Courts and Health Policy: Judicial Policy Making and Publicly Funded Health Care in Canada

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Abstract The 1982 Canadian Charter of Rights and Freedoms provided political actors with the opportunity to make rights-based challenges to public policy decisions. Two challenges launched by providers and consumers of health care illuminate the impact of judicial review on health care policy and the institutional capacity of courts to formulate policy in this field. The significant impact of rights-based claims on cross-jurisdictional policy differences in a federal regime is noted.

In 1997 two Canadian courts delivered important decisions affecting the management of health care policy in the province of British Columbia. In July, the British Columbia Supreme Court (the province's highest trial court) decided *Waldman v. Medical Services Commission of British Columbia* (30 July 1997, Supreme Court of British Columbia, Docket Nos. A952722, A961607), which dealt with the constitutional validity of billing restrictions on physicians newly admitted to practice in the province. The restrictions spotlighted two distinct physician supply management problems: a general oversupply of physicians in British Columbia, combined with a chronic shortage of physicians in rural areas. The court held that these restrictions constituted an unreasonable limit on the mobility and equality of rights guaranteed under the 1982 Canadian Charter of Rights

The authors wish to thank the journal's editor and the anonymous reviewers for comments that greatly improved this article. The authors also thank Matt Hennigar and Julia Gray for their effective research assistance. Finally, both authors acknowledge the financial assistance of the Social Sciences and Humanities Research Council of Canada. In addition, Antonia Maioni acknowledges the financial assistance of the Fonds pour la Formation de Chercheurs et l'Aide à la Recherche.

Journal of Health Politics, Policy and Law, Vol. 27, No. 2, April 2002.

and Freedoms. Three months later, in *Eldridge v. British Columbia* ([1997] 3 S.C.R. 624), the Supreme Court of Canada reviewed the discretionary spending authority granted to the Medical Services Commission and individual hospitals under the province's Hospital Insurance Act. The Court held that the decision not to provide a comprehensive system of publicly funded sign language interpretation for deaf patients denied those patients equal benefit of the law by limiting their ability to communicate effectively with health care practitioners.

In this study we use these two cases as vehicles for examining more general issues concerning the impact of rights-based judicial review on the development of health care policy. Between 1982 and 1997 Canadian courts decided twenty-four cases involving judicial review of health care policy under the Canadian Charter of Rights and Freedoms (see Appendix).[1] The issues raised in these cases have involved physician supply management, medical practice regulation, hospital restructuring, and the regulation or provision of specific treatments and services. Although health care–related claims were more successful during this period than charter claims generally (43.5 percent versus 33 percent),[2] some health care claims were less successful than others. For example, Canadian courts denied every claim against provincial hospital restructuring, where the fiscal stakes and institutional interests of legislatures are high. Courts were less reluctant, however, to protect the individual rights of physicians and other health care providers to locate and organize their practices where and how they wish.

Given this universe of cases, why focus on *Waldman* and *Eldridge*? We argue that there are at least three reasons for examining these cases. First, British Columbia has been a particularly fertile ground for rights-based claims against various elements of health care policy, generating eight cases during the fifteen-year period under consideration (including three—*Eldridge*, *Rodriguez*, and *Stoffman*—that reached the Supreme Court). Second, the two cases represent successful claims by both providers (*Waldman*) and consumers (*Eldridge*) of health care. Third, these

1. We include all cases reported in the Dominion Law Reports under the following index headings:

Constitutional Law—Charter of Rights: Application; Enforcement of Rights; Equality Rights; Freedom of Association; Freedom of Expression; Freedom of Religion; Fundamental Justice; Mobility Rights; Right to Life, Liberty, and Security of the Person; Remedy.

Professions—Physicians and Surgeons: Rights and Privileges; Regulation.

Insurance—Health Insurance

2. The overall success rate of charter claims in the Supreme Court of Canada from 1984–1997 was 33 percent. See Kelly 1999.

cases encompass decisions in two levels (provincial and national) and types (trial and appellate) of courts. Thus, while one must always recognize the inherent limitations of case studies, particularly where they are drawn from only one category (i.e., successful claims), *Waldman* and *Eldridge* cover the range of issues raised by judicial policy making. Moreover, the specific policy issues they raise are central to contemporary health care debates in Canada.

Following R. Shep Melnick (1994: 20–22) we are interested in the impact of judicial review on the ideas and evidence that shape judicial analysis of health care policy as well as the impact of judicial review on the balance of power between national and subnational policy-making institutions. In particular, we examine three propositions about judicial policy making: (1) rights discourse narrows the range of feasible policy alternatives, (2) the adversarial structure of adjudication impedes comprehensive information gathering, and (3) rights-based judicial review systematically favors national norms and standards. As *Waldman* and *Eldridge* illustrate, the impact of rights-based judicial review on health policy raises increasingly important questions in Canada, where health care is a social policy that lies within provincial jurisdiction and is far removed from the core area of judicial expertise in procedural matters. Moreover, these questions have cross-national relevance to other comprehensive systems of publicly funded health care as well as to those where public funding plays a subordinate role (Anderson 1992; Rosenblatt 1993; Reynolds 1995).

Our examination of these questions proceeds in four steps. First, we develop and elaborate more fully the propositions that guide our analysis. Second, we provide a general overview of the policy issues involved in the cases. Third, we explore the applicability of the propositions derived from the judicial policy-making literature to the judgments in *Waldman* and *Eldridge*. Finally, we reflect on the broader implications of these propositions for the development of health care policy.

Constitutional Rights and Judicial Policy Making

Judicial policy making is the process whereby judges "exercise power on the basis of their judgment that their decisions will produce socially desirable results" (Feeley and Rubin 1998: 5). According to Malcolm Feeley and Edward Rubin (1998: 148), this process occurs in two steps, with courts first invoking a legally authoritative text to establish their

jurisdiction over an issue, and then deriving the policy response to that issue from legally nonauthoritative sources. Although it is not exclusive to rights-based judicial review, the existence of constitutionally entrenched rights increases the opportunity for judicial policy making by expanding the range of policy issues that can be brought within a court's jurisdiction. In *Waldman* and *Eldridge*, for example, the two courts used their interpretation of the legally authoritative text of the charter to assert jurisdiction over contested areas of health care policy and then relied on nonauthoritative sources beyond the constitutional text to specify new policy practices.

