Evaluating Patterns of Juridification in the Health Care Arena in the Netherlands, Italy and Canada.

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Evaluating Patterns of Juridification

Vallinder characterized the expansion of judicial power broadly as "the infusion of judicial decision-making and of courtlike procedures into political arenas where they did not previously reside (1995, 14)." This definition of judicialization was meant to comprise both the greater involvement of judicial actors in policy-making, as well as the greater use of courtlike processes by legislative and administrative actors. The increased utilization of courtlike processes within both judicial and legislative/administrative venues mirrors the expansion, both in breadth and depth, of the regulatory state within complex modern societies. Social theorists such as Habermas (1987) have referred to this broader socio-political trend as "juridification" wherein the imperatives of the free market are mitigated through the legislative expansion of welfare state programs. Juridification not only encompasses both sides of Vallinder's definition of judicialization, it also recognizes the socio-political necessities for the increased incursion of laws, rules and legal processes, on the lives of citizens of modern states. While normative and empirical critiques of the impact of judicialization have provided valuable insight into the magnitude of the interference of one branch upon another, a turn towards the study of juridification signals an acceptance that in some policy areas increased inter-branch interactions are more or less inevitable.

Silverstein has attempted to bring the analysis of juridification from the heady world of social theory to variables more amenable to the mundane arena of empirical political science:

> "Juridification is not the product of an imperial judiciary imposing its will or of an abdicating legislature or weak executive…Juridification is, instead, the product of the interaction of these institutions, along with interest groups, parties, lobbyists, and policy entrepreneurs alike (2009, 4).

Juridification, in this sense, is a process or a chain of interactions between institutional arenas across time in response to increasingly complex policy demands. Its effects, as a result, are unlikely to be uniform or easily predicted across policy contexts (Stone Sweet 1995). As juridification progresses, the structure of interest intermediation among policy participants becomes more reliant on legal reasoning at the expense of political bargaining.[1] If policy-making becomes dominated by judicial or quasi-judicial processes, then the "policy horizon" within which societal actors engage each other can become unduly constrained. Understanding how juridification takes shape, in what balance across the judicial and legislative-administrative divide, has important ramifications for evaluating the quality of democratic governance.

Ideally, juridification would progress in a manner that takes advantage of the strengths of legal reasoning and judicial review without blocking out policy options from the push and pull of political debate. This is what I will refer to as a "constructive" pattern of juridification. Constructive juridification has much in common with Dyzenhuis' (1997) theory of judicial deference as a kind of "respect" that is earned when

[1] In this respect, my analysis takes a similar perspective as the adapted neo-functional approach utilized by Stone Sweet (2004) and Chichowski (2007) in explicating the emergence and evolution of EU-level "governance" through interactions moderated by the European Court of Justice.

legislative and administrative actors provide clearly articulated reasons for their actions, together with an explicit concern for the legal and constitutional rights of those affected. Judicial deference as respect also seeks to ensure that political choices are not disguised as administrative rules and that political motives for administrative decisions are transparent.[2] While this definition is admittedly imprecise, its contours I believe become clearer through the comparison of patterns of juridification across concrete policy contexts.

The health care policy sector since the late 1980s is an especially useful context within which to compare different patterns of juridification. Health care systems everywhere have been under intense fiscal scrutiny.[3] Whether or not near apocalyptic forecasts based on aging populations and the rapid pace of medical innovation are accurate,[4] the sheer magnitude of health care budgets have attracted the attention of governments around the world. Two of the primary tools used by governments to address rising health care costs are the rationing of the supply of health care service providers and the reduction of the scope of services within the publicly funded health care basket. A recent cross-national survey (Flood et al. 2005) that includes countries as diverse as South Africa, Israel, Norway and the United States, reveals that the use of such crude measures by governments are likely to spur efforts to construct a substantive 'right to health care' in hope of imposing legal/constitutional constraints upon the political debate concerning the scope of publicly funded medical care. This makes the study of attempts to reform the structure and financing of 'universal' health care systems fertile ground for the evaluation of the pros and cons of various patterns of juridification.

The three countries I have chosen, the Netherlands, Italy and Canada, allow for a comparison of how the process of juridification under fiscal pressures varies between social or 'fund' based insurance systems (the Netherlands) and state-based insurance systems organized predominantly around both the national (Italy) and the sub-national (Canada) level. These cases also allow for a comparison across judicial systems with different legal traditions (civil versus common law) and that have developed distinct legal foundations for judicial review within the healthcare area. What emerges from this comparison are two interesting, if still preliminary, findings. First, it is in the Netherlands, where the formal civil law constraints on judicial review have historically been the tightest, that the interactions between judicial and legislative-administrative institutions have been the most constructive. Second, the establishment of quasi-judicial tribunals/committees within the legislative/administrative arena serves to structure a more constructive dialogue across branches.

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[2] A good example of this is the courts failure to accept the provincial governments efforts to de-list non-urgent abortion services through claiming they were not "medically necessary" in *B.C. Civil Liberties Assn. v. British Columbia (Attorney General) [1988] B.C.J. No. 373*. The court allowed that the B.C. cabinet could have de-listed abortion services outright, but they could not do so under the cover of the claim that it was not always "medically necessary" as they lacked the required expertise to come to that conclusion.

