Proceduralism in Social and Economic Rights

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ABSTRACT

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This dissertation engages with and contributes to a growing literature on procedural approaches in theorizing, monitoring and adjudicating social and economic rights, with reference to new governance literature. It analyzes a move in social and economic rights away from the generation and monitoring of substantive norms by treaty monitors, judges, and scholars, and toward processes designed to generate accountable, participatory, non-uniform, iterative responses to rights broadly conceived. The first paper explores the emphasis on new governance style proceduralism in the adjudication of these rights. The second focuses on the right to health and considers how collaborations among criminal justice, public health, and community actors can be informed by the new proceduralism in state responses to non-disclosure of HIV-status in sexual relationships. The third and final article argues that the use of new governance style proceduralism for rationalizing the distribution of publicly-funded health care resources in Canada dovetails with the emergent focus on process in human rights to open space for more meaningful human rights scrutiny. Each of the three papers concludes with a discussion of the limits of these emerging approaches.
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DEDICATION

This work is dedicated to the memory my four grandparents, Max and Sonia Garmaise and Abraham M. and Bessie Klein.
My three doctoral papers engage with and contribute to a growing literature on procedural approaches in theorizing, monitoring and adjudicating social and economic rights. The reliance on procedural approaches is a logical (and pedigreed) response to objections that have long hindered the development and enforcement of these rights at the international and domestic levels – charges that the rights are too vague and potentially far-reaching to be included among enforceable rights, and threaten to wrest democratic decisionmaking from more legitimate institutions than those typically charged with human rights monitoring and enforcement. Recently, however, the growing influence of new governance principles have resulted in reliance on particular forms of proceduralism, geared toward generating accountable, participatory, non-uniform, iterative responses to human rights goals broadly conceived.

All three papers evaluate and place this turn toward new governance principles in the context of broader human rights – especially right to health – frameworks and emerging governance structures within states. The first paper explores the emphasis on new-governance-style proceduralism in judicial decision-making; the second examines inter-agency and community collaboration; and the third looks at the use of new governance style proceduralism for rationalizing the distribution of publicly-funded health care resources. Each paper explores a set of interrelated themes within these.

1 Note that among the papers, my treatment of the rights varies: the first paper calls them social and economic rights (SERs), because it is mainly concerned with constitutional interpretation and enforcement of rights to education and housing; the second and third papers are more concerned with international human right to health, and so place this right in the context of economic, social and cultural rights – ESCRs, those reflected in the International Covenant on Economic, Social and Cultural Rights.
different contexts. These themes include human rights methodologies' growing engagement with—as opposed to avoidance of—"unknowingness" in the content of social and economic rights; the contextual value of the belief that governance processes geared toward transparent, accountable, participatory monitoring will help bring abusive or irrational conduct to light; and a reluctance on the part of human rights theorists and institutions to abandon traditional features of human rights protection in case it doesn't.

This short piece begins with a brief summary of each of the three articles, followed by an analysis of theoretical tensions raised and revealed by each paper in the turn toward proceduralism in health and human rights.

I. Overview of the three papers


The first paper, Judging as Nudging: New Governance Approaches for the Enforcement of Constitutional Social and Economic Rights, identifies and critically examines a move in adjudication of constitutional social and economic rights away from traditional rights-as-trumps models, where normative content is defined at the judicial level, to a loosened connection between violation and remedy whereby judicial intervention is more directed toward generating accountability than to directly remedying individual violations. In addition to "reasonableness review", which has been analyzed and endorsed by numerous scholars as a defining feature of, for example, the South African approaches, the paper identifies five common features in a number of prominent judicial decisions purporting to enforce different versions of SERs. These, the paper argues, "nudge" institutions toward SER enforcement. They include: (1) declaring the
content of rights at high levels of generality; (2) reliance on comparative data to identify reasonableness of government choices in pursuit of realizing positive constitutional obligations; (3) the use of prophylactic remedies conceived of as floors from which governments might improve; (4) encouraging participation in norm-setting; and (5) requiring ongoing monitoring of rights. I argue that these features represent a measured judicial openness toward collaborating with other stakeholders within an experimentalist frame toward the more meaningful enforcement of social and economic rights. The paper concludes that although this emphasis presents a promising route toward collaborative approaches that avoid some of the institutional capacity and legitimacy concerns traditionally voiced around judicial enforcement of SERs, it arguably merely puts off constitutional standoff. There may be a temptation to return to more substantively, normatively prescriptive approach, with all its attendant risks related to capacity and legitimacy.

B. Criminal Law, Human Rights and the Governance of HIV Exposure and Transmission

The second paper shifts the focus away from judicial methodologies for engaging with social and economic rights and toward collaboration among public health, criminal justice and community stakeholders guided by emerging proceduralist conceptions of the right to health. It addresses the relationship between the human right to health and criminalization of HIV transmission and exposure.

In this paper, I argue that the principal human rights, ethical, and policy concerns that have been raised time and again over the past twenty-five years about criminalization
of non-disclosure of positive HIV status to sex partners are not easily addressed within traditional criminal law paradigms; nor can traditional human rights analysis provide conclusive answers to inform state policy on when, if ever, it is appropriate to apply the criminal law to consensual sex of people living with HIV. Among the difficulties are the fact that the negative public health implications of criminalization don’t submit easily to empirical analysis, and there is little space in criminal law doctrine for modified or contextualized versions of the rational actor.

Instead of seeking answers within traditional human rights and criminal law doctrine, I suggest that emerging conceptions of the right to health support existing but undertheorized and underdeveloped approaches that encourage collaboration between public health actors, criminal justice actors, and people living with HIV in addressing the potential for perverse public health effects and criminal justice’s blindness toward contextual factors that may affect moral blameworthiness. I argue that public health interventions have the capacity to be more targeted, flexible, and contextually informed than criminal justice approaches. Appropriately conceived, and informed by new themes in the right to health, such interventions can provide police and prosecutors with a richer factual record and a principled basis for deference to generate better-contextualized, more resonant justifications for the imposition of criminal sanction in this area.

C. As Long as You Have Your Health: Distribution of Publicly-Funded Health Care in Canada and Proceduralist Human Rights

The third paper expands on and further contextualizes the proceduralist turn in international human right to health and considers its implications for evaluating Canada’s
evolving structures for distributing public health care. Publicly-funded health care in Canada has been criticized for its ossified structures that unfairly prioritize access to hospital and physician services over “upstream” services including social determinants of health, for lack of transparency and accountability for determining which services do get funded and how they are designed, and for being beholden to entrenched professional and corporate interests.

Over the last twenty years, consistent with trends in public sector governance, each of Canada’s provinces has pursued a form of regionalization which both devolved and consolidated decisionmaking authority to sub-provincial regional units founded to varying degrees on principles of transparency, accountability, and stakeholder participation. In parallel, right to health scholars, advocates, and international institutions have increasingly relied on similar procedural devices to drive progressive realization of the right to health on the view that governance on the basis of transparency, participation, and accountability – including benchmarking and reporting requirements – will generate equitable, evidence-based distribution and therefore drive progressive realization.

Drawing on new governance literature and to emerging proceduralist conceptions in human rights, the paper considers how Canada’s regionalized governance structures may open its health care systems to human rights review and facilitate progressive realization. It suggests that both human rights and new governance theories support expanding the scope of services allocated through regionalized structures and for strengthening legislation in support of participation, transparency, and adoption of best practices including administrative sanctions. Where the intellectual frameworks of new
governance and proceduralist human rights do not align as neatly is over the role of predetermined normative positions and the extent to which existing human rights protections are required supplement and support deliberation. The paper concludes, consistent with the first and second papers, that human rights structures’ reliance on governance-based approaches may end up as a stepping stone en route to substantive definitions of the content of rights.

II. Research directions and theoretical tensions

A. The evolution of the project

As this project evolved, my focus gradually changed. I started out with an interest in judicial enforcement of social and economic rights, noticing that growing discussions about legislative-judicial dialogue or collaboration in rights definition and enforcement seemed to leave out some important ways in which judges shape legislative responses – through encouragement of things like public reporting, consultation, transparency in policymaking. By the end of my work on the first paper, I came to think more deeply about how the role of the courts are intertwined with other institutional actors, particularly in regard to SER enforcement. Reading the new governance literature suggested that the ultimate value of these kinds of judicial approaches – and their weaknesses – depended very much on the extent to which their themes are reflected in existing and emerging governance arrangements.

I chose the second project on criminalization of HIV exposure and transmission for a number of reasons. Following from my first paper, it was it was clear to me that meaningful responses to the human rights-based objections to criminalization could not
be expected to come from individual judicial decisionmaking. This conclusion derives from the necessary substantive fluidity of a right to health that fairly recognizes social determinants. Emerging conceptions of the human right to health explore an instinct, shared with new governance approaches, that right to health norm generation and enforcement must be "pushed outward and downward" within mediating institutions using procedural approaches directed toward ensuring reasonable, transparent decisionmaking that directed toward revealing and disentrenching illegitimate exercises of power. A final reason why I chose this topic is that HIV — along with women's rights — is the paradigmatic case driving the emerging focus in international human right to health on recognizing and mediating the indeterminacy of the very concept of health and its determinants through process-based, human rights-based participatory approaches. As a result, I felt that there would be traction for understanding relationships between communities and state institutions within governance structures here.

My analysis revealed that collaborations between criminal justice, public health and community actors in delimiting the scope of criminalization presented a promising way of addressing these shared instincts of new governance and the proceduralism in human rights and in particular the right to health. New governance theory also proved a fertile source of ideas for how to maximize the potential benefits of proceduralist approaches. So, for example, in response to the concern that police and prosecutors may see no reason to defer to public health actors collaborating with communities of people living with HIV (or their representatives), new governance would suggest closer monitoring of successful alternative to prosecution and flexible methods of determining successful diversion, and greater use of incentives to encourage police and prosecutor
collaboration in deliberative approaches. New governance could push the instinct reflected in new approaches to the right to health that inducing reflection and better understanding among police and prosecutors about root causes of human behavior might reveal and avoid arbitrary and ineffective policy.

At the same time, this narrow example revealed some areas of concern about the turn toward human rights proceduralism that are expressed throughout the three articles, in particular about weaknesses of deliberative processes in the context of marginalization that human rights approaches are meant to address. I feared I may have “cherry-picked” my case study: public health actors have historically been inclined to take seriously the real-life circumstances of communities where HIV risk is high because the success of their interventions have demonstrably depended on it. In addition, at least in North America, collaboration was facilitated by vocal and relatively united gay communities. In other words, collaborations may be promising in part because there has been an AIDS movement and state institutions that have historically been responsive to it.

In the final paper, I took on more direct assessment of perhaps the most far-reaching claim of the new proceduralism in the right to health – that it might provide an answer to the vexing question of measuring progressive realization and therefore lend greater meaning to the right to health in countries with well-developed public health care systems. In considering relationship between domestic governance structures and conceptions of the international human right to health, the third paper responds indirectly to a question left open in the first paper – whether key health institutions in Canada are structured in a way that would render them responsive to proceduralist approaches to developing and enforcing the substantive content of the right to health.
Much of the paper was directed at explaining how the human right to health and health care governance in Canada came to converge on common governance principles for eliminating illegitimate capture and creating space for more informed, evidence-based, democratically legitimate governance in determining how public health care resources in Canada are distributed. In relation to my overall project, my research confirmed my belief that new governance-like features in emerging structures for determining allocation of public health care resources in Canada could be leveraged to create spaces for proceduralist human rights approaches to thrive. In other words, it would not be a great step for domestic systems geared toward monitoring the effects of health allocation decisions on vaguely defined health-related outcomes to be expanded to include key right-to-health indicators.

The final paper also brought into focus key differences between proceduralist human rights and the new governance ideas upon which Canada’s move toward deliberative governance for distribution of health care resources are founded. In doing so, it drew out a number of persistent tensions in the move toward governance-based approaches to human rights reflected in all three of my papers. I turn to these now.

B. Some tensions implicit in the move toward human rights proceduralism

New governance, like proceduralist human rights, tends to depend heavily on participation to ensure that all important information will be brought forward for deliberation, and to allow decisionmaking to better take into account the needs of all stakeholders. Because proceduralist human rights approaches recognize that
disproportionate wielding of power lies at the root of many human rights abuses, the human rights project must address the longstanding concern expressed in critical analysis of new governance approaches that not all voices will be equal in deliberation. The final two papers reflect this challenge. In the paper on health care governance, even where deliberation was ostensibly open, experience revealed that traditionally more powerful voices wielded more influence. In collaborative approaches to criminalization, the voices of people living with HIV, as well as those belonging to groups at higher risk of infection, would resonate less loudly as risk is diffused among less unified groups and faithful representation through community organizations becomes more difficult. Moreover, even if power inequalities in deliberation could be addressed or minimized, deliberative approaches have not yet worked out what to do when majorities favor conceptions of right to health and its indicators that fail to align with normative assumptions of the human rights project.

A second tension thus follows: there is always a possibility, so long as inequalities in governance structures persist (as they necessarily will) and so long as majorities favor their own or irrational interests, that substantive outcomes generated by necessarily imperfect deliberative structures will fail to align with the normative inclinations reflected in existing and developing frameworks set out by human rights bodies and structures. New governance reflects a general anxiety about adopting too many fixed, prior normative conclusions. Human rights institutions and theorists, in embracing a system of thought that generally seeks to avoid adopting substantive norms at the outset,

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may relegate foundational human rights concept like human dignity to being just one more question for deliberation and negotiation. For example, the Committee on Economic, Social and Cultural Rights emphasizes the dignitary importance of end-of-life care. Should deliberative structures fail to generate indicators and outcomes that align with these assumptions – for example should they value investing in longer lives over end of life care – human rights proceduralists will be faced with a choice between accepting outcomes from what is ultimately a modified majoritarian governance structure or wielding top-down normativity.

Indeed, international human rights experts have developed draft sets of indicators which reflect broad substantive preconceptions about the issues that a state’s health framework must address to be human rights compliant. However provisional, these draft indicators suggest that substantive normativity retains an important place in guiding and framing the very proceduralist approaches that were developed in response to difficulties in ascertaining a normative core in relation to the right to health.

These tensions are not fatal to the proceduralist project, particularly for areas that have – like the criminalization of HIV exposure or the distribution of health resources within Canada’s single-payer system – substantially eluded meaningful human rights engagement. New governance-like approaches may generate deliberation about what qualifies as informed decisionmaking. It may open up spaces for participation of marginalized individuals around issues that human rights has determined it ought to have more of a say. It may thus remove informational obstacles to progressive realization of

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3 Paul Hunt & Gunilla Backman, *Health systems and the right to the highest attainable standard of health*, 10 HEALTH & HUM. R. 81–92, 83
the right to health, or to understanding and responding to different conceptions of the rational actor, as in the case of HIV exposure and transmission. But deliberation may also reveal potential abuse without necessarily addressing it. In doing so, it highlights the human rights project’s struggle between knowingness and unknowingness.

These tensions carry implications for how the proceduralist human rights project is understood going forward. First, given the central role played by participation, the human rights project will have to take seriously its own commitment to attend to the preconditions of capable participation and carefully monitor and consider responses to the implications of inequality or representative participation in deliberation for substantive outcomes.

Second, new governance-style proceduralism within the human rights project should not be understood as an alternative to traditional methods of norm-setting and enforcement, but as a supplement. In all three papers, I suggested that governance-based approaches might inform and enrich the factual record with which traditional decisionmaking is made. The relative importance of procedural to the substantive in the human rights project will depend on how much remains relegated to the sphere of the “unknowable”. This may shift over time, and may be affected by information generated through proceduralist approaches.

A modest appreciation of the proceduralist project is therefore appropriate: it sets out to re-politicize, or politicize differently, decisionmaking in key areas identified as closely connected to human dignity that have proved resistant to traditional forms of human rights analysis. The precise modalities and implications of this re-framing may
only become known as the proceduralist project, still in its infancy, plays out. The extent to which the reliance on governance will succeed in satisfying expectations of right to health proceduralists will depend in part on structural features surrounding the proceduralist approaches, as well as on the extent to which normative goals of human rights ultimately align with norms that deliberative structures are able to draw out. The move toward proceduralism in human rights may be best understood, for now, as setting out new terrains for human rights struggle and new sites for revealing previously hidden abuses of power.
JUDGING AS NUDGING: NEW GOVERNANCE APPROACHES FOR THE ENFORCEMENT OF CONSTITUTIONAL SOCIAL AND ECONOMIC RIGHTS

Alana Klein*

ABSTRACT

There is little agreement among legal thinkers about whether and how courts can competently and legitimately enforce constitutional social and economic rights (SERs). The principal concern is that judicial enforcement would require courts to design and manage costly social welfare programs, tasks for which judges lack the requisite democratic mandate and institutional expertise. However, courts have been increasingly willing to enforce SERs in recent years while remaining mindful of limits on their institutional capacity to do so. This article classifies and critiques the dominant ways that such courts—primarily in Canada, the United States, and South Africa—enforce SERs. It concludes that the prevailing approaches are weakest where governments have done the least to fulfill their constitutional SER obligations. Further, this article identifies emerging approaches that require structured accountability in government efforts toward SER realization. It suggests that these approaches, understood within the context of new governance or

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"experimentalist" theory, better provide for the effective, coherent, and competent enforcement of SERs in the face of government recalcitrance than do the prevailing tools. The paper concludes with a case study assessing the usefulness of experimentalist SER enforcement with reference to a possible right to health under the Canadian Constitution.

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INTRODUCTION

Most new constitutions protect a number of so-called social and economic rights (SERs),\(^1\) such as rights to education, housing,

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1. I note at the outset the problem of defining social and economic rights. The current sharp distinction frequently drawn between civil and political rights, on the one hand, and social, economic, and cultural rights, on the other, can be traced in part to the creation, after the Universal Declaration of Human Rights, G.A. Res. 217A (III), U.N. Doc. A/771, at 71 (Dec. 10, 1948), of two separate international human rights treaties—the International Covenant on Civil and Political Rights, Dec. 16, 1966, 999 U.N.T.S. 171 (hereinafter "ICCPR") and the International Covenant on Economic, Social and Cultural Rights, Dec. 16, 1966, 999 U.N.T.S. 3 (hereinafter "ICESCR"). However, I do not confine my discussion to the rights catalogued in these international instruments because I am
health care, welfare and the like. But there is little agreement on what, if anything, courts can do when governments are acting slowly, haphazardly, foolishly, in bad faith, or not at all in fulfillment of these kinds of positive constitutional obligations. If a constitution guarantees a right to decent housing, for example, and the government has not made sufficient public housing stock available, what can courts offer a homeless person who seeks to challenge government policy or to obtain housing that the constitution appears to promise?

Traditionally, many legal thinkers have opposed the inclusion of SERs in bills of rights, arguing that constitutional rights must be enforceable in courts in order to be meaningful but that courts would stray too far from their legitimate role in a constitutional democracy if they adjudicated these kinds of rights. Their essential argument is that SERs are too vague, costly, and institutionally complex for the judiciary to implement. In order to enforce a housing guarantee in the face of government neglect, for example, courts might have to design housing programs, require money be spent to implement them, and perhaps even take over their administration. Thus, it is argued, courts cannot enforce SERs without usurping the role of the legislative and/or administrative primarily concerned with domestic constitutional guarantees, which vary and do not mirror the international guarantees precisely. Here, I define social and economic rights roughly as rights against the government for the satisfaction of basic needs, including food, shelter, education, healthcare, and the like. Some authors refer to these as social welfare rights. See, e.g., Mark Tushnet, Social Welfare Rights and the Forms of Judicial Review, 82 Tex. L. Rev. 1895 (2004). Others simply call them welfare rights. See, e.g., Frank I. Michelman, In Pursuit of Constitutional Welfare Rights: One View of Rawls’ Theory of Justice, 121 U. Pa. L. Rev. 962 (1973). Avi-Ben Bassat and Momi Dahan provide the following definition of social rights: “A constitutional social right is . . . one that grants a personal entitlement to monetary transfers (including social insurance) or transfer in kind on a universal basis.” Avi-Ben-Bassat & Momi Dahan, Social Rights in the Constitution and in Practice (Hebrew U. of Jerusalem, Sch. of Pub. Policy Working Paper No. 05-03, May 2003), available at http://papers.ssrn.com/sol3/papers.cfm?abstract_id=407260.

2. See Mary Ann Glendon, Rights in Twentieth-Century Constitutions, 59 U. Chi. L. Rev. 519, 521 (1992) ("[T]he constitutions of . . . most . . . liberal democracies . . . contain[] . . . language establishing affirmative welfare rights or obligations.").

3. See infra notes 23–77 and accompanying text. Some might oppose the protection of SERs on ideological grounds. I leave these objections aside for the purposes of this essay and focus instead on the legitimacy and capacity concerns.
branches of government. In response, defenders of SERs have pointed out conceptual flaws in rigid distinctions between civil and political rights (CPRs) on the one hand and SERs on the other that place only the latter outside judicial reach.¹

Yet even those who argue for a robust judicial role in the enforcement of SERs admit that their full implementation threatens to strain judicial capacities and push boundaries of judicial legitimacy.⁵ There is no single comprehensive theory of the judicial role in enforcement even among the SER-friendly. Those who favor adjudication of SERs agree that courts ought to share the task of defining and enforcing the rights with government and other actors, but there is little agreement on how.

Current prevailing approaches to SER enforcement work best where governments are willing to follow the judicial lead or where governments have already taken steps toward fulfilling their obligations. These prevailing approaches, however, leave courts facing a negligent or recalcitrant government with a choice between more aggressively setting out and enforcing the precise details of government obligations or backing away from enforcement. This dynamic limits the potential of courts to meaningfully guarantee SERs when judicial protection is most needed—where majoritarian politics neglect them. The result is haphazard enforcement that fails to protect vulnerable minorities against the majority's neglect. From the point of view of would-be rights claimants, haphazard judicial enforcement may be better than no enforcement at all. A more comprehensive jurisprudential method that does not give governments the power to avoid or frustrate adjudication would more consistently hold governments to their constitutional obligations.

Recently, some courts have turned to deferential modes of review and remedial approaches to enforce SERs.⁶ These approaches leave governments considerable flexibility in how they fulfill SERs, but still allow citizens to use the courts to force governments to demonstrate reasonable progress toward that end. A problem with these approaches is that they can be unstable: courts seeking to meaningfully enforce SERs may have difficulty maintaining a deferential stance where governments do not respond to their

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4. See infra notes 78–91 and accompanying text.
5. See infra notes 91–94 and accompanying text.
6. See infra Parts II.B & III.
satisfaction.

It can be argued that the principal benefit of deferential styles of judicial review is that they require governments to account for choices that affect SER outcomes as part of their constitutional obligations. A focus on accountability can help to reconceive the role of courts and their relationship to political actors and civil society in a manner more hospitable to SER enforcement than traditional views of rights as trumps.7

The most developed and theorized accountability-centered approaches to constitutional rights realization have been called experimentalist.4 Experimentalist systems require participation of all stakeholders in defining goals and measuring SER achievement at a local level,9 and require political units to measure and share data about progress toward these goals and to adopt best practices of other units.10 Courts ensure that there is appropriate consultation, reporting, and adoption of best practices.11 They may also contribute to the creation of experimentalist systems by suggesting that such governance systems meet SER obligations.

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7. See generally Ronald Dworkin, Rights as Trumps, in Theories of Rights 153 (Jeremy Waldron ed., 1984) (arguing that rights should be understood as trumps over justifications for political decisions that focus on the goals of the community as a whole); Ronald Dworkin, Taking Rights Seriously 82-90, 131-49, 194 (1977).


10. Id. at 341–56.
11. Id. at 388–404.
Experimentalist governance systems seem particularly well-suited to the protection of SERs. They may guard against stagnation by generating information and providing a process-based engine for change.\textsuperscript{12} These governance systems require governments to demonstrate progress and to seriously consider input from stakeholders, including the poorest and least powerful members of society who are often neglected in majoritarian politics.\textsuperscript{13} As experimentalist approaches to constitutional rights realization consider rights to be constantly under development, they accommodate concerns about the indeterminacy of SERs.\textsuperscript{14} They also allow the content of rights to be developed through more direct democratic participation in addition to or instead of judicial exposition.\textsuperscript{15}

The constitutional jurisprudence of several jurisdictions supports experimentalist, governance-based approaches to protecting SERs. This paper examines the enforcement of positive constitutional SERs in the United States, South Africa, and Canada. I suggest that judges supporting deliberative enforcement regimes, which focus on measuring the effects of SER policy, may be able to move beyond the democracy-versus-enforcement muddle that has stymied attempts to carve a meaningful, coherent role for courts in constitutional SER definition and protection. Where experimentalist systems work best, they can more fruitfully draw upon a polity’s commitments to SER norms than either ordinary majoritarian politics or traditional judicial decision-making.

At the same time, because these approaches are procedural and somewhat hostile to judicial articulation of substantive norms, they do not provide answers about what judges should do if the systems fail to generate results that live up to judges’ senses of what the constitution requires. Where experimentalism does not produce optimal SER outcomes, judges will face the familiar choice between declaring the system a failure and articulating their own vision of the content of SERs or withdrawing from the field due to institutional incapacity. Even in an optimally functioning experimentalist system, however, the level of popular commitment to SER norms will limit

\begin{itemize}
  \item \textsuperscript{12} \textit{Id.} at 314–23.
  \item \textsuperscript{13} \textit{Id.}
  \item \textsuperscript{14} \textit{Id.} at 444–69.
  \item \textsuperscript{15} \textit{Id.}
\end{itemize}
their realization. Ultimately, it is this very constraint that might retain the legitimacy of judicial enforcement of SERs under a well-functioning experimentalist system.

This paper proceeds in six parts. Part I sets out the traditional concerns associated with the constitutional enforcement of SERs. Part II identifies and criticizes the dominant approaches to SER enforcement. It suggests that these approaches, in seeking to avoid drawing courts too far outside their proper sphere, are unlikely to contribute significantly to the systematic implementation of SERs, particularly when there is government resistance. Part III discusses and evaluates a shift toward judicially-mandated accountability as a remedy where courts reach the limits of their capacity to define and enforce SERs. Part IV introduces experimentalist approaches and suggests that they provide a promising method of ensuring that positive SER outcomes are achieved by shifting the judicial focus from the substantive content of rights to the procedures through which content is developed. Part V presents a case study of the potential of experimentalism for addressing constitutional rights related to health care in Canada. Finally, part VI discusses the limits of experimentalist approaches.

I. SOCIAL AND ECONOMIC RIGHTS AND THE PROBLEM OF JUSTICIABILITY

Other than political will,16 perhaps the biggest obstacles to ensuring the faithful, meaningful judicial enforcement of SERs are (1) their perceived cost, (2) the lack of agreed-upon standards for the meaning of SERs, and (3) the view that rights enforcement requires agreed-upon standards.17 Traditionally, many legal thinkers have opposed constitutionalizing SERs on the basis that constitutional rights must be enforced in courts in order to be meaningful and that

16. For an exhaustive discussion of the moral and philosophical case for the inclusion of SERs in a constitution, see Cécile Fabre, Social Rights Under the Constitution (2000).

judicial articulation and enforcement would take courts too far outside their legitimate role in a constitutional democracy. This view has led some constitution drafters to omit SERs from bills of

18. See Cass R. Sunstein, Against Positive Rights, in Western Rights? Post-Communist Application 226, 225–29 (András Sajó ed., 1996) (hereinafter Sunstein, Against Positive Rights) (arguing that social and economic rights should not be included in constitutions of Eastern European countries shifting from communist to capitalist systems). But see Cass R. Sunstein, The Second Bill of Rights 228 (2004) (hereinafter Second Bill of Rights) (arguing that the South African Constitutional Court’s approach to social and economic rights “has provided the most convincing rebuttal yet to the claim that judicial protection of SERs could not possibly work in practice”). See also Joel Bakan, What’s Wrong with Social Rights?, in Social Justice and the Constitution: Perspectives on a Social Union for Canada 85, 86 (Joel Bakan & David Schneiderman eds., 1992) (arguing that entrenched SERs will not live up to their promise because they are “too vague to guarantee anything of substance, do not touch the complicated causes of poverty and disadvantage, and their symbolic message is at best ambiguous”); David Beatty, The Last Generation: When Rights Lose Their Meaning, in Human Rights and Judicial Review: A Comparative Perspective 821, 850 (David M. Beatty ed., 1994) (arguing that judicial enforceability of social and economic rights would give courts power to determine government priorities which would threaten the separation of powers); Frank B. Cross, The Error of Positive Rights, 48 UCLA L. Rev. 857, 880–83 (2001) (arguing that the recognition of positive rights to public assistance would be ineffective given the economic and political realities of judicial enforcement of rights); Wiktor Osiatynski, Social and Economic Rights, in Western Rights? Post-Communist Application 233, 238 (András Sajó ed., 1996) (arguing that “the more [SERs there are] in the constitution, the less enforceable [are] those rights” and that “the constitutionalization of social and economic rights does not result in their automatic protection”); D. M. Davis, The Case Against the Inclusion of Socio-Economic Demands in a Bill of Rights Except as Directive Principles, 8 S. Afr. J. Hum. Rts. 475 (1992) (arguing that because SERs are judicially unmanageable, the new South African bill of rights should treat SERs as guiding principles for legislation and grounds for setting aside legislation that violate them); Michael J. Dennis & David P. Stewart, Justiciability of Economic, Social and Cultural Rights: Should There Be an International Complaints Mechanism to Adjudicate Rights to Food, Water, Housing and Health?, 96 Am. J. Intl L. 462, 475 (2004) (arguing against the creation of an individual complaints mechanism for the implementation of the ICESCR on the ground that adjudication of SERs will not “contribute to a practical, useful resolution of the issue at hand, which relevant parties will, in turn, respect and implement”); E.W. Vierdag, The Legal Nature of the Rights Granted by the International Covenant on Economic, Social and Cultural Rights, 9 Neth. Y.B. Intl L. 69, 73 (1978) (arguing that the term “right” should be reserved for those rights “that are capable of being enforced by their bearers in courts of law, or in a comparable manner”).

rights entirely, or to include them but declare that they cannot be judicially enforced. Courts have also declined to read rights to education, medical services, housing, and subsistence-level social assistance into existing bills of rights owing, at least in part, to concerns about the justiciability of SERs.

There are no clear a priori criteria for determining justiciability. Definitions tend to sound circular: a question is justiciable when it is apt for judicial solution. Whether a question is

19. See, e.g., Paul Hunt, Reclaiming Social Rights 43-53 (1996) (tracing concerns about judicial enforceability in the debate over whether to include second generation rights in the New Zealand Bill of Rights and the country’s eventual decision to adopt an eighteenth-century style bill of rights containing mainly civil and political rights).

20. See, e.g., Ir. Const., 1937, art. 45 (“The principles of social policy set forth in this Article are intended for the general guidance of the Oireachtas. The application of those principles in the making of laws shall be the care of the Oireachtas exclusively, and shall not be cognizable by any Court under any of the provisions of this Constitution.”); India Const. art. 37 (“The provisions contained in this Part shall not be enforced by any court, but the principles therein laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the State to apply these principles in making laws.”).

21. See, e.g., San Antonio Independent School District v. Rodriguez, 411 U.S. 1, 12 (1973) (“We have carefully considered each of the arguments supportive of the District Court’s finding that education is a fundamental right or liberty and have found those arguments unpersuasive.”).

22. See, e.g., Harris v. McRae, 448 U.S. 297, 318, n. 20 (1980) (holding there is no constitutional obligation to provide assistance to indigent women seeking medically necessary abortions).

23. See, e.g., Lindsey v. Nemerz, 405 U.S. 56, 74 (1972) (holding that there is no fundamental right to housing).

24. See, e.g., Gosselin v. Quebec (A.G.) [2002] 4 S.C.R. 421 (Can.) (“The question therefore is not whether s. 7 has ever been—or will ever be—recognized as creating positive rights. Rather, the question is whether the present circumstances warrant a novel application of s. 7 as the basis for a positive state obligation to guarantee adequate living standards. I conclude that they do not.”); Dandridge v. Williams, 397 U.S. 471, 487 (1970) (stating famously, “the intractable economic, social, and even philosophical problems presented by public welfare assistance programs are not the business of this Court”).

justiciable depends exactly on what courts in any given system are (or ought to be) willing to adjudicate. 26 As Scott and Macklem have observed,

Justiciability is a deceptive term because its legalistic tone can convey the impression that what is or is not justiciable inheres in the judicial function and is written in stone. In fact, the reverse is true: not only is justiciability variable from context to context, but its content varies over time. Justiciability is a contingent and fluid notion dependent on various assumptions concerning the role of the judiciary in a given place at a given time as well as on it changing character and evolving capability. 27

Although some constitutions do specify in positive terms which rights can be judicially enforced, 28 for the most part courts have themselves developed their own justiciability doctrines. 29 And indeed, many courts faced with claims relating to social welfare rights have found those rights to be outside judicial competence. 30

The essential argument against the justiciability of SERs is that they are vague, costly, and institutionally complex to implement. 31 A court setting out the content of government obligations to provide food, housing, health care, education and the like 32 would, it is feared, dictate how much of the budget is spent

(stating that a right is justiciable when “the terms leave interpreters with little room for serious dispute about how to apply them”).

26. Dennis & Stewart, supra note 18, at 474–75 (arguing for a “more substantive” approach to justiciability that asks whether adjudication will “contribute to a practical, useful resolution of the issue at hand which the relevant parties will, in turn, respect and implement”).


28. See supra notes 19–24 and accompanying text.

29. For example, the doctrines of mootness, ripeness, standing, and political questions have been developed mainly through judicial decisions. See generally Richard H. Fallon, Daniel J. Meltzer & David L. Shapiro, Hart and Wechsler’s The Federal Courts and the Federal System 114–253 (5th ed. 1996); Lorne M. Sossin, Boundaries of Judicial Review: The Law of Justiciability in Canada 27–199 (1999).

30. See supra notes 21–24.

31. See supra note 8.

32. The view that SERs cannot be enforced in courts results, at least in part, from a perception that SERs impose positive obligations on governments to
that it would set vast tracts of social policy with neither popular legitimacy nor the necessary expertise and factual information for designing social institutions. In order to enforce a housing guarantee in the face of government neglect, for example, courts might have to design housing programs, require money to be spent to implement them, and perhaps even take over their administration. Thus, it is argued, courts cannot enforce SERs without usurping the role of the legislative and/or administrative branches of government.

In response, defenders of SERs have pointed out conceptual flaws in rigid distinctions between civil and political rights (CPRs) and SERs that place only the latter outside judicial reach. The enforcement of CPRs can also have cost implications, require interpretation of constitutional text, or lead courts to require positive government action.

Yet even those who argue for a robust judicial role in the enforcement of SERs admit that their full implementation threatens to strain judicial capacities and push boundaries of the judicial role. Although SER adjudication may not present challenges of a unique nature, it may give rise to familiar problems to a greater degree.

create programs in relation to housing, health care, education and the like. Although SER protection may not in all circumstances require positive government action (see infra notes 82 to 89 and accompanying text), I set out the arguments against constitutional rights assuming, as the critics do, that full realization of SERs often requires positive government action. See Scott & Macklem, supra note 27, at 45 (observing that “the strongest critics of social rights . . . have difficulty conceptualizing social rights as being anything but positive”).

33. Scott & Macklem, supra note 27; Victor Abramovich, Courses of Action in Economic, Social and Cultural Rights: Instruments and Allies, 2 Int. J. on Hum. Rts. 181, 186 (2005) (suggesting that SERs and CPRs can be analyzed within a continuum of negative and positive obligations).

34. Scott & Macklem, supra note 27, at 43; Abramovich, supra note 33, at 187.

35. See, e.g., Scott & Macklem, supra note 27, at 43–45 (noting that some scholars “have argued that social rights should be treated as nonjusticiable . . . because the courts are perceived as institutionally incompetent institutions” that are better suited to “demarcate the limits of negative liberty”); Abramovich, supra note 33, at 193 (noting that the judiciary is ill-suited to determine public policy priorities, lacks the means to compel governments to provide new services, and could create new inequalities in ad hoc adjudication).

36. See Mauro Capelletti, The Judicial Process in Comparative Perspective 150 (1989) (“[I] am very skeptical about the possibility of drawing an abstract line to determine how far judicial review can legitimately go.”); Tushnet, supra note 1,
Even the strongest SER proponents acknowledge that new, potentially high economic costs, a lack of agreement over the content of SERs, and the institutional complexity that might be involved in remedying SER violations may present special challenges to the individual enforcement of positive, self-standing SERs. Frank Michelman, for example, suggests that courts should avoid cutting welfare rights “out of whole cloth of speculative moral theory... and foist[ing] them on recalcitrant legislatures.” Nonetheless, proponents argue, once a society accepts that a constitutional system without a social rights guarantee is illegitimate, “political liberals are not free just to shuck the belief if it happens to become theoretically inconvenient.” A government’s failure to meaningfully deliver SERs may raise as many legitimacy concerns as the judicial enforcement of these rights.

II. DOMINANT APPROACHES TO SER ENFORCEMENT

Three broad (and to some extent overlapping) approaches to conceiving of and enforcing constitutional SERs predominate in light of justiciability concerns. According to the first—nonjusticiability—SERs should be treated as norms by which all constitutional actors ought to guide their behavior, but should not form the sole basis of an individual constitutional challenge in court. The second—case-by-case—suggests that individual enforcement of SERs need not place too great a strain on judicial capacities in every circumstance, and courts ought to implement SERs using traditional tools where concerns about judicial capacity and usurpation of the legislative role are attenuated. Under a third, more recent approach, individuals can challenge government policies (or lack of policies) that affect SERs, but judicial review is deferential, allowing government

at 1897; Schachter v. Canada, [1992] 2 S.C.R. 679, 709 (Can.) (extending a legislative paternity benefit scheme to adoptive fathers and stating that although any court-ordered remedy will have budgetary repurcussion, “[a] remedy which entails an intrusion into this sphere so substantial as to change the nature of the legislative scheme in question is clearly inappropriate”).

37. Michelman, supra note 1, at 1010.
39. Frank Michelman, an early advocate of judicial enforcement of SERs, seems to adopt this view. See supra note 25.
40. See infra notes 44–74.
flexibility to design programs aimed at fulfilling SERs. According to this last model—administrative-style-review—courts set the broad bounds within which government can operate and interfere only when governments fail to act or where governments fail to show that policies are reasonably directed toward SER fulfillment. In this way, courts would leave the government both to develop the content of rights and to determine remedies for SER violations.

Neither of the first two approaches is sufficient to hold negligent or recalcitrant governments to their SER obligations. The third approach appears more promising but has been justly criticized as unstable: in the event of government recalcitrance, courts might be tempted to intervene too much or shy away from the confrontation and intervene too little. In this section, I set out each of these approaches and assess their potential for holding governments accountable for SER obligations.

A. Case-by-case Justiciability Assessment

Some SER proponents suggest that courts can and should adjudicate individual claims to SERs in some circumstances, without venturing further than their judicial role in enforcing traditional CPRs. Instead of declaring particular kinds of rights to be prima facie non-justiciable, courts ought to gauge the extent to which adjudication of a particular case risks drawing courts outside their proper role. Where concerns around judicial capacity and legitimacy


42. See infra Part II.B.

43. See Tushnet, supra note 1, at 1909–12 (finding that courts sometimes ratchet up substantive requirements, set benchmarks, and sometimes loosen requirements in response to new facts).

44. See, e.g., Scott & Macklem, supra note 27; David Wiseman, The Charter and Poverty: Beyond Injusticiability, 51 U. Toronto L. J. 425, 441 (2001) (arguing that distinctions between negative and positive rights are "ill-founded" and that the courts do not successfully account for the fundamental values underlying SER claims); Michelman, supra note 1; Abramovich, supra note 33, at 183–85 (arguing that the difference between SERs and CPRs is more one of degree than kind).
are sufficiently low, the claim should be justiciable. A number of factors may be relevant to the justiciability of a particular claim.

For example, the constitutional text might specify clear and precise SER obligations, leaving little room for judicial interpretation or "policy-making". Thus, the Supreme Court of Canada has enforced positive minority language education rights but has refused to read a right to basic subsistence or health care into Section 7 of the Canadian Charter of Rights and Freedoms. Its reluctance may be due to the extent of judicial interpretation required to find a right to health, or a right to welfare in the relatively imprecise guarantee of "security of the person."

Similarly, enforcement might be less problematic where a constitutional text specifies few, but very precise SERs. Aggressive judicial enforcement of the narrower category of Canadian minority language education rights would have a relatively low impact on government policies compared with a judicially-enforced right to health care or welfare.

The historical context of a guarantee might reduce uncertainty as to its meaning and purpose, attenuating concerns about judicial lawmaking. Courts in Canada and in South Africa have invoked the remedial purposes of constitutional housing guarantees and minority language education rights, respectively, as justifications for intervening in the face of government neglect.

45. See Wiseman, supra note 44, at 441, 448; Abramovich, supra note 33, at 192.
46. Guzdon, 4 S.C.R. 421 at para. 69.
49. See also 1975 Syntagma [SYN] [Constitution] Art. 21(2), 22(1) (Greece) ("All persons have the right to be protected from the collection, processing, and use, especially by electronic means, of their personal data, as specified by law."); Const. Art. 38(3) (Italy) ("Disabled and handicapped persons are entitled to education and vocational training.").
50. Both the Canadian and the South African constitutions contain SERs aimed at remedying historical injustice. S. Afr. Const. 1996, Ch. II, §§ 26-27, see infra note 88 and accompanying text; see also Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982, ch. 11, §23 (U.K.). Canada's constitutional minority language education rights were designed to prevent the progressive erosion of official minority language groups in Canada, preserve their culture, and encourage their...
Courts might also consider the extent to which legislation, prior judicial decisions, and society have elaborated the content of a right. Where governments have acted toward fulfillment of particular rights, courts might look at this activity as a legitimate democratic expression of the content of the right.\textsuperscript{51}

In addition, where the protection of constitutional rights can be achieved without significantly realigning government priorities, the need for deference is diminished because the effect on competing priorities is lessened. Governments may have already committed

\begin{quote}

\textsuperscript{51} See Lawrence Sager, \textit{Justice in Plain Clothes: Reflections on the Thinness of Constitutional Law}, 88 Nw. U. L. Rev. 410, 429 (1983) ("In some cases, the Court ought to be able to act on entitlements associated with minimum welfare once other institutions of government have acted and created contexts in which the issue of right surfaces largely unencumbered by other questions."). In United States v. Burns, [2001] 1 S.C.R. 283, for example, the Supreme Court of Canada held that it is unconstitutional for Canada to extradite two men wanted for murder to a jurisdiction that might impose the death penalty unless assured that it would not. In support of its decision, which reversed two earlier Supreme Court rulings, the Court referred, \textit{inter alia}, to Canada's international advocacy against the death penalty and its domestic abolition of the death penalty as reflections of the fundamental Canadian view that the death penalty violates the right to liberty and security of the person. The court stated: "While government policy at any particular moment may or may not be consistent with principles of fundamental justice, the fact that successive governments and Parliaments over a period of almost 40 years have refused to inflict the death penalty reflects, we believe, a fundamental Canadian principle about the appropriate limits of the criminal justice system." \textit{Burns}, [2001] 1 S.C.R. 283 at para. 75. See also Abramovich, \textit{supra} note 33, at 198 (describing the process by which a court "accepts a measure" created by the other branches of government, and then "transform[s] its character from a mere arbitrary decision into a constituted obligation").
\end{quote}
sufficient funds to fulfilling the right, allowing courts simply to take issue with the means.\textsuperscript{52} Government forbearance from rights-violating behavior might suffice to remedy the wrong under some circumstances.\textsuperscript{53}

Finally, courts should be mindful of the particular conception of separation of powers in the constitutional order in which they operate. Regarding the U.S. legal system, Helen Hershkoff suggests, for example, that the counter-majoritarian difficulty\textsuperscript{54} that militates against expansive federal judicial intervention is attenuated in the state context where state judges are popularly elected and retained,\textsuperscript{55} and where constitutional amendment is much easier.\textsuperscript{56}

Where, on the other hand, the content of a right is not clear from the constitutional text, prior judicial decisions, popular understandings, or legislation, and where enforcement threatens to have wide-ranging consequences on government allocative choices,


\textsuperscript{53} See infra notes 55–59 and accompanying text.