As we suggested initially, the institutional attributes of adjudication affect judicial policy making in several important ways. These attributes flow from the traditional structure of adjudication,[3] and they give judicial policy making "its own devices for choosing problems, its own habits of analysis, its own criteria of the relevance of phenomena to issues, [and] its own repertoire of solutions" (Horowitz 1977: 33). Unlike politics, which is a bargaining process that relies on exchange to accommodate conflicting interests and is characterized by flexibility, dynamism, and power, adjudication resolves conflicts through the authoritative articulation of norms (Diver 1979: 46–48). According to Donald Horowitz (1977: 34–56), the result is a process that is passive, incremental, focused on rights and remedies, concerned with historical rather than social facts, and less amenable to policy review than other forms of policy making. From this perspective, there is a tension between the type of analysis needed to solve complex and multifaceted social problems and techniques used in the judicial process to gather, process, and evaluate information.[4]

The U.S. experience with judicial policy making is increasingly relevant to the Canadian case for at least two reasons. First, the degree to which politics has become judicialized in Canada is rapidly converging to the level observed in the United States. This convergence is apparent in at least five areas: litigation activity, jurisprudential influence, threshold width, liability risk, and remedial activism (Manfredi 1997: 319–327).[5]

3. According to Chayes (1976: 1282–1283), in traditional adjudication lawsuits are bipolar and self-contained, litigation is retrospective, rights and remedies are interdependent, and the process is party initiated and party controlled.

4. There are, of course, more positive assessments of judicial policy making. See Carter 1977; Cavanagh and Sarat 1980; Lawrence 1990; McCann 1994; Feeley and Rubin 1998.

5. The meaning of the last three items in this list is perhaps less than self-evident. Threshold width refers to the requirements that parties must meet in order to present their claims in court. The rules of standing are the most obvious threshold requirement, and courts can widen

For example, in 1984 the proportion of rights-based cases in the U.S. Supreme Court's docket was six times higher than the proportion in Canada, but by 1992 the difference had decreased to less than two to one. The last decade has seen even this difference all but disappear, with both courts now devoting almost the same proportion of their dockets to rights cases. Moreover, the proportion of Canadian citations to U.S. authorities has almost tripled during the same period. Finally, these citations have fueled jurisprudential changes that give Canadian courts a degree of freedom to intervene in policy matters that is now much closer to that enjoyed by their American counterparts. Consequently, the extensive theoretical work on the tension between adjudication and policy making in the U.S. context now finds rich new empirical ground to work in the Canadian case.

A second reason is that, to the extent that a tension exists between the institutional attributes of adjudication and the demands of policy making, it is exacerbated in Canada by the very structure of charter adjudication. In the majority of charter cases courts perform their most important task not in defining the substantive meaning of rights or liberties or in measuring government action against those definitions but in determining the scope of "reasonable limits" on rights under section 1 of the charter.[6] The controlling jurisprudence on this question dictates that a limit is reasonable if it is proportionate to a "pressing and substantial" legislative objective (R. v. Oakes [1986] 1 S.C.R. 103.). Proportionality is determined according to a three-pronged test: (1) rational connection between means and ends, (2) minimal impairment of the right or freedom, and (3) social benefits outweigh individual costs. Given the absence of any legally authoritative measure of proportionality, the reasonable limits analysis almost by definition entails judicial policy making. Judicial policy making is not merely an accidental by-product of charter adjudication; therefore, it is the sine qua non of the judicial function under the charter.

Our reading of the literature derived from the U.S. experience leads to three propositions about judicial policy making. The first proposition is

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the threshold by liberalizing standing rules. Liability risk refers to the type of questions that courts consider justiciable. Finally, remedial activism refers to the willingness of courts to impose positive remedies for rights violations. On all of these dimensions Canada was behind the United States at the beginning of the 1980s. The Canadian court has subsequently caught up with, and in some ways surpassed, its U.S. counterpart.

6. Section 1 provides that the charter "guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society."

that the passive, rights-focused nature of adjudication narrows the range of alternatives available to judicial policy makers. Since adjudication is party initiated and controlled, rights-based judicial review is triggered by the legal mobilization efforts of society-based actors (e.g., interest groups, social movements). As Susan Lawrence (1990: 40) argues, legal mobilization is "a planned effort to influence the course of judicial policy development to achieve a particular policy goal." In this sense, the very purpose of articulating policy demands in the form of constitutional rights is to exclude alternative policy choices from consideration. "Rights talk," in other words, narrows the scope of policy discussion by equating legally enforceable rights with a single, "correct" policy choice (Glendon 1991). As a result, even such ardent supporters of judicial policy making as Feeley and Rubin (1998: 16) concede that "courts rarely engage in a sort of systematic survey of alternatives." In particular, rights talk delegitimizes concern with the financial costs of alternative solutions to complex policy problems. As one Canadian analyst has put it, "constitutional rights . . . must receive a higher priority in the distribution of available government funds than policies or programs that do not enjoy that status. A different preference for allocation of resources cannot justify encroachment on a right" (Weinrib 1988: 486). Given this predisposition of judicial policy making, it is hardly surprising that the Supreme Court of Canada has explicitly excluded administrative efficiency and cost from the list of "pressing and substantial" objectives that might justify limiting a protected right (Singh v. Minister of Employment and Immigration, [1985] 1 S.C.R. 177, 218–219).