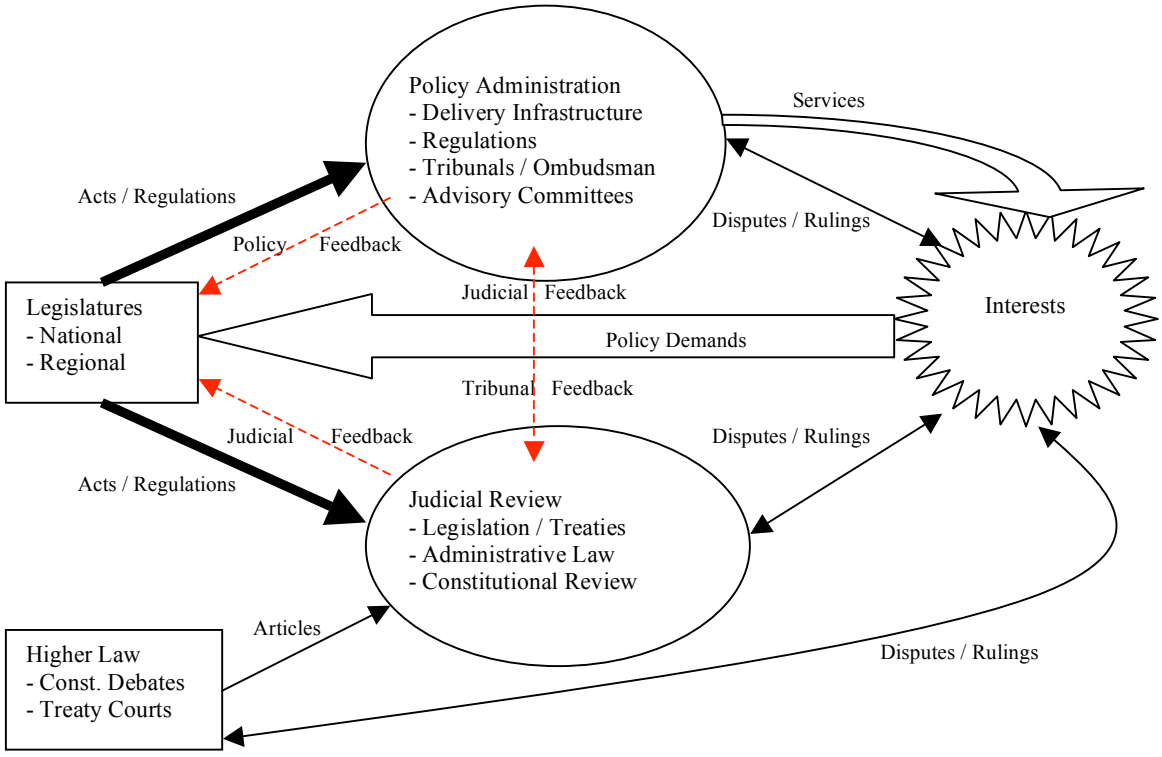
[3] Across the OECD health care spending as a percentage of GDP between 1990 and 2005 rose at twice the rate of total social expenditures (27% overall versus 13%). More than half (58%) of new public social expenditures between 1990 and 2005 across the OECD went to health care. (OECD Factbook 2009: Economic, Environment and Social Statistics)

[4] The OECD projects that effect of ageing populations is likely to be moderate when compared to the impact of non-demographic factors such as higher incomes and the wider availability of new treatments and products (OECD Health Expenditure: Long-term trends, accessible at: http://puck.sourceoecd.org/vl=3398208/cl=14/nw=1/rpsv/factbook/10/02/01/index.htm)

Analytical Framework for Comparing Patterns of Juridification

Certainly changes in the formal or informal powers of judicial review (whether packaged in a single constitutional moment or agglomerated by judges to themselves over time) are relevant to how juridification evolves, but so are changes within non-judicial institutions. The character and mix of administrative organs and policy rules within complex policy areas are likely to influence the viability of litigation strategies that ultimately serve to activate judicial review. In some cases, a change in the formal powers of judicial review may unlock litigation opportunities that were previously closed. Alternatively, major changes in policy design may open up avenues for litigation even when the formal reach of judicial review appears unchanged. Either case is likely to prompt a further response from legislative and administrative actors aimed at narrowing the litigation opportunities available (see dashed lines depicting feedback mechanisms in Figure 1. below). My analysis will focus on how these interactions across institutional boundaries unfold and when they appear constructive – i.e. where interactions lead to policy adaptations that fairly reflect both judicial and legislative-administrative priorities – versus when they appear reactive – i.e. where interactions lead to policy adaptations that effectively negate either judicial or legislative-administrative priorities. The overall framework for my analysis is depicted below:

Figure 1. Overview – Framework for Analysis of Juridifcation



My analysis of each case will be broken down into three parts. I will begin with a brief overview of the foundations of judicial review followed by a discussion of key changes affecting its reach within the analysis period. I will then provide a basic outline of the public healthcare system and relevant healthcare reform initiatives. I will then trace interactions between changes in the scope of judicial review and the impact of health reform initiatives through an analysis of selected cases and changes to legislative acts and administrative regulations/guidelines.

The Netherlands – Social Insurance within a Civil Law Tradition.

The centralization of the administration of justice in the Netherlands was first realized under annexation by Napoleonic France and the basic framework of judicial institutions and administrative law still reflects its influence.[5] Following Montesquieu's definition of the 'trias politica', the courts, as the 'bouche de la loi' were granted little interpretive or lawmaking freedom (Heringa 2005, 100-101). This has had two important implications for the general development of the powers of judicial review. First, the Constitution of the Netherlands embodies a commitment to parliamentary sovereignty and a strict recognition of the separation of powers. As a result, the judiciary has no power to invalidate legislative acts through constitutional review.[6] Paradoxically, a Constitutional amendment in 1953 that was originally crafted to deal with the cutting of constitutional ties with Indonesia, enabled Dutch high courts to invalidate laws 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 (Koopmans 2003). As a result, this has put Dutch high courts in the rather incongruous position of recognizing that Acts of Parliament prevail even if they appear to conflict with fundamental rights outlined within the Dutch Constitution, but can be declared invalid when conflicting with similar rights within self-executing provisions of international treaties (Alkema 1999, 322-323).

Second, the development of judicial powers of review under administrative law has occurred in the shadow of the principles of 'droit administratif'.[7] While Dutch citizens have had the right of appeal to a civil judge in the case of disputes over the actions of administrative bodies since the early twentieth century, these claims have historically only been admissible when there was no recourse available within the administration itself.[8] The primary vehicle for challenging administrative acts up until

[5] French-inspired institutions first arrived in the short-lived Batavia Republic (1795-1806) and later more thoroughly when the Netherlands was annexed by Napoleonic France (1810-1815). The French occupation resulted in the codification of civil and criminal law in the universalistic tradition of the Napoleonic codes. After 1815 Dutch codes gradually were nationalized and their substantive content increasingly reflected the influence of common 'Germanic' traditions (Blankenburg 1998, 16).

[6] Article 120 of the Dutch Constitution succinctly states: "The constitutionality of Acts of Parliament and treaties shall not be reviewed by the courts."

[7] As per Dicey's contrast with common law notions of the rule of law, droit administratif ensures that "servants of the State are in their official capacity to a great extent protected from the ordinary law of the land, exempted from the jurisdiction of the ordinary tribunals, and subject to official law, administered by official bodies (Dicey 1889, 314)."

[8] This reflects the principle developed through judgments of the Dutch Supreme Court (Hoge Raad) of the civil judge as "'residual' judge offering additional legal protection" (Seerden and Stroink 2002, 174).

1985 was either through a direct hierarchical appeal to the Crown (Kroonberoep)[9] or through a judicial body tasked with managing disputes within a specific functional area such as social security (Blankenburg 1998, 40). Prior to the Second World War, this method of dealing with administrative disputes was seen as consistent with democratically preserving the legitimate independence of administrative decision-making from the unnecessary incursions of judicial 'outsiders' and leaving the sorting out of inevitable disputes to direct interactions between the citizenry and the Crown. After the Second World War, the spread of the welfare state led to the creation of additional specialized courts to handle different facets of the regulatory infrastructure. Social security courts (Raad van Beroep), which had originally been established in 1902 to deal with issues arising from the introduction of work hazard insurance, gained a broad jurisdiction over all social security matters, including health care, by 1957. Decisions of the social security courts, especially those at the appeal level (Centrale Raad van Beroep), contributed significantly to the development of unwritten principles of proper or 'due' administration such as the principles of due care, reasonableness, transparency, proportionality and legitimate expectation (Seerden and Stroink 2002, 147).