\textsuperscript{54} See, e.g., Alexander M. Bickel, The Least Dangerous Branch: The Supreme Court at the Bar of Politics 111, 128 (Yale University Press 1962) (1962) (describing how political democracy creates bounds within which the Court should exercise its powers); Paul W. Kahn, Community in Contemporary Constitutional Theory, 99 Yale L.J. 1, 7–16 (1989) (discussing Bickel's theory of judicial review and judicial legitimacy as linked to popular consent).

\textsuperscript{55} Helen Hershkoff, Positive Rights and State Constitutions: The Limits of Federal Rationality, 112 Harv. L. Rev. 1132, 1156 (1999) ("The fact of judicial election [subjects state judges] to a kind of popular veto that in theory sets a boundary or tether on judicial decisionmaking."). See also Burt Neuborne, Foreword: State Constitutions and the Evolution of Positive Rights, 20 Rutgers L.J. 881, 900 (1989) (listing the reasons why states enjoy on "enhanced democratic pedigree," including the fact that well over half of the nation's state judges are elected in some fashion).

\textsuperscript{56} Hershkoff, supra note 55, at 1170; Neil E. Komesar, Imperfect Alternatives: Choosing Institutions, in Law, Economics, and Public Policy 3, 12 (Timothy R. Ryan ed., 1994) (urging "comparative institutional analysis" that avoids reliance on "idealized institutional conceptions"); Martha Minow, Making All the Difference: Inclusion, Exclusion and American Law 362 (1990) ("Questions of separation of powers concern not so much whether one branch has invaded the prerogatives of another as whether the branches all remain able to participate in the process of mutually defining their boundaries.").
courts using the case-by-case approach should be reluctant to intervene.

The case-by-case approach suffers from a few fundamental weaknesses, however. First, it may be difficult to determine when justiciability concerns are in fact sufficiently attenuated and thus, judicial implementation may appear haphazard. In addition, to the extent that courts treat legislation as partially fulfilling constitutional norms, case-by-case adjudication risks discouraging legislative experimentation. Perversely, courts have less ability to intervene when an SER has been neglected by other actors. This is at least arbitrary and possibly contrary to the purpose of constitutionalizing rights. Some examples illustrate these difficulties.

1. SERs as Negative Rights

The case-by-case approach underlies the assertion, common among SER proponents, that courts can enforce SERs that are negative rights. Where SERs can be enforced by prohibiting, rather than requiring government conduct, there may be fewer concerns both about new government spending and about judicial capacity to design and implement social programs. Many argue that this type

57. Some question the conceptual distinction between positive and negative rights. See Stephen Holmes & Cass R. Sunstein, The Cost of Rights 26 (1999) (contending that all rights require government enforcement and can therefore be seen as positive rights); Susan R. Bandes, The Negative Constitution: A Critique, 88 Mich. L. Rev. 2271, 2297–305 (1990) (arguing that as a practical matter, there is little difference today between a government penalty and a refusal to extend a subsidy); Amartya Sen, Resources, Values and Development 513 (1994) (noting that while there is a distinction between a “positive assertion” and a “negative assertion” of rights, “valuing negative freedom” itself “must have some positive implications”) (emphasis in original); Scott & Macklem, supra note 27, at 46 (arguing that the difference between positive and negative rights depends on one's choice of baseline). Despite this difficulty in distinguishing negative rights from positive ones in the abstract, the positive/negative distinction has had practical significance, as courts have tended not to question the normative baseline. Thus, Sunstein questions the distinction between positive and negative rights, and yet continues to use it “for ease of exposition.” Sunstein, Against Positive Rights, supra note 18, at 225–26; see also Cross, supra note 18, at 864–68 (defending the distinction and setting out its importance in the American Bill of Rights).

58. The argument is that any right, whether traditionally considered to fall in the civil and political category or the social and economic category, can give rise to numerous kinds of obligations, some positive and some negative.
of judicial enforcement may not raise concerns about judicial legitimacy and competence.\textsuperscript{59} For example, the Supreme Court of India has imposed a duty on the Bombay municipality not to evict pavement-dwellers without prior notice and without providing them with other sites for resettlement.\textsuperscript{60}

Concerns about judicial capacity and legitimacy may persist, however, even when rights are conceived as negative. For example, a court might not have the requisite facts or expertise to pass judgment on a government's attempt to decrease public dependence on state funds by choosing to scale back direct welfare payments in favor of a welfare-to-work program. This kind of difficult decision might lead a court using the case-by-case approach to refuse to give relief when the applicant seeks relief that would require far-reaching realignment of government priorities or practices even as it is willing to decide cases challenging a particular eviction. The result is that protection of SERs will appear haphazard. Judicial treatment of SERs as negative rights thus permits governments to avoid fulfilling them either by embedding the denial within government policy schemes or by failing to implement any programs at all.

Conceptualizing SERs as negative rights avoids the concern that courts will engage in large-scale realignment of government budgets. \textit{See} Henry Shue, \textit{Basic Rights: Subsistence, Affluence and Foreign Policy} 53 (2d. ed. 1966) (arguing for the recognition of subsistence rights generally and arguing that all basic rights have both positive and negative dimensions, referring to duties to respect, protect and fulfill); Hunt, \textit{supra} note 19, at 32 (similar); Scott & Macklem, \textit{supra} note 27, at 74 (similar); Ashjorn Eide, \textit{Economic, Social and Cultural Rights as Human Rights, in Economic, Social and Cultural Rights: A Textbook} 26 (Ashjorn Eide et al. eds., 2d ed. 2001) (giving a brief overview of the International Bill of Human Rights and later discussing the resources necessary to achieve the international human rights standard).

59. \textit{See} Eide, \textit{supra} note 58, at 25 ("Economic and social rights . . . can in many cases best be safeguarded through non-interference by the state with the freedom and use of resources possessed by the individuals.").

2. Gap-filling

A court might also be able to impose some positive obligations with the case-by-case approach by, for example, filling in gaps in programs that governments have already substantially designed or where enforcement would be relatively inexpensive. In countries that already have relatively thick systems of social service provision, courts might be able to enforce SERs by policing arbitrary legislative or government decisions and distinctions in ways that do not either require massive public spending or significantly alter the government’s chosen means for addressing basic needs. So for example, the New York Court of Appeals has interpreted the state’s positive constitutional welfare right as prohibiting the legislature from “refusing to aid those it has classified as needy” by erecting procedural barriers to aid that have nothing to do with need.

Similarly, in Gosselin v. Quebec (Attorney General), two dissenting Supreme Court of Canada Justices would have struck down a Quebec “workfare” law as a violation of the security of the person guarantee in Section 7 of the Canadian Charter of Rights and

61. This kind of “gap-filling” can be distinguished from judicial gap-filling in statutory cases. In the latter context, judges can be expected to rely, at least partly, on the intent of the legislature in interpreting a statute. See Cass R. Sunstein, Interpreting Statutes in the Regulatory State, 103 Harv. L. Rev. 405, 411 (1989) (describing the necessity of consulting “background principles” drawn from context and “legal culture” in order to interpret statutes); John P. Manning, Legal Realism and the Canon’s Revival, 5 Green Bag 2d 383, 395 (2002) (citing Sunstein on the deficiencies of textualism and the interpretive problems inherent in consulting legislative intent to supplement those deficiencies). In the context of enforcing constitutional SERs, judges engaged in gap-filling might make decisions that are explicitly contrary to the intent of the legislature. See, e.g., notes 65–75 and accompanying text.

62. N.Y. Const. art. 17, § 1 (“The aid, care and support of the needy are public concerns and shall be provided by the state and by such of its subdivisions, and in such manner and by such means as the legislature may from time to time determine.”).

63. Tucker v. Toia, 371 N.E. 2d 449, 452 (N.Y. 1977) (holding that the state cannot deny home relief to people under twenty-one years old who are classified as needy under the state’s regulations, but who cannot provide court orders proving that their parents were not supporting them); see also Minino v. Perales, 589 N.E. 2d 385 (N.Y. 1992) (holding that the state cannot deny benefits to legal immigrants who are unable to produce information about their sponsor’s income despite their best efforts).

64. Gosselin, 4 S.C.R. 429 (Can.).
Freedoms. The law reduced social assistance benefits for people under thirty who failed to participate in work or education programs. Justice Arbour, dissenting, found that Section 7 of the Charter could be read to impose positive obligations on the government to provide the basic means of subsistence and that the state, by enacting a social assistance scheme, had engaged in sufficient state action to trigger these obligations. Since the under-thirtys could not survive on their reduced benefits, according to Justice Arbour, their right to security of the person was violated.

Justice Arbour acknowledged that concerns about justiciability were valid. Nonetheless, she held, the Court could legitimately and competently acknowledge the right without stepping outside its proper role. The only truly non-justiciable question in her view was setting out precisely "what is required, or how much expenditure is needed, in order to safeguard the right." But because the Quebec Legislature had already set out a basic level of welfare designed to meet the ordinary needs of a single adult, she concluded the court was relieved of this responsibility. It could simply require that the government provide this amount for everyone. The welfare right under Section 7 would not be unlike that of the New York state

65. The majority held that § 7 of the Canadian Charter of Rights and Freedoms might one day be interpreted to place positive obligations on the government to guarantee adequate living standards, but that the case at bar did not provide sufficient evidence to support such an interpretation of § 7. Justice McLachlin stated:

I leave open the possibility that a positive obligation to sustain life, liberty, or security of the person may be made out in special circumstances. However, this is not such a case. The impugned program contained compensatory 'welfare' provisions and the evidence of actual hardship is wanting. The frail platform provided by the facts of this case cannot support the weight of a positive state obligation of citizen support.

Id. at para. 82.
66. Id. at para. 326.
67. Id. at para. 330.
68. Id. at para. 331. Justice Arbour's reasoning is consistent with the view of Canadian constitutional scholar David Beatty. Arguing against the judicial protection of subjective, individual social and economic rights, he has stated: "[C]ourts have consistently and without exception held that claims . . . which ask [the courts] to establish basic levels of economic and cultural well-being beyond those fixed by the elected representatives of the people are 'non-justiciable.'" Beatty, supra note 18, at 348.
welfare right, under which a court could prohibit exclusions from welfare so long as it did not set the precise amount of payment required. 70

Justice Arbour's justification is not entirely convincing here, in part because she addresses only one aspect of the justiciability difficulties. The non-justiciability argument asserts that the legislature is better suited not only to determine what "basic" needs are and what level of social assistance is required to meet them, but also to balance the right to subsistence-level services against other government priorities. In addition, the government ought to be able to choose the means by which it will safeguard the right: through direct payment, or by maintaining economic, social, political, or legislative conditions in which citizens might themselves be able to secure fulfillment of the right. Justice Arbour does not fully account for these concerns. Chief Justice McLachlin, writing for the majority, noted that the claimant did not give an explanation for the low participation rates of men and women aged under thirty in the workfare and education programs. 71 Unlike Justice Arbour, she seemed reluctant to blame the government. 72 Support for interest-balancing by the government might explain why the Chief Justice concluded that the facts in Gosselin were insufficient to support an expansive reading of Section 7 of the Charter. 73

The varying opinions in Gosselin show that judges might differ widely as to when justiciability concerns are sufficiently attenuated to allow for legitimate judicial intervention. Even if such concerns were not an issue, Justice Arbour's approach reveals the most important flaw of the case-by-case approach: it leaves government with the power to defeat justiciability. Had the Quebec government decided to reduce social assistance benefits to all, for example, or had the government not indicated a basic subsistence-

72. *Id.* at paras. 8, 83.
73. New York's highest court considered a similar issue in *Barie v. Lavine*, in which the plaintiff challenged regulations suspending certain welfare benefits to people who refused to accept workfare assignments. The court upheld the regulation, deferring to legislative choices about who is needy. *Barie v. Lavine* 357 N.E.2d 349, 362 (N.Y. 1976) ("The Legislature may in its discretion deny aid to employable persons who may properly be deemed not to be needy when they have wrongfully refused an opportunity for employment.").
level amount, Justice Arbour might have found the claim to be non-
justiciable. Once again, it is precisely when the government has not
acted toward fulfilling SERs that judicial prodding is most needed,
and where the judicial hands are tied under the case-by-case
approach.

3. Minimum Core Content

Justiciability concerns are lessened if courts enforce only a
minimum core content of rights, such as that required for basic
subsistence. At the international level, the CESC R has recognized
that the progressive implementation of SERs might make it difficult
to detect violations. Its response has been to suggest that states can
competently enforce a

minimum core obligation to ensure the satisfaction of, at
the very least, minimum essential levels of each of the
rights . . . . Thus, for example, a State party in which any
significant number of individuals is deprived of essential
foodstuffs, of essential primary health care, of basic shelter
and housing, or of the most basic forms of education is,
prima facie, failing to discharge its obligations under the
Covenant.

Courts enforcing only a minimum core content presumably
would have less say in how government resources were spent than if
they could direct the full implementation of SERs, which guarantee,
for example "an adequate standard of living . . . including adequate
food, clothing and housing and . . . the continuous improvement of
living conditions[,]" as well as the "highest attainable standard of

74. Gosselin, 4, S.C.R. 429 at para. 331 (asserting that the amount of aid
determined by the state to meet one's basic needs would be non-justiciable); thus,
Justice L'Heureux-Dubé qualified her concurrence with Justice Arbour on this
point: "However, although governments should in general make policy
implementation choices, other actors may aid in determining whether social
programs are necessary. In the present case, the government stated what it
considered to be a minimal level of assistance but a claimant can also establish
with adequate evidence what a minimal level of assistance would be." Id. at para.
142.

75. U.N. Econ. & Soc. Council [ECOSOC], Comm. on Econ. Soc. And

76. ICESCR, supra note 1, art. 11.
physical and mental health."\textsuperscript{77}

The minimum core content approach limits the threat that judicially-ordered SER fulfillment imposes on democratic decision-making to the extent that it simply curtails the rights' potential reach. There may also be less variability in views of what constitutes subsistence-level fulfillment. Even if this minimum core content could be reliably determined,\textsuperscript{78} the greater a state's obligations, the greater the risk that judges will undermine democratic choices while enforcing compliance. Moreover, this approach does not help courts determine the most appropriate means for fulfilling SERs. Thus, the South African Constitutional Court has rejected the minimum core content approach to the adjudication of constitutional SER provisions, stating:

\begin{quote}
In dealing with such matters the courts are not institutionally equipped to make the wide-ranging factual and political enquiries necessary for determining what the minimum-core standards called for... should be, nor for deciding how public revenues should most effectively be spent. There are many pressing demands on the public purse.\textsuperscript{79}
\end{quote}

4. Assessment of the Case-by-case Approach

Defenders of the case-by-case approach hope that even if courts adjudicate only when competent to do so, judicial enforcement will reinforce the importance of these rights, leading governments to

\textsuperscript{77} Id. art. 12.8.

\textsuperscript{78} Some commentators have suggested that even the core content varies depending on the resources available to a state because states can justify their failure to protect the minimum core. In describing the nature of states parties' obligations under the ICESCR, the CESC explained that art. 2(1) of the ICESCR obliges a state to take the necessary steps toward fulfillment of SERs "to the maximum of its available resources." General Comment 3, supra note 75. A state that fails to meet any minimum core obligation has the burden of proving that it has made "every effort" to satisfy the minimum obligations. General Comment 3, supra note 75. Eide observes, then, that "[t]he immediate obligations of states under Article 2 imply that countries with more resources have a higher level of core content or immediate duties than those with more limited resources." Eide, supra note 58, at 27.

\textsuperscript{79} Minister of Health v. Treatment Action Campaign (No. 2), 2002 (5) SA 721 (CC) at 740 (S. Afr.) [hereinafter "TAC"].
give them greater priority.\textsuperscript{80} Patchy enforcement, by tweaking existing systems or prohibiting government interference with existing rights, may be better than no enforcement at all. Given the SER enforcement paradox—people cannot participate in a democracy if their basic needs are not met, but judicial enforcement of SERs threatens democracy by taking social policy-making out of the hands of the people—perhaps only imperfect protection can be expected.

However, the case-by-case approach is weakest in the situations that most warrant judicial intervention: where governments have done little or nothing to fulfill particular rights.\textsuperscript{81} This approach largely deflects, rather than addresses, the enforcement question. If a polity constitutionalizes SERs, either because they are of fundamental value in and of themselves or for instrumental reasons, the government should not be able to avoid its responsibilities by choosing not to act.

B. The Administrative Review Model

An emerging set of solutions to the problem of judicial enforcement of SERs looks not to the circumstances of judicial intervention, but rather to its forms by calling for deferential review of government policies and actions that affect SERs. Its proponents suggest that even where justiciability concerns are great, courts can participate in the enforcement of SERs in ways that are less threatening to democratic values. They gesture toward creative approaches designed to ensure cooperation among branches of government in defining the content of positive SERs and in enforcing them where courts cannot or should not act alone.\textsuperscript{82} These

\begin{footnotesize}
\begin{itemize}
  \item \textsuperscript{80} See, e.g., Herskoff, supra note 55, at 1156 (asserting that social and economic goals, as elaborated in constitutions, compel governments to act to achieve these goals, and that the justiciability of these goals is an integral part of that process); see also Martin Scheinin, Economic and Social Rights as Legal Rights, in Economic, Social and Cultural Rights, supra note 58, at 54 (suggesting that recognizing the justiciability of social rights will lead states to understand them as legally binding and requiring positive obligations). But see Dennis & Stewart, supra note 30 (criticizing the "build it and they will come" approach to creating a binding adjudicative method for enforcing SERs).
  \item \textsuperscript{81} See Abramovich, supra note 33, at 193. ("[I]n an extreme case . . . when the state completely and absolutely fails to fulfill all of its positive obligations, it would be extremely difficult to compel direct fulfilment through judicial action.").
  \item \textsuperscript{82} See, e.g., Herskoff, supra note 55, at 1156 ("By committing the state to
\end{itemize}
\end{footnotesize}
approaches do not necessarily see courts defining and ordering full, immediate individual realization of a given right. Instead, they tend toward blending of legislative-judicial functions and are designed to promote legislative-judicial cooperation.

A model commonly advanced in recent years in academic works and judicial decisions across wide-ranging constitutional

explicit public goals, state constitutions compel state legislatures to enact policies that carry out these goals . . . [SERA] are no longer merely aspirational goals of political justice; they are . . . part of the constitutional fabric and a nondiscretionary feature of the legal order.

83. See Scott & Macklem, supra note 27, at 41–42 ("Interpreting constitutional guarantees as requiring positive governmental action, and invoking the constitution to prod the state into better protecting the necessaries of life for members of society, would involve some blending of the judicial and legislative functions.

84. Id.; see also Frank I. Michelman, Welfare Rights in a Constitutional Democracy, 1979 Wash. U. L.Q. 659, 684–85 (1979) (stating that the duty to fulfill unmet human needs "seems to be one that the courts acting alone cannot or ought not undertake to define, impose and enforce"); Abramovich, supra note 33, at 197, 203 (arguing that the judiciary should not formulate public policy but instead have a "procedural focus" that directs judicial review toward "guaranteeing the conditions that make it possible to adopt deliberative processes for producing legislative directives or administrative acts").

85. See Johan Van de Lanotte and Tom De Paelemaeker, Economic, Social and Cultural Rights in the Belgian Constitution, in Social, Economic and Cultural Rights: An Appraisal of Current European and International Developments 263, 273 (Peter Van der Auweraert et al. eds., 2002) ("Some authors have already pointed out that the fear of the judiciary supervising the political bodies and adjudicating socio-economic rights can be reduced by guaranteeing a margin of discretion to the public authorities. The judiciary will only intervene if and to the extent that the limits of this margin of discretion are transgressed."); Fabre, supra note 16, at 148 (same); Sandra Liebenberg, The Protection of Social and Economic Rights in Domestic Legal Systems, in Economic, Social and Cultural Rights: A Textbook, supra note 58, at 55, 67 (same); Helen Hershoff, Welfare Devolution and State Constitutions, 67 Fordham L. Rev. 1901, 1913–26 (1999) (arguing that a court interpreting Article XVII of the New York State Constitution, N.Y. Const. Art. XVII, § 1, should "not itself construct welfare policy but [should] impose a burden on the legislature to show that the chosen 'manner' and 'means' are likely to carry forward the specified constitutional aim").

systems sees courts setting out the broad bounds of the right in question, leaving governments a margin of appreciation within which to achieve that right. This model suggests an administrative-law style of review whereby government actions that are not, in a court's view, reasonably directed toward fulfillment of the constitutional right in question can be found unconstitutional.

This emerging model, reflected most famously in the South African Constitutional Court's jurisprudence, but also in Canadian minority language education rights jurisprudence, has been hailed as the most promising approach for judicial protection of positive SERs. Its advantages are clear: (1) the legislature, under some judicial pressure, sets its own obligations, and (2) courts are relieved of the task of setting complex, detailed policies and weighing competing budgetary claims, but judicial review is not excluded entirely. Governments are held to account, in court, for decisions where ordinary political processes might not have required such accounting. In this way, ineffective and sub-optimal policies can be brought to light. Social and economic rights holders who may lack power in the political arena are given an additional way to be heard and to bring political pressure. At the same time, because courts do not themselves set the precise terms of compliance, the usual governmental and popular institutions formulate policy.

As with the case-by-case approach, however, a closer examination reveals that many of the usual concerns associated with adjudication of SERs may persist within the administrative-review style model. These difficulties are evident in the South African experience. The South African Constitution contains numerous positive social and economic rights, including rights to access to housing, health care, food, water, and social security. It qualifies the

86. See infra notes 128–148 and accompanying text.
87. See, e.g., Sunstein supra note 21, at 229 ("By requiring reasonable programs, with respect for limited budgets, the [South African Constitutional] court has found a way of assessing claims of constitutional violations without requiring more than existing resources will allow. In so doing the court has provided the most convincing rebuttal yet to the claim that judicial protection of [social and economic rights] could not possibly work in practice.").
88. S. Afr. Const. 1996, Ch. II, §§ 26–27. Section 7(2) requires the state to "respect, protect, promote and fulfill the rights in the Bill of Rights," including its social and economic rights provisions, making clear that the constitution imposes positive obligations on government. In certifying the constitution, the Constitutional Court explicitly considered separation of powers concerns and held
state's corresponding duty for each: "the state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights."\textsuperscript{89}

Courts interpreting the South African Constitution’s SER provisions have used some elements of the case-by-case approach,\textsuperscript{90} but for positive, substantive dimensions of the South African progressive SER guarantees, the Court employs the administrative review approach. Qualified guarantees protected under the administrative review approach do not provide positive, individual, free-standing rights to health care, housing, and the like, but rather allow the courts to review, deferentially in principle, whether governments are acting reasonably toward fulfilling the constitutional right in question. The government largely determines the content of constitutionally required provisions, subject to review by the courts. The “rather restrained and focused role for the courts” is thus to “require the state to take measures to meet its constitutional obligations and to subject the reasonableness of those measures to evaluation.”\textsuperscript{91}

In Soobramoney v. Minister of Health (KwaZulu-Natal),\textsuperscript{92} in which the South African Constitutional Court upheld the state’s refusal to provide dialysis treatment to a claimant with chronic renal failure as reasonable, the claimant needed dialysis in order to live and could no longer afford to pay for it privately. In light of budgetary constraints, people suffering from acute renal failure and that the constitution’s socio-economic rights are nonetheless “at least to some extent, justiciable.” Ex Parte Chairperson of the Constitutional Assembly, 1996 (4) SA 744 (1996) (10) BCLR 1243 (CC) at para. 78 (S. Afr.). Its reasons for so finding included the familiar assertion that “many of the civil and political rights entrenched . . . will give rise to similar budgetary implications without compromising their justiciability.” Id. At the same time, the court qualified its assertion of justiciability, stating that at “the very minimum, socio-economic rights can be protected negatively from improper invasion.” Id. The court here seemed to be endorsing the case-by-case approach.

\textsuperscript{89} S. Afr. Const. 1996, Ch. II §§ 26(2), 27(2).

\textsuperscript{90} See supra note 50 and accompanying text.

\textsuperscript{91} See, e.g., TAC, 2002 (6) SA 721 at para. 70 (partly basing its analysis on fact that “this case concerns particularly those who cannot afford to pay for medical services [and that] [t]o the extent that government limits the supply of Nevirapine to its research sites, it is the poor outside . . . these sites who will suffer”).

\textsuperscript{92} Soobramoney v. Minister of Health (KwaZulu-Natal), 1997 (12) BCLR 1696, 1998 (1) SA 765 (CC) (S. Afr.).
those on waiting lists for kidney transplants were prioritized over those who, like the claimant, had chronic renal failure and were deemed medically unsuitable for transplants. The majority held that given competing demands on resources, the government policy of prioritizing people suffering from acute renal failure and those on waiting lists for kidney transplants over those with chronic renal failure was reasonable, stating, "[a] court will be slow to interfere with rational decisions taken in good faith by political organs and medical authorities whose responsibility it is to deal with such matters."

However, in the *Grootboom* case, the government's policy was found not to be reasonable; this is where the difficulties associated with administrative review approach become evident. The plaintiffs in *Grootboom* were some 900 poor people living in intolerable conditions on a football field, who were on the list for low-cost housing but had no real prospect of obtaining housing in the near future. Although the Cape Metropolitan Council, the supervisory tier of local government, had created a program to provide housing for those in desperate need, the program had not yet been implemented.

The Constitutional Court set out in broad strokes the content of the government's obligation to those who cannot afford to pay for housing themselves, holding that a housing program had to (1) be in place; (2) be comprehensive, coherent, and coordinated; (3) be balanced and flexible and make appropriate provisions for short-, medium-, and long-term needs; (4) be reasonably conceived and implemented; and (5) be continuously reviewed to account for changing social conditions. The most substantive requirement, and the one on which the decision ultimately hinged, was that programs should take into account degree of need and extent of denial of the rights they aim to realize. In other words, those whose needs are most urgent must not be ignored. Applying this standard, the

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93. *Id.* at para. 2.
94. *Id.* at para. 29.
96. *Id.* at paras. 39–41.
97. *Id.* at para. 43.
98. *Id.* at paras. 40–44.
99. *Id.* at para. 43.
100. *Id.* at para. 44.
Grootboom. Court found that the state housing program failed the reasonableness test because it made no provision for temporary relief for those in desperate need. It held that “[a] program that excludes a significant segment of society cannot be said to be reasonable.”  

Though it found a constitutional violation, the Court declined to give the respondents relief in the form of temporary housing so as not to offer the litigants preferential treatment over others similarly situated. Instead, it issued a declaratory order requiring the state to meet the obligation to devise, fund, implement, and supervise measures to provide relief to those in desperate need, such as, but not limited to, those contemplated by the Cape Metropolitan Council’s program. The Court added that the Human Rights Commission, which was an amicus in the case and is constitutionally required to monitor and assess compliance with human rights in South Africa, would monitor and if necessary report on the efforts made by the state to comply with it the Grootboom judgment. This reporting requirement seems to simply repeat and draw attention to the Human Rights Commission’s usual mandate. 

One difficulty with the administrative review approach is that the government may not respond with adequate programs, and parties may be unwilling or unable to bear the costs of re-litigation. Indeed, although the Grootboom case has been hailed as a great

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101 Id. at para. 43.  
102 Id. at para. 80. It did, however, approve a settlement agreement between the parties. Con. Ct. Order 38/00 (Sept. 21, 2000), available at http://www.constitutionalcourt.org.za/Archives/2574.PDF.  
103. Declaratory orders are becoming increasingly common in Canada and South Africa. See Kent Roach, Remedial Consensus and Dialogue Under The Charter: General Declarations and Delayed Declarations of Invalidity, 35 U. Brit. Colum. L. R. 21, 218 (2002) (describing the Canadian trend toward staying declarations of statutory invalidity to give governments the opportunity to modify the legislation to comply with the Constitution). See also London Clubs International (Overseas) Investments (Pty.), Ltd. v. The Free State Gambling and Racing Board, 1 SCA at 23 (noting that legislation has partially abrogated the common law rule against declarations without consequent relief); S. Afr. Const., 1996, § 38 (Courts “may grant appropriate relief, including a declaration of rights” in cases in which they find a Bill of Rights violation). But see President of the Republic of South Africa and Another v. Modderkloof Boerdery (Pty.), Ltd., 2005 (8) BCLR 786 at para. 26 (holding that the State must “take reasonable steps to ensure effective relief for landowners faced with mass invasions of their property” and that a declaratory order did not constitute effective relief).  
104. S. Afr. Const. 1996, §§ 184 (1) (e), 184 (2) (a), § 184 (3).
victory for SERs,¹⁰⁵ there has been some dissatisfaction with the government’s response.¹⁰⁶ Until the post-litigation program is brought before the court for review once again, it is impossible to know whether it is a legally sufficient response to the needs of the most desperate.

The potential for inadequate responses exists whenever courts use general declarations to review remedial governmental action instead of more precise injunctive relief. As Kent Roach has observed in the Canadian context, “some dissatisfaction by Charter applicants with the eventual governmental response to the court’s decision may ultimately be the price that is paid for a democratic and dialogic approach to remedies.”¹⁰⁷ Nonetheless, Roach suggests that courts should “pay special attention to such signs of dissatisfaction with the ultimate results of general declarations,”¹⁰⁸ and should consider less deferential remedies in some circumstances.¹⁰⁹

This brings us to the next difficulty with the administrative-review style model: courts may not stay faithful to a deferential standard of review. In Treatment Action Campaign (TAC),¹¹⁰ for example, the South African Constitutional Court purported to use the administrative review approach to rule that government restrictions on the use of Nevirapine (NVP), a drug used to combat mother-to-child HIV transmission, violated the constitution’s right of access to health care. The drug had been approved by the relevant state body for use to reduce the risk of mother-to-child HIV transmission, and its manufacturers had offered to make the drug available free to the South African government for five years. However, the government decided to offer the drug only in certain pilot sites such that doctors outside those pilot sites were unable to prescribe the drug to their patients.¹¹¹ A group of civil society members, led by the Treatment Action Campaign, challenged the

¹⁰⁵. See supra note 41.
¹⁰⁸. Id.
¹⁰⁹. Id. at 227.
¹¹¹. Id. at para. 19.
policy.

This time, the level of judicial review seemed to be far more searching and the intervention much stronger than in Grootboom.\(^{112}\) The court rejected the government’s justifications for the restriction. One government justification was that the benefits of NVP would be counteracted by HIV transmission through breastfeeding and that mothers would therefore require breast milk substitutes and counseling bearing in mind cultural factors and the lack of available clean water for mixing formula. The government also raised concerns about safety risks and the potential of developing resistance to the drug.\(^{113}\) The court’s corresponding order was also more precise than it had been in Grootboom. It ordered the government to remove restrictions on NVP availability and to develop a comprehensive plan to prevent mother-to-child HIV transmission. Here, the court defined the right of access to health care more specifically than it did the right to housing in Grootboom.

So, how do we account for the Court’s more searching inquiry under the reasonableness standard of review in TAC? One answer is that justiciability concerns were attenuated in this case. The claim had many hallmarks of a negative rights claim. The prohibition on distributing NVP was the underlying issue. However value-laden, this issue was not polycentric under the circumstances. The drug was available free of charge. Moreover, the government had provided additional funds for HIV treatment, including efforts to reduce mother to child transmission, during the lifetime of the case. By the time the court rendered its decision, the government had already gone some way toward incorporating NVP in its health policy by offering it at pilot sites,\(^{114}\) making it easier for the court to determine that its inclusion was feasible.\(^{115}\) Finally, the Court did not lack the

\(^{112}\) Tushnet, supra note 1, at 1908 (“The Constitutional Court’s examination of the government’s justifications for restricting the drug’s availability was quite searching, and nothing in the relevant sections of the opinions indicates that the Court was giving any real deference to the government’s judgments.”). Similarly, Sunstein, who is sympathetic to the South African Constitutional Court’s approach, states that the TAC court “rejected a policy judgment that seemed, on its face, to have at least some logical foundation.” Sunstein, Second Bill of Rights, supra note 18, at 225.

\(^{113}\) TAC, 2002 (5) SA 721 at paras. 51–54.

\(^{114}\) Id. at para. 118.

\(^{115}\) Id. at para. 119.
facts it needed to rule. The Government had already made the necessary legislative findings in formulating its HIV policies.116 Also, the medical information was relatively straightforward in the case. Thus, the court might have found it easier to weigh the risks and benefits of NVP than the relative merits of different ways of providing housing to the poor.

In addition, the Court may have undertaken a more searching inquiry because the TAC litigants posed a more concrete question than those in Grootboom.117 Where litigants seek review of the details of policy, even a court that endeavors to remain faithful to a deferential standard of review may be more likely to detect irrationalities. In other words, TAC may not represent a change in standard of review. Rather, the case shows that given enough data, courts will detect irrationalities in legislative schemes and act upon them even while applying a deferential standard of review.

An alternative explanation for the court's more aggressive intervention may be political. Sunstein observes:

This decision must be understood in the context of the South African's palpably inadequate response to the HIV crisis, a response bred partly by the irresponsible denial, among high-level officials, that HIV is responsible for AIDS at all. In these circumstances, it made sense for the court to do something other than rubber-stamp the government's failure to make a life-saving medicine available to young children.118

116. Id. at para. 4.

117. The Constitutional Court summarized the claim in TAC as: "The programme imposes restrictions on the availability of Nevirapine in the public health sector . . . . The applicants contended that these restrictions are unreasonable when measured against the Constitution." 2002 [5] SA at para. 11. On the other hand, the applicants' claim in Grootboom, that an order for a municipality's provision of temporary accommodation was improper, involved the question of "how to enforce [socio-economic rights] in a given case." 2001 (1) SA at para. 20. See also Applicant's Notice of Application for Leave to Appeal, Minister of Health v. Treatment Action Campaign, 2002 (5) SA 721 (CC) (S. Afr.) (listing various grounds of error that entail the unreasonableness of the government's program); Applicant's Notice of Application for Leave to Appeal, Gov't of the Rep. of South Afr. v. Grootboom, 2001 (1) SA 46 (CC) (S. Afr.) (listing various grounds of error that entail justiciability issues).

118. Supra note 41, at 226; Victor Abramovich likewise observes: An analysis of the historical circumstances that led up to a greater judicial activism concerning economic, social and
Thus, where (a) political factors lend greater legitimacy to judicial intervention; the (b) court has enough information to support its decision; (c) implementation will not be costly or require the creation of new institutions; or (d) litigants ask precise questions, there is a risk that a court may substitute its own judgment for that of the legislature. Instead of merely setting out the broad goals of the right, it might review the details of how the government goes about fulfilling those rights.

There may be nothing wrong with the shift to more aggressive judicial review of policy details from the point of view of those concerned with ensuring that SERs are justiciable, so long as legislatures willingly accept the court's invitation for collaboration. There may be a promising dialogic model here. When justiciability concerns are high, the courts may prompt action by requiring a reasonable program and thus redirecting government attention in constitutionally-required directions. When governments return with programs, justiciability concerns drop as judges can merely react to policy instead of creating it, ensuring that careful attention has been paid to designing programs reasonably. The more detail the government provides about the content of the right, the more information a court will have in which to detect irrationalities, and the more closely it might be drawn into the details of the policy.119

Nonetheless, if more detail provokes heightened standards of judicial review, government flexibility is jeopardized. Once a court has given the constitutional seal of approval to a particular substantive way of achieving entrenched rights, a government seeking to steer clear of constitutional challenges may be reluctant to try improving upon the judicially-approved standard or policy, particularly where positive results are not assured.120

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119. See supra note 51 and accompanying text.
120. The concern about the seeming finality of judicial enforcement motivated Justice Black to dissent in Goldberg v. Kelly, 397 U.S. at 271–79, in which the majority held that due process guarantees welfare recipients a hearing before termination of welfare benefits. Justice Black stated that because "the cultural rights in Latin America is directly related to the existence of political factors that assigned the Judiciary a special legitimacy to occupy a place in the decision-making arena that was previously restricted to other branches of the state.

Supra note 33, at 196.
More serious consequences might follow where governments fail to respond appropriately to declarations or are not progressing at a rate that the court considers appropriate. Tushnet invokes the example of the American school desegregation cases, in which the circuit courts began by giving schools latitude in determining how to go about desegregation. The result was that school desegregation did not proceed. The U.S. Supreme Court responded by authorizing lower courts to set out detailed desegregation plans and closely supervise their implementation. The South African court has not ruled out more aggressive judicial intervention.

Alternatively, instead of progressively detailed intervention, a court faced with a recalcitrant government might simply tolerate the latter’s lack of action, electing neither to set the right out in greater detail nor to issue correspondingly precise injunctions. The same concerns that underlie the view that SERs are not justiciable

operation of a welfare state is a new experiment for our Nation[,] the court should avoid having “new experiments in carrying out a welfare program . . . frozen into our constitutional structure.” Id.; Herskhoff, supra note 55, at 1162.

121. Tushnet, supra note 1, at 1916; see also Lino A. Craglia, Disaster by Decree: The Supreme Court Decisions on Race and the Schools 38–39 (1976) (describing circuit court decisions that essentially allowed school desegregation to continue). In Canada and South Africa, courts have tended to dismiss this concern. See e.g., Doucet-Boudreau, [2003] 3 S.C.R. 62 at paras. 27–8 (“Fortunately, Canada has had a remarkable history of compliance with court decisions by private parties and by all institutions of government . . . . This tradition of compliance takes on a particular significance in the constitutional law context, where courts must ensure that government behaviour conforms with constitutional norms but in doing so must also be sensitive to the separation of functions among the legislative, judicial and executive branches.”); TAC, 2002 (5) SA 721 at para. 129 (“The government has always respected and executed the orders of this Court. There is no reason to believe that it will not do so in this case.”).

122. Tushnet, supra note 1, at 1917; see infra notes 181–183 and accompanying text.

123. In Groottoom, the court indicated that it might have been willing to enforce a minimum core content of SERs without any deference to legislatures had the content of the rights been better fleshed out, as they were at the international level. Groottoom, 2001 (1) SA 46 at para. 65 (“The [CESOR] developed the concept of minimum core over many years of examining reports by reporting states. This Court does not have comparable information.”). In TAC, the court stated that so long as government complied with its decisions, the court would decline to use the more aggressive measure of retention of jurisdiction, but did not rule out retention of jurisdiction in the future. TAC, 2002 (5) SA 721 at para. 129.
might motivate a court in that position to refuse to proceed further. It might back off subtly, for example, by narrowing doctrinal bases of intervention, declare that further elaboration of the right and more aggressive enforcement measures would take courts outside the proper judicial role, or it might, as Pamela Karlan put it, "declare victory", claiming that the problem is solved when it is not.\textsuperscript{124}

Thus, the administrative review approach is potentially unstable.\textsuperscript{125} A government's failure to act may provoke judicial micromanagement (which the administrative review model was designed to avoid) or withdrawal (which effectively renders the rights non-justiciable). In essence, the administrative review approach risks the same objections made of the direct enforcement of SERs.

Tushnet notes that the potential for instability may be outweighed by the benefits of forcing a government to justify its policy choices in terms of its effects on SERs.\textsuperscript{126} Where governments respond to judicial decisions reasonably and courts are satisfied, both will have succeeded in jointly defining the content of the right and enforcing it. Even unheeded declarations may represent a form of dialogue by tapping into a polity's understanding of the content of SERs. As Tushnet states:

 judges should interpret resistance to the implementation of strong substantive rights as civil society's mobilization in support of a conception of rights alternative to the one the judges have offered. Further, judges should also come to see that mobilization is itself a way of enforcing what civil society understands social welfare rights to be.\textsuperscript{127}

If the administrative review model's principal benefit is promoting accountability by encouraging civil society to articulate its own conception of the content of SERs regardless of whether judicial decisions are followed, it may make sense for courts to target accountability and encourage societal articulation of norms directly. Courts enforcing SERs have imposed accountability requirements as an alternative to dictating precise detailed contents of constitutional rights when faced with recalcitrant governments.

\textsuperscript{125} Tushnet, supra note 1, at 1897, 1912.
\textsuperscript{126} Id. at 1910–11.
\textsuperscript{127} Id. at 1918.
III. ACCOUNTABILITY IN COURT

Methods of judicial review that are more directly targeted to requiring accountability are more procedurally focused. Instead of issuing precise orders and forcing legislatures to disobey the courts in order to communicate a different view of the content of SERs, courts could require a government to provide more information and account for progress toward constitutional goals as part of its constitutional duty. This is a useful alternative for judges who wish to avoid the choice between micromanagement and withdrawal.

The example of Canadian minority language education rights, which have been protected mainly through declarations of rights consistent with the administrative review approach, may be instructive here. The only SER explicitly provided for in Canada's Constitution is a minority language education right. Section 23 of the Canadian Charter of Rights and Freedoms gives parents who are members of the English-speaking minority in Quebec or the French-speaking minority in other English-speaking-majority provinces the right to have their children receive primary and secondary education in their mother tongue. 128

Courts have not denied the justiciability of Section 23 but have preferred to set the broad content of the rights rather than the details, and have generally favored declaratory over injunctive relief to avoid overstepping the judicial role. This preference reflects, in Roach's view, an "antipathy among many Canadian judges toward American-style detailed orders or structural injunctions to remedy unconstitutional conditions in schools, prisons and other institutions." 130 In addition, the remedial choice has been based, like the South African one, on an "assumption that governments would act in good faith to implement the relevant constitutional entitlements and that governments, not the courts, were in the best position to decide precisely what steps should be taken to comply with the Charter." 131 So long as governments did not show an unwillingness to comply with declarations, the Supreme Court of

130. Roach, supra note 107, at 211.
131. Id.; see also supra note 211 and accompanying text.
Canada continued to issue general declarations of the broad content of the right 132 to avoid "unduly fettering the discretion of the province to choose the 'modalities' by which to provide for the management and control of [minority] language education." 133

Of course, legislatures have not always proceeded to the satisfaction of the courts. Where governments have dragged their heels, some lower courts have issued injunctive relief. 134 These injunctions are viewed as an exceptional remedy in Canadian constitutional law 135 and have never been explicitly endorsed by the Supreme Court of Canada. 136

In Doucet-Boudreau v. Nova Scotia (Minister of Education), 137

132. See, e.g., Arsenault-Cameron v. Prince Edward Island, [2000] 1 S.C.R. 3 at paras. 32-34 (Can.) (recognizing that "the province has the duty to actively promote educational services in the minority language and to assist in determining potential demand" and favoring a "sliding scale" approach to the demand for French instruction that accords deference to the government's measured demand).


135. Rosch, supra note 107, at 217 (noting "a distinct preference for general declarations as opposed to detailed injunctions as a means of enforcing section 23 of the Charter.").

136. The cases in note 134 were cited with approval in Doucet-Boudreau, [2003] 3 S.C.R. 62 at para. 29, though their content was not discussed at length.

where a provincial government was slow to build constitutionally-required French-language schools, a trial judge took a tack novel to Canadian constitutional doctrine. He decided that no further clarification of the content of Section 23 was necessary; the government understood its obligation to build schools from previous Charter jurisprudence. Another declaration would add very little. The problem was that the government was failing to accord due priority to its Section 23 duties, citing budgetary concerns and lack of consensus in the community around the details of construction. The government would subvert the very purpose of the right, the preservation of Francophone culture, through additional delay because progressive assimilation would leave fewer and fewer French-speaking students. Assimilation would also defeat the application of the right because governments are only required to build minority-language schools when there are a sufficient number of prospective students. The court had thus reached the point where, under the administrative review model, it might be forced to consider issuing more precise injunctions. But instead of issuing such an order, enforceable only by contempt actions if the government failed to comply once again, the trial judge directed the government to use its “best efforts” to build schools and design programs by more or less specific deadlines and retained supervisory jurisdiction to hear reports on the government’s progress. The trial judge’s order in this case was designed to prompt quick government action by requiring ongoing accountability without requiring fresh litigation and descending into details of how the right ought to be implemented, which might draw a court out of its usual role and into that of the legislature or the executive.

The Supreme Court of Canada approved the retention of jurisdiction by a 5-4 majority. The essence of the remedy approved in Doucet-Boudreau is that the court, while remaining within justiciability limitations, sets the goal to be achieved and requires

138. Id. at para. 204.
139. Id. at para. 210.
140. See Mahe, [1990] 1 S.C.R. at 345-6, 366 (Can.) (setting out the factors relevant to determining when the “numbers warrant” minority language education facilities, including “the number of persons who will eventually take advantage of the contemplated program or facility.”).
the government to set its own shorter-term targets, justify them, and explain its progress toward them under the court’s eye and as part of its constitutional obligation. In this sense, the remedy makes public accountability for the achievement of rights part of the government’s constitutional obligations. Insofar as the remedy reflects the right, public accountability becomes a part of the definition of the SER.

