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***The Role of the Courts in the Governance of Health Care:
Lessons from the Canadian Experience***

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Introduction:

The impact of court decisions involving rights-based claims on the contours of existing health policy – particularly policy that involves the public funding of health care services – raises important questions about future of health care governance. Recent developments in Supreme Court of Canada decisions offer important cases through which to examine the impact of rights-based court decisions on health policy. In this paper, we examine three critical judgments involving the Canadian Charter of Rights and Freedoms: *Eldridge* (1997), *Auton* (2004) and *Chaoulli* (2005), all of which involved individuals' challenging the policy status quo of health care systems. Building on an examination of the objectives and outcomes of these cases, we examine their impact on public policy decision-making, and attempt to contextualize in a broader reflection on the role of the courts in health care governance.

Courts and Policy-making in Canada

Since the advent of the Canadian Charter of Rights and Freedoms in 1982, there has been much debate about the impact of judicial review in Canada (see, for example, Roach, 2001; Manfredi, 2001). The delicate balance between political institutions and public policy is perhaps best captured in the idea of a “dialogue” between court and legislatures that attempts to strike a balance between individual rights and policies aimed at the collective good (Hogg and Bushell 1997).

The courts remain a difficult arena within which to settle disputes in which individual claims are argued against policies designed for a larger purpose and involving considerable sums of public money. This is especially true in the case of health care in Canada, which is arguably the single most important area of public policy, representing over 10% of the country's GDP and the lions' share of every province's program budget. These provincial health plans provide comprehensive care on a universal basis to all legal residents by regulating the funding, payment and delivery of services (see Maioni 2014).

It is precisely in the realm of these provisions and prohibitions that there has been increasing judicial activity. In the three cases under study, litigation provided an alternative access to the policy process for individuals unhappy with their access to specific health care services. In the following sections of the paper, we trace these cases by looking at the objectives, outcomes and impact.

The trilogy of cases under study have certain logic to their selection. Anchored in the equality rights provision in Section 15 of the Charter, *Eldridge v. British Columbia* represented the first real foray of the Supreme Court into the specific provision of health care services, while *Auton v. British Columbia* challenged the authority of provincial governments to determine the scope of their public health care systems. Then, *Chaoulli v. Quebec* brought the Court well beyond the margins of policy-making in challenging the very legitimacy of publicly funded health care.

Our focus is on how the issues moved onto and through the judicial process, and the reasons why the claims succeeded or not. We then look at the impact of these rulings on subsequent policy decisions made by legislatures or through regulatory changes.

Analysis

Eldridge v. British Columbia

Canada is a signatory to the United Nations *Convention on the Rights of Persons with Disabilities* (2007), but it has not adopted the equivalent to a national legal framework specific to disability and access to medical services in the same way, for example, as the American with Disabilities Act (1990) in the United States. Instead, legal residents have access to medical care through provincial health services governed by the stipulations in their respective legislations. The rights of the disabled, meanwhile, are more broadly captured by the Charter of Rights and Freedoms, which prohibits discrimination on the grounds of mental or physical disability. Section 15 (known as the equality rights provision), makes it illegal for governments to discriminate against disabled persons in designing laws or policy programs.

With the introduction of the Charter and the absence of a national legal framework for disability, it would only be a matter of time before challenges would ensue with regard to insured medical services. In this case, it would be through a case known as *Eldridge v. British Columbia* (for more on this case, see Manfredi and Maioni, 2002; Jackman, 1998).

At issue in *Eldridge* was the constitutionality of the province of British Columbia's Hospital Insurance Act and Medicare Protection Act. It began in 1990 with two plaintiffs: a deaf couple, John and Linda Warren, who claimed they did not receive appropriate communication during the birth of their twins; and a deaf woman, Robin Susan Eldridge, who requested sign language interpretation at the hospital. Their claim was that sign language interpretation should be considered an insured service. The case was unsuccessful: in 1992, the BC Supreme Court argued these were "ancillary" rather than necessary services (like transportation); in 1995, the BC Court of Appeal ruled that such services were subject to hospitals' "budgetary discretion" not government legislation (Tate, 2001).