Our second proposition about judicial policy making—that its adversarial character impedes comprehensive information gathering and processing—is derived from several attributes of adjudication. The judicial process is designed primarily to ascertain historical/adjudicative facts about discrete events that transpired in the past, rather than social/legislative facts about causal relationships, "recurrent patterns of behavior," and future impact (Horowitz 1977: 45). Policy making, however, requires extensive reliance on social/legislative facts. Adversarial fact-finding complicates matters further at the trial court level by presenting information in a manner that detracts from its comprehensiveness, quality, and integrity; that promotes unrealistic simplification; and that hinders the "logical order needed for a systematic consideration of findings on a specific topic" (Wolf 1981: 259–260; Elliott 1987). At the appellate level, the adversarial nature of adjudication tends to exaggerate the authoritativeness of information and to encourage courts to treat hypotheses as

axioms (Marvell 1978: 184; Lieberman 1984: 148; Rossum 1984: 23). The adjudicative process's affinity for historical facts also affects its capacity to measure the impact of decisions on future behavior (Horowitz 1977: 51). Courts may be equipped to determine cause-and-effect relationships in the context of discrete, historical events, but their ability to do so in the context of ongoing phenomena is limited.

The passive, rights-focused nature of adjudication has two additional consequences for judicial policy making. First, it transforms an attribute of adjudication that might be an asset in other policy-making contexts—incrementalism—into a liability. In ordinary litigation, courts contribute to the evolution of legal-moral principles and public policy by resolving disputes on a case-by-case basis. This attribute of adjudication enhances judicial decision-making capacity in ordinary litigation because it allows judges to implement small changes, measure their impact, and respond to new information. As a result, incrementalism can reduce the likelihood of large-scale policy errors. However, rights-based judicial policy making negates the value of incrementalism because the demands to which it is a response generally require comprehensive and conclusive solutions. The problem with incrementalism in this context is that individual cases are often unrepresentative of general conditions. Just as conventional legal wisdom holds that hard cases produce bad law, easy cases may generate bad policy.

Adjudicative passivity and the emphasis on rights also limit opportunities for policy review. The need to rely on parties to initiate litigation can make the process of discovering and responding to unintended consequences relatively cumbersome (Horowitz 1977: 52–53). The inability of courts to initiate policy review is especially important in view of the implementation difficulties that judicial policy making faces (Rosenberg 1991: 15–21). Ultimately, poor compliance with, and the weak impact of, judicially formulated policies can be traced back to the adjudicative process's difficulty in gathering and processing social/legislative facts. These difficulties hinder the communication of expected consequences to individuals and institutions affected by the decisions, leading to frustration and inhibiting compliance (Miller and Barron 1975: 1222).

Our third proposition about judicial policy making is that rights-based judicial review systematically favors national norms and standards.[7]

7. This proposition needs some qualification for the U.S. case, where judicial review by state courts, based on state law, can work against national standards by creating variation in legal rules from state to state.

Although judicial review can be an important mechanism for maintaining the constitutional division of powers in federal systems, there is strong comparative evidence that it tends to enhance the power of central governments and promote policy homogeneity across subnational jurisdictions (Bzdera 1993; Melnick 1994: 235, 245). The explanation for this tendency lies in three aspects of judicial review. First, the ultimate authority for constitutional interpretation lies with the final courts of appeal whose members are selected by central governments and that derive their normative standards from national rather than regional communities (Feeley and Rubin 1998: 171–177). Second, rights-based constitutional claims transcend jurisdictional boundaries, and successful rights claims in one jurisdiction can quickly diffuse to others and produce policy convergence across jurisdictions. Third, jurisdictional policy differences may themselves be held to violate constitutional norms of equality, particularly where statutes authorize territorial differences in the application of national laws and policies.

These factors have had a profound effect in the United States. In the 1960s, rights-based judicial review produced significant nationalization of state criminal procedure through judicial interpretation and application of the Bill of Rights. By the mid-1980s federalism jurisprudence had evolved to the point where the U.S. Supreme Court had virtually disavowed any role in protecting the constitutional powers of the states (Marks 1997; Stephenson and Levine 1987). Thus, despite some recent decisions to the contrary (Marks 1997: 548–553; Rossum 1999: 732–741), U.S. constitutional jurisprudence asserts the supremacy of the national government and gives it significant authority to regulate local matters. Indeed, in May 2001 an allegedly more federalism-sensitive U.S. Supreme Court held that the federal Controlled Substances Act supersedes a state law granting a medical exception to cannabis distribution and manufacturing prohibitions (United States v. Oakland Cannabis Buyers' Cooperative and Jeffrey Jones, 532 U.S. 483 [2001] [No. 00-151]).

The impact of judicial review in Canada in these respects has been mixed. As a final court of appeal under the exclusive control of the national government, the Supreme Court has provided the federal government with decisions containing both important legal victories and bargaining resources in federal-provincial negotiations (Russell 1985). In particular, the court has upheld the constitutionality of the "federal spending power," which allows the national government to make conditional grants to the provinces for use in areas of provincial policy juris-

diction (Hogg 1992: 152–154). However, in quantitative terms the court's charter decisions have not affected provincial policies more negatively than federal policies (Morton, Russell, and Riddell 1994; Kelly 1999). Between 1984 and 1997 the court nullified thirty-four federal and seventeen provincial statutes, and in forty-six other cases where the court ruled against government policies without necessarily nullifying the statutes, it ruled against the federal government thirty-three times and against provincial governments thirteen times. The federal government's success rate in defending policies against charter challenges (62.5 percent) is also lower than the provincial rate (72.3 percent). Finally, the court has declared that the charter's equality rights provision permits "differential treatment based upon province of residence [and] mandates and encourages geographical distinction" (R. v. S. (S.) [1990] 2 S.C.R. 254, 287–288).

Despite the relative success of provincial governments, the charter has had a greater impact on provincial governments with respect to *recent* policy choices. This is evident in the mean "age" of statutes at nullification, which is twenty-three-and-a-half years for federal statutes and ten years for provincial statutes. Judicial nullification of older statutes, which may have been enacted when there was less sensitivity toward rights issues, is arguably less interventionist than nullification of statutes that reflect a more contemporary balance between rights and public policy. In addition, charter litigation affecting individual provinces has influenced policy choices in other provinces. For example, prisoners' voting rights litigation has led many provinces to revise electoral laws even in the absence of direct challenges to their existing statutes. Similarly, litigation concerning the absence of protection from discrimination on the basis of sexual orientation in provincial human rights codes has led all but one province to include sexual orientation within their codes. Indeed, it is unclear whether the Supreme Court of Canada is willing to permit meaningful normative differentiation among the provinces, which is one measure of federalism's robustness (Feeley and Rubin 1998: 173).