While the majority in *Doucet-Boudreau* went no further than approving the trial judge’s retention of jurisdiction to hear reports, it did not preclude judges from retaining jurisdiction to issue further orders in the future. The court issued guidelines for what kinds of constitutional remedies are available, stating that an appropriate and just remedy is one that

(a) “meaningfully vindicates the rights and freedoms of the claimants”; (b) “employs means that are legitimate within the framework of our constitutional democracy”; (c) judicially “vindicates the right while invoking the function and powers of a court”; (d) is “fair to the party against whom the order is made”; and (e) “remain[s] flexible and responsive to the needs of a given case.”

If in-court reporting alone did not achieve the desired goals, courts would be allowed to retain jurisdiction to issue further orders superintending the government’s choice of means to implement the court’s declaration. Governments are most likely to respond to

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143. *Id.*

144. *Id.* at paras. 55–58.

145. Indeed, Kent Roach, supra note 107, at 266–67, writing about *Doucet-Boudreau* before the Supreme Court of Canada issued its judgment, extolled the virtues of the trial judge's retention of jurisdiction assuming that it did include the power to issue further orders, stating:

Retention of jurisdiction by the trial judge after the general declaration would allow the implications of the general declaration to be fleshed out in a less confrontational manner than a contempt motion or fresh second round litigation . . . .

Retention of jurisdiction by the trial judge would allow governments the opportunity and the flexibility to develop the precise means to implement the court’s declaration. At the same time . . . successful *Charter* litigants will not be forced to commence fresh litigation should they not be satisfied with the manner in which the government responds to and interprets the general declaration or uses any court-approved period of delay. A motion to a trial judge already familiar with the facts...
retention of jurisdiction to hear reports (and not to issue further orders), in cases like Doucet-Boudreau, when the constitutional end is sufficiently clear and uncontested, and where the court can foresee a relatively short timeline for full achievement of the right. Canadian minority language education rights are not progressive: where the numbers warrant, governments are required to build and maintain schools. The parties in Doucet-Boudreau agreed on this relatively clear constitutional end. At issue was merely the timeline for construction; there was no dispute (yet) about the quality of the schools or facilities. Retention of jurisdiction would end once schools were built.

Where the content of the right is constantly under development and where there is no clear end goal in sight, it will make less sense for a court to retain jurisdiction to hear reports. Courts cannot retain jurisdiction indefinitely. This might explain the South African Constitutional Court’s reluctance, up to this point, to grant structural relief in SER litigation. Rather than retain jurisdiction to supervise the implementation of the case, the Constitutional Court in Grootboom instead indicated (however redundantly) that the Human Rights Commission was to monitor compliance with its judgment instead of the court. Indeed, the Human Rights Commission has been dissatisfied continually with the government’s implementation of Grootboom. If the courts were to retain jurisdiction in cases like Grootboom, as some commentators have argued they should, and as some high courts enforcing SERs in South Africa have done, when does the retention of jurisdiction

\[\text{provides a relatively accessible vehicle for which the successful Charter applicant to question the government's response to a [declaration].}\]

(emphasis added).

146. Occupiers of 51 Olivia Road, Berea Township and 197 Main Street, Johannesburg v. City of Johannesburg and Others, Case No. CCT 24/07, pending before the South African Constitutional Court at the time of this publication, raises the issue of whether it is appropriate for a lower court to issue a limited supervisory order requiring the City of Johannesburg to register a compliance affidavit within four months of the order. The case concerns the eviction of poor people from allegedly unsafe buildings in Johannesburg and thus implicates the government’s compliance with Grootboom.

147. See also TAC, 2003 (5) SA 721 at paras. 96–103.


149. See, e.g., the High Court orders in Grootboom v. Oostenberg Municipality and Others, 2000 (3) BCLR 277 (CC) at paras. 298H–294C; TAC &
end? Further, if retention of jurisdiction comes to include the power to issue further orders—a likely development if the government's progress is unsatisfactory—then the risk of judicial micromanagement continues.

A requirement that the government report on its progress in court makes sense where there is legislative-judicial consensus on ends, a relatively short timeline for their achievement, and where the court wants to leave the government with discretion as to means. Where the ends are themselves unclear or contested, such as where the content of rights is expected to change over time, retention of jurisdiction is a less practicable means of ensuring that governments do not neglect positive constitutional obligations.

IV. NEW GOVERNANCE AND ACCOUNTABILITY BEYOND THE COURTROOM: BRINGING THE ADMINISTRATIVE REVIEW MODEL HOME

Facing recalcitrant governments but worried about their own institutional competence, some courts have approved legislative schemes that promote stakeholder driven accountability and empirically measurable accountability. Such schemes can be seen in the enforcement of American state constitutional rights to education.\(^{150}\) In this part, I argue that such process-oriented or “new governance” approaches, the most heavily theorized of which have been called “experimentalist,”\(^{151}\) provide promising insights into how courts can hold governments to account for progress toward fulfilling SERs both through and beyond the litigation context.

Few consider the United States a source of models for the judicial enforcement of SERs. Aside from a brief period when the US Supreme Court was willing to enforce procedural guarantees in support of social and economic rights,\(^{152}\) US federal courts have generally been hostile to the notion of positive constitutional rights. The US Supreme Court has affirmed the Constitution as a charter of

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150. Lieberman & Sabel, supra note 8.
151. Dorf & Sabel, supra note 8.
negative liberties. At the same time, the American experience with detailed command-and-control injunctive relief in constitutional institutional reform litigation in areas like schools, mental health institutions, prisons, police, and housing has been heavily criticized both domestically and internationally. The worried tones adopted by the Nova Scotia Court of Appeals in Doucet-Boudreau and the reluctance of the South African court to order structural relief in TAC reflect the desire of courts seeking deferential, co-operative methods of protecting SERs to avoid the ostensible perils of the American structural injunction. Correspondingly, the pervasiveness of the command-and-control structural injunction as the remedy of choice where American social institutions fail to meet constitutional standards may in part explain judges’ reluctance to recognize positive constitutional obligations.

But in recent years, state courts have begun to enforce state constitutional rights to an adequate public education, marking

153. DeShaney v. Winnebago County Department of Social Services, 489 U.S. 189, 204 (1989) (“The Court’s baseline is the absence of positive rights in the Constitution and a concomitant suspicion of any claim that seems to depend on such rights.”).


155. Doucet-Boudreau v. Nova Scotia (Attorney General), [2001] NSCA 104, paras. 43–46 (“I am loathe to open the door, even slightly, to American jurisprudence on the enforcement of mandatory injunctions. The experience in the United States, of ‘hands on’ judicial intervention into the administrative and legislative branches of government, has found little favour in this country. In a pre-Charter address to the Law Society of Upper Canada, 1981, Justice Estey, then of the Supreme Court of Canada, referring to this American jurisprudence, said that it ‘leaves lawyers breathless.’ He said further: ‘This line of remedy is wholly foreign to us, so far, and I would suggest that no amount of prodding by our law schools, professors, and commentators will bring this kind of litigation through the doors of our court-rooms.’”).

156. TAC, 2002 (5) SA 721 at para. 129 (indicating that structural injunctions should not be made unless necessary); id. at para. 113 (arguing that “due regard must be paid to the roles of the legislature and the executive in a democracy” in deciding whether to grant structural relief).

157. Nearly every state constitution contains some provision guaranteeing
American courts' first significant experience in enforcing positive constitutional SERs.

And over the years, courts employing injunctive relief in institutional reform litigation have, at least on some accounts and in some instances, moved away from command-and-control structural relief to more deferential remedial approaches that seek to attenuate capacity and legitimacy concerns. Some of these approaches require ongoing monitoring of substantive progress beyond the litigation, not by courts, (as under the Canadian Doucet-Boudreau approach) nor by a human rights commission (as in Grootboom), but instead by stakeholders through a legislatively-designed system that measures progress toward ever-evolving outcomes.

A. Experimentalism in Theory

Experimentalist approaches are part of a constellation of so-called "new governance" methods originally advocated in

public education. Formulations vary, but education clauses in state constitutions almost always impose positive obligations on governments. Most require the establishment or maintenance of public schools. Qualitative standards like "general and uniform," "general and efficient," "uniform," "adequate," "efficient," "high quality," and "thorough and efficient" are often set out. The Mississippi state Constitution is the only one not to contain a positive education clause. In the last 15 years or so, after over 100 years of state courts essentially ignoring education adequacy clauses, courts have begun to apply them with some success. The New Jersey Supreme Court was the first to attempt to define and enforce the right to an adequate education in Robinson v. Cahill, 303 A.2d 273 (N.J. 1973), cert. denied, sub nom; Dickey v. Robinson, 414 U.S. 973 (1973). Washington and West Virginia followed suit in Seattle Sch. Dist. No. 1 v. State, 555 P.2d 71 (Wash. 1976) and Pauley v. Kelly, 255 S.E.2d 869 (W. Va. 1979). The vast majority of successful challenges to state education systems have been founded in whole or in part on the adequacy clauses. Michael A. Rebell, Adequacy Litigation: A New Path to Equity?, 141 U.P.I.N.Y. 211, 222 (2004).

158. Without coming to firm definitions, Susan Sturm notes that the terms institutional reform litigation, public law litigation, and structural reform litigation are often used to refer to "a class of cases involving public institutions and policies, such as school desegregation, prison and mental hospital conditions, environmental management, housing discrimination, and electoral reapportionment." Susan Sturm, A Normative Theory of Public Law Remedies, 79 Geo. L. J. 1355, 1387 (1991) (cataloguing different ways in which judicial remedial practice has adapted from the traditional adversarial model to accommodate the competency and legitimacy concerns in public law litigation).

159. The term was originally proposed in Dorf & Sabel, supra note 8.

160. See Orly Lobel, The Renew Deal: The Fall of Regulation and the Rise
industrial and managerial context, and since applied to fields including government regulation of social problems. "New governance" approaches to regulation share a number of features. Instead of a top-down, hierarchical rule-based system where failures to adhere are sanctioned, or unregulated market-based approaches, the new governance school posits a more participatory and collaborative model of regulation in which multiple stakeholders, including, depending on the context, government, civil society, business and nonprofit organizations, collaborate to achieve a common purpose. In order to encourage flexibility and innovation, "new governance" approaches favor more process-oriented policy strategies like disclosure requirements, benchmarking and standard-setting, audited self-regulation, and the threat of imposition of default regulatory regimes to be applied where there is a lack of good-faith effort at achieving desired goals. "New governance" has

of Governance in Contemporary Legal Thought, 89 Minn. L. Rev. 342 (2004) (chronicling and setting out the essential features of the new governance model).


163. Freeman, Collaborative Governance, supra note 162, at 22–33.

164. The default regulatory regime has been called the "penalty default," and can be defined as a regulatory solution imposed in the event that parties fail to reach satisfactory agreement. The regime is generally suboptimal for all parties and so operates to encourage parties to reach agreement. See Cristie L.
been proposed as fruitful for reconceiving, *inter alia*, constitutionalism, individual constitutional rights, and institutional reform litigation. 

Michael Dorf and Charles Sabel present an exhaustive theoretical account of how individual constitutional rights would be protected under a new governance approach which they call democratic experimentalism. Democratic experimentalism, in the new governance tradition, requires an institutional structure in which multiple units pursue social policy ends in parallel with one another. The experimentalist program requires each local unit to generate data about its progress toward goals that the localities set in consultation with one another. With the information so generated, citizens can "participate directly in determining and assessing the utility of the services local government provides, given the possibility of comparing the performance of their jurisdiction to the performance of similar settings." A requirement that units adopt the best practices, it is hoped, will generate a race to the top. "In this way," the authors explain, "experimentalism provides ever

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166. Dorf & Sabel, *id.*

167. Sabel & Simon, supra note 8.


169. In this sense, Dorf and Sabel do not advocate that the judiciary require democratic experimentalism as a remedy. Rather, in their vision, the institutional structures of democratic experimentalism would be adopted by democratic means, but would in the result create a special role for courts. *Id.* at 419–20.

170. Dorf & Sabel, *supra* note 8, at 286–87 ("To establish intitiel product designs and production methods, firms turn to *benchmarking*; an exacting survey of current or promising products and processes which identifies those products and processes superior to those the company presently uses, yet are within its capacity to emulate and eventually surpass.")

171. *Id.* at 288.
more rigorous benchmarks, and rights... are rolling too."\textsuperscript{172}

A court in an experimentalist system thus does not come up with once-and-for-all solutions to threats against individual rights.\textsuperscript{173} Instead, courts superintend an experimentalist procedure by detecting potential threats to constitutional values, and by assessing whether the state is engaging in the appropriate \textit{deliberative process}.\textsuperscript{174} Where entities engage in the required consultative and deliberative processes, generate enough data on the effectiveness of their chosen mechanisms to make rolling best-practice standards possible, and adopt the best practices of other localities or justify deviations, courts will defer to these choices. The idea is that the experimentalist system itself provides citizens in individual jurisdictions with information to hold their own institutions to account so courts do not have to get involved in substance.\textsuperscript{175} At the stage of constitutional litigation, the challenge is to distinguish bona fide and successful experiments from sham and unsuccessful ones.\textsuperscript{176} With due regard for the fact that some experiments may take longer to prove successful or unsuccessful than others, a reviewing court should verify whether all local units are engaging in the required consultation and careful consideration of best practices.\textsuperscript{177} Where local entities fail to engage in the experimentalist project, a court can impose a "penalty default"—its own benchmark or minimum—using whatever evidence is available to it in the litigation or, where possible, with reference to those generated from other localities’ experiments. Entities would be required to adopt that so-called prophylactic rule\textsuperscript{178} unless and until they participated in the experimentalist search for a superior articulation and implementation of constitutional rights. Thus, judicial review is procedural in the sense that it "asks what entities, jurisdictions, and

\textsuperscript{172} Id. at 464.
\textsuperscript{173} Id. at 385.
\textsuperscript{174} Id. at 380.
\textsuperscript{175} Id. at 288.
\textsuperscript{176} Id. at 464.
\textsuperscript{177} Id. at 389.
\textsuperscript{178} Dorf and Sabel provide the following unique definition of a "prophylactic rule": "The court adopts a prophylactic rule when it identifies circumstances that threaten constitutional values, without necessarily being able to specify the causal chain by which the threat will eventuate, and where, accordingly, it may both fix general preventive measures and invite other actors, with better knowledge of the specifics, to improve on them." Id. at 453.
agencies did to look for solutions, rather than whether the solutions were the right ones."

The important addition that these kinds of schemes make to the administrative review approach is that, once in place, they relieve courts (and other agencies) from having to decide precisely what, for example, an adequate education consists of without abandoning enforcement to political discretion. The idea is that maximum consultation, systematic information-generation, and required adoption of best practices will generate a "race to the top," so that the court need only superintend the process and not the substance.

The approach holds particular appeal for the elaboration and enforcement of SERs. The experimentalist vision sees all constitutional rights as suffering from the same infirmities that are generally alleged against SERs, namely that they lack precision, constantly evolve, and that their judicial enforcement may undermine democratic choices. The allegation that SERs are less precise than CPRs and therefore less susceptible to "objective" determination loses its teeth under a system where the meaning of all rights is constantly determined and re-determined through the participation of relevant actors. Because superintending courts do not try to define the substance of a right but merely ensure that actors have engaged in an inclusive, bona fide effort to do so, concerns about judicial usurpation of legislative and executive roles are alleviated. An experimentalist system avoids problematic judicial supervision of the progressive implementation of rights by governments with a rolling best practices requirement.

B. Experimentalism in Practice: The Example of U.S. State Constitutional Education Clauses

State courts have been faced with the anticipated SER-related hurdles in enforcing constitutional education clauses. Some judges have responded to the difficulty of defining the content of constitutional rights and fashioning appropriate remedies by deferring to political branches or interpreting the enforcement of education clauses as exclusively a matter of legislative discretion. In

179. Id. at 397.
180. Id. at 451–52.
other words, they have treated state educational adequacy clauses as non-justiciable. Others have begun by setting out the broad content of the rights and then moving toward more precise injunctive relief, not unlike the trajectory followed after Brown v. Board of Education. Still others have supported experimentalist structures in an effort to enforce rights while avoiding the remedial difficulties that followed Brown. After finding that chronically faltering school systems did not pass constitutional muster and after setting out the broad bounds of the right to an adequate education in a manner consistent with the administrative review approach, they endorsed statutory accountability schemes rather than dictating the details of the rights themselves.

Some commentators credit growing popularity of standards-based accountability regimes (the most well-known example being the federal No Child Left Behind Act) for some courts' successful moves towards enforcing the right to an adequate education. These accountability regimes focus on educational outcomes. They call for standards, both for student achievement and school performance in generating student achievement, in the major subject areas. Michael Rebell explains:

In theory, once the content standards have been

181. Ex parte James v. Alabama Coalition for Equity, 836 So.2d 813, 819 (Ala. 2002) (hereinafter James II) ("[W]e now recognize that any specific remedy that the judiciary could impose would, in order to be effective, necessarily involve a usurpation of that power entrusted exclusively to the Legislature. Accordingly . . . we complete our judicially prudent retreat from this province of the legislative branch in which we may remain obedient to the command of the people of the State of Alabama that we 'never exercise the legislative and executive powers, or either of them; to the end that it may be a government of laws and not of men.' Ala. Const. 1901, § 43 (emphasis added)."), see also Committee for Educational Rights v. Edgar, 672 N.E.2d 1178, 1193 (Ill., 1996) ("We conclude that the question of whether the educational institutions and services in Illinois are "high quality" is outside the sphere of the judicial function.").

182. See Owen M. Fiss, The Civil Rights Injunction 6 (1978) (arguing for the increased use of injunctive remedies in civil rights cases).

183. See Liebman and Sabes, supra note 8 (attributing the retreat from Brown v. Board of Education to difficulties posed by the vagueness of the right and the aggressiveness of the remedy).

184. Rebell, supra note 157, at 231 ("It is not a coincidence that the implementation of standards-based reforms and the accelerating plaintiff successes in the education adequacy litigations have occurred almost simultaneously since 1989."),
established, every other aspect of the education system—
including teacher training, teacher certification, curriculum
frameworks, textbooks and other instructional materials,
and student assessments—must be revamped to conform to
these standards. The aim is to create a seamless web of
teacher preparation, curriculum implementation, and
student testing, all coming together to create a coherent
system which will result in significant improvements in
achievement for all students.\(^{185}\)

Leaving aside the success or failure of the No Child Left
Behind Act itself, James Liebman and Charles Sabel claim that
movements for this kind of standard-setting and performance-
monitoring at the community level allowed courts, wary of the
dangers of structural reform, to meaningfully participate in ensuring
educational adequacy.\(^{186}\) On their account, multiple community
stakeholders began to support standards-based accountability
systems in response to common dissatisfaction with public schools. At
the same time, courts generated additional pressure from above by
adjudicating state constitutional rights to an adequate education,
finding that schools were not meeting constitutional standards. The
combination of pressures, they argue, allowed courts to meaningfully
participate in ensuring educational adequacy and avoiding the
dilemma of dictating the content of educational adequacy or
withdrawing from the debate entirely.\(^{187}\)

According to Liebman and Sabel, adequacy-based school
finance litigation helped contribute to the creation of experimentalist
governance structures in Texas and in Kentucky. In the series of
decisions that have come to be known as “the Edgewood saga,”\(^{188}\) the

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\(^{185}\) *Id.* at 230.

\(^{186}\) See Liebman & Sabel, supra note 6, at 289.

\(^{187}\) *Id.* at 280–81.

\(^{188}\) In *Edgewood Indep. Sch. Dist. v. Kirby*, the Texas school system was
declared unconstitutional. 777 S.W.2d 391 (Tex. 1989) (hereinafter *Edgewood I*). In *subsequent cases* the court assessed the constitutionality of the resulting
Edgewood Indep. Sch. Dist., 826 S.W.2d 489 (Tex. 1992) (hereinafter *Edgewood
*Edgewood IV*). For a thorough discussion of the Texas litigation, see J. Steven
Farr & Mark Trachtenberg, *The Edgewood Drama: An Epic Quest for Education
Equity*, 17 Yale L. & Pol'y Rev. 697 (1999) (detailing Texas litigation challenging
the constitutionality of state public school funding).

Texas Supreme Court ruled Texas’ school financing system unconstitutional for its failure to create an “efficient system of free public schools” to ensure a “general diffusion of knowledge” as required by the Texas constitution. Rather than attempt a positive definition of “efficiency,” however, the court simply said what efficiency was not, threatening to shut down the schools until the legislature came up with a satisfactory solution. Lawmakers operating in a climate hostile to wealth redistribution had a hard time coming up with a financing scheme that satisfied the court as well as their constituents. In the various cases, the legislature’s finance reform laws were rejected time and again. Only when the legislature coupled finance reform with Senate Bill 7, an accountability system that provided for standards and monitoring while allowing richer districts to supplement beyond well-specified (however rolling) minimum standards, did the court finally find that the legislation passed constitutional muster. By approving procedures that generated the standards rather than setting them itself, the court was able to avoid defining “an adequate education.” Although Edgewood has been criticized for falling short of equalizing funding for all schools, the court addressed the content of an adequate education right in a way that it had previously refused to do. It did so indirectly, however, by approving an ongoing means of creating that content.

Once the accountability scheme was in place, the trial judge was able to determine based on evidence at trial that each child would require $3500 in funding and that the financing scheme in Senate Bill 7 provided enough, without requiring the poorer districts to tax at a higher rate. Had it not been for the detailed accountability regime, which the court agreed met the legislature's

189. Edgewood I, 777 S.W.2d at 397.
190. Id. at 399.
193. For a description of the details of the accountability scheme, see Liebman & Sabel, supra note 8, at 239–50.
194. See Farr & Mark Trachtenberg, supra note 188, at 637 (arguing that the Edgewood rulings and subsequent Texas cases do not go far enough in correcting funding inequalities).
195. Edgewood IV, 917 S.W.2d at 731 n.10.
duty, the court may have felt less equipped to determine the cost of an adequate education.

In Kentucky, similarly, the courts’ starting point resembled the administrative review approach. In *Rose v. Council for a Better Education*, the Kentucky Supreme Court ruled the entire school system, which rated among the worst in the country, unconstitutional. It set out seven capacities that an efficient school must be designed to provide to each student. In this sense its remedial approach was more substantive than the Texas court’s. It also required that the General Assembly monitor the schools “to assure that they are operated with no waste, no duplication, no mismanagement, and with no political influence” and held that the General Assembly bears the sole responsibility for providing funding sufficient to provide each child with an adequate education. It expressed that additional money would be required but did not go so far as to specify how much. Interestingly, it did overrule the trial judge’s retention of jurisdiction to oversee the implementation of its orders, citing separation of powers concerns.

The Kentucky Education Reform Act (KERA), which has been described as “the most sweeping education package ever conceived by a state legislature[,]” passed less than a year after the court’s decision in *Rose*. The KERA included performance-based assessments and an accountability system of rewards and sanctions, combined with modification of goals and monitoring tools in light of

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196. **Id.** at 730.
197. See Lieberman & Sabel, *supra* note 8, at 236 (noting that Senate Bill 7 “unblocked the logjam” by increasing funding while conditioning disbursement on performance measures, which helped satisfy the courts that the new proposal would improve the condition of the schools).
199. **Id.** at 212.
200. **Id.** at 213.
201. **Id.** at 213, 216.
202. **Id.** at 214.
information generated through monitoring, similar to those in Senate Bill 7 in Texas.\footnote{205}

It is still unclear whether these innovations have increased school quality, or whether they have been thwarted by difficulties such as political will, participation, money, and power.\footnote{206} Nonetheless, they reveal that courts are willing to support experimentalist-style interventions to press the development of rights to an adequate education and to avoid judicial over-definition of the right. While other courts enforcing SERs have not endorsed such robust experimentalist schemes as those in Texas and Kentucky, the jurisprudence indicates that they might be willing to do so.

C. Experimentalist Leanings in the Judicial Enforcement of Social and Economic Rights in Canada and South Africa

Canadian and South African jurisprudence reveal some sympathy toward comparison and accountability-centered remedies for SER deficiencies. Consistent with the administrative review approach, both show a preference for declaring rights at the high level of generality that the experimentalist model suggests.

Second, both tend to use comparative analyses, looking to the results of similarly-situated, better-performing actors both to gauge the reasonableness of the defendant's choices at the level of detecting violations and in fashioning remedies. Comparative information is used to generate benchmarks as courts look to the results of other jurisdictions' experiments with similar problems to justify judiciously-set standards. In TAC, for example, the court pointed to the fact that

\footnote{206. Sabel and Simon, supra note 8, at 1027, observed in 2003 that "it is too soon to claim that the judicial efforts along these lines have been successes." See also Maurice Dyson, The Death of Robin Hood? Proposals for Overhauling Public School Finance, 11 Geo. J. Poverty Law & Pol'y 1 (2004) (analyzing Senate Bill 7 and concluding that "only time will tell" if it is successful); Debra H. Dawahare, Public School Reform: Kentucky's Solution, 27 U. Ark. Little Rock L. Rev. 27 (2004) (analyzing the progress made since the passage of KERA, and cautioning lawmakers not to undermine the implementation of the reforms); Steve Smith, Education Adequacy Litigation: History, Trends, and Research, 27 U. Ark. Little Rock L. Rev. 107, 114 (2004) ("KERA became a national model for implementing standards-based reforms across the country.").}
other provinces had created programs to prevent mother-to-child HIV transmission in support of its view that the defendants could too. 207 Similarly, a majority of the Supreme Court of Canada recently ruled that Quebec's prohibition on obtaining private health insurance for publicly insured health services violated the Canadian and provincial constitutional and quasi-constitutional guarantees of security of the person. 208 The Quebec government justified the prohibition as a method for protecting the quality of the public system. 209 In finding the violation, the Court looked to other jurisdictions, both in Canada and internationally, and thought that they managed to protect their public systems without prohibiting the purchase of the kind of private insurance. 210

Third, courts have ensured that any remedies are prophylactic. In TAC, for example, the court added that the government could still adapt its policy in a manner consistent with the constitution if equal or better methods for preventing mother-to-child HIV transmission became available. 211

Fourth, courts have encouraged broad participation in defining and implementing SERs. In Grootboom, the court held that effective implementation would require cooperation between all spheres of government to plan, budget, and monitor the fulfillment of immediate needs and to manage crises. 212 At the same time, this

207. TAC, 2002 (5) SA 721 at para. 123 (finding it "regrettable" that only three of nine provinces have developed treatment programs, and calling for a "concerted, co-ordinated and co-operative national effort" to be made throughout the country).

208. Choukili, [2005] 1 S.C.R. 791 (Can.). This case is the first in which the Canadian courts have considered the constitutional sufficiency of the public health care system. Although the case concerned guarantees of life and security of the person, which are classified as CPRs, and although the right in issue was framed as a negative right, it presented many of the same justiciability concerns often alleged against SERs.

209. Id. at para. 71 (citing respondent's expert witnesses who argued private health insurance would adversely affect public health insurance due to increases in: (1) "popular support," (2) incentives for influential citizens to require quality control, and (3) the number of doctors in the public health system due to profit motive). See also id. at para. 112 (citing Quebec's claim that resources will be diverted from public health insurance when wealthy individuals opt-out).

210. Id. at paras. 70–74, 140–49.


212. Grootboom, 2001 (1) SA 48 at para. 68.
requirement of participation did not stop the court from holding the state ultimately responsible.

Fifth, courts have recognized that ongoing monitoring, aimed at generating accountability for progress toward goals, is a necessary part of SER enforcement. In Grootboom, for example, the Court ordered monitoring by the Human Rights Commission.\(^{213}\)

Finally, even in the absence of a specific accountability regime, the government’s burden to prove that its policies are reasonably directed to pursuing the full realization of the SER in question encourages collecting information to justify those choices and presenting that information in court.

V. CASE STUDY: POTENTIAL FOR EXPERIMENTALIST REALIZATION OF HEALTH CARE RIGHTS IN CANADA

The recent Supreme Court of Canada case, Chaoulli v. Quebec, is an especially ripe opportunity for exploring experimentalist SER enforcement. With the exception of minority language education rights, positive SERs have not been recognized in Canadian constitutional doctrine. In this section, I argue that Chaoulli and recent institutional and political developments pave the way for possible judicial participation in experimentalist enforcement of positive SERs in Canada.

In Chaoulli, the Supreme Court of Canada struck down a health care law on the ground that it violated the rights to life and to security of the person protected by the Quebec Charter of Human Rights and Freedoms (“Quebec Charter”).\(^{214}\) Six of seven judges on the Court held that, given wait times in the public system, the prohibition on obtaining parallel private insurance for publicly ensured services violated Section 1 of the Quebec Charter.\(^{215}\) The six

\(^{213}\) Grootboom, 2001(1) SA 46, at para. 97.

\(^{214}\) Charter of Human Rights and Freedoms, R.S.Q., ch. C-12, § 1 (“Every human being has a right to life, and to personal security, inviolability and freedom.”).

\(^{215}\) Chaoulli, [2005] 1 S.C.R. 791, at para. 45; id. at para. 102 (McLachlin, Major, and Bastarache, JJ., concurring); id. at paras. 200, 272–73 (Binnie, LeBel, and Fish, JJ., dissenting) (arguing that while some individuals’ rights are at risk, the plaintiffs failed to establish any infringement that was not justified under Section 9/1 of the Quebec Charter).
judges who pronounced on whether the law violated Section 7 of the Canadian Charter were evenly split. 216

Although the claim at issue was a negative rights claim—the litigants sought to strike down a prohibition on obtaining private health insurance, and were not demanding that the government spend more money on health care or reduce wait times—the case raised the same difficulties associated with positive SER enforcement. Similar to the education context, the court had to determine when the public system fell below a constitutional standard, in order to find whether the restrictions barring obtaining insurance for private services interfered sufficiently with the guarantees of life and security of the person. The court’s decision to strike down the insurance prohibition could have had vast policy ramifications. 217 In particular, the Quebec government argued that the prohibition against private insurance was necessary to prevent the single-tier health insurance system from disintegrating into a two-tier system. 218 None of the judges could convincingly conclude that this consequence would not arise. 219 And, as I argue below, the decision of the court revealed deficiencies in the factual record available to the court about whether and how different measures designed to protect the public system actually work.

The judges split on the effects of the private insurance ban and whether it could be justified as a way to protect the public health care system. The judges all agreed that the prohibition on private insurance, at least in some cases, violated the rights to life and security of the person (or in Justice Deschamps’ analysis of the Quebec Charter, to “personal security and inviolability”). 220 The

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216. Id. at para. 102 (McLachlin, Major, and Bastarache, JJ., concurring); id. at para. 265.
217. Id. at paras. 107–08 (recognizing the issue is “complex” and “may have policy ramifications”) (McLachlin, Major, and Bastarache, JJ., concurring); id. at paras. 161–64 (“The resolution of such a complex fact-laden debate does not fit easily within the institutional competence or procedures of courts of law.”) (Binnie, LeBel, and Fish, JJ., dissenting).
218. Id. at para. 108 (McLachlin, Major, and Bastarache, JJ., concurring).
219. Id. at paras. 78–83 (examining health insurance systems in states comparable to Canada) (majority opinion); id. at paras. 140–49 (comparing the virtues of foreign states’ two-tiered health insurance systems to Canada’s) (McLachlin, Major, and Bastarache, JJ., concurring).
220. Id. at paras. 43, 46 (majority opinion); id. at para. 124 (McLachlin, Major, and Bastarache, JJ., concurring); id. at paras. 200, 205–07) (Binnie,
justices all agreed that ensuring access to quality health care based on need, not wealth, was a valid government objective.\textsuperscript{221} However, they were unable to agree on whether the measure was justified. The justices differed in their approach, but the problem was the same. Does the prohibition on private insurance really protect the public health care system? Are there other measures available? Who bears the burden of proving the connection between the insurance ban and the protection of the public system?

The various opinions turned on whether the government or the plaintiff bore the burden of demonstrating that the private insurance ban was related to and necessary to protect the public health care system. I argue that this reliance on burdens of persuasion shows that the evidence in the case did not support a judicial resolution of what is and is not necessary to ensure a functioning universal public health care system, and can be viewed as a call to government to better justify how it manages health care resources.

Justice Deschamps placed the burden on government to justify the law, having found that it violated the rights to life and security in the Quebec Charter. Section 1 of the Quebec Charter provides that “every human being has a right to life, and to personal security, inviolability, and freedom.”\textsuperscript{222} Justice Deschamps found that the provision was violated because some patients risk death or suffer physical and psychological pain as a result of waiting times.\textsuperscript{223} The burden then shifted to the defendant, the government, which then had to demonstrate that the legislation served a pressing and substantial objective; and if so, that the legislation was rationally connected to that objective, that it minimally impaired the protected rights, and that its objectives were proportionally related to its goal.\textsuperscript{224} She rejected the government’s justifications, which included

\textsuperscript{LeBel, and Fish, JJ., dissenting).}  
\textsuperscript{221} Id. at para. 56 (majority opinion); id. at para. 155 (McLachlin, Major, and Bastarache, JJ., concurring); id. at para. 169 (Binnie, LeBel, and Fish, JJ., dissenting).  
\textsuperscript{222} Charter of Human Rights and Freedoms, R.S.Q., ch. C-12, § 1.  
\textsuperscript{223} Chaoulli, [2005] 1 S.C.R. 791 at paras. 40, 42.  
\textsuperscript{224} Id. at paras. 48, 60. Justice Deschamps emphasized at para. 60: “The burden of proof does not rest on the appellants. Under s. 9.1 of the Quebec Charter, the onus was on the Attorney-General of Quebec to prove that the prohibition is justified. He had to show that the measure met the minimal
concerns that those using private insurance would have less
incentive to invest in the public system over time, that physicians
would leave the public system in order to make more money in the
private system, and that insurers would reject the most acute cases,
leaving them to the public system.\textsuperscript{225} Justice Deschamps found that
there was insufficient evidence to support these concerns,\textsuperscript{226}
emphasizing once more that, "the appellants did not have the burden
disproving every fear or every threat. The onus was on the
Attorney-General of Quebec to justify the prohibition."\textsuperscript{227}

Justice Deschamps reasoned, "[t]here is other evidence in the
record that might be of assistance in the justification analysis,"\textsuperscript{228}
and discussed measures adopted by other provinces to protect the public
system without a ban on private health insurance, some of which
used other methods, like restrictions on doctors, to protect the public
system, and three of which are open to the private sector. She
concluded,

[The variety of measures implemented by different
provinces shows that prohibiting insurance contracts is by
no means the only measure a state can adopt to protect the
system's integrity. In fact, because there is no indication
that the public plans of the three provinces that are open to
the private sector suffer from deficiencies that are not
present in the plans of the other provinces, it must be
deduced that the effectiveness of the measure in protecting
the integrity of the system has not been proved.\textsuperscript{229}

She then conducted a similar analysis of legislation in other
OECD countries, drawing a similar conclusion: "A measure as drastic
as prohibiting private insurance contracts appears to be neither
essential nor determinative."\textsuperscript{230}

Justices McLachlin, Major, and Bastarache, concurring,
agreed with Justice Deschamps that the anti-insurance provision
unjustifiably violated the Quebec Charter.\textsuperscript{231} They also held that the

\begin{itemize}
  \item 225. \textit{Id.} at paras. 63–66, 74.
  \item 226. \textit{Id.} at paras. 64, 66.
  \item 227. \textit{Id.} at para. 68.
  \item 228. \textit{Id.} at para. 69.
  \item 229. \textit{Id.} at para. 74.
  \item 230. \textit{Id.} at para. 83.
  \item 231. \textit{Id.} at para. 102.
\end{itemize}
law violated the rights to life, liberty, and security of the person enshrined in Section 7 of the Canadian Charter. Under their analysis, the benefit of the doubt, given the dearth of evidence about the effects of the anti-insurance provision, went to the government once again. This was so despite the fact that the burden of proof formally fell on the applicants to show that the provision both violated the rights to life, liberty, and security of the person and that it did so in a way that violated the principles of fundamental justice.\(^{232}\)

Section 7 of the Canadian Charter differs from Section 1 of the Quebec Charter in that it is qualified. It states that “everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.” Under Section 7, the claimant bears the burden of proving both that there has been a deprivation of life, liberty and security of the person and that the deprivation violated the principles of fundamental justice.\(^{233}\)

The McLachlin trio concluded that the claimant had met its burden. Like Justice Deschamps, it found that the anti-insurance law violated the rights to life, liberty, and security of the person by requiring people to undergo serious physical and psychological suffering, even risking death, while on waiting lists.\(^{234}\) The relevant principle of fundamental justice the McLachlin trio identified was that a deprivation of life, liberty, or security of the person must not be arbitrary.\(^{235}\) Relying on previous jurisprudence, Chief Justice McLachlin and Justice Major stated that an arbitrary law is one that “bears no relationship to, or is inconsistent with, the objective that lies behind it.”\(^{236}\) They added a new qualification to the rule, however, that “in order not to be arbitrary, the limit on life, liberty

\(^{232}\) Id. at para. 131.

\(^{233}\) See, e.g., R. v. Malmo-Levine, [2003] 3 S.C.R. 571 at para. 83 (Can.) (citing R. v. Mills [1999] 3 S.C.R. 668 at paras. 65-67) (explaining that in contrast to Section 1 of the Charter, “it was affirmed that under s. 7 it is the claimant who bears the onus of proof throughout. It is only if an infringement of s. 7 is established that the onus switches to the Crown to justify the infringement under s. 1.”).


\(^{235}\) Id. at para. 129 (citing Malmo-Levine, [2003] 3 S.C.R. at paras. 594–95).

\(^{236}\) Id. at para. 130 (citing Rodriguez v. British Columbia (A.G.), [1993] S.C.R. 519, para. 694 (Can.).
and security requires not only a theoretical connection between the limit and the legislative goal, but a real connection on the facts. The onus of showing a lack of connection in this sense rests with the claimants.\footnote{Id. at para. 131 (emphasis added).}

It would seem to be a difficult, if not impossible, burden to require that the claimants show the absence of connection between the anti-insurance provision and the viability of the public health care system. Nonetheless, Chief Justice McLachlin and Justice Major concluded that the claimants had met their burden of showing such an absence of factual connection.\footnote{Id. at para. 152. Colleen M. Flood and colleagues observe: "[I]t does not seem that the applicants in the Chaoulli decision had to do more to satisfy this burden than refute the evidence of the government witnesses called to satisfy the majority." Colleen M. Flood et al., Finding Health Policy Arbiterary: The Evidence On Waiting, Dying, And Two-Tier Systems, in Access to Care, Access to Justice: The Legal Debate over Private Health Insurance in Canada 296–306 (Colleen M. Flood et al. eds., 2005).} All the arguments about how prohibiting insurance protects the public system were merely theoretical, they concluded, and no evidence from other jurisdictions showed that prohibiting private health insurance does anything to protect the public system.\footnote{Chaouilli, [2005] 1 S.C.R. 791 at paras. 135–38.} After a cursory review of other countries' health care systems, the McLachlin trio concluded that because those other countries don't prohibit private insurance and yet appear to maintain healthy parallel public health care systems, Quebec's insurance prohibition bore no relationship with protecting the public system.\footnote{Id. at paras. 140–49.} Under the McLachlin trio's paradoxical analysis, this small amount of evidence seems sufficient for the claimants to discharge their "burden." I would argue that if a shortage of proof fails to the favor of the claimants, then the burden is effectively shifted to the government, contrary to the McLachlin trio's assertion that the claimants bear the burden of demonstrating that the insurance prohibition was arbitrary.

The three dissenters, Justices Binnie, LeBel, and Fish appear to have more faithfully applied the burdens of proof. They expressed doubt as to the Court's competence to deal with such a complex fact-laden policy issue.\footnote{Id. at para. 164.} Nonetheless, they ran the analysis through and
concluded that even though there could be a violation of life, liberty, and security under certain circumstances, the principles of fundamental justice were not violated because claimant (who bore the burden) could not show on the facts that the law is arbitrary. They defined arbitrariness differently from the McLachlin trio—in their view, it was not enough to show that the prohibition was unnecessary to protect the public system. Rather, the ban simply had to be related to the protection of the public system to not be arbitrary. The dissenters stated that those who design public institutions can't always predict when their measures cross the line from reasonable to unreasonable, so they deserve a margin of appreciation. Moreover, they accepted the arguments dismissed by the majority as theoretical, finding that there was sufficient empirical evidence to justify the connection between the insurance ban and the protection of the public health care system. Finally there was factual disagreement with the majority: the dissenters were of the view that in other countries that have some privatization, such as the UK and Australia, the public system suffers for it. In the face of that evidence, in their view, the ban could not be considered arbitrary.

The decisions can be explained as turning largely on what happens in the absence of facts, or in the presence of disputed facts about the relationship between private health insurance and a well-functioning public system. According to the majority, the lack of conclusiveness of the facts worked to the benefit of the claimants. According to the dissent, it worked to the benefit of the government.

The Chaoulli decision has been analyzed as a call to government to reduce wait times and improve accountability within the public health care system. First, the decision is, strictly

242. Id. at para. 191.
243. Id. at para. 234.
244. Id. at para. 276.
245. Id. at para. 258.
246. Id. at para. 254.
speaking, binding only on Quebec. Though four of seven justices found a violation of the Quebec Charter, the justices split three-three on whether the Canadian Charter was violated. Moreover, the justices in the majority called on the government to provide better justification for the anti-insurance provision, grounded in facts.

Justice Deschamps stated:

because there is no indication that the public plans of the three provinces that are open to the private sector suffer from deficiencies that are not present in the plans of the other provinces, it must be deduced that the effectiveness of the measure in protecting the integrity of the system has not been proved. The example illustrated by a number of other Canadian provinces casts doubt on the argument that the integrity of the public plan depends on the prohibition against private insurance.\(^{248}\)

She later added, “[i]t cannot be said that the government lacks the necessary resources to show that its legislative action is motivated by a reasonable objective connected with the problem it has undertaken to remedy.”\(^{249}\) She further invited government response by discussing the complementary roles played by courts and legislatures that engage in dialogue to determine the content of constitutional norms.\(^{250}\) Finally, in her most explicit call for government accountability, she stated, “the government cannot argue that the evidence is too complex without explaining why it cannot be presented. If such an explanation is given, the court may show greater deference to the government.”\(^{251}\) Although she did state that “[t]his is not a case in which missing scientific data would allow for a

Institute) (predicting that future court decisions will be unable to deny the logic of Chaoulli that an interest in a public health care system cannot override an individual right to seek timely private care). Cf. Colleen Flood, Just Medicare: The Role of Canadian Courts in Determining Health Care Rights and Access, 33 J. L. Med. & Ethics 669, 676 (2005) (describing equivocally that “Chaoulli is a strong signal to governments that unless they run publicly-funded Medicare well the courts will not tolerate constraints on patients who wish to ‘go private’ and that “on the other hand, [Chaoulli] is not doing much to improve the quality of decision-making either; it is not sending signals to decision-makers that they must be fair, open, and transparent”).

249. Id. at para 87.
250. Id. at paras. 89–90.
251. Id. at para. 92.
more informed decision to be made," she also emphasized that the decision was a response to government neglect. "Inertia cannot be used as an argument to justify deference." She concluded that "[t]he government has not proved, by the evidence in the record, that the measure minimally impairs the protected rights."

Similarly, Chief Justice McLachlin and Justice Major's opinion emphasized that theoretical justifications for the anti-insurance provision were insufficient. They relied on evidence from other countries to conclude that there is no real connection between the prohibition on private insurance and a quality public health care system. They did, however, qualify the reliance on that comparative data, stating that "unless discredited ... [it] stands as the best guide with respect to the question of whether a ban on private insurance is necessary and relevant to the goal of providing quality public health care." Thus, the decision in Chaoulli could be viewed, in experimentalist parlance, as creating a prophylactic rule: unless and until the government proves that its policies, including the insurance ban, are directed toward maintaining the public health care system, its measures risk being struck down.