When the case was granted leave for appeal to the Supreme Court of Canada, it attracted a number of intervenors: the province of British Columbia was now joined by the provinces of Ontario, Manitoba, and Newfoundland, and by the government of Canada; while the Warrens and Eldridge were joined by the Canadian Association of the Deaf, the Canadian Hearing Society, and the Council of Canadians with Disabilities as well as the Charter Committee on Poverty Issues, the Women's Legal Education and

Action Fund (LEAF), and the DisAbled Women's Network (DAWN). While the plaintiffs claimed that the existing health insurance statutes violated their right to equality under the Charter because neither statute provided for sign language interpretation as an insured benefit, the broader scope of the case was made by LEAF, which had been established in 1985 with the specific goal of ensuring equality provisions under Section 15 of the Charter.

At its core, the *Eldridge* case was about health insurance and the provision of medical care services, even though once it reached the Supreme Court in 1997 the focus of the appellant intervenors was on moving forward jurisprudence on equality rights in Canada. In fact, the unanimous decision, written by Justice Laforest, did not declare the provincial health statutes unconstitutional for failing to include sign language interpretation as an insured service, but it did support the argument that hospitals have a constitutional obligation to provide deaf patients with sign language interpretation (*Eldridge* 1997). Specifically, it concluded that effective communication *is* an integral part of health care provision and that, for deaf persons, this includes sign language interpretation. The court then directed British Columbia to administer its statutes in a manner consistent with section 15 of the charter. Although it did not specify province should implement this policy change, nor did the Court really address the province's concerns about the cost of providing such interpretation services (which the Court estimated at « \$150,000 or approximately 0.0025 percent of the provincial health care budget », *op. cit.*, para. 87). The other government intervenors in the case were also concerned about the reach of the decision, primarily due to fiscal reasons. While the Court reiterated the role of the federal spending power and of provincial autonomy in health care, it downplayed these fiscal concerns.

The impact of *Eldridge* was important for both rights-based claims and for federalism. In the first instance, the Court listened to the non-governmental litigants and agreed that provincial health care statutes were subject to the Charter with regard to equality provisions, even extending this into the realm of hospital care (since hospitals are voluntary rather than state-owned institutions) when they are delivering publicly-funded services. In fact, the Court flexed its muscle by reversing two sets of lower court decisions and government arguments (provincial and federal), and instead supporting individual-based rights claims bolstered by non-governmental organizations and legal mobilization activities.

Since the *Eldridge* decision, the government of British Columbia covers interpretation for all *insured* medical services (i.e., physician care, hospital care, but not physiotherapy, dental care, optometry, etc.), upon request of deaf and hard-of-hearing patients. The Provincial Health Services Authority contracts for interpretation with the Western Institute for the Deaf and Hard of Hearing (this organization had, in fact, been cited in *Eldridge* with reference to the costs estimates for providing such services). The volume of requests has grown over time, but it is not clear as to the total budget being provided to fund these interpretation services, nor the total cost to the province over time. And, these services are more accessible to patients living in the urban areas of Vancouver and Victoria, as well as the lower mainland of the province, than in more remote regions (Manfredi and Maioni, forthcoming).

As for the larger impact of *Eldridge*, it seems that Ontario is the only other province to officially offer similar services; in other cases, the Supreme Court has not followed its precedent in instructing governments to provide specific services (Flood, 2014, p. 89-90). Still, as we shall see, the matter of equality rights under the Charter continues to provide grist for the health policy mill.

Even if, from the point of view of substantive impact on health policy, the *Eldridge* decision was limited, it had an important impact in setting the stage for further legal challenges against provincial governments' provision of services, raising the issue of the judicial process's role in health policy decision-making, and providing an alternative arena for plaintiffs and intervenors seeking to expand the notion of rights through the courts.

Auton v. British Columbia

The next case in this trilogy also originated in British Columbia, took its cue from the American concept of rights for the disabled, and involved the legal mobilization of claims. And it was a case worthy of considerable sympathy: the plight of autistic children and their access to necessary and appropriate services in a publicly funded health care system (for more on the *Auton* case, see Manfredi and Maioni 2005).

