The Canadian Health Care System’s Accountability for Reasonableness: An Update

by

Michael Da Silva
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Michael Da Silva

Abstract: Norman Daniels and James Sabin provide a plausible and influential account of procedural justice in health care allocation, which can arguably double as an account of the procedural dimension of the right to health care. Daniels and Sabin’s accountability for reasonableness framework requires that any health care allocation decision-making process include three components: public display of decisions and the reasons for those decisions, the use of publicly accepted/acceptable rationales in those decisions, and mechanisms for challenging and/or appealing the decisions. These components not only provide metrics for assessing the extent to which a given health care allocation process is fair, but also provide benchmarks for evaluating whether states are progressively realizing the procedural dimensions of the right to health care. Adding accountability for reasonableness components counts as progressive; removing them is retrogressive. This paper uses existing applications of the accountability for reasonableness framework to the Canadian health care system as a baseline for evaluating Canada’s progressive realization of the demands of the accountability for reasonableness framework and, accordingly, the procedural aspects of the right to health care. In the process, it also identifies some difficulties with applying the framework to Canada and draws new connections between some facts about the Canadian health care system. It concludes that Canada is making some progress in meeting the demands of the accountability for reasonableness framework, but still requires further work on what Daniels and Sabin call the publicity and relevancy criteria.

Identifying the health care goods and services (henceforth ‘health care goods’) states should provide is notoriously difficult. While many agree that people ought to access the health care goods they need and should at least be able to access certain basic health care goods, resource constraints entail a need for some form of rationing. An uncontroversial principle for identifying which goods and services should be prioritized remains elusive. Norman Daniels and James Sabin accordingly champion a procedural approach to identifying the health care goods that ought to be provided by the state: “[j]ustice requires limits to care, and the lack of consensus on principles of distribution means that we must develop a fair process for setting limits and learn how to apply them in real world situations” (2008, 10). A purely procedural understanding of health care justice may not account for all of its most important elements (see, e.g., Mahowald 2001; Ashcroft 2008), but the basic point about the need for procedural justice remains.

The vast literature on Daniels and Sabin’s framework for ensuring a fair process of selection provides a helpful starting point for studying whether health care systems meet the demands of (at least one influential account of) procedural justice. Daniels and Sabin articulate their “accountability for reasonableness” (AFR) framework in several works (e.g., Daniels and Sabin 1997; Daniels and Sabin 1998; Daniels 2000; Daniels and Sabin 2002; Daniels and Sabin 2008). Other authors apply Daniels and Sabin’s indicia of fair processes

Biography

Michael Da Silva is a doctoral student in the University of Toronto Faculty of Law’s Doctor of Juridical Science (SJD) program. He is also a Canadian Institutes of Health Research (CIHR) Vanier Canada Graduate Scholar. He was a CIHR Training Fellow in Health Law, Policy and Ethics and a Graduate Associate of the Centre for Ethics when he served as a Senior Doctoral Fellow in the Comparative Program on Health and Society and wrote this working paper. Between law school and his present degree, he served as a Foreign Law Clerk at the Supreme Court of Israel, conducted graduate studies in legal philosophy at Rutgers University, and worked as a research assistant in the Codification Division of the United Nations Office of Legal Affairs. His published works can be found in journals such as the Canadian Journal of Law and Jurisprudence, Criminal Justice Ethics, and Ratio Juris. Other works are forthcoming in Dalhousie Law Journal and the McGill Journal of Law Health.
to real world contexts. The resultant literature includes pieces that assess how the Canadian health care system fares from the AFR perspective (e.g., Martin and Singer 2003; Pitfield and Flood 2005; Flood and Zimmerman 2007). This work updates the earlier research on the Canadian health care system in light of recent developments and provides additional facts and analysis.

This update begins with three sections that provide basic information about AFR, the Canadian health care system, and why it is appropriate to assess the latter in light of the former. The next three sections examine the extent to which the Canadian health care system includes three substantive components required by the AFR framework: public display of decisions and the reasons for those decisions, the use of publicly accepted/acceptable rationales in those decisions, and mechanisms for challenging and/or appealing the decisions. I first confirm earlier work suggesting that Canada fails to provide reasons for its decisions. I further demonstrate that even some appeal bodies are not bound to make the reasons for their decisions public and argue that the online provision of reasons by some appeal bodies counts as an expansion of Canada's reason giving component of AFR. I then provide an original take on two different ways one can understand the publicly accepted/acceptable rationale criterion and argue that Canada's reason giving deficiencies make it difficult to determine how Canada fares on either construal of the requirement (at least without engaging in potentially costly appeals). Finally, I provide an overview of the challenge/appeal mechanisms in Canada. I update the list of Canadian provinces with administrative appeal boards for health care allocation decisions and add a treatment of Aboriginal appeal mechanisms. A seventh section provides an original take on the possible implications of this framework for Canada's progressive realization obligations. A conclusion follows. Ultimately, this updated and expanded analysis suggests that Canada requires further work on the first two components of AFR, but Canada's score on the first metric is improving and its score on the third metric may be higher than earlier work suggests.

**AFR: AN OVERVIEW**

Daniels and Sabin argue for distribution of health care goods in conformity with basic demands of political justice. Their approach rests on an argument of the following form:

1. The distribution of health care goods is a concern of distributive justice (e.g., Daniels 1985).
2. Authority for distributive justice vests in the public.
3. Therefore, authority for the distribution of health care goods vests in the public (e.g., Daniels and Sabin 1998, 58).
4. Where public authority is given to a representative body, such as the government, the representative body's decisions must still be responsive to the public entity from which the body receives its delegated authority.
5. Distributive decisions about health care goods are made by some form of representative body.
6. Thus, distributive decisions with respect to health care goods must be responsive to the public.