If provincial governments were to respond to Chaoulli with an experimentalist system that systematically measured universal access to quality health care under different circumstances, facts would be generated to determine what kinds of measures are and are not necessary to protect the public system. All the justices in Chaoulli use a comparative methodology, consistent with experimentalist theory, to determine the reasonableness of the insurance prohibition. The problem, however, is that in the various strands of the judgment, nobody has any really useful, comparable data on whether the measures adopted in other states and provinces to protect the public system actually worked. As Colleen Flood and colleagues have observed:

"[In reviewing the experiences of other jurisdictions, Deschamps J. glides over the health care systems in Austria, Germany, the Netherlands, the UK, New Zealand, Austria and Sweden. Drawing on the Kirby Report,"

252. *Id.* at para. 97.
253. *Id.*
254. *Id.* at para. 98.
255. *Id.* at para. 150 (emphasis added).
McLachlin C.J. and Major J. provide a quick tour of the purported benefits of the health care systems of Sweden, Germany and the UK. There is also passing reference to Australia, Singapore and the U.S. They conclude: 'that many western democracies that do not impose a monopoly on the delivery of health care have successfully delivered to their citizens medical services that are superior to and more affordable than the services that are presently available in Canada.' But they provide no justification or explanation of the measures or variables considered to reach their sweeping conclusion that the health care systems discussed are 'superior' to or more affordable than that of Canada's.\textsuperscript{256}

Justice Deschamps also notes that many provinces operate public systems without bans on private insurance. But we don't really know whether the system means lesser wait times. Likewise, Ontario and Manitoba protect their public systems by regulating what physicians can charge.\textsuperscript{257} Does this work as well as prohibitions on private insurance? In other words, the justices compared the different systems without any performance measures. Flood and colleagues stated: "through their comparative analysis of health care systems, the majority amply demonstrates why courts should be extremely cautious of wading into these difficult areas."\textsuperscript{258}

An experimentalist system would provide useful facts for proving or disproving government assertions about the value of the insurance prohibition, and a mechanism for governments to be held to account for not taking those facts into consideration. The court might not have found that the prohibition on public insurance was arbitrary or not minimally impairing had the government seriously considered and rejected other measures for protecting the public system as part of a systematic effort to determine best practices for maintaining a quality public system. Indeed, Justice Deschamps placed the burden squarely on government to show minimal impairment, but then clearly adverted to the dialogue between the courts and the legislature, and their cooperation in the molding of constitutional standards. She indicated that she might be willing to

\textsuperscript{256} Flood et al., \textit{supra} note 238, at 307.


\textsuperscript{258} Flood et al., \textit{supra} note 238, at 308.
loosen the minimal impairment requirement where government is not dragging its heels.\textsuperscript{259}

It is important to note here that from an experimentalist point of view, a very strict construal of the minimal impairment test is problematic—how can government experiment with different measures if it must always use the least impairing one? Justice Deschamps seems willing to show greater deference where the government has a good reason why it cannot present evidence and where it can show it needs time to implement a well-designed program.\textsuperscript{260} A government can more convincingly argue that it needs time to evaluate the effects of different measures if it can show it is in an ongoing process of doing so.\textsuperscript{261} Her problem, it seemed, was with the government's choice to do nothing. An experimentalist system might satisfy a loosened minimal impairment test because it is itself designed to come up with the best practice.

Although the McLachlin trio denied any free-standing, positive constitutional right to health care, it required, rather vaguely, that "where the government puts in place a scheme to provide health care, that scheme must comply with the Charter."\textsuperscript{262} The Binnie trio similarly accepted that the rights to life, liberty, and security of the person contained in Section 7 of the Charter could apply outside the traditional spheres of the administration of justice, citing \textit{Gosselin}.\textsuperscript{263} In their view, however, the "real control over the scope and operation of Section 7 is to be found in the requirement that the applicant identify a violation of the principles of fundamental justice."\textsuperscript{264}

An experimentalist system that pursued health-care related goals could be seen as consistent with the principles of fundamental justice. If courts were to accept that experimentalist-style accountability structures were consistent with the principles of fundamental justice, this could provide a sufficient brake on the McLachlin trio's expansive view that any unproven measures that interfere with individual liberty in the health context violate the

\begin{itemize}
\item\textsuperscript{259} \textit{Choulii}, [2005] 1 S.C.R. 791 at para. 92.
\item\textsuperscript{260} \textit{Id.} at para. 94.
\item\textsuperscript{261} \textit{Id.}
\item\textsuperscript{262} \textit{Id.} at para. 104.
\item\textsuperscript{263} \textit{Id.} at para. 196.
\item\textsuperscript{264} \textit{Id.} at para. 199.
\end{itemize}
principles of fundamental justice. With such a brake in place, the reasons for choosing not to find positive rights to health care in Section 7 of the Charter would fall away.

Finally, experimentalist approaches are consistent with the dialogic approach favored in recent Supreme Court of Canada jurisprudence. Where complex questions of social policy design are at issue, courts have shown a preference for declaring rights at the high level of generality that the experimentalist model suggests and inviting legislative responses.265 As discussed previously in this paper, an experimentalist model might allow courts to avoid moving too far beyond that level of generality by approving of procedural accountability structures.

The Canadian social and political context favors the creation of experimentalist mechanisms. The Chaoulli decision was rendered in a context, like the American education context, where governments, institutional insiders, and the public are increasingly calling for systematic accountability in terms of access, coverage, level and source of funding, quality of and evidence base for care, cost-effectiveness of current instruments, and existing health disparities within jurisdictions.266 Poocks and Maslof identify citizen engagement, legal approaches, public reporting, and citizen governance as types of accountability mechanisms that have been


called for in recent health care system reviews, including the Romanow and Kirby commission reports\textsuperscript{267} that were heavily referred to in Chaoulli.\textsuperscript{268} An experimentalist system purports to bring each of these mechanisms into play. Moreover, the Canadian federal structure is well-suited to the creation of systems for parallel experimentation.\textsuperscript{269}

VI. LIMITS OF THE EXPERIMENTALIST MODEL

Despite the theoretical promise of experimentalist approaches for SER protection and the sympathy of courts for experimentalist techniques, there are reasons to doubt that the model will genuinely allow for the protection of a universal right of timely access to quality health care in Canada.

First, government and the public may not create an experimentalist system in response to a court's broad definition of a right, even if the court more explicitly invites one. Experimentalist theory requires that there be some level of consensus that there is a problem and a desire to fix that problem collaboratively. This consensus may be motivated, in part, by common fear of the penalty default—the imposition of a judicial solution—if the accountability system is not adhered to.\textsuperscript{270} But in fact, at least in the short term,

\begin{footnotesize}
\begin{enumerate}
\item See Romanow, id.; Kirby, id.
\item See Colleen M. Flood & Tom Archibald, Hamestrung and Hogtied: Cascading Constraints on Citizen Governors in Medicare, Health Care Accountability Papers No. 6 (June 2005).
\item Sturm, supra note 158, at 1437, discusses the incentive structure that gets parties to cooperate and argues that:
\end{enumerate}
\end{footnotesize}
some actors might prefer the judicially-imposed solution, for all its flaws. Those who would seek a two-tier health care system in Canada, for example, might prefer Chaoulli’s “penalty default” of parallel public and private systems.

Even where the parties are committed to experimentalist solutions, and the appropriate architecture is in place or created, experimentalist systems might fail to produce the best possible results. Additional resources might be needed to make the systems work. The existence of an accountability structure will not itself provide the money that may be necessary to support necessary improvements. Participants, which in an experimentalist health care system would include citizens, consumers, health care professionals, and institutional administrators, may lack the capacity to respond to the information that the accountability system generates. Not all units will be operating with the same budget; limited experience with the adversary process and at the remedial stage teaches that the parties’ interests are unlikely to be served through the adversary model. The threat of formal adjudication predisposes participation in deliberation.

Liebman and Sabel similarly admit that a precondition for the creation of accountability systems is the “politically consequential diffusion of a new calculus of consent. People dispossessed by the current system are sufficiently aggrieved by the resulting costs that it is worth their while to coalesce to disentrench established interests, provided that there is a minimally acceptable prospect of success and accountability.” James S. Liebman & Charles F. Sabel, The Fragile Promise of Provisionality, 28 N.Y.U. Rev. L & Soc. Change 369, 370 (2003).


272. Martha Minow discusses a similar problem in the educational reform context, remarking that

even assuming that tests are administered and results come in a timely fashion to teachers, most teachers lack the knowledge and understanding to perform the new role imagined for them. Student test scores offer at best partial evidence about when and how different instructional methods work. Linking test scores to alternative curricular methods and instructional techniques requires levels of knowledge and skill that are not currently well-distributed . . . . Analogous . . . problems occur for parents and community advocates; how are they to acquire the capacity to understand and use the testing information to assess, monitor, and improve the schools?

they may not have the money to implement best practices. 273
Impoverished, tired, busy stakeholders may lose the momentum
necessary if reforms are to take their knowledge and expertise into
account and if capture by the more powerful is to be avoided. 274
These problems may be overcome if the state pours sufficient resources into
facilitating the functioning of an experimentalist system. But the
administrative review approach (as opposed to the case-by-case
approach) is most needed where governments are failing to fund SER
fulfillment. Resource-related problems are likely to persist within,
and undermine, an experimentalist system. 275

Experimentalist systems are threatened by difficulties that
go beyond funding. 276 How can a good health care system be
identified? Political pressure to generate results quickly might result
in less than effective short-term strategies being favored over better
long-term ones. 277 The tools used to measure successful programs
might be flawed: critics of No Child Left Behind have complained
that teaching to the test distorts measurements of real educational
successes. 278 To the extent that experimentalist systems require the

273. Id. at 333.
274. Id. at 333, 335.
275. Dorf & Sabel, supra note 8.
276. See Jacob E. Adams, Jr., Results or Retrenchment: The Real Race in
(arguing that "false accountability systems suffer from principal-agent ambiguity,
contested standards, rudimentary accounts, weak technology (that is, tests
unable to do the job) difficulty assigning responsibility for results, and conflicts
between internal and external (to schools) accountability expectations").
277. See Terrence J. Sullivan et al., A Just Measure Of Patience: Managing
Access To Cancer Services After Chauvili, in Access to Care, Access to Justice:
The Legal Debate over Private Health Care in Canada 454 (Colleen M. Food et al.
eds., 2005) (commenting on the difficulty of setting priorities in prevention and
treatment).
278. See James E. Ryan, The Perverse Incentives of the No Child Left
system that rewards and punishes schools based on absolute achievement levels
will thus reward relatively affluent schools and punish relatively poor ones"). See
also William Firestone, Teaching to the Test in New Jersey: the Good, the Bad,
and the Ugly 1, CEPA Newsletter available at http://www.cepa.gse.rutgers.edu/Old%20CEPA%20Newsletters/CEPA_SP01NEW S.pdf; and Ctr. on Educ. Policy, From the Capital to the Classroom: Year 4 of the
No Child Left Behind Act 10 (2006), available at http://www.ccpd-
dc.org/index.cfm?fuseaction=Page.viewPage&parentid=495&parentid=481 (finding
that most school districts surveyed have reduced classroom time for subjects
adoption of best practices, there is a risk of encouraging homogenization of practices instead of experimentation.

Ensuring participation is especially problematic when experimentalism is transposed from its place of birth as a business management model into highly contested areas of social policy. Although experimentalist approaches accommodate changes in intermediate goals over time, at any given point it is assumed that there will be "strong points of commonality that dominate the concerns and ethos of the network"—to maximize profit, to build the best quality product, etc. Where complex social questions are concerned, parties are likely to have divergent interests, which, especially where there are power imbalances among the deliberators, pose serious problems for a consensus-driven process. Deliberators may simply fail to come to any agreement. Networks might not provide a voice for all participants. More powerful groups may wish to exclude the views of relatively powerless minorities (e.g., those who suffer from conditions which disproportionately affect marginalized populations, such HIV/AIDS) in designing local policy experiments where those views would interfere with the majorities’ countervailing interests and visions of success. Comparison of progress among units may be difficult. The process is less likely to generate clear and comparable results as diverging interests among units may mean that they are not in fact seeking to move toward the same, ostensibly agreed upon goals.

In addition, the experimentalist system says nothing about rates of progress. In its effort to avoid setting out the substance of the right itself, experimentalism creates a procedure where the baseline content of a right is set by the unit generating the best possible SER outcomes. Where all the units are lagging in concert, the court should

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281. Hershkoff & Kingsbury, supra note 279, at 321 ("Corporate investors, for example, deciding whether to relocate to a region, may want state-of-the-art public schools for the children of top management, yet insist on tax abatements that block any but the most modest improvements in schools of the children of factory floor workers.") (footnote omitted).

282. Minow, supra note 272, at 338.
in principle defer, on the theory that the units are expressing their vision of the content of SERs at the time.

Finally, the focus on achieving results may also discourage practices that might have intrinsic or expressive, but not instrumental value. Unmeasurable values abound where SERs are concerned. In the controversy over privatization of health care in Canada, the Romanow Commission found that Canadians found important symbolic value in having a socialized health care system. Even if the moral worldview of Canadians could be gauged for its instrumental value (i.e., if it could be demonstrated that the presence of a socialized health care system engendered values that led to better SER realization), an experimentalist system would likely be unable to function effectively on timelines set long enough to measure these kinds of effects.

Identifying some best practices and distinguishing resource-related problems from design deficiencies may be better than no accountability at all. In other words, an experimentalist system does not have to be working perfectly, with seamless sharing and adoption of best practices, in order to produce better substantive outcomes than ordinary political processes. But should these problems sufficiently cripple the experimentalist project, judicial intervention in dictating substance is arguably justified, just as it might be when governments fail to respond to judicial calls for action under the administrative review model.

Since experimentalism eschews traditional substantive notions of rights in that it posits that judges will recognize that the metaphysical project of defining the content of rights is inferior to systematic deliberation, there is no moment internal to the theory when experimentalism can be declared a substantive failure so that judges can impose the penalty default using traditional adjudicatory

283. Hershkoff & Kingsbury, supra note 279, at 323 ("[T]he existing literature does not yet show that networks can work well as motors for political community in the sense of identity-maintenance or the transmission of distinct cultures or the protection of disadvantaged groups. Indeed, it seems difficult to design network-type processes and markets in ways that will not intensify the erosion of conventional identity-markers.").

284. Romanow, supra note 266, at xvii.


286. Hershkoff and Kingsbury, supra note 279, at 324.
techniques. In fact, judges who are faithful to the experimentalist vision should accept that if governments adhere to the right procedures, then the policy's expression of best practices should be accepted.

Whenever judges are pushed to intervene substantively—because the relevant parties fail to create the experimentalist architecture, because they fail to adhere to it, or because the results fail to live up to judges expectations, the familiar capacity and legitimacy concerns may re-emerge. The retention of the power to impose the penalty default—which is necessary for the courts to play a significant role in pressing for reform—means that more aggressive intervention remains as a possibility.

CONCLUSION

Constitutional, judicially enforceable positive SERs sit poorly with the idea of constitutional rights as absolute trumps, whose exact substantive boundaries are precisely defined and fully enforced by courts. At the same time, modern constitutions increasingly include SER protections in constitutional bills of rights with the intention of constraining democratic decision-making by requiring it to move toward particular outcomes. Very broadly, courts have either haphazardly enforced SERs where they have tried to remain faithful to the rights-as-trumps vision, or have had to move away from the notion that rights can be completely defined and enforced at the judicial level.

This paper suggests that positive constitutional SERs get the most meaningful judicial protection where courts enlist collaboration

287. Jacob Adams states:
Accountability ... rests on a plausible theory of action, indicating how incentives, accounts and consequences can, in the language of principal-agent theory, induce agents to act diligently while also enabling principals to know the results and to respond accordingly. However, adequacy's theory of action says little more than that resources should be sufficient to accomplish the student performance that states desire. The legal theory establishes new constitutional obligations, but adequacy suits have yet to produce a clear, justiciable standard that enables courts to know adequacy when they see it.

with governments and other stakeholders in defining and enforcing all dimensions of the rights. There is a range of available options for collaborative realization, all of which are designed to allow courts to require action while avoiding too much involvement in substantive policy-making and priority-setting. Courts can hope to engender SER values and sporadically enforce them by treating SERs as nonjusticiable guiding principles of interpretation. They can declare the broad content of rights without issuing orders and injunctions. They can declare the broad content of rights and require government to demonstrate that it is making reasonable progress toward them. They can issue specific injunctions and orders where they can competently and legitimately do so.

None of these options entirely eliminates the possibility of a standoff between a court committed to SER protection and a government dead-set against it. As long as judges have the power to superintend the substance of government policy, the capacity and legitimacy concerns associated with the enforcement of costly, positive SERs will persist at some level. Where governments fail to respond to judicial invitations for collaboration, courts will be tempted to intervene more aggressively. But each tool may be a useful way to tap into whatever potential energy exists within the polity toward SER fulfillment. Methods, like the experimentalist ones, that lead judges away from substance and toward procedural review and that generate the kind of information that might prompt political action create intermediate steps that might hold off more aggressive judicial articulation and enforcement of substantive aspects of rights. Where governments fail to create the court-invited accountability systems or where those systems are captured by more powerful actors or do not function effectively, courts might legitimately be drawn toward more aggressive substantive intervention. But where those systems function well, even if they do not yield progress to the satisfaction of judges’ preferences, they may be a better way of tapping into society’s level of commitment to SER norms than majoritarian politics alone.
CRIMINAL LAW, HUMAN RIGHTS, AND THE GOVERNANCE OF HIV EXPOSURE AND TRANSMISSION

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Introduction

Since the early days of the HIV/AIDS epidemic in the 1980s, scholars and activists have been preoccupied with the question of whether people should be held criminally liable for engaging in risky sexual behavior without disclosing their HIV-positive status. 1 Objections, which have made up the bulk of responses to criminalization, have largely been based on questions of policy and ethics: Will the stigma associated with criminalizing the sexual behavior of people living with HIV undermine the fight against HIV/AIDS, or increase

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discrimination against people living with HIV? Can the criminal law appropriately target morally blameworthy behavior in this context?

The focus of academic and policy discussions to date on the criminalization of HIV exposure and transmission has largely concerned whether and how criminal law statutes and doctrines should develop to cover sexual activities that create a risk of HIV transmission. Some have agreed with a general judicial and legislative consensus that the application of the criminal law is appropriate: society should impose criminal sanctions on those who knowingly expose others to the risk of a fatal, incurable disease to express societal disapproval; to punish offenders for their wrongdoing; to prevent the person from repeating the conduct; and to deter others from similar conduct. Others have argued that the net will inevitably be cast too wide, punishing those who do not rightly deserve to be punished, and that criminalization will interfere with public health objectives by stigmatizing people living with HIV, driving the epidemic further underground and sending to the community the message that the law will protect them from the virus. Instead, caution in extending the criminal law to this area is suggested.

Objections to criminalization of HIV exposure and transmission have been framed, to varying degrees and in varying ways, in human rights terms. But the human rights-based effort to forestall criminalization has met with relatively little demonstrable success, at least in terms of legal doctrine. Now, in most jurisdictions that have considered the issue, the basic question of criminal liability appears to be settled: the precise requirements for conviction vary, but as a general rule people living with HIV may be prosecuted under certain circumstances for consensual sex that transmits, or risks transmitting, the virus.

This paper argues that the principal human rights, ethical, and social policy concerns that have been raised around criminalization time and again over the past twenty-five years are not easily addressed within traditional criminal law theory and doctrine; nor can traditional human rights analysis provide neat answers to inform state policy on when it ever, it is appropriate to apply the criminal law to consensual sex of people living with HIV. Instead, this paper explores how emerging conceptions of the right to health – ones that attempt to engage with, rather than wrestle down, indeterminacy – may undergird, explain, and justify novel approaches toward addressing the potential for perverse public health effects and criminal law’s blindness toward contextual factors that may call moral blameworthiness into question.

With the focus on the narrow question of decriminalization, little attention has been paid to other legal and quasi-legal orders that affect the operation of the criminal law in practice. But public health actors, in tacit or explicit collaboration with criminal law actors and people living with HIV, can and often do play a mediating role by shaping and tailoring the application of the criminal law here so it is more faithful to its own retributive and instrumental purposes. Public health interventions have the capacity to be more targeted, flexible, and contextually informed. Appropriately conceived, and informed by new themes in the right to health, such interventions can provide police and prosecutorial authorities with a basis for principled deference. Human rights dimensions of criminal law policy may be addressed with more nuance and precision. Criminal law’s position as a site for negotiation of

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3 Elliott, supra note 1; Weait, On Being Responsible, supra note 1; Dwyer, supra note 1; Lazzarini, Bray, and Burris, supra note 1; Sullivan & Field, supra note 1; Weait, Criminal Law and the Sexual Transmission of HIV, supra note 1; Wolf & Vezina, supra note 1.
normativity is enhanced, and its traditional incapacities to adapt to individual circumstances and to take into account emerging insights in behavioral approaches to HIV/AIDS may be mitigated. Space is created for more resonant, better-contextualized justifications for criminal punishment.

This paper also considers some practical and theoretical implications for human rights discourse of viewing and constructing the collaboration among criminal justice, public health, and community actors in this context through a process-oriented human rights lens. A move in social and economic rights (and specifically right to health) discourse away from naming-and-shaming and judicial challenges and toward participatory, collaborative norm setting and enforcement not only accommodates indeterminacy in the precise contours of the right to health, but also clarifies and refocuses the human rights agenda as it intersects with criminal justice. In particular, it provides conceptual justification for policy agendas that support community-building and research among the marginalized groups most vulnerable both to HIV and to criminal sanction. At the same time, risks associated with the broader conceptions of a human rights agenda are highlighted. Policy agendas may appear unwieldy, and practical risks associated with broad positive state human rights duties are brought to the fore. The increasing focus on process may distort the substantive justice orientation of traditional human rights thinking and in practice extend the reach of criminal sanction if human rights might come to be used as a justification for, rather than that a limit on, the reach of the criminal law.

This paper proceeds in three parts. Part I traces the debate over the criminalization of HIV exposure and transmission, with reference to the laws of Canada, the United Kingdom, and the United States. It demonstrates that many of the policy and human rights objections raised about the criminalization of HIV exposure and transmission can be addressed from within criminal law and traditional human rights doctrine only incompletely.

Part II considers how emerging conceptions of norm-generation and enforcement in the right to health literature – particularly a shift in focus to processes over substance – may support novel forms of collaboration and coordination among criminal justice actors, public health actors, and community members, collaboration which has a capacity to restrain some of the elusive negative human rights implications of criminalization. The idea is that appropriately conceived public health interventions could provide a basis for principled deference by police and prosecutorial authorities, supplementing or even supplanting formal criminal law in an area like this one. In the process, these public health interventions might help mediate tensions and eliminate blind spots within traditional human rights and criminal law analysis.

Part III places a right-to-health based collaboration in theoretical context in order to draw out some concerns around emerging governance-and-human-rights based approaches in this context. This part draws on new governance and community-oriented justice literatures and concludes with principles to inform a new human rights agenda to guide the interrelationship between the criminal justice system and neighbouring legal orders in this context.

I. The limits of traditional legal and human rights based objections to the criminalization of HIV transmission and exposure

The debate over the criminalization of HIV exposure and transmission has scarcely changed since 1988 when Kathleen Sullivan and Martha Field published the first major law review article setting possible legal bases for criminalization and arguing that it would be a
mistake to enact criminal measures to deal with the problem of HIV transmission. Over the years that have followed, Sullivan and Field’s concerns have been echoed and elaborated by academics and human rights activists. Meanwhile, courts and legislatures across jurisdictions have, for the most part, determined that the criminal law prohibits people with HIV from having sex that risks transmitting or actually transmits the virus without disclosing to their partners in advance that they are HIV-positive.

For some, the matter is simple: exposing others to risks of a fatal disease is morally indefensible conduct that merits sanctions both to punish obviously dangerous behavior and to deter others from engaging in similar conduct. For others, criminal law is too blunt an instrument to deal with a matter as complex as HIV exposure and transmission; Burris sets out this orientation:

[Sex] is a complex behavior, psychologically and morally; disclosure and safe sex are negotiated non-verbally and contextually; risks vary according to the behavior, and are often not as significant as they are portrayed in lurid news reports; a person who practices safe sex or disclosure most or even some of the time represents a public health success.

On this latter view, criminalization of exposure or transmission provides no assistance to governments trying to prevent the spread of HIV. Opponents of criminalization point to the vast body of public health literature on the kinds of interventions that promote testing, safer sex and disclosure and note that there are no studies that demonstrate the effectiveness of criminal justice approaches. Rather, they contend, criminalization of people who are HIV-positive will perpetuate the stigma associated with the disease, which is harmful in itself and also hinders public health efforts that depend on stigma reduction. A number of more precise concerns about how criminalization in its different forms may undermine public health programs are also raised. Finally, concerns about justice and the coherence of criminal law often figure in critiques. This Part begins with a summary of legal bases for criminal liability for HIV exposure or transmission in Canada, the United Kingdom and the United States. It then traces the principal concerns and tensions around criminalization as they arise in these jurisdictions, with reference to emerging scientific understandings about HIV transmission.

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5 Sullivan & Field, supra note 1, at 197.
6 See supra note 1.
8 Holland, supra note 2; Spencer, Reckless Infection: Part 1, supra note 1, at 244; Spencer, Reckless Infection: Part 2, supra note 1.
A. The state of the law

In the majority of jurisdictions where courts or legislatures have explicitly considered the issue, people who are HIV-positive can be prosecuted for certain kinds of behavior that may expose or transmit the virus to a sex partner. A minority of states in the U.S. have adopted HIV-specific statutes that criminalize certain sexual activities of people who are HIV-positive;\(^{12}\) in the remaining U.S. states,\(^{13}\) as well as in Canada\(^{14}\) and the United Kingdom,\(^{15}\) laws of general application that existed prior to the epidemic have been used to prosecute individuals who engage in unprotected sex without disclosing their HIV-positive status. Although it is difficult to track the precise number of prosecutions as many convictions are unreported, prosecutions appear to be taking place in a broader range of circumstances and are, it seems, increasingly frequent.

1. United Kingdom

In Scotland in 2001, Stephen Kelly became the first person in the UK to be convicted for HIV transmission for the Scots common law offence of recklessly causing injury to another.\(^{16}\) Two years later, Mohammed Dica was convicted for HIV transmission in England.\(^{17}\) Dica was found to have violated section 20 of the Offences Against the Person Act 1861, which applies throughout the UK except in Scotland.\(^{18}\) Section 20 of the OAPA states that “[w]hoever shall unlawfully and maliciously wound or inflict grievous bodily harm upon any person, either with or without any weapon or instrument, shall be found guilty of [an offence].” To date, there have been twelve convictions for sexual HIV transmission in the UK.\(^{19}\)

The primary distinguishing feature of the UK approach is that, thus far, they have concerned themselves only with HIV transmission; there have been no convictions for mere

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13 Id. at 857-859.
17 Dica, 2 Cr App R 28.
18 The Offences Against the Person Act, 1861, c. 100 §78 (1861) (providing that the Act does not apply in Scotland.
exposure.\textsuperscript{20} It should also be noted that the \textit{mens rea} requirement is of intention or recklessness. To prove recklessness, the prosecution must establish that at the time of the offence the defendant was aware of the risk that some degree of bodily harm might be caused by his act or omission and nonetheless ran that risk.\textsuperscript{21}

2. United States

Every U.S. state has criminal laws that apply to conduct exposing others to HIV.\textsuperscript{22} In 1990, the federal government encouraged criminalization of knowingly exposing others to HIV when it passed the Ryan White Comprehensive AIDS Resources Emergency (CARE). The law provided funds for AIDS treatment and care, but required states to demonstrate that their criminal laws were ‘adequate to prosecute any HIV infected individual’ who knowingly exposed another to HIV through donation of blood, semen, breast milk, sexual activity or needle-sharing.\textsuperscript{23} By 2000, all states had certified that they had laws addressing knowing HIV exposure and the requirement was repealed.\textsuperscript{24} It was possible to meet the requirement without enacting HIV-specific offences by demonstrating that criminal laws of general application were sufficient to prosecute knowing HIV exposure. Nonetheless, as of 2008, eighteen states have adopted HIV-specific statutes creating a separate crime for knowing sexual exposure to HIV.\textsuperscript{25} Some states have public health statutes criminalizing the exposure or transmission of sexually transmitted diseases, STD exposure or transmission, including HIV,\textsuperscript{26} but a 2002 study found that there were no cases in which these laws had been applied in the HIV context.\textsuperscript{27} The remaining states may use laws of general application, including murder, attempted murder, manslaughter, reckless endangerment, and assault. Moreover, some prosecutors rely on such laws of general application even where HIV-specific statutes are available.\textsuperscript{28}

\textsuperscript{20} See James Chalmers, \textit{Sexually Transmitted Diseases and the Criminal Law}, 5 JURIDICAL REVIEW 259, 266-7 (2001) [hereinafter Chalmers, \textit{Sexually Transmitted Diseases and the Criminal Law} (articulating that theoretically, prosecution could be brought under Scottish law for the offence of “reckless endangerment”); See National AIDS Trust, CRIMINAL PROSECUTION OF HIV TRANSMISSION: NAT POLICY UPDATE (National AIDS Trust August 2006), http://kennowps.co.uk/crimin.pdf (last visited August 23, 2010) (indicating that in England, prosecution for exposure would not be possible under English Law unless the defendant had acted with the intention of transmitting HIV); The Offences Against the Person Act, 1861, c. 100 §18 (1861).


\textsuperscript{22} For a summary of state criminal statutes, see American Civil Liberties Union, \textit{STATE CRIMINAL STATUTES ON HIV TRANSMISSION -- 2008} (American Civil Liberties Union 2008), http://www.aclu.org/hiv/gen/34228res20080221.html.


\textsuperscript{25} Arkansas Code of 1987- Annotated §514-123 (1987); California Health & Safety Code §120291; Florida Statutes Annotated- Title XXIX- Public Health Section §384.24; Georgia Code Annotated §165-60(c); Idaho Code Annotated §39-608; 720 Illinois Compiled Statutes 5/216.2; Indiana Code Annotated §35-42-1-7; Iowa Code §709 C; Louisiana Revised Statutes §43.5; Maryland Health Code Annotated Health-General §18-601.1; Michigan Compiled Laws §333.5210; Missouri Revised Statutes 19.1677; Nevada Revised Statutes §21-205; New Jersey Statutes §2C:34-5; North Dakota Century Code Annotated §12-1-29-17; Oklahoma Statutes 1192.1; 18 Pennsylvania Consolidated Statutes §2703; South Carolina Code Annotated §4429-145; South Dakota Codified Laws §22-18-31; Tennessee Code Annotated §39-13-109; Virginia Code Annotated §18.2-67, 4:1.


\textsuperscript{27} Lazzarini, Bray & Burris, \textit{supra} note 1, at 241.

It is difficult to ascertain how many people have been successfully prosecuted for HIV transmission or exposure in the United States in the context of consensual sexual activity. Researchers typically rely on case reports and newspaper articles and therefore likely underestimate the number of prosecutions. One study, however, showed that between 1986 and 2001 there were 84 prosecutions, 64 of which resulted in convictions, for HIV exposure through consensual sexual activity in the United States. In addition, 40 prosecutions arose in the context of prostitution, 22 of which resulted in convictions. All but twelve states and the U.S. territory of Puerto Rico had at least one reported prosecution.

3. Canada

In Canada, sexual exposure or transmission of HIV may be prosecuted under general criminal laws, most frequently the laws of assault and sexual assault and, sometimes, common nuisance. Charges for criminal negligence causing bodily harm may also be brought where there is actual transmission. In 1998, in the seminal case of R. v. Cuerrier the Supreme Court of Canada pronounced on the issue for the first time, holding that a person may be found guilty of sexual assault for having unprotected sex without disclosing known HIV-positive status, even if the virus is not transmitted. The rationale is that unprotected sex with an HIV-positive person presents a "significant risk of serious bodily harm" and that non-disclosure of that risk rises to the level of fraud and thus vitiates any consent to sexual activity.

Since the first successful prosecution in 1989, at least sixty-five people have been convicted for HIV exposure or transmission through otherwise consensual sexual activity in Canada. More than one-third of known prosecutions were brought between 2005 and 2008.

B. Concerns over criminalization

A number of preoccupations drive the criticisms of criminalization in this context. One is that the very association of HIV transmission with criminality will reinforce stigma against people who are HIV-positive, stigma that governments have an interest in fighting both for human rights and public health-related reasons. Another is that the criminal justice system cannot be tailored to reliably distinguish behavior that is both truly risky and morally blameworthy. Relatedly, there is a concern that notions of reasonableness that triers of fact are likely to bring to their determinations in this area may be so divorced from the realities of people who are HIV-positive that standards of behavior will be unfair. These concerns can be identified in the more precise objections to criminalization that have been reiterated time and again over the years.

29 Lazzarini, Bray & Burris, supra note 1, at 245.
30 Id.
34 Id. at ¶128.
1. Setting wrong incentives and undermining public health programs

From the earliest days of the debate, critics have asserted, generally without direct empirical evidence, that recourse to the criminal law would interfere with and undermine the fight against the HIV epidemic. Encouraging voluntary testing and frank discussion of HIV status remains a central part of most HIV/AIDS prevention strategies, as people who know their status tend to be less likely to engage in high-risk behaviors. There is a concern that people may shy away from testing for fear of exposing themselves to criminal liability for knowingly exposing or transmitting HIV. The court in Cuerrier considered and rejected this concern about testing, simply stating that “[t]hose who seek testing basically seek treatment. It is unlikely that they will forego testing because of the possibility of facing criminal charges should they ignore the instructions of public health workers.”

Partner notification schemes could also be adversely affected. Throughout Canada, the United Kingdom and the United States, public health policies include programs for partner notification, which rely on those who have tested HIV-positive to voluntarily disclose the names of sex partners who may have been infected. These partner notification schemes generally try to maintain the anonymity of the tested individual. However, individuals notified may nevertheless be able to deduce that person’s identity. As a result, people who have tested HIV-positive may not want to cooperate in partner notification fearing that the information may be used against them. Without patient cooperation, public health officials cannot conduct effective partner notification.

In cases where people living with HIV may have engaged in risk-taking behavior that is unplanned or inadvertent, they should advise their sexual partners that they may want to use post-exposure prophylaxis – a course of antiretroviral drugs which is thought to reduce the risk of seroconversion after exposure to the virus. However, where HIV exposure is a criminal offence, this would be tantamount to admitting to a crime. Some might thus prefer to not disclose and instead to rely on the probability that there has been no transmission or hope that the behavior will go unnoticed by the law.

Finally, there is an inconsistency in approach between a criminal law that would punish every act of unprotected sex without disclosure and the view, prevalent among scientists, that learning to practice safer sex is a complex social and psychological process.

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38 See, e.g., Elliott, supra note 1; Weait, On Being Responsible, supra note 1; Dwyer, supra note 1; Lazzarini, Bray & Burris, supra note 1; Weait, Criminal Law and the Sexual Transmission of HIV, supra note 1.
39 Wolf & Verzina, supra note 1, at 870.
40 See, e.g., Elliott, supra note 1; Lazzarini, Bray & Burris, supra note 1, at 250; C.f. Holland, HIV/AIDS and the Criminal Law, supra note 2.
42 See, e.g., James G. Hodge & Lawrence O. Gostin, Handling Cases of Willful Exposure Through HIV Partner Counseling and Referral Services, 23 WOMEN’S RIGHTS LAW REPORTER 45, 54-56 (2001) (describing New York and California’s partner notification laws and recognizing the tension resulting from the need to respect an HIV infected individual’s privacy so that he or she will participate in public health efforts and the need to warn those who are at risk of being HIV-infected after being exposed to the virus, which despite efforts to maintain confidentiality of the HIV infected individual may nonetheless deduce that person’s identity).
43 Lazzarini & Klitzman, supra note 11, at 537.
44 National AIDS Trust, supra note 20.
One review has noted that for a variety of reasons a sizeable percentage (in some studies as high as 56 per cent) of people living with HIV continue to have unprotected sex without disclosing their HIV status. The comments of Ekstrand et al. reflect a scientific consensus:

It is important that people who occasionally engage in unprotected intercourse are not blamed for their behaviors. Relapse into unsafe sex may simply reflect the normal process of any behavior change. Once new behaviors have been acquired, whether they involve a new diet, a new exercise regimen, or condom use, many individuals need and want additional assistance in maintaining this behavior change over time. We do not believe that this struggle should be a stigmatized condition, but simply perceived as a human one.

The recent conviction of a Quebec woman is illustrative. The woman, D.C., claimed that she had had sex with her partner only once before disclosing her HIV status, and that a condom was used. Following the initial encounter, she consulted with her doctor about the risk of transmission if a condom broke, and was advised to disclose her HIV status to her partner. She did so. The couple went on to practice safe sex for four years before the complainant brought charges against D.C. based on the initial encounter. The trial judge found that no condom was used the first time the couple had sex, and convicted D.C. of sexual assault. From a public health point of view, D.C.'s overall behavior should be reinforced as a successful adoption of safer sex practices through medical consultation. Where every act of unsafe sex without disclosure is stigmatized as criminal, however, the capacity for frank discussion and support through a process of moving toward safer sex practices may be compromised.

2. Undermining notions of shared responsibility/misallocation of responsibility

Another long-standing objection to the application of criminal sanctions in this area, and one that likewise resists empirical validation, is that imposing criminal liability only on the HIV-positive partner undermines notions that both partners are equally responsible for the practice of safe sex. Correspondingly, regular recourse to the criminal law might create a "false sense of security" if it leads people to believe that the law protects them from being exposed to or contracting HIV.

A shared responsibility approach, in which consent to sexual activity is understood to include consent to all the attendant risks, would obviate the application of the criminal law in this area altogether. That said, self-protection may not always be equally available to sexual partners; a woman may risk abuse from her sexual partner if she asks for condoms, and a married person may have a greater reason to assume fidelity from her or his partner. In these contexts, it may be sensible to impose a duty of disclosure on the more powerful partner.

The difficulty is fashioning a rule that is appropriately context-sensitive. Placing criminal responsibility for unsafe sex only on the HIV-positive partner is consistent with a

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46 Gary Marks, Scott Burris & Thomas A. Peterman, supra note 10.
49 Id. ¶ 130-31.
50 See Gary Marks et al., Meta-analysis of High Risk Sexual Behavior in Persons Aware and Unaware They are Infected with HIV in the United States: Implications for HIV Prevention Programs, 39 JOURNAL OF ACQUIRED IMMUNE DEFICIENCY SYNDROMES 446 (2005) (indicating that people who do not know they are HIV-positive are more likely to engage in risky sexual practices).
view that one may assume, unless told otherwise, that unprotected sex does not carry a risk of infection. In practice, however, this assumption may not always be reasonable. Thus, for example, the outcry among HIV/AIDS activists, when a Vancouver street-based sex worker was charged with having unprotected sex with a client without disclosing her HIV status, was that the client ought to be understood to have assumed a risk of transmission.\footnote{51}

As a matter of criminal law doctrine, courts and criminal law scholars consider the issue of allocation of responsibility through the lens of consent: does a person who consents to having unprotected sex also consent to the risks of sexually transmitted infections? In answering this question, courts have rejected a shared-responsibility approach, in which any consent to sexual activity is understood to include consent to all the attendant risks. Courts have also tended to avoid any contextual weighing of responsibility by rejecting any argument of implied consent. Instead, the conclusion has been that person who is aware of the heightened risk— the HIV-positive partner— bears the primary responsibility to inform their partner. Justice Cory of the Supreme Court of Canada expressed the view sharply in \textit{Cuerrier}:

> It is true that all members of society should be aware of the danger and take steps to avoid the risk. However, the primary responsibility for making the disclosure must rest upon those who are aware they are infected. I would hope that every member of society no matter how 'marginalized' would be sufficiently responsible that they would advise their partner of risks. In these circumstances it is, I trust, not too much to expect that the infected person would advise his partner of his infection. That responsibility cannot be lightly shifted to unknowing members of society who are wooed, pursued and encouraged by infected individuals to become their sexual partners.\footnote{52}

The English Court of Appeal in \textit{Dicu} was more nuanced, recognizing that different kinds of relationships carry different assumptions about sex:

> At one extreme, there is casual sex between complete strangers, sometimes protected, sometimes not, when the attendant risks are known to be higher and at the other, there is sexual intercourse between couples in a long-term and loving and trusting relationship, which may from time to time also carry risks.\footnote{53}

Nevertheless, the context of the sexual encounter was not treated as relevant to the question of whether a person accepts the risk of harm simply by agreeing to have unprotected sex with someone whose HIV-status is unknown: consent to the risk of harm would require knowledge, and not mere suspicion, that a sexual partner had HIV.

In \textit{Konzani}, the English Court of Appeal recognized certain limited circumstances in which a complainant’s knowledge of their partner’s HIV seropositivity might be imputed:

> By way of example, an individual with HIV may develop a sexual relationship with someone who knew him while he was in hospital, receiving treatment for the condition. If so, her informed consent, if it were indeed informed, would remain a defence, to be disproved by the prosecution, even if the defendant had not personally informed her of his condition. Even if she

did not in fact consent, this example would illustrate the basis for an argument that he honestly believed in her informed consent. Alternatively, he may honestly believe that his new sexual partner was told of his condition by someone known to them both. Cases like these, not too fanciful, may arise.\textsuperscript{54}

The suggestion here is clearly not that consent to risk of infection may be implied by a person’s general knowledge about the risks of unprotected sex with a partner whose HIV status is unknown; rather, the court points to specific indications that would lead a person to know that their particular sexual partner was in fact HIV-positive.

An expanded, context-sensitive exception to the requirement of explicit disclosure may allow for more nuanced, contextualized analyses of shared responsibility, but only at the risk of stereotyping and moralizing. A court might determine, for example, that a man who has anonymous sex in a gay bathhouse consented to the risk of exposure and transmission, or that an HIV-positive man in the circumstance had an honest belief in such consent.\textsuperscript{55} Should the man in the gay bathhouse, absent disclosure, be entitled to less protection than a woman whose husband who unbeknownst to her has been unfaithful and is carrying the virus? On one hand, such an approach by triers of fact could be a good thing if it more fairly reflects shared responsibility in some circumstances. On the other hand, there is a risk of discrimination if triers of fact determine when assumptions of risk should be implied based on stereotypes or moral evaluations of gay sex or sex outside traditional unions.

3. Vagueness and the criminalization of lower risk and risk-free activities

The reach of the criminal law may not track the real likelihood of HIV transmission reflected in scientific research for a number of reasons. Legislators creating HIV-specific statutes setting out prohibited acts may fail to attend to real levels of risk. For example, HIV-specific statutes in Michigan and Arkansas prohibit sexual penetration by an infected person without disclosure, with sexual penetration defined to include “any other intrusion, however slight, of a part of a person’s body or of any object into the genital or anal openings of another person’s body”.\textsuperscript{56} Activities that do not pose any risk of transmission – such as penetration by sterile sex toys, for example – are clearly encompassed by this definition. Legislative oversight may be to blame for the language of these provisions: the definition seems to have been adopted without modification from rape and sexual assault statutes.\textsuperscript{57} For other U.S. states, the reasons for poorly tailored drafting are unclear. Missouri, South Carolina and Virginia laws include oral intercourse, along with vaginal or anal intercourse, in their definitions of sexual HIV-exposure offences,\textsuperscript{58} and Missouri’s legislation in particular explicitly states that the “use of condoms is not a defense.”\textsuperscript{59}

Where statutes and the general criminal law leave it to judges and juries to determine whether a risk of HIV transmission is significant enough to attract criminal sanction,\textsuperscript{60}

\textsuperscript{54} R. v. Konzani, [2005] 2 Cr.App.R. 198 (English Court of Appeal), ¶44.
\textsuperscript{56} Arkansas Code Annotated §5-14-123; Michigan Compiled Laws Annotated §333.5210.
\textsuperscript{57} Wolf & Veczina, \textit{supra} note 1, at 851.
\textsuperscript{58} Missouri Revised Statutes Annotated §191.677; South Carolina Code Annotated §44-29-145; Virginia Code Annotated §18.2-67.4:1(A).
\textsuperscript{59} \textit{Id}.
\textsuperscript{60} This may be the case where general criminal laws are used to prosecute exposure or transmission (as in the US and Canada) or where statutes explicitly leave risk determination to juries. \textit{See, e.g.}, Tennessee Code Annotated §39-13-109 (prohibiting people with HIV from knowingly taking part in intimate contact, which makes another individual vulnerable to HIV transmission through exchange of
boundaries between criminal and non-criminal sexual acts may not be drawn consistently and based on clear and identifiable principles. First, it can be difficult to determine with certainty the HIV transmission risks of any particular sexual act. Whether HIV is transmitted during a given sexual encounter will depend in part on the particular sexual act involved, but also depends on a number of other factors, which are the subject of ongoing scientific inquiry. The consistent and correct use of condoms reduces the risk of transmission by 90 to 95 percent, but condom use is never perfect. Recent research reveals that viral load, the presence of other sexually transmitted infections as well as circumcision, also affect transmission risk. Second, even if risk levels could be clearly ascertained, given that risk is relative, there is no obvious way to determine the point at which a risk becomes high enough to attract criminal sanction. In these circumstances, social values can be expected to play an important role and may lead to convictions based on lower-risk or no-risk activities.