How do *Waldman* and *Eldridge* illuminate the core conceptual issues captured by the three propositions concerning judicial policy making? First, health care is arguably the most important single area of public policy in Canada. Public and private spending on health care constitutes about 9 percent of Canadian GDP, and health is the largest single expenditure item in provincial government budgets. For example, in 1996–1997, as courts considered and decided *Waldman* and *Eldridge*, health accounted for 27.3 percent of total provincial and territorial government

expenditures. This was more than eight percentage points higher than the next largest expenditure item, education. Moreover, the two areas of health spending at issue in *Waldman* and *Eldridge*—physicians and hospitals—accounted for 63.4 percent of public sector health expenditures in 1996. The courts that decided *Waldman* and *Eldridge* were not, therefore, operating at the margins of public policy. Instead, they were engaging themselves in the dominant Canadian public policy issue of the past thirty years.

The second reason for the importance of *Waldman* and *Eldridge* is that this judicial engagement came as the result of a party-initiated demand for policy review, driven by the special interests of narrow constituencies within the health care system.[8] These cases illustrate how rights-based claims allow stakeholders in the system to redistribute significant public resources through a process outside the ordinary arena of political conflict where alternative views about resource allocation must be considered. Rights-based claims present courts with a choice between an allegedly rights-deficient allocation and a new, constitutionally mandated policy regime consistent with a claimant's own interests. Consistent with our first proposition, *Waldman* and *Eldridge* illustrate the tendency of rights claims to narrow the scope of analysis and range of permissible alternatives. The cases thus allow for some examination of the distorting effects of the passive, rights-focused nature of adjudication.

Third, as one might expect in a policy area involving close to Can$60 billion in annual public spending, the need for comprehensive analysis is crucially important. However, *Waldman* and *Eldridge* illustrate the proposition that adjudication tends to oversimplify the informational requirements for effective policy making. By focusing attention in each case on a small piece of the health care policy puzzle, the judicial analysis in *Waldman* and *Eldridge* suffered from many of the deficiencies associated with the second proposition. Finally, the cases illustrate the impact of nationally oriented rights-based litigation on a subnational policy jurisdiction. Indeed, as our third proposition suggests, in both cases nationally appointed judges, wielding a national constitutional document, intervened in the single most important policy area controlled by provincial governments.

The importance of *Waldman* and *Eldridge* for understanding the impli-

8. Although the deaf and hearing impaired may be more sympathetic claimants than physicians, both sets of claimants were demanding discrete benefits, the costs of which would be borne by the general population.

cations of judicial policy making in the health care field should thus be clear. However, they can also provide insight into the broader role of courts in policy making in Canada, at least in those policy areas not considered within the traditional expertise of judges. For example, everything that one might say about health care could also be said about the two next most important areas of provincial jurisdiction: education and social services.[9] Both have been the object of charter litigation, and the health care experience is relevant to understanding that litigation. Moreover, given the common legal traditions and convergence in the political role of U.S. and Canadian courts, *Waldman* and *Eldridge* can provide insights into the "global expansion of judicial power" (Tate and Vallinder 1995). While this phenomenon has its origins in the United States, the Canadian experience, as reflected in decisions like *Waldman* and *Eldridge*, demonstrates its diffusion across national boundaries.

The first step in using these cases as laboratories for examining our propositions about judicial policy making is to summarize the policy context out of which they emerged. The second and more important step is to test the propositions themselves against the evidence provided by the two case studies.

The Policy Context

As indicated in the previous section, health care is the most expensive policy function performed by Canadian provincial governments. Although the provinces must respect the five fundamental principles of the Canada Health Act in order to qualify for federal funding, they are otherwise free to design their health care systems to address the specific needs of their residents by regulating health care delivery and financing.[10] Hospitals and physicians consume the bulk of health care spending, and the provinces have continuously searched for ways to control the costs associated with these two components of their health care systems.

Hospitals have remained for the most part self-governing, nonprofit institutions rather than government operated facilities. Nevertheless, they depend on public funds and are subject to government budgetary decisions. In 1977, when hospital budgeting became the sole responsibility of provincial health ministries, the provinces adopted fixed annual

9. In 1999–2000 education consumed 20 percent of provincial budgets (Can$38 billion), while social services accounted for 17 percent of those budgets (Can$32 billion).

10. The five principles of the Canada Health Act are public administration, comprehensiveness, universality, portability, and equal access.

budgets to control hospital expenditures. Hospitals are not permitted to run deficits in most provinces and must be creative in matching available funds to patient and staff demands. Typical control measures include closing beds and operating rooms, establishing waiting lists for nonemergency surgery, reducing staff availability, and outsourcing nonmedical services (Leatt and Williams 1997: 12–15).

Physician supply management is a second strategy for controlling health care costs. This strategy emerged in the 1980s, with British Columbia becoming the first province to introduce a "billing number" policy to control the number of physicians in the province. This policy was the subject of successful court challenges in 1985 and 1988 (Mia v. Medical Services Commission of B.C. [1985] 61 B.C.L.R. 273 [B.C.S.C]; Wilson v. Medical Services Commission of B.C. [1988] 30 B.C.L.R. 1 [B.C.C.A]), leading to the enactment of interim measures in 1994 and permanent measures in 1996. Under the 1996 measures, the compensation rate for "new billers" depended on whether they practiced in underserviced (100 percent compensation), adequately serviced (75 percent), or overserviced (50 percent) geographic regions of the province. Any new biller who chose to practice in an adequately or overserviced region would not be entitled to full compensation until after five years of practice. These measures contained various exceptions for British Columbia–trained physicians and for physicians returning to the province after an absence of less than twenty-four months.

