Health Care Reform and Judicialization in the Netherlands, Italy and Canada: Accounting for both the Supply and Demand side of Judicialization

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Health care policy in the Netherlands, Italy, and Canada over the last two decades has been dominated by the theme of reform. The reality of ever-rising health care expectations within an era of widespread welfare state retrenchment has motivated policy actors in each state to revisit long-held policy assumptions, and to experiment with new paradigms of health care delivery and health care funding in order to control costs. While in many ways the primary causes of increased health care expectations and shrinking welfare state budgets are similar across these cases, each state's policy response has been influenced by their respective health care policy legacies (Pierson 1996, 2001).

The same can be said of how each state has experienced another 'global trend' – judicialization. As "post-industrial" societies have become ever more complex and difficult to govern (Luhman 1972, Inglehart 1977), disaffected citizens have sought out new avenues through which to influence public policy (Crozeir et al. 1975, Norris 1999). At the same time, the "new constitutionalism" (Hirschl 2004, 2008) and the maturation of "rights-based support structures" (Epp 1998) have encouraged the choice of courts as a venue to pursue policy goals. Yet these common socio-political pressures have not had a uniform affect on the power balance between legislatures and judiciaries across all states. As is the case for welfare state retrenchment, knowing how judicialization is likely to evolve begins with an understanding of how its constituent elements were formed.

The nexus of these common trends in judicialization and health care reform over the last two decades has yielded high profile cases in each of the Netherlands, Italy, and Canada. These have focused the attention of both scholars and the public on the validity of judicial involvement in what for many citizens represents the very core of the welfare state. While the legal analysis of key high court decision is undeniably important[1], additional insight may be gained by comparing the trends observed in these decisions to changes within each state's broader judicial and political context. In the Netherlands this comparison reveals how a resilient core of judicial activism can emerge in what may appear the most unlikely of scenarios. In Italy, where judicial interventions into health care policy were both earlier to arrive and more radical, episodes of judicial activism still persist, but are moderated by a deference to a more active state. Canada, by comparison, has experienced relatively little judicialization of any kind, despite experiencing many of the same pressures that contributed to its emergence within the Netherlands and Italy. What a comparison across states suggests for Canada is that it is its relatively unique reliance on the single payer model that has prevented the pace of judicialization from increasing. What emerges from the comparison across cases is not only a greater understanding of how judicialization has influenced health care reform, but perhaps more interestingly, how health care reform (or the lack thereof) shapes judicialization.

The "Judicialization of Politics" revisited

Tate and Vallinder's (1994) timely exposition of *The Global Expansion of Judicial Power* provided wide-raging support for the general hypothesis that the

[1] See Flood et. al (2005), Den Exter and Hermans (1998) and France (1999) for examples of legal analyses for Canada, the Netherlands, and Italy respectively.

combination of several common conditions (Tate, 21-36)[2] encouraged two processes that together comprised the 'judicialization of politics'. In short, these common conditions encouraged judicial processes to become more political and political processes to become more judicial. Alec Stone Sweet in the same volume provided a more complex rendering of this hypothesis with a subtly different emphasis: "In judicialized environments, constitutional courts behave legislatively. But the following is also true: the *degree to which any legislative process is judicialized is equivalent to the degree to which parliament behaves judicially* (221 my italics)." On the judicial side, Tate also distinguished between the existence of the conditions favouring judicialization, and the act of judges actually taking advantage of these conditions to advance their own policy preferences (33). The conditions favouring judicialization could 'open the door', but judges still had to 'walk through'. On the political side, Stone Sweet's *disaggregated* depiction of judicialization recognized that "judicialization is neither *permanent nor uniform*…each policy area manifests its own dynamic of constitutional possibility and constraint, conforming to the intensity of judicial-political interaction and the development of constitutional control (207, my italics)." Put simply, there was actually more than one doorway in any given state, and political actors were not incapable of reaching through on occasion to the judicial side, or perhaps getting up and closing (or at least narrowing) a door or two.

My analysis builds on these concepts of judicialization and its "enabling conditions" as put forward by Tate and Stone Sweet. As per Tate, it attempts first to delineate judicial activity from judicial activism. An increase in the number of cases heard and decided in a particular area (judicial activity) does not, necessarily, imply that judges' policy preferences are replacing those of a legislative majority (judicial activism). Indeed, *an increase in judicial activity may be a necessary, if not necessarily desired, consequence of the policy preferences of a legislative majority*. Despite Tate's initial framework, legal-political analyses of judicialization, including chapters in the Tate and Vallinder text itself, continue to blur this distinction. My analysis goes a step further than Tate in operationalizing the enabling conditions and their relation to judicialization and organizing them into two main categories – those that affect "judicial supply" and those that affect "policy demand". The conditions that affect judicial supply influence the level of judicial discretion across policy areas and "open the doors" to judicial activism. Those that affect policy demand influence the level of judicial activity within a particular policy sector and, in effect, determine how many 'invitations' judges get to walk through a particular door. They also influence the degree to which political processes become "judicialized", or, to stretch the running metaphor, the likelihood that politicians hire in-house quasi-judicial staff in order to cut down on the number of potential invitations to members of the official judiciary.

In addition, my analysis takes a different view of how to gauge the normative impact of judicialization. In Tate's simple construction, activism existed when left-leaning judges frustrated right-leaning majorities or vice versa. Although left-right

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[2] These conditions were "democracy, a politics of rights, a system of interest groups and a political opposition cognizant of judicial means for attaining their interests, weak parties or fragile government coalitions in majoritarian institutions leading to policy deadlock, inadequate public support (for governments), at least relative to judiciaries, and the delegation to courts of decision-making authority in certain policy areas (33)."

criteria are generally well understood and hence could serve the purpose of relaying important information regarding the normative character of judicial activism, it is simply not a straightforward issue to comprehensively gauge activism in this manner in complex and far-reaching policy fields like health care. The left-right considerations of any decision to enhance system performance in one area of health care, or in health care overall as opposed to other areas that may more directly target issues of inequality, are increasingly controversial within mature welfare states (Glied 2008). While these controversies are undoubtedly politically relevant, they are beyond the scope of this paper. I will instead capture profiles of judicial activism through relatively objective criteria focusing primarily on two decision areas:

1) *Access to benefits/choice of provider* – examples here include decisions that concern the extension of benefits (services or drugs) beyond normal limits to accommodate exceptional cases or the right of a patient to choose between or among private and public providers of care. These cases often revolve around the applicability of general standards of clinical effectiveness /procedural fairness to specific circumstances or the balancing of competitive incentives with the management of overall health care expenditures.

2) *Rationalizing care/downloading* – examples here include cases related to the 'downloading' of responsibilities for deficits, facilities rationalization, as well as capping, de-listing, and the development of minimum standards of care. Cases in this area balance system level concerns for sustainability and preserving universality with patient and provider concerns regarding quality and comprehensiveness.

The criteria for both areas examine how often judiciaries make decisions that negate or overturn the actions of legislatures and executives and on what bases were these decisions grounded. Within area 1) judges could be generally reluctant to extend benefits in other than very exceptional cases where the impact of their decision can be contained. Alternatively, other judiciaries may show a greater willingness to take principled decisions that affect whole classes of individuals. That same judiciary may over time begin to innovate new principles in order to participate even more directly in how the basket of health care benefits adapts to changing requirements. Similarly, within area 2) judges may demonstrate varying degrees of sensitivity to the government's stated policy goals when considering cases that object to rationalization efforts. Judges can act as willing agents of government and serve primarily to reinforce rationalization or instead they may draw on independent constitutional or legal principles in order to participate jointly with governments in determining how rationalization programs are implemented. Any significant changes in judicial decision-making patterns within individual settings can then be related back to coincident changes in judicial supply and policy demand conditions.

The scope covered by these two areas, while by no means addressing all areas of health care reform, includes elements of each of the primary functions of an independent judiciary from asserting individual rights and providing for judicial review of

administrative actions, to safeguarding the constitutional division of powers within the state. How the response of judiciaries has evolved (or failed to evolve) over time in both these areas is thus likely to provide insight into the broader judicial-political evolution of health care policy-making as a whole.

Methodology – Dealing with Causal Complexity

Intuitively, one might expect that the causal conditions that influence judicial supply and policy demand will have an unambiguous relation with both forms of judicialization. The more doors that are opened, and the more invitations extended, the greater the likelihood of traffic increasing between the judicial and political 'rooms'. The complexities of actual interactions between supply and demand side conditions may reveal a less tidy reality. Certain invitations may be accepted in one setting and yet still rejected in others. Others may need to be offered a few times before being grudgingly accepted. To prepare for this potential, I will rely on an adapted version of Ragin's *Qualitative Comparative Analysis* or QCA. QCA recognizes that outcomes of interest to social scientists are often the result of a *combination of variables acting together*. This *complex* and *conjunctural* understanding of causality allows for the possibility that "different conditions combine in different and sometimes contradictory ways to produce the same outcome" (Ragin 2000, 40). The focus of QCA is not the measurement of the independent contribution of a particular condition to changes in an outcome of interest[3], but rather to determine if particular conditions, whether separately or together in various combinations, are either necessary or sufficient with relation to outcomes actually observed. The mechanics of QCA rely on the construction of "truth tables" that relate the values assigned to each set of conditions to observed outcomes and that enable the relationship between conditions and outcomes to be reduced to "minimum formulas" through the use of Boolean logic. Given the conditions I will outline below are inherently non-dichotomous, I will rely on the multi-value variant of QCA (mvQCA) (Rhioux and Ragin 2009, ch. 4) wherein conditions are assigned scale values based on a mix of quantitative and qualitative criteria.

