold the lower court judgments. Interestingly, the individual intervener—Michelle Dawson, an adult autistic woman—urged the Court to reverse the earlier judgments on the grounds that those decisions, rather than the province’s refusal to fund LAT,

perpetuated a stereotype that autistic individuals are incapable of living fulfilling lives and are doomed to institutionalization.

The submissions on behalf of the *Auton* group sought to preserve the equality rights liability ruling and to expand the province's liability to encompass section 7 of the Charter. The *factum* thus argued that British Columbia was liable for the entire cost of providing LAT to the children named in the lower court proceedings. Consequently, the families asked the Court to order reimbursement of their LAT expenses from the date they were first incurred instead of from the date of the initial declaration of a Charter violation. For the families, therefore, the Supreme Court proceedings were less about public policy than about compensation for expenses incurred in securing therapy for their children which had been unconstitutionally denied them by the provincial government. This was apparent in oral argument, where Christopher Hinkson tried to focus the justices' attention on a specific instance of intransigent behavior by government officials rather than on the broader implications of the litigation. Hinkson denied that he was asking the Court to substitute its health policy preferences for those of the province. All the families were demanding, he argued, was that bureaucratic funding decisions be transparent and non-arbitrary. For British Columbia, by contrast, the issues before the Court were very much about public policy. Indeed, British Columbia argued that the lower court judgments would "distort the process" of health care funding decisions by creating "a category of constitutionally mandated medical services" (British Columbia: para. 5). In oral argument the province submitted that decisions about refusing, delaying, or rationing services were polycentric decisions within the general discretion of government.

The Court delivered its judgment in *Auton* on November 19, 2004 (*Auton* 2004). The unanimous decision, delivered by the Chief Justice, was a stunning legal defeat for FEAT BC. The Court reversed both lower court decisions, dismissed the petitioners' cross-appeal, and held unconditionally that British Columbia's refusal to fund LAT did

not constitute discrimination under section 15. Although expressing sympathy for the petitioners and the lower court decisions in their favour, Chief Justice McLachlin was clear that the issue before the Court was *not* “what the public health system should provide,” but whether “failure to fund” certain services under that system can be “an unequal and discriminatory denial of benefits” (*Auton* 2004: para. 2). She drew a clear distinction, in other words, between decisions about what is included in the health care “basket” (“a matter for Parliament and the legislature”) and the delivery of services authorized by law (to be done “in a non-discriminatory manner”).

Four considerations—two factual and two legal—drove the Chief Justice’s judgment. One factual consideration, referred to by the Chief Justice at three points in her judgment, was the “controversial” or “emergent” nature of the autism treatment under consideration (*Auton* 2004: para. 5, 11, 60). Indeed, she referred explicitly to Michelle Dawson’s intervention against the therapy, and cited specific objections to it such as “its reliance in its early years on crude and arguably painful stimuli” and “its goal of changing the child’s mind and personality” (*Auton* 2004: para. 5). The second factual consideration was the existence of some government funded programs for autistic children and their families (*Auton* 2004: para. 7). “At the time of trial,” she noted, “the government funded a number of programs for young autistic children, and appeared to be moving toward funding some form of early intervention therapy” (*Auton* 2004: para. 9, 59). Although the Chief Justice suggested that, in retrospect, the government should have moved more quickly, she concluded that “it is difficult to say that the government in purpose or effect put autistic children and their families ‘on the back burner’” (*Auton* 2004: para. 61). By focusing on these facts—rather than on the tragic impact of autism, bureaucratic intransigence, personal economic sacrifice, or individual progress under LAT—the Chief Justice provided a relatively benign picture of the pre-*Auton* policy status quo.

However, it was in her legal analysis of the claim that the Chief Justice dealt her harshest blow to the claimants. In her view, their claim simply did not involve a benefit provided by law; moreover, even if it did, there was no discrimination in the decision not to fund LAT. On the first point, the Chief Justice concluded that nothing in the legislative framework of public health care “provides anyone with all medically required treatment” (*Auton* 2004: para. 31). In her view, the legal benefit conferred by this framework was restricted to “core” medical services, which did not include EIBI therapy under either federal or provincial law. Although provinces have discretion to extend public funding to “non-core” services, she continued, there is no constitutional obligation to do so either generally or for specific services. A government, she stressed, is “under no obligation to create a particular benefit,” but is “free to target the social program as it wishes to fund as a matter of public policy, provided the benefit itself is not conferred in a discriminatory manner” (*Auton* 2004: para. 41). From this perspective, EIBI autism therapy was simply outside the range of health services to which the claimants had a legal right—whether by statute or constitution. There could not, therefore, be any violation of s. 15(1) in a decision not to fund LAT.

Although the Chief Justice could have ended her inquiry there, she nevertheless considered whether there was any basis to the claim of discrimination in this case. On this point, she defined the comparator group in such narrow terms as to make a finding of discrimination virtually impossible. She rejected the suggestion that autistic children should be compared to non-disabled children or to adults with a mental illness (*Auton* 2004: para. 49). Instead, she argued that the “appropriate comparator” is “a non-disabled person or a person suffering a disability other than a mental disability (here autism) seeking or receiving funding for a non-core therapy important for his or her present and future health, which is emergent and only recently becoming recognized as medically required” (*Auton* 2004: para. 55). The lower courts had erred, in other words, in comparing the claim for an “emergent” non-core therapy to funding for established

therapies (*Auton* 2004: para. 56). Discrimination could only exist, she concluded, if the province had acted more quickly in funding equally emergent non-core therapies for non-disabled or physically (rather than mentally) disabled persons. Not only was there no evidence of such action, according to the Chief Justice, but the government's conduct, "considered in the context of the emergent nature of ABA/IBI therapy...raises doubts about whether there was a real denial or differential treatment of autistic children" (*Auton* 2004: para. 59).