Daniels adopts (1) because health care is required for fair equality of opportunity (1985). It can also be derived from the fact that health care goods are a bounded, valuable resource (as suggested by Daniels and Sabin 2008, 1-2) and/or that there is a social obligation to meet people's health needs (and rationing is required to maximally meet these obligations) (Daniels and Sabin 1997, 310-312). (2) follows from a complicated account of public authority that cannot be treated in detail here; it is granted for the sake of argument here. (5) is complicated by the fact that in practice many decisions are made by non-representative bodies, including authoritative rulers or their proxies. Yet where one takes (3) seriously, just health care decision-making is only possible where the conditions in (5) obtain; the only legitimate government or corporate authority for health care decision-making is delegated authority. Thus, all health care decision-making ought to be responsive to the public. This helps explain why Daniels and Sabin hold that their framework should spell out principles for decision-making by private entities that may not derive their authority from the public (1997).

Ideally, some universal principle would determine how distribution ought to take place, simplifying the decisions in (6). For instance, few would challenge the assertion that need is a good reason to prioritize
certain goods. A principle whereby ‘All persons ought to receive the health care goods they need’ is thus appealing. Yet Daniels’s earlier work suggests that even this uncontroversial principle is unlikely to solve the broader problem given the scarcity that requires prioritization in the first place. The principle leaves an important question open: “Even if we decide that access to health care should be based on need for services, which needs should we meet when we cannot meet all?” (Daniels 1985, 15). Further principles must be invoked to ensure fair distribution. One may, for instance, seek to prioritize goods in light of the values they promote. Daniels’s prioritization of the goods that are required for fair equality of opportunity arguably takes this form (1985). Yet even if health care allocation decisions were made on the basis of the best ethical principle we could conjure, this alone would not necessarily provide legitimacy to such decisions. Political legitimacy for invoking that principle would still be required. There can be and is reasonable disagreement over many political concerns. Daniels alludes to this fact in his discussion of the fact of pluralism (Daniels 2000). This reasonable disagreement arguably not only includes principles for prioritizing certain goods in a distribution, but also values that could be used to justify new principles and how best to understand basic concepts underlying these principles, like ‘need’ and ‘opportunity.’ Daniels and Sabin explicitly note such “lack of consensus” on principles for decision-making in the health care context (2008, 10 [see also 1997, 307]). There may also be a lack of consensus on the meaning of terms underlying those principles. Fulfilling the demands of (6) is thus difficult to do from the armchair. This helps explain why Daniels and Sabin expressly placed their work in the model of deliberative democracy (even if they also suggested that their argument for AFR can succeed independently from a commitment to deliberative democracy) (1997, 307). Representative decision-makers must be responsive to the needs of a wide constituency that includes people with radically different views on what ought to be done in the health care context. Infrastructure may be required to ensure that this responsiveness to real people is taking place.

Daniels and Sabin accordingly set further conditions for a fair process of distribution that is responsive to the public who maintains ultimate authority over decision-making. For Daniels and Sabin, the responsiveness in (6) has two components. Decision-makers must make decisions that the public would (and perhaps does) accept and must make these decisions known to the public. The conditions necessary for these demands of distributive justice to be met fall under the title of “accountability for reasonableness.” There are four basic conditions:

(i) the “Publicity Condition” (Daniels and Sabin 2008, 12, 45; Daniels 2008, 118), which requires decisions and reasons for decisions to be made public;

(ii) the “Relevancy (or “Relevance” [Daniels and Sabin 2008, 45, 169, etc.; Daniels and Sabin 1998, 57]) Condition” (Daniels and Sabin 2008, 12; Daniels 2008, 118), which requires that those reasons be relevant to health care decision-making;

(iii) the “Revision and Appeals Condition” (Daniels and Sabin 2008, 45; Daniels 2008, 119) (originally just the “Appeals Condition” [Daniels and Sabin, 1998, 57]), which requires that decisions be subject to challenge and/or appeal and capable of revision in light of these challenges; and

(iv) the “Regulative (formerly “Enforcement” [Daniels and Sabin 1998, 57]) Condition” (Daniels and Sabin 2008, 45; Daniels 2008, 119), which further requires “some form of regulation to ensure that the other conditions are met” (Daniels and Sabin 2008, 12).

These conditions, in turn, suggest a test for determining whether a given nation’s health care system is fair. In the most succinct statement of the necessary conditions of AFR, Daniels states that a health care process is fair only if it involves:

transparency about the grounds for decisions; appeals to rationales that all can accept as relevant to meeting health needs fairly; and procedures for revising decisions in light of challenges to them. Fair procedures must also be empirically feasible. They must involve practices that can be sustained and that connect well with the goals of various stakeholders in the many institutional settings where these decisions are made (Daniels 2000, 1300).
To count as fair, in other words, a method for selecting what goods a given nation’s health care system should provide accordingly ought to include:

(A) the public display of the product of and reasons for decision-making,
(B) the use of publicly accepted (or at least publicly acceptable) rationales in those decisions, and
(C) procedures for challenging and/or appealing the initial decisions.

These structural features of a legal system regulating health care meet the conditions in (i)-(iii). A separate requirement for

(D) the legal protection of (A)-(C) (though e.g., through binding legislation)

arguably ought to follow from (iv). After all, it is difficult to see how one can ensure that the first three conditions will be met without proper entrenchment. Yet Daniels does not make this claim and instead states that the condition can be met by “voluntary or public recognition of the process” short of full legal protection (Daniels 2008, 119). Call this recognition (D).*

Now that the basic features of the AFR framework are clear, I can examine the extent to which this framework should and can be used to assess particular contexts. The AFR conditions were developed because of concerns about managed care organizations (Daniels and Sabin 1997) and framed as conditions on decision-making for “insured patients” (Daniels and Sabin 1998, 52). Given the centrality of the notion of the public to Daniels and Sabin’s views, it would be reasonable to assume that their conditions are meant to apply primarily to public health insurance regimes, but managed care organizations are private entities and the problem Daniels and Sabin identify is a universal one. Prioritization is a universal requirement, suggesting that the AFR framework can be applied to a variety of contexts. Indeed, Daniels’s later work on health justice not only expands the scope of his subject to include the social determinants of health but has also broadens the geographical scope of his inquiries considerably (e.g., Daniels 2008). The following reasons suggest that the AFR framework can at least be applied to Canada.