My analysis will also rely on two adaptations to standard mvQCA. First, to organize more coherently the analyses of judicial supply and policy demand conditions as a whole, while still allowing for unique interactions across this distinction, I will organize my mvQCA analysis within a two-level framework (Goetz and Mahoney 2005). Second, QCA techniques in general have been criticized for relying on "snapshot" analyses and thus failing to adequately accommodate the "temporality problem" (Rhioux and Ragin 2009, 161-164) associated with understanding how changes to political outcomes happen "in time" (Pierson, 2004). To partially address this I will segment each main case into 3 or 4[4] temporally defined 'subunits'. The patterns across subunits will be qualitatively

[3] Any attempt to do this given the small-n nature of my analysis coupled with the number of conditions of interest and their possible interaction effects would be fraught with methodological peril in any case. Alternatively, to fallback upon a reliance on descriptive cases studies lacks methodological rigour – hence the inspiration to attempt to utilize QCA that combines to good effect (as will be demonstrated) elements of both alternative approaches.

[4] The number of subunits is dependent on my evaluation of when significant changes in the underlying conditions are observed for each case within the overall analysis time period. The subunits within each case will try to demark periods wherein these conditions are relatively stable.

evaluated first prior to being compared across cases. This will allow for the possibility that particular outcomes are not only related to the existence of a specific combination of conditions within a particular period, but may also be dependent on the evolution of these condition values in a particular sequence across periods.

My preliminary two-level framework of judicial supply and policy demand conditions with a brief explanation of the theoretical grounding of each condition is below:

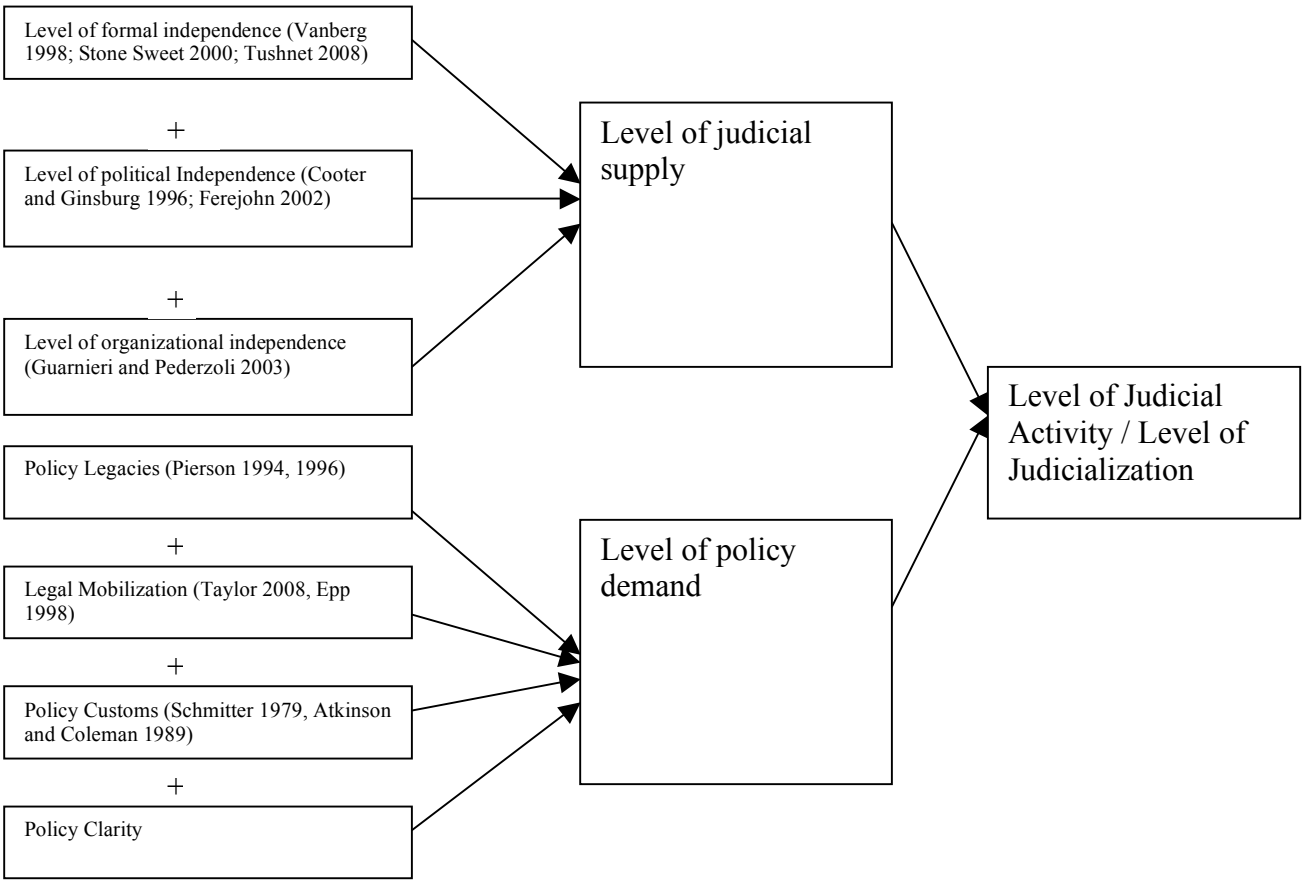

Figure 1. A two-level theoretical framework for the analysis of judicial activity and judicialization.

This framework is devised from a review of the relevant literature in the fields of judicial politics, policy analysis, and welfare state theory and has been adapted as information has been collected for the cases selected. The secondary conditions for both judicial supply and policy demand cover some of the same territory as Tate's original set, but also strike new ground (Policy Clarity) and are generally defined with a more specific theoretical grounding (what I will refer to as "partial theories" (Scharpf 1997, 20-35)) in the related research area. At this stage in my research the framework provides the basis

for the deductive definition of hypothesis concerning the relation between combinations of conditions that develop over time to the impact of judicialization on health care reform (and potentially vice versa). These theories need then to be evaluated through further qualitative analysis of each case. To enable this in the second stage of my research project I will rely on the techniques of "process-tracing" (George and Bennett 2005). New insights about important conditions not considered may be gained within this second stage and will need to be reintegrated back into what would then be a revised version of this framework. This refinement of the set of causal conditions through an on-going interaction between available theories and case-related data is inherent to the "diversity-oriented" focus of QCA methods (Ragin 2000, 74-76).

The judicial supply secondary level conditions are primarily "institutional" considerations that together define the zone of discretion available to judges through reference to multiple dimensions of independence. The first secondary variable measures the extent of formal independence as determined by constitutional provisions for judicial review. This is perhaps the most obvious criteria and involves consideration of both the model of judicial review within the polity (Vanberg 1998), as well as the scope and character of constitutionalized formal rights (Stone Sweet 2000, Tushnet 2008). Generally the partial theories that support this variable posit that the greater the formal provisions for judicial review, the greater the area of interpretation available to judges to influence policy outcomes.

The next secondary variable addresses the level of political independence and is measured as a function of the level of power fragmentation within the political branches. Judges are generally seen to be more likely to engage in policy-making when they perceive their decisions are unlikely to be overturned by a fractious parliamentary setting and alternatively have less freedom when they face an executive dominated by a single disciplined party (Cooter and Ginsburg 1996, Ferejohn 2002).

The last secondary variable on the supply side of the framework examines the level of organizational independence through consideration of judicial recruitment and advancement policies. Guarnieri and Pederzoli (2003) have argued that different factors operate in common law (Canada) versus continental legal systems (the Netherlands and Italy). In the former, the more politicized the process for evaluating candidates for judicial appointments, the greater the likelihood that judges will engage in policymaking. Within the latter, the impacts on judicial discretion are related instead to the extent to which "judicial associations" such as "Higher Councils of the Judiciary" (51) have taken control of judicial advancement processes. The greater the control exercised by Higher Councils as opposed to political executives, the greater the independence of senior level judges.

On the policy demand side of the two-level framework the secondary conditions are less easy to distinguish, as the dividing lines between conditions within the political policy arena are not as easy to fix. 'Policy legacy' (adapted from Pierson 1994, 1996) attempts to measure whether the inherited structure of a given health care system is likely to provide for greater or fewer litigation opportunities. This can be seen as a function of the form of health care insurance (whether social/fund-based or national/tax-based[5]) and the mix of public and private providers involved in delivery. The more varied the organization of health insurance and the delivery of care (i.e. the greater the number of

[5] These do not exhaust the possibilities, as hybrids of the both these archetypes are increasingly the norm.

sources of finance and the greater the mix of private and public delivery) the greater the potential opportunities for litigation, as shared reference standards of what is owed by and to patients may be administered differently across disparate organizational cultures.