Despite her vindication of British Columbia's position, the Chief Justice did not let its actions escape criticism altogether. She described the decision to transfer jurisdiction over child and youth mental health from the Ministry of Health to the Ministry of Children and Families as "inauspicious" (*Auton* 2004: para. 60). She also concurred with the trial court's finding that the government's actions "did not meet the 'gold standard of scientific methodology'."⁴ Nevertheless, she concluded that "there is no evidence suggesting that the government's approach to ABA/IBI therapy was different than its approach to other comparable, novel therapies for non-disabled persons or persons with a different type of disability" (*Auton* 2004: para. 62). Whatever the weaknesses of the government's decision making process, they were not constitutional deficiencies.

Analysis

The emergence of a rights-based argument for public funding of Lovaas Autism Treatment in British Columbia was planned and strategic rather than accidental. FEAT BC was connected to an organizational network dedicated to ensuring accessibility to LAT through legal action. Its website referred readers to more than twenty US and Canadian judgments—based primarily on statutes and administrative law—imposing obligations on public authorities to fund LAT. It proactively sought legal counsel to pursue its claim in court, and secured the participation of a highly qualified lawyer with

specialized expertise in health related litigation. FEAT BC's contribution to the movement was to raise the stakes beyond other Canadian autism litigation by framing its argument as a Charter claim. In this sense, *Auton* was not simply about getting access to a service, but about entrenching that service in such a way as to immunize it from shifting policy preferences or scientific evidence. Among the factors accounting for the case's initial success were sympathetic plaintiffs (autistic children and their struggling parents), good facts (evidence of family sacrifice and individual progress under the therapy), and a favourable venue (BC courts had established a track record of intervening in health care policy). These factors came together to link a broad definition of "medically necessary treatment" to fundamental statutory (universality) and constitutional (equality) principles.

Why were these factors ineffective in the Supreme Court? One answer, as discussed above, lies in the Chief Justice's alternative factual framing. She chose to emphasize the controversial and emergent nature of LAT, as well as the province's good faith (even if imperfect) efforts to provide EIBI to progressively larger numbers of autistic children. A second answer lies in her understanding of *Eldridge*, which differed from the trial court's understanding. According to the Chief Justice, *Eldridge* "did not assist the petitioners" because it concerned unequal access to a benefit already provided by law while their claim was for "access to a benefit that the law has not conferred (*Auton* 2004: para. 38). Finally, although not cited in her judgment, the relevance of the Court's 2002 decision in *Gosselin v. Quebec* should not be underestimated (*Gosselin* 2002). In *Gosselin* a majority of the Court, led by the Chief Justice, held that a differential welfare regime for young adults (under 30) did not violate the Charter's equality rights. As the Chief Justice noted then, the issues raised by that case had "implications for the range of options available to governments throughout Canada in targeting welfare programs to address the particular needs and circumstances of individuals requiring social assistance" (*Gosselin* 2002: para. 12). Her judgment, easily transferable to other social programs, was that this range of options should not be unduly

narrowed. Although narrowly decided, *Gosselin* was a good indicator of the Chief Justice's thinking on the issue.

The *Auton* case offers an important glimpse into both the promise and limitations of legal mobilization. Its ultimate resolution in the Supreme Court suggests the most obvious limitation: legal mobilization can fail to establish the desired legal rule. Certainly, the Court's unanimous rejection of the lower court rulings in *Auton* was an unambiguous reversal of legal fortunes for the LAT movement. Yet, even when the case was legally successful, it provided FEAT BC with mixed results. On the positive side, two courts recognized a constitutional right to government-funded EIBI treatment for autism, awarded monetary damages to four families, and granted compensation for incurred expenses and future autism treatment of their choice to 27 families. The decisions also led British Columbia to convert a small pilot program of treatment into full-fledged government policy, even as it appealed its legal losses. Finally, the victories supported legal mobilization outside BC as FEAT branches in other provinces, notably Ontario, began leveraging the BC judgments to press for extended EIBI funding. Indeed, eleven autism funding cases were decided in various provinces in 2003 and 2004.⁵ On the negative side, FEAT BC never achieved its objective of obtaining a legal declaration that LAT is the only effective treatment for autism. Consistent with Rosenberg's observations, the BC courts were reluctant to exercise their full remedial authority in a social policy field outside their traditional area of expertise in legal procedure. The legal victories never provided the LAT movement with its ultimate goal.

Nor, however, did the Supreme Court defeat, as disappointing and deflating as it must have been, remove all of the energy from the movement. Governments still face significant, and potentially successful, autism litigation. According to the Autism Society of Canada, there were more than 180 other cases, involving over 1,600 families, still pending in November, 2004.⁶ Moreover, in January, 2005 the Ontario Superior Court granted an interlocutory injunction against the province, requiring it to continue funding

EIBI treatment for two six-year-old boys despite the *Auton* ruling (*Bettencourt* 2005). The court distinguished the two cases on the grounds that Ontario provided funding through its Ministry of Community and Social Services rather than through the Ontario Hospital Insurance Plan. As such, the boys were being denied a benefit provided by law on the basis of age. Finding that the boys would suffer “irreparable harm” if withdrawn from treatment, the court held that it would be discriminatory to do so. In this sense, *Auton* may have simply shifted the focus of legal mobilization efforts from one constitutional arena to another.