In 1985 the European Court of Human Rights (ECHR) in *Bentham*[10] ruled that the process of appealing to the Crown did not constitute a 'fair and impartial' trial with respect to Article 6 of the European Convention of Human Rights. In the wake of the ruling, and in the face of rapidly rising caseloads that were making management of the disparate components of administrative justice more difficult, the Netherlands initiated an ambitious reorganization of the machinery of administrative justice. Structurally, the jurisdiction of the specialized courts, together with virtually all other issues dealing with acts of the administration, were centralized in 1994 within special administrative chambers established at the level of the district courts (Rechtbanken). The judicial divisions of the Council of the State and the Centrale Raad van Beroep were maintained as specialized appellate courts, but greater effort was taken to ensure their bona fides as independent judicial bodies through the strict separation of judicial and advisory functions. In the same year, the General Administrative Law Act (GALA)[11] codified much of the unwritten general principles of proper administration that had been developed by the specialized courts and their appellate bodies.

Culminating with the coming into effect of the GALA, the structure of administrative law in the Netherlands has gradually progressed away from its origins in 'droit administratif' and toward a more uniform court hierarchy that spans civil and administrative law. Despite this, the relatively lengthy Dutch experience with specialized courts and the process of Crown appeal has left its mark on the process of judicial review. Social security courts have historically favoured the appointment of lay experts as judges to deal with specific policy areas and this significantly reduced the gap in expertise that otherwise generally encourages judicial bodies to defer to the discretionary decisions of administrative officials. While this practice has been affected by the incorporation of

[9] This primarily involved challenging the decisions of lower administrative bodies at the level immediately above (i.e. community decision at the regional level) with final recourse to the Council of the State which provided advice to the Crown. While the advice was non-binding, arduous procedural rules made deviating from the position of the Council difficult for the Crown (Blankenburg 1998).
[10] *Bentham v. Staat der Nederlanden*, ECHR 23 Oct 1985.
[11] General Administrative Law Act of 4 Jun 1992.

social security courts within administration chambers with a broader ambit at the District Court level, the history of social security case law provides a rich resource for the new, more generalist, administrative judge. As a result, there has been historically less deference afforded administrative discretion within the social security ambit of the Centrale Raad van Beroep when compared to other administrative areas handled at appeal by the judicial divisions of the Council of the State (de Graaf and Marseille 2007, 88-92).

Another element of judicial review inherited from the era of specialized administrative courts concerns how 'policy rules' ('beleid') affect the intensity of judicial scrutiny. Policy rules are a uniquely Dutch conception that attempt to articulate the principal goals that regulations are intended to address so as to leave some room for local officials to exercise discretion when applying them to concrete situations. The classic Dutch example is with reference to drug enforcement regulations where the stated goal (beleid) is to reduce the cost to society of addiction rather than to penalize those addicted. This has lead to the practice ('actual beleid') of not prosecuting those found in possession of small amounts of drugs despite it still being technically illegal (thereby minimizing the costs related to unnecessary prosecution and imprisonment) (Blankenberg 1998, 45-47). Policy rules can be seen then as providing guidance to administrative actors when weighing the interests affected by a particular decision. If enforcing the regulations too literally in a particular context appears to practically run counter to stated policy rules, then the value of enforcement is reduced. In cases where policy rules can be articulated in fairly clear terms (i.e. possession of below a particular amount of a banned substance within a particular geographic area), this weighing of interests is fairly routine. In other cases, such as arise within the health care arena where the crafting of policy rules often involves recourse to vague legal terms such as 'medically necessary' or 'urgent', the exercise of administrative discretion necessarily involves interpreting the meaning of these terms with respect to a wide variety of situations. While judges are generally deferential to the exercise of administrative discretion when more than one reasonable decision is possible, they have historically engaged in a more intense review of decisions that involve the interpretation of vague legal terms. Whether a 'marginal' (beoodelingsruinmte) or a 'full/intense' (beoordelingsvrijheid) legality test is employed by a court depends on the wording of the regulation and associated policy rules (Seerden and Sroink 2002, 184). The practical effect of this treatment of policy rules within administrative law has been formalized with their characterization as administrative decisions within the meaning of GALA (Article 1:3, para. 4).[12]

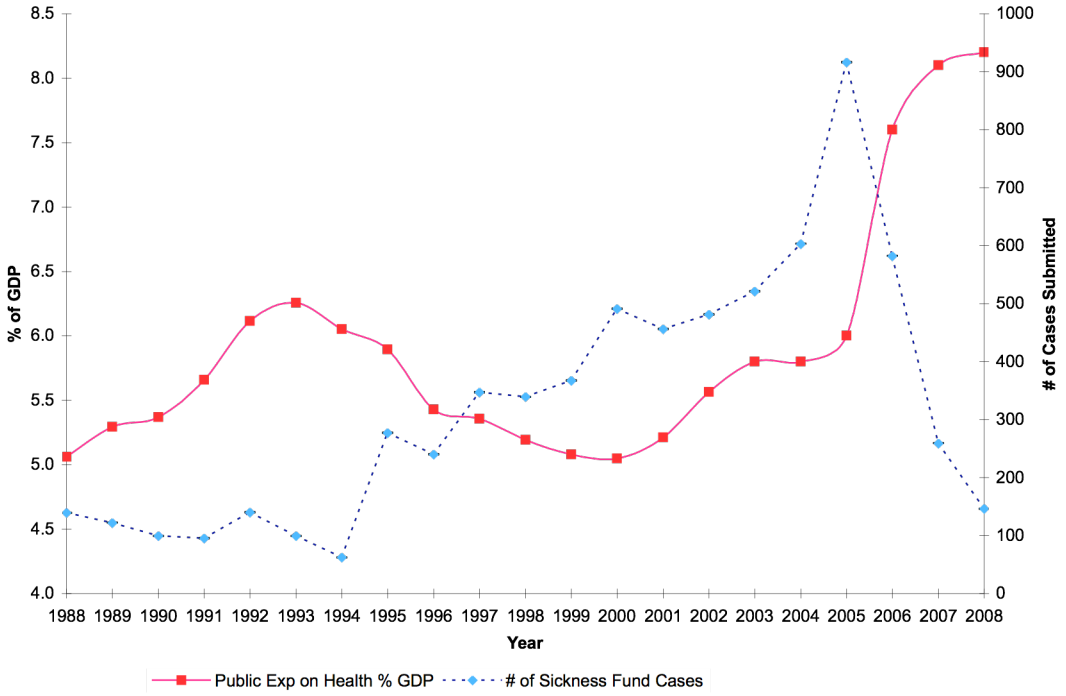
The Dutch health care system has historically been financed through a mix of private and public insurance funds. Prior to 2006, those individuals who fell below a certain target income level were required to enrol in one of several non-profit "sickness funds" that each offered a standard basket of services defined by the Health Insurance Act (Ziekenfondswet – ZFW). Generally only about 60% of the population was covered at any one time by the ZFW making the Dutch health system historically one of the most privatized in Europe (Minogiannis 2003). Those who made more than the target income