By the mid-1990s, every province in Canada except Alberta had adopted mechanisms for managing physician supply (Barer, Lomas, and Sanmartin 1996: 222). Most of these measures imposed restrictions on foreign-trained physicians and on new physicians regardless of residence. In addition to British Columbia, Newfoundland and Prince Edward Island also impose 50 percent fee reductions for new physicians. In other provinces, like Quebec, fee reductions vary by regional plans. Although it is not clear that such measures alone can reduce the demand for health services or act as an effective cost control, their imposition has stabilized the numbers of practicing physicians and, in some provinces, effected a more equitable balance in the regional distribution of physicians (Brown 1991: 115–119).

The cases brought by the claimants in *Waldman* and *Eldridge* were an explicit attempt to alter or reconfigure the policy status quo described above. In the first case, Dr. Deborah Waldman and two other physicians raised three separate charter objections to British Columbia's physician supply management measures. First, they argued that the measures vio-

lated their right as citizens or permanent residents "to pursue the gaining of a livelihood in any province" (section 6). Second, they asserted that the measures infringed their right to practice a profession as protected by the general right to liberty and security of the person (section 7). Finally, they argued that the measures denied them the equal benefit of the law and discriminated directly on the basis of province of residence and indirectly on the basis of age, sex, and religion (section 15). Although the trial court judge rejected the section 7 claim and the indirect discrimination claim, she accepted both the section 6 argument and the direct discrimination claim raised under section 15.

The court also concluded that none of these limits could be justified under the reasonable limits definition of section 1 of the charter. Although it accepted the province's argument that the measures served the pressing and substantial objectives of maintaining quality health care and containing costs, it failed to find any rational connection between the measures and these objectives. The court did not base this conclusion on any specific empirical finding. Indeed, it argued that the causal relationship between the impugned measures and the behavior of physicians "is not scientifically measurable" and must be "demonstrated on the basis of reason and logic" (*Waldman* [1997] at 152). Applying this standard to the province's arguments in favor of the measures, the court rejected the proposition that the financial disincentives contained in the measures would either redistribute physicians to underserviced areas or control costs by reducing the number of physicians in the province.

At issue in *Eldridge* was the constitutionality of the province's Hospital Insurance Act and Medical and Health Care Services Act, with the appellants' claiming that both statutes violated their right to equality under the charter because neither statute provided for sign language interpretation as an insured benefit. Although the Supreme Court declined to declare the statutes themselves unconstitutional, it nevertheless supported Robin Susan Eldridge's claim that hospitals have a constitutional obligation to provide deaf patients with sign language interpretation. According to the court's unanimous judgment, the failure of subordinate entities—hospitals and the Medical Services Commission—to provide such services denied the appellants the equal benefit of the two laws. The court directed British Columbia to administer its statutes in a manner consistent with section 15 of the charter within six months of the judgment, but it stopped short of issuing detailed instructions as to how the province should implement this policy change.

Constitutional Reasoning and Health Care Policy Making

In *Waldman* and *Eldridge* constitutional litigation became the vehicle for altering the health care policy status quo. In the first case, the judgment forced British Columbia to abandon its preferred policy of controlling physicians' access to the province and to return to an earlier version of the status quo. In *Eldridge* the judgment imposed new policy responsibilities on health care administrators with respect to deaf patients. If our three propositions about judicial policy making are correct, then we should observe the following phenomena in the two cases. First, we should see a policy analysis process profoundly shaped by legal arguments and reasoning. That this should be the case is hardly surprising since the only warrant that courts have for intervening in policy is that a legislative or executive decision is legally deficient in some way. However, the necessary transformation of policy questions into legal rights claims limits the range of alternatives canvased by courts, alters the value attached to outcomes, and elevates some stakeholder claims over others.

A second phenomenon we should observe is a disjunction between the information and evidence found persuasive by courts—as revealed in their judgments—and the information and evidence on which they *could* have relied—either because they were included in the parties' submissions or were accessible by consulting readily available data. In other words, the analytical parameters set by the reliance on legal arguments by courts to establish their jurisdiction affect the transmission and analysis of relevant information. Finally, we should observe a preference for national standards over local policy variation. The universal nature of rights claims advanced in cases like *Waldman* and *Eldridge* raises important questions about the degree of provincial policy diversity permissible under the Canadian Charter of Rights and Freedoms.

Rights, Legal Arguments, and Policy Analysis

The dominant position of legal arguments and reasoning is the most striking and easily observable of the three expected phenomena. For example, in *Eldridge* two-thirds (sixty-five paragraphs) of the Supreme Court's ninety-seven-paragraph judgment is devoted to two key legal issues: whether the charter applies to the decision to deny funding for sign language interpreters (thirty-four paragraphs) and whether this denial violates equality rights (thirty-one paragraphs). The court's legal

judgment had three central components. First, it stipulated that the objectives underlying the charter's equality rights provisions—which are to promote the equal worth and dignity of all persons and to prevent and remedy discrimination against particular groups—cannot be achieved simply by granting formally equal access to benefits. Second, the court determined that effective communication between patients and practitioners is an integral component of adequate health care and that deaf patients must rely on sign language interpretation to communicate effectively. Finally, it concluded that the absence of public funding for sign language interpretation denies deaf persons the equal benefit of British Columbia's health care regime since it results in inferior medical service relative to the general population by diminishing their ability to communicate effectively.

What effect did this have on the quality of policy analysis in *Eldridge*? Having declared a constitutional right to "effective communication" in the provision of health care and extending that right to encompass sign language interpretation, the Supreme Court in *Eldridge* did not devote any serious attention to the costs of providing this service. It took at face value the claim that the annual cost of providing provincewide sign language interpretation would be only $150,000, or .0025 percent of the total provincial health care budget (*Eldridge* [1997] at par. 87). However, as we indicate below, the informational basis for this claim was problematic.