Equally, and perhaps more importantly, the legal defeat may have favourably mobilized public opinion. Editorial reaction to the decision was generally to the effect that governments should fund the treatment whether constitutionally required to or not (*Globe and Mail* 2004: A18; *Globe and Mail* 2004a: A26; *Vancouver Sun* 2004: A16). Even the *National Post*—an outlet not generally known for its support of government spending, publicly-funded health care, or judicial activism—criticized provincial governments for not funding LAT and for undertaking costly court battles to avoid any obligation to do so (*National Post* 2004: A6). An Ipsos-Reid poll reported in December, 2004 that 84 percent of Canadians supported public funding for EIBI despite the Court’s decision,⁷ and two MPs (Scott Reid (Con) and Tony Martin (NDP)) tabled petitions in Parliament supporting funding for EIBI. As McCann might argue, the six year litigation campaign for autism funding brought the issue to public attention and shifted the policy advantage toward the movement behind it.

An Unfinished Story: *Chaoulli v. A.-G. Quebec*

Triggering Litigation

In 1993, sixty-one year old George Zeliotis, a salesman for a chemical company, suffered several medical problems, including depression and a heart attack. In 1994, he began having recurring hip problems which led him on a quest for a several consultations

and diagnoses with a variety of medical practitioners. His general practitioner referred him to an orthopedic specialist in 1995 and he was operated on his left hip; in 1997, after some delay, he was operated on his right hip. During his year-long wait in 1996, Zeliotis investigated whether he could pay privately for surgery and realized that he could not, under the terms of Quebec's health care laws, either obtain private insurance or pay directly for private services from a physician. He called upon administrators, politicians and the local media to plead his case without success.

Although it was Zeliotis's condition and waiting time for surgery that led to the eventual court case, the actual protagonist in the judicial battle was Dr. Jacques Chaoulli, who one observer portrayed as "preparing and fighting this case almost single-handedly" (Pinker 2000). Trained in France and Quebec, Chaoulli received his permit to practice medicine in Quebec in 1986. At that time, as is the case today, new physicians are required to practice outside "over serviced" urban areas, such as greater Montreal, or receive lower reimbursement rates for their services. Dr. Chaoulli decided to return to Montreal after only two years. He soon became well-known in medical circles through his attempts to set up a home-based, 24-hour practice for doctors making house calls in Montreal's south shore region. After intense lobbying of government officials and the refusal of the Regional Board to recognize his practice in 1996, Dr. Chaoulli began a hunger strike to draw attention to the situation. The strike lasted three weeks, and at that point Dr. Chaoulli decided to become a "non-participating" doctor in the Quebec health care system (Sibbald, 1998).

In Quebec, as in every other province, physicians may "opt-out" of the public system and bill patients directly for services rendered; however, as Dr. Chaoulli soon discovered, the disincentives for opting out are very high. Under the terms of Quebec's health care laws, patients may not seek reimbursement from the public system if they consult non-participating doctors; in addition, such doctors may not provide private services in publicly-funded hospitals (Flood and Archibald 2001). From 1996 to 1998,

Dr. Chaoulli attempted to gain permission, from both Quebec officials and the federal ministry of Health, to create a private hospital. After this initiative failed, Dr. Chaoulli returned to the public system and worked as a general practitioner in a walk-in clinic.

Dr. Chaoulli was not Mr. Zeliotis's physician at the time of his wait for surgery, but the two plaintiffs in effect "teamed up" together in their legal challenge of Quebec health and hospital insurance laws before the province's Superior Court. In 1997, they presented two motions for a declaratory judgment against two articles of these laws which they alleged to be unconstitutional. First, they asked the court to invalidate Article 15 of the *Quebec Health Insurance Act* which proscribes private insurers from covering publicly-funded services.⁸ Second, they asked the courts to invalidate Article 11 of the *Quebec Hospital Insurance Act* which prevents non-participating physicians from contracting for services in publicly-funded hospitals.⁹

The motivation and modus operandi of the two plaintiffs were somewhat different, however. Dr. Chaoulli chose to represent himself in the initial trial, claiming that he had a "duty" to provide services, and called upon several high-profile critics of public health care to testify on his behalf. Mr. Zeliotis, who stated that his personal goal was to ensure that any future surgery would not be "delayed again", retained the services of Philippe Trudel, of Trudel & Johnston (Pinker 1999). The Montreal law firm, which specializes in constitutional litigation, consumer protection and health and medical liability, was also associated with a high-profile class action suit in the late 1990s against the tobacco industry on behalf of Quebec smokers and ex-smokers who became addicted to nicotine (*Info-tabac*, 2003).

Liability Proceedings

Trial proceedings in *Chaoulli c. Québec* began in December 1997 and went on for four weeks before Madam Justice Ginette Piché in the Superior Court of Quebec (civil chamber). In the trial, the plaintiffs were identified as Jacques Chaoulli and George

Zeliotis, while the respondents to the motion were the Procureur général du Québec (Attorney General of Quebec) and the Procureur général du Canada (Attorney General of Canada) as *mis-en-cause* (third party). The basic question was this: are waiting times for health care services in the public system and the restrictions on private insurance outside of the public system a violation of the rights to life, liberty and security of the person enshrined in the *Canadian Charter of Rights and Freedoms*.