[12] Article 1:3, para. 4 states: "'Policy rule' means an order, not being a generally binding regulation, which lays down a general rule for weighing interests, determining facts or interpreting statutory regulations in the exercise of a power of an administrative authority."

level were free to choose from a wide variety of private insurers, but could also choose not to buy health insurance. 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 so-called 'managed competition'.

During the 1980s attempts to contain costs through corporatist consultations with health care insurers and health care providers failed, and led to calls for more drastic reforms. The influential Dekker Report issued in 1987 cautioned that the containment of cost through increased government regulation would not work (Okma 2000). Rather than centralizing control, the Dekker Report recommended that government should delegate the responsibility for cost management to health insurers and providers, as well as citizens, who would respond to market-driven incentives (Schut 1995). While much of the spirit of the Dekker Report would eventually be fulfilled in 2006 with the shift to managed competition, early incremental efforts to implement market-driven reforms were largely stalled by a lack of political consensus (Maarse and Paulus 2003). Beginning in 1992 the regional monopolies previously held by individual sickness funds were eliminated and sickness funds were also allowed to selectively contract with health care providers. Top-down supply-side rationing measures were also introduced through gradually increasing the proportion of risk-adjusted capped payments versus retrospective reimbursements made to sickness funds. As a result, the market mechanisms earlier introduced in response to the Dekker Report finally began to take hold. The amount of risk borne by sickness funds grew 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 and enrolees were allowed to switch funds more often. These reform efforts were relatively successful at controlling the growth in expenditure (see Figure 2. below), but they did little to directly 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)."

Figure 2. Public Expenditures on Health and Level of Judicial Activity - The Netherlands



(Sources: OECD Factbook 2009: Economic, Environment and Social Statistics, 1988-1995 *Burgerlijke en administratieve rechtspraak;* 1996-2000 *Kwartaalbericht Rechtsbescherming en Veiligheid*; 2001- http://statline.cbs.nl/.)

Taken together these reforms increased the likelihood of disputes arising as wait lists increased for some procedures and sickness funds became more aggressive in narrowly interpreting the scope of services they were required to offer under the ZFW.[13] After the coming into effect of the GALA the overall caseload with respect to social security began to decline signalling that the reorganization of administrative justice at the District Court level had perhaps reduced the number of minor disputes taken to court.[14] As a result of the impact of market-based reforms, within the health care area the trend was nevertheless in the opposite direction with the caseload rising rapidly from a low of 62 in 1994 to a high of 916 in 2005 (see Figure 2. above).

Prior to 1994, the District Courts and the CRvB had taken a relatively cautious approach to dealing with disputes concerning access to care. While being generally

[13] In addition, the market incentives encouraged sickness funds to selectively contract with providers who could provide lower cost alternatives. This led to disputes wherein patients sought to access services with perceived better quality at alternative (non-contracted) providers (Den Exter and Hermans 1999, 278).

[14] The total number of cases submitted declined quickly from a peak of 48871 in 1994 to a low of 14308 in 2001. The caseload since then has fluctuated between 14000 and 20000 (Sources: 1996-2000 *Kwartaalbericht Rechtsbescherming en Veiligheid*; 2001- http://statline.cbs.nl/).

sensitive to issues where patients were frustrated by procedural hurdles[15] or the lack of a thorough review by the sickness fund with respect to the necessity of care,[16] administrative courts generally adhered to a strict interpretation of the content of the ZFW when it came to whether or not a particular service was covered (Den Exter and Hermans, 1999). During 1995, in the face of a growing number of cases that saw patients attempting to work around waiting lists by accessing health services elsewhere in the EU, the CRvB affirmed its cautious approach by clarifying that patients were only entitled to care from non-contracted providers in cases of medical necessity and only for services covered by the ZFW.[17] Patients also could not expect to receive reimbursement for procedures deemed outside the "circle of professional practice" within the Netherlands.[18]

The Dutch administrative courts became more active in revising the definition of 'medical necessity' in the wake of three important rulings by the ECJ. The *Kohll*[19] 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 ZFW where benefits were delivered "in-kind" (Van Thiel and Lugtenberg 1999). The *Smit-Peerbooms*[20] 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 in fact a barrier to free movement in all cases but hospital care, and even then needed to be justified on an "objective basis". This allowed Dutch courts to broaden the range of data and opinions they considered when judging whether to grant reimbursement for exceptional cases to include the perspective of "international medical science". The *Muller-Faure and Van-Riet*[21] 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 an acceptable delay on a case-by-case basis. Within this context of expanded avenues for judicial review, the CRvB broke new ground of its own in 2000 in a case involving a drug (Cellcept) not on the ZWF formulary.[22] 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, in the general spirit of 'beleid', 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).

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[15] As an example, a district court granted the appeal of a patient who required an urgent procedure, but was refused by a hospital because the budget from the associated sickness fund was already exceeded (*Rb. 's-Hertogenbosch November 24, 1989*, nr. 704/89).
[16] *Rb. Zwolle, Sector Bestuursrecht June 18, 1993*, nr. 92/1165.
[17] *CRvB, January 24, 1995*, nr. 1992/5.
[18] CRvB, May 23, 195, nr. 1993/17.
[19] *Kohll v Union des Caisses de Maladie* [1998] ECR I-1931
[20] *Geraets-Smits and Peerbooms* [2001] ECR I-5473
[21] *Muller-Faure and Van-Riet* [2003] ECR I-4509
[22] *CRvB September 28, 2000*, nr. 98/8878 ZFW

As a result of this series of rulings, and the follow-on cases they inspired, the Dutch administrative courts became active participants in the definition of objective criteria through which the scope of services provided by the ZFW were to be defined. Since 1992 when the Dunning Committee had proposed a "funnel system" for managing the minimum basket of care offered,[23] policy makers had struggled to reach a consensus on a principled approach to managing the health care basket (Hoedemaekers and Oortwijn 2003). The gradual incorporation of the spirit of the ECJ patient mobility rulings by the CRvB[24] provided a de facto compromise that could be utilized effectively by both sickness funds as well as by administrative tribunals tasked with actively managing the content of the ZFW and with hearing initial administrative appeals lodged by patients.