'Legal mobilization' evaluates how easy or hard it is for motivated individuals to move their issues to the courts. The decision by individual actors to pursue litigation is dependent on their evaluation of their potential costs versus their expected benefits.[6] Uncertainty about either can be a significant disincentive to engage in litigation as a strategy (Taylor 2008). If the costs of initiating litigation are known to be relatively low and the time to judgment relatively short, the incentives to litigate are higher. In addition, if legal resources (lawyers. legal aid, advocacy groups) are well established within the policy area (Epp 1998), then easier access to reliable legal advice and legal support may remove some uncertainty with respect to expected benefits and allow for costs to be shared or subsidized.

The next condition, 'Policy customs', attempts to take account of the norms and practices that shape state-society negotiations within the legislative policy-making arena. Coherent groups of practices and norms have been conceptualized as pluralist (informal negotiations with ad-hoc state response), state-directed (informal but state-led), collaborative (formal with shared development of policy), and corporatist (state-sanctioned negotiations between peak organizations) (Atkinson and Coleman 1989, Schmitter 1979). The impact of this condition is as yet largely unexplored with respect to issues of judicialization.[7] I suggest that policy customs that tend towards the corporatist extreme will be less likely to encourage policy actors to transfer their issues to courts given their integration within hierarchically organized negotiation structures. Policy actors that are embedded within corporatist policy regimes may be unwilling to risk their ongoing place at the policy-making table by challenging policy losses in other venues such as courts. As a consequence, they may eschew litigation opportunities even if they are plentiful. In contrast, those that tend toward pluralist norms will be more likely to transfer their issues to courts as "one agency among many" (Shapiro 1964). Actors within pluralist policy networks will hence be more likely to take advantage of litigation opportunities as and when they arise.

'Policy clarity' is a function of the consistency of the legal text of health care acts and regulations. In general, the greater degree to which the set of legislative acts and regulations that administer a policy area share common and clearly articulated core principles, the more likely they are to resist innovative judicial interpretation – in Canadian legal parlance they become "Charter-proof". This is not to say that less consistent policy regimes are necessarily unstable, only that their stability is more likely dependent on the continual piecemeal construction of guiding principles through an accumulation of judicial decisions and case law.

In Appendix 1. I have outlined how each of these partial theories discussed above can be translated into criteria that guide the assignment of values for each condition. Wherever possible, I have attempted to take advantage of objective criteria while still remaining faithful to the insight these theories lend to my analysis. As the overall

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[6] These benefits may also be of a moral or ethical rather than monetary value.

[7] Guarnieri and Pederzoli (2002, p103-105) provide some reflections on the impact of corporatism that is similar to the approach I take.

framework is applied to multiple cases and sub-units, the logic behind these assignments can be evaluated and refined as required.

Case 1. The Netherlands (1987-2008)

The Dutch health care system has historically been financed through a mix of private and public insurance funds. Prior to 2006, those individuals who fell below a certain target income level were required to enroll in one of several non-profit "sickness funds" (ZWF - Ziekenfondswet) that each offered a standard, well-defined basket of services. Generally only about 60% of the population was covered at any one time by the ZWF making the Dutch health system one of the most privatized in Europe (Minogiannis 2003). Those who made more than the target income level were free to choose from a wide variety of private insurers, but could also choose not to buy health insurance. In addition, a universal program of long-term care insurance (AWBZ) continues to cover all citizens against exceptional medical risks and provides for long-term stays in hospitals and nursing homes, as well home care. The provision of services has always been in private hands such as individual doctors and charitable organizations with the more recent participation of vertically integrated health care companies. Beginning in 2006 the sickness funds were privatized and the distinction between private and public insurers collapsed into a regime of 'managed competition'.

During the 1980s attempts to contain costs by working together with health care insurers and health care providers failed, and governments were forced to implement top-down supply-side rationing measures to reduce hospital capacity and cap expenditures to doctors and specialists. These top-down methods managed to control the growth in expenditure, but they did little to address inefficiencies and "brought the government and private interests, health care providers and insurers into a permanent state of conflict (Helderman et al. 2005, 197)." The suggestions for reform that were to emerge from the experiences of the 1980s were captured by the Dekker committee which in 1987 issued a report that would chart the course that would eventually lead to the 2006 reforms.

The overriding message of the Dekker report was that the containment of cost through increased government regulation did not work (Okma 2000). Rather than centralizing control, government should delegate the responsibility for cost control to health insurers and providers, as well as citizens, who would respond to market-driven incentives (Schut 1995). Between 1988 and 1994 a series of incremental steps were taken towards the Dekker vision. Sickness funds were allowed to compete across regions or merge and were also allowed to selectively contract with providers and negotiate lower fees that the regulated rates. A portion of sickness fund premiums was converted to a flat rate charge and formed the basis for cost comparisons between funds. Enrollees were then allowed to switch sickness funds once every two years closing the new circle of competitive incentives (Helderman et al. 2005). Within the same time period the Dunning Committee proposed a "funnel system" for managing the minimum basket of care offered. They recommended that "services in the basic package must satisfy four criteria: the care must be necessary, effective, efficient and cannot be left to individual responsibility (cited in Minogiannis 2003, 133). The 'Dunning Principles' were to become important tests utilized by both policy-makers and judges when considering the composition of the "basic basket". Despite the early optimism surrounding both the

Dekker and Dunning reports, by 1994 the reform process had stalled as the consensus on the general shape of reform yielded to disagreements on the details of its implementation.

In 1995 the first coalition government since 1917 not built around the CDA (Christian Democrats) took office. The so-called "purple coalition" joined the left-leaning PvDA with the right-leaning Liberals and promised an incremental approach to health care reform. They began by reducing the role of advisory bodies within the still dense corporatist policy network and also removed interest groups from the policy consultation process. At the same time, the peak organizations for health providers and insurers were declining in relevance as organizations consolidated both vertically and horizontally. The larger conglomerates that emerged became powerful policy actors able to pressure government directly (Heldermann et al. 2005). The purple coalition also reintroduced elements of top-down rationing, especially within the AWBZ, creating long wait lists for places in long-term care facilities and nursing homes.

By 2000 some of the changes focused on introducing market incentives within the ZWF had begun to take hold. The amount of risk borne by sickness funds had grown from 2.5% in 1995 to 36% in 2000 and rose to 50% by 2004 (Minogiannis 2003, Heldermann et al. 2005). Differences in the flat rate portion of the premium charged by sickness funds also began to vary more from fund to fund. The cost structure on the provider side was radically altered as fee-for-service payment for specialist care eventually evolved to lump-sum payments based on diagnostic treatment combinations (DBCs – the Dutch equivalent of diagnosis-related groups (DRGs)). The increased use of market incentives drew in the oversight of the Dutch Competition Authority (NMa) to protect against price fixing and to ensure competition complied with EC requirements. When the CDA returned to power in 2002 the incremental changes over the past decade had seen the administration of sickness funds and private insurers begin to converge on similar market-driven practices.

The transition to "managed competition" in 2006 was nevertheless a significant achievement. The new Zorgverzekeringswet (ZvW) eliminated the remaining distinctions between sickness funds and private insurers and ushered in a new and complex risk equalization scheme to help ensure that funds did not "cherry pick" their clients (Maarse and Bartholomee 2007). A new administrative tribunal, the Health Insurance Complaints and Disputes Foundation (SKGZ) combined both ombudsman (mediation) and dispute resolution functions. The SKGZ can ask the Health Care Insurance Board (CvZ) for opinions on cases where medical expertise is required (the CvG and its predecessor the Ziekenfondsraad dealt with these type of disputes directly prior to 2006), but it does not have to abide by their recommendations. The CvZ also has responsibility for "package management" generally and utilizes a network of subcommittees that provide advice to the cabinet.[8] The Netherlands Health Authority (NZa) was established to supervise care markets (both for cure and for long-term care) replacing both the College for Health Tariffs (CTG) and the College for Health Monitoring (CTZ). The CTG and CTZ had primarily dealt with managing the total costs

[8] The three main sub-committees are the Pharmaceutic Aid Committee for assessing new drugs; the Package Clarification Committee for questions of whether a drug or service is in the basic package; and the Package Advice Committee that ensures the package contents are "society-oriented". These were first established when the CvZ replaced the Ziekenfondsraad in 1999.

of the ZWF and the AWBZ through supply side caps and rate-setting while the NZa's emphasis is to identify market mechanisms through which to manage costs.

This brief overview of major health care policy reform efforts over the past two decades in the Netherlands yields four different periods wherein policy demand conditions were relatively stable. These are: the initial Dunning reform era (1988-1994); the purple coalition's attempts at incremental reform (1995-1999); the transition to managed competition (2000-2005); and the era of managed competition (2006-2008). The level of judicial activity across these eras has fluctuated significantly, especially when compared to levels of activity within the area of Social Insurance[9] as a whole. Table 1 below provides details of the level of judicial activity across the relevant time periods for both the Rechtbanken (Regional Administrative Courts) and the CRvB (Central Board of Appeal).