If in *Eldridge*, the case "found" advocacy group that supported it as it made its way to the Supreme Court, in *Auton*, advocacy groups seeking specific redress founded the case from the outset. Although the case centered around Conor Auton, a young boy diagnosed with autism, it was built on the campaign of a BC based advocacy group modeled on its American predecessor known as FEAT (Families for Early Autism Treatment). FEAT began in California in 1993 specifically to lobby and litigate for insurance coverage and funding for an "early intensive behavioral intervention" known as the Lovaas Autism Treatment (or LAT) and Applied Behavior Analysis (ABA). Developed by Dr. Ivar Lovaas, it was an expensive and intensive treatment, but with a startling "success" rate in a small sample of children (Lovaas, 1987), it became a source of hope for families with autistic children across the United States. The first Canadian FEAT branch was set up in British Columbia in 1996 and, after failing to make inroads with government officials on public funding of the treatment, it took the BC government to court for failing to recognize LAT as a medically necessary service in the province's health plan.

The case began in 1998 with Conor Auton and three other children whose parents claimed the denial of LAT funding contravened their constitutional rights, not only under the equality provisions for the disabled (Section 15) but also under the rights of life, liberty and the respect of the person (Section 7). Their petition also sought an order of "mandamus" that is to say, a specific judicial remedy in asking for compensation for the costs their children's therapy had already incurred and for the future costs of such treatment.

The first part of the proceedings took place in April 2000 and centered on the "clinical" effectiveness of LAT; the parents argued that both Lovaas' own research and their children's progress provided such evidence, while the BC government argued that these were insufficient to consider it "medically necessary." The BC Supreme Court was unswayed by the government defense and, taking a page from *Eldridge*, determined that, "having created a universal medicare system of health benefits, the government is

prohibited from conferring those benefits in a discriminatory manner.” (Auton 2000, paras. 126-27). By November 2000, when the remedy phase began, the BC government had already set up a Provincial Centre for Autism and Related Disorders and planned to phase in services, including 20 hours per week of intensive behavioral therapy to all diagnosed autistic children less than six years of age. The remedy decision did not rule on the effectiveness of this or any other plan, instead declaring a denial of equality rights, directing the funding of early intensive behavioral therapy for children with autism, and awarding the four parents \$20,000 in monetary damages.

When the BC government also lost the case on appeal, it moved to the Supreme Court. By the time the case was heard in June 2004, the case had amassed an impressive group of intervenors; for BC, this included the federal government and the other nine provinces in Canada; and for the parents, eight organizations including three that had been involved in *Eldridge* (the Council of Canadians With Disabilities, Women’s Legal Education and Action Fund, DisAbled Women’s Network). Although the BC government saw this case in terms of its impact on the province’s ability to make public policy, not to mention decision-making that would have an impact on the public purse, the Auton group was seeking redress in the form of compensation for LAT therapy which they claimed had been unconstitutionally denied them.

Despite the sympathetic plaintiffs and their cause, the Supreme Court delivered a unanimous decision in November 2004 that reversed both lower court decision and dealt a convincing blow to FEAT’s legal mobilization. The Chief Justice, Beverley McLachlin, declared that the issue was not “what the public health system should provide,” but whether “failure to fund” certain services under that system can be “an unequal and discriminatory denial of benefits.” In drawing a clear distinction between decisions about what is or ought to be included in the health care “basket” (“a matter for Parliament and the legislature”) and the delivery of services authorized by law (that must be provided “in a non-discriminatory manner”).

At least two additional comments warrant note. The Court agreed with the lower courts about the lack of a “gold standard of scientific methodology” as to the proper treatment for autism (Auton, para 61). However, the decision also chastised the lower courts for comparing the claims of autistic children, considered here to be “emergent” non-core therapy, to the claims of non-disabled or mentally disabled persons receiving funding for established therapies, thus rejecting the claim of discrimination (Auton, para 58).