In 2006 the Zorgverzekeringswet (ZvW) eliminated the remaining distinctions between sickness funds and private insurers. 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,[25] but it does not have to abide by their recommendations.[26] The CvZ also has responsibility for "package management" generally and utilizes a network of subcommittees that provide advice to the cabinet (Maarse and Bartholomee 2007).[27] Rulings of the SKGZ since 2006 have consistently rejected claims for reimbursement of exceptional medical expenses and very few of the SKGZ's binding decisions have been challenged in District Courts.[28] This can be seen to reflect the consistency with which the de facto regime of basket management engineered by the CRvB has been applied by both private insurance funds and the administrative bodies tasked with managing access to care.

Italy – National Health Insurance with a Fundamental Right to Health

While virtually all interactions between legislative/administrative branches and the judiciary in the Netherlands took place within the purview of administrative law, the jurisdiction for disputes related to health care in Italy is spread across civil,

[23] Officially the 'Government Committee on Choices in Health Care' and it 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).

[24] See *CRvB November 3, 2004*, nr. 99/2687 and *CRvB June 29, 2005*, nr. 03/4060 as representative examples.

[25] The CvG and its predecessor the Ziekenfondsraad dealt with these types of disputes directly prior to 2006.

[26] For example, the ZvW incorporates the possibility of requests being granted on "compassionate grounds" in exceptional cases. This can be seen as a recognition by legislators of the reasoning in the Cellcept case discussed earlier – see note 22 above.

[27] 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.

[28] Based on author's review of 30 sample cases related to specialist medical care. Of the few that have reached the regional civil court chambers (which now have jurisdiction for access to care issues under the private insurance based ZvW), decisions of the SKGZ have almost always been upheld – see *Rb. Arnhem October 12, 2009* nr. 178683 and *Rb. Arnhem April 16, 2009*, nr. 157237 as representative examples.

administrative, and constitutional contexts. Despite sharing similar French civil law origins,[29] the Italian legal framework was significantly altered in the wake of fascism's defeat in the Second World War. The new Italian Constitution of 1948 contained a more comprehensive Bill of Rights and established a special Constitutional Court consistent with the Austrian or 'Kelsen' model of constitutional review (Comba 2002).[30] Among the fundamental rights recognized were guarantees in the area of social and economic rights,[31] which are further protected by limitations placed on contract and property rights.[32] The inclusion of a progressive catalogue of rights was a compromise necessary to gain the support of socialists and communists who feared that the rest of the Constitution's focus on checks and balances placed unnecessary constraints on the democratic possibilities for working-class based reforms (Bull and Newall 2005, 6-7).

The structure of administrative justice was initially similar to that of the Netherlands with disputes against local administrative organs handled by provincial administrative tribunals ('giunte provinciali amministrative') with appeal to the Council of the State (Varano 2002, 118-121). Italy did not develop as extensive a network of specialized courts as the Netherlands after the Second World War and instead made an earlier move to establish regional courts with general administrative jurisdiction in 1971.[33] The jurisdiction of the Tribunali amministrativi regionali (TARs) was limited to issues that dealt with the violation of a citizen's "legitimate interests" by the administration, whereas disputes that concerned "subjective rights" were considered within the reach of civil or ordinary courts. The distinction between these two concepts remains controversial with respect to concrete situations, but legitimate interests can generally be seen as those interests that may be owed to individuals under certain legal standards (i.e the granting of a license), while subjective rights mandate a need for all persons (officials and fellow citizens) to behave in a certain way toward a specific individual interest (i.e. respect for contract rights as well as other fundamental human rights like the right to health). The difficulty in determining the appropriate jurisdiction to deal with situations that often mix or blur the boundary between these two has prompted several efforts to grant exclusive jurisdiction on the basis of topical area to administrative courts.[34]

Administrative decisions can be attacked for incompetence, excess of power (including considerations of ultra vires, reasonableness, impartiality, and proportionality), and violation of law (including EC regulations). Current judicial doctrine[35] generally encourages administrative judges to restrict themselves to reviewing the legality rather than the merits of administrative action unless the act can be attacked under the heading of excess of power. This is especially true when considering discretionary decisions

[29] The first efforts to create national codes following unification in 1865 were based on the Piedmontese model which in turn was inspired by the Napoleonic codes (Padoa-Schioppa 2002).
[30] References to the Constitutional Court can only be made by way of referral by another court or by special request of the President, Parliament, the Executive, or regional governments.
[31] Articles 32, 34, and 38 contain guarantees to health, education, and social assistance respectively. The wording of Article 32 is as follows: "The Republic safeguards health as a fundamental right of the individual and as a collective interest and guarantees free medical care to the indigent."
[32] Articles 41 thru 43.
[33] Appeals would continue to be heard by the Council of the State.
[34] Law n. 80/1998 and n. 205/2000
[35] Case law has historically played a relatively minor role in the Italian legal system.

wherein the administration must balance different interests (both public and private). A body of case law has also accumulated in support of respecting the "technical discretion" of agencies when evaluating decisions that are nominally bound by law, but are based on conflicting evidence. As in the Netherlands, an attempt was made to create a uniform code for administrative law in 1990, but its objectives were less ambitious.[36] The law improved access for citizens to administrative records (which had previously been scandalously poor), provided for minimal standards addressing the participation of citizens in administrative decisions that affected them, and mandated officials to issue written decisions containing clear rationale (Sorace 2002, 131-138).

Italy's universal health care system, the Servizio Sanitario Nazionale (SSN), was established in 1978[37] as a national health service similar to Britain's. Between 75-80% of health care expenditure is publicly funded[38] 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 meant to be mechanisms for democratic participation in the delivery of health services and the 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 2003). 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[39] aimed at stabilizing rising health care expenditures (see Figure 3 below). 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 the use of market mechanisms such as the use of selective contracting for private providers. While ambitious, the impact of the 1992 reforms was uneven across regions and hampered by the lack of bureaucratic experience with the new managerial approach (Anessi-Pessina and Cantu 2006).