Leaving the line-drawing exercise to triers of fact may also result in uncertainty about which acts are criminal. In both Canada and the UK, for example, courts have been

bodily fluids); Oklahoma Statutes Annotated tit. 21, §1192.1; South Dakota Codified Laws §22-18-32 (prohibiting behavior with a reasonable likelihood of culminating in the transmission of the person's blood, semen or vaginal secretions into the bloodstream of the other person).


63 Thomas C. Quinn et al., Viral Load and Heterosexual Transmission of Human Immunodeficiency Virus Type 1, 342 NEW ENGLAND JOURNAL OF MEDICINE 921 (2000). Jesus Castilla et al., Effectiveness of Highly Active Antiretroviral Therapy in Reducing Heterosexual Transmission of HIV, 40 JOURNAL OF ACQUIRED IMMUNE DEFICIENCY SYNDROMES 96 (2005) (outlining the results of a recent study of 593 sero-discordant couples in Spain that found that 8.3% of partners of participants who were not taking retroviral therapy became infected during the study period, whereas no partner was infected in couples where the HIV-positive participant had been treated with highly active antiretroviral therapy (HAART)); Pietro Vernazza et al., Les personnes séropositives ne souffrant d'aucune autre MST et suivant un traitement antirétroviral efficace ne transmettant pas le VIH par voie sexuelle (finding that HIV-positive people not suffering from any other STDs and following effective antiretroviral therapy do not transmit HIV through sexual means), 89 BULLETIN DES MéDECINS SUISSES 165 (2008) (Fr.), http://www.saez.ch/pdf/2008-05/2008-05-089.PDF (last visited September 19, 2010).

64 See, e.g., Anna Wald & Katherine Link, Risk of Human Immunodeficiency Virus Infection in Herpes Simplex Virus Type 2-seropositive Persons: a Meta-analysis, 185 JOURNAL OF INFECTIOUS DISEASES 45 (2002).


66 There have been efforts to determine the per-act risk of transmission for various sex acts. See Martin Fisher et al., UK Guideline for the Use of Post-exposure Prophylaxis for HIV Following Sexual Exposure, 17 INTERNATIONAL JOURNAL OF STD & AIDS 81 (2006) (outlining efforts to determine the per-act risk of transmission for various sex acts; estimating that a woman's risk of contracting the virus through receptive vaginal sex with a man is 1 in 500 to 1 in 1000; a man's risk of contracting HIV through penetrative vaginal or anal intercourse is 1 in 1666; a receptive partner's risk of contracting the virus through anal sex is 1 in 500; and a person's risk of contracting HIV by performing oral sex is negligible to 1 in 2500).

somewhat equivocal about the availability of a "condom defence," and have not clearly pronounced on whether unprotected oral sex may attract criminal sanction.

There do not appear to have been any convictions in Canada or the UK based on protected intercourse or unprotected oral sex alone. Indeed, a British Columbia Supreme Court judge directed a jury that "[t]here is no legal duty on [the accused] to disclose his HIV status if he used condoms at all times" as there was no evidence at trial of any significant risk of serious bodily harm if he was using condoms. Likewise, in the Nova Scotia case of R. v. Edwards, the prosecution had acknowledged that "unprotected oral sex is conduct at a low risk that would not bring it within [the sexual assault provision] of the Criminal Code [and that] had only unprotected oral sex taken place, no charges would have been laid."

Nonetheless, the ambiguity in R. v. Cuerrier has left room for some questionable guilty pleas, such as that of an Ontario woman who pleaded guilty to aggravated sexual assault after she had sexual relationships with two men. The defendant had had unprotected oral sex as well as protected and unprotected vaginal intercourse with the first complainant. With the second complainant, she had had unprotected oral sex and vaginal intercourse with a condom that broke. Both men later tested negative for HIV. It appears that that conviction was based only on the unprotected sexual intercourse with the first complainant, but the sentencing judge ordered the defendant to stay away from both complainants. The court did not discuss the relative sexual risk of oral sex or the implications of the broken condom, nor did it consider relative risk levels of male to female exposure versus female to male exposure. The case was the first case and the only published decision in which a woman in Canada was convicted for HIV exposure. There have been several other charges laid against women for exposure, and in only one of those cases the complainant later tested positive.

UK law requires actual transmission (rather than mere exposure) for a conviction of causing grievous bodily harm under section 20 of the Offences Against the Person Act or reckless transmission under Scots law. Given the limited scope for prosecutions for exposure in the UK, the relevance of any condom defence in the UK has been rather limited. Nevertheless, the Crown Prosecution Service in England has indicated that it would be "highly unlikely" that the facts would support prosecution for recklessness absent a "sustained course of conduct during which the defendant ignores current scientific advice.

_Cuerrier, 2 S.C.R. 371, ¶129 (pointing to potential conclusions indicating that the prudent use of condoms decreases the risk of transmission such that it might no longer be perceived as significant); Accord the English Court of Appeal in _Dica_, 2 Cr App R 28, ¶11.


The Offences Against the Person Act, 1861, c. 100 §20 (1861). Offences against the Person Act, 1861, s. 20 (providing that "whosoever shall unlawfully and maliciously wound or inflict any grievous bodily harm upon any other person, either with or without any weapon or instrument, shall be guilty of a misdemeanor," and demonstrating that there is no offence for attempting to violate s. 20). See Crown Prosecution Service, POLICY FOR PROSECUTING CASES INVOLVING THE INTENTIONAL OR RECKLESS SEXUAL TRANSMISSION OF INFECTION (Crown Prosecution Service), http://www.cps.gov.uk/publications/prosecution/sti.html (last visited September 6, 2010) (pronouncing that if a defendant intended to sexually transmit an infection to a person but failed to do so, a charge could be brought for attempting to violate section 18 of the Offences against the Person Act, which prohibits the intentional (as opposed to reckless) infliction of grievous bodily harm).
regarding the need for and the use of safeguards, thereby increasing the risk of infection to an unacceptable level.\textsuperscript{75} Likewise, in Scotland, which has its own system of criminal prosecution, there has been recognition of the availability of a "condom defence". Although the finding of fact in *HM v Mola* was that the defendant had not used a condom, the trial judge deferred (if somewhat hesistantly) to instructions to Mola from medical practitioners that disclosure was not required if the defendant wore a condom at all times.\textsuperscript{76}

Chalmers suggests that criminalizing only transmission and not exposure "appears to accord to chance an unduly prominent role in the attribution of criminal responsibility."\textsuperscript{77} In Chalmers' view, the level of control of the non-discloser over the possibility of transmission is so low that it "seems proper to treat the transmission as a matter of luck, at least as far as his own culpability is concerned."\textsuperscript{78} However, given the criminal justice system's failures - and perhaps inability - to carefully assess the risk of a particular sexual act given the multitude of factors involved, the author may be overstating the point. Criminalizing only actual transmission may go some way towards making up for the fact that judge and juries tend to do a less-than-perfect job in determining which activities pose such a sufficient risk as to warrant being considered "reckless".

It may be unprincipled to rely on actual transmission as a proxy for assessing the level of risk of a particular sexual behavior;\textsuperscript{79} a better answer would be to call on judges and juries to accurately determine levels of risk for particular sexual activities and draw consistent lines about when that risk is significant. However, as discussed, such assessment may not precisely accord with developing understanding as to the level of risk involved. Properly assessing risk may present evidentiary problems and draw courts into difficult-to-ascertain factual territory (was there enough lubrication? was it rough sex? slow sex?). Judges may prefer to continue to rely on assumptions that treat all risky activity as alike; at best, they may clearly delineate broad but clear categories of risk behavior that will remain arbitrary.

Both policy- and justice-related concerns are raised if lower-risk activities may be prosecuted. There is a disjunction with public health policy that emphasizes knowledge of relative risk in the sexual behavior of people living with HIV. The concept of 'safer sex' was developed by gay men in the 1980s as a short-term response to an immediate health crisis, and has continued to develop in light of the recognition that consistent condom use may be difficult for a wide variety of psychological and social factors.\textsuperscript{80} Today, the term is generally understood to mean using a condom for anal (or vaginal) sex, but not necessarily for oral sex; it appears that many gay men are indeed having more oral sex and less anal sex than in the past.\textsuperscript{81} Although public health strategies do not universally explicitly endorse the safer sex message, scientific researchers suggest that realistic understandings of actual risk levels of

\textsuperscript{75} See Crown Prosecution Service, POLICY FOR PROSECUTING CASES INVOLVING THE INTENTIONAL OR RECKLESS SEXUAL TRANSMISSION OF INFECTION, supra note 74.

\textsuperscript{76} See HM Advocate v. Mola, [2007] SCCR 124 (Scotland), (available via www.scotcourts.gov.uk).

\textsuperscript{77} See generally Andrew Ashworth, Belief, intent, and criminal liability, in OXFORD ESSAYS IN JURISPRUDENCE 3\textsuperscript{rd} SERIES 1, 16-20 (John Eekelaar and John Bell eds., Clarendon Press 1987); Chalmers, Criminalization of HIV Transmission, supra note 1, at 161.

\textsuperscript{78} Id.


\textsuperscript{80} Jonathan Elford, Changing patterns of sexual behavior in the era of highly active antiretroviral therapy, 19 CURRENT OPINION IN INFECTIONOUS DISEASES 26 (2006).

\textsuperscript{81} Timothy Schacker et al., Clinical and Epidemiologic Features of Primary HIV Infection, 125 ANNALS OF INTERNAL MEDICINE 257 (1996).
different activities will help individuals make effective and sustainable changes in behavior. Criminal laws that set unrealistic standards of behavior or fail to distinguish among levels of risk may undermine the development of risk reduction strategies and result in poor public health consequences. It also appears unjust to prohibit behavior that creates little or no risk of harm. This concern may be particularly acute given the tendency for people living with or at risk of HIV to belong to marginalized or stigmatized groups, including those who use injection drugs, sex workers, members of ethnic minorities, and gay men.

4. The potential for discriminatory application:

The possibility that laws will be disproportionately applied to racial and ethnic minorities or otherwise marginalized groups raises justice and fairness concerns. It also raises public health concerns if criminalization drives already vulnerable populations, such as migrants or racial and ethnic minorities, further underground and away from public health services. Evidence on this point is equivocal. The National AIDS Trust in the UK observed in 2006 that four of the six convictions in England at that time had been of migrants, three from Africa and one from Portugal, though a recent update suggests that white males are overrepresented among heterosexual people charged with HIV transmission in England and Wales. It is difficult to determine the racial and ethnic patterns in U.S. and Canadian prosecutions, where there have been substantially more convictions and where the media have not always reported demographic information about those charged and convicted. However, a number of authors have suggested that discriminatory application is likely, even taking into account the higher rates of HIV among certain already marginalized groups.

The parallel with the differential impact of drug control laws in the U.S. is easy to draw: African Americans use illegal drugs in proportion to their representation in the population. However, rates of arrest, conviction, and incarceration remain higher than for white Americans: African Americans have been reported to comprise some 46% of people charged with drug offences in the United States, and 39% of people admitted to prisons for

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84 National AIDS Trust, supra note 20, at 12.
86 See, e.g., Sullivan & Field, supra note 1; Wolf & Vezina, supra note 1.
drug related offences. African Americans serve an average federal drug sentence that is 49% longer than those imposed on whites. Such patterns may be replicated in prosecutions for HIV exposure or transmission, particularly given the low number of prosecutions compared to the number of people with HIV who engage, whether regularly or occasionally, in behaviors that the law would appear to prohibit. What seems to determine who gets prosecuted is the "accident of being caught and brought to the attention of a willing prosecutor." Prosecutorial discretion may be suggested as a backstop to the potential negative public health impact of criminalization; yet it is precisely prosecutorial discretion that could lead to discriminatory application of the law over time.

Further opportunity for discrimination and stereotyping can arise where offenders may include not only those who were aware that they were HIV-positive when they had unprotected sex, but also those who "ought to have known." In the vast majority of prosecutions, the accused had previously tested positive for HIV. However, judges in Canada, the U.K., and the U.S. have left open the possibility that a person might be convicted where they were aware of a risk that they were HIV-positive, even if they had never actually tested positive. Indeed, the notion of recklessness as unjustified risk-taking seems to warrant prosecution of someone who, for example, may have shared needles with someone they knew was HIV-positive and was themselves exhibiting symptoms known to be consistent with HIV seropositivity. However, a rule that someone "ought to have known" about HIV seropositivity may invite stereotypical reasoning and disproportionate convictions against men who have sex with men, people who use illegal drugs, aboriginal people, or people from endemic countries who may, simply by virtue of belonging to those groups, be considered to have more reason to suspect HIV seropositivity. There is little scope for an argument that the complainant assumed any risk of exposure or transmission given the general rule that a person cannot be considered to have consented to a risk of HIV infection virtue of having sex with people in elevated risk groups. A recent civil case, in which each partner alleged that the other had "brought HIV into the relationship," is illuminating: based on the "ought to have known" standard for determining liability, a California court authorized discovery – where one party is authorized to compel the other to produce information in preparation for trial – into every circumstance in which the husband had had sexual relations with other men during the course of his life to determine whether he should have recognized that he was at risk of HIV infection.

Prevailing national HIV/AIDS strategies tend to prioritize reaching so-called vulnerable populations and tailoring responses to the needs of those specific populations. The Canadian Federal Initiative on HIV/AIDS, for example, identifies eight separate at-risk

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89 Timothy Hughes, New Court Commitments to State Prison, 2000 (National Corrections Reporting Program, Bureau for Justice Statistics).
90 Lazzarini & Xitzman, supra note 11, at 536.
91 Marks et al., supra note 50.
92 Lazzarini, Bray & Burtis, supra note 1, at 247.
93 In R. v. Williams, [2003] 2 S.C.R. 134, ¶28 (Can.) (Justice Binnie stating in obiter, "once an individual becomes aware of a risk that he or she has contracted HIV, and hence that his or her partner's consent has become an issue, but nevertheless persists in unprotected sex that creates a risk of further HIV transmission without disclosure to his or her partner, recklessness is established"); James Chalmers, Criminalization of HIV Transmission, supra note 1 & James Chalmers, Sexually Transmitted Diseases and the Criminal Law, supra note 20 (noting that at least one of the UK convictions to date involved a man who had never taken an HIV test, but had been diagnosed with other sexually-transmitted infections, warned he was at risk of HIV infection, and failed thereafter to attend an appointment for testing; and detailing the case of Kouassi Adaye, who pleaded guilty to inflicting grievous bodily harm for HIV transmission despite never having actually taken an HIV test). See Nigel Bunyan, Refugee infected woman with HIV, TELEGRAPH, January 10, 2004, http://www.telegraph.co.uk/news/uknews/1451309/Refugee-infected-woman-with-HIV.html.
populations and commits to developing distinct approaches for each based on the need for “evidence-based, culturally appropriate responses that are better able to address the realities that contribute to infection and poor health outcomes for the target groups.” Discriminatory application of the criminal law and perpetuation of negative stereotypes ran contrary to such programs.

C. Justification and criminal law theory

Despite the concerns outlined above, the criminal law has continued to maintain a place among state responses to the epidemic. Criminal law theory has traditionally offered five primary justifications for punishment: incapacitation, general and specific deterrence, rehabilitation and retribution and denunciation. As suggested in the above analysis, consequentialist justifications – those that would claim that the criminal law prevents or deters behavior that creates a risk of transmission – tend to be the most vigorously disputed. In fact, the story of criminalization of HIV exposure and transmission would appear to reflect waning influence of consequentialist justifications for punishment, and the rise of retributivism in criminal law theory.

Thus, for example, to those who would note that the criminal law serves to incapacitate those who continue to endanger others, it has been pointed out that prisons are increasingly becoming venues where high-risk behavior is common and that those serving sentences will eventually be released into the community. Others note that given the low number of prosecutions, to have an appreciable effect on HIV rates in broad population terms, “incapacitation would seem to require far more people being prosecuted and jailed than current practice exhibits.” On an individual basis, separation of a given persistent non-discloser from the general population might protect individuals with whom the persistent non-discloser might have gone on to have unprotected sex. Opponents of criminalization have conceded that a given individual’s behavior can significantly affect local HIV rates. However, as a tool of incapacitation in this context, the criminal law is weak and blunt. It is weak because periods of incarceration and the proportion of eligible individuals prosecuted are limited; it is blunt because, as discussed in the previous section, it limits freedom more than may be necessary to prevent risk in the community.

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97 See JOHN BRAITHWAITE & PHILIP PETTIT, NOT JUST DESERTS: A REPUBLICAN THEORY OF CRIMINAL JUSTICE 4 (1990) at 305 (detailing the rise of retributivism in light of the decline of consequentialism: “positive criminology accumulated masses of evidence testifying to the failures of such utilitarian (consequentialist) doctrines” and “deterrence literature also failed to produce the expected evidence that more police, more prisons, and more certain and severe punishment made a significant difference to crime”); Martin R. Gardner, The Renaissance of Retribution: An Examination of Doing Justice, 3 WISCONSIN LAW REVIEW 781, 783-4 (1976) (explanating that “faith in the ability of science to provide effective therapy for social deviants has begun to decline and disenchanted with the traditional model of isolation and rehabilitation is growing rapidly,” thereby increasing the influence of retribution).
98 Holland, supra note 2, at 288-9.
100 See Elliott, supra note 1.
101 Burris et al., supra note 9 at 505.
102 Id. at 510. Citing Wolf & Vezina, supra note 1, at 824 (noting that “Williams was ultimately alleged to have exposed forty-eight young women in Jamestown, and an additional fifty to seventy-five young women in New York City.”).
One could imagine that imprisonment would serve rehabilitative functions. However, most people living with HIV who have unsafe sex without disclosing their HIV status fail to disclose or avoid risky conduct for a complex set of psychosocial reasons. There is no empirical evidence supporting the proposition that criminal sanctions lead individuals to learn to disclose and/or practice safer sex in the future; there is, however, evidence of effectiveness of other tools such as counseling and support addressing the underlying reasons for disclosure difficulties and practicing unsafe sex.

Deterrence claims tend to figure more prominently in judicial decisions, generally as assertions and without empirical support. For example, Justice Cory stated in Cuerrier: "If ever there was a place for the deterrence provided by criminal sanctions it is present in these circumstances." Noting rising rates of new HIV infections in Canada and low condom use (particularly for women), he determined that "public education alone has not been successful in modifying the behavior of individuals at risk of contracting AIDS. It follows that if the deterrence of criminal law is applicable it may well assist in the protection of individuals and it should be utilized." Finally, Justice Cory concluded that "[i]t is right and proper for Public Health authorities to be concerned that their struggles against AIDS should not be impaired. Yet the Criminal Code does have a role to play. Through deterrence it will protect and serve to encourage honesty, frankness and safer sexual practices." In R. v. Nduwayo, a British Columbia Supreme Court judge similarly asserted that "others who might be inclined to emulate such actions must not be allowed to gain any impression that they can pursue such a deplorable course of conduct without risking sanctions. The consequences are too grave for society not to take every means at its disposal to curb such conduct and the court has a duty to protect the public accordingly."

But judges' reliance on any deterrent function of criminal law with respect to non-disclosure is ultimately unconvincing. On the one hand, there has been very little direct empirical evidence about the impact of the criminal law on HIV risk behavior. One recent study – apparently the first attempt to directly assess the impact – failed to find that the existence of HIV-specific laws and their knowledge of those laws had any significant effect on their sexual practices. People who believed that the law required disclosure or condom use did not practice safer sex any more than those who did not. In any case, despite a wide body of empirical scholarship seeking to understand the real-world deterrent effects of the imposition of criminal sanctions, deterrence justifications for punishment may not always require a clear, empirical link between the imposition of criminal sanction and human behavior. Policymakers, judges and theorists have long recognized that the actual deterrent

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104 Id.
105 See, e.g., R. v. Cuerrier, [1998] 2 S.C.R. 371 (Can.), ¶147, stating 'It is right and proper for public health authorities to be concerned that their struggles against AIDS should not be impaired. Yet the Code does have a role to play. Through deterrence it will protect and serve to encourage honesty, frankness and safer sexual practices.'
106 Id. Cuerrier, 2 S.C.R. 371, ¶142.
107 Id., ¶146.
108 Id., ¶147.
110 Burris et al., supra note 9, at 501.
effects of the criminal law are uncertain, particularly in areas related to sexual behavior and drug use, where individuals may not conform to predictions of "rational actor" models. The recognition of the uncertain effects of deterrence, along with the problem of recidivism, has played a part in a move among criminal law theorists away from utilitarian (or consequentialist) and toward retributive justifications for punishment through the criminal justice system. There is increased support for the notion that much of criminal law cannot — and need not — discernibly maximize overall social welfare. In light of this shift away from utilitarian justifications for imposing criminal sanction, it is not surprising that, despite the capacity for empirical analysis of the deterrent effects of criminal sanction, criminal law doctrine does not seem to require demonstrable deterrent effect of the criminal law to justify imposing criminal liability at the individual level. Indeed, as so-called new retributivists have suggested, it may make sense to view assertions of deterrence by judges as more aspirational — and thus expressive — than truly consequence-based. When judges speak in terms of deterrence, they are effectively pursuing a desert-based agenda.

Acknowledging the limitations of instrumentalist arguments here thus redirects the focus toward what may be a more significant driver of criminalization: retributive, desert-based concerns that focus on moral blameworthiness. Desert-based arguments do not rely on any individual or public health consequences of criminalization. Instead, they posit, the purpose of imposing criminal sanction is to punish offenders and express society's disapproval for conduct that is considered morally blameworthy.

Opponents of criminalization observe the difficulty of defining moral blameworthiness in the context of HIV exposure and transmission. If the requisite mens rea remains recklessness or negligence — as is generally the case in Canada, the U.S. and the

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112 See, e.g., Canadian Sentencing Commission, SENTENCING REFORM: A CANADIAN APPROACH: REPORT OF THE SENTENCING COMMISSION 136 (Minister of Supply and Services 1987). See JAMES Q. WILSON, THINKING ABOUT CRIME 1117-121, 123 (1983) (demonstrating that the evidence about general deterrence is inconclusive and difficult to interpret). See also JEFFRIE G. MURPHY & JULIE L. COLEMAN, PHILOSOPHY OF LAW: AN INTRODUCTION TO JURISPRUDENCE 119 (1999) (summarizing problems with deterrence generally: people misweigh, or are undeterrence, and are not rational actors).

113 Andrew von Hirsch, Penal Theories, in THE HANDBOOK OF CRIME AND PUNISHMENT (Michael Tonry ed., 2000) 659-682; David Dolinko, The Future of Punishment, 46 UCLA L. REV. 1719, 1729 (1999) (noting that beginning in the 1970s, retributivism re-emerged as the central rationale for the criminal punitive system; thereby impeding more restorative approaches to criminal justice); see also Kahan, supra note 111.


115 Braithwaite & Petit, supra note 97.

116 See Matthew D. Adler, Expressive Theories of Law: A Skeptical Overview 143 U. PA. L. REV 1363-66, 1369-70, 1414-27 (2000) (chronicling how in recent years, theorists are increasingly explaining justifiable criminal punishment in expressive or communicative terms); See also, e.g., ANTONY DUFF, PUNISHMENT, COMMUNICATION, AND COMMUNITY 200 (2001) (equating deterrence with threats).


118 Michael S. Moore, The Moral Worth of Retribution, in PUNISHMENT AND REHABILITATION 94, 95 (Jeffrie G. Murphy ed., 1995); Jeffrie G. Murphy & Jean Hampton, Introduction- The Retributive Emotions, in FORGIVENESS AND MERCY 1, 3-4 (Jeffrie G. Murphy ed., 1990); ROSCOE POUND, CRIMINAL JUSTICE IN AMERICA 56-7 (Henry Holt & Company/Transaction Publishers 1930/1998); See also JAMES FITZJAMES STEPHEN, LIBERTY, EQUALITY, FRATERNITY 152 (1873/1967) (articulating that some models of retribution are instrumental, as it has long been pointed out that institutions of criminal justice have served the functions of satisfying community desires for vengeance in a socially acceptable, orderly fashion); But see Elliott, supra note 1, at 39 (rejecting the argument that criminalization — by directing anger at those who engage in the most egregious behavior — can provide an appropriate "outlet" for community outrage, and predicting that "the more lasting impression to remain in the mind of the (HIV-negative) public is one of HIV-positive people as a "them" who present a threat to "us").
UK – behavior is measured against that expected of the ordinary, reasonable person. This may leave little room for consideration of the complex social-scientific factors that may underlie failures to disclose. This standard may be difficult to conceive and apply without bias to risk-taking in the context of HIV/AIDS. As Dalton observes:

Concepts like recklessness and negligence assume a common psychology, a common set of concerns, a common way of viewing the world. However, one of the realities spotlighted by the HIV epidemic is that we don’t always identify successfully with one another, or comprehend the lived experience of people very different from ourselves. Especially when sexual risk-taking is at issue, there is palpable risk that jurors will bring to the evaluative process pre-existing images and attitudes towards the groups most closely identified with AIDS . . . There is a risk that jurors will be predisposed to see HIV-positive defendants as abnormal, deviant, and reckless.119

Burris raises a similar point. Noting that risky behavior and non-disclosure are not uncommon in the context of HIV infection, he argues that “[a]s we move to behavior that is more contextually “normal”, and throw in the complexities of sexual norms, expectations, forms of disclosure and gradations of risk, it gets harder to find consensus on what, precisely, is bad and so harder for the criminal law to draw clear moral lines that make sense to all stakeholders.”120 This argument would appear even stronger in the context of women’s failures to disclose, which may be mediated by complex power dynamics.121 Some opponents of criminalization accept that at least some of the time retribution and denunciation may be called for. The difficulty is fashioning a legal rule that can guide that determination when the criminal justice system has so little opportunity to engage with those realities.

In sum, the criminal law is not set up to test the instrumental justifications advanced in its support, and has a limited capacity to place normative expectations in context. It is unsurprising that it has been mostly unresponsive to critiques that it is overbroad, that it punishes those who lack moral blameworthiness, and that it may increase, rather than decrease, the frequency with which people are unknowingly exposed to HIV in practice.

II: Human rights: ambiguous objections, indeterminate rights

Human rights arguments, which have featured prominently in anti-criminalization discourse, have likewise generally been unsuccessful at limiting the reach of the criminal justice in this area.122 This failure may relate to the vague language in which the most significant rights-based critiques are cast. At the margins, there have been arguments that

118 Contra California Health and Safety Code §12029 (limiting criminal sanction to deliberate transmission or exposure).
119 Harlon L. Dalton, Criminal Law, in AIDS LAW TODAY: A NEW GUIDE FOR THE PUBLIC 242, 250 (Scott Burris et al., 1993).
120 Burris et al., Do Criminal Laws Influence HIV Risk Behavior? An Empirical Trial, supra note 9, at 510. See also Weak, On Being Responsible, supra note 1.
122 Anand Grover, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (UN Doc A/HRC/14/20April 27, 2010) ¶¶ 54-55.
criminalization of HIV exposure and transmission violates established human rights norms. Prosecutions based on objectively risk-free behavior like spitting, for example, have been criticized as overtly discriminatory. And the procedures surrounding criminal prosecution, it has been argued, may lead to human rights violations. Critics have seemed reluctant, however, to argue that criminalization of exposure and transmission is per se a human rights violation. Instead, objections are expressed in terms of “inconsistency with human rights-based approaches” to the epidemic and “negative human rights impacts” arising from criminalization. Human rights objections also tend to relate less to the individual rights of those charged with transmission or exposure as to the collective right to a sound public health policy. As one recent UNAIDS document states, “there are clear arguments from a health and human rights perspective about why the application of the criminal law to HIV is doing more harm than good.” UN Special Rapporteur on the right to health Anand Grover provides one of the more pointed critiques of criminalization from an international institution, a critique which nonetheless falls short of declaring criminalization to be itself a violation of a state’s human rights obligations. Instead, he states that, “with little benefit demonstrated in terms of achieving the aims of the criminal law or public health, and a corresponding risk of alienation, stigmatization, and fear, it is difficult to see why the criminalization of HIV transmission is justified at all” and that therefore “the criminalization of HIV transmission should not form the mainstay of a national HIV/AIDS response.” (emphasis added). The argument is that criminalization is a distraction from the need to address the “real” drivers of the epidemic, such as women’s inequality, stigma and discrimination, that it does not recognize and in fact reinforces barriers and inequalities to accessing health services because it fails to create an environment that protects and enables people to look after their own health and disclose easily.

123 See, e.g., Brief for Lambda Legal Defense and Education Funds Inc.’s Amicus Curiae in Support of Jurisdiction of Appellant Jimmy Bird, filed with the Supreme Court of Ohio, February 14, 1997, Ohio v. Bird, No. 97-376 (1998) (Supreme Court of Ohio), (suggesting prosecution and subsequent imposition of a 3 to 15 year sentence for assault with a deadly weapon).
124 See Richard Elliott, CRIMINAL LAW, PUBLIC HEALTH, AND HIV TRANSMISSION: A POLICY OPTIONS PAPER 22 (UNAIDS 2003) [hereinafter Elliott, Criminal Law, Public Health, and HIV Transmission] (articulating that in a prosecution, the state would have the burden of proving that the accused was HIV-positive at the time of the alleged offence; and therefore, testing a person without their consent, on the basis of criminal allegations can lead to significant human rights violations pertaining to liberty, security of the person, and privacy). Grover, supra note 122, ¶ 51 (stating that these issues lie at the margins of policies of criminalization, which should be re-examined.) Paul Hunt, Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (UN Doc A/HRC/4/28, January 17, 2007)
125 For an explanation of the development of human rights based approaches to HIV, see infra at text accompanying notes 209-211.
129 Grover, supra note 122 at ¶ 51 (noting that the public health objectives of legal ramifications surrounding HIV transmission are often impeded through criminalization, as criminalization of HIV/AIDS transmission violates many human rights, including the rights to privacy, to be free from discrimination, and to equality, thereby impeding the actualization of the right to health).
130 Id., ¶73. See National AIDS Trust, supra note 20.
The seeming imprecision in the human rights-based objections to criminalization reflects more than simply the lack of conclusive evidence about impacts; more fundamentally, it reflects tensions and areas of ambiguity in existing conceptions of health-related rights. The health and human rights movement generally has called for "rights-based approaches" to health, most prominently in the context of HIV/AIDS. These rights-based approaches are widely supported but considered poorly understood. The more specific right to health forms part of the broader notion of rights-based approaches to health, and is most prominently expressed in Article 12 of the International Covenant on Economic, Social and Cultural Rights. The right to health likewise has been criticized for lack of clarity of its content.

According to traditional conceptions, rights are defined by a substantive content; the norms might be disputed and might evolve over time, but the idea is that they have a definable content, with duties and violations clearly identifiable. This dominant vision of rights has always been open to challenge, but the challenge has been especially evident as attention to the development of the content of social and economic rights, and particularly the

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131 Sofia Gruskin, Edward J. Mills & Daniel Tarantola, History, Principles and Practice of Health and Human Rights, 370 THE LANCET 449 (2007); UNAIDS, INTRODUCTION TO BEST PRACTICE GUIDE AND DRAFT DOS AND DON'TS DOCUMENTS. ISSUE PAPER FOR THE FIFTH MEETING OF THE UNAIDS REFERENCE GROUP ON HIV AND HUMAN RIGHTS, PREPARED BY THE REFERENCE GROUP SECRETARIAT (Joint United Nations Programme on AIDS 2005) (discussing the lack of one clear description of the rights-based approaches to health employed by many organizations; indicating that these organizations utilize these rights-based approaches at disparate phases of the process: from assessment of the circumstances to analysis of the outcome; delineating the central elements of rights-based approaches as employed by organizations to ensure that marginalized populations have access to health services: assessing the applicable laws and policies; incorporating community input, lack of prejudice, and transparency into program structures; and emphasizing high standards and ease of access when developing benchmarks for delivery of health services).


133 Recognizing the “right of everyone to the enjoyment of the highest attainable standard of physical and mental health” and requiring states to take steps to achieve the full actualization of this right “include[ing] those necessary for ... the prevention, treatment and control of epidemic ... diseases.”

134 Alyn L. Taylor, Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health, 18 AM. J.L. & MED. 301, 327 (1992) (characterizing the guarantee as goals in contrast to actions that member states are obligated to carry out); Lawrence Gosin & Jonathan Mann, Toward the Development of a Human Rights Impact Assessment for the Formulation and for the Formation and Evaluation of Public Health Policies, in HEALTH AND HUMAN RIGHTS: A READER 54, 54 (Jonathan M. Mann et al. eds., Routledge 1999) (noting that the concept of a human right to health “has not been operationally defined”). See also DAVID P. FIDLER, INTERNATIONAL LAW AND INFECTIOUS DISEASES 188, 197 (1999) (pronouncing that “the text of Article 12(2) is too general to provide insight into concrete state actions parties need to take,” and that the right to health is an international human right because it is outlined in treaties, but the right is so expansive that it lacks a coherent definition and is tempered by the principle of progressive realization); ROBERT BEAGLEHOLE & RUTH BONITA, PUBLIC HEALTH AT THE CROSSROADS 223 (1997) (noting that the UHDR and the ICESCR, although significant and legally binding in international law, do not facilitate the determination of the particular obligations involved); Audrey Chapman, Core Obligations Related to the Right to Health, in CORE OBLIGATIONS: BUILDING A FRAMEWORK FOR ECONOMIC, SOCIAL AND CULTURAL RIGHTS 185, 193 (Audrey Chapman & Sage Russell eds., 2002) (explaining that because of confusion surrounding its contents, few countries use right-to-health norms as a framework for developing health policy); Hunt, The Right to the Highest Attainable Standard of Health, supra note 132 (recounting that the right served as little more than a "slogan" for 50 years, until the United Nations Committee on Economic, Social and Cultural Rights adopted General Comment 14 in 2000).
right to health, has increased. The search for the substantive content of health-related rights—both for monitoring and enforcement purposes—has been frustrated by the progressive nature of the rights, as well as by the view that states, the duty-holders, might guarantee those rights in any number of different ways. It is within the context of these dominant conceptions of rights that allegations of vagueness in the right to health should be understood.

Scholarly and institutional efforts to develop the content of the right to health have been marked by tension between the desire for clear, enforceable content on the one hand, and difficulty of defining health and understanding and controlling pathways toward health outcomes on the other. The idea that the right to health should be understood as an individual right to a certain health status was quickly recognized as unworkable on the basis that health itself is a relative construct and people’s health outcomes are affected by individual choices as well as natural forces beyond human control. Notions like progressive realization and the highest attainable standard of health included in the text of the Covenant on Economic, Social and Cultural Rights, are meant to limit the ambit of the right, but they do little to set determinate bounds on content. Instead, in an effort to cabin the right’s indeterminacy, and in keeping with a medicalized conception of health that prevailed in the early days, the right to health was initially understood as a right to individual health care, services and conditions. This understanding remained problematic because it raised concerns about the extent of services that government must undertake for its citizens, among other difficulties associated with rate of progress under progressive realization. And indeed, an overlapping consensus on the definition of essential care has been elusive, particularly where developing countries are concerned. Nonetheless, the right-to-services model represented an effort to eliminate or mitigate some of the uncertainty, vagueness, open-endedness that is perceived as undermining the “teeth” of social and economic rights including the right to health.

The concept of the “minimum core content,” developed by the Committee on Economic, Social and Cultural Rights in a General Comment released in 1989, can

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137 David P. Fidler, International Law and Global Public Health, 48 U. KAN. L. REV. 1, 40, 44-48 (1999) (setting out how the concept of progressive realization and the breadth of factors affecting health have complicated the search for a legally meaningful content of the right to health).
139 Id. at 5 (noting the view that “being healthy is primarily a matter of individual responsibility”).
140 Supra note 136.
141 Id. at Article 12.
142 See Benjamin Mason Meier, Advancing health rights in a globalized world: responding to globalization through a collective human right to public health, 35 J.L. MED. & ETHICS 545, 548 (2007).
143 See, e.g., Fidler, supra note 137, at 46.
likewise be understood as an effort to delimit obligations associated with social and economic rights in order to encourage meaningful implementation within a traditional rights-and-principles model. The “minimum core” concept purports to create a concrete, objective set of immediate obligations whose enforcement is not hampered by the “inherent relativism of the programmatic standard of ‘progressive realization’”. As Matthew Craven states, “the clear appeal of [the minimum core] approach is that it becomes possible to speak of a widespread violation of economic, social and cultural rights in a technical legal sense instead of merely as a moral injunction.”

But the fundamental problem of indeterminacy in the right to health has proved difficult to wrestle down or hive off. Over time, the right-to-services model has lost currency, and the minimum core concept has either receded in importance or shifted away from its original mandate of substantive restriction. A number of related factors have contributed to emerging, less determinate conceptions of the right to health. First, there has been an increasing recognition of social determinants of health within medical and health policy circles, resulting in rise in the importance of public health as well as a broadened conception of health among health scholars and policymakers, especially at the international level. In the context of rights advocacy, women’s rights movements have pressed for the recognition that women’s disparately low health outcomes were linked to their societal subjugation, in all its complexity. And the HIV/AIDS and human rights movement, fueled

that a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party. Thus, for example, a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education is, prima facie, failing to discharge its obligations under the Covenant.) For a history of the concept of the minimum core, see Katharine G. Young, The Minimum Core of Economic and Social Rights: A Concept in Search of Content, 33 Yale J. Int'l L. 113, 118-125 (2008).

Young, supra note 145 at 121.

144 Matthew M. Craven, The International Covenant on Economic, Social and Cultural Rights: A Perspective on Its Development 143 (1998) (citing the following Committee Statement: "The fact that one fifth of the world's population is afflicted by poverty, hunger, disease, illiteracy and insecurity is sufficient grounds for concluding that the economic, social and cultural rights of those persons are being denied on a massive scale" U.N. Committee on Economic, Social and Cultural Rights, Statement to the World Conference on Human Rights on Behalf of the Committee, UN Doc. E/1993/22 at ¶9).

145 See Meier, supra note 142, at 548 (2007); See also Meier & Mori, supra note 44.

146 Young, supra note 145.


by similar recognition of the social and human rights determinants of HIV status and outcomes, has had a significant influence on the content of the right to health itself. Further expanding the potential scope of the right to health is the increasing recognition within legal scholarship of the “horizontality” of rights, revealing how the state can structure the actions of private parties in ways that reveal its role in supporting or undermining social and economic rights. Current conceptions of the right to health thus extend far beyond the traditional medical field, with a far greater emphasis on public health (and therefore the collective aspects of the right to health) and on social determinants of health understood quite broadly.

Recently, a growing number of voices in the social and economic rights and right to health literatures favor approaches that engage with, rather than seek to avoid, indeterminacy. There is less emphasis on supervisory bodies – courts or the Committee on Economic, Social and Cultural Rights, for example – setting out a precise and limited content of the right to health and identifying violations; instead, processes that generate more open-ended norms, seek to engage more directly the needs of the most marginalized and vulnerable, and are geared toward motivating change are favored. These emerging models of norm development and enforcement represent a move away from what have been described as traditional rights-and-principles approaches to law, and toward more management-based approaches, which focus on participation and collaboration, accountability, justification requirements, benchmarks, indicators, and impact assessments.

Some champions of social and economic rights reject altogether the idea that there ought to be any set of associated core duties, either on the theory that the rights are too indeterminate to be specified in any substantive terms or on the theory that the search for an enforceable abstract minimum core distinguished from a “progressive” periphery creates unnecessary hierarchies, excluding certain questions from rights-based litigation and leading...
to absurd results.\footnote{160} Instead, enforceability is tied to institutional capacity to determine when and how social and economic rights ought to be enforced.\footnote{161} This group would favor reasonableness review (in the case of litigation) or justification and consultation requirements (in the case of monitoring) where actions touch on the right to health, broadly conceived to include its determinants.\footnote{162}

Even among those who embrace the concept of the minimum core, a close examination of recent literature reveals that fluid norms are favored over fixed ones, and that participatory, procedural mechanisms for norm generation and enforcement are preferred. That is, rather than trying to set out the substantive content of social and economic rights in definitive terms as the minimum core idea would suggest, there is a tendency to work with ambiguity by building flexible norms into the minimum core content of a right to health, to be determined through participatory processes.

Katharine Young, noting the indeterminacy problem in social and economic rights, argues that the project behind the concept of minimum core – which is essentially one of “claiming, ranking, and limiting in the area of social and economic rights.”\footnote{163} – can be directly addressed, with the recognition that any concept of minimum core must remain inherently indeterminate.\footnote{164} Instead of demarcating certain substantive rights and obligations as core and non-core, she suggests that theorists should look for new “concepts to facilitate the rights’ content, operating as law.”\footnote{165} She favors the use of indicators and benchmarks, combined with participatory processes and the articulation of clear connections (presumably between state policies on the one hand and progress toward benchmarks and generation of indicators on the other). She would reject the idea that there is a substantive core which cannot be assailed under any circumstances, and would instead suggest a more fluid definition of the content, with a greater emphasis on requiring explaining and justifying how and why its policies, however rights-impacting, are nevertheless proportionate to competing considerations. In this respect, Young’s suggestions on the minimum core bring it closer to the minimum-core-rejecting institutional capacity group.

Young’s proposed approach to the development of social and economic rights reflects the principles that right-to-health theorists and international institutions have increasingly embraced in recent years. Paul Hunt, for example, who served as UN Special Rapporteur on the Right to Health from 2002 to 2008, recognizes in his reports the multiplicity of policies affecting health and the need to ensure the integration of the right to health in all health related policies. Given this polycentricism, he rejects “traditional human rights methods” – naming and shaming and test cases – as insufficient. Instead, he would favor such tools as indicators,\footnote{166} benchmarks, and right-to-health impact assessments to draw out the right to


\footnote{161} See e.g., id. at 288. See similarly Rosalind Dixon, Creating dialogue about socio-economic rights: Strong form versus weak form review revisited,” 5 INTERNATIONAL JOURNAL OF CONSTITUTIONAL LAW 391 (2007).


\footnote{163} Young, supra note 145, at 164.

\footnote{164} Id. at 116.

\footnote{165} Id. at 118.