Still, despite this legal defeat, there was plenty of “copycat” legal mobilization in and outside of BC that continued to press for the Lovaas Autism Treatment. In the wake of the Auton decision, it was estimated that 180 cases, involving over 1600 families, were still pending (Manfredi CITATION NEEDED). Although the Auton decision may have quashed attempts for Lovaas Autism Treatment specifically, many more cases arose of families resorting to the courts for early intensive behavioral treatment and for treatment in schools. The Ontario government, for example, spent over \$2 million fighting a \$1.2 billion class action lawsuit in 2007 (Tyler 2008). The Supreme Court of Canada, however, has been circumspect, having rejected to hear that particular case as well as others.

While the victory of *Eldridge* led to only modest changes in public policy terms, the defeat of *Auton* seemed to galvanize Canadian public opinion as to the predicament

of families of autistic children, and certainly inspired pro-active policy initiatives. For example, the BC pilot project was converted into a more robust policy response; other provinces also followed suit with autism programs. By 2006, all ten provinces and two of the territories had some form of (albeit limited) early intervention in place, although not the kind of therapy represented by the LAT (Madore and Paré 2006). Furthermore, autism has become a familiar term in federal policy discussion as well; as a result of the attention garnered by legal challenges involving autistic families, the Senate Standing Committee on Social Affairs, Science and Technology decided to take on the issue of autism funding, and the title of its report reveals the nature of its conclusions: *Pay Now or Pay Later: Autism Families in Crisis* (Senate of Canada, 2007).

Chaoulli v. Quebec

Like the preceding cases, the origins of *Chaoulli v. Quebec* go back to the 1990s and involve both the personal drama of human protagonists seeking medical services and the struggle over health policy between courts and legislatures. Much has been written about the *Chaoulli* case (see, for example, Manfredi and Maioni 2006 from which the analysis below derives), but the essential point is that it did not emerge from a vacuum. Instead, it follows from the preceding context of rights-based claims. Here, the locale moves from British Columbia to Quebec, and from the relatively narrower realm of disability rights to a much broader challenge to the foundations of publicly funded health insurance in Canada.

There are two central actors in the case, but they were initially unrelated to one another. The first was a suburban Montrealer named George Zeliotis: in 1994, the sixty-one year old began experiencing hip problems. His general practitioner referred him to an orthopedic specialist in 1995, and he had surgery on his left hip. But he was then subjected to a year-long wait for surgery on his right hip, which occurred in 1997. Upset at the wait, Mr. Zeliotis learned that the terms of Quebec's health care laws prohibited him from "jumping the queue": he could neither pay directly for services provided by a physician in a public hospital, nor could he purchase private insurance that could pay for surgery in a private facility.

The second actor was Dr. Jacques Chaoulli. Trained in France and Quebec, Chaoulli was known as a bit of a maverick, having attempted to set up a home-based, 24-hour practice for doctors making house calls in Montreal's south shore region. After intense lobbying and the subsequent refusal of the Regional Health Board to recognize his practice in 1996, Dr. Chaoulli began a hunger strike. He then decided to become a 'non-participating' doctor in the Quebec health care system.

This disgruntled patient and impatient doctor are part of a larger context of the economic austerity of the 1990s that saw sharp cuts in federal transfers and provincial spending on health care. This sense of crisis would propel Chaoulli even farther than its precedents in riveting attention on the case, and on the role of the courts not at the margins of public policy, but at the very heart of health policy debates.

The two protagonists were brought together at the trial proceedings in *Chaoulli*, which *began* in December 1997 in the Superior Court of Quebec. The court heard the testimony of medical specialists and the opinions of several health policy experts. The case focused on article 11 of Quebec's hospital insurance act (which did not allow non-

participating Quebec doctors, such as Dr. Chaoulli, from using public hospital facilities) and article 15 of its health insurance act (which did not allow Quebec residents, such as Mr. Zeliotis) from using their own financial resources to insure them for private care. The two plaintiffs argued that these stipulations were contrary to the Canadian Charter of Rights and Freedoms with regard to section 15 (equal treatment) and section 7 (life, liberty and security of the person).