**THE APPLICABILITY OF THE AFR FRAMEWORK TO THE CANADIAN HEALTH CARE SYSTEM**

Even if one holds that Canada’s “public/tax-financed” health care system (Flood and Gross 2014, 5) is not a traditional health insurance-based health care system, there are at least three reasons why it is appropriate to apply the AFR framework to the Canadian health care system.

First, the framework is specifically tailored for the evaluation of the procedural fairness of health care systems in liberal states. The impetus for the framework is the aforementioned “lack of consensus” on principles for decision-making (Daniels and Sabin 2008, 10) that clearly arises in liberal states. Daniels identifies the lack of consensus as a problem for “pluralist” states (e.g., Daniels 2000), and empirical research confirms that public opinion on social justice falls on a wide spectrum (Aalberg 2003). The earliest in-depth application of AFR thus focused on the United States of America (Daniels and Sabin 1998). Similarly divergent views exist in Canada. The persistent lack of unanimity on whether cosmetic dentistry or in vitro services ought to be publicly insured, for example, arguably stems from more fundamental disagreements about principles for decision-making. Canada’s status as a liberal democracy, then, suggests that the Canadian health care system is the type of entity for which the AFR framework is appropriate. Indeed, Canada is mentioned in the first article outlining the AFR framework (Daniels and Sabin 1997, 308, 324, etc.). This suggests that Daniels and Sabin’s understanding of health insurance-based regimes is broad enough to include the Canadian health care system; even if this is an improper characterization of the Canadian health care system, Canada remains a liberal democracy.

Second, Canada’s commitments to administrative justice and non-discrimination (as an aspect of administrative justice and a standalone value) imply that public decision-making in Canada ought to be reasonable. Administrative justice demands that administrative decisions be made on the basis of reasons. The AFR framework provides resources for assessing the extent to which these reasons are given in a particular context and provides metrics for assessing the extent to which decision-makers are accountable for their commitment to this aspect of administrative justice. As Colleen M. Flood (2006, 452) points out,
the AFR “factors map onto our understanding of the basic requirements for procedural fairness.” Non-discrimination, in turn, is a principle of Canadian law⁴ and many international legal documents to which Canada is party.⁴ It also requires procedural safeguards against discriminatory reasons in decision-making. AFR can provide that bar. Where the Canadian health care system is in the domain of public administrative decision-making and Canada is committed to administrative justice and non-discrimination, it is appropriate to apply the AFR framework to that system.

Finally, the AFR framework provides good metrics for examining the extent to which the procedural elements of the international right to health care Canada bound itself to realize are safeguarded. Canada is signatory to several international covenants that recognize a “right to health.”⁹ One aspect of this right is a right to health care. What obligations this fact can and should impose upon Canada is contested. The international right to health care clearly requires some commitment to the provision of health care, but it can be difficult to identify what the content of this right should be. A right to all health care risks bankrupting those duty-bound to fulfill it,⁶ whereas a narrow scope risks making such a right content-less. There should, however, at least be a procedural dimension to the right. A right to a fairly administered system for identifying the content of the right in a given context arguably falls out of international human rights law’s aforementioned commitment to non-discrimination in decision-making.⁷ What ‘fairness’ means here is contested, but I believe that Daniels and Sabin provide one of the better articulations thereof.

Of course, AFR may not perfectly mirror international norms and the fact of reasonable pluralism that grounds the framework may be unique to liberal societies, but, as Daniels and Sabin also note, limit setting is required in states with varying socioeconomic systems and health care delivery designs (2008, vii). Where this problem is universal and international norms require procedural fairness, AFR’s attempt to solve the problem for liberal societies by ensuring procedural justice may provide guidance in any context. I argue elsewhere that there is also some substantive content to the right to health care, but the AFR framework can nonetheless provide useful measures of the extent to which Canada’s health care system meets the procedural demands that arguably form part of the international right.

Given the compelling reasons for applying AFR to the Canadian health care system, it is unsurprising that there is some work on this topic already. Some of this work even appears in Daniels and Sabin’s limited transnational analysis of health care systems’ AFR bona fides (180-184). The existing literature provides a baseline for further analysis of the extent to which Canada comports with Daniels and Sabin’s account of procedural justice in health care decision-making. I am open to the possibility that other accounts of procedural justice may be equally applicable to the Canadian health care system so long as they can account for the demands of reasonable pluralism, administrative justice, and international human rights law. Yet the existing literature’s provision of a baseline for comparison provides a practical reason to conduct further study on Canada’s responsiveness to AFR norms.⁸ The present paper both updates and expands upon the earlier research. To understand this broader analysis, however, one must first know some basic background information on the structure of the Canadian health care system. I provide it in the next section.

THE CANADIAN HEALTH CARE SYSTEM: AN OVERVIEW

In Canada, health care is an area of ‘concurrent jurisdiction’ between the federal and the provincial governments.⁹ ‘Health’ and ‘health care’ are not explicitly placed under the purview of either level of government in the original constitutional division of powers.⁰ Provincial authority over hospitals, guaranteed in section 92 of the constitution,¹¹ and a federal spending power which is not explicitly mentioned in the text of the constitution but is instead “inferred” from a variety of other, enumerated powers (Jackman 2000, 97), provide the concurrent jurisdiction required to establish the joint federal-provincial health care provision collaboration that frames the mainstream Canadian health care system. This collaboration is primarily established by perhaps the most important example of federal action in the health care domain: the Canada Health Act (CHA).¹² The CHA has been described as the “institutional core of Canada’s health care system” (Lahey 2011, 2) and sits at the centre of the mainstream Canadian health care system and the legal regulation thereof. It gives the federal government the power to transfer funds to the provinces for health care provision through provincial insurance regimes.
To receive federal funding under the CHA, provinces must meet a variety of requirements, including the provision of certain 'hospital services' and 'physician services' (though provision and/or insured coverage of non-hospital dental services, prescriptions, and some other goods are specifically not required). The definitions of these terms provide limits on the provinces' discretion on what services they insure. For the purposes of the CHA:

“hospital services” means any ... services provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability...