Nor did the *Eldridge* court take seriously the province's concerns about the broader implications of the decision. It dismissed as mere "speculation" (*Eldridge* [1997] at par. 89) the argument that a positive decision for the claimants might generate additional claims on behalf of the hearing impaired and other disabled groups, as well as analogous claims to language interpretation services by linguistic minorities (*Eldridge* [1997], Respondent's Factum, at pars. 125–126). While British Columbia may have exaggerated the likelihood of additional or analogous claims, its concern was not entirely unreasonable. Six nongovernmental advocacy groups intervened in the case,[11] and it is unlikely that they would have deployed scarce resources to support a rights claim solely intended to generate a benefit worth only $150,000 to a relatively small and circumscribed group. Their broader interest was in acquiring a legal resource that might be mobilized to achieve additional policy gains.

Although one might expect issues of law to dominate issues of fact in

11. These groups were the Women's Legal Education and Action Fund, the Disabled Women's Network Canada, the Charter Committee on Poverty Issues, the Canadian Association of the Deaf, the Canadian Hearing Society, and the Council of Canadians with Disabilities.

an appellate court decision, a similar phenomenon is apparent in the trial court judgment in *Waldman*. More than half (206) of the judgment's 405 paragraphs deal with administrative law matters (183 paragraphs) and issues of charter law (23 paragraphs). The gist of the court's charter analysis was that section 6 of the charter protects the right to enter and work in a province and that the physician supply measures limited this right by restricting the ability of physicians moving to British Columbia from earning a professional livelihood. In particular, the exemptions granted to British Columbia–trained physicians, and to physicians returning to the province after temporary absences, persuaded the court that the measures improperly discriminated on the basis of present or previous residence. Thus, although the court rejected the claim that the measures disproportionately harmed women, younger physicians, and members of certain religious faiths,[12] it agreed that they did discriminate on the basis of province of residence.

The effect of this emphasis on legal questions meant that the trial judge in *Waldman* did not engage in a comprehensive analysis of physician supply management but simply focused on that aspect of the problem (control of new billing numbers) dictated by the specific nature of the rights claim. While the court at least acknowledged cost reduction as a legitimate legislative objective, it used the countervailing mobility and equality rights claims to reduce significantly the weight attached to that objective. As a result, the court essentially required that the province demonstrate that the measures would achieve their objectives with a high degree of probability, if not certainty. This requirement affected the value the court attached to the two expert opinions (one for each side) concerning the impact of financial disincentives on the supply and distribution of physicians. It also focused on the court's attention on what it described as the "microdecisions" of physicians entering the provincial health care system (*Waldman* [1997] at 154). A more comprehensive policy analysis, however, might have placed British Columbia's physician supply experience in the broader context of national trends.

Information and Evidence

The second phenomenon is less easy to observe than the first, but there are nevertheless some indicators of its impact on policy making in the

12. Waldman had argued that the effective practice of her faith required that she live in an area with a significant Jewish community, which she could not find in the underserviced areas.

two cases. The clearest example from *Eldridge* is the court's analysis of the cost of providing sign language interpretation. The court based its Can$150,000 estimate on an informal examination of the costs incurred by a private institute in providing interpretation services in Victoria and the lower mainland (Vancouver area) of British Columbia (*Eldridge* [1997], Appellants' Factum, at pars. 48–50). This examination appeared in a briefing note prepared for the executive committee of the Ministry of Health, and it simply extrapolated the costs of providing 800 hours of interpretation services to 400 clients to the total estimated population of the hearing impaired in the province (approximately 4,000 to 5,000). There were at least two problems with this cost determination. First, the institute's interpreters provided services on a voluntary basis, and there was no serious analysis at any stage of the proceedings of whether this would be an adequate basis for supplying the more extensive services implicit in the appellants' claim. Second, neither the court nor any of the parties analyzed whether these services could be provided at the same cost in more remote regions of the province as in the densely populated urban areas of Victoria and Vancouver.

This feature of judicial policy making also influenced the *Waldman* judgment, where the court missed some important information about physician supply in British Columbia. As the data in Table 1 indicate, from 1986 to 1996 the number of physicians in British Columbia rose by 30.8 percent during a period when the national increase was 20.5 percent. Moreover, the increase in British Columbia was 11 percentage points higher (30.8 versus 19.8) than in Canada's most populous province (Ontario). More significantly, as Table 2 indicates, British Columbia experienced the highest average annual growth in physicians (2.7 percent) of any province between 1988 and 1994, a period when previous judicial decisions left the province without any operative physician supply management system. The overall increase in the number of physicians (17.0 percent) was also higher than for any other province and almost 7 percentage points higher than the national increase (10.7 percent). The physician supply measures appear to have had some impact on these trends between 1994 and 1996. British Columbia reduced its annual growth rate in physicians to 1.0 percent in 1994–1995 before having it rebound to 2.2 percent in 1995–1996 (still below the 1988–1994 annual increases). Overall, the number of physicians in British Columbia increased by 3.3 percent between 1994 and 1996.

Although British Columbia clearly remained a relatively attractive destination for physicians even after implementation of the supply man-

Table 1 Active Civilian Physicians, 1986–1996

Provinces	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	Percentage change 1986–1996
Newfoundland	847	873	929	973	931	910	892	971	968	940	928	9.6
Prince Edward Island	174	181	186	180	177	175	173	179	178	176	170	-2.3
Nova Scotia	1,536	1,611	1,676	1,752	1,751	1,760	1,759	1,857	1,775	1,733	1,746	13.7
New Brunswick	853	891	935	968	977	1,010	1,024	1,056	1,075	1,108	1,122	31.5
Quebec	12,564	13,151	13,611	13,767	13,992	14,241	14,543	14,842	15,016	15,159	15,243	21.3
Ontario	16,881	17,709	18,685	19,598	19,782	20,125	20,473	20,799	20,581	20,447	20,216	19.8
Manitoba	1,856	1,865	1,833	1,928	1,953	2,011	1,995	2,017	1,978	1,983	1,973	6.3
Saskatchewan	1,423	1,470	1,508	1,520	1,507	1,510	1,493	1,507	1,545	1,527	1,475	3.7
Alberta	3,650	3,831	4,065	4,151	4,209	4,351	4,441	4,584	4,552	4,485	4,472	22.5
British Columbia	5,736	5,912	6,200	6,200	6,477	6,682	6,953	7,243	7,266	7,341	7,505	30.8
Yukon	29	32	35	38	39	38	38	39	42	44	47	62.1
Northwest Territories	46	46	43	45	46	50	61	61	64	63	61	32.6
Canada	45,595	47,572	49,706	51,316	51,841	52,863	53,863	55,155	55,040	55,006	54,958	20.5

Sources: Health and Welfare Canada 1993; Canadian Institute for Health Information fact sheets, available on-line at http://www.cihi.ca.