TABLE 1. Judicial Activity Levels – The Netherlands [10]

	1988- 1994 Avg / Yr	1995-1999 Avg / Yr	2000-2005 Avg / Yr	2006-2008 Avg / Yr
Central Board of Appeal:				
Sickness funds Cases				
Submitted (new)	19	35	72	72
Total Judgments	20	21	40	60
Total All Social Insurance				
Submitted (new)	5638	6875	4327	4209
Total Judgments	5866	5512	3152	3642
Sickness funds as % of all S.I.				
Submitted (new)	**0.34%**	**0.51%**	**1.67%**	**1.70%**
Total Judgments	**0.34%**	**0.39%**	**1.26%**	**1.63%**
Regional Admin Courts:				
Sickness funds Cases				
Submitted (new)	108	314	578	419
Total Judgments	115	284	397	466
Total All Social Insurance				
Submitted (new)	36859	27431	17747	16429
Total Judgments	32458	36916	13551	13238
Sickness funds as % of all S.I.				
Submitted (new)	**0.29%**	**1.14%**	**3.26%**	**2.55%**
Total Judgments	**0.35%**	**0.77%**	**2.93%**	**3.52%**

[9] The Social Insurance category includes cases related to disability, unemployment, and pensions among others.

[10] Sources – 1988-1995 *Burgerlijke en administratieve rechtspraak;* 1996-2000 *Kwartaalbericht Rechtsbescherming en Veiligheid*; 2001- http://statline.cbs.nl/.

The process for contesting a decision of the Dutch government within health care has remained stable over the analysis period.[11] Once an individual has exhausted the appeals process within the CvZ/SKGZ, they are able to register and appeal at one of the regional Rechtbanken. A nominal fee[12] is required to register an appeal and you do not need legal representation to appear before the regional administrative court. Appeals of administrative court decisions can currently be registered at the Central Board of Appeal (CRvB) and litigants must appear represented by legal council when their case is before the Board. Decisions of the CRvB are generally final with no right of appeal to the Hoge Raad (the Supreme Court). Administrative justices evaluate whether the decision made by the administrative body is consistent with the act or regulation that governs their conduct. In most cases this involves ensuring that the authorities followed the correct procedures in reaching a decision, but judges are also free to challenge the "correctness" of a given decision (whether it fits the facts or considers properly relevant guiding principles).

The Dutch Constitution specifically prohibits the judiciary from declaring acts of parliament invalid through constitutional review (Koopmans 2003) so appeals to Article 22's claim that "the authorities shall take steps to promote the health of the population" are of little value. Paradoxically, as a result of a Constitutional amendment in 1953 that was originally crafted to deal with the cutting of constitutional ties with Indonesia, national laws can be invalidated if they conflict with a self-executing provision of an international treaty (Article 94). Over time, Dutch jurisprudence has made increasing use of this anomaly to craft a form of constitutional review based on elements of EU law. Within the health care arena a string of high profile rulings of the ECJ concerning the relation of health care policy to EC competition law have gradually been incorporated into the reasoning of administrative judges.

The *Kohll*[13] ruling established that "prior authorization" procedures for ambulatory health services could represent a barrier to the free movement of services within the EC. Dutch courts initially ignored this ruling as they felt it did not apply to systems like the ZWF and AWBZ where benefits were delivered "in-kind" (Van Thiel and Lugtenberg 1999). The *Smit-Peerbooms*[14] ruling (a reference from the CRvB asking for clarification with respect to the applicability of *Kohll* to in-kind systems) confirmed that prior authorization schemes were a barrier to free movement in all cases but hospital care and even then needed to be justified on an "objective basis". This forced Dutch courts to broaden the range of data and opinions they considered when considering whether to grant reimbursement for exceptional cases. The *Muller-Faure and Van-Riet*[15] rulings took this one step further by mandating that national courts also take account of the individual's medical condition when considering if equivalent treatment options were available within national boundaries. This raised the question of how long of a delay was valid and how to evaluate this on a case-by-case basis.

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[11] Dedicated regional administration courts and the CRvB were established in 1992 via the General Administrative Law Act (AwB) as the workload in administrative justice swelled. The data above includes cases from prior to 1992 on an equivalent basis.

[12] The registration fees in 2009 were 41 Euro for cases at the regional level and 110 Euro for cases at the CRvB.

[13] *Kohll v Union des Caisses de Maladie* [1998] ECR I-1931

[14] *Geraets-Smits and Peerbooms* [2001] ECR I-5473

[15] *Muller-Faure and Van-Riet* [2003] ECR I-4509

The CRvB broke new ground with two of its own rulings in 2000[16] and 2008.[17] The 2000 case involved a request for a drug (Cellcept) not on the ZWF formulary. The drug was necessary because the alternative medication (on the formulary) would likely cause kidney failure for the plaintiff. The regional court had denied the request but the CRvB invoked principles of "unwritten law" in allowing the appeal. The CRvB reasoned that administrative officials should have considered the fact that strict interpretation is not necessary in exceptional circumstances where death or serious injury is likely and alternatives are less costly than costs of inaction (given the health care system would need to bear the costs of dealing with the failed kidney). In 2008 a patient who sought to have a breast prosthesis removed prior to it causing her serious injury was denied reimbursement because the procedure had been deleted from the insured list of benefits. This denial was despite the fact that the prosthesis had been inserted with the assurance that the sickness fund would cover the cost of removal if necessary. The CRvB appropriated the framework provided by the Hoge Raad in the *Agricultural Spray Fly Case* (NJ 1987, 52) and claimed the government had acted contrary to "arbitrary prohibition" and declared the act invalid. While theses judgments may appear unremarkable to analysts of common law systems, they represented a marked departure from what was accepted judicial practice only a few years earlier. The data summarized in Table 2. confirm that these rulings are not exceptions.

Table 2. The Netherlands: Judicial Activism across Eras.[18]

	Dekker Reforms 1988-1993			Purple Coalition 1994-1999		
Decision Area	Cases of Activism	Total Cases	% Activist Rulings	Cases of Activism	Total Cases	% Activist Rulings
Acc. to Benefits / Choice of Provider	1	11	**9%**	9	34	**26%**
Rationalization of Care	0	3	**0%**	3	29	**10%**
	Transition to Comp. 2000-2005			Managed Competition 2006-2008		
Decision Area	Cases of Activism	Total Cases	% Activist Rulings	Cases of Activism	Total Cases	% Activist Rulings
Acc. to Benefits / Choice of Provider	15	50	**30%**	13	24	**54%**
Rationalization of Care	13	50	**26%**	12	27	**44%**

The remarkable expansion of the formal scope of judicial review intimated in the analyses of pivotal ECJ and CRvB rulings is reinforced by the data derived from the sample cases. Dutch judges are to an increasing degree bending the boundaries of

[16] *CRvB September 28, 2000*, No. 98/8878 ZFW

[17] *CRvB, February 06, 2008*, nr. 06/6606 ZFW

[18] Based on my own analysis of approximately 100 relevant sample cases – see Appendix 2 for the list of sample cases.

administrative law to provide positive benefits to individuals. This finding is even more relevant given that the sample data from later subunits was more heavily weighted towards rulings of the CRvB.[19]

In contrast to the factors discussed above that influenced judges' formal judicial independence, the factors that affect the political and organizational independence of Dutch judges have remained remarkably stable. Despite a marked increase in electoral volatility as the popularity of new political parties increased and the central position of the CDA declined (Mair 2008), the analysis period does not stand out against Dutch parliamentary history as one with unstable governing coalitions (Andeweg 2008). In fact, excluding the first Balkenende coalition in 2002[20], four of five coalitions governments remained in power for virtually their full term (Andeweg 2002, 270). The management of judicial careers has also remained stable and for the most part apolitical over the analysis period (Andeweg and Irwin 2005, 169-170).[21]

The only significant change in the policy legacy criteria occurred when the private and public insurers were merged in 2006 yielding a uniform insurance system. The careful design of the 2006 reforms has served to foreclose a number of litigation strategies as evidenced by the ECJ's favourable ruling in 2005[22] regarding the content of the reforms with respect to EC competition laws. The level of legal mobilization has increased as the incorporation of EC regulations into judicial reasoning has served to increase the options for lawyers and legal support groups to craft litigation strategies. Litigants are also presenting more comprehensive and exacting scientific research to pursue their claims as evidenced by the quality of arguments within the sample cases analyzed. The policy customs have shifted decidedly towards a state-led approach since the purple coalition's initial dismantling of the formal organs of corporatist negotiations and as peak organizations lose their relevance in a era of active competition between consolidated entities. The level of policy clarity has increased as the 'closed list' benefit system of the ZWF era has been further refined by the gradual incorporation of the Dunning Principles into administrative policy discourse. The level of judicialization within the political arena has also increased through the proliferation of tribunals and committees (SKVZ, CvZ and its sub-committees, NMa) organized around the framework of managed competition.

Applying the overview of developments in the Netherlands since 1988 to the criteria for each condition as outlined in detail in Appendix 1. yields the following initial truth table entries:

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[19] More CRvB rulings were used as the volume of relevant rulings at the CRvB increased.

[20] This was the ill-fated cabinet including the upstart party of Pim Fortuyn (LPF) who was assassinated in 2002.

[21] A study in 1991 that found that the party preferences of judges largely did not match those of the general population led to some calls for a more "proportional" political composition of the judiciary, but did not result in any changes to the appointment process. In 1999 the government also "publicly cautioned the judiciary against overprotection of individual rights at the cost of the general interest (Andeweg and Irwin 2005, 170)."