\footnote{166} For a definition of human rights indictors and a discussion of how they can fruitfully be incorporated into national and international human rights strategies to enforce social and economic rights, see AnnJanette Rosga & Margaret Sattherthwaite, The Trust in Indicators, 27 Berkeley J. Int’l L. 253 (2009).
health implications of the broadest range of government policies. 167 These will not, in his view, provide "neat answers" to the complex questions of prioritizing among competing objectives, but instead give the human rights movement the opportunity to make a "constructive contribution" to these discussions. 168 The UN Office of the High Commissioner for Human Rights adopted Hunt's framework 169 for using human rights indicators in monitoring the right to health, with a significant emphasis on participation in the development and use of the indicators. 170 His suggestions are likewise reflected in the literature on human rights mainstreaming, an increasingly popular concept which suggests procedural approaches for analyzing and considering the human rights impact of a broad range of policies. 171

Right to health and social and economic rights scholars, including Ann Jannette Rosga and Margaret Satherthwaite, Alicia Ely-Yamin, and Audrey Chapman have expressed skepticism about indicators and emphasized that such data-oriented tools must be open to contestation, variation and development and accompanied by participatory processes for design and implementation if they are to avoid problems turning human rights monitoring into a technocratic, depoliticized process. 172 Alicia Ely-Yamin, for example, fears that indicators and benchmarks in the right to health may be too output-focused. 173 She would reject any objective, abstract conception of the right to health that would render it "one more output to be produced by proximate determinants . . . and broad determinants to be measured according to standardized morbidity and mortality indicators." Instead, she proposes what she terms "a paradigm of empowerment," under which advocates are to ask "what are the specific exercises of power that are denying a given person or group control over her or their health in a given context." 174 In this perspective, the nature of the evidence through which we may recognize power over health or its absence must be open to constant reconsideration. In terms

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167 Hunt, supra note 124, ¶¶ 26, 30 (emphasizing that the right to health cannot be incorporated into national and international policies solely by "naming and shaming, conducting letter-writing campaigns and test cases, and uttering slogans," but further approaches, "techniques, and skills," including "benchmarks, indicators, impact assessment, and budgetary analysis" must also be employed).
168 Id. ¶29.
170 See Rosga & Satherthwaite, supra note 166 at 297 (describing the process by which the Office of the High Commissioner for Human Rights has relied on Paul Hunt's framework, and its eventual reliance on broad participation over reliance on experts for development and using indicators).
171 See William G. O'Neill, THE CURRENT STATUS OF HUMAN RIGHTS MAINSTREAMING REVIEW OF SELECTED CCA/UNDAF AND RC ANNUAL REPORTS (April 11, 2003) (describing Human Rights Mainstreaming as a process of using human rights principles to inform development work, which is both "new" and a "work in progress," and outlining key elements of Human Rights Mainstreaming, such as: incorporating human rights frameworks into situation analyses; focusing on meaningful participation as a human right throughout development projects; valuing human rights claims of marginalized groups; and implementing data-gathering, assessment, and distribution to determine whether human rights are being progressively actualized).
172 See Rosga & Satherthwaite, supra note 166 at 302-304; Alicia Ely Yamin, The Future in the Mirror: Incorporating Strategies for the Defense and Promotion of Economic, Social and Cultural Rights into the Mainstream Human Rights Agenda, 27 HUM. RTS. Q. 1200, 1205-06 (2005) [hereinafter Yamin, The Future in the Mirror]; Chapman, supra note 134 at 202 (rejecting reliance on indicators on the view that these simply constitute another way of "understanding the minimum core as entailing obligations for specific outcomes," was well as for difficulties of measurement and varying capacities of states to meet universal indicators.)
173 See similarly, id. Chapman.
of prescriptions for enforcing such an indeterminate right to health, Yamin proposes inclusive and transparent processes that follow fundamental principles of equity in order to identify situations in which political expediency and power over-determine health-affecting policy. She ultimately suggests that despite their dangers, indicators may be useful if developed and applied within this paradigm of empowerment, in consultation with the appropriate stakeholders, such as non-governmental organizations and the public health communities. Rosga and Satterthwaite likewise suggest the necessity of guarantees of participation in the development of indicators as well as in institutional design and policy implementation in order to avoid turning human rights compliance into a technical exercise that ultimately would undermine democratic participation and accountability in setting out scope and content of discussion on the right to health.

The Committee on Economic, Social and Cultural Rights has been slow to weigh in on the discussion about how and the extent to which the right to health should consider the broader health determinants. Scholars have traditionally recognized that Article 12 of the International Covenant on Economic, Social and Cultural Rights requires states to protect their populations from “obvious risks and hazards to their health” but attending to the underlying determinants of health, particularly those contemplated in the most expansive views, is a much broader endeavor, arguably one of limitless scope. Finally, in 2000, viewing the predominantly curative conception of health reflected in Article 12 of the ICESCR as anachronistic in light of modern understandings of health disparities, the Committee on Economic, Social and Cultural Rights issued General Comment 14. General Comment 14 was designed with two possibly conflicting goals in mind: first, to set out in concrete terms what exactly states are required to do in service of the right to health; and second to reflect an increasingly broad (and therefore potentially less determinate) conception of the determinants of health and the subject of right-to-health scrutiny.

The tension is most evident in the minimum core content set out in General Comment 14, which is meant to concretize a state’s obligations, cloaking any seeming imprecision with

175 Id. at 423.
176 Chapman, supra note 134, at 194; Hunt, supra note 124, ¶9 (noting that General Comment 14 presents, for the first time, a substantive understanding of the right to health that can be made operational and improved on in light of practical experience).
177 Virginia A. Leary, Implications of a Right to Health, in HUMAN RIGHTS IN THE TWENTY-FIRST CENTURY 481, 486 (Kathleen E. Mahoney & Paul Mahoney eds., 1983); See also U.N. Econ. & Soc. Council [ECOSOC], Comm. on Econ., Soc. & Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (art. 12), U.N. Doc. E/C.12/2004 (Aug. 11, 2000) [hereinafter General Comment 14] at ¶50 (identifying a violation of the state obligation to prevent those “state actions, policies or laws that contravene the standards set out in article 12 of the Covenant and are likely to result in bodily harm, unnecessary morbidity and preventable mortality”).
178 Id. General Comment 14. See Scott Leckie, The Committee on Economic, Social and Cultural Rights: Catalyst for Change in a System Needing Reform, in THE FUTURE OF UN HUMAN RIGHTS TREATY MONITORING (Philip Alston & James Crawford eds., 2000); Meier & Mori, supra note 144, at 12 (noting that General Comment 14 implicitly recognizes a connection between individual and public health, perceiving access to health services and information as vital aspects of the right to health).
179 Young, supra note 145, at 163-164 (outlining the conundrum thus: identifying core obligations is ineffective because the duties are “polycentrio”, and therefore cannot be ordered into a ranking.) Citing Jeremy Waldron, Introduction in, THEORIES OF RIGHTS 1, 10-11 (Jeremy Waldron ed., 1984).
180 See, e.g., id. at 113 (describing the “minimum core as a concept trimmed, hosed and shorn of deontological excess”).
181 General Comment 14, supra note 179 ¶4 (recognizing that the right to health includes a broad spectrum of socio-economic factors that contribute to conditions in which people can cultivate a healthy life.).

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an assertion that its norms are non-derogable. Close examination reveals, however, that the minimum core content – particularly with respect to public health and social determinants – is cast in general, often qualified terms, with many of the more concrete obligations remaining procedural.

The General Comment does contain a number of specific substantive obligations, most of which align with early right-to-health-services models. Thus, at the more precise end of the spectrum are the core obligations to provide essential drugs as defined by the WHO’s Action Programme on Essential Drugs and to provide immunization against major infectious diseases. There is a core duty of nondiscrimination in access to existing facilities, goods, and services. Other obligations are more open-ended: states must ensure the satisfaction of “minimum essential levels of each of the rights enunciated in the Covenant,” but those minimum levels are sparingly defined; many core obligations are framed in terms of “ensuring access” – for example to maternal and child health care to basic shelter, water, sanitation – but the extent and type of care, and the question of who pays remain unclear. The most open-ended obligations relate to public aspects of health and to the social determinants that the General Comment explicitly endorses as central to the right to health: states are required to “take measures” to prevent, treat and control epidemic and endemic diseases, though steps are not specified; there are duties to provide education – to the general population about the main health problems in the community, or to health personnel about health and human rights – but scope, modalities, extent and content of education are left out.

Most remarkable about General Comment 14 is that, though it shies away from setting out detailed substantive requirements in relation to the social determinants and public health, it does contain remarkably precise procedural prescriptions for public health duties under Article 12 of the CESCK. In particular, as part of their core obligations, states are required to “adopt and implement a national public health strategy and a plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of participatory and transparent process; they shall include mechanisms, such as the right to health indicators and benchmarks, by which progress can be closely monitored; the process by which a strategy and plan of action is devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.” This has been described as a turn away from substantive monitoring on the part of the committee, and toward “monitoring of monitoring” as a way to deal with the indeterminate aspects of the right to health. The obligation of transparent and participatory planning can also be understood to direct attention to areas where rights-holders, and especially those vulnerable groups traditionally kept out of

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184 Id. ¶47 (stating that “[a] State party cannot, under any circumstances whatsoever, justify its non-compliance with . . . core obligations . . . which are non-derogable”).
185 Id. ¶43(d).
186 Id. ¶44.
187 Id. ¶43.
188 Id.
189 Id. ¶44(a).
190 Id. ¶43(c).
191 Id. ¶44(c).
192 Id. ¶44(d).
193 Id. ¶44(e).
194 Id. ¶43(f).
195 Rosga & Satterthwaite, supra note 166 at 275-278.
power, require opening up of spaces and knowledge in order to claim a place in decision-making affecting health. In sum, although it would seem to be geared toward prescribing rights or ranking obligation under a rights-and-principles approach, General Comment 14 reflects a number of the prevalent trends in the recent right-to-health literature, trends that contrast with traditional notions of rights: a comprehensive but relatively open set of norms, to be created and enforced through methods that ensure participation, transparency, accountability, and focus on the most vulnerable. General Comment 14 thus favors what may increasingly be understood as key underlying goals and purposes of human rights, and particularly social and economic rights: to direct attention and priority to areas where illegitimate exercises of power might result in deprivation of dignity, and to create a source of momentum for motivating change and reform. At the same time, General comment 14 hedges its bets. It continues to rely on the “minimum core content” concept as though it adheres to a traditional rights-as-trumps vision, for example through the use of language of non-derogability and immediate obligation not subject to progressive realization. Perhaps the Comment should be understood (or criticized) as reflecting pastiche of models for generating and ascertaining the content of the right to health. It is thus not surprising that human rights objections to criminalization seem to lack precision given, first, that the content and framework of the rights remain under construction, and second, that conceptions of health are only becoming more fluid and far-reaching.

III: The public health alternative and emergent proceduralism in the right to health

In the context of the criminal law doctrine’s limited capacity to single out morally blameworthy conduct or mitigate negative human rights impact, and human rights conceptions of the collective aspects of public health that focus more heavily on processes of policy-creation than substantive policy, it may make sense to seek solutions for mitigating the impact of criminal justice in processes surrounding criminalization of HIV transmission and exposure to determine whether they might bring the application of the criminal law in closer

196 See Yamin, supra note 174 at 424 (stating, “Infringements of control over health can often be characterized in the same way as most violations of traditionally conceived civil and political rights. These situations can generally be conceptualized in terms of the government or its agent(s) making its citizens do something that they would not otherwise do.”)
200 See Meier, supra note 142, at 550 (arguing that because General Comment 14 places the public health systems and collective aspects of health under the aegis of an individual right to health, it “focus[es] the preponderance of its normative weight behind aspects of health services (availability, acceptability, accessibility and quality) and thereby continu[es] to advance medical/technological solutions to problems requiring societal reforms”).
201 See Michael J. Dennis & David P. Stewart, Justiciability of economic, social, and cultural rights: should there be an international complaints mechanism to adjudicate the rights to food, water, housing, and health?, 98 AMERICAN JOURNAL OF INTERNATIONAL LAW 462 (2004) (detailing a criticism of this “build it and they will come” approach).
harmony with human rights-based approaches to the epidemic. Given the low number of charges relative to the likely number of cases that may meet the legal requirements for prosecution, it would seem that police and prosecutorial discretion play a significant though under-examined role in shaping the application of the criminal law in the context of HIV. In the next section, I suggest that collaboration among prosecutors, police and public health authorities and community members, through police and prosecutorial discretion, can create possibilities for a more rational, nuanced role for the criminal justice system, and one that is in greater harmony with emerging procedural conceptions of human rights.

A. Public health responses to non-disclosure, collaboration, and place of coercion

Public health authorities in Canada, the U.K. and the U.S. have statutory powers that allow them to use coercive measures against people, including those who are HIV-positive, whose behavior may be considered to pose a threat to public health. With historical roots in the power of quarantine, the use of coercive measures by public health authorities against those who are HIV-positive was controversial from the outset, and for many of the same reasons reflected in the criminalization debate. However, as the following analysis reflects, public health systems enjoy some kinds of flexibility that criminal justice systems do not. Moreover, public health authorities may be motivated and able to engage more deeply with some aspects of the relationship between HIV/AIDS and human rights than the criminal justice system. Thus, I argue that public health authorities may be better equipped to integrate lessons from health-and-human-rights approaches to HIV/AIDS prevention.

One of the most remarkable consequences of the HIV/AIDS epidemic is that it fundamentally changed the way public health researchers and policymakers looked at disease; it led them to consider the relationship between disease and broad social factors in greater depth and in new ways, with human rights as a central guidepost. At the outset of the epidemic, human rights were viewed largely as a legal and moral constraint on policymaking, limiting, for example, forced testing, treatment or quarantine. By the late 1980s, however, public health experts came to recognize human rights violations as themselves a driver of the epidemic. Jonathan Mann, who popularized the health and human rights movement as the founder and director of the World Health Organization’s Global Program on AIDS, noted that in each society, regardless of how HIV entered the community, the epidemic evolved along predictable lines: members of groups who before HIV were marginalized, stigmatized and discriminated against, over time came to bear the brunt of the epidemic. He argued that policies that further marginalized those groups and undermined their human rights would likely undermine efforts to curb the epidemic. For instance, when rumors were spread that HIV testing facilities were providing lists of HIV-positive people to


Lazzarini, Bray, and Burris, supra note 1, at 247 (noting that prosecution is not systematic but depends on the accident of getting caught and the willingness of prosecutors to proceed).


governments, participation in HIV testing programs declined. Yet where anonymous testing facilities were made available, participation of at-risk individuals in HIV testing and counseling programs rose. 207

This public health rationale for the protection of human rights found purchase among public health scholars and policymakers, where a shift in theoretical approach was underway. While traditional public health approaches considered diseases as dynamic events occurring within an essentially static context, newer approaches were beginning to look into the structural factors or social determinants of epidemic diseases. These include political, social, cultural and economic considerations that drive health outcomes. The human rights framework, Mann argued, "offers a more coherent, comprehensive, and practical framework for analysis and action on the societal root causes of vulnerability than any other framework inherited from traditional public health or biomedical science." 208

Since then, human rights have come to occupy a central place as a set of organizing principles for effective public health policy, rather than simply a limit on what governments could do for the public good. Strategies that place human rights principles at the center of government responses to the epidemic have by no means been universal. However, particularly in countries like Canada, the U.S. and the UK where HIV is not endemic but disproportionately affects particular groups that are socially vulnerable and may fear agencies of the state, it is now generally accepted by public health policymakers should make every effort should be made to engage with, rather than threaten, those communities. 205 The human rights orientation that has come to characterize the new HIV public health consensus connotes a shift away from coercive and privacy-limiting practices of previous public health approaches. 210

Although the new health and human rights consensus has not meant a wholesale abandonment of coercive approaches to public health — for example, calls for mandatory testing have resurfaced in recent years over the objections of human rights organizations — public health authorities are increasingly recognizing the limits of coercive practices as a means to effect behavioral change. 211 The development of this public health and human rights consensus may underlie the tendency within some public health agencies to shy away from aggressive use of coercive measures provided for by public health statutes.

In the mid-1980s, as the debate over criminalization was gaining momentum, there were calls for renewed use of public health laws, left over from earlier epidemics, 212 to restrict the behavior of people living with HIV whose actions might endanger others. Initial discussion focused on quarantine powers. There was little support for quarantining people

207 Id.
208 Id. at 223.
209 See Samuel R. Bagenstos, The Americans with Disabilities Act as Risk Regulation 101 COLUM. L. REV. 1479, 1503 (2001) (noting "when public health officials forewent coercive measures in their responses to AIDS, their position reflected less a capture by an important interest group than a hardhearted calculation that an epidemic spread by the intimate contact of particular segments of the community simply could not be brought under control by measures that failed to pay attention to the interests of those segments of the community").
211 Burris & Gostin, supra note 205.
212 See Parmet, supra note 204 (explaining that these laws had generally fallen into desuetude since the mid-20th century when the antibiotics rendered quarantine redundant in most contexts).
based on positive HIV status alone. However, for those who remained unwilling or unable to disclose their HIV status, opinions varied. Concerns over the use of public health powers largely mirrored those about criminalization. Some believed that these laws could contribute to the prevention of the spread of the epidemic by isolating those who persisted in behaviors linked to the spread of HIV. For others, such as Sullivan and Field, the risk of overly broad or discriminatory application to members of vulnerable groups was too great to justify its application, particularly when it would do "pathetically little to curb the broader problem of AIDS transmission." Parmet agreed that laws providing for the quarantine of those who refuse or are unable to conform to medical or behavioral guidelines could conceivably be modernized to contain appropriate due process protections and be tailored to meet the goals of public health protection. Like Sullivan and Field, however, Parmet remained doubtful of public health authorities' ability to predict future dangerous conduct and questioned whether procedural safeguards in an even a revamped public health law could match those of a criminal trial, such as criminal burdens of proof and enhanced discovery rights.

By the late 1980s, it appeared that the quarantine option, along with other coercive measures like broad-scale mandatory testing, had generally rejected. By this point, in line with the public health and human rights consensus described above, coercive public health measures were seen as likely to undermine community trust necessary for governments to deal effectively with the epidemic. Through the 1990s, however, times began to change: public health officials had begun to reassert their professional dominance over infectious disease, and a return to the use of some traditional public health powers, including partner notification mandatory reporting, and limited mandatory testing became more common.

The result has been the renewed use of public health laws to structure and restrict the behavior of people living with HIV who are considered to pose risks to public health, particularly in Canada and in the U.S. In the 1980s, in some U.S. jurisdictions, public health laws were amended, or new laws enacted, with the HIV epidemic in mind. In Canada, public health laws remain largely unchanged from earlier epidemics but are drafted generally enough to be applied to people living with HIV, either through regulatory definitions or through discretion of public health officials. (In the U.K., by contrast, legislation has provided only a narrow scope for the use of coercive public health measures.

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213 Sullivan & Field, supra note 1, at 154-155.
214 Parmet, supra note 204, at 82-90.
215 Id. at 86.
217 Id. at 96.
Legislation and regulations in England, Wales and Northern Ireland, require that a person be “suffering from” AIDS in order to justify detention for failure to take “proper precautions”; HIV infection alone would not suffice to warrant public health intervention.\textsuperscript{223} Scottish public health law seems to make no mention of HIV/AIDS.\textsuperscript{224} As a result, confinement of people with HIV under public health laws seems to have been rare in the U.K.\textsuperscript{225}) These public health laws draw on a variety of mechanisms, including treatment and counseling orders,\textsuperscript{226} isolation and hospitalization,\textsuperscript{227} and orders to refrain or desist from conduct that might infect others.\textsuperscript{228} Generally, those who fail to follow these orders could face confinement,\textsuperscript{229} or even charges for contempt of court.\textsuperscript{230}


\textsuperscript{224} Public Health etc. (Scotland) Act 2008, asp 5.


\textsuperscript{229} For the United States, see, e.g., Arkansas Annotated Code s. 20-15-1704; California Health & Safety Code §120280; General Statutes of Connecticut §19a-131c, Delaware Code §16-1705; Maine Revised Statutes §§22-250-810; Michigan Compiled Laws §§333-5205; New York Annotated Code §2120; North Dakota Century Code Annotated §§23-07-4-02; Texas Statutes §§81.161-167; Code of Virginia §§32.1-A-801; West Virginia Code §§16-4-12, 16-4-14; Wisconsin Statutes §§251.21; For Canada, see, e.g., - Public Health Act, 1994, S.S. 1994, c. P-37.1, §§45.1(1) (Saskatchewan); Public Health Act, C.C.S.M. c. P-210, §22.7 (Manitoba); Health Promotion and Protection Act, R.S.O. 1990, c. H-7, §35 (Ontario); Public Health Act, S.N.B. 1998, c. P-224, §§30(1) and (2) (New Brunswick); Health Protection Act, S.N.S. 2004, c.4, §38(1), 46 (Nova Scotia); Public Health Act, R.S.P.E.I. 1988, c. P-30, §5(4) (Prince Edward Island).

\textsuperscript{230} For the United States, see, e.g., Florida §384.34; Iowa Code, §139A.25; Mississippi Annotated Code §41-23-2; Nebraska Code §71-506; South Carolina Code Annotated §44-4-530; Code of Virginia
Some scholarly and judicial attention has been paid to these public health laws – notably to determine whether they contain sufficient procedural safeguards, are capable of correctly identifying threats to public health, and whether laws providing for confinement conform with legal and public health principles including that of least restrictive means.\footnote{231}

Less attention, however, has been given to how public health authorities make use of these laws in practice. In the U.S., Bayer and Fairchild-Carrino in a 1993 survey found that the power to quarantine under newly created public health statutes had been used “very rarely.”\footnote{232} They found many states, including some where revised public health statutes permitted it, did not have formal public health mechanisms for dealing with people living with HIV who persistently failed to follow medical or legal instructions about risk behaviors, or took no action on receiving reports of risky practices. In only 18 cases across the United States, state public health authorities had responded to reports of recalcitrant behavior with counseling, and in 15 cases “cease and desist” orders were issued requiring individuals to modify their behavior or face further criminal sanctions, indicating a “complex interplay between public health law and criminal law in the effort to impose social control on those deemed a public health threat.”\footnote{233} In 3 of those 15 cases, the result was eventual confinement in a psychiatric facility.\footnote{234}

The most interesting aspect of Bayer and Fairchild-Carrino’s study, however, was the more complex institutional responses of five states – Colorado, Indiana, Minnesota, Missouri, and Washington. Those states accounted for only 4 per cent of people living with HIV in the United States at the time but had documented more cases of people engaging in HIV risk behaviors than the remaining 45 states and the District of Columbia combined – some 450, with 350 found to warrant further action.\footnote{235} In Missouri, Bayer and Fairchild-Carrino reported, authorities responded to reports of recalcitrant behavior first with counseling followed by access to support services, and finally with referral to a local prosecutor for criminal prosecution. The remaining four states followed the model of issuing cease and desist orders backed by the possibility of confinement. In no cases was there resort to criminal


\footnote{236} See, e.g., American Public Health Association, Public Code of Ethics (citing the principle of least restrictive means is an ethical principle in public health); Lawrence O. Gostin, The Resurgent Tuberculosis Epidemic in the Era of AIDS: Reflections on Public Health, Law and Society, 54 MARYLAND LAW REVIEW 1, 110 (1995) (emphasizing that the principle of least restrictive means is also a legal principle requiring the use of less coercive means, such as education and arguably social resources that might be necessary for compliance, including safe housing, before the state can resort to more coercive approaches such as detention); See Bayer & Fairchild-Carrino, AIDS and the Limits of Control: Public Health Orders, Quarantine, and Recalcitrant Behavior, supra note 222, at 1471; Robyn Martin, Law as a Tool in Promoting and Protecting Public Health: Always in our Best Interests?, 121 PUBLIC HEALTH 846 (2007) (questioning whether public health detention legislation meets the “least restrictive means” principle); See Enborn v. Sweden, (Application 56529/00), [2005] E.C.H.R., (2005) 41 E.H.R.R. 30 (Eur. Ct. H.R.) (outlining a judicial treatment of the concept of least-restrictive means in the context of detention orders for non-compliance with behavioral orders to prevent HIV transmission).

\footnote{237} Id. at 1475.

\footnote{238} Bayer & Amy Fairchild-Carrino, AIDS and the Limits of Control: Public Health Orders, Quarantine, and Recalcitrant Behavior, supra note 222, at 1473.

\footnote{239} Id. at 1474.

\footnote{240} Id.; See also Donald E. Woodhouse et al., Restricting personal behavior: case studies on legal measures to prevent the spread of HIV, 4 INTERNATIONAL JOURNAL OF STDs AND AIDS 114 (1993).
sanction, and authorities resorted to the use of confinement powers five times, and only in one state – the state of Indiana.

A more recent model of how public health authorities limit their own use of coercive public health measures can be observed in Calgary, Alberta. As in most Canadian provinces and territories, the Alberta Public Health Act permits the issuance of public health orders and eventual confinement of people who fail to comply with conditions to limit the spread of disease. The legislation does not require efforts to use less restrictive measures before resort is had to public health orders and confinement. In practice, however, the Calgary Health Region has used a graduated approach that begins by addressing the psychosocial factors that mediate non-disclosure before moving toward public health orders restricting behavior, temporary apprehension orders, isolation orders, and finally criminal charges either under public health or criminal laws. The model, developed in conjunction with AIDS service organizations (ASOs), police and prosecutors, is premised on the belief that the vast majority of HIV non-disclosure cases may be traced to a lack of coping skills, mental health issues, insecure housing, and coercion from others. Since the implementation of the model, the only criminal convictions for non-disclosure have been of individuals who entered guilty pleas and who seemed to have escaped the attention of public health authorities altogether.

Why did public health officials so seldom resort to coercive measures under these models? According to Bayer and Fairchild-Carrino, authorities came to recognize coercion as not particularly useful for public health purposes and that behavioral change would be more likely to be achieved through program initiatives that would not provoke the same kind of profound opposition. In other words, although legislation may allow for coercive measures, the public health and human rights consensus did not favour maximalist uses of coercive sanctions.

One advantage of the move away from rights-and-principles approaches and toward collaborative, deliberative procedural approaches is that these latter seem to offer a richer answer to criminal law theorists who may be dissatisfied with traditional criminal justice approaches. Consequentialist theorists take seriously concerns that criminalization of HIV exposure and transmission will deter testing, interfere with efforts to encourage less risky activities, and stigmatize people with HIV with the result that disclosure actually becomes harder. As discussed in Part I, these potential negative effects are raised time and again but are notoriously difficult to ascertain through empirical studies. The collaborative model cannot test these empirical questions, but at least it can give policymakers an opportunity to consider them when they make policy choices about which kinds of interventions in fact

236 AIDS Calgary, the local AIDS Service Organization, receives public and private funding. Its members are health and social work professionals. Its mission is to “reduce the harm associated with HTV and AIDS for all individuals and communities.” In this context it “provides HIV prevention and education; provide[s] support, enhance[s] the quality of life and advocate[s] on behalf of people living with HIV; promote[s] awareness and understanding of HIV issues; work[s] together with partners in the community to create a caring and compassionate society in the face of HIV/AIDS. See AIDS Calgary Awareness Association, www.aidscalgary.org.
237 Interview with Gordon Kliwer, former HIV designated nurse for the Calgary Health Region (April 13, 2008).
239 Bayer & Fairchild-Carrino, AIDS and the Limits of Control: Public Health Orders, Quarantine, and Recalcitrant Behavior, supra note 222, at 1475.
make disclosure easier. This offers an advantage over the leading law and social norms criminal law literature which relies on abstract law-and-economics analysis to try to guess at what some contextualized version of the rational actor would do in response to different legal pressures.242 It also offers something to retributivists by providing better information for determining and understanding what kind of behavior really is morally blameworthy in context; for example, it eliminates the need to regard a woman who does not disclose for fear that disclosure will leave her homeless as someone who is similarly situated with the exceptional worst-case actor who simply does not care about the health of his or her sex partners.243

Finally a criminal law and public health governance system can respond more satisfactorily to particular preoccupations of alternative and restorative justice literature, particularly with regard to reforming social conditions that lead to crime. The restorative justice school shares much common ground with new governance theory, most clearly in how it favors deliberative civic participation in defining and punishing crime over mere populism.244 Unlike the traditional criminal justice system from which it deviates, theories of restorative justice take more seriously the political community’s responsibilities for social exclusions that lead to crime. Thus, Antony Duff states:

If criminal punishment is to be justified even in the tentatively doubtful way I am suggesting here, what is minimally required is both a serious collective commitment to reform the content and operations of the penal system, and a serious collective commitment to begin to remedy the kinds of exclusion that undermine the preconditions of criminal liability and punishment.245

Where social exclusion has been so clearly linked with vulnerability to criminal prosecution, as is the case for HIV transmission and exposure, a criminal law experiment that seeks to link social support with responses to potentially criminal behavior more directly seems particularly suitable.

The public health and human rights consensus, together with evolving conceptions of criminal justice, has thus paved a path toward novel forms of governance that may set and apply a more human-rights-oriented criminal law as an aspect of state responses to HIV/AIDS. This informal coordination between public health and criminal law actors in this context can, in turn, reflect, inform and sharpen concerns about right-to-health proceduralism. The next section of this paper will consider the elements of emergent procedural features of the right to health in this context.

B. Criminal justice/public health coordination and emergent proceduralism in the right to health

In order for public health based alternatives to criminal prosecution to function as true alternatives, police and prosecutors must defer to and coordinate with public health

243 Cf. Weisit, On Being Responsible, supra note 1 (noting that the criminal law, rooted as it is in classic western liberal traditions, posits a decontextualized subject when it measures all actors’ behavior against an idealized reasonable person).
245 Duff, supra note 116, at 200.
authorities. In fact, formal and informal forbearance of criminal justice in favor of other actors is not at all uncommon, particularly as the criminal justice system increasingly reflects the fact that issues of individual wrongdoing have significant social and health-related aspects.246 As faith in traditional courts’ abilities as an objective, value-neutral arbiter comes under question, and as disciplines of law and health and social services become more sensitive to one another, we are seeing an unprecedented number of experimental collaborations between criminal justice and other social institutions, such as drug courts, family violence courts, youth courts, and even informal police and prosecutor deference to community organizations. For their part, as discussed, public health authorities, particularly in respect of HIV/AIDS, have recognized the need to address underlying root causes of risk behavior and to enlist the expertise and insider knowledge of people living with HIV if they are to devise successful prevention and response programs. As a result of these combined forces, prosecutorial deference to public health interventions to deal with non-disclosure can be understood to set a kind of bottom-up (or at least middle-out), non-statutorily created diversion program that can go some way towards reshaping the way the criminal justice system views the limits of its own role.

The resulting coordination between criminal law and public health for managing criminalization reflects many key elements of emerging conceptions of right to health. Of course, coordination between public health and criminal justice actors shifts the policy focus toward collective health impacts of state policy regarding those with difficulty disclosing and away from punishment as a first response. This is consistent with any human rights-based approach to policy, which places the right – health – as the foremost consideration in policy design. But more importantly, the system relies on a number of key features evident in the proceduralist consensus described earlier, including participation, transparency, accountability and evolving norms.

A system like the Calgary Health Region’s invites participation of interested parties at a local level – public health authorities, police, prosecutors, lawyers, and community organizations working with people living with HIV – in setting up what essentially amounts to a vetting system for criminal prosecution. It takes into account changing, on-the-ground understandings of what constitutes a contextually appropriate and health-promoting response. By including AIDS Service Organizations as representatives of communities of people living with HIV, as well as those at heightened risk, the system represents a collaboration with a broader range of actors; it is not merely the imposition of a public health solution in place of a criminal justice solution. By attending to conflicting values, it facilitates more explicit negotiation of boundaries between the criminal law and neighboring orders. It also does a better job than the criminal law alone at attending to what the HIV/AIDS community and public health experts think or know will work in practice. In effect, the program attends to relationships between overlapping and competing orders, favouring multi-disciplinary, multi-agency interventions.

In addition, the program reflects a dynamic conception of health in which the focus is on learning and innovation, and contextually informed practice. The contents of the right to health are understood as constantly in the process of being discovered through iterative processes that both enforce and generate ever-changing norms. Under public health/criminal law collaborative approaches, individuals facing disclosure difficulties need to be making progress toward lower-risk behavior, but state approaches and plans need to be demonstrably based on research and experience indicating the likely efficacy of the measures prescribed in order for police and prosecutor deference to be likely.247 The terms of vetting – that is, the understanding of what psychosocial factors impede disclosure, and which can fairly be


247 See and compare Simon, supra note 158, at 56.
understood as state responsibilities — will vary with new evidence. Reasonableness of progress is evaluated both individually and contextually, taking into account a broader range of factors than the narrow set of relevant questions that determine the applicability of criminal sanction.

As a consequence, a program like Calgary Health Region’s, operating as it does alongside a principled independent prosecutorial discretion as to whether to initiate prosecution, puts a premium on transparency: the program must demonstrate its effectiveness in terms of reducing incidents of exposure or singling out truly morally culpable behavior in order to retain the fragile legitimacy it enjoys in the eyes of criminal law advocates. If the program fails to play this preventive and vetting role, criminal law actors may see little point in deferring, and the call to resort to the criminal law for deterrence purposes may prove difficult to resist.248 The interesting result in practice is that these kinds of programs could create a record of performance that can supply the criminal justice system with a richer and more nuanced understanding of the rational actor, and thus a richer and more nuanced understanding of the appropriate circumstances for pursuing criminal sanction in the context of people living with HIV.249

Relying on public health/criminal justice collaboration to mitigate negative justice and human rights-related implications of criminalization of HIV transmission and exposure is not, however, without risks. The retreat to proceduralism250 in health policy and ethics has been criticized for “doing nothing to ensure the rights of the rationales put forward” and for failing to “provide any assurance of substantively just outcomes.”251 The problem is all the more salient when human rights — traditionally by definition rooted in substantive fundamental norms — shift toward the procedural. The suggestion that appropriately structured public health/criminal justice collaboration might better respond to human rights-based objections to the epidemic merits critical attention, both for a consideration of the value and limits of proceduralist approaches, and in order to suggest how those proceduralist approaches might be refined. To that end, this section draws attention to some of the concerns around treating public health/criminal justice collaborations as a move toward right-to-health respecting criminal law.

Recently, a literature on deliberative, procedurally-orientated solutions to complex social problems has emerged in various contexts, including drug and family violence

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249 See, e.g., Zita Lazzarini, Richard A. Goodman & Kim S. Dammers, Criminal law and public health practice, in LAW AND PUBLIC HEALTH PRACTICE 136, 161 (Richard A. Goodman ed., 2007) (discussing conceptions of indicators for an appropriate relationship between the criminal law and public health, which include criminal law’s role in supporting public health objectives through established monitoring systems, well-known standards for compliance, and the absence of highly intrusive monitoring).


courts, death penalty, sexual harassment in the workplace, public housing and prostitution. This literature has been described collectively as part of "experimental governance" or "new governance" literature. The procedural focus of the right to health and of collaborative public health/criminal law approaches both share new governance's basic skepticism that fixed rules fail to account for all relevant and intended consequences, and prefer institutions that are flexible, context-sensitive, and designed to collect and pool local knowledge. New governance suggests that instead of issuing these detailed regulations, the state should "set general goals and monitor effects of appropriate actors to achieve those goals by means of their own devising." The strengths and weaknesses of approaches like Calgary's -- and of proceduralism in the right to health -- can be usefully appraised with reference to this experimentalist literature.

First, an obvious problem with Calgary's system is that criminal justice actors -- police and prosecution -- can withdraw at any time and default the traditional, decontextualized model of criminal prosecution. For the system to work, they must be willing to cede some authority to public health actors and community organizations to determine the appropriate bounds of their role in responding to HIV non-disclosure. New governance theory would suggest that deliberation and interaction among the various actors can educate participants, in this case about realistic behavioral norms for people living with HIV, or to recognize behavioral success stories in a way that is more consistent with the lived experience of people living with HIV and with scientific findings. In other words, police and prosecutors' own normative stance might be transformed through deliberation itself. Even if public health interventions short of coercion proved demonstrably successful on an individual, group, or population level, police and prosecutors might be more responsive to public demands to "do something" in the face of the threat of HIV/AIDS, however ineffective criminal interventions might be. The absence of the public in deliberation, discussed more fully below, might in fact Harden such positions. Criminal justice actors might be also driven by individual prejudices about people living with HIV or individual values of the appropriate bounds of criminal justice responses to non-disclosure.

252 Dorf & Sabel, supra note 202.
260 See Dorf & Sabel, supra note 202, at 831-34.
261 See Elliott, supra note 1.
New governance might suggest giving police and prosecutors incentives to collaborate. Here, judges could support collaboration, for example by refusing to impose criminal sanction based on an isolated incident of unprotected sex without disclosing, where public health authorities were making progress through a system like Calgary's. In the body of criminal case law on prosecutions and transmissions, judges commonly refer to an offender failing to comply with public health interventions to justify the imposition of criminal sanction, most often in support of the *mens rea* requirement. But neither judges nor prosecutors seem to have referred to a person's general efforts to comply with public health intervention as a reason for failing to find intent for an isolated risky behavior. This can be attributed in part to the strictures of criminal law doctrine discussed earlier. In addition, in the absence of any explicit, clearly justiciable (collective) right to (public) health in the domestic jurisdictions, human rights analysis is unlikely to rule such prosecutions as counterproductive to any collective right to health. Political factors may also be at play, as judges may not themselves face significant sanctions for overuse of harsh penalties but gain political capital for being "tough on crime." This may be especially of concern where judges are elected.

A second option for ensuring police and prosecutor participation, which draws on foundational new governance principles, is to provide for more systematic accountability to ensure greater responsiveness of participants to new information. Some suggest that new governance approaches are not suited to issues that are highly charged morally. Simon counters that even morally charged questions might be answered differently in the presence of clearer, more structured information generated through new governance approaches. He notes Jim Liebman's suggestion for legislative reform around the death penalty that would require prosecutors and judges to justify their decisions to seek and impose the death penalty, and generate comparative data (particularly at the appellate level) to ensure consistency and proportionality in sentences. Liebman's proposed reforms, drawing on new governance principles, can enhance sentencing in a number of ways. First, they induce learning; even those who accept that vindication of accepted norms justifies the death penalty in principle disagree about when the death penalty ought to be imposed. The same reasoning would apply in exercises of prosecutorial discretion: accountability requirements imposed on Attorneys-

*Token, 26 SETON HALL LEGISLATIVE JOURNAL 415, 419-24 (2002)) (indicating that decisions to back off enforcing criminal law tend to be motivated by discrimination and the socio-economic and racial or ethnic identities of the victim and the accused, the limited financial resources allotted to police forces particularly in disadvantaged communities, the absence of political will and negative police-community interactions, the seriousness of the crime, and the perspective that enforcement of criminal law within the context of certain crimes would prove ineffective or unnecessary; more than discretion based solely on random and therefore, just and non-discriminatory rationales; or the victims and the accused's gender identities); See also Kay L. Levine, *The Intimacy Discount: Prosecutorial Discretion, Privacy and Equality in the Statutory Rape Caseload*, 55 EMORY L.J. 691 (2006) (discussing how informal norms develop among prosecutors both around when to charge and not to charge and throughout various stages of the criminal process, based on whether offenders are perceived as serious, explicative, and predator or non-serious, intimate, and peer statutory rape offenders).* 


264 But see The Crown Prosecution Service, UK CROWN PROSECUTION SERVICE GUIDELINES (The Crown Prosecution Service) http://www.cps.gov.uk/publications/prosecution/stl.html#_07 (explaining that in relation to establishing the mens rea for recklessness under Section 20 of the Offences Against the Person Act 1861: "it is highly unlikely that the prosecution will be able to demonstrate the required degree of recklessness in factual circumstances other than a sustained course of conduct during which the defendant ignores current scientific advice regarding the need for and the use of safeguards, thereby increasing the risk of infection to an unacceptable level." (emphasis added)).

266 See Simon, supra note 158, at 61.

267 See Liebman, supra note 253.
General and Crown Prosecutors for their charging decisions might, as in Liebman’s death penalty proposal, “generate information that makes more consistent and thoughtful judgments possible.”\textsuperscript{266} Where decisions were made with reference to efforts by public health authorities to effect behavior change, such accounting might generate benchmarking and root cause analysis. Simon, in his support of Liebman’s proposal, acknowledges that these accountability measures cannot be expected to provide any kind of final resolution to a question about when the death penalty ought to be imposed. Rather, as a response to concerns about erratic, unequal imposition of the death penalty, his suggestion is meant to “induce reflection and generate information that makes more consistent and thoughtful judgments possible.”\textsuperscript{269}

Although the Calgary approach mandates collaboration between police, prosecutors, public health authorities and community organizations that ostensibly represent people living with HIV, as well as people who belong to groups at elevated risk, it does not explicitly provide for comparative data generation on prosecutors’ ultimate decisions whether to charge. With the voluntary deference of police and prosecutors, public health authorities set standards of behavior to social science and community standards and seek to address root causes of poor compliance before referring cases for prosecution. Methods of demonstrating aggregate success remain undefined. If Liebman’s suggestions in the death penalty context were brought to bear on a model like Calgary’s, they could effectively lead prosecutors, rather than simply acquiescing to the judgment of public health authorities, to engage more significantly with the root causes of poor compliance and to better contextualize individual behavior to distinguish between isolated incidents of risky behavior and more entrenched patterns of non-compliance. These kinds of accountability requirements would give police and prosecutors a greater opportunity to engage with the social science and community norms that the criminal process would normally have difficulty accommodating.

A second problem is participation. New governance approaches depend on the participation of a broad range key stakeholders both for their legitimacy\textsuperscript{270} and effectiveness, given that norm-generation and enforcement are so closely intertwined that input from most-affected actors is necessary to ensure effective design. The emphasis on participation is reflected in the current proceduralist social and economic rights approaches.\textsuperscript{271}

The Calgary model, however, performs relatively poorly in terms of openness to participation, calling into question both its legitimacy and its likelihood of effectively identifying and serving community goals. Its terms are negotiated among police, prosecutors, public health authorities and ASOs. These participants reflect a broader range of views than those that might affect prosecutorial discretion in traditional criminal approaches. But the range of actors falls far short for the legitimacy that new governance theorists extol of truly open, participatory deliberative structures. Members of the general public have no direct place in deliberation. People living with HIV (unless they find themselves among those otherwise invited to participate) have their views represented – accurately or not – through ASOs. Those who might later become infected might be understood as falling with the general population or, perhaps, as members of “vulnerable groups” which public health authorities and ASOs might, based on historical practice, be expected to engage with more directly.

The problem of representative participation is further complicated by the shifting demographics of the epidemic and its impact on the relationship between communities and

\textsuperscript{266} Simon, supra note 158, at 63.

\textsuperscript{269} Id.

\textsuperscript{270} See Dorf & Sabel, supra note 202 (hypothesizing that an open call to all truly interested actors to participate in rule-making may be no less democratic than judges interpreting ambiguous legal text on the basis of an especially decontextualized concept of the rational legal subject.).

\textsuperscript{271} See supra notes 170-177 and accompanying text.
the state. Of course, people living with HIV, much less those who might one day become infected, have never spoken with one voice. However, in the early days of the epidemic, the gay community – including members who had the virus and those who didn’t – came together to promote condom use and stigma reduction as the most contextually appropriate ways to respond to the epidemic. 272 Public health authorities were motivated to listen. But as women, particularly poor and marginalized women, people from endemic countries, and people who use drugs (all of which are less mobilized groups) are increasingly represented in the epidemic, 273 there is less assurance not only that their voices will be heard by community and government bodies, but that those disparate voices will cohere. The views of those infected may differ from those who are uninfected but at risk. Evaluations of contextually appropriate behavior might vary widely among the groups. Such divergent views are not a problem for new governance theorists, as long as every view gets a chance to be heard. But the representative participation in the Calgary model does not permit all these views to be heard.

Changing demographics also raise the risk that civil society members might withdraw from participation themselves. The AIDS movement was arose from perceived local crisis, that at first affected a readily identifiable group. As affected communities become less cohesive and less mobilized, the risk of withdrawal goes up. This might generate a return to technocratic approaches.

Even if space for participation from all interested actors could be made, power disparities might result in some voices being heard over others. Recall Jonathan Mann’s observation that the brunt of the epidemic is borne by people who are most marginalized, stigmatized, and discriminated against. Under such circumstances, it is possible that individuals living with HIV, as well as those who are at the greatest risk, might be heard the least.

The problem of power imbalances, particularly those that run deeply along lines of race, class, gender and sexuality has been a challenge for new governance theorists. 274 Proponents of new governance will point out that the very factors that led public health actors

272 See supra notes 80 to 83 and accompanying text.
274 See Amy J. Cohen, Negotiation, Meet New Governance: Interests, Skills, and Values 33 LAW & SOC. INQUIRY 501, 553 (suggesting that new governance theory has been criticized for its failure to attend to power asymmetries in deliberation.); Lobel, supra note 257 at 373 (stating that if the governance school is to continue to focus on substantive areas like low-wage work, welfare, and distributive social policy, it must “develop a richer basis for approaching collaboration in situations of pervasive competition, power imbalances, and limited resources”; David A Super, Laboratories of Destitution: Democratic Experimentalism and the Failure of Antipoverty Law, 157 U. PA. L. REV. 541, n. 122 (2008). (“Exponents of new governance] passionately insist that autonomy of the formally powerless is vital to democratic experimentalism, but they do not explain how that will be achieved.”).
to seek solutions through input of people living with HIV remain at play. As discussed previously, public health authorities’ engagement with at-risk communities was born of perceived necessity if interventions were to be successful in context. That engagement, however, remains affected by multiple types of power difference. People living with or at risk of HIV are the only ones at risk of prosecution or coercive public health orders in this context. Moreover, as discussed, HIV itself tends to target those who are marginalized and who lack bargaining power in sexual relationships and in general. There is a chance that public health authorities might favor coercive solutions despite suggestions from groups and individuals living with HIV that those solutions are likely to be effective in the long term, and despite information-forcing regimes that would demonstrate those successes. So long as traditional legal processes permitting public health orders or referral for criminal prosecution remain in place, government authorities will retain the option of withdrawing from collaborative processes.