Table 2 Average Annual Growth Rate of Active Civilian Physicians, 1988–1994

Provinces	1988	1994	Average Annual Growth (%)
Newfoundland	929	968	0.69
Prince Edward Island	186	178	
Nova Scotia	1,676	1,775	0.96
New Brunswick	935	1,075	2.35
Quebec	13,611	15,016	1.65
Ontario	18,685	20,581	1.62
Manitoba	1,833	1,978	1.28
Saskatchewan	1,508	1,545	0.40
Alberta	4,065	4,552	1.90
British Columbia	6,200	7,266	2.68
Yukon	35	42	3.09
Northwest Territories	43	64	6.85
Canada	49,706	55,040	1.71

Note. Tabulation does not include interns and residents. *Sources*: Health and Welfare Canada 1993; Canadian Institute for Health Information fact sheets, available on-line at http://www.cihi.ca.

agement measures, data such as those provided in Tables 1 and 2 may have changed the logical inferences the court drew from the expert evidence and the facts of the case. Thus, the court's lack of access to a broad range of legislative/social facts hampered its analysis of the physician supply measures.

The court's analysis of legislative facts also led to some inconsistencies in the reasoning underlying the judgment. For example, although the court found that 50 percent billing numbers make the practice of medicine financially nonviable in British Columbia (*Waldman* [1997] at 38–39), it also found "no direct evidence that the financial disincentives contained in the measures will lead to reduced numbers of physicians establishing practices in B. C." (*Waldman* [1997] at 158). Taken together, these findings seem to suggest that physicians are willing to establish financially nonviable practices, which might tend to undermine any mobility rights claim. Although the physician supply measures clearly imposed additional costs on out-of-province physicians wishing to establish practices in British Columbia, according to the court's own reasoning those costs did not constitute an absolute (or permanent) barrier to entry into the British Columbia medical market. In fact, what seemed to disturb the court more was unequal access to medical practice in British Columbia.

National Rights and Federal Policy Diversity

The *Waldman* judgment's equality rights analysis illustrates some of the federalism effects of rights-based judicial policy making. The court concluded that out-of-province physicians constitute a "discrete and insular minority," deserving of special charter protection because they are not represented by the British Columbia Medical Association and have no voice in determining the policies governing medical practice in the province (*Waldman* [1997] at 140–141). Moreover, in addition to the obvious financial penalties, the court found that the physician supply measures prohibited this "disadvantaged" group from practicing medicine "on an equal basis with other equally trained physicians," thereby denying their "essential human dignity" (*Waldman* [1997] at 141). These were particularly bold conclusions since, as the court noted, the Supreme Court of Canada had on three occasions rejected equality rights claims based on province of residence as a prohibited ground of discrimination (R. v. S. (S.) [1990]; R. v. Turpin [1989] 1 S.C.R. 1296; R. v. Haig [1993] 2 S.C.R. 995). However, the trial court viewed these judgments as leaving "the door open for a contrary finding in the appropriate case," and *Waldman* was in its judgment the appropriate case in which to cross the threshold (*Waldman* [1997] at 140).

The *Waldman* court's decision that "province of residence" constitutes a prohibited ground of discrimination under the charter has important implications for federalism, even given the court's benign interpretation that it simply prevents provinces from discriminating against new arrivals from other provinces (*Waldman* [1997] at 143). For example, a broader interpretation, which would allow individuals to challenge policies adopted by their own provinces if those policies depart from some "national" standard, would have even more serious implications. In more concrete terms, the specific policy decision concerning physician supply management provided physicians in other provinces with a credible litigation threat in negotiations concerning similar measures in those provinces. Finally, the judgment created an opportunity to circumvent the normal process of policy coordination in federal systems, which involves negotiation among and between levels of government. Indeed, the *Waldman* judgment added new complications to interprovincial discussions about medical workforce harmonization that were then ongoing.

Eldridge also illustrates the tension between rights-based litigation and federalism since some version of global budgeting exists in every province. Given the case's potential impact on policy developments in

other provinces, it is not surprising that three provinces (Ontario, Manitoba, and Newfoundland) intervened to support British Columbia's position. As Manitoba argued, the appellants' claim "has potentially enormous implications, not just in this area, but in respect of every benefit program implemented by government and every statutory right to receive public services" (*Eldridge* [1997], Factum of the Intervener the Attorney General of Manitoba, at par. 6). Ontario argued that rights analysis must "take into account the finite nature of resources available to address the satisfaction of competing demands made by different groups in society" (*Eldridge* [1997], Factum of the Intervener the Attorney General of Ontario, at par. 34). Newfoundland suggested five different options for payment of interpretation services, along with five factors that should be considered in choosing among those options (*Eldridge* [1997], Factum of the Intervener the Attorney General of Newfoundland, at pars. 19–20). Even the Government of Canada, which has overall responsibility for administering the Canada Health Act, intervened to support the denial of some benefits as consistent with a province's duty to "provide reasonable access to a fiscally sustainable health care system" (*Eldridge* [1997], Factum of the Attorney General of Canada, at par. 41).

The court made only a single reference to the interveners' arguments, describing their claim that section 15 of the charter "does not oblige governments to implement programs to alleviate disadvantages that exist independently of state action" as a "thin and impoverished" vision of equality (*Eldridge* [1997] at pars. 72–73). It also ignored entirely the federal government's support for provincial autonomy on this issue, instead declaring almost in passing that the federal government's inherent spending power permits it to set "national standards for provincial medicare programs" (*Eldridge* [1997] at par. 25). Together, these two elements of the judgment imply significant constraints on provincial policy discretion in an area that the court ironically described as "within the exclusive jurisdiction of the provinces" (*Eldridge* [1997] at par. 24). Indeed, the court seemed to view *itself* as having the responsibility for imposing national standards for the accommodation of at least this type of physical disability in the provision of health care services. In this instance, rights-based litigation allowed the court to transform the charter into a "meta" Canada Health Act through which the judicial process could impose specific requirements on provinces beyond the broad guidelines established by legislation.