[22] Europese Commissie, D-G Concurrentie 03 mei 2005, nr. C(2005)1329

Table 3. The Netherlands: Initial Truth Table Values

	Condition Value by Subunit of Analysis			
	Subunit 1 1988-1994	Subunit 2 1995-1999	Subunit 3 2000-2005	Subunit 4 2006-2008
Judicial Supply Conditions:				
Level of Formal independence	1	1	3	3
Level of Political Independence	2	2	2	2
Level of Organizational Independence	1	1	1	1
Policy Demand Conditions:				
Policy Legacy	3	3	3	2
Legal Mobilization	1	1	2	2
Policy Customs	1	2	2	2
Policy Clarity	1	1	0	0
Outcomes				
Level of judicial activity – within judiciary	0	2	3	2
Level of judicial activity – within political arena	1	1	2	2
Activism re Acc. to Benefits / Choice of Prov.	0	1	2	3
Activism re Rationalizing Care	0	0	2	3

A few interesting patterns emerge when comparing the changes in condition and outcome values across eras. First, the initial jump in the level of judicial activity within subunit 2 appears to coincide with the breakdown of collaborative policy negotiations. This spike appears to have provided a broad enough profile of cases to allow judges to experiment with activist decisions that provided relief for individuals in exceptional circumstances. What pushed both the level of activity and activism even higher in subunit 3 is the sudden increase in formal independence coincident with a increase in resources to support legal mobilization. The sensitivity of the response in both measures suggests that other pre-existing conditions may have contributed to the rapid increase in judicialization. The coincident drop in the level of judicial activity and policy legacy relevance in subunit 4 suggests that policy legacy criteria may have also contributed to the rise (and subsequent fall) in the level of judicial activity. Overall, the pattern suggested by the subunits taken as whole is that the conditions were ripe for judicialization in the Netherlands leading up to 2000 and that the increase in scope for judicial review, aided by the related increase in legal support, was sufficient to trigger significant changes in the level of judicial activity and in the level of judicial activism. Increases in judicial activism lagged judicial activity and was targeted at both increasing access to benefits and mitigating the impacts of efforts to rationalize care. Government efforts to incorporate a principled and more comprehensive internal review process for administrative decisions may have begun to mitigate this trend in the periods after 2006

as the growth in judicial activity has slowed when annual data across periods are compared.[23]

Case 2. Italy (1987-2006)

Italy's universal health care system, the Servizio Sanitario Nazionale (SSN), was established in 1978[24] as a national health service similar to Britain's. Approximately 70% of health care expenditure is funded through general taxation and while the bulk of care is delivered in public facilities, private and non-profit contract hospitals are also a significant part of health care delivery (France and Taroni 2005). The original design of the SSN incorporated autonomous local health authorities (Unita Sanitarie Locali (USLs)) that were ostensibly managed by municipal and regional authorities. The USLs were meant to be mechanisms for democratic participation in the delivery of health services and management of costs, but soon were captured by the patronage apparatus of the established political parties (Ferrara 1989). The SSN's heavy reliance on contracted independent providers also made budgets difficult to control and by the mid 1980s reform proposals were initiated in Parliament, but were consistently stalled at the committee stage (France and Taroni 2005, 174-175).

The window of opportunity for reform opened wide in 1992 with the virtual collapse of the established party system as many leading politicians were embroiled in a massive corruption scandal that unveiled the web of intricate party-led patronage networks that had infiltrated all levels of government (Ginsbourg 2001). The ensuing aftermath that included the collapse of the lira and the exit of Italy from the European Monetary System, allowed the caretaker or 'technical' government under Amato to initiate significant reforms including a 1992 law[25] aimed at stabilizing rising health care expenditures. The 1992 health care reforms drastically reduced the number of USLs and turned them into public enterprises (Aziende Sanitarie Locali - ASLs) with CEOs appointed by the regions (France and Taroni 2005). The 1992 reforms also laid the groundwork for ASLs and regions to combine market mechanisms such as the use of selective contracting for private providers, with new methods of finance for hospital care (DRGs) and ambulatory / specialist care (fee-for-service). While ambitious, the impact of the 1992 reforms was uneven across regions and hampered by the lack of bureaucratic experience with the new tools (Anessi-Pessina and Cantu 2006).

Italy adopted a new less proportional electoral system in 1994 and in 1996 this eventually led to the election of a stable centre-left "Olive Tree" coalition led by Romano Prodi. Prodi's government ran its full term, an unprecedented feat in Italian parliamentary politics, and implemented significant changes in the administration of health care policy. Responding to widespread dissatisfaction with the cost-based managerial focus of the 1992 reforms, the official National Health Plan 1998-2000 emphasized equality in access to care and introduced guiding principles - human dignity, effectiveness, appropriateness, and efficiency - that would guide the creation of clear national guidelines with respect to

[23] The data in Table 1. for the managed competition era is somewhat skewed by the presence of many cases stemming from ZWF-related issues that pre-date the 2006 reforms. If this is taken into account the level of judicial activity is slowing at an even greater rate.
[24] Law n. 833 / 1978.
[25] Law n. 502 / 1992.

the essential levels of care (Livelli Essenziali di Assitenza – LEAs) (Torbica and Fattore 2005). In 1999 a package of reforms[26] was introduced that reinforced the powers of the regions to selectively contract with private providers, while at the same time curbing the power of CEOs within the ASLs in favour of a return to greater local participation. The 1999 reforms also restated the commitment to combining centralized responsibility for defining the essential standards of care (LEAs) with greater regional control over the administration of the SSN. This eventually led to constitutional amendments in 2001 that both confirmed the national state's responsibility for setting the LEAs (Article 117.2 (m)) and granted regional governments virtually full residual administrative and legislative responsibility (including the management of budget shortfalls) for health care (Article 118.3 and 4).

To accommodate the participation of the regions in defining the LEAs[27] a National LEA Committee, comprised of representatives of the Ministry of Health, the Treasury, and the regional governments, was created in 2002 to monitor the impact of the LEAs on costs. In 2004 the process of updating the LEAs was assigned to a new National LEA Commission made up of 6 healthcare experts appointed by the Ministry of Health, 7 regional representatives and one Treasury appointee (Torbica and Fattore 2005). The overall impact of the 1999-2001 reforms was to transfer a significant part of the business of health policy-making from the national Parliament to the sphere of inter-governmental negotiations familiar to analysts of Canadian health care policy. The regions remain dependent on the central government for funding[28], but are able to use own source revenues to cover deficits in meeting the standards of care proscribed by the LEAs or to offer additional benefits. This has translated into increasing variations in the delivery of care across regions.

The judiciary in Italy is split into 'ordinary' courts that deal with civil and family law and questions of 'subjective rights', administrative courts that deal with cases where a government action has affected an individual's 'legitimate interests', and a Constitutional Court that deals with issues of constitutional legitimacy. Except for the national or regional governments, only another court can refer questions to the Constitutional Court. The Court of Cassation operates as the Supreme Court of Appeal for ordinary courts and the Council of the State hears appeals from administrative courts. Issues of jurisdiction can be complex within the Italian system and a long-running debate over where cases that touch on the right to health protected by Article 32 should be heard has lead to some 'access to benefits' cases being heard within the ordinary courts.[29] Within my analysis I have focused primarily on rulings of the Constitutional Court and administrative courts.

The role of the Constitutional Court in health care policy has evolved over the life of the SSN from a guarantor of the social right to health care as defined by Article 32

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[26] Law n. 229 / 1999.

[27] The LEAs were finally formalized for the first time in 2001 coincident with the constitutional changes and included extensive positive and negative lists of services. A drug formulary had always been part of the SSN and was integrated into the LEAs. (Torbica and Fattore 2005).

[28] Funding is allocated based on a formula that attempts to account for variations in demographics from region to region and is the source of continuing debate among regions and the central government (France et al. 2005).

[29] These are mainly cases which involve reimbursement for emergency care received out-of-state without prior approval – see Court of Cass. sent. 558/2000.

of the Constitution, to the main arbiter in disputes between the central government and the regions. The contours of the content of Article 32 have been developed over time in the case law of Italy's Constitutional Court and its Supreme Court of Cassation and have influenced the shape of both the 1992 and the 1999/2001 reforms. Early cases focused on the right to choose between private and public providers of health care and stressed that there existed no "abstract freedom" of choice between private and public providers and that the SSN could limit patients to choose only from among accredited providers.[30] The Court of Cassation (sent. 1504/1985) extended the meaning of Article 32 to include access to necessary and non-substitutable drugs and in 1988 the Constitutional Court (sent. 992/1988) equated Article 32 with a right to "full and exhaustive protection" making it unconstitutional to refuse "necessary and non-postponable care" to SSN patients for financial reasons. This ruling was followed up by a clarification that the right to healthcare was not "unlimited" and needed to be balanced with "legitimate financial interests".[31] Later rulings stressed that financial considerations could not have a "preponderant weight" and that there existed an "irreducible core" in the right to health that could not be overcome by considerations of cost.[32] What represented the "irreducible core" was not definitely stated, but generally the Court appeared to object to laws that drew arbitrary distinctions that prevented some from receiving benefits while providing them to others, or that put fixed limits on when emergency care could be reimbursed.[33]