“physician services” means any medically required services rendered by medical practitioners[.]

To receive funding, then, the provinces must insure “medically necessary” or “medically required” services. This suggests that necessity and requirement are reasons provinces ought to consider when making distributive decisions. Yet “medically necessary” and “medically required” are undefined, leaving latitude on what to cover. Each province then has its own health insurance act which spells out who gets to decide what ‘necessary’ or ‘required’ goods are insured in their respective health care systems. As discussed in further detail below, these decisions must be reasonable to comport with general administrative law principles and must not discriminate in their intent or effect as a matter of both constitutional law and human rights law, but the provinces can reach vastly different substantive outcomes in their decisions on what to cover.

There are also a series of federal health care programs for specific groups. For instance, unlike the general situation under the CHA, Canada, not the provinces, is the leader in Aboriginal health provision (as a result of the division of powers, treaties, and fiduciary law) (MacIntosh 2011, 576). The federal government clearly has some power over Aboriginal health care, including the power to provide health care on Aboriginal reserves, but the scope of this power is contested (Jackman 2000, 106). The scope of the federal government's responsibilities is similarly contested. As Constance MacIntosh notes, “whether Canada has legal discretion to not address the health care needs of Indigenous peoples” is a live question (2011, 576). Some Aboriginals can access a wider variety of goods and services using government funds than their non-Aboriginal counterparts (including pharmacy benefits and dental services) through the Non-Insured Health Benefits (NIHB) Program (605). Yet controversy over the nature of this program persists. As MacIntosh notes, “[i]n contrast to Canada's position that NIHB is a discretionary policy-driven initiative, Indigenous organizations characterize the NIHB program as a manifestation of Canada’s lawful obligations to Indigenous Canadians emanating from treaty rights and the federal fiduciary obligation” (608). Other federal programs, such as the refugee claimant-focused Interim Federal Health Program, face similar controversies.

These broad structural features of the Canadian health care system do not tell the whole story of Canadian health care coverage, delivery, or the legal regulation thereof. They do not, for instance, account for the complexities of the Interim Federal Health Program, federal programs designed for veterans, or federal prisoners, or the workers’ compensation regime. The facts above nonetheless provide basic background necessary for analyzing the details of the system that are relevant to the AFR framework. It is now prudent to examine these details in light of the substantive demands of the AFR framework. As the following makes clear, Canada lacks (A) and it is difficult to determine the extent to which it fulfills (B). Canada thus clearly lacks (D) in all but the minimal sense of having a health care system that is legally regulated. I accordingly focus only on the extent to which Canada provides (A)-(C). I begin with (A).

**REASON-GIVING AND THE CANADIAN HEALTH CARE SYSTEM**

In her earlier work on this topic, Flood stated that Canada's Medicare regime does not follow the AFR framework (2006, 452). Yet following the framework may not be an all-or-nothing affair. The legal system regulating Canada’s health care system arguably does feature some of the structural features required by AFR.

The provision of reasons was not one of the structural features of the Canadian health care system at the time of Flood’s work. While some headway has since been made in the public provision of reasons for health care coverage decisions, work remains to be done if Daniels and Sabin's call is to be fully heeded. The problems here are clear. The reasons for decisions on what health care goods are covered in a given province
are generally not publicly available, nor do the committees charged with deciding what is covered under our health insurance regimes tend to be explicitly required to provide reasons for their decisions, let alone make them public. For instance, Ontario legislation establishes rules for the composition of the Physician Services Committee but does not suggest that the Committee needs to provide reasons for action under those powers.15 The only clear exception is that denial of particular claims for coverage by the General Manager of the health insurance regime must be reported to the Ministry of Health and the report must include an account of the grounds for that decision; these decisions do not explicitly need to be made public.16 Even if one thinks that requiring reasons for every coverage decision on an item-by-item basis is too demanding, a system that leaves its principles for decision-making undefined and fails to provide general reasons for decisions fails any reasonable reason-provision standard.

Even administrative appeal bodies are not always required to provide reasons for their decisions and there may be impediments to accessing decisions that are supposed to be public. There is a general rule of administrative law, dating back to the Supreme Court of Canada (SCC)’s decision in Roncarelli v Duplessis, [1959] SCR 121, that administrative decisions cannot be arbitrary. This arguably entails that at least some public decisions must be based on reasons. The circumstances in which these reasons must be publicly available, however, are more limited. The SCC has stated that “in certain circumstances, the duty of procedural fairness will require the provision of a written explanation for a decision.”17 If one takes Daniels and Sabin’s claims about the status of health care as a public good in the domain of distributive justice seriously, the health insurance coverage context is arguably one in which the provision of written reasons for decisions ought to be required. It is thus heartening that the body charged with hearing appeals in Ontario, the Health Services Appeal and Review Board (HSARB), provides written reasons in several cases despite not being explicitly required to do so. Yet even where this condition is fulfilled, impediments to the public display of these reasons may remain. For instance, Flood and Michelle Zimmerman’s work on that Board raises two potential problems: “The Boards’ judgments are not online and appointments must be made to view the judgments archived in Toronto. Furthermore, because the judgments are not indexed, in order to locate a decision one needs to know the name and year of the case” (2007, 35). There may be impediments to accessing the written reasons for appeal decisions and, consequently, the reasons for first instance decision-making that are necessary for appeals.

An update on the public display of appeal decisions provides evidence that Canada has taken some strides in its public reason provision. Obtaining reasons from the initial decision-makers in Ontario remains difficult, but access to the decisions of the aforementioned HSARB is improving. HSARB decisions are now indexed on CanLII (the Canadian Legal Information Institute), an online non-profit managed by the Federation of Law Societies of Canada. Initial indexing took place in 2010 and digitization of the backlog of decisions continues; one case dating back to 2002 was on the website as of 22 January 2015.18 The site, which includes a search option, is also kept relatively up-to-date; two 2015 decisions, one on a hearing request19 and one substantive decision on a November 2014 hearing,20 appeared within the first three weeks of the year. Quebec’s main administrative tribunal, which is the site of first instance for insurance decision appeals, similarly maintains an online database of its decisions at http://citoyens.soquij.qc.ca/.21 While accessing the reasons for decisions on what services are covered remains difficult, a systematic review of appeal decisions could yield some insight on what reasons decision-makers use to decide what is covered under the health insurance regimes of at least two provinces. This indirect reason provision falls short of the reason-giving requirement envisioned by Daniels and Sabin,22 but it signifies progress since Flood et al, wrote on the applicability of the AFR framework to the Canadian health care system.