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 core principles - human dignity, effectiveness, appropriateness, and efficiency - that would guide the creation of national guidelines with respect to the essential levels of care (Livelli Essenziali di Assitenza – LEAs) (Torbica

[36] Law 241/1990.
[37] Law n. 833 / 1978.
[38] OECD Health Data 2009 – Version: November 2009. Available at: www.ecosante.org/oecd.htm
[39] Law n. 502 / 1992.

and Fattore 2005).[40] In 1999 a package of reforms[41] was introduced that reinforced 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[42] 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 healthcare experts, regional representatives and one Treasury appointee (Torbica and Fattore 2005). The overall impact of the 1999-2004 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.[43] The regions remained dependent on the central government for funding,[44] but became 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 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 of the Constitution, to the main arbiter in disputes between the central government and the regions. The substantive content of Article 32 has been developed over time in the case law of Italy's Constitutional Court and its Supreme Court of Cassation and has significantly influenced the contents 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'.[45] The Court of Cassation extended the meaning of Article 32 to include access to necessary and non-substitutable drugs[46] and in 1988 the Constitutional Court 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.[47] This was followed up by a ruling that stressed the right to healthcare was not "unlimited" and needed to be balanced with "legitimate financial

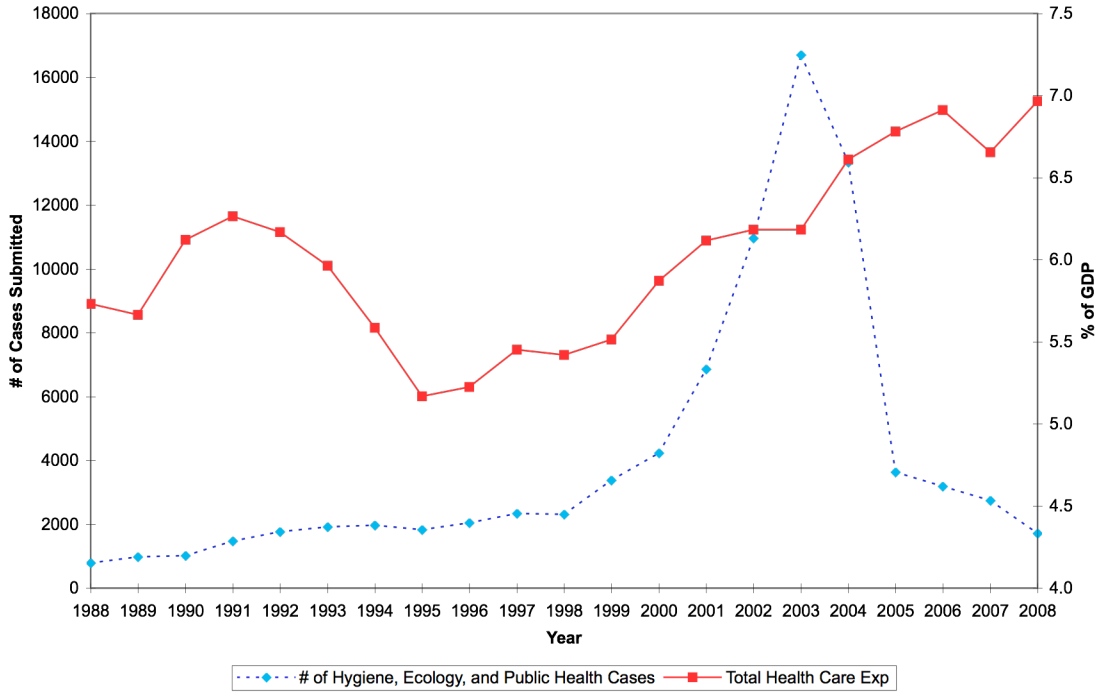
[40] The SSN had been committed to creating LEAs since the 1992 reforms, but little real progress had been made.
[41] Law n. 229 / 1999.
[42] The LEAs were finally formalized for the first time in 2001 coincident with the constitutional changes and included extensive positive and negative lists of services. A drug formulary had always been part of the SSN and was integrated into the LEAs. (Torbica and Fattore 2005).
[43] Only it Italy's case the structure of the institutions of national-regional interaction are more formal and possess specific mandates.
[44] 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).
[45] Court of Cass. sent 6129/1983, Const. Court sent. 173/1987
[46] Court of Cass. sent 1504/1985.
[47] Const. Court sent 992/1988.

interests".[48] Later rulings noted 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.[49] 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 arbitrary limits on when emergency care could be reimbursed.[50]

Initial rulings of the Constitutional Court with respect to disputes arising from 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.[51] After the 1992 reforms the Court consistently sided with the national government citing both the new tools available to the regions to raise revenues and the urgency of the fiscal "emergency" that confronted the nation.[52] Similar cases were also initiated after the 1999 reforms but were eventually made irrelevant by the content of the constitutional amendments of 2001. Given the relative lack of detail that accompanied these 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 government's responsibility to define the minimum standards of care[53] and cautioned the national government against moving forward with further healthcare reforms without consulting the Permanent Conference for Relations between the State and Regions.[54] In general terms, the court has sought to reinforce the national government's ability to download responsibility for budgets to the regions while ensuring that it does not work around the inter-governmental bodies tasked with allowing the regions to have input into the definition of the minimum care basket.

[48] Const. Court sent. 445/1990.
[49] Const. Court sent. 304/1994, 267/1998 and 309/1999.
[50] 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.
[51] Const. Court sent. 254/1984 and 452/1989.
[52] Const. Court ord. 416/1995
[53] Const. Court sent. 282/2002 and 338/2003.
[54] Const. Court sent. 88/2003

Figure 3. Public Expenditure on Health and Level of Judicial Activity - Italy



(Sources: OECD Factbook 2009: Economic, Environment and Social Statistics / 1987-1999 – Extracts received from the 'Ufficio Servizi per l'Automazione e l'Informatica' at the Council of the State; 2000-2008 http://giustiziaincifre.istat.it/

The regional administrative courts (TARs) dealt with an explosion in the number of cases involving health care (see Figure 3. above) between 1999 and 2005. This rapid rise correlates to the era within which administrative courts exercised exclusive jurisdiction to deal with all disputes related to health care (including issues dealing both with legitimate interest and subjective rights).[55] Early rulings of the administrative courts dealt with disputes concerning clinical effectiveness and were inconsistent in their approach (France 1998). Some cases appeared to favour relying on general standards of clinical effectiveness[56] while others focused more on the needs of the individual patient (judgments 'ad personam').[57] A ruling of the TAR Lazio 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.[58] More recently, the Council of the State have in a series of rulings

[55] Law n. 80/1998 and n. 205/2000 transferring exclusive jurisdiction to administrative courts was ruled unconstitutional in 2004 (Const. Court sent. 204/2004). The Constitutional Court cited the need for uniformity with respect to protecting rights against the state under the supervision of the Court of Cassation.
[56] TAR Toscana Sent. 376/1994
[57] TAR Toscana Sent. 368/1994 and 370/1995.
[58] Sent. 384/1998

demonstrated clear support for an ad personam approach. 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[59] and in 2004 the Council strengthened this position by refusing to accept counter-arguments related to containing costs.[60] A ruling in 2005 made clear that it was not enough for an ASL to indicate that a similar treatment was available through the NHS in order to reject a request for the reimbursement of health services received from non-contracted providers, it also had to specify the centres that could deliver the treatment and verify whether the wait time for treatment was appropriate for the given patient.[61] 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.[62]