Initial rulings of the Constitutional Court with respect to efforts to download responsibility for budget deficits to the regions and USLs went against the national government. Prior to the 1992 reforms, the Court viewed the deficits as a function of decisions that were controlled by the national government and the regions could not therefore be held accountable.[34] After the 1992 reforms the Court consistently sided with the national government citing both the new tools regions had to raise revenues and the urgency of the fiscal "emergency" that confronted the nation.[35] Similar cases were also initiated after the 1999 reforms but eventually made irrelevant by the content of constitutional changes in 2001. Given the relative lack of detail that accompanied the amendments, the Court has since 2001 taken on the role of crafting the conventions that guide national-regional interactions within the now shared legislative jurisdiction of health care. It has both rebuked the regions for passing laws that encroached on the national governments responsibility to define the minimum standards of care[36] and cautioned the national government against passing laws without consulting the Permanent Conference for Relations between the State and Regions.[37] In general terms the court has sought to reinforce the national government's ability to download responsibility for budgets to regions while ensuring that it does not work around the inter-governmental

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[30] Court of Cass. sent 6129/1983, Const. Court sent. 173/1987
[31] Const. Court sent. 445/1990.
[32] Const. Court sent. 304/1994, 267/1998 and 309/1999.
[33] Sent. 309/1999 above ruled unconstitutional a law that differentiated between workers and other citizens traveling abroad with respect to reimbursement for care received abroad and 267/1998 struck down a law that precluded payment for any care, without exceptions, for which prior approval was not granted.
[34] Const. Court sent. 254/1984 and 452/1989.
[35] Const. Court ord. 416/1995
[36] Const. Court sent. 282/2002 and 338/2003.
[37] Const. Court sent. 88/2003

bodies tasked with ensuring the regions at least have input into the definition of the minimum care basket.

The regional administrative courts (TARs) have dealt with an increasing number of cases involving health care (see Table 4. below) and with experience have become more uniform in their appraisal of cases through reference to judgments of the Council of the State. The subunits have been defined as the period leading up to the 1992 reforms; the period between 1992 and the election of the Prodi government (first reform era); the Prodi government's time in office (second reform era); and the post-Constitutional amendment period (era of LEAs and regionalization).

Table 4. Judicial Activity Levels – Italy[38]

	1987- 1991 Avg / Yr	1992-1996 Avg / Yr	1997-2001 Avg / Yr	2002-2006 Avg / Yr
Council of the State				
Pharmacy and Hospital Charges[39]				
Submitted (new)	58	71	107	212
Total Judgments				
Total Council of the State				
Submitted (new)			11076	10580
Total Judgments				
Pharm. and Hospital % of Total				
Submitted (new)			**1.00%**	**2.00%**
Total Judgments				
Regional Admin Courts:				
Hygiene, Health and Ecology[40]				
Submitted (new)	970	1906	3824	9566
Total Judgments				7723
Total Regional Admin Courts				
Submitted (new)			86635	68783
Total Judgments				102694
Sickness funds as % of all S.I.				
Submitted (new)			**4.41%**	**13.91%**
Total Judgments				**7.52%**

[38] Sources – 1987-1999 – Extracts received from the 'Ufficio Servizi per l'Automazione e l'Informatica' at the Council of the State; 2000-2006 http://giustiziaincifre.istat.it/

[39] This category is the lowest level of mandatory detail captured by ISTAT data definitions and includes all cases related to the SSN. Extracts requested from Ufficio Servizi per l'Automazione e l'Informatica at the Council of the State for details related to a non-mandatory classification specific to the SSN confirms similar patterns in growth and that the majority of cases in this category are SSN-related.

[40] see 39 above.

Early rulings of the TARs dealt with issues of clinical effectiveness and were inconsistent in their approach (France 1999). Some cases appeared to favour general standards of clinical effectiveness[41] while others put more relevance on the needs of the individual patient.[42] A ruling of the TAR Lazio (Sent. 384/1998) that ordered the ASL to make available free of charge drugs used in a controversial and untested cancer therapy demonstrated the difficulty some TARs were having in dealing lucidly with issues of clinical effectiveness. More recently a series of rulings of the Council of the State has refined the parameters for evaluating clinical effectiveness and these generally have favoured the individual patient. In 2002 the Council upheld a ruling that had granted reimbursement for a procedure not standard in Italy, but more effective for the patient in question[43] and in 2004 the Council strengthened this position by refusing to accept counter-arguments related to containing costs.[44] A ruling in 2005 (Sent. 6729) made clear that it was not enough for an ASL to indicate that a treatment was available in order to reject a request, it also had to specify the centres that could deliver the treatment and verify the wait times. Finally in 2006 the Council ruled that even treatments with a minimal chance of full success could not be refused if they offered a possibility of some degree of improvement for the patient in question.[45]

Unfortunately, data is not easily available for the administrative courts prior to 2001 so a true sample of cases could not be selected for early periods. The Constitutional Court cases are few in number overall in earlier periods and a numerical analysis adds little to the qualitative review above for periods prior to 2001 as well. I have summarized sample cases for both the Constitutional Court and the administrative courts for the last subunit in Table 5.

Table 5. Italy: Judicial Activism 2002-2006.[46]

Constitutional Court	LEAs and Regionalization. 2002-2006		
Decision Area	Cases of Activism	Total Cases	% Activist Rulings
Acc. to Benefits / Choice of Prov.	0	3	**0%**
Rationalization of Care	3	14	**21%**

Administrative Courts	LEAs and Regionalization. 2002-2006		
Decision Area	Cases of Activism	Total Cases	% Activist Rulings
Acc. to Benefits / Choice of Prov.	16	23	**70%**
Rationalization of Care	0	2	**0%**

[41] TAR Toscana Sent. 376/1994
[42] TAR Toscana Sent. 368/1994 and 370/1995.
[43] Council of the State Sent. 5192/2002.
[44] Council of the State Sent. 5132/2004.
[45] Council of the State Sent. 1902/2006.
[46] Based on my own analysis of approximately 30 relevant sample cases from the administrative courts and all relevant cases from the Constitutional Court. See Appendix 2 for the list of sample cases.

The high ratio of activist cases within the access to benefits area in the administrative courts may require a larger sample set for confirmation, but it does appear to be consistent with the activist reasoning within recent key Council-level rulings.

In order to complete the initial truth table, values for the remaining conditions will now be addressed. The level of political independence of the judiciary has decreased from earlier eras as changes in the electoral system have led to more enduring coalitions and a more active role for the executive within parliament (Bull and Newell 2005). The organizational independence of the judiciary was secured when elections to determine members of the Higher Council of the Judiciary (who control all higher level appointments) became fully democratic leaving the executive with little control of appointments to higher positions (Guarnieri 1995). On the policy demand side, the policy legacy has become more complex through the increased devolution of power to the regions and ASLs. The slow pace of Italian justice has consistently hampered legal mobilization, as it is not unusual for initial appeals to wait years before they are heard. Initial appeals in the administrative courts also require representation and issues of jurisdiction further complicate the preparation of the appeal. The policy customs have remained state-led with the incorporation of inter-governmental bargaining apparatus and policy clarity has increased with the establishment of the LEAs and the guiding principles to manage them (although these principles do not seem yet to have permeated other areas fully, nor been taken up by the judiciary explicitly).

Table 6. Italy: Initial Truth Table Values

	Condition Value by Subunit of Analysis			
	Subunit 1 1987-1991	Subunit 2 1992-1996	Subunit 3 1997-2001	Subunit 4 2002-2006
Judicial Supply Conditions:				
Level of Formal independence	3	3	3	3
Level of Political Independence	3	2	2	2
Level of Organizational Independence	3	3	3	3
Policy Demand Conditions:				
Policy Legacy	0	0	1	1
Legal Mobilization	0	0	0	0
Policy Customs	2	2	2	2
Policy Clarity	3	3	2	1
Outcomes				
Level of judicial activity – within judiciary	0	1	2	3
Level of judicial activity – within political arena	0	0	1	1
Activism re Acc. to Benefits / Choice of Prov.	2	2	2	3
Activism re Rationalizing Care	2	1	1	1

Three potentially interesting patterns emerge from the initial truth table for Italy. First, the more deferential stance of the Constitutional Court with respect to rationalizing

care after the 1992 reforms could be related to the decrease in political independence as stronger executives began to emerge. Second, the rise in activity in the administrative courts may have been affected by the increased devolution of administrative power to the regions (policy legacy). The subsequent inevitable variability in the delivery of care across regions may have created more litigation opportunities. Finally, as was the case in the Netherlands, if the level of judicial activity within administrative courts rises quickly, judges appear to take advantage of the greater range of opportunities to render innovative decisions that take an active role in shaping access to benefits.

Case 3 – Canada - The Province of Ontario

The Canadian case is perhaps better understood as ten separate cases given that health care provision and policy-making varies significantly from province to province. Although federal funding is linked to compliance with the Canada Health Act, each provincial health care sector is a self-contained system of legislation and regulation with its own history and trajectory (Flood 2002). For this preliminary comparison across states I will focus on the province of Ontario since 1990. In the next stage of my research project I plan to include British Columbia and Quebec.