Even where administrative appeal reasons are (or even must be) made public, however, appeals are an inefficient means to get reasons that ought to be required as a matter of procedural justice prior to review. Human rights law tribunals have a history of long wait times. Ontario accordingly recently overhauled its human rights mechanisms to ensure greater accessibility.23 Where a further judicial review is required to get reasons, this problem is even more pressing, as the judicial review process can be time-consuming. Even if the concerns about trial level wait times commonly cited in the media prove unwarranted, some of the wait times at the nation’s highest courts are suggestive of possible timelines if one wants to take one’s appeal to the highest level and further gain relief for what one takes to be an injustice. For instance, by
the SCC’s measures, in the period 2003 to 2013, the average wait time on a decision on an application for leave hovered around four months; even when leave was granted, it took an average of nearly ten months to receive a hearing, and at least another four months to receive judgment.²⁴ Even then, fewer than 4% of cases between 1995 and 2000 dealt with health issues (Campbell 2007, 371). General administrative law procedures can at least be less time-consuming. While waiting for a hearing may still prove onerous, some of these bodies take less time to provide reasons. For instance, while Ontario’s appeal body for its health care insurance decisions can take three months to provide reasons, Alberta’s equivalent, which has a more limited jurisdiction, should provide reasons within five days of a hearing (Pitfield and Flood 2005, 493-494). Yet, even then, these procedures are an inefficient way to get reasons one should have as a matter of justice, and judicial review may be required to gain substantive outcomes.

THE PUBLIC ACCEPTANCE/ACCEPTABILITY OF DECISION-MAKING IN THE CANADIAN HEALTH CARE SYSTEM

There are two ways of understanding the second requirement of AFR. It is difficult to determine how Canada fares on either interpretation. On one articulation of this requirement, AFR requires that “the grounds for decisions must be ones that fair-minded people can agree are relevant to meeting health care needs fairly under reasonable resource constraints” (Daniels and Sabin 2008, 12, emphasis added). Elsewhere, however, the Relevancy Condition is formulated such that decisions must be based on “evidence, reasons, and principles that are accepted” by such fair-minded people (45, emphasis added). Whether the reasons for decisions need to be accepted or merely acceptable is ambiguous. The lack of reason-giving in the Canadian health care system makes it difficult to determine whether the public accepts the reasons for health care decision-making. If the public does not know why decisions are made, how can they decide whether they think those decisions were made for good reasons? Access to reasons seems prerequisite for acceptance of reasons. The systematic review of all appeal decisions in Ontario and Quebec suggested above could be helpful, but such a review would require its own study beyond the scope of this work and is currently unavailable to the public.

The best we can say about how Canada fares on the acceptance of reasons understanding of this requirement is that many Canadians do not accept the decisions relating to their health insurance and this can be seen as an implicit issue with the reasons for these decisions. To take issue with an outcome is to implicitly critique the reasons for that outcome. The constitutional challenges identified below are just one example of Canadians showing a lack of acceptance of decisions about health care rationing.²⁵ Frequent demands for greater long-term care coverage provide another. But since no public will ever accept all decisions made by a rationing body,²⁶ one should not take this lack of acceptance of decisions too seriously. Again, it is difficult to evaluate the public’s actual acceptance of reasons for decisions without better access to reasons.

The hypothetical acceptability of reasons used to make decisions about Canadian health care distribution is similarly difficult to parse. Daniels and Sabin structure their analysis in terms of the views of ‘fair-minded people.’ Some further detail on their characteristics is necessary to perform the hypothetical agreement thought experiment. Daniels and Sabin’s fair-minded people are “people who in principle seek to cooperate with others on terms they can justify to one another…. [They] seek reasons…they can accept as relevant to meeting consumers’ or citizens’ needs fairly under resource constraints” (44).²⁷ Yet this information about who must accept reasons is unhelpful if we do not know what reasons they are being asked to hypothetically accept. This information is lacking in Canada. In the abstract, it seems reasonable to assume that fair-minded persons could accept decisions made on the basis of what is “medically necessary” and “medically required.” Yet the undefined status of those two terms means that they are, in practice, open to wide interpretation. On a wide enough interpretation, the phrases lack substantive content. Even the guiding principles on how to interpret these terms are generally undefined (Flood and Zimmerman 2007, 30). The threat of arbitrary decision-making looms. In their original work, Flood and Zimmerman state that “resource allocation decisions . . . in Canadian Medicare . . . [are] generally opaque. Lack of transparency allows decision-making on an ad hoc politicized basis” (27). They suggest that it “allows for the possibility of self-interest or irrelevant considerations to guide these fundamental decisions” (30). In the absence of public reasons for decisions, it is unclear to what extent the allowance or possibility of arbitrary decisions
actually exists. Yet fair-minded individuals clearly would not accept arbitrary decision-making. They are
defined by their commitment to relevant reasons and arbitrary decisions are by definition not based on
relevant reasons. If medical necessity is a proxy for political expediency, as Flood and Zimmerman worry,
hypothetical agreement is unlikely. Even if decisions are non-arbitrary, focus on the medically necessary
and medically required criteria do not get us far in the absence of more precise definition. Decisions based
on empty concepts may seem less problematic, but fair-minded individuals are still unlikely to accept that
such decisions were fairly made.