The court heard testimony from both Dr. Chaoulli and Mr. Zeliotis, the physicians who had cared for Mr. Zeliotis, a former minister of health in Quebec, and several physicians and health policy specialists. The court also heard testimony from Barry Stein, a Montreal lawyer who had initiated successful proceedings against the Quebec government for reimbursement of cancer treatment he received in New York after having had his surgery cancelled at a Quebec hospital.

Dr. Chaoulli emphasized the mental anguish caused to him as a victim of an allegedly discriminatory law that prohibited him from practicing his profession as a “non-participating” doctor outside the public system, and portrayed the Quebec’s health care monopoly as being infused with Marxist-Leninist theories of egalitarian ideology. His testimony was so dramatic and intense that the judge commented on his “tireless” efforts (Pinker 2000). Mr. Zeliotis’ counsel, meanwhile, focused on how article 11 of the hospital insurance act and article 15 of the health insurance act were contrary to the *Charter* under section 7 (life, liberty and security of the person) and under section 15 (equal treatment) as they did not allow non-participating Quebec doctors from using public hospital facilities or allow Quebec residents from using their own financial resources to insure themselves for private care (*Chaoulli* 2000: 5).

The court heard the testimony of five medical specialists. Dr. Eric Lenczner and Dr. Come Fortin expressed concern with the problems of access to timely care in orthopedic surgery and cataract surgery; while waiting lists were not fatal, they claimed, they could seriously reduce the quality of life of patients in the interim. Dr. Abendour

Nabid, meanwhile, argued that there could not be any reasonable delay for cancer patients. Although all of the physicians expressed frustration with the health care system in Quebec, there was no consensus that the system should be changed in the way in which the plaintiffs were demanding (*Chaoulli* 2000: 10-11). Barry Stein also testified about his problems with waiting for surgery, although the testimony was contradicted by his physician, Dr. André Roy, who told the court that the delay for the surgery had not been expected to be more than one week in duration (*Chaoulli* 2000: 11).

Surely the witness with the highest profile and gravitas was Claude Castonguay, the minister of health and social services in the early 1970s who was considered the “father of medicare” in Quebec. He claimed that while he still agreed with the objective of the 1970 law to ensure equal access to health care, the province’s strained financial situation and growing elderly population meant that new solutions and partnerships had to be created in the health care system, although he disagreed with the solutions being asked for by the plaintiffs in the case (*Chaoulli* 2000: 12).

The court also heard the opinions of several “experts” in the health care sector, who provided historical and comparative perspectives on the Quebec health care system. Dr. Fernand Turcotte, a professor of medicine at Laval University, reminded the court of the historical impetus for public health care and the relationship between access to health care and socio-economic status (*Chaoulli* 2000: 16-18). Dr. Howard Bergman, director of geriatrics at the Jewish General Hospital in Montreal, agreed that their patients were unsettled by the rapid changes in the health care system, but deplored privatization (the “healthy” versus “the wealthy”) as a panacea (*Chaoulli* 2000: 18-20). Dr. Charles Wright, a British Columbia surgeon, commented on the administrative efficacy of the single-payer system in Canada, while Jean-Louis Denis, a professor of health system organization at the University of Montreal, pointed out that rationing is explicit in every health care system, either through need as in Quebec, or the ability to pay, as in the United States (*Chaoulli* 2000: 20-24). Theodore Marmor, a professor of public policy at

Yale University, was asked what the likely effects of a parallel private system would be in Canada; his response was that the “undesirable side effects” included decreased support in the public system and increased costs of care and administration (*Chaoulli* 2000: 24-28). The last expert witness was Dr. Edwin Coffey, a retired ob/gyn and research associate for the Montreal Economic Institute, a conservative think tank that advocated the privatization of health care in Canada.¹⁰ His lengthy testimony deplored the “ideological and politically driven myths” in health care (*Chaoulli* 2000: 29).

Justice Piché delivered her judgment on February 25, 2000. Unlike Justice Allan in British Columbia, who reacted sympathetically to the claims of the autistic children and their parents, Justice Piché was severe in her criticism of the plaintiffs in *Chaoulli*. She began her summary by remarking “Let’s say it from the start: in light of Mr. Zeliotis’ testimony and an examination of his medical record, it is apparent that he did not really suffer all of the misfortune and delay that he claims in his deposition” (*Chaoulli* 2000, 6). As for Dr. Chaoulli, she questioned his motivation, pointed to contradictions in his testimony, and deplored his use of the court in a personal “crusade” against the Quebec health care system (*Chaoulli* 2000, 7-9). Although the Justice emphasized that the court had to take into account all sides of the expert testimony, she concluded that Dr. Coffey was very much a “lone ranger” in his heavy-handed criticism of the shortcomings of the Quebec health care system (*Chaoulli* 2000: 29).

Justice Piché’s legal analysis discussed the question of whether sections of Quebec’s health care laws, in prohibiting the exercise of private medicine and private insurance, were analogous to criminal law and therefore beyond provincial jurisdiction; the court characterized these provisions as regulations, not prohibitions, in the practice of medicine and therefore correctly conforming to provincial responsibility (*Chaoulli* 2000: 30-41). She also dismissed the claim that these laws violated the Charter’s equality rights provision, and reminded the plaintiffs that the Canadian Supreme Court had been careful

in its interpretation of the *Charter* to make sure that it did not serve as an instrument to undermine laws that served the public good (*Chaoulli* 2000: para 314).