In circumstances where power imbalances continue to hamper deliberation, the principal solution from within new governance theory is to attempt to minimize those inequalities by adding further procedural rules; more accountability requirements to measure long-term impacts on stigma (presuming everyone agrees that stigma is bad), for example, or more extensive consultation and deliberation so that more powerful actors fully recognize the benefits of collaboration. New governance scholars like Michael Dorf are quick to note that these may be incomplete solutions, but observe that power imbalances are relative: “It is true that power disparities load the dice against the weak, but this is hardly uniquely true of collaborative processes.” Traditional criminal justice approaches are notorious for taking into account only a narrow range of interests, and earlier discussion in this paper reveals the criminal approaches’ truncated vision of the issues at stake in responses to non-disclosure. New governance theorists thus defend the relative virtues of deliberative over hard-law approaches in terms of mediating power imbalance.

Another solution, about which the new governance literature is equivocal, would be to provide some “hard law” protections to those who are less powerful. As discussed, new governance is loosely defined, and describes a wide range of processes and practices involving a “shift in emphasis away from command-and-control in favor of ‘regulatory’ approaches which are less rigid, less prescriptive, less committed to uniform outcomes and

275 See Oliver Gerstenberg and Charles F. Sabel, Directly-Deliberative Polyarchy: An Institutional Ideal for Europe? In GOOD GOVERNANCE IN EUROPE'S INTEGRATED MARKETS, 293 (Christian Joerges, and, Renaud Dehousse eds., 2002), cited in Lobel, supra note 257, at 461 (“strong” actors cannot rule out the possibility that they will come to depend on solutions discovered by ‘weak’ ones.) See also Michael C. Dorf, Problem-Solving Courts and the Judicial Accountability Deficit, in PUBLIC ACCOUNTABILITY: DESIGNS; DILEMMAS AND EXPERIENCES, 301 (Michael C. Deswalde, ed., 2006); See similarly JOEL F. HANDELER, LAW AND THE SEARCH FOR COMMUNITY, 13-38 (1990).

276 See Super, supra note 274 at 565-66. (“The democratic experimentalists assume that uncertainty about the political situation will cause powerful interests to co-operate but fail to consider that it could do just the opposite . . . . [S]uch a regime is likely to prove unsustainable if one side or other seizes the reins of power.”).

277 See Dorf, supra note 275.

278 Id. at 316.


280 Gráinne de Búrra & Joanne Scott, Introduction: New Governance, Law, and Constitutionalism, in LAW AND NEW GOVERNANCE IN THE EU AND THE US 1, 6-8 (Gráinne de Búrra & Joanne Scott, eds. 2006). (Setting out possible conceptions of the relationship between law and new governance); Cohen, supra note 274, at 534 (suggesting that although new governance approaches tend to minimize the value of “hard law”, there are nonetheless some proponents who suggest that some entrenched, justiciable, binding rights might “serve as minima against which experimentalist governance takes shape.”).
less hierarchical in nature."^281 There is little consensus about the ways and extent to which legal entitlements (protected in the traditional ways) ought to operate with these shifts. In this context, the question could be posed thus: should there be, for example, a right to public health available to individual litigants that would preclude state responses to HIV/AIDS that were not over time demonstrated to be effective? Could there be a right against insufficiently justified resort to coercive approaches to health? Would the existence of such enforceable rights, or at least the risk of their development, be a better way to enhance the bargaining power of people living with HIV in collaborative policy design as contemplated here?

Some view governance as an alternative to hard legal rules. They would thus reject reliance on law’s “formal and trump-like qualities as a means of preventing law’s disintegration into ‘politics’.”^282 In Sabel and Simon’s view, for example, encouraging reliance on external legal rights, traditionally conceived, would only exaggerate the spurious coherence and legitimacy of traditional legal approaches. They would prefer what they call the “transformation thesis”: that governance ought to interact with law to transform it in the former’s image. They might predict, for example that deliberation would eventually lead public health authorities and prosecutors to the conclusion that coercive approaches are generally inappropriate and ineffective, and that the indeterminacy-related concerns that have hampered the development of the right to health would continue to do so.

Others, however, suggest that traditional law and new governance approaches might co-exist and inform one another. It is interesting to note that this view – known as the “hybridity thesis” – seems especially prominent among those considering new governance approaches to problems where issues around power and marginalization are at the core – social housing and poverty reduction programs, for example. In these contexts, there is a tendency to suggest that governance programs ought to be encouraged against a background in which substantive rules set in hard law continue to act as a constraining force. For example, in the public housing context, Lisa Alexander observes that “residents [engaging in deliberative processes] were rarely respected until they threatened litigation or court intervention”, and that “in the absence of traditional public law, . . . protections, the increased participation of organizations and institutions that purport to represent marginalized constituents will only legitimate regulatory structures that further the interests of more empowered stakeholders . . .”

^281 De Búrca & Joanne Scott, id at 2.
^282 Cohen, supra note 274 at 534, citing Charles F. Sabel & William H. Simon, Epilogue: Accountability without Sovereignty, LAW AND NEW GOVERNANCE IN THE EU AND THE US, 395, 400-407 (Gráinne de Búrca & Joanne Scott, eds. 2006). See also Dorf, supra note 275, at 317 (“If a right to participate backed by a right to sue is sometimes necessary to ensure the evenhandedness of collaborative processes, it will rarely be sufficient.”).
^283 Id.
^284 Id.
^285 See de Búrca and Scott, supra note 280 ( canvassing possible ways of conceiving the relationship between rights and new governance); See also David M. Trubek & Louise G. Trubek, New Governance & Legal Regulation: Complementarity, Rivalry and Transformation, 13 COLUM. J. EUR., L, 539, 543 (2007).
^286 See de Búrca and Scott, supra note 280, at 6 (describing arrangements which require a continuing role for binding justiciable rights as a regulatory bottom line below which experiments in new governance may not go as “baseline hybridity”).
^287 Alexander, supra note 255.
^288 Melish, supra note 135.
^289 Those who defend this kind of “hybridity” will point out that some substantive rights – like, for example, rights to property – will inevitably remain protected in new governance systems, and that “granting judicial protections to the substantive interests of one set of actors and not those of another set has profound political consequences.” David Super, Laboratories of destitution at 567.
^290 Alexander, supra note 255.
Although hybridity might form a partial response to those who worry about power imbalances and lack of principled guideposts in new governance, it is not without its risks. These risks go beyond fundamental objections leveled against traditional rights-based approaches by theorists like Sabel, Simon and Dorf. There are a number of ways in which blending or coordination of criminal law and public health functions through a governance-based approach like Calgary’s could do more harm than good.\textsuperscript{291}

First, procedures might generate solutions that bump up against emerging but un- or under-defined human rights norms, for example where coercion proves effective on an individual level but continues to raise longer-term concerns around stigma and discrimination that may be difficult to demonstrate in the short term. The concern is that rights to health might come to be improperly defined through experiments conducted in context of great power imbalance. Again, the response here might be to examine the relative virtues of deliberative approaches in context.

A related point, and one of the key critiques that have been leveled against approaches where scientists and patients groups collaborate to determine approaches to health, is that models based so closely on data-generation may have the effect of “extending the territory to which scientific authority lays claim, proposing science once again as a practice with the privilege of acting as arbiter of all others.”\textsuperscript{292} Concepts such as human dignity, which forms the core organizing principle in human rights, will become just one more question for deliberation and negotiation.

Further, on a practical level, closer links between public health and police could have the function of extending, rather than limiting, the role of criminal justice.\textsuperscript{293} For example, under the kind of governance model discussed here, police, prosecutors and policymakers retain the discretion whether to continue to defer to public health authorities (and in turn people living with HIV) or to favor criminal sanction. At present only a very small percentage of potential cases are pursued through the criminal justice system, usually depending on the initiative of members of the public reporting cases to the police. If public health and criminal orders became more closely linked, information gathered by public health actors could be used for any number of ends, including expansion of the reach of the criminal law. Thus, in a similar system operating in the prostitution context, transparency requirements have raised awareness of the sheer number of youth involved in prostitution, resulting in the expansion of coercive state approaches to youth prostitution.\textsuperscript{294} Similarly, there is a risk here that, for those who fail to get in line quickly enough, criminal sanctions will be even harsher. Likewise, this kind of coordinated system has the potential to bring all aspects of a person’s behavior – not just risky sex – under scrutiny: suddenly, the law may be looking at whether a person attends counseling sessions, manages to live in stable conditions, even stays off drugs – all with the possibility of criminal sanction in the background.

New governance theorists have hopeful responses here too. Compared with pure criminal law approaches, deliberative approaches would require claims of deterrence – which, as discussed, appear spurious\textsuperscript{295} – to be justified if they are to play any role in determining

\textsuperscript{291} This paper did not discuss in detail, for example, many of the due process safeguards that appear to be absent in much public health legislation.
\textsuperscript{292} Greco, supra note 156 at 15.
\textsuperscript{293} See Dorf & Sabel, supra note 202, at 868-869 for a similar point in the context of drug treatment courts (considering and ultimately rejecting the argument that drug treatment courts “actually make the situation [of an overly far-reaching criminal justice system] worse by creating incentives for the extension of the criminal justice system and entrenching criminalization.)
\textsuperscript{294} Phoenix, supra note 256, at 73.
\textsuperscript{295} See supra notes 105 to 116 and accompanying text.
responses to non-disclosure. New governance approaches would also favor comparisons among different jurisdictions that might employ collaborative criminal law/public health/community approaches; these comparisons would shine a light onto areas where overreaching was perceived to increase stigma and the extent to which that stigma undermined responses to HIV/AIDS.

These suggested benefits of transparent deliberation, information forcing, participation assurance, and performance comparison remain largely conjectural as collaborative approaches are only beginning to be recognized and formalized in this context. Concerns about proceduralism reflected in the new governance literature – around power, measurement difficulties, and of substantive conceptions of justice may explain the apparent reluctance of human rights institutions to abandon the backstop of the substantive development of the content of the right to health as it begins to favor procedural solutions.  

Conclusion

This paper considers the role of structured coordination among police, prosecutors, public health authorities and people living with HIV in mediating criminal justice’s response to those who have unprotected sex without disclosing their positive HIV status. This is an area, like other areas of criminal justice, where approaches rooted in traditional human rights and criminal law doctrine have failed to respond to criticisms about overreaching and perverse effects. Recent developments in thinking about the right to health favor deliberative, participatory approaches in which public health experts, police, prosecutors and people living with HIV together determine, based on scientific understandings about human behavior in the context of HIV, the circumstances in which criminal justice solutions might be appropriate. These approaches might better align principles of criminal justice with practice, and might better address inconsistencies in health-affecting policies among different responsible government agents. Through the lenses of an increasingly procedurally-oriented conception of the right to health and through this paper has examined the principles that might inform such a relationship.

The foregoing analysis reveals that when it comes to the promise of re-conceiving the idealized rational actor posited by the criminal justice system in light of emerging understandings in health and social science, public health/criminal law governance models may offer promise for a new understanding, but it is an understanding that is still in its infancy. These models may well accommodate a greater and more flexible range of rational actors – accepting the legitimacy of not disclosing when it would mean risking abuse (as long as you do your best, under the circumstances, to get out of the situation) or substituting less risky oral sex for riskier activities. But ultimately, they may yet again justify coercion against those who fail to fit the modified profile of the rational actor. Does it really get us that much further ahead to say that a subjugated woman should only be exposed to criminal sanctions for failing to disclose her HIV status if she has already been offered housing and counseling?

In this kind of context, the relationship between traditional rights-and-principles approaches and proceduralist approaches will need to be closely monitored. If the model is to avoid replicating existing oppression that directed the reach of HIV infection in the first place, careful attention must be paid to ensuring that weaker parties are continually empowered to prevent system manipulation by the stronger parties, either through agreed-upon features of institutional design or, if necessary, through support external to the governance system for example by continued government funding and support for groups at risk of or living with HIV. Importantly, the emergence of psychosocial support theories that

296 See supra notes 178 to 196 and accompanying text (explaining that the Committee on Economic, Social and Cultural Rights continues to rely on procedural and rights-and-principles approaches)
underlie graduated response models in the first place requires the empowerment of the HIV/AIDS community, at the very least to promote the view that public health intervention efforts should be designed with careful consideration of the most-affected actors. A central project in tracking the move toward more process-oriented approaches to the right to health will therefore be to monitor the limits of information-forcing and deliberation promotion to addressing issues around power parity within criminal law and public health coordination systems.

Despite the concerns about building programs based on a deliberative, proceduralist conception of a collective right to health, public health/criminal law collaborations may open up new possibilities for the collaborative exercise of the agency of people living with or at risk of HIV in an area where their agency has been denied. The modest hope is that appropriately conceived coordination between criminal law and public health actors will give rise to new opportunities for community members, particularly those who are least understood, to have a more meaningful role in defining and shaping the legal systems that affect them.
SO LONG AS YOU HAVE YOUR HEALTH: HEALTH CARE DISTRIBUTION IN CANADA AND PROCEDURALIST HUMAN RIGHTS

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Introduction

In 1984, the Canada Health Act (CHA) was passed, launching what is known as the modern era of Canadian health care reform.\(^1\) The CHA effectively ensured that hospital and physician services deemed medically necessary at the provincial level would be paid by a single government insurer and distributed on the basis of need and not ability to pay. This was achieved by a federal promise of dollar-for-dollar matched funds for provincial spending on covered services so long as provinces ensured that there would be no “user charges” by hospitals or “extra billing” by physicians for insured services.\(^2\) Furthermore, prohibition or disincentives for private insurance for publicly insured services discouraged the establishment of a private parallel system.\(^3\) The “core of Medicare”\(^4\) – 100% government coverage for “medically necessary” hospital and physician services – was thereby established, and this core has remained more or less intact ever since.

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\(^1\) GREGORY MARCHILDON, HEALTH SYSTEMS IN TRANSITION: CANADA (2006).
\(^2\) Canada Health Act, R.S.C. 1985, c. C-6, §§19-20 (1985) (Can.) (under the Act, any user fees charged by provinces would be withdrawn dollar for dollar).
\(^4\) MARCHILDON, supra note 1.
But the ban on user fees for hospital and physician services has hardly eliminated concern over fairness in distribution of health care resources in Canada. Colleen Flood has questioned the opaque and physician-interest-driven processes for determining what is medically necessary. The set of services that ultimately qualify have been the subject of litigation and other critical attention. Others have pointed out that overall distribution of health care resources is slowly becoming less equitable as a greater proportion of health services fall outside the ambit of the Canada Health Act's user fee ban. For example mental health care, palliative care, post-acute care, home care and pharmaceuticals, among numerous other services, are increasingly relied upon by Canadians, yet remain unconstrained by the Canada Health Act's user fee ban. These non-CHA-covered health services are funded (or not) at provincial discretion. In addition, wait times and other non-financial barriers to access have received increasing attention, particularly following a succession of reports that investigated the state of publicly-funded health care in Canada around the new millennium. The related question about the relationship between health care services and social determinants of health has

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8 See, e.g., The Fyke Commission, supra note 6, at 34 (discussing palliative care in the Canadian Health Care System); Canada Health Action, supra note 6 (discussing post-acute care in the Canadian Health Care System); Donovan, C. Donovan, *HOME CARE AND PHARMACEUTICAL DIVISION, POLICY AND CONSULTATION BRANCH, HEALTH CANADA, OVERVIEW OF POLICY ISSUES IN FINDING AND FINANCING HOME AND COMMUNITY CARE: A PRESENTATION TO PARTICIPANTS OF THE HOME AND COMMUNITY CARE POLICY MEETING, HEALTH CANADA, TORONTO* (Health Canada 2000) (discussing home care in the Canadian Health Care System); Romanow and Beyond, supra note 6, at 9 (discussing pharmaceuticals and mental health care in the Canadian Health Care System).
10 See Carolyn Hughes Tuohy, *The Hedgehog and the Fox: Glueberman and Marmor on Towards a New Perspective on Health Policy*, 2 *HEALTH ECONOMICS, POLICY AND LAW* 107 (2007). (Defining social determinants of health as "that broad set of socio-economic factors well beyond the purview of health care systems, strikingly correlated with socio-economic status, that influence the health of populations.")
likewise been difficult to address within existing Canadian frameworks for distribution of health-affecting resources. Finally, an overarching concern in each of these areas is accountability: overlapping and unclear lines of responsibility for decisions affecting the provision of health services have made it difficult to determine whether decisions are achieving desired goals and who is responsible where they do not. In this context, it is fair to conclude that although the single-payer model initially equalized distribution of health care resources in Canada, the increased reliance over time on health-related services not covered by Medicare has reduced the extent to which health care is distributed based on need rather than ability to pay.

The lack of profound human rights scrutiny around the distribution of health care resources in Canada can be attributed to a largely inhospitable domestic human rights case law, an international human right to health whose methodology remains in development, combined with opaque and disaggregated but overlapping spheres of authority under domestic legal and political frameworks for determining the funding, administration and delivery of services. But recent developments in health care governance in Canada, dovetailing with an emergent focus on governance and social determinants of health in human rights law opens new doors for human rights scrutiny and the integration of rights-based approaches to questions of distribution of health-related goods and services.

This paper thus examines two interrelated lines of inquiry about accountability in Canadian health care distribution. First, it looks at ways in which Canada’s health care systems are being restructured to permit better identification of who is responsible for health policy outcomes and whether policy choices achieve what they claim to. Second, it examines the ways in which this emphasis on domestic accountability serves emerging expectations among human rights scholars, activists and monitors for better-justified, more transparent, participatory decisionmaking in relation to health-affecting policies.

I. The limits of human rights scrutiny of distribution of health care services in Canada

This paper begins from the premise that the distribution of health care resources – whether public or not – is a question of human rights significance. Canada is a signatory to the International Covenant on Economic, Social and Cultural Rights (ICESCR), which

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12 See Bhatia, supra note 7, at 46 (explaining:
This policy drift – that is, the failure of governments to expand Medicare to include the large and growing number of services that fall outside its ambit – called into question the solidarity claims of Medicare’s advocates. As the private component of health care expenditures rose faster than the public component, a larger burden was placed on supplementary health insurance plans and out-of-pocket payments by individuals. The burden was heaviest for those who were the most vulnerable: the very sick or those with chronic illnesses, many of whom are on fixed incomes and lack supplementary insurance.)
recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."\textsuperscript{13} Article 12(2)(d) of the ICESCR requires all signatory states to take all steps necessary for the "creation of conditions which would assure to all medical service and medical attention in the event of sickness."\textsuperscript{14} Article 2(2) of the ICESCR adds that the right to health is to be enjoyed "without discrimination", and, in particular, without discrimination based on "social origin, property, birth or other status."\textsuperscript{15} The United Nations Committee on Economic, Social and Cultural Rights (CESCR) adds, in its non-binding but influential General Comment No. 14 on the Right to the Highest Attainable Standard of Mental and Physical Health (General Comment No. 14) interprets that states have a "core obligation" to, \textit{inter alia} "ensure rights of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable and marginalized groups" and "to ensure equitable distribution of all health facilities, goods and services".\textsuperscript{16}

Although international human rights obligations clearly have a distributive dimension, bodies charged with human rights monitoring and enforcement – judges, UN bodies, human rights commissions – have appeared to engage relatively minimally with human rights – domestic or international – when dealing with questions about allocation of health care resources in Canada.

\subsection*{A. Domestic-level scrutiny}

At the domestic level, judges have tended to shy away from intervening with legislative and policy decisions about health care allocation challenged under the \textit{Canadian Charter of Rights and Freedoms}\textsuperscript{17} (Charter) or provincial human rights legislation. There is no explicit right to health in the Charter or in provincial human rights legislation. Instead, challenges tend to be made under both the equality guarantee (s. 15 (1) of the Charter) and the guarantees of life and security of the person (s. 7 of the Charter), as well as under their provincial-level counterparts.\textsuperscript{18} These decisions have tended to reinforce a vision of human rights as guaranteeing at most non-discriminatory access to services that governments have chosen to cover publicly and as protecting only a negative right to health – that is, a right against state interference with individual health-seeking behavior.

\textsuperscript{14} \textit{Id.} at Art. 12(2d).
\textsuperscript{15} \textit{Id.} at Art. 2(2).
\textsuperscript{17} \textit{CAN. CONST.} (Constitution Act, 1982) pt I (Canadian Charter of Rights and Freedoms) [hereinafter Charter].
\textsuperscript{18} See e.g., infra notes 25-26 and accompanying text.
The high water mark in challenges to health allocation under s. 15 (1) of the Charter was Eldridge v. British Columbia (Attorney General)\(^\text{19}\) in which the Supreme Court of Canada held that the provincial government’s failure to provide sign language interpretation where this was necessary to ensure equal access to health care violated the constitutional equality guarantee enshrined in s. 15(1) of the Charter.

By 2004, the Supreme Court had narrowly circumscribed the reach of Eldridge. In Auton (Guardian ad litem of) v. British Columbia, a unanimous Court held that failure to provide a particular behavioral treatment to children with autism did not violate the Charter’s equality guarantee. The court reasoned that s. 15 (1) protected only equal access to benefits “provided by law”;\(^\text{20}\) since the province had decided not to fund Early Intensive Behavioural Intervention (EIBI), the service sought by the appellants, there could be no discrimination. In the court’s view, the legislative framework for public health care promised funding for core physician-delivered services only. While the province had the discretion to grant “non-core” services like EIBI, there was no constitutional obligation to do so.\(^\text{21}\) The court thus drew a distinction between imposing an obligation to ensure reasonable access for everyone, regardless of disability, to the existing health care system (as in Eldridge) and second-guessing government decisions about general scope of services in what the court characterized as a partial health care system.\(^\text{22}\) On this reasoning, legislative allocation decisions within Canada’s health care system would appear to be immunized from s. 15 scrutiny.

The Supreme Court in Auton did go on to preclude funding decisions with a “discriminatory purpose, policy or effect.”\(^\text{23}\) But somewhat tautologically, it reasoned that absent a “readily identifiable”\(^\text{24}\) discriminatory purpose or policy, an allocation decision could generally only be considered discriminatory where it failed to comport with the overall scheme of its own governing legislation. Since the federal and provincial laws establishing public health care in Canada create only a partial-coverage scheme, the exclusion of some treatments from coverage would not engage the equality right. The near-total immunity of health care resource allocation decisions from scrutiny under the equality guarantee is maintained.\(^\text{25}\)

\(^\text{19}\) [1997] 2 S.C.R. 624 (Can.).
\(^\text{21}\) Id. ¶41 (A government “is under no obligation to create a particular benefit. It is free to target the social programs it wishes to fund as a matter of public policy…”).
\(^\text{22}\) Id. ¶43 (“The legislative scheme in the case at bar... does not have as its purpose the meeting of all medical needs. As discussed, its only promise is to provide full funding for core services, defined as physician-delivered services. Beyond this, the provinces may, within their discretion, offer specified non-core services. It is, by its very terms, a partial health plan. It follows that exclusion of particular non-core services cannot, without more, be viewed as an adverse distinction based on an enumerated ground. Rather, it is an anticipated feature of the legislative scheme. It follows that one cannot infer from the fact of exclusion of ABA/JIBI therapy for autistic children from non-core benefits that this amounts to discrimination. There is no discrimination by effect”).
\(^\text{23}\) Id. ¶41.
\(^\text{24}\) Id. ¶42.
\(^\text{25}\) See similarly, Ali v. Canada, [2006] 4 C.T.C. 2087, ¶12 (Can.) (citing Auton and finding that the exclusion of vitamins, herbs, and minerals recommended by a naturopath from the regime for medical expense tax credits was not discriminatory, on the basis that the tax credit was not a benefit “provided by
The insistence in *Auton* that s. 15 is not engaged in health service funding allocation decisions because such funding is discretionary seems somewhat at odds with s. 15 jurisprudence. For example, *Gosselin v. Quebec*\(^{26}\) concerned the legislative exclusion of people under 30 who failed to participate in a workfare program from full welfare benefits. The discrimination claim was dismissed not on the basis that the choice to exclude people under 30 who failed to participate in workfare meant that there was no benefit provided to them by law, and thus no basis for a claim of discrimination. Instead, the analysis progressed further to consider whether the scheme was discriminatory in substance. Ultimately, the court held that there was no discrimination, on the basis that the denial affirmed the dignity of those under 30 by underscoring the legislature's confidence in their ability to work for a living. The development of the *Auton* rule, which effectively precludes a substantive consideration of effects-based discrimination in the context of health care allocation decisions, may reflect a generalized anxiety around judicial review of health care allocation.

Judicial doctrine has appeared more interventionist in relation to Charter rights to life and to security of the person, but in the direction of reinforcing free-market rather than redistributive agendas. In *R. v. Morgentaler*, the Supreme Court of Canada held that provisions of the Criminal Code restricting abortion violated a woman's right to bodily integrity and inflicted "serious, state-imposed psychological distress."\(^{27}\) In *Chaoulli v. Quebec (Attorney-General)*\(^{28}\), the Supreme Court of Canada accepted, by a four-to-three majority, that a provincial prohibition on obtaining private health insurance for publicly insured services violated the Quebec Charter of Human Rights and Freedoms' "right to life, and to personal security, inviolability, and freedom." The government had defended the legislation as a means of protecting the public system. The majority reasoned that the insurance ban, in conjunction with excessive wait times for covered services in the public system, forced Quebeckers onto unduly long wait lists, thus compromising their ability to attend to their own health needs. Three of the majority judges also ruled that the prohibition violated the similar life and security of the person guarantee enshrined in s. 7 of the *Canadian Charter*. Since *Chaoulli*, state decisions whether to fund any given treatment – and even state decisions to withdraw funding from particular treatments – have been held not to meet the threshold for "state deprivation" required to ground a s. 7 claim.\(^{30}\) In other words, while a ban on private insurance constituted a state action depriving claimants of access to health services, a decision to fund one treatment over another did not. Critics have argued that the result is a Lockner-type jurisprudence that favors individual freedoms over social legislation, a jurisprudence

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\(^{27}\) 1 S.C.R. 30 (Can.) at 39.

\(^{28}\) *Chaoulli v. Quebec (Attorney General)* [2005] 1 S.C.R. 791 (Can.).


which would undermine any view that the Charter might support a rights agenda with redistributive consequences.31

Health-related claims brought under provincial and federal human rights legislation have met with slightly more success, though, I would argue, the failure to extend discrimination analysis to the ground of disability limited judicial appraisal of the reasonableness of distribution decisions. In Buffett v. Canadian Armed Forces, a male member of the Canadian Armed Forces sought funding for in-vitro fertilization (IVF) and intracytoplasmic sperm injection (ICSI)32 through the Forces’ health plan. He argued that the Armed Forces’ policy of funding IVF for its female members while denying fertility treatment to men was discriminatory. He succeeded, but only in part. The Canadian Human Rights Tribunal had ordered the Canadian Forces to fund both IVF and ICSI on the basis of discrimination based on sex and disability (male factor infertility).33 On judicial review, however, the Federal Court narrowed the grounds of discrimination to gender alone.34 It held that the Canadian Forces discriminated in the administration of their health plan by funding only “women’s beneficiaries” infertility problems – egg- and womb related abnormalities, treated with IVF – but denying men the funding to correct their own fertility difficulties – sperm-related abnormality, which is treated with ICSI. Since the Canadian Forces were funding IVF for women, they were required to pay for “Mr. Buffett’s” ICSI treatment only, but not for “his wife’s” IVF.35

While the claim in Buffett resulted in an extension of covered services, its implications are limited. The court refused to consider effects-based discrimination based on disability, restricting its analysis to sex. In some circumstances, as arguably in Buffett, men and women’s treatment for comparable medical conditions will not be equally covered. However, if equality analysis is to play its most significant role in policing reasonableness, evidence-base, and good faith in health care allocation decisions, it will be through the lens of disability. But a disability-based equality analysis of health care allocation would effectively bring every health care decision into question, to the extent that medical services are responses to conditions that might be classified as disabilities. In other words, by keeping the focus on sex, the Federal Court decision in Buffett avoids engaging with the fundamental question of how health services are ranked and classified for coverage determinations; it ultimately confirms the Auton trend to avoid scrutiny of allocation of resources.

31 Sujit Choudhry, Worse than Lockner?, in ACCESS TO CARE, ACCESS TO JUSTICE: THE LEGAL DEBATE OVER PRIVATE HEALTH INSURANCE IN CANADA 75 (Colleen M. Flood, Kent Roach, & Lorne Sossin eds.).
32 Buffett v. Canadian Armed Forces 2006 CHRT 39 (Can.) (The Canadian Human Rights Tribunal described IVF as a process by which a woman’s eggs are fertilized in a dish and then placed in her uterus. Where the problem is sperm motility, IVF has proven to have very little success. In those cases, the recommended treatment is to use ICSI to isolate normal-looking, active sperm from a sample, followed by the IVF process).
33 Id.
34 Attorney General of Canada v. Buffett, 2007 FC 1061, ¶62 (Can.): (Parliament has left it to the Director General, Health Services, subject to Ministerial control, to decide on the range of health services to be included or excluded in the Spectrum of Care Policy. It is not for the Court to second-guess that policy decision. However, having decided to give female members of the Canadian Forces benefit of IVF, male members cannot be denied ICSI.”)
35 Id. ¶57.
Ontario Human Rights Commission & Hogan et al. v. Ontario (2006) is a rare example of judicial treatment of discrimination based on disability in a government decision not to fund a particular treatment. In that case, claimants argued that removal of sex reassignment surgery (SRS) from the list of medical services covered under the province's health insurance scheme discriminated based on both sex and disability. The Ontario Cabinet, in the late 1990s, was engaged in a “tightening and modernization” process designed to save the province $50 million a year in health care. Although the service only cost the government only $123,891.81 per year, the Ontario Cabinet around the same time, removed SRS and a number of other services from the schedule of publicly insured benefits.

Ontario Human Rights legislation contains relatively forceful discrimination protection: s. 1 of the Ontario Human Rights Code protects the “right to equal treatment with respect to services, goods and facilities, without discrimination because of race, ancestry, place of origin, colour, ethnic origin, citizenship, creed, sex, sexual orientation, age, marital status, family status or disability.” But in addition, the s. 1 guarantee is “appreciated” by s. 11, an “interpretative and applied provision of the Code.” Section 11 provides protection against effects-based discrimination by stating that a claimant who can show that a rule that is neutral on its face has an adverse impact on an individual or group identified by one of the prohibited grounds, and that he or she falls within one of those grounds, will have made out a prima facie case of discrimination. The burden then shifts to the alleged discriminator to show that the rule or measure is reasonable and bona fide in the circumstances, and that the respondent cannot accommodate the claimant without incurring undue hardship. This represents a broader equality protection than is available under s. 15 (1) of the Charter, which requires selection of a comparator against which to assess a claim of discrimination. Finally, the state action requirement that was used as the basis for denying the applicability of equality analysis under the Charter in Auton is absent here: the equality guarantee applies to all “services, goods and facilities,” publicly or privately delivered. The result is that the analysis under the Ontario Human Rights Code proceeds quickly to an examination of the reasonableness and bona fides of the rule or decision.

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38 Hogan, supra note 36, ¶96.
39 Ontario Human Rights Code, supra note 37, ¶11.
41 For excellent criticisms of approaches to selecting comparator groups in Canadian judicial decisionmaking under § 15(1) of the Charter, see Daphne Gilbert & Diana Majury, Critical Comparisons: The Supreme Court of Canada Dooms Section 15, 25 WINDSOR Y.B. ACCESS JUST. 111 (2006) (arguing that current approaches to comparison undermines substantive equality analysis and leads to overly simplistic analysis); Sophia Reibetanz Moreau, Equality Rights and the Relevance of Comparator Groups 5 J. L. & EQUAL. 81 (2006) (explaining why not all equal treatment claims are inherently comparative).
In this legal context, it is not surprising that the majority and dissent agreed that it was within the Tribunal’s mandate to examine the substance of the decision.\(^{43}\) The difference between the majority and dissenting opinions lay in their characterization of the facts: how the de-listing took place and whether it was reasonable and \textit{bona fide} in the circumstances.\(^{44}\) The majority set its emphasis early, beginning by citing Supreme Court of Canada jurisprudence on the importance of deferring to governments on questions around policy choice and budgetary allocation. It held that the de-listing process was satisfactory, and that removal of SRS from the schedule of benefits was “reasonably fashioned to its objective to preserve the universality of the health care system.”\(^{45}\) Instead of making reference to where SRS fit within overall prioritization, however, it pointed to evidence suggesting that SRS was not “money well-spent”\(^{46}\) – mainly with reference to statements of one Dr. Dickey, who had been one of the primary opponents of the removal of SRS from the schedule of insured services.\(^{47}\) It noted that by Dr. Dickey’s account, results of phalloplasty in particular were not always satisfactory. Corrective measures were frequently required for post-operative complications. Patients, according to Dr. Dickey, did not always report subjective satisfaction with procedures. The Tribunal also relied on the fact that 90 per cent of people with Gender Identity Disorders, who might qualify for SRS, “go away and learn to live with it.”\(^{48}\) It declined to attribute any weight to the “turbulent political wrangling” that surrounded the delisting.\(^{49}\) The majority also rejected the contention that the de-listing had taken place without sufficient consultation with the Ontario Medical Association, Gender Identity Disorder Specialists, and the transsexual community. In any event, it added, since de-listing was a Cabinet decision, no reasons were required.\(^{50}\)

Vice-chair Ross Hendriks had a different appreciation of the facts, both around the necessity of SRS and the way that the de-listing process took place. In her view, there was little dispute as to the effectiveness of SRS for people with the most profound

\(^{43}\) \textit{Hogan, supra} note 36, ¶¶ 9, 16, 19, 247 (Majority and dissent agreeing that the sex-reassignment surgery, before the decision to de-list, fell under the definition of “services” under the Code, and that delisting had an adverse effect on the claimants based on disability and gender).

\(^{44}\) \textit{Id.} ¶105 (majority reasons) (outlining why the decision was reasonable and \textit{bona fide}); \textit{Id.} ¶106 (examining the grandparenting provision, determining that the period was too short under the circumstances to effectively constitute reasonable accommodation; this finding, however, is beyond the scope of the present inquiry which is directed at determining the extent to which equality analysis figures in decisions about prioritizing health care resources more generally).

\(^{45}\) \textit{Id.} ¶¶106, 178, 181 (The majority also found that the government had failed to reasonably accommodate the specific claimants in the case by making the grandparenting period too short; SRS was eliminated as an option for them when they were already midway through the process toward it. This question, however, is outside the scope of this inquiry which is more specifically directed at the extent to which equality analysis figures in decisions about prioritizing health care resources more generally).

\(^{46}\) \textit{Id.} ¶105.

\(^{47}\) \textit{Id.} ¶62 (Dr. Dickey was the supervising psychiatrist of the Centre for Addiction and Mental Health in Toronto (CAMH) Gender Identity Disorder (GID) clinic and, ironically, a vocal proponent of maintaining public funding for SRS).

\(^{48}\) \textit{Id.} ¶105.

\(^{49}\) \textit{Id.} ¶108.

\(^{50}\) \textit{Id.} ¶109.
Gender Identity Disorder. At the time the decision to de-list was made, she determined there was no evidence that the government had any medical, policy or budgetary rationale, or any other non-discriminatory reason for this decision. She also placed heavy emphasis on the fact that while other de-listing decisions were made pursuant to a “tightening and modernization review” process that included extensive consultation with medical experts and publicity on the Ministry of Health’s website, de-listing of SRS was undertaken without any meaningful consultation. In her view, the “way in which sex reassignment surgery was de-listed was so reckless, particularly when compared to the way in which other services were reviewed and de-listed at the same time, it constituted an abuse of power.” The decision was taken in bad faith, and as a result constituted direct discrimination.

Health-related claims under the Charter, whether based on life, liberty and security of the person guarantees or equality guarantees, have thus generally been unsuccessful in promoting needs-based or transparent distribution of health care resources. Charter jurisprudence since Chaoulli and Auton reflects a narrow, traditional vision of rights as negative entitlements to be free from government intervention. Although the Supreme Court of Canada has not precluded the possibility that the Charter might be construed to directly or indirectly impose positive obligations in relation to health and social services, jurisprudence appears to be moving away from, and not toward, such a likelihood. In the context of Charter equality jurisprudence, the treatment of health care allocation decisions seems especially, and even idiosyncratically deferential: the requirement that a health benefit must be “provided by law” to engage the Charter equality concern renders discretionary government spending effectively immune from Charter scrutiny. Although human rights tribunals — unlike the courts — seem more amenable to considering the substantive reasonableness of health care allocation decisions, there is a clear reluctance to second-guess decisions about how health services are ranked for funding. The question of the role that facts about processes of de-listing play in judicial decisionmaking will be taken up later in this paper. At this point, it suffices to note that in the context of health care spending, courts have — since affirming liberal-libertarian conceptions of health care rights in Chaoulli — generally refused to look closely at the substance or manner of government priority-setting.

51 Id. ¶260 (“it is a legitimate, international, medically-recognized, effective, non-cosmetic treatment of longstanding for transsexuals who have the most profound [gender identity disorder].”)
52 Id. ¶260.
53 Id. ¶260 (indicating that the delisting of SRS was not accompanied by the same level of consultation as other delisting of services, due to a discriminatory and arbitrary decision-making process; in light of the seriousness of this disability, there was “no medical, policy or budgetary rationale, or any other non-discriminatory reason for this decision.”)
54 Hogan, supra note 36, ¶444.
56 See infra at Part IV(c).
B. International-level scrutiny

As stated above, cutbacks, de-listing, and the increasing proportion of health resources distributed based on ability to pay and not need, along with a lack of transparency about the effects of allocation decisions, raise right-to-health concerns on their face.68 The duty of progressive realization has been understood to imply non-retrogression: if states must extend satisfaction of economic, social and cultural rights (ESCRs) over time, certainly they must not backslide.69 Yet distributional features of Canada’s health care system have received little mention in international-level human rights monitoring.

Non-governmental organizations have certainly raised concerns about coverage in their submissions to the CESCR.60 One NGO shadow report has noted that the exclusion of prescription drugs, dental and vision from coverage under the public plan, and provincial de-listing of hospital and physician services together make health services unaffordable for those who lack the means to pay.61 Another has argued that the increasing reliance on private insurance and the lack of coverage of prescription drugs and physiotherapy has a disproportionate impact on First Nations people and people with disabilities.62 Another has expressed concerns about increasingly long waitlists in the public system.63

The committee, however, has been reluctant to take up these concerns. In its 1993 Concluding Observations, the CESCR praised Canada’s high standard of health

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68 Supra notes 13 to 16 and accompanying text.
60 See the Canadian Council for Refugees, the Canadian Council for Churches, and the Inter-Church Committee for Refugees, DRAFT STATEMENT TO THE UN COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS (the Canadian Council for Refugees, the Canadian Council for Churches, and the Inter-Church Committee for Refugees 1998), http://www.equalityrights.org/ngos/98/interchurch.htm (last visited May 6, 2011). (The Canadian Council for Refugees, the Canadian Council for Churches, and the Inter-Church Committee for Refugees have noted “severe cutbacks” in health care for Canadians or permanent residents).
care, as well as accountability created by through the Canada Health Act.\textsuperscript{64} In 1998, it recommended in general terms that "federal and provincial agreements . . . be adjusted so as to ensure, in whatever ways are appropriate, that services such as mental health care [and] home care . . . are available."\textsuperscript{65} In 2006, the Committee expressed concerns about health outcomes and access barriers faced by Aboriginal people, African Canadians, and homeless girls,\textsuperscript{66} but had nothing but praise (however brief in length) for Canada’s health care systems as a whole.\textsuperscript{67}

The CESC’s relative silence may result from unwieldiness of the principle of non-retrogression, particularly in the context of a relatively well-developed single-payer health care system like Canada’s. The concept of non-retrogression, which represents an effort to concretize the duty of progressive realization, has been variously defined,\textsuperscript{68} and criticized as an "extremely crude and unsatisfactory yardstick"\textsuperscript{69} for measuring compliance with progressive realization. The principle notably fails to address what it means to move backward and obscures the need for old strategies to be abandoned and new strategies to be adopted in light of changing socio-economic circumstances.\textsuperscript{70} In the case of health care in a well-developed country like Canada, retrogression and progression cannot easily be disentangled.\textsuperscript{71} Indeed, critics of health care governance in Canada have complained that entrenched interests have blocked the abandonment of costly, antiquated treatments in favor of more cost-efficient ones.\textsuperscript{72}

\textsuperscript{67} Id. ¶8 ("The Committee notes with satisfaction the numerous health programmes conducted by the State Party, such as the 10-year Plan to Strengthen Health Care and the launch of the Public Health Agency.")
\textsuperscript{68} The principle is rarely carefully explored, and has been defined in numerous ways. General Comment No. 3, supra note 59, ¶ suggests that it imposes a strong justificatory burden on states that would take any "deliberately retrogressive measures"; Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, Maastricht, January 22-26, 1997, ¶14(e) (going somewhat further and declaring it a violation for states to "adopt any deliberately retrogressive measure that reduces the extent to which any right is guaranteed."); Siddiqur Osmani, Globalization and the Human Rights Approach to Development, in DEVELOPMENT AS A HUMAN RIGHT 265 (Bård A. Andreasen & Stephen P. Marks, eds., 2007). (Professor Osmani understands the principle to mean that "nobody should be allowed to suffer an absolute decline in the enjoyment of any right at any time" and that the principle "does not permit the level of enjoyment of any right to decline in comparison with the past.")
\textsuperscript{69} MARY DOWELL-JONES, CONTEXTUALISING THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS: ASSESSING THE ECONOMIC DEFICIT (2004).
\textsuperscript{70} Id. at 52-54.
\textsuperscript{71} See, e.g., Gunilla Backman et al., Health systems and the right to health: an assessment of 194 countries, 372 THE LANCET 2047, 2049 (2008). (suggesting that the right to health is violated by an absolute lack of mental health facilities, and asserting, without reference to a standard, that few countries devote adequate resources to mental health.)
\textsuperscript{72} Flood, Tuohy, & Stabile, supra note 5. See also Lauchlan T. Munro, The "HUMAN RIGHTS-BASED APPROACH TO PROGRAMMING": A CONTRADICTION IN TERMS? PAPER PRESENTED TO THE UNIVERSITY OF MANCHESTER CONFERENCE ON "WINNERS AND LOSERS FROM RIGHTS-BASED APPROACHES TO DEVELOPMENT" (University of Manchester 2005), http://www.scd.man.ac.uk/research/events/conferences/documents/Winn%20and%20Losers%20Papers/
The principle of non-retrogression is rendered even more difficult to apply in light of the Covenant's purported neutrality as to mode of delivery. The CESC has stated that the Covenant "neither requires nor precludes any particular form of government or economic system" and that it "cannot accurately be described as being predicated exclusively upon the need for, or the desirability of a socialist or capitalist system, or a mixed, centrally planned, or laissez-faire economy, or upon any other particular approach."\textsuperscript{73}

This neutrality may explain why the principle of non-retrogression has been weakly applied. A representative example is the Committee's response to extensive and unprecedented cutbacks in New Zealand's social welfare programs in the early 1990s.\textsuperscript{74} The New Zealand government justified the cutbacks rather generally as part of a program to "revers[e] economic decline and the growth of dependence on welfare,"\textsuperscript{75} Rather than declare the reforms retrogressive and a violation of the Covenant, or demand better justification from the country, the CESC simply expressed concern that "recent extensive reforms may negatively affect the enjoyment" of economic, social and cultural rights (ESCRs), and urged the state to monitor those effects.\textsuperscript{76}

Finally, the continued influence of early "minimum core content" conceptions of ESCRs may suggest that right to health has greater application in developing countries or countries with very rudimentary health care infrastructure.\textsuperscript{77} In its early work, the CESC, reflecting prevailing academic views at the time,\textsuperscript{78} sought to cabin and clarify obligations in the ICESC not only through the principle of non-retrogression, but also through a concept of minimum core obligation linked primarily to subsistence-level need.\textsuperscript{79} Some theorists have doubted that anyone can properly define basic survival level needs, or that human dignity should be situated primarily at the level of what it takes to survive.\textsuperscript{80} Others have suggested a more flexible minimum core that would place different obligations on countries of different levels of development.\textsuperscript{81} In addition, the

\textsuperscript{73} General Comment No. 3, supra note 59, ¶8.

\textsuperscript{74} For a description of the cutbacks, See Susan St. John, Tax and Welfare Reforms in New Zealand, 26 AUSTR. ECON. REV. 37 (1993).


\textsuperscript{76} Id. ¶18.

\textsuperscript{77} See e.g., MATTHEW CRAVEN, THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL, AND CULTURAL RIGHTS: A PERSPECTIVE ON ITS DEVELOPMENT 143-44 (1998).