THE PRESENCE OF CHALLENGE AND/OR APPEAL PROCEDURES IN THE CANADIAN HEALTH
CARE SYSTEM

There are several challenge and/or appeal procedures related to the Canadian legal regulation of health care
and the health care insurance regime in particular. One can challenge decisions on health care coverage and
provision using constitutional law, human rights law, or administrative law. The first two procedures can be
summarized briefly. Sections 7 and 15 of the Canadian Charter of Rights and Freedoms protect rights to “life,
liberty and security of the person” and “equality” respectively and allow for the challenge of any Canadian
law;28 both have been used to challenge aspects of Canada’s regulation of health and even to demand
provision of certain goods.29 Every province, in turn, has a human rights tribunal.30 If one feels that one has
been discriminated against in the coverage or provision of health care, one can challenge the decision before
the tribunal. These tribunal decisions are then themselves reviewable by courts.

General (non-human rights) administrative law avenues require a more lengthy discussion. A more
expansive view on what counts under this branch suggests that earlier work may have underestimated how
well Canada fares on this metric. For instance, Flood and Zimmerman (2011, 34) only list Ontario, Quebec
and British Columbia (B.C.) as provinces with “administrative tribunals to which citizens can bring… an
application to review a decision not to publicly fund a service or a treatment” and briefly mention that
Alberta has a more limited appeal mechanism. This list is arguably under-inclusive. Ontario, Quebec, and
Alberta maintain appeal mechanisms for (at least some) health insurance decisions. In Ontario, appeals can
be made by e.g., “an insured person who has made a claim for payment for insured services may appeal a
decision of the General Manager refusing the claim or reducing the amount so claimed to an amount less
than the amount payable by the Plan.”31 In Quebec, someone “who believes he has been wronged by a
decision of the [Quebecois Insurance] Board may apply for a review of the decision” at the Administrative
Tribunal of Quebec.32 In Alberta, there is a limited right of review of one’s request for out-of-country
provision of goods not available in Alberta under regulations.33 Yet other provinces also allow for limited
administrative appeals. The Manitoba Health Appeal Board has the power to hear appeals on several
grounds, including appeals by those who have been “denied entitlement to a benefit under this Act or the
regulations.”34 and New Brunswick regulations charge the Insured Services Appeal Committee with hearing
appeals arising from “disputes or disagreements with respect to… refusal of a claim for payment for entitled
services or reduction of the amount so claimed.”35 These two provinces suggest that Canada fares better on
AFR’s challenge/appeal component than previously thought.

A separate line of appeal exists for Aboriginals in the NIHB Program, though it appears to be more limited
and does not allow for appeal to a government-independent body. This also counts as a hitherto largely
unrecognized limited addition to Canada’s score on this metric. The program claims to have an appeal
mechanism for drug, dental, and orthodontic goods and services, but all three levels of appeal in that
system are to different branches within the program, beginning with the Manager of the Pharmacy Policy
Development Division or the Dental Policy Unit, moving on to the Director, Benefit Management and
Review Services Division, and ending with the NIHB Director General.36 The inter-departmental nature of
these mechanisms raises questions about the extent to which they are genuine ‘appeal’ procedures, given
that one must resort to the courts to receive executive-independent review. But the inter-departmental
mechanisms should nonetheless count at least minimally as challenge procedures.

In nearly every case, administrative decisions can then be reviewed by courts. Ontario explicitly states that
people making challenges under their system have a right of appeal to the Divisional Court.37 In Manitoba,
the relevant statute does not explicitly refer to a right of review at court, but it is also not barred. Albertan
laws are generally silent on how its appeal mechanisms work. In Quebec, arbitration is required for disputes arising from “an agreement,” but this does not explicitly preclude judicial review of non-“agreement”-based decisions. There is, then, an extra level of possible challenge before the judicial level in several Canadian provinces and none of them precludes further review at court. As previous scholars recognized, this also counts in favour of Canada’s challenge/appeal score. Judicial review of NIHB decisions is also theoretically available after internal review procedures are exhausted.

Constitutional law, human rights law, and the general (non-human rights) administrative law of several provinces, then, allow for challenges and/or appeals of health care allocation decisions. To count as fulfilling the AFR conditions, revision of challenged decisions must also be possible. Revision is formally available under all of the challenge and/or review mechanisms listed here. Whether these mechanisms are effective means of challenging decisions and actually lead to the revision of decisions is a further concern. Daniels and Sabin do not explicitly require substantive revision at any level, but their framework seems to imply that revisions ought to take place. There is reason to question the extent to which Canadian mechanisms result in real change. Successful constitutional claims in the health care domain are rare at best. General administrative law faces similar concerns. Flood and Zimmerman only identified one “substantive administrative law challenge in health rationing” (2011, 52-53) and that case, Stein v. Quebec (Regie de l’Assurance-maladie), [1999] QJ No 2724 (QC Sup Ct), merely secured reimbursement for the provision of a specific health care good. Human rights law presents a mixed bag. As Nola M. Ries (2011, 634-635) makes clear, it has successfully been used as a channel for reimbursement for otherwise uninsured goods, ensuring that professionals provide goods on a non-discriminatory basis, and reducing wait times, but it is not always a successful avenue. A full assessment of the potential value of these mechanisms is beyond the scope of this piece. At minimum, the existence of the mechanisms does count in favour of Canada’s legal regulation of health care according to Sabin and Daniels’s initial formulation of the AFR framework.

THE RIGHT TO HEALTH CARE AND PROGRESSIVE REALIZATION: A FURTHER CONCERN

If one regards the AFR framework as a useful mechanism for analyzing the international right to health care, then the AFR conditions can also serve as metrics for determining the extent to which states are meeting the procedural goals of the right to health care. International human rights law does not oblige states to comply with AFR as developed by Daniels and Sabin, but AFR may be helpful in tracking what those international obligations ought to achieve. I conclude this piece by examining how this could be the case for the progressive realization component of the international right to health care.