Justice Piché's central analysis had to do with the claims relating to the right to life, liberty and security of the person under section 7 of the *Charter* (for a review, see Jackman, forthcoming 2005). Here, Justice Piché's review of case law from the Supreme Court of Canada led her to conclude that access to health care was indeed a right, since "without access to the health care system, it would be illusory to believe that the rights to life and security are respected" (para. 223), but she also pointed out that there existed no right to determine the "provenance" of that care (para 227). On the question of whether the existing limits on private insurance coverage were in violation of these same rights, the Justice affirmed that these restrictions could limit an individual's timely access to care, but such limitations would only contravene life, liberty and security of the person if the public system could not guarantee access to similar care. The Justice was careful to point out, even though these limitations existed and could be a "threat," that this was not in conflict with the principles of fundamental justice and therefore could not be considered to contravene section 7 of the *Charter* (para 310). She relied here on the guarantees of section 1 of the *Charter*, which allow for reasonable limits prescribed by law on rights and freedoms where these can be "demonstrably justified".

The use of the principle of fundamental justice to defend the public health care system was a central feature of the legal analysis that portrayed the limitations on private insurance that impeded personal rights as a way of protecting the collective rights of the rest of the population (*Greschner* 2002: 11). In effect, Piché argued that Quebec's health care laws did limit economic rights, but that "preventing discrimination based on one's ability to pay does not violate the values of the charter" (*Pinker* 2000: 1348). Justice Piché referred at length to the expert testimony that compared the efficiency and access to care offered by public and private health care systems, and cited at length Professor

Marmor's description of the negative impact of a parallel system of private insurance on the viability of the public system (Jackman 2002: 6).

Justice Piché concluded her analysis with a remarkable observation: she pointed out that while the health care system in Quebec was based on sound principles, there was evidently need for some change but that this question was political, rather than legal. In effect, Justice Piché understood well the political ramifications of the legal case at hand, and argued that health care reform was the responsibility of legislators, not judges: "the Court notes that solutions to problems of the health care system are not to be found on the legal side" (*Chaoulli* 2000: 315).

Despite these caveats, Justice Piché's decision was received as a strong defense of the existing health care legislation in Quebec that limited private insurance: her decision included a clear admission of the right to receive health care, but nuanced considerably the right to provide privately-contracted services. The plaintiffs were convinced, however, that by losing the battle, they "had a chance to win the war" (Pinker 2000: 1348) since Piché had agreed that the limitations on private insurance could constitute a violation of the charter under section 7.

Chaoulli and Zeliotis's appeal of the Superior Court judgment was heard on November 27, 2001 in the Montreal area Quebec appeals court (Cour d'appel du Québec). Chaoulli appeared as the appellant, again representing himself, against the Quebec Attorney General and the Canadian Attorney general as third party. Chaoulli changed his tactics slightly by arguing that the "excessive" limitations on private delivery and insurance in Quebec's health care legislation could be remedied by allowing less restrictive regulations based on European examples. The strategy was to show that parallel private systems did not necessarily jeopardize the public system, as had been argued by experts in the trial proceedings on the basis of US experience.

The appeals court delivered its judgment on April 22, 2002. The three justices, Jacques Delisle, André Forget, and André Brossard, again examined whether the sections

Quebec's health care laws under scrutiny were (1) *ultra vires* in terms of provincial jurisdiction; (2) violated section 15 equality rights under the charter and 3) violated section 7 rights to life liberty and security of the person. The three justices upheld Justice Piché's decisions on each of these questions in their concurrent judgments. Justice Delisle made an important contribution in emphasizing the broadened definition of the right to access to care, and agreed with the Superior Court that, although the health care legislation constituted a *prima facie* limitation on section 7 rights, this limitation was not inconsistent with principles of fundamental justice. He also argued that, while the right to enter into a private contract is prohibited by Quebec's health care legislation, this remains an economic right, and not "fundamental to the life of the person" and, furthermore, that the violation of section 7 rights had to be immediate and real, which was not evident in the case at hand (*Chaoulli* 2002: para 23-29). Justice Delisle also invoked an earlier Supreme Court decision in reminding the appellants that the Charter was not an instrument to remedy "societal choices" in the public domain; in other words, as Piché had argued, the courts cannot be expected to meddle too far in the realm of legislative responsibility. Justice Forget agreed on the overriding principles of fundamental justice, while Justice Brossard agreed on the distinction between economic and fundamental rights in this case.

After the appellate court judgment, Dr. Chaoulli immediately turned his efforts toward the Supreme Court of Canada, which he had publicly stated as being his ultimate objective at the start of the legal battle (Sibbald 1998). Chaoulli's argument in applying for leave to appeal to the Supreme Court relied on the *Morgentaler* (1988) precedent, in which Canada's abortion law had been declared unconstitutional under the Charter. In that judgment, the Supreme Court held that administrative delays in granting permission for therapeutic abortions violated a woman's right to security of the person under section 7 in both the physical and psychological sense. Mr. Zeliotis once again joined the effort,

with his counsel Trudel and Johnston, providing their services pro bono for this high-profile case (Gagnon 2003).