The judge in the case remained skeptical, dismissing the claim that Quebec health care laws violated the Charter's equality rights provision, and concluding that

Access to health care may well be a right, but not the right to determine the "provenance" of that care. And, even though restrictions on private medicine and insurance could limit an individual's timely access to care, this would contravene life, liberty and security of the person if the public system could not guarantee access to similar care. The judge went on to make the more technical argument that such limitations were not in conflict with the principles of "fundamental justice" and therefore could not be considered to contravene the *Charter* (based on the reasonable limits prescribed by law on rights and freedoms where these can be "demonstrably justified").

The decision ended with the opinion that, even though there was need for health system reform, "solutions to problems of the health care system are not to be found on the legal side" (*Chaoulli and Zeliotis*: 315). Although the Quebec Court of Appeal upheld this decision in 2001, the plaintiffs appealed to the Supreme Court and, to the surprise of many court watchers, were granted leave.

By the time the case was heard in June 2004 (the very day after the Auton hearing) *Chaoulli* had morphed from a lone crusade in Quebec to a widespread debate about public versus private health care in Canada. Intervenors for the government of Quebec included five other provinces (Ontario, Manitoba, British Columbia, New Brunswick and Saskatchewan) and a raft of groups committed to the protection of publicly funded health care. Meanwhile, the plaintiffs were supported by the powerful Canadian Medical Association, as well as private care facilities. They were joined by an unusual form of support from the Senate Standing Committee on Social Affairs, Science and Technology, which had published a report on health reform recommending a "Care Guarantee" (a maximum waiting time for treatment or procedure, after which time the provincial government would have to make that service available by other means) (Senate of Canada, 2002). Dr. Chaoulli represented himself, but it was Mr. Zeliotis' claims that received the Court's attention; namely, whether Canadians should be allowed to buy health care if the public system cannot provide it in a timely fashion; and, whether governments can prohibit individuals from using their own resources to do so.

The difficult nature of the decision is illustrated by the time it took to reach a verdict in June 2005, and the fact that it included three different judgments. The dissenting opinion, written by Justice Binnie, reiterated the lower courts' arguments and also insisted that the question at issue was not one that could "be resolved as a matter of law by judges" (*Chaoulli* 2005: para. 161). The divided decision, written by Chief justice McLauchlin, ruled that the Quebec laws violated Section 7 of the Charter and cut to the quick in deeming that "access to a waiting list is not access to health care," (*Chaoulli* 2005: paras. 123-124). While such a ruling would have put every province's health legislation under the gun, the majority decision, written by the only Quebec justice to hear the case, Marie Desjardins, instead ruled that these laws were in in

violation of Section 1 of *Quebec* Charter of Rights and Freedoms (right to life and inviolability of the person).

Criticisms of the decision abounded not least of which were focussed the way in which evidence was used – or misused – in the *Chaoulli* decision (see for example, Jackman 2005). The Quebec government, however, was compelled to act. After being granted a stay of one year to respond to the judgment, it passed Bill 33 in December 2006. The new legislation provided a patient wait-time guarantee mechanism centralized in hospitals but limited to three targeted surgeries (hip, knee and cataract); those unable to access these surgeries within an acceptable delay would be referred to private medical clinics affiliated to public sector at the government’s expense. In addition, Bill 33 removed the ban on duplicate private insurance on these services. The Quebec government also created a new legal regime for the exercise of medical activities in specialized surgical centres: one for doctors practicing in the public regime, the other for “opted-out” physicians.

Even critics of *Chaoulli* saw the benefit of Bill 33 in centralising the management of waiting lists and coordinating services across the system, as well as taking steps to prohibit ‘hybrid medical practice’ (Prémont 2007). Nevertheless, the law also gave credence to the use of “private facilities” and through the subsequent Bill 34 introduced the use of regulation to change key areas of health policy (ibid). Moreover, it had a galvanizing impact on public debate over health reform in Canada (Quesnel-Vallée) and in Quebec, led to discussions about breaking down the public-private divide as well as the Canada Health Act (Castonguay 2008; Maioni 2010).