Summary

Although the claimants in *Waldman* and *Eldridge* may have identified legitimate flaws in the policy status quo, the structure of the judicial process affected the analysis of those claims in important ways. It required that the claims be articulated in the form of rights, which profoundly affects how claims are evaluated. Rights clearly carry greater normative value than preferences and to argue that the status quo is flawed because it is rights deficient is qualitatively different from arguing that a different policy might simply be more efficient or consistent with the claimant's preferences. By narrowing the range of permissible policy choices, the type of rights discourse deployed by the claimants also artificially simplified the information gathering and processing tasks of judicial policy making. In addition, the adversarial structure of litigation was less amenable to information transmission and communication than the more fluid legislative process. Finally, rights discourse depreciated the value of policy diversity by relying on universal, or at least national, standards for evaluating the policy status quo and the proposed alternative to it.

Conclusion

In both *Waldman* and *Eldridge*, the respective courts accepted the rights-based claims of particular stakeholders and engaged in micromanagement of the British Columbia health care system. In *Waldman*, dissatisfied physicians were able to claim charter rights as a way of circumventing a negotiated agreement between provincial officials and physicians' associations. This allowed the court to rebuke provincial policy makers and to stipulate the basic structure of future agreements. In the process, the court was, in effect, imposing a financial burden on the province or, at the very least, ruling against a cost-control measure that is in widespread use across most of the Canadian provinces. *Eldridge* also involved judicially stipulated directives to provincial treasuries in holding that sign language interpretation services should be made available in British Columbia hospitals. Despite the relative small amount of money involved in this particular case, it engaged important aspects of health care financing: global budgeting and institutional discretion.

The provision of health care, whether in publicly funded, single-payer systems or not, is among the most complex policy tasks facing governments. Although litigation based on constitutional or statutory rights may seem an attractive means to redress consumer or provider grievances, our

analysis of *Waldman* and *Eldridge* highlights some of the difficulties that courts face in this area. Perhaps most important, litigation encourages piecemeal rather than coordinated policy solutions. As Horowitz (1977: 44) suggests, courts tend to make law for the best or worst case but not for the modal case. There is no guarantee that the policy regime generated through the accumulation of judicial decisions will be superior or even equal to that produced by an admittedly imperfect legislative process.

Appendix Charter of Rights Claims and Health Policy, 1982–1997

Case	Court	Date	Claimant	Type	Right	Successful?
B.(R) v. Children's Aid Society	SCC	1995	Consumer	Specific treatment	ss. 2(a), 7	
Borowski v. Canada	SCC	1989	Consumer	Specific treatment	s. 7	
Brown v. Minister of Health (B.C.)	BCSC	1990	Consumer	Specific treatment	s. 15	
Costco Wholesale v. BC	BCSC	1998	Provider	Practice regulation	s. 2(d)	Yes
Eldridge v. BC	SCC	1997	Consumer	Specific treatment	s. 15	Yes
Fernandes v. MB	MCA	1992	Consumer	Specific treatment	ss. 7, 15	
Jaeger v. QC	QCA	1998	Provider	Physician supply management	ss. 7, 15	
Jamorski v. ON	OCA	1988	Provider	Physician supply management	s. 15	
Jewish Hospital of Hope v. QC	QCA	1997	Provider	Hospital restructuring	s. 2(d)	
Kirsten v. SK College of Physicians	SCQB	1996	Provider	Physician supply management	ss. 6, 7	
Lachine General Hospital v. QC	QCA	1997	Provider/ Consumer	Hospital restructuring	s. 15	
Lister v. ON	OHCJ	1990	Provider	Practice regulation	ss. 7, 15	
New Brunswick v. B.	NBCQB	1990	Consumer	Specific treatment	ss. 7, 12	Yes
R. v. Morgentaler	SCC	1988	Provider	Specific treatment	ss. 7, 15	Yes
R. v. Rodriguez	SCC	1993	Consumer	Specific treatment	ss. 7, 12, 15	
Re Mia and Medical Services Commission of BC	BCSC	1985	Provider	Physician supply management	ss. 6, 7	Yes
Rocket v. Royal College of Dental Surgeons	SCC	1990	Provider	Practice regulation	s. 2(b)	Yes
SGEU v. SK	SCA	1997	Provider	Practice regulation	s. 2(d)	
Sniders v. NS	NSCA	1989	Provider	Physician supply management	s. 15	Yes

Appendix (Continued)

Case	Court	Date	Claimant	Type	Right	Successful?
Stoffman v. Vancouver General Hospital	SCC	1991	Provider	Physician supply management	s. 15	
Tremblay v. Daigle	SCC	1989	Consumer	Specific treatment	s. 7	Yes
Waldman v. Medical Services Commission of BC	BCSC	1997	Provider	Physician supply management	ss. 6, 7, 15	Yes
Wellesley Central Hospital v. ON	On. Div. Ct.	1997	Provider/ Consumer	Hospital restructuring	ss. 2(a), 7, 15	
Wilson v. Medical Services Commission of BC	BCSC	1987		Physician supply management	ss. 6, 7	Yes

Court names:
SCC = Supreme Court of Canada.
BCSC = British Columbia Supreme Court.
MCA = Manitoba Court of Appeal.
QCA = Quebec Court of Appeal.
SCQB = Saskatchewan Court of Queen's Bench.
OHCJ = Ontario High Court of Justice.
NBCQB = New Brunswick Court of Queen's Bench.
SCA = Saskatchewan Court of Appeal.
NSCA = Nova Scotia Court of Appeal.
On. Div. Ct. = Ontario Divisional Court.

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