In 1990[47] Ontario moved away from a premium-based system with coverage based on dependent status to a tax-based funding system with individual eligibility. Extra-billing by doctors was also severely curtailed by preventing doctors that had opted out of the public system from billing more than the public rates for services (Flood 2001). Although the reform was brought in under the Peterson Liberal government, the left-of-centre Rae NDP government that followed managed the transition to the new system, but plans for additional initiatives were curtailed by budget constraints exacerbated by a recession beginning in 1991. Subsequent drastic federal reductions in fiscal transfers beginning in 1994, combined with spiraling provincial deficits, led the newly elected right-of-centre Harris Conservative government to quickly cut health care costs through the de-listing of services and the tightening of eligibility requirements.[48] In 1996 the newly created Health Services Restructuring Commission began to oversee efforts to reduce acute care cost. Over the next four years the HSRC closed thirty-one public hospitals and forced others to amalgamate and rationalize their service offerings (Sinclair et. al. 2000). After re-election in 1999, the Harris government followed up with an effort at primary care reform in 2001 by launching the Ontario Family Health Care Network that involved rostering patients with teams of doctors that would be paid on a capitated basis for providing round-the-clock access to primary care. The primary care reform effort stalled over the next two years and participation outside of the initial pilot projects was slow to develop (Hunter et. al. 2004).

With the election of the McGuinty Liberals in 2003 the emphasis shifted to reducing wait times for key procedures and devolving responsibility for administering acute care institutions (Fenn 2006). Local Health Integration Networks were established in 2006, and by 2007 had taken over responsibility for the funding of health services related to hospitals, community care centres, mental health services and long-term care within their respective jurisdictions. Ontario was the last province to adopt a form of

[47] *Health Insurance Act,* R.S.O. 1990, c.H.6.
[48] Eligibility requirements primarily targeted non-citizens.

'regional health authority' and as is the case in all other provinces (except Saskatchewan) LHIN Boards are government appointed. While LHINs are still in their infancy in Ontario, their evolution seems likely to include the incorporation of market-like incentives like the use of DRGs to allocate funding to priority areas.

In comparison to the Netherlands and Italy, Ontario is remarkable for its lack of judicial activity within the health care policy sector. A thorough review of cases at the Divisional Court branch of the Superior Court[49] and Appeal Court level reveals only about 35 cases that touch on the decision areas of interest within the analysis period for this study.[50] Unlike the Netherlands and Italy, the use of administrative courts by dissatisfied patients has not become routine. The establishment of the Health Services Appeal and Review Board in 1998[51] may have served to keep demand from rising[52], but the existence of similar internal appeal boards in the Netherlands and Italy have coexisted with much higher caseloads within administrative courts.

Policy demand factors may instead be more important in keeping administrative court caseloads low. Perhaps most significantly, in comparison to the Netherlands and Italy the policy legacy of Ontario until the creation of LHINs in 2006 was one of centralized control with little direct competition between private and public providers (outside of long-term care). As a result, patients did not have the same ready access to potential care alternatives that were developed outside of the public plan. In Italy, private providers continue to operate both inside and outside of the SSN and the historical split of sickness funds versus private insurance in the Netherlands allowed for the development of a market for care alternatives that were not funded by the public system.

Legal mobilization is also more difficult in the Canadian scenario as the costs and complexity related to filing an initial appeal are higher than in the other cases.[53] Initiating litigation is further discouraged by the standard of review utilized by judges when considering most administrative law cases within the health care arena. Historically judges have applied the standard of "patent unreasonableness" which is the most deferential standard of review possible in administrative law (Flood 2007).[54] Legal challenges based on the Charter of Rights have also been problematic with none[55] having been successful with respect to health care within Ontario on either a section 15 (equality) or section 7 (right to life) grounds. Charter-based challenges are also very costly to mount in comparison to Constitutional Court rulings in Italy that are initiated by

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[49] The Divisional Court hears all initial appeals with respect to actions of the government of Ontario – appeals from Divisional Court rulings can be heard at the Court of Appeal for Ontario.

[50] Authour's own review of cases utilizing Quicklaw and scrutinizing cases that made reference to the core legislative acts and regulations that govern health care in Ontario. In the entire "Health Law" practice area (within which the majority of cases concerned issues of civil liability, tort and professional ethics) there were only 3764 cases in total within the analysis period.

[51] Prior to this appeals were made to a panel of the Health Services Appeal Board.

[52] The HSARB has heard between 100 and 250 cases per year since 2002 (www.hsarb.on.ca/scripts/MOHSearchFile_Public.asp).

[53] Fees for an initial appeal can range between $400 and $800 without accounting for lawyers fees. While legal representation is not required, the complexity of the filing process and of the arguments given the standard of review virtually requires it.

[54] The other standards are "reasonableness simpliciter" and "correctness" although the Supreme Court of Canada has recently collapsed the former with "patent unreasonableness" into a "reasonableness" standard – see *Dunsmuir v. New Brunswick,* 2008 SCC 9.

[55] Author's own analysis of relevant cases to February of 2009.

the referring court and are not paid for by litigants directly. Table 7. summarizes the cases analyzed for Ontario with the subunits for analysis in this case being linked to the timing of changes in government. Given the strong majorities each government within the analysis period enjoyed each can be seen to represent a uniform era within the evolution of health care policy.

Table 7. Canada: Judicial Activism across Eras in Ontario.[56]

	Rae Government 1990-1995			Harris Government 1996-2003		
Decision Area	Cases of Activism	Total Cases	% Activist Rulings	Cases of Activism	Total Cases	% Activist Rulings
Acc. to Benefits / Choice of Provider	1	4	**25%**	1	3	**33%**
Rationalization of Care	4	8	**50%**	1	7	**14%**

	McGuinty Gov't 2004-2009		
Decision Area	Cases of Activism	Total Cases	% Activist Rulings
Acc. to Benefits / Choice of Provider	2	10	**20%**
Rationalization of Care	0	3	**0%**

The relatively high number of successful cases in the rationalization area under the NDP government is related to a set of cases dealing with "block fees" charged by physicians in response to restrictions on extra-billing.[57] The only other case of activism in response to rationalization efforts concerned the attempted closing of a French-language teaching hospital by HSRC and involved the minority language provisions of the Constitution.[58] All three of the successful cases in the access to benefits area involved the court overturning the decision of the Appeal Board because they had failed to adequately consider the urgent nature of the care required when rejecting claims for reimbursement of out-of-province expenses.[59]

The remaining condition values necessary to derive an initial truth table are relatively uncomplicated. The federal government appoints all judges with no public vetting yielding a low level of organizational independence. Policy-making has remained state-led and policy clarity has remained low with the bulk of primary and acute care still managed on an 'open list' basis with a relatively short negative list specifying items not

[56] Based on my own analysis of approximately 35 relevant sample cases – see Appendix 2 for the list of sample cases.
[57] *Shomair v. Ontario*, 1990 O.J. No. 1503, *Evans v. Ontario* [1990] O.J. No. 1086, *Redhill v. Ontario*, 1990 O.J. No. 1504, *Burko v. Ontario* [1991] O.J. No. 625
[58] *Lalonde v. Ontario*, 2001 O.J. No. 4488.
[59] *Segal v. Ontario* 1994 O.J. No. 2680, *Powell v. Ontario* 2000 O.J. No. 4483, *C.C –W v. Ontario* 2009 O.J. No. 140.

covered.[60] The resulting initial truth table for Ontario (Table 8.) presents a stark contrast with those in the other two cases examined.

Table 8. Canada – Ontario: Initial Truth Table Values

	Condition Value by Subunit of Analysis		
	Subunit 1 1990-1995	Subunit 2 1996-2002	Subunit 3 2003-2007
Judicial Supply Conditions:			
Level of Formal independence	2	2	2
Level of Political Independence	0	0	0
Level of Organizational Independence	0	0	0
Policy Demand Conditions:			
Policy Legacy	0	0	0
Legal Mobilization	0	0	0
Policy Customs	2	2	2
Policy Clarity	3	3	3
Outcomes			
Level of judicial activity – within judiciary	0	0	0
Level of judicial activity – within political arena	0	1	1
Activism re Acc. to Benefits / Choice of Prov.	0	0	0
Activism re Rationalizing Care	1	0	0

As a negative case of judicial activity and judicial activism, conditions absent in Ontario, and present in the other two cases, may have a special relationship with judicialization. Policy legacy and the level of political and organizational independence stand out in the comparison across the three cases as conditions that are present in cases where judicial activism develops and absent when it does not. While each case has its own unique sequence and combination of condition changes that spur activity and activism, these three appear to be perhaps necessary for the impact of other conditions to take hold.

Conclusions

The comparison of the Netherlands, Italy and Canada (Ontario) has provided the basis for some preliminary hypotheses regarding the development of judicialization within the health care arena. The Netherlands case revealed that changes in judicial supply criteria can unlock a rapid increase in judicial activity if pre-existing policy demand conditions favouring external judicialization exist. If this combination persists, judicial activism is likely to increase, but can potentially be mitigated by focused efforts to internalize judicialization (through policy clarity and the proliferation of tribunals).

[60] *General,* R.R.O. 1990, Reg. 552.16-24.

The Italian case provides partial support for the importance of policy legacy criteria to increases in the level of judicial activity and also highlights how judicial activism can increase in one area in response to policy demand conditions while decreasing in another in response to changes in judicial supply (political independence). Finally, the Ontario case raises a series of interesting counter-factual scenarios. Would judicial activism in Ontario be likely to increase if minority governments were to become the rule and the judicial appointment process became more politicized?[61] Would the pace of change in levels of judicial activism be accelerated if LHINs continue to grow in relevance and more market mechanisms are introduced?[62] This analysis has at minimum raised some interesting hypotheses about judicialization that perhaps would not have been visible without its unique design.