The international right to health care requires that states progressively realize components of the right to health care. The Universal Declaration of Human Rights calls on “every individual and every organ of society” to take “progressive measures, national and international, to secure…universal and effective recognition” of human rights. The International Covenant on Economic, Social and Cultural Rights, in turn, requires that parties “take steps” toward fulfilling social rights “with a view to achieving progressively the full realization” thereof. This means that states that cannot fulfill all their duties immediately (due, e.g., to resource constraints) must continue to fulfill more of their duties over time. Once they take these steps and fulfill these demands, moreover, they cannot cease fulfilling their obligations. International human rights law explicitly states that one cannot be “deliberately retrogressive” in one’s right to health care achievements. When combined with the AFR criteria, this framework allows for a useful way of analyzing the extent to which states are meeting the procedural components of the right to health care. If one takes the procedural justice and progressive realization components of the right to health care seriously, the addition of a component of a fair system on the AFR framework ought to count in favour of a nation’s right to health care achievements. The elimination of such a component ought to count against it. This understanding allows for further analysis of the Canadian health care system and the legal regulation thereof.

The seeming disappearance of B.C.’s aforementioned administrative appeal body for health insurance coverage and provision claims is problematic on this view. B.C.’s health insurance legislation no longer outlines any powers of an appeal body, including the Medical and Health Care Services Appeal Board highlighted by Flood and Zimmerman. There is a reference to “each former member of” that board in a
list of persons “engaged in the administration” of that Act, but this is one of the only legal recognitions of the board and refers to it in the past tense. The provincial Ministry of Health’s online list of “Health Major Boards and Commissions” (sic) highlights the Medical Services Commission, the first instance decision-maker, and four related boards, but it does not list the Medical and Health Care Services Appeal Board or any board that fulfills all of its previous functions. The Medical and Health Services Appeal Board no longer maintains a website of its own. It appears to no longer exist. At best, it is no longer publicly promoted. This suggests some deliberate retrogression in one Canadian province. There may be good reason to disband (or electronically erase) the Board, but these reasons are at least partially offset by diminishing AFR.

At the same time, progressive measures in the legal regulation of Canada’s health care system can be identified. For instance, the additional online fora for reading appeal decisions noted above does not mean that Canada provides more reasons for its decisions, but where we are concerned with the public provision of reasons, these fora could count as progressive steps taken since the original work on the Canadian health care system’s AFR was conducted. In the absence of (D), however, this reason provision remains discretionary and the threat of retrogression looms. Further, no new broad structural features have been added and the provision of public reasons for original decisions on what is covered really need to be added before progressive realization of AFR measures reaches a point where a thorough AFR assessment can be made.

CONCLUSION
The AFR framework provides useful tools for analyzing the extent to which a state is ensuring that its health care system and the legal regulation thereof is meeting the procedural components of distributive justice. Unfortunately, most decisions on what goods individuals are entitled to in the Canadian health care system are shielded from public view. Canada thus fails one of the tests for AFR compliance: the public provision of reasons for decisions. This makes it difficult to determine whether Canada meets the second requirement—that decisions be made on the basis of publicly accepted or acceptable reasons. Canada’s many appeal mechanisms, including mechanisms not identified in earlier research, provide some insight into the reasons decisions are made and further count in favour of Canada’s ability to ensure that its health care system and the legal regulation thereof comports with the demands of AFR. The removal of an appeal mechanism from one province suggests a step backward in meeting the demands of distributive justice in this area, but additional online fora for appeal mechanisms raise hopes that Canada recognizes a need for greater provision of information in this area and will progressively come to provide the transparency in decision-making that AFR demands.

REFERENCES
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NOTES

1. There are problems with the use of the term ‘Aboriginal.’ As MacIntosh (2011, 579) notes, “[t]he term ‘Aboriginal’ is unique to Canada and Australia,” may not reflect Aboriginal self-understanding, and may impose homogeneity at odds with facts. Given the use of the term in Canadian constitutional law, however, it has some value here. Even MacIntosh notes that the constitution clearly states that the term “Aboriginal” “includes” but is not limited to the “Indians, Inuit, and Metis” discussed elsewhere in the text and thus may be a useful catchall. The fact that some powers are discussed only in terms of “Indians, Inuit, and Metis” complicates even this picture somewhat.
2. Perhaps this is because (D) is parasitic on (A)-(C). The existence of a system regulating health care weakly fulfills 
(iv), but it only fulfills it in full if the system already includes (A)-(C) (and arguably only if it then ensures that (A)-
(C) will remain). If the structural features needed to ensure (i)-(iii) (namely (A)-(C)) are not present in a system,
(iv) also necessarily fails. This does not suggest (iv) is similarly parasitic on (i)-(iii), but it points to difficulties 
identifying concrete analogues of the AFR conditions that can serve as tests for identifying the extent to which 
countries conform to the framework.

3. This norm is foundational for human rights legislation in every province and implied by the Constitutional protection 
of equality in Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the 
Canada Act 1982 (UK), 1982, c 11, s 15 [Charter].

is just one of several examples.

5. The most famous example is the International Covenant on Economic, Social and Cultural Rights, 16 December 1966, 
993 UNTS 3 (entered into force 3 January 1976), art 12 [ICESCR]. Similar language appears in several documents.

6. Indeed, Colombia's domestic right to health care arguably crippled their government (Yamin et al, 2001, 121).

7. The commitment to non-discrimination is common throughout international human rights law. For instance, the 
ICESCR's references to “equal and inalienable rights of all” and the rights of “everyone” are read as entailing equality 
and non-discrimination respectively; United Nation, Committee on Economic, Social and Cultural Rights, General 
at para 3.

8. International human rights law provides its own standards for whether its procedural duties are being fulfilled. 
It is also arguably equally responsive to the fact of reasonable pluralism and to the demands of administrative 
justice. Further, there is a vast literature on how Canada (and other countries) fare on international human rights 
law standards. International human rights law may accordingly provide an equally applicable standard. Where 
international human rights bodies already track these metrics, the scholar's time is arguably well-spent on AFR 
analysis, which is equally applicable but not formally required by any particular body.