The rulings of the ECJ discussed above, so critical for the development of a coherent framework for assessing access to care issues in the Netherlands, are rarely referred to and never decisive in Italy. The status of Article 32 as a 'fundamental right' has appeared to make the incorporation of ECJ rulings irrelevant to Italian courts at all levels.[63] Instead, access to care issues have been handled as a matter of substantive positive right, the content of which has been shaped across civil, administrative and constitutional courts. This has resulted in the move towards an increasingly ad personam basis for determining clinical effectiveness that can make evaluating the probability of a successful appeal difficult for patients to judge. When coupled with the notoriously long wait times for an appeal to be heard within both civil and administrative courts in Italy,[64] the practical value of the substantive right to health for patients who feel aggrieved by administrative decisions is difficult to appraise. This uncertainty is further complicated by the lack of effective intermediate venues within the administration for patients to challenge the decision of the ASLs to deny access to services prior to lodging their appeal at the appropriate court (a decision which in itself contains some risk given the continuing lack of clarity with respect to jurisdiction in many situations). The overall effect is one wherein there is little incentive for administrative officials faced with fiscal constraints to effectively integrate the cross-court refinement of the substantive right to health into the day-to-day operations of health care administration.

The role of the Constitutional Court in helping shape cooperation between state and regional levels of government has been more constructive. The Court's intervention was instrumental in the shaping of national-regional responsibilities with respect to the on-going management of the national health care basket. While considerable variation still exists between regions, this has helped to facilitate the refinement of the parameters of fiscal federalism with respect to healthcare and address chronic issues in ex ante health care budget deficits (Tediosi et al. 2009).

[59] Council of the State Sent. 5192/2002.
[60] Council of the State Sent. 5132/2004.
[61] Council of the State Sent. 6729/2005.
[62] Council of the State Sent. 1902/2006.
[63] Since the protections afforded by Article 32 appear to surpass those resident in the ECJ rulings.
[64] Cases often take up to 10 years to reach the appeal level and regularly take in excess of 3 years at the first instance (Sorace 2002).

Canada – Regional Health Insurance within a Common Law Tradition

Following the common law tradition of a uniform court hierarchy, the judicial review of administrative acts falls under the jurisdiction of the ordinary courts in Canada[65] and can be challenged either under the rubric of administrative law or for violation of one of the sections of the Charter of Rights and Freedoms[66]. Charter-based claims usually revolve around either section 7 (the right to life, liberty and security of the person) or section 15(1) (equality before the law / protection against discrimination). The Supreme Court in Canada, unlike the Italian Constitutional Court, has been extremely reluctant to recognize that either section can be used to place positive obligations on the state. In 2002, in a decision with reference to the provision of minimum levels of social assistance,[67] the Supreme Court recognized that section 7 could eventually be interpreted as supporting positive rights, but the case would have to be a compelling one in order to "support the weight of a positive state obligation of citizen support".[68] One of the most prominent section 15(1) cases involved the provision of health care services to deaf patients[69] and directed the British Columbia government to provide for interpretation services within its healthcare facilities. While this was seen by some as imposing a positive obligation on the state, the Court's stated intention was to ensure that the appellants could enjoy equal access to the same bundle of services as other citizens (Flood 2005, 673). This more narrow interpretation of the ruling is confirmed by the failure of later health care related cases that attempted section 15(1) arguments aimed more explicitly at expanding the basket of health care services.[70]

Administrative law in Canada has evolved from a grounding in common law principles of natural justice (due process), ultra vires (lack of jurisdiction), and errors of law, to a preoccupation with the determination of the appropriate "standard of review". In the 1970s, superior courts began to more aggressively consider issues of jurisdiction in order to apply the more intense standard of "correctness" in cases that involved the decisions of administrative tribunals.[71] As per David Mullan, "(t)he concept of 'jurisdiction' was manipulated to allow review for virtually all errors of law, irrespective of privative clause protection" (2006, 49). This era of relatively active judicial review was short-lived and by 1979 the Supreme Court had already reversed course and allowed that administrative tribunals were likely in many cases to be in a better position to

[65] Larger provinces such as Ontario have established special divisions at the first instance to hear administrative cases.

[66] The Supreme Court has struggled recently with the question of when disputes that relate to matters of administrative discretion should proceed on Charter versus administrative law principles. Its most recent position was outlined in *Multani v. Commission scolaire Marguerite-Bourgeouys* [2006] 1 SCR 256 where the majority favoured a "purposive" approach wherein the primary purpose of judicial review in the matter at hand would take precedence. This is opposed to a "categorical" approach wherein the choice would rest on whether the case involved an administrative decision (administrative law) or a law (Charter-based review).

[67] *Gosselin v. Quebec (Attorney General)* [2002] 4 SCR 429.

[68] Ibid. at para. 85.

[69] *Eldridge v. British Columbia (Attorney General)* [1997] 3 SCR 624.

[70] See *Auton v. British Columbia* (Attorney General) [2004] 3 SCR 657

[71] The Supreme Court signalled this less deferential approach in *Metropolitan Life Insurance Co v International Union of Operating Engineers* [1970] SCR 425.

determine the appropriate boundaries of their own jurisdiction.[72] In addition, the decision taken by a tribunal operating within its valid jurisdiction should not be overturned unless the court found that it was "so patently unreasonable that its construction cannot be rationally supported by the relevant legislation and demands judicial intervention by the court upon review."[73] Over the next thirty years the Supreme Court refined its approach to determining the appropriate standard of review through the development of a series of questions or tests.[74] This led both to the discovery of a third standard (reasonableness simpliciter),[75] which was seen to lay between correctness and patent unreasonableness, and the gradual broadening of the applicability of the analysis to virtually all matters of administrative law and not just those involving decisions of administrative tribunals (Mullan 2006, 48-50). The Supreme Court refined their analysis further in 2008 in a ruling wherein it also collapsed the distinctions between the patent unreasonableness standard and reasonableness simpliciter into one standard of "reasonableness". [76]

The Canadian health care system is perhaps better understood as ten separate systems 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 system represents a self-contained body 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.[77]

In 1990[78] 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 and Archibald 2001). Subsequent drastic federal reductions in fiscal transfers beginning in 1994, combined with spiralling provincial deficits, led the newly elected right-of-centre Harris Conservative government to quickly address rising health care costs through the de-listing of services and the tightening of eligibility requirements.[79] 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