The data suggests that the effect of Bill 33 on wait times is still mixed. Quebec wait list results have been marginally better for cataracts but not for hip replacements or knee surgery, which were benchmarked at 90% to attain surgery within 6 months (CIHI). Part of the problem is that regional variations still exist within the province. And, there has been little to no uptake by insurance companies to expand private health insurance offerings to Quebec residents (Cohn 2015). In effect, Bill 33’s narrow interpretation of the *Chaoulli* ruling effectively blocked the private/public overlap of physician care, thus making it difficult for alternative private care to proliferate (see Flood 2014).

Like Eldridge and *Auton*, the *Chaoulli* decision led to “copycat” cases elsewhere. Daniel Cohn (2015) has compiled details on fifteen cases across Canada that have to do with health care financing and delivery in which *Chaoulli* is cited. Although some of them were high-profile cases, none of these made it to the Supreme Court. In four of the decisions (including *Wynberg*, the autism case in Ontario), the lower courts reiterated that *Chaoulli* does not create a “positive” right to care that obliges provincial governments to act.

One outstanding case, however, has yet to be decided, and may have further consequences. Known as *Cambie Surgeries Corp. v. British Columbia*, it returns to the BC courts and involves one of the intervenors in the *Chaoulli* case. Like *Chaoulli*, the case involves a constitutional challenge involving Charter rights and access to private health care. Dr. Brian Day, the owner of a network of private clinics (mainly for orthopedic and cataract surgery) is protesting the governments audit against “extra billing.” The practice of charging patients directly for services covered under the public system is strictly prohibited under the BC *Medicare Protection Act* (which incorporates the principles of the *Canada Health Act*). Dr. Day, a former president of the Canadian

Medical Association and outspoken critic of the public system, claims this will be an historic decision with repercussions across Canada (Vogel 2014).

Conclusion

Taken as a whole, these cases provide important insights into the way in which rights-based litigation emerged as an instrument of health care policy reform. They also address key questions about the organization and implementation of health care policy, as well the extent of the judiciary's decision making capacity in health care governance.

The three case studies reviewed here offer some important insights of the way in which the participation of the courts can present challenges to policy-making and health care governance. First, the courts offered an alternative access point into the policy-making process for individuals who felt stymied by existing avenues or procedures. As the cases progressed, the courts amplified the voice of these individuals, drawing considerable public attention to their cause and additional groups to their claims. Second, at various points in the process, the decisions forced politicians to provide legislative and regulatory responses (as in *Eldridge* and *Chaoulli*), or at least goaded them into some form of pre-emptive action (as in *Auton*). And, as these cases inspired "copycat" litigation, they extended their reach well beyond the scope of the specific individuals and governments to a wider potential pool of players (as in *Auton* and *Chaoulli*).

Third, these cases show that litigation can shift the parameters of public policy discussion, even where litigation is unsuccessful or where the direct policy effects have less of an impact. The cases of *Eldridge* and *Auton*, for example, mobilized public opinion about the needs of "special" groups and their recognition. In *Chaoulli*, the short-term effect was a new legislation, Bill 33, but the longer-term effect was to inject a new dynamic into the health policy debate in which the possibility of increased access to private care has become a central theme.

Fourth, however, these cases also reveal how the remedial and adversarial nature of the courtroom may not be the best place to make health care policy. This is especially true in the Supreme Court cases that address individual rights and Charter-based claims against public policy designed within the context of a much larger range of considerations, costs, and effects, and a multiplicity of stakeholders and interests. While at various points in time, some of the court decisions did reflect on the necessity of legislative power to determine the contours of health policy, overall judges did not shirk from playing a pro-active role in weighing in on health policy matters. And because of the inherently interpretative nature of legal decision-making, they did not equally or coherently measure and use evidence in the way that "evidence-based" policy-making, based on "hard" empirical analysis, would suggest.

Litigation, then, introduces a new dynamic into policymaking. It opens the door to the role of new actors; namely, non-elected judges but also activist-oriented advocacy groups. It also changes the role of evidence, which is considered differently in a court of law than in bureaucratic review or parliamentary deliberations. Furthermore, litigation on the basis of the Canadian Charter is focused on the establishment of a constitutional right, and thus less subject to the kinds of constraints that traditional policy-makers face in the court of public opinion and in the limitations of the public purse.

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