9. As recently as the 1980s, a claimed primacy of provincial governments over health care was endorsed by the Supreme 
Court of Canada. In Schneider v. The Queen, [1982] 2 SCR 112 at 137, Dickson J (as he was then), writing for the 
majority, summarized earlier decisions and reports on the powers over health and health care and stated that the 
“view that the general jurisdiction over health matters is provincial (allowing for a limited federal jurisdiction either 
ancillary to the express heads of power in s. 91 or the emergency power under peace, order and good government) 
has prevailed and is now not seriously questioned;”. Yet even in that case, the move toward recognition of 
current jurisdiction was beginning. In a concurring judgment, Estey J offered a competing understanding on 
federalism’s implications for health and health care; he wrote that “‘health’ is not a matter which is subject to specific 
constitutional assignment but instead is an amorphous topic which can be addressed by valid federal or provincial 
legislation, depending in the circumstances of each case on the nature or scope of the health problem in question;” 
ibid at 142. A subsequent opinion in RJR-MacDonald Inc v Canada (Attorney General) [1995] 3 SCR 199 at para 53, 
positively cited this finding and further discussed “the ‘amorphous’ nature of health as a constitutional matter, and 
the resulting fact that Parliament and the provincial legislatures may both validly legislate in this area;”. Both are 
now recognized as early statements of the doctrinal norm that health is an area of “concurrent jurisdiction;” Carter 
v Canada (Attorney General), 2015 SCC 5 at para 53.

further support for this interpretation, see Jackman (2000, 110).

11. 1867, ibid.


13. Canada Health Act, ibid, c C-6, s 5, 7-12.


18. VR v Ontario (Health Insurance Plan), 2002 CanLII 61089 (ON HARB).

20. MS v Ontario (Health Insurance Plan), 2015 CanLII 1390 (ON HSARB).

21. The Manitoba Health Appeal Board does not post its decisions on its website, http://www.gov.mb.ca/health/appealboard/, or CanLII.

22. The reasons for decisions are supposed to create something analogous to a case law (Daniels and Sabin 1997, 327-328). Going to case law to get those reasons in the first place seems to get things backward.

23. For a report on the recent reforms to the Ontario human rights system following widespread access problems, see Pinto (2012).


25. The fact that constitutional challenges are possible in this area provides some insight into the reasons decisions ought to be made in Canada. The point that all decisions must comport with constitutional law, human rights law, and general administrative law appears above. The fact that other laws are publicly available and ought to guide decision-making is not non-dispositive on the question of whether they do guide decision-making. In the absence of public reasons, one must instead infer that these reasons are guiding decisions. As noted above, one can use appeal challenges to ensure these reasons are guiding decisions, but this can be costly.

26. In the American context, there is a worry that “the litigious public will accept no limits” on health care provision (Daniels and Sabin 1998, 58).

27. Elsewhere, Daniels and Sabin suggest that fair-minded people seek cooperation on “mutually justifiable” terms (1998, 51).


31. HIA - ON, supra note 15, s 20.

32. Health Insurance Act, CQLR c A-29, s 18.1 [HIA – QC].


34. The Health Services Insurance Act, CCSC c H35, s 9-10.

35. General Regulation, NB Reg 84-20, s 33.01.


37. Ibid, s 24.


39. HIA – QC, supra note 32, s 54ff.

40. There were no references to review or appeal mechanisms for would-be patients in the health insurance acts of Newfoundland and Labrador, Nova Scotia, Prince Edward Island, Saskatchewan, or the territories; Medical Care Insurance Act, 1999, SNL 1999, c M-5.1; Health Services and Insurance Act, RSNS 1989, c 197; Health Services Act, RSPEI 1988, c H-1.6; Saskatchewan Medical Care Insurance Act, RSS 1978, c S-29; Health Care Insurance Plan Act, RSY 2002, c 107; Hospital Insurance and Health and Social Services Administration Act, RSNWT (Nu) 1988, c T-3.

41. An entitlement to a sign-language interpreter in a hospital setting was found in Eldridge, supra note 29. Yet there is some debate about whether this constitutes a health care service and as Flood (2014) notes, access to the service is minimal throughout much of Canada even after Eldridge. Challenges to criminal prohibitions on health care goods or services had some success in R v Morgentaler, [1988] 1 SCR 30 and Canada (Attorney General) v PHS Community Services Society, 2011 SCC 44, [2011] 3 SCR 134. A right not to be criminalized for accessing health care services is not the same as a right to have a good covered. Most other health rights litigation at the Supreme Court of Canada did not result in a court-mandated entitlement. Lower court decisions have not been any more promising. The Federal Court of Appeal (Toussaint v Canada (Attorney General), [2013] 1 FCR 374; Covarrubias
v Canada (Minister of Citizenship and Immigration), [2007] 3 FCR 16), the Federal Court (Canadian Doctors for Refugee Care v Canada (Attorney General), 2014 FC 651), and the Ontario Court of Appeal (Flora v Ontario (Health Insurance Plan, General Manager), 2008 ONCA 538) have all variously stated that there is no positive right to have a particular medical service covered under a health insurance regime or to otherwise have the government provide a particular health care service.


44. The commonly cited cases here are Newfoundland and Labrador v Sparkes et al., 2004 NLSCTD 16 is one of the most commonly cited cases for this proposition.


46. See note 2.


48. Medicare Protection Act, RSBC 1996, c 286. See also: Hospital Insurance Act, RSBC 1996, c 204.

49. Medical Protection Act, ibid, s 49.

50. British Columbia, Ministry of Health, online: (2015) <http://www.gov.bc.ca/health/>. The listed boards are the Hospital Appeal Board, the Community Care and Assisted Living Appeal Board, the Patient Care Quality Review Boards, and the Health Professions Review Board. They also link to information on the Health Sector Agencies, Boards & Commissions Appointee Remuneration. The Patient Care Quality Review Board can hear appeals and challenges related to “the delivery of, or the failure to deliver, health care…the quality of health care delivered…the delivery of, or the failure to deliver, a service relating to health care, or…the quality of any service relating to health care,” but these challenges concern the decisions and actions of regional health authorities, not the Medical Services Commission; Patient Care Quality Review Board Act, SBC 2008, c 35. The Patient Care Quality Review Board should count in favour of British Columbia’s challenge score, but it does not replace the Medical and Health Care Services Review Board as an appeal mechanism.