The Supreme Court granted leave to appeal in May 2003. By the end of the year, twelve separate constitutional questions had been formulated, dealing with (1) whether the provisions of Quebec's health (s. 15) and hospital insurance (s. 11) acts were ultra vires under the division of powers in the *Constitution Act*; (2) whether these provisions infringe the rights guaranteed under sections 7 (life, liberty, security) and 15 (equality) of the Charter *and if so*, whether this infringement can be "demonstrably justified" under section 1 of the Charter; and (3) a new question, reflecting Dr. Chaoulli's direct concerns, as to whether the limitations on non-participating physicians in Quebec's hospital insurance legislation violate s.12 of the Charter, the right to freedom from "cruel and unusual treatment or punishment".

By this time, the scope and stakes of the case had expanded significantly, as had the number of intervenors, from Chaoulli's "lone crusade" to a fundamental question about the legality of restrictions to private health care in Canada. There were several new intervenors in the case, including five other provinces (Ontario, Manitoba, British Columbia, New Brunswick and Saskatchewan), demonstrating the importance of the stakes at issue for provincial governments and their health care systems, since any decision reached by the Court on Quebec legislation would apply to legislation in the other provinces as well. In addition, there were now a substantial number of non-governmental intervenors in the case. These included interest groups committed to the maintenance of restrictions on private insurance and the protection of public health care system, namely the Canadian Labour Congress (the largest umbrella organization for organized labor in Canada) and the Canadian Health Coalition, representing labor groups, consumer groups, and segments of the community of health care professionals.

The intervenors supporting Chaoulli and Zeliotis were mainly organizations and businesses with a direct economic stake in the Supreme Court's decision and,

significantly, were not located within the province of Quebec. Two such groups included surgical centers in British Columbia that provided privately contracted care, such as eye and cosmetic surgery, as well as private diagnostic facilities. One of these groups, led by the Cambie Clinic in Vancouver which had been providing private orthopedic services since 1996 for groups exempt from the BC's health legislation (e.g., the Workmen's Compensation Board of BC), included nine patients and their physicians who claimed that they had been unable to receive and provide services despite their unavailability in the public system. In addition, the Canadian Medical Association, the Canadian Orthopedic Association, and the British Columbia Anesthesiologists Society were also represented in the case, although with a "middle-of-the-road stand": supporting the public system but denouncing existing obstacles to care (Nexus Online 2004).

This position was echoed by a highly unusual third party intervener in the form of a group of ten Senators from the Parliament of Canada. In 2002, two public reports had presented the results of exhaustive studies of the state of health care in Canada. The Commission on the Future of Health Care in Canada (known as the Romanow Commission, after its director former Saskatchewan social-democratic premier, Roy Romanow) published a vigorous defense of public health care against privatization, and its recommendations had been widely acclaimed by public interest groups. The Senate Standing Committee on Social Affairs, Science and Technology (known as the Kirby committee, after its chairman, the Conservative Senator Michael Kirby) also produced a six-volume report that, while also a defense of the merits of the public health care system, suggested that there might be a better mix of public and private concerns in the delivery of health care. Relevant to the *Chaoulli* case, as well, the Kirby committee recommended a "Care Guarantee" to establish a maximum waiting time for each treatment or procedure, after which time the provincial government would have to make that service available by other means (such as funding treatment provided elsewhere).

On June 8, 2004, the appellants brought their case before seven justices of the Supreme Court of Canada.¹¹ There was some agitation outside the courtroom as groups defending the public health care system gathered in Ottawa. The four-hour long hearing began with questions directed at Dr. Chaoulli by Justices Michel Bastarache and Marie Deschamps, who focused on the “socially undesirable” consequences of private services on access to health care as a whole. Chaoulli, representing himself, framed his answer in terms of how the “deficiencies” of the health care system were leading to “discord” between federal and provincial governments. He referred to countries such as Australia and Sweden that he claimed allowed for parallel private health care. He also cited Hayek in arguing that the freedom of contract is a right protected section 7 of the Charter.

Philippe Trudel again represented George Zeliotis, and asked the Justices two questions: should Canadians be allowed to use their own resources to buy care that they need if the public system cannot provide it in a timely fashion because of inadequate resources, and whether the state can prohibit individuals from using their own resources to do so. He was quizzed by Justice William Binnie as to whether the existing means to protect public health care were “grossly disproportionate,” but stood firm on the point that the Court’s responsibility was on the rights of the individual at hand rather than the integrity of the public system. Bruce Johnston, also representing the appellant, argued that more money was needed in the health care system, and that individuals should be allowed to inject that money even if governments were unwilling to do so.

Zeliotis’s case was supported by submissions on behalf of Cambie Surgeries, whose counsel claimed that the health care system was in “desperate” condition but that the waiting list problem could be easily solved by a readily available, parallel system of access to private care. More nuanced, Earl Cherniak, representing the Kirby committee, agreed that the health care system was in dire straits, but also insisted that there was a constitutional obligation for governments to deliver necessary services to their residents, preferably through a federal “health care guarantee” enforced by the federal government.

The Canadian Medical Association, vigorously reminding the Court of the physicians' obligation to "advocate for life, all life" supported this view on timely care, and reiterated that governments must provide a timely guarantee, or stop promising that they can deliver such care. Guy Pratte, the CMA's counsel, urged an *Eldridge*-type remedy in this case, in which the Court should mandate provincial governments to remedy their health care legislations to conform to care guarantees, but suspend any declaration of unconstitutionality to allow the governments to explore alternate means of meeting this obligation.