References:

Andeweg, R.B. 2008. "Coalition Politics in the Netherlands: From Accommodation to Politicization" *Acta Politica* 2008: 254-277.

Andeweg, R.B. and G.A. Irwin. 2005. *Governance and Politics of the Netherlands*. Hampshire: Palgrave Macmillan.

Anessi-Pessina, E. and E. Cantu. 2006. "Whither managerialism in the Italian National Health Service?" International Journal of Health Planning and Management 21: 327-355.

Atkinson, M. and W.D. Coleman. 1989. "Strong States and Weak States: Sectoral Policy Networks in Advanced Capitalist Economies," *British Journal of Political Science* 19: 47-67.

Bull, M.J. and J.L. Newall. 2005. *Italian Politics: Adjustment Under Duress*. Cambridge, UK: Polity Press

Cooter, R. and T. Ginsburg. 1996. "Comparative Judicial Discretion: An Empirical Test of Economic Models," *International Review of Law and Economics* 16: 295-313.

Crozier, M., S. Huntington and J. Watanuki. 1975. *The Crisis of Democracy*. New York: New York University Press.

Den Exter, A. and B. Hermans. 1998. "Constitutional Rights to Health Care: The Consequences of Placing Limits on the Right to Health Care in several Western and Eastern European Countries," *European Journal of Health Law* 5: 261-289.

Epp. C.R. 1998. *The Rights Revolution: Lawyers, Activists, and Supreme Courts in Comparative Perspective*. Chicago: University of Chicago Press.

Fenn, W.M. 2006. "Reinvigorating Publicly Funded Medicare in Ontario: New Public Policy and Public Administration Techniques," *Canadian Public Administration* 49: 527-547.

Ferejohn, J. 2002. "Judicializing Politics, Politicizing Law," *Law and Contemporary Problems* 65: 41-68.

Ferrara, M. 1989. "The Politics of Health Reform: Origins and Performance of the Italian Health Service in Comparative Perspective," in G. Freddi and J.W. Bjorkman eds. *Controlling Medical Professionals: The Comparative Performance of Health Governance.* London: Sage.

[61] A scenario perhaps not unlikely given a shift to a more proportional electoral system.

[62] A scenario similar to the Italian situation post 2001.

Flood, C.M., 2002. "The Anatomy of Medicare." In J.Downie, T. Caulfield and C. Flood eds., *Canadian Health Law & Policy*, 2nd ed. Markham: Butterworths.

Flood, C.M., T. Archibald. 2001. "The Illegality of Private Health Care in Canada," *Canadian Medical Association Journal* 2001 164(6): 825-830.

Flood, C.M., K. Roach, and L. Sossin. Eds.. 2005. *Access to Care Access to Justice: The Legal Debate over Private Health Insurance in Canada*. Toronto: University of Toronto Press.

France, G.F., "The Changing Nature of the Right to Health Care in Italy," in A. Den Exter and H. Hermans eds., *The Right to Health Care in Several European Countries*, London: Kluwer Law.

---------., and F. Taroni. 2005. "The Evolution of Health-Policy Making in Italy," *Journal of Health Politics, Policy and Law* 30: 169-187.

---------., F. Taroni and A. Donatini. 2005. "The Italian Health-Care System" *Health Economics 14*: S187-S202.

George, A. and A. Bennett. 2005. *Case Studies and Theory Development in the Social Sciences*. Cambridge: MIT Press.

Ginsbourg, P. 1990. *A History of Contemporary Italy: Society and Politics*, *1943-1988*. Harmondsworth: Penguin.

Glied, S. "Health Care Financing, Efficiency, and Equity," NBER Working paper No. 13881. http://www.nber.org/papers/w13881.pdf

Goertz, G and J. Mahoney. 2005. "Two-level Theories and Fuzzy-Set Analysis," *Sociological Methods and Research* 33: 497-538.

Guarnieri, C. 1995. "Judicial Independence and Policy-Making In Italy" in C.N. Tate and T. Vallinder, *The Global Expansion of Judicial Power*. New York and London: New York University Press.

Guarnieri, C. and P. Pederzoli. 2002. *The Power of Judges: A Comparative Study of Courts and Democracy*. Oxford: Oxford University Press.

Helderman, J., F.T. Schut, T.E.D. van der Grinten, W.P.M.M. van de Ven. 2005. "Market-Oriented Health Care Reforms and Policy Learning in the Netherlands," *Journal of Health Politics, Policy, and Law Vol 30. No 1-2*.

Hirschl, R. 2004. *Towards Juristocracy*. Cambridge and London: Harvard University Press.

----------. 2008. "The Judicialization of Mega-Politics and the Rise of Political Courts," *Annual Review of Political Science* 11: 93-118.

Hunter, D., S. Shortt, P. Walker and M. Goodwin. 2004. "Family Physician Views about Primary Care Reform in Ontario: A Postal Questionnaire," *BMC Family Practice* 5:2 www.biomedcentral.com/1471-2296/5/2

Koopmans, T. 2003. Courts and Political Institutions: A Comparative View. Cambridge: Cambridge University Press.

Mair, P. 2008. "Electoral Volatility and the Dutch Party System: A Comparative Perspective," *Acta Politica* 43: 235-253.

Maarse, H.and Y. Bartholomee. 2007. "A Public-Private Analysis of the New Dutch Health Insurance System." *European Journal of Health Economics* 8:77-82.

Minogiannis, P. 2003. *European Integration and Health Care: The Artful Dance of Economics and History*. New Brunswick, N.J.: Transaction Publishers.

Norris, P. Ed. 1999. *Critical Citizens: Global Support for Democratic Government*. Oxford: Oxford University Press.
Okma, K., "Heath Care, Health Policies and Health Care Reform in the Netherlands." Ministry of Health, the Hague, the Netherlands, March 2000.
Pierson, P. 1994. *Dismantling the Welfare State: Reagan, Thatcher and the Politics of Retrenchment*. Cambridge: Cambridge University Press.
---------. 1996. "The New Politics of the Welfare State," *World Politics*. 48 (2): pp. 143-179.
---------. 2001. "Post-Industrial Pressures on the Mature Welfare States," in P. Pierson, ed., *The New Politics of the Welfare State*. New York: Oxford University Press, pp. 80-106.
---------. 2004. *Politics in Time*. Princeton, New Jersey: Princeton University Press.
Ragin, C. 1987. *The Comparative Method: Moving Beyond Qualitative and Quantitative Strategies*. Berkley: University of California Press.
----------. 2000. *Fuzzy-Set Social Science*. Chicago: University of Chicago Press.
Rihoux, B. and C. Ragin. 2009. *Configurational Comparative Methods: Qualitative Comparative Analysis (QCA) and Related Techniques*. Thousand Oaks, California: SAGE Publications, Inc.
Scharpf, F. 1997, *Games Real Actors Play: Actor-Centered Institutionalism in Policy Research*. Boulder: Westview Press.
Schut, F.T. and W.P.M.M. Van de Ven. 2005. "Rationing and Competition in the Dutch health-care system," *Health Economics 14*: S59-S74.
Schmitter, P. 1979. "Still the Century of Corporatism?" in P. Schmitter and G. Lehmbruch Eds., *Trends Toward Corporatist Intermediation*. London: SAGE Publications.
Schut, F.T. 1995. "Health Care Reform in the Netherlands: Balancing Corporatism, Etatism, and Market Mechanisms." *Journal of Health Politics, Policy, and Law* 20: 615-652.
Shapiro, M. 1964. "Political Jurisprudence". *Kentucky Law Journal* 52: 294-345.
Sinclair, D., M. Rochon and P. Leatt. 2005. *Riding the Third Rail: The Story of Ontario's Health Services Restructuring Commission, 1996-2000*. Montreal: IRPP.
Stone, A. 1995. "Coordinate Construction in France and Germany" in C.N. Tate and T. Vallinder. 1995. *The Global Expansion of Judicial Power*. New York and London: New York University Press.
Stone-Sweet, A. 2000. *Governing with Judges: Constitutional Politics in Europe*. Oxford: Oxford University Press.
----------. 2004. *The Judicial Construction of Europe*. Oxford: Oxford University Press.
Tate, C.N. 1995. "When the Courts go Marching In" in C.N. Tate and T. Vallinder, *The Global Expansion of Judicial Power*. New York and London: New York University Press.
Tate, C.N. and T. Vallinder, eds., 1995. *The Global Expansion of Judicial Power*. New York and London: New York University Press.
Torbica, A. and G. Fattore. 2005. "The 'Essential Levels of Care' in Italy: When Being Explicit Serves the Devolution of Powers," *European Journal of Health Economics* 6: 46-52.

Tushnet, M. 2008. *Weak Courts, Strong Rights: Judicial Review and Social Welfare Rights in Comparative Constitutional Law*. Princeton: Princeton University Press.
Vanberg, G. 1998. "Abstract Judicial Review, Legislative Bargaining, and Policy Compromise," *Journal of Theoretical Politics* 10: 299- 326.
Van Thiel, J. and T. Lugtenberg. 1999. "Decker and Kohll and the Dutch System of Social Benefits" *European Journal of Health Law* 6: 389-395.