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[72] *C.U.P.E. Local 963 v N.B. Liquor Corp*. [1979] 2 SCR 227.
[73] Ibid. at 237.
[74] Up until recently this was referred to as the "pramatic and functional analysis" (Union des employes des service local298 v Bibaeault [1988] 2 SCR 247 at para. 44). The most recent incarnation of this analysis looks at the following three factors: 1. Is their a privative clause indicating the need for deference; 2. Is the case within a special administrative regime in which the administrative decision maker has special expertise; 3. Is the nature of the question of law of central importance to the legal system. With reference to health care disputes in Canada, positive answers to the first two questions leads to the application of the more deferential "reasonablenss" standard (*Dunsmuir v. New Brunswick,* [2008] 1 SCR 190 at para. 55).
[75] Reasonableness simpliciter attempted to account for situations when more than one reasonable decision was possible on the part of the administration. Under this standard the court was not to substitute its own choice among the reasonable options for that of the administration.
[76] *Dunsmuir v. New Brunswick,* [2008] 1 SCR 190.
[77] With my larger research project I aim to discern if the differences between common and civil law contexts that emerge from my cross-state comparison are also present when comparing Ontario to Quebec wherein a pre-Confederation civil law system is partially preserved.
[78] *Health Insurance Act,* R.S.O. 1990, c.H.6.
[79] Eligibility requirements primarily targeted non-citizens.

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 '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 to allocate funding to priority areas.

Despite the upheaval in health care delivery caused by the reforms of the mid 1990s, in comparison to the Netherlands and Italy, Ontario is remarkable for its lack of routine judicial activity within the health care policy sector. A thorough review of cases at the Divisional Court branch of the Superior Court[80] and Appeal Court level in Canada's largest province yields only 35 cases that touch on access to care issues (broadly defined) between 1990 and 2009.[81] The establishment of the Health Services Appeal and Review Board (OHSARB) in 1998[82] may have served to limit the number of cases that reach the courts,[83] but the existence of similar internal appeal boards with much longer histories in the Netherlands have coexisted with much higher caseloads within administrative courts. The relative high cost and complexity of legal mobilization in Canada[84] may deter potential litigants, but the hurdles they face within Italy are certainly no less challenging.

Three other factors emerge that, when taken together, may help to explain the relative lack of judicial activity within Ontario. First, in comparison to the Netherlands and Italy virtually all acute care providers work exclusively within the public system. As a result, patients do not have historically not had the same ready access to potential care alternatives outside of the public plan. In Italy, private providers continue to operate both

[80] 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.
[81] 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.
[82] Prior to this appeals were made to a panel of the Health Services Appeal Board.
[83] The HSARB has heard between 100 and 250 cases per year since 2002 (www.hsarb.on.ca/scripts/MOHSearchFile_Public.asp).
[84] 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. Charter-based claims are prohibitively expensive for all, but the most determined of litigants.

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. Lacking an awareness of viable care alternatives, patients in Ontario may simply be less contentious about the care they receive. Second, the design of the single payer system in Ontario provides few openings for administrative law. There are no "third parties" such as sickness funds or ASLs within Ontario who can serve as ready targets for judicial review. Accountability is instead fractured across the system making "it difficult to identify a particular decision maker and a particular decision to which administrative law can attach (Flood 2008, 10)." Third, absent the unilateral appropriation of external principles by the courts,[85] or a move towards a Constitutional recognition of positive rights,[86] judges have few tools with which to question administrative discretion within the health care arena (Cherniawsky 1996).

The recent Ontario rulings in *Wareham* and *Flora*[87] (section 7) and *Wynberg*[88] (section 15) reaffirm that the door to Charter-based positive rights claims remains firmly closed. Within the purview of administrative law though, Ontario courts have recently demonstrated some ability to interact constructively with the OHSARB. In *C.C.-W. v. Ontario*[89] a group of three patients sought reimbursement for emergency out-of-province services received without prior approval. The Appeal Board had rejected all the initial requests on the basis that the legislation under which the OHSARB operates did not provide the Board with the authority to grant claims without prior approval. The court ruled that in the case of emergency claims, the power to grant reimbursement after the fact should be seen as implicitly lying within the Board's authority and accepted the appeal in two of the three cases. As a result of the ruling, the Board immediately incorporated the reasoning the court used in differentiating the appeals into the evaluation of new cases before the Board.

Some Preliminary Conclusions Regarding Factors Contributing to Constructive Juridification

The dynamics of dealing with mature programs of social provision within an era of fiscal constraints, yields challenges that transcend national settings. Determining how to manage demands within the health care arena is particularly vexing given the necessarily open-ended nature of health services bounded only by contentious terms such as "clinically effective", "medically necessary", and "urgent". Meeting these challenge requires that the interactions across legislative/administrative and judicial branches of government are "constructive". I have defined constructive interactions as those wherein legislative and administrative actors provide clearly articulated reasons for their actions, together with an explicit concern for the legal and constitutional rights of those affected. The comparison of patterns of juridification across the Netherlands, Italy, and Canada

[85] As was the case in the Netherlands with respect to the content of the ECJ rulings.
[86] As was the case in Italy with respect to Article 32.
[87] *Flora v. Ontario (General Manager, Health Insurance Plan)* [2008] OJ No. 2667 and *Wareham v. Ontario (Minister of Community and Social Services)* [2008] OJ No. 4598.
[88] *Wynberg v. Ontario* [2006] OJ No. 2732.
[89] *C.C.-W. v. Ontario (General Manager, Health Insurance Plan)* [2009] OJ No. 140.

suggests that these interactions are more constructive when confined to the arena of administrative law. This is most clearly demonstrated in the case of the Netherlands where the civil law tradition of 'trias politica' continues to constrain review on other grounds. In Italy, where access to care questions are dealt with both in the context of administrative law and as a matter of fundamental positive right, interactions have not been as constructive in yielding effective coordination across branches.

The comparison between the Netherlands and Italy also demonstrates that interactions are more constructive when well-established administrative tribunals provide an intermediate venue for claims. The interaction between judicial review within administrative law and administrative panels occurs at a level that both limits the ambit of judicial review and allows for the operationalization of its output. The recent interactions in Ontario between courts and the OHSARB provide an additional example of the benefits of intermediate venues. The positive contributions made by the Italian Constitutional Court to the establishment of LEAs and the inter-governmental regime to manage their content can also be seen to provide some support for the underlying rationale that interactions between legislative/administrative and judicial actors are more constructive when judicial output can be easily operationalized.

Interactions to date between judicial and legislative/administrative branches within the health care arena have been comparatively infrequent to date within Canada. The pace of medical innovation, continued fiscal constraints, as well as the potential impact of reforms aimed improving accountability for managing access to care,[90] suggests these interactions will likely increase. The comparison of patterns of juridification within this paper provides support for the claim that these interactions will likely be more constructive if channelled through administrative law rather than Charter-based claims.

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[90] Thereby creating both a more effective 'target' for judicial review and the potential for 'tri-partite' disputes wherein judges act to resolve issues that arise out of variations in local implementation of regional objectives.

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