The Justices were persistent in their questioning, but prudent and clearly cognizant of the implications of the case. Four of the justices were particularly exacting in questioning representatives of the governments in the courtroom, all of whom cautioned the Court not to get involved in the policy issues at hand. Justices Bastarache and Lebel remained incredulous before Quebec's position that Zeliotis' experience was an isolated incident and that the delays in care are often due to patient decisions, not system failures. Justice John Major grilled Jean-Marc Aubry on the federal government's insistence that private services would have harmful effects on the public system, while Justice Binnie expressed exasperation at the Ontario government's conclusion that services must be rationed in order to control costs, and that a two-tiered health care system would not solve the waiting list problem. In her argument on behalf of the Canadian Health Coalition, Martha Jackman, a legal scholar widely known for her analyses of health care and the Charter, reminded the Court of the distinction between private care (which is available) and private insurance (which is prohibited by Quebec and other provincial legislation).

Analysis

At the time of writing, the final outcome of *Chaoulli* now rests with the Supreme Court of Canada. In concrete terms, so far the litigation in this case has not been

successful for either Chaoulli or Zeliotis. Despite some judicial recognition that excessive waiting times in the public health care system limit section 7 rights, the case suffered a rather clear defeat in the lower courts, with a total of four judges rejecting the plaintiffs' arguments. Mr. Zeliotis is still worried about his ability to access services in the future, while Dr. Chaoulli is still required to practice medicine within a health care system that limits the provision of private services.

In a broader sense, however, the litigation has been extremely successful. From 1997 to 2004, the scope and stakes of the case have expanded significantly from Chaoulli's "lone crusade" against Quebec's health care legislation to a fundamental question about the legality of restrictions on private health care in Canada. Chaoulli succeeded in getting to the Supreme Court, and in so doing galvanized an impressive array of competing visions of the future of Canada's health care system.

The stakes of *Chaoulli* for the health care system itself are considerably higher, and the potential effects much more immediate, than in the case of *Auton*. The Court is being asked to expand services under the existing health care system in *Auton*, which opens the door to more litigation from other, specific, groups seeking redress and compensation. But in *Chaoulli*, the Court is being asked to declare unconstitutional the central premises that allow for a single-payer health care system in the Canadian provinces. Should the Supreme Court rule in favor of the appellants or invoke an *Eldridge*-type solution, this decision will affect every piece of health care legislation in Canada, essentially forcing major amendments to those provincial systems that preclude private insurance coverage.

The news media characterized *Chaoulli* as "medicare on trial" and yet in many ways this is a sleeper trial. While the past decade has seen a sustained concern among Canadians, their political leaders, and the media, over the "crisis" in the health care system, and a literal avalanche of reports on the past, present and future condition of health care, relatively little attention has been paid to the role of the courts in health care,

and few individuals outside of specific medical circles or outside of Quebec would have known about the *Chaoulli* case until the Supreme Court hearing.

Until the Supreme Court presents its decision, *Chaoulli* can be considered to have a silver lining for all sides on the health reform debate in Canada. Opponents of the public “monopoly” in health care are buoyed by the fact that *Chaoulli* has reached the Supreme Court with the potential to allow the private sector a larger place in the health care sector. The middle-road position considers *Chaoulli* as a wake-up call to force governments to address the under funding of health care services in the public system. Staunch supporters of the status quo position are relieved that the case is contributing to the development of a constitutional “right” to health care that takes into consideration the principles of fundamental justice. Despite Justice Piché’s caveats, the courts are becoming the arena in which policy decisions are being fashioned, and her initial decision, which implied a right to access health care services without specifying precisely how those services should be provided was an important step in that direction.

Conclusion

The *Auton* story, at least as rendered here, is in many ways consistent with both sides of the debate concerning legal mobilization. Although litigation ultimately failed to establish the sought-for legal rule, it nevertheless nudged public policy in the desired direction and strengthened the autism treatment reform movement by energizing its participants and raising public visibility. Consistent with McCann’s position, the litigation effort succeeded in using legal arguments to reconstitute the policy debate about effective autism treatment. Moreover, the nature of the claimants meant that the effort did not generate a countermovement similar to what scholars have found in the case of abortion and gay rights litigation (Rubin 1982: 161; Anderson 2005: 218). Nevertheless, *Auton* is also consistent with aspects of Rosenberg’s argument. Although there was no organized countermovement, the lower court successes generated an article by two highly

respected scholars—Donna Greschner and Stephen Lewis—that was highly critical of those lower court decisions. In addition, those successes opened the door to Michelle Dawson’s intervention, which raised doubts about the universal acceptance of LAT as an appropriate treatment for autism. Institutionally, limited judicial independence and implementation capacity manifested itself in the form of remedial caution in the British Columbia courts, which meant that even legal victories did not translate directly into optimal policy change. Finally, the decision to invest six years and significant resources in a litigation campaign obviously entailed opportunity costs the magnitude of which is difficult to measure.

What are the broader implications of litigating health care reform? In the specific case of autism treatment, the combination of *Auton* and the Ontario decisions suggest a number of possible consequences, none of which are intended or desirable. First, given that there is no constitutional obligation to fund ABA or EIBT, but that there may be a constitutional obligation to fund treatment indefinitely once programs are in place, current autism litigation may have a chilling effect on provincial innovation. Second, the current state of the law in Ontario may provide an incentive for parents whose children have any kind of learning difficulty to encourage autism diagnoses in order to access these programs. Finally, as increased demand meets the reality of finite resources—in the form of money and qualified therapists—treatment waiting lists will lengthen. In each of these scenarios, the provincial response will undoubtedly generate even more litigation.

More generally, both *Chaoulli* and *Auton* are products of frustration with the inability of apparently unresponsive health care decision makers to provide a desired level of service. Although the desire of Canadians, frustrated by perceived bureaucratic and legislative inaction, to seek health care solutions from the courts is understandable, the benefits and costs of this path to policy change merit closer attention. The obvious benefit is that, when litigation is successful, courts may be able to order governments to

act quickly and forcefully. Yet litigation is not without disadvantages. First, the articulation of policy demands in the form of constitutional rights can exclude alternative policy choices from consideration. Rights-based litigation aims at altering policy priorities in an especially powerful way because of the difficulty of reversing, or even modifying, the priorities set through it. In this sense, health care litigation may, in some circumstances, be understood as a sophisticated form of queue jumping because it posits that a particular health care need deserves a higher priority than it has because of its grounding in a constitutional right. Second, the adversarial nature of litigation is best suited to resolving concrete disputes between two parties by imposing retrospective remedies. Complex policy issues—like health care—involve multiple stakeholders, constantly changing facts and evidence, and predictive assessments about the future impact of decisions. Finally, rights-based litigation, particularly at the Supreme Court level, by definition imposes national solutions on inherently local problems. These solutions can ignore differences among provinces and suppress the provincial experimentation necessary to find innovative approaches to policy problems. Canadian health care faces a multitude of complex challenges, which requires careful consideration of the contribution that courts can make in meeting those challenges before embracing litigation as an instrument of reform in health care policy.

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Notes

¹ . Rosenberg was not entirely pessimistic, however. Litigation can be effective, he argued, when certain conditions are met. First, incentives must exist for key actors to implement changes. Second, there must be costs associated with resisting change. Third, compliance is more likely where the possibility exists that social change can be implemented by parallel institutions. Finally, success will be higher where court orders can be used as leverage to extract additional resources (Rosenberg 1991: 33-35).

² . The Winter 1999 and Spring 2000 issues of *Law and Courts* (newsletter of the Law and Courts Section of the American Political Science Association) also have interesting discussions of the lack of comparative study among US political scientists in this field.

³ . According to one of the authors of the 1993 study, there have been no other controlled studies of EIBI programs for autistic children (*Auton* 2000: 62).

⁴ . *Auton* 2004: para. 61, citing *Auton* 2000: para. 66. One should note that the trial court also recognized that the original Lovaas study also failed to meet the “gold standard” for experimental studies” because it did not randomly assign children to the experimental and control groups. See *Auton* 2000: para. 38.

⁵ . *E. (G.) v. Alberta (Child Welfare Appeal Panel)* (2003) ABQB 846; *Cucek v. British Columbia (Ministry of Children & Family Development)* (2003) BCHRT 44; *Clough (Litigation guardian of) v. Ontario* [2003] O.J. No. 1074; *Lowrey (Litigation guardian of) v. Ontario* [2003] O.J. No. 2009; *P. (M.) v. Chinook Regional Health Authority* [2004] A.J. No. 32; *K. (L.) v. Alberta (Child Welfare Appeal Panel)* (2004) ABQB 65; *Fleischmann (Litigation guardian of) v. Toronto District School Board* [2004] O.J. No. 160; *Wynberg et al. v. Ontario* [2004] O.J. No. 1066; *Eisler (Litigation guardian of) v. Ontario* [2004] O.J. No. 1864; *N. (R.) (Litigation guardian of) v. Ontario* (2004) Carswell Ont 1073; *Newfoundland & Labrador v. Sparkes* [2004] N.J. No. 34.

⁶ . <http://www.autismsocietycanada.ca/docs/FINALAuton%20Decision.pdf>.

Accessed 24 February 2005.

⁷ . <http://www.ipsos-na.com/news/pressrelease.cfm?id=2505>. Accessed 28 February, 2005.

⁸ . The text of Article 15 is: “No person shall make or renew a contract of insurance or make a payment under a contract of insurance under which an insured service is furnished or under which all or part of the cost of such a service is paid to a resident or temporary resident of Québec or to another person on his behalf” (*Loi sur l’assurance-maladie*, L.R.Q. A-29).

⁹ . The text of Article 11 is: “No one shall make or renew, or make a payment under a contract under which (a) a resident is to be provided with or to be reimbursed for the cost of any hospital service that is one of the insured services; [and] (b) payment is conditional upon the hospitalization of a resident” (*Loi sur l’assurance-hospitalisation*, L.R.Q. A-28).

¹⁰ . Coffey and Chaoulli later co-authored a text on “universal private choice” (MEI, 2001).

¹¹ . Sources for this testimony include notes from the proceedings in Ottawa by Christopher Manfredi, June 8, 2004; *CTV News* transcript, June 8, 2004; the *Canadian Press* report by Dennis Bueckert, June 9, 2004; and Matt Borsellino in *The Medical Post*, June 22, 2004. Two Justices, Louise Arbour and Frank Iacobucci, had announced their intention to leave the Court and therefore did not participate in the deliberations.