\textsuperscript{79} See General Comment No. 3, supra note 59, ¶10 ("The Committee is of the view that a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon each State party. Thus, for example, a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or the most basic forms of education is, prima facie, failing to discharge its obligations under the Covenant.")

\textsuperscript{80} See Young, supra note 78 at 130-131.

\textsuperscript{81} See id. at 114 (citing authors for and against a core content that would vary depending on resource availability, including Asbjorn Eide, Economic, Social and Cultural Rights as Human Rights, in
CESCR's concept of the minimum core has evolved to include largely procedural obligations that extend beyond basic subsistence, alongside a substantive mainly survival-level minimum. Nonetheless, the idea that the primary role of ESCRs is to protect against the most severe cases of material deprivation has retained a persistent influence. Whether the concept of minimum core, the difficulties progressive realization, or political factors are to blame, the fact remains that while developing countries have attracted significant human rights scrutiny in relation to the right to health, the human rights dimensions of policies in developed countries have received less attention.

Human rights institutions, both domestic and international, have thus been generally unresponsive to concerns around inequitable distribution of health-related funding in Canada framed in human rights terms. This unresponsiveness is driven by a number of factors, including reliance on traditional, negative conceptions of rights in judicial contexts, and limitations in theories of international rights that limit engagement with developed countries where human rights problems lie outside of basic subsistence. As the next section will demonstrate, however, conceptions of human rights, and most notably the right to health, are evolving so that the limitations in accountability within Canada's health care system are increasingly questions of human rights concerns in themselves.

II. Human Rights, health, and a turn toward the procedural

The strategies, methodologies, and rhetoric employed to identify and remedy exclusions of marginalized groups and individuals from social and state institutions have shifted in recent years. This shift is reflected prominently, though by no means exclusively, in developments in advocacy, monitoring, and academic writing in social

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82 See General Comment No. 14, supra note 16.
83 See, e.g. DAVID BILCHITZ, POVERTY AND FUNDAMENTAL RIGHTS: THE JUSTIFICATION AND ENFORCEMENT OF SOCIO-ECONOMIC RIGHTS 179-180 (2007) (preferring a universal survival-based definition of the minimum core; See also Young, supra note 78, at 128-129. (discussing how the focus on survival-level need helps bridge the divide between the better-established CFRs and ESCRs through a focus on the right to life, and on the necessity of meeting basic needs if other rights are to be meaningfully enjoyed, citing HENRY SHUB, BASIC RIGHTS: SUBSISTENCE, AFFLUENCE, AND U.S. FOREIGN POLICY 19 (1996).
and economic rights, including the right to health. Parallel developments in bioethics, health law and policy emphasize a broadened field of health inquiry and increase the focus on social and structural determinants of health, evidence-based decisionmaking, and transparent and participatory approaches to norm-setting. The combined results of these changes sets the stage for more meaningful integration and human rights engagement with priority-setting in Canadian health care than has been evident to date.

The twenty-first century has been described as ushering in a changing vision of human rights, one that focuses less on detecting and remedying clear violations of pre-defined, universal and concrete rights and freedoms arising from overt government action, and instead places greater emphasis on the role of rights in "consolidating citizenship and democratic self-governance." Tara Melish describes, for example, how the “legalist and consumerist” modalities of the U.S. rights revolution of the 1960s and the “narrow and absolutist” methodologies of the international human rights movement are giving way to a “new, broader, more democratic understanding” of human rights law. This understanding remains grounded in the concept of human dignity, but instead of focusing on protecting citizens from a repressive state apparatus, it focuses on meaningful engagement of the powerless in community-defined goals and priorities. It reflects a substantive fluidity and stronger emphasis on democratic processes. It may make more room for meaningful human rights based appraisal of systems -- including, of course, the health care system -- affecting social and economic rights.

The story of how and why ESCRs came to be understood as somehow less important, less meaningful, less “rights-like,” if not generally ignored, by the human rights community, provides a useful starting point for understanding the shift. Although

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84 See, e.g., Norman Daniels & James Sabin, The Ethics of Accountability in Managed Care Reform, 17 HEALTH AFF. 50 (1998).
85 M. Gregg Bloche, The Emergent Logic of Health Law, 83 SOUTHERN CALIFORNIA LAW REVIEW 389, 393, 396 (2009). (considering whether “health law” is a coherent field, concluding that it is, but suggesting that its content will remain in flux and shaped by iterative processes.)
86 See THEODORE MARMOR, FADS IN MEDICAL CARE MANAGEMENT AND POLICY (2004), canvassing themes (or ‘fads’ in Marmor’s view) that have characterized health care reform across nations including: attempts to develop open and explicit criteria to inform the rationing of access to health care; calls for evidence-based decision-making about costs and efficacy in treatment; and the development of a broad “healthy public policy” agenda, embracing a wide range of social objectives within a framework of population health.
89 Ann Janette Rosga & Margaret L. Satterthwaite, Trust in Indicators: Measuring Human Rights, The, 27 BERKELEY J. INT’L L. 253, 259 (2009). (“It is almost a cliché to say that economic, social and cultural rights (ESCRs) were ignored by the international community, and the human rights world, for too long”).
ESCRs and civil and political rights (CPRs) enjoyed equal recognition within the Universal Declaration of Human Rights in 1948.\footnote{Universal Declaration of Human Rights, art. 21, G.A. Res. 217A, at 71, U.N. GAOR, 3d Sess. 1st plen. mtg., U.N. Doc. A/810 (Dec. 12, 1948); See United Nations High Commissioner for Human Rights, Fact Sheet No. 16 [Rev. 1], The Committee on Economic, Social and Cultural Rights (July 1991), http://www.ohchr.org/Documents/Publications/FactSheet16rev1en.pdf (last visited May 7, 2011) [Fact Sheet No. 16].} There is little dispute that ESC rights have occupied the lesser place within the catalog of human rights.\footnote{CRAVEN, supra note 77 at 8-9. See also STEINER, ALSTON, AND GOODMAN, supra note 88, at 263-80; Craig Scott, Reaching Beyond (Without Abandoning) the Category of “Economic, Social and Cultural Rights,” 21 HUMAN RIGHTS QUARTERLY 633-660, 633 (1999) (describing how Cold-War tensions, rather than any specific understanding of human rights, led to the creation of separate treaties—the ICCPR and the ICESCR—to implement the Universal Declaration of Human Rights). Scott Leckie, Another Step Towards Indivisibility: Identifying the Key Features of Violations of Economic, Social and Cultural Rights, 20 HUM. RTS. Q. 81 (noting that responses to violations of economic, social and cultural rights have paled in comparison to the seriousness accorded to infringements of civil and political rights.); STEINER, ALSTON & GOODMAN, supra note 88 at 264 (describing how the “debate over the relationship between the two sets of rights became a casualty of the Cold War,” with Western States insisting on two separate covenants and Communist countries abstaining from voting on the ground that provisions protecting economic and social rights were weak.)} The original decision to create two treaties—the International Covenant on Civil and Political Rights, and the International Covenant on Economic, Social and Cultural Rights—has been attributed to Cold War tensions. Matthew Craven explains:

[T]he reason for making a distinction between first and second generation rights could be more accurately put down to the ideological conflict between East and West pursued in the arena of human rights during the drafting of the Covenants. The Soviet States, on the one hand, championed the cause of economic, social, and cultural rights, which they associated with the aims of the socialist society. Western States, on the other hand, asserted the priority of civil and political rights as being the foundation of liberty and democracy in the “free world.” The conflict was such that during the drafting of the International Bill of Rights the intended treaty was divided into two separate instruments which were later to become the ICCPR and the ICESCR.\footnote{International Covenant on Civil and Political Rights, Dec. 16, 1966, S. EXEC. DOC. E, 95-2 (1978), 999 U.N.T.S. 171 [hereinafter ICCPR].}

The rights in the two treaties are framed rather differently. The ICCPR\footnote{International Covenant on Civil and Political Rights, Dec. 16, 1966, S. EXEC. DOC. E, 95-2 (1978), 999 U.N.T.S. 171 [hereinafter ICCPR].} provides that “no one shall be subjected to” violations of their civil and political rights, and the ICESCR is formulated in terms of states “recogniz[ing] the right of everyone to...” each of the enumerated rights. The rights enumerated in the ICESCR, unlike the rights in the ICCPR, also have the distinction of being limited by the principles of progressive realization and the resource availability set out in s. 2(1) of the Covenant.
Despite the General Assembly’s clear statement that it did not intend to ascribe relative value to the two sets of rights through the separation,94 the existence of the two treaties, and their distinct framing, allowed “western scholars and statesmen” to succeed in “[giving] priority to civil and political rights, emphasizing individual liberties [and promoting the view that] socio-economic right were ‘pseudorights’. . .”95 The notion that the rights in the ICCPR were more meaningful was initially reinforced by the International Law Commission (ILC) in its early draft articles on state responsibility further entrenched the difference between the two sets of rights when it classified rights as creating either “obligations of result” – which were understood as less strict since they allowed states to meet their obligations in any number of ways – and “obligations of conduct,” which set out more precisely what states were expected to do.96 Arguably, the ICESCR, to the extent that it “recognizes” rights toward which states are required to “take steps” imposes the less strict kind of obligations of result.

Though the distinction has since been dropped from the ILC draft articles,97 the notion that the two treaties create different types of rights, economic, social and cultural rights more aspirational than legally binding, has been persistent.98 Viewed through this lens, for example, the CESCR’s currently-expressed neutrality as to how states meet their obligations, and its explicit acknowledgement of the need for local-level negotiation over the content of the rights,99 would place SERs squarely within the category of not-quite-rights – “development goals”100 perhaps – and therefore arguably of little importance within first-world countries.

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94 G.A. Res. 543, preamble (5 February 1952).
96 JAMES CRAWFORD, THE INTERNATIONAL LAW COMMISSION’S ARTICLES ON STATE RESPONSIBILITY: INTRODUCTION, TEXT, AND COMMENTARIES 22 (2002). M. MAGDALENA SEPÚLVEDA & MARÍA MAGDALENA SEPÚLVEDA CARMONA, THE NATURE OF THE OBLIGATIONS UNDER THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS 189 (2003). (Noting the traditional view that economic, social and cultural rights impose obligations of result in contrast to civil and political rights which are said to impose obligations of conduct, and concluding “The reasoning behind this dichotomy is that economic, social and cultural rights allow a wide margin of discretion to states and that this flexibility results in these rights being somehow “less binding” or “less rights” than civil and political rights which are said to require more concrete steps.)
99 The Committee states in General Comment No. 3 on the Nature of States Parties Obligations under the Covenant, supra note 59: (“The Committee notes that the undertaking ‘to take steps ... by all appropriate means including particularly the adoption of legislative measures’ neither requires nor precludes any particular form of government or economic system being used as the vehicle for the steps in question, provided only that it is democratic and that all human rights are thereby respected. Thus, in terms of political and economic systems the Covenant is neutral and its principles cannot accurately be described as being predicated exclusively upon the need for, or the desirability of a socialist or a capitalist system, or a mixed, centrally planned, or laissez-faire economy, or upon any other particular approach in question.”)
100 SEPÚLVEDA AND CARMONA, supra note 96, at 189.
The persistent marginalization of ESCRs is not merely a casualty of politicized framing. Although Cold War tensions fell away in the 1970s, and despite continued affirmations of the interdependence and indivisibility of the full catalog of rights, the perception of ESCRs as programmatic persists. Ideological debate continues along the North-South dimension, with developing countries arguing that they cannot be held to the same universal standard in regard to ESCRs and insisting on the duties of richer states to make economic concessions to poorer ones.

In addition, the continued marginalization of ESCRs have been driven by the conception of rights that was favored in a post-Cold War social and political context characterized by struggles toward transitions from authoritarian to liberal political systems, and as such was centered around protecting individuals politically targeted by repressive state apparatuses from assaults on liberty and bodily integrity. The human rights discourse that prevailed in the latter half of the twentieth century became a state-centric and absolutist one, focused on liberties from state intervention. Human rights were understood to draw lines states were not to cross; they were a fixed set of rules for mandatory and uniform compliance. Within this vision, the differences between ESCRs and CPRs were exaggerated. CPRs, as rights that seek to protect against the overarching state, occupied a privileged place. Dignity-based claims that were the proper subject of local democratic processes and negotiation, either because they required consideration of competing resource needs or varied between local contexts and cultures – ESCRs, mainly – were not viewed as “real” rights, or at least not ones that the international human rights movement should take up.

The currency of the traditional vision of human rights has been called into question in a more globalized twenty-first century characterized by liberalizing governments, the increasing political power of transnational corporations, and decentralization of power and authority. When power is less concentrated in states, and embedded within private or less institutionalized actors who may be acting beyond state reach or through its economic capture, the state-centric human rights paradigm loses currency as a means of protecting dignity, human agency, and citizenship.

One might have imagined that individuals and groups marginalized through changed vectors of power or ignored by traditional human rights conceptions – workers, consumers, women, the poor – would abandon the mantle of human rights where its paradigm failed to speak to their dignity-based concerns. Instead, advocates – particularly on behalf of the poor – have embraced the language of human rights but reconceptualized

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162 See Steiner, Alston & Goodman, supra note 88, at 264.
166 Melish, supra note 87, at 73.
They urge a model that views human rights less as substantive trumps on local political processes and democratic choices, but rather as a set of tools for guaranteeing that the voices and dignity-based interests of the poor and marginalized are seen and considered—that those poor and marginalized people have a meaningful role in the construction of the public agenda.\textsuperscript{108}

The reasons for moving toward procedurist, information-forcing tools are illustrated by the way Human Rights Watch Executive Director’s Kenneth Roth explains his approach to ESCRs. Consistent with his organization’s roots in “old” human rights paradigms and its historically restive approach to ESCRs,\textsuperscript{109} Roth, wary of losing NGO legitimacy by weighing in on complex questions of distributive justice where the nature of a violation, the identity of the violator, and the violation might not be clear. He would limit international human rights NGO intervention to circumstances where there is clear arbitrariness or discrimination.\textsuperscript{110} His approach, however, denies one of the central claims of the accountability-centered human rights agenda: that arbitrary, abusive, or dignity infringing allocations may not always be evident on their face, particularly for something as profoundly polycentric as health. Accountability-based approaches, to which we now turn, are designed to consolidate information to reveal these arbitrary, abusive, or dignity infringing arrangements.

The shift in human rights conceptions and methodologies is evident in academic literature and among UN actors. Methodologies that seek to identify explicit state violations of fixed rules against individual rights claimants have not been abandoned. However, a recent dynamism has emerged around new tools geared toward enhancing people’s (especially marginalized people’s) say in policies that touch on human rights, broadly understood.\textsuperscript{111} Rights thus become more about ensuring—beyond the basic

\textsuperscript{107} Elisabeth Martin, Marie-Pascale Pomey & Pierre-Gerlier Forest, One Step Forward, One Step Back: Quebec’s 2005–04 Health and Social Services Regionalization Policy, 53 CAN. PUB. ADMIN. 467 (2010). (explaining how NGOs concerned with poverty and inequality have recently adopted the mantle of human rights.)


\textsuperscript{110} See Roth, supra note 104 at 69 (offering the following examples of discriminatory and arbitrary acts: government construction of medical clinics solely in communities where their supporters live; government failure to utilize available resources to ameliorate the populations’ health; the arbitrary exclusion of child laborers from laws that protect their health; the failure to address violence or bonded child labor).

\textsuperscript{111} Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, UN General Assembly Doc A/CHR4/28 17 January 2007, at ¶26, 87 [hereinafter Report of the Special Rapporteur, 2007]. (stating that “traditional” human rights tools like “naming and shaming, letter writing campaigns, test cases, sloganizing and so on” may have “served the human rights community well” for a time, but, recognizing the breadth of areas that affect the right to health, the need for the right to be operationalized through all of those areas, and recognizing the potential fluidity that lies beneath a concept like progressive realization, recommending “additional methods, techniques, and skills” including benchmarks, indicators, and impact assessments. See also Jonathan Klaaren, A Second Look at the South African Human Rights Commission, Access to Information,
democratic processes and beyond international-level monitoring – transparency, accountability, and stakeholder participation in policies affecting human rights.

The idea that states’ internal processes toward achieving treaty obligations are of human rights significance is, of course, not new. But early academic and institutional efforts to render ESCRs more meaningful sought to wrestle their content down to something more bounded, concrete and unchanging, to bring them in line with the traditional model. For example, in 1990 the CESCR introduced the idea of “minimum essential levels” of each right which would be immediately enforceable and not subject to vague limitations like progressive realization and maximum available resources. Similarly, Audrey Chapman has championed a “violations approach” to ESCRs, when she argued that the monitoring bodies should focus on defining and identifying explicit violations of ESCRs by government actors, rather than attempt to assess progressive realization. The approach came under criticism from NGOs reluctant to abandon more aggressive enforcement of progressive realization. Yet, Chapman in those early years maintained her position largely because, in her view, there were insufficient tools and information to assess fulfillment of programmatic aspects of the right to health.

Newer interventions, advanced by human rights scholars and reflected in international institutions emphasize the need to address, rather than avoid, the problems of progressive realization and gaps in information by requiring states to identify and attend to obstacles to assessing progressive realization within their states as part of their international human rights obligations. This has been described as a move away from

and the Promotion of Socioeconomic Rights, 27 HUM. RTS. Q. 539 (2005). (suggesting a national model of socioeconomic rights protection based on participation, transparency, and a constitutional right of access to information).

The ICESCR itself requires states to “take steps” toward progressive realization of the rights. See ICESCR, supra note 13, at Art. 2(1).

See, e.g., Audrey R. Chapman, A “Violations Approach” for Monitoring the International Covenant on Economic, Social and Cultural Rights, 18 HUM. RTS. Q. 23 (1996). (arguing that the CESCR should focus on identifying explicit violations of ESC rights rather than attempting to assess compliance with progressive realization. Although there are some aspects of the violations approach evident in comments of the CESCR (see, e.g., General Comment No. 14, supra note 16, ¶¶ 30-1), the Committee has not shied away from suggesting novel methods for assessing progressive implementation.

See, e.g., id. (Although there are some aspects of the violations approach evident in comments of the CESCR (see, e.g., General Comment No. 14, supra note 16, ¶¶ 30-1), the Committee has not shied away from suggesting novel methods for assessing progressive implementation.

Chapman, supra note 114 at 202.

Audrey R. Chapman, Core Obligations Related to the Right to Health, in Core Obligations: Building a Framework for Economic, Social and Cultural Rights 185, 202 (2002). (I am sympathetic to the intent of those proposing that the right to health be interpreted to include an obligation of result... [but] I am... reluctant to endorse this approach. Several published articles have convinced me that reliable data for assessing the progress of most developing countries in meeting these goals are just not available); see similarly, See also Chapman, supra note 114 at 32.

See Rosga & Satterthwaite, supra note 89 at 275; See also Report of the Special Rapporteur, 2007, supra note 111, ¶87 (stating “Without accountability, a State could use progressive realization and the scarcity of resources as an excuse to do virtually nothing - or to respond to whichever interest group has the loudest voice. Independent, effective and accessible mechanisms of accountability compel a State to explain what it is doing and why and how it is moving, as expeditiously and effectively as possible, towards the realization of the right to health for all.”) See also General Comment No. 14, supra note 16,
substantive monitoring and toward “monitoring-of-monitoring”\textsuperscript{119} or “managing accountability.”\textsuperscript{120} Moreover, states are expected to self-monitor using tools and processes which are themselves grounded in human rights principles and which themselves aim to render rights meaningful even when the rights’ substantive content might vary over time and context.

Procedurally-grounded human rights measures – such as human rights indicators, benchmarks, and impact assessments – are being developed so as to enhance somewhat less substantive human rights principles like accountability, transparency, non-discrimination, democratic participation, and individual self-determination.\textsuperscript{121} They do not purport to give conclusive answers to questions about how priorities should be set among competing objectives.\textsuperscript{122} Rather, in addition to being valued norms in themselves, these principles are expected to drive progressive realization\textsuperscript{123} by seeking to ensure that decisions about priority setting are reasonable, transparent, informed by evidence, and take into account the needs of the most marginalized as understood by the most marginalized.\textsuperscript{124} The growing popularity of these tools – for ESCRs but also for CPRs\textsuperscript{125}

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\textsuperscript{119} Ibid. at 259.
\textsuperscript{120} Id. at 259.
\textsuperscript{121} See Joseph Raz, Human Rights in the Emerging World Order, 1 TRANSNAT’L LEGAL THEORY 31 (2010). (Describing a threefold role of human rights in the post-Cold War period as: “first . . . expressing the worth of all human beings; second . . . placing on the agenda concerns other than those of inter-governmental relations or big business profit; and third . . . empowering individuals and voluntary associations in creating an additional channel for exerting influence and affecting the international order” while expressing concerns about institutional capacity and legitimacy of international institutions for enforcement of rights to health and education.) See similarly Brigitte I. Hamm, A Human Rights Approach to Development, 23 HUM. RTS. Q. 1005 (2001); Mac Darrow & Amparo Thomas, Power, Capture and Conflict: A Call for Human Rights Accountability in Development Cooperation 27 HUM. RTS. Q. 471, 493 (2005) (noting that there can be normative or instrumental rationales for adopting human rights-based approaches to programming and development, but that instrumental conceptions “seem to be the most compelling”; noting also that “this rationale harnesses human rights ideas and energies in order to reach the excluded, or reinforces participatory approaches to situation assessment, empowering people as actors for their own development, strengthening institutions of governance and accountability, and so on.”
\textsuperscript{123} Id. ¶27. See also Alicia Ely Yamin, Defining Questions: Situating Issues of Power in the Formulation of a Right to Health under International Law 18 HUM. RTS. Q. 398, 407 (1996) [hereinafter Right to Health] (suggesting that the “distinction between instrumental and normative value of defining health as a human right collapses” when rights are understood to advance empowerment as both as goal and strategy).
\textsuperscript{124} See Paul Hunt & Gillian MacNaughton, Impact Assessments, Poverty and Human Rights: A Case Study using the Right to the Highest Attainable Standard of Health 30 (2006) (Noting, for example, that “a further important aspect of the right to health is the participation of the population in all health-related decision-making at the community, national and international levels.” Participation implicates, among other factors, the rights to seek and impart health-related information, the right to express views freely, and the right to basic health education, as well as transparency in policy-making processes. Full participation on a non-discriminatory basis
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suggests that human rights are relied upon increasingly for their values-driven governance-enhancing function over any fixed, detailed substantive normative content they might prescribe.\textsuperscript{126} That is, deliberation-enhancing, accountability-oriented processes are used to create spaces of contestation – and to suggest values that might inform that contestation.

The history of the use of indicators for human rights monitoring by UN institutions reveals a developing orientation toward building up structures for internal accountability in service of the right to health. As early as 1990, Danilo Türk, Special Rapporteur on the Realization of Economic, Social and Cultural Rights identified indicators as a potentially useful proxy for measuring the realization of socio-economic rights, providing a "yardstick" that would provide a way of assessing progressive realization over time and facilitating comparisons of rights realization across countries with similar levels of socio-economic development.\textsuperscript{127} At that time, however, Türk was referring to traditional social and economic indicators: data sets developed by social scientists and economists around, for example, infant mortality for the right to health, or child literacy for the right to education.\textsuperscript{128} These are indicators of substantive health or education outcomes, which Chapman had rejected as insufficiently available or underdeveloped in order to help the ICESCR to monitor progressive rights realization.\textsuperscript{129}

By 2006 – notably after the content of the right to health had been developed through the promulgation of General Comment No. 14 – the work of the UN Special

also requires special attention to sharing information with and seeking the views of women and men, as well as the views of vulnerable and marginalized people (citing General Comment No. 14, supra note 16 at ¶11) See also Paul Hunt & Gunilla Backman, \textit{Health systems and the right to the highest attainable standard of health}, 10 HEALTH & HUM. R. 81–92, 83 (2008).

\textsuperscript{125} Rosas & Satterthwaite, supra note 89 at 266. (explaining how social scientists interested in applying statistical tools to civil and political rights began using indicators to assess states’ overall human rights performance, citing Charles Humana’s \textit{World Human Rights Guide} assigning percentage ratings to countries based on scores concerning forty CPRs, and ranking them “good, fair, poor or bad.”)

\textsuperscript{126} Cummings & Trubek, supra note 104.

\textsuperscript{127} Special Rapporteur Danilo Türk, \textit{The New International Economic Order and the Protection of Human Rights, Realization of Economic, Social and Cultural Rights, Progress Report, Prepared by Mr. Danilo Türk, Special Rapporteur}, U.N. Doc. E/CN.4/Sub.2/1990/19 (July 6, 1990) (stating at ¶7: Indicators can provide one means of assessing progress over time towards the "progressive realization" of these norms. Additionally, indicators can help to reveal some of the difficulties associated with fulfilling these rights. They can assist in the development of the "core contents" of some of the less developed rights in this domain, and can provide a basis from which a "minimum threshold approach" can be developed. Indicators can reveal information about the extent to which certain rights are enjoyed or not enjoyed within the ambit of States, information which might not generally be available if other forms of measuring progress were employed. Similarly, they can provide yardsticks whereby countries can compare their own progress with that of other countries, especially countries at the same level of socio-economic development.)

\textit{See also} Todd Landman, \textit{Studying Human Rights} 90 (2006) (describing development indicators as "suitable proxy measures to capture the degree to which states are implementing [their human rights] obligations. For example, literacy rates and gender breakdown of educational attainment are seen as proxy measures of the right to education. . . ")

\textsuperscript{128} See, e.g., \textit{id.}, ¶23.

\textsuperscript{129} Chapman, supra note 108, at 33-34.

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Rapporteur on the Right to Health reflected a far broader concept of dignity-based right-to-health indicators. These indicators reflect processes, structures and institutions linked to health, in addition to health itself. For example, indicators now measure whether, as required by General Comment No. 14, states have adopted a national public health strategy that includes the right to health; whether the plan is formulated and monitored through the participation of “the most vulnerable and disadvantaged” individuals and groups; and whether there are effective internal monitoring and accountability mechanisms. Emphasis is placed on states’ duties to generate data in relation to health indicators that is disaggregated to reflect contextual vulnerability and discrimination, and on state duties to monitor their own progress internally through indicator-based benchmarking. The depth of monitoring-of-monitoring is vividly reflected in the fact that right-to-health indicators even measure the extent to which states undertake health or right-to-health impact assessments prior to adopting national health plans. The result is that indicators move from being a tool for Committee-level assessment of states’ progressive realization to driving internal processes likely to improve right to health outcomes by bringing to light discriminatory, arbitrary, or ineffective policies. Indicator-based monitoring is relied upon for opening up spaces for civil society participation in generating systemic human rights-based reform at national and subnational levels.

130 See Paul Hunt, Report of the Special Rapporteur on the right to the highest attainable standard of health to the Commissioner on Human Rights, 2006, UN Doc E/CN.4/2006/48 (2006). A recent effort to operationalize this model to evaluate the health systems of the full range of states sets out some 72 indicators. Many of these can be understood as outcome indicators, such as infant mortality rates and life expectancy, but many are better understood as requirements for domestic monitoring designed to leverage local political processes: the existence of a health plan, whether there is legal protection for participation of the marginalized within that health plan, and even transparency in national financing. See Backman et al., supra note 71 at 2057-2058.

131 General Comment No. 14, supra note 16, ¶43.

132 Id. ¶49(c).

133 Id. ¶49(b).

134 Id. ¶ 34-35, 58. (See especially ¶34, emphasizing the key role indicators play in driving internal accountability and participation: “[I]ndicators and benchmarks fulfil two important functions that underpin much of the discussion in this chapter. First, they can help the State to monitor its progress over time, enabling the authorities to recognize when policy adjustments are required. Second, they can help to hold the State to account in relation to the discharge of its responsibilities arising from the right to health, although deteriorating indicators do not necessarily mean that the State is in breach of its international right to health obligations, an important point which is discussed further below. Of course, indicators also have other important roles. For example, by highlighting issues such as disaggregation, participation and accountability, indicators can enhance the effectiveness of policies and programmes.”)

135 For a discussion of right to health impact assessments, see notes 138-150 and accompanying text.

136 See also HUNT and MACNAUGHTON, supra note 124, at 57. (Defining the right to health as the “right to enjoy a variety of goods, facilities and services that are necessary to realize the highest attainable standard of health.”

137 See, e.g., Alicia Ely Yamin, The Future in the Mirror: Incorporating Strategies for the Defense and Promotion of Economic, Social and Cultural Rights into the Mainstream Human Rights Agenda, 27 Hum. RTS. Q. 1200, 1207, 1212 (2005). [hereinafter Yamin, Economic, Social and Cultural Rights] arguing that human rights organizations should move beyond indentifying individual-level violations and instead collaborate with other disciplines like public health to use indicators, such as rates of access to emergency obstetric care, in order to advocate in relation to structural and institutional factors in human rights and to
The recent attention to human rights impact assessments reflects a similar thrust. Human rights impact assessments appear to have been first advanced in the context of public health policy in relation to HIV/AIDS, on the view that public health programs needed to be structured along core principles of human rights and dignity if they were to be effectively and legitimately address the epidemic. Human rights impact assessments have received the greatest attention, however, through John Ruggie’s mandate as Special Representative to the UN Secretary-General on business and human rights. In direct response to the limitations of more absolutist, narrow, and state-centric approaches to human rights outlined above, Ruggie rejects the idea of imposing a subset of international human rights obligations on corporations. Instead, he urges soft-law “due-diligence” obligations placed on private-sector actors to project potential human rights impacts of business projects. Under the proposed framework, companies would adopt human rights policies, integrate human rights throughout their organizations, conduct impact assessments in consultation with affected stakeholders, and monitor and track their own human rights performance, with a view toward sharing information and standardizing metrics for comparability. Ruggie understands corporations to be in a good position to undertake such “human rights due diligence,” given their experience with legal obligations to manage and assess financial and other related risks.

Although Ruggie does not call for human rights impact assessments for state policies, he does maintain a focus on self-monitoring, consultation and transparency at the state level. Noting that corporate human rights abuse is most likely to take place in countries with the greatest governance challenges, he emphasizes the need to reduce gaps in governance and information in relation to existing obligations. Thus, he suggests moving the human rights agenda beyond narrow, typically weak state

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138 The human rights impact assessment has been described as a set of tools or methods designed to predict the likely effects of a program, policy, or project in order to inform and improve. See, e.g., HUNT AND MACNAUGHTON, supra note 124, at 8.
140 See John Ruggie, Protect, Respect and Remedy: A Framework for Business and Human Rights, 3 INNOVATIONS: TECHNOLOGY, GOVERNANCE, GLOBALIZATION 189-212, 191-192 (2008). [hereinafter Ruggie Framework] (Recognizing that business can affect virtually all human rights and so rejecting the idea of limited list of human rights for which businesses would have international responsibility; and noting that the “root cause of the business and human rights predicament today lies in the governance gaps created by globalization” and therefore preferring mechanisms designed to address governance directly.) Ruggie’s Framework is further elaborated in the Report of the Special Representative of the Secretary-General on the issue of human rights and transnational corporations and other business enterprises- John Ruggie, March 21, 2011, U.N. Doc A/HRC/17/31 [hereinafter Ruggie Report to the Secretary-General].
142 Ruggie, Framework, supra note136 at 199-204.
143 Id. at 199.
144 Id. at 192. Ruggie does not, of course, eschew traditional state duties to protect against human rights abuses within their territory through traditional human rights law enforcement.
145 See Ruggie Report to the Secretary-General, id., at ¶14;
institutions dedicated to their protection — presumably he means human rights commissions — in order to ensure investigation of the human rights implications of choices within the full range of government policy domains that shape business practice, such as commercial, investment policy, securities regulation, and corporate governance.\textsuperscript{146} The implication, very much in line with the mainstreaming approach he suggests for corporate human rights responsibility, is that state fidelity to human rights obligations can be understood as, in some contexts, a matter of degree, and will be enhanced by the ways in which states monitor compliance with those obligations internally.

There has been a renewed energy for human rights impact assessment for driving and monitoring governments' human rights obligations as a result of its increased profile in the corporate context.\textsuperscript{147} Paul Hunt and Gillian MacNaughton, even as they admit the novelty of the concept,\textsuperscript{148} argue that human rights impact assessment is "highly recommended, if not required, [for states] to comply with [their] international human rights obligations to progressively realize human rights."\textsuperscript{149} (emphasis added). Their suggested methodology, presented as a case study in relation to the right to health, draws on NGO-developed tools used to help governments and NGOs perform human rights impact assessments for a range of government programs, policies and projects.\textsuperscript{150}

In line with the proceduralist monitoring-of-monitoring approach outlined above in relation to indicators, the methodology explicitly acknowledges the key roles of transparency, accountability, and participation of the most marginalized in driving progressive realization beyond the minimum core.\textsuperscript{151} Of course, human rights impact assessment requires policies to be evaluated against human rights norms. But, as suggested above, Hunt and MacNaughton would require the processes of assessment themselves to be explicitly grounded in fundamental human rights principles. Thus, for example, equality and non-discrimination are not only external norms against which proposed policies are to be tested; they also require that impact analysis disaggregate information along marginalized group lines, and that poor and marginalized groups are given room to take part in transparent and accessible impact assessment processes.\textsuperscript{152}

This changed conception of rights is not limited to ESCRs. Commentators have relied on the diminishing importance of the difference between thresholds of "violation"

\textsuperscript{146} Ruggie, \textit{Framework}, supra note 136 at 193.
\textsuperscript{147} TODD LANDMAN, \textit{STUDYING HUMAN RIGHTS} 127 (2006).
\textsuperscript{148} HUNT AND MACNAUGHTON, \textit{supra} note 124, at 9.
\textsuperscript{149} Id. at 7.
\textsuperscript{151} Id. at 33. (stating "A rights-based approach . . . demands that the state take deliberate steps to progressively realize the right to health as expeditiously and effectively as possible. Impact assessment provides state with the methodology to do so." [emphasis added].
\textsuperscript{152} Id. at 33. (citing the following general principles underlying rights-based approaches to impact assessment: (1) explicit human rights framework; (2) progressive realization; (3) equality and non-discrimination; (4) participation; (5) information; (6) accountability; and (7) interdependence of rights.)
and "fulfillment," in order to argue that neither set of rights can be understood simply as a set of clear substantive entitlements of individuals against states. So, for example, women's rights to non-discrimination cannot be guaranteed simply through recognition and remedy of equality rights violations at the individual level, but must be understood in terms of women's rights to equal participation in democratic and institutional processes, and rights to transparency and accountability in relation to that participation.

Nor is the shift in emphasis toward meaningful participation over substantive outcomes as a driver of progressive realization limited to the UN institutional actors and those who explicitly adopt their frameworks. Much right-to-health scholarship shares, but elaborates upon and refines the vision that human rights should primarily be understood in terms of locating responsibility and opening spaces for meaningful participation in determining health-affecting state policies through monitoring processes.

Alicia Ely Yamin, for example, emphasizes empowerment as an underlying theme in human rights, and suggests framing the right to health in terms "the highest attainable standard of control over health." (emphasis in original). She notes that poor health is "the product not only of human beings' incomplete domination of nature, but of the domination of some people by others." The central task of human rights and right to health activists is redefined as an exploratory one: "to discern the societal relations, combinations, and alignments of power that both produce and distribute disease..." She would seek to shift the dialogue in the right to health to "reveal the human role in constructing health and illness." In doing so, she would reject (perhaps provisionally) any normative account of an ideal health care regime, and focus instead on fleshing out the meaning of empowerment in context, and through collaboration with affected communities themselves. In 1996, Yamin was skeptical of indicators as a process for achieving empowerment; she worried they render human rights monitoring too

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153 For example, Rosga and Satterthwaite note that the rubric of "respect, protect, fulfill", which was once thought to apply only to ESCRs, has been invoked in relation to CPRs as well. Rosga & Satterthwaite, supra note 89, at 43. (UNITED NATIONS. INTERNATIONAL LAW COMMISSION & JAMES CRAWFORD, THE INTERNATIONAL LAW COMMISSION'S ARTICLES ON STATE RESPONSIBILITY: INTRODUCTION, TEXT, AND COMMENTARIES 22 (2002)): Similarly, the International Law Commission's has dropped the distinction between obligations of conduct and obligations of result from its final Articles on State Responsibility.


156 E.g. HUNT & MACNAUGHTON, supra note 124; Backman et al., supra note 71.

157 Yamin, Right to Health, supra note 123, at 400.

158 Id. at 402.

159 Id.

160 Id. at 412

161 Id. at 436, 438.
technocratic. By 2005, Yamin advocated that progressive realization could be driven by indicators, so long as those indicators remain contestable, not overly technocratic in that they include the qualitative, and defined through the collaboration of human rights NGOs with other stakeholders including public health actors.

Ann Jannette Rosga and Margaret Satterthwaite likewise respond concerns over the risks of indicators with an emphasis on meaningful participation in creating a contestable set of indicators. They suggest that “indicators must be created that will measure the participation of the populace in decisions affecting both institutional design and policy priorities in the field of human rights,” and that “participation should . . . extend to the process of designing and implementing indicators themselves.”

Under this developing model, the role of government is understood differently than under traditional rule-and-principle based approaches to human rights. The model promises to pry open spaces for democratic engagement by requiring states to account for their role in rights realization even when responsibility for outcomes is only partly or remotely within state control. This new emphasis casts human rights more as a framework set of tools for guaranteeing meaningful enfranchisement, grounded in principles linked to human dignity – rather than simply a set of substantive entitlements. It recognizes that lack of voice in democratic governance lies at the root of much human rights abuse. Under these newer models, Government is no longer simply as an object of human rights accountability, a potential human rights violator. It is also a “manager of accountability processes” between citizens and both state and private actors, increasingly recognized as implicated in human rights realization.

This new accountability-centered model, whereby public goods are scrutinized not (primarily) for their substantive distribution, but for whether processes for distribution comply with foundational human rights principles, holds a great deal of theoretical promise for human rights-based assessments of health systems in Canada. Generally, it diminishes the argument that CPRs and ESCRs are of fundamentally different natures, with ESCRs occupying the lower rung. Likewise, where states’ duties to self-monitor, disaggregate data, benchmark, and open up participation in policymaking in areas of human rights significance occupy a more central place among their human rights obligations, the differences between “violations” and “minimum core” approaches on the one hand and progressive realization on the other diminish.

162 Id. at 406-7 (Expressing the concern that indicators will render health status an objective, quantitative quality . . . one more output to be produced. . . to be measured according to standardized morbidity and mortality indicators . . [turning] human beings (and their behaviors) into one more input and thus the targets of incentive changes and objects of surveillance.)
163 Yamin, Economic, Social and Cultural Rights, supra note 137 at 1210 (“If human rights groups are willing to work with other disciplines . . . [indicators] can form the basis for the standard-setting work the human rights movement has successfully engaged in for years with respect to many civil and political rights issues, including prison conditions.”
164 Rosga & Satterthwaite, supra note 89 at 313-314.
165 Melish, supra note 87, at 74.
166 Id. at 75.
167 See supra note 95-100 and accompanying text. See also Yamin, Right to Health, supra note 123.
168 See Young, supra note 78, at 166. Rosga & Satterthwaite, supra note 89, at 265.
the need for universal substantive normativity, "immediately enforceable" ESCRs need not be restricted to the level of basic survival and can have greater resonance in a well-developed health care system. Insufficiently justifiable choices rooted in power, ignorance or stereotype — what some might consider systemic discrimination, which traditional approaches have failed to address — cannot hide as easily behind privatized and disaggregated lines of responsibility and authority. Concerns about transparency, accountability, and substantive distribution in Canadian health care — well-voiced in the political sphere — may be structured in concrete human rights terms.

Although the new emphasis on processes in human rights is relatively recent, its set of core themes is not. A number of authors have noted common intellectual underpinnings and features of the new conceptions of accountability and responsibility in human rights and new ideas about governance in the public sector (including health policy). That is, the driving themes in the "new human rights" — enhancing democratic governance through flexible norm-setting that responds to community-level needs, reliance on transparent, deliberative processes, evidence-based decisionmaking, and citizen participation — are closely paralleled in public (including health) policy literature in Canada and internationally. The emphasis has increased as resource constraints have put pressure on Canadian health care and raised concerns about accountability in the scope and distribution of publicly-funded services. The next section will examine the evolution of health governance in Canada along such lines, with a view to exploring how Canada might respond to the demands of the procedural dimensions of the human rights to health, and to expose contextual challenges to the procedural project in the human right to health.

III. Governance and accountability in Canada’s public health care system

There has been a resounding call in recent years for better stewardship and management of publicly-funded health care in Canada. In the first years of the twenty-first century, no fewer than five commissions or task forces were set up to review Canada’s health care system. Each system review made a different set of recommendations for reform, but all concluded with a call for greater accountability. The call has been echoed by institutional and academic observers.

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169 See e.g., supra note 41.
Concerns around accountability must be understood in relation to the overlapping institutional orders governing Canada's health care system. The administration and delivery of health care services in Canada has always been highly decentralized and disaggregated, despite its well-known Medicare program based on universal and equitable access.\textsuperscript{174} The decentralization has been maintained by provincial constitutional responsibility for administration and delivery of health care (though the federal government has, over the years, taken an increasing leadership role through spending); the historic arms-length relationship between provinces and hospitals and physicians delivering care; and recent regionalization in health care services in which sub-provincial health authorities have taken an increasing role in allocating a portion of health care resources as a response to rising health care costs. Disaggregation results from the multiple institutions, organizations, and individuals responsible for funding and delivery of health care at both levels of government whose efforts may not always be coordinated — what has been referred to as the "field of silos" that obscure responsibility for policy outcomes.\textsuperscript{175}

Canada has a predominantly publicly financed system, where services are delivered mainly privately but underwritten through public insurance. Each province and territory maintains its own universal system of hospital and physician care, defined as "insured services" under the Canada Health Act (CHA). Funding for these services is financed through federal subsidies and conditioned on terms set in the CHA.\textsuperscript{176} Services that fall outside of what the CHA defines as hospital and physician services — e.g., long-term care, dental and vision care, home care, pharmaceuticals, public health — are provided through a mix of private and public funding through provincial budgets. Thus, while the CHA requires that a core of services — legislatively defined as hospital and physician services — be delivered free of charge as a condition for funding, hospitals and physicians deliver care at arm's length from government.

The government's role in shaping the distribution of health care has been incremental. From its inception, the Medicare model was concerned with maintaining professional control over clinical decisionmaking, effectively leaving the scope and delivery of services to individual physician discretion. For this reason, it took a very long time before public values of any kind played a role in distribution of health care. Colleen Flood and her colleagues have noted the stubborn persistence of the view that

\textsuperscript{174} MARCHILDON, supra note 1, at 19.
\textsuperscript{176} Canada Health Act, R.S.C. 1985, c. C-6 (Can.). The federal government also directly finances and administers health services in a limited number of other areas: First Nations People living on reserves, Inuit, members of the armed forces and the Royal Canadian Mounted Police, veterans, and inmates in penitentiaries. See MARCHILDON, supra note 1, at 1.
government acts as "mere insurer, funding any care that a physician thinks is necessary," even in the face of changing conceptions of health care.

The professional dominance over delivery and distribution of publicly funded health care in Canada stretches as far back as the nineteenth century. At this time, provincial governments began encouraging the distribution of hospital services based on need rather than ability to pay by requiring existing nonprofit municipal, charitable and religious hospitals to admit all patients on the basis of medical need in exchange for reimbursement and some regulatory oversight. Private for-profit hospitals did not qualify for the subsidy, and there were few state-owned and controlled hospitals at the time. By 1947, provinces began experimenting with government-funded hospital insurance to supplement largely employer-based private insurance plans: Saskatchewan implemented a plan to underwrite all medically necessary hospital, stays, x-rays, laboratory services and some prescription drugs. British Columbia and Alberta soon followed suit, and after the federal government agreed to conditional cost-share in the mid-1950s, all ten provinces signed on.

In the early 1960s, after federal cost-sharing was put in place for universal provincial insurance for medically necessary hospital services, Saskatchewan began to pioneer a similar scheme for physician services. Fearing incursions on professional autonomy, the physicians responded by going on strike for 23 days in 1962. Saskatchewan returned with a plan emphasizing physicians' contractual autonomy, and physician autonomy remained an important feature in future negotiations over the form and content of Medicare. What is known today as Medicare was created in 1966 when, following recommendations from a Royal Commission report on Health Services, the federal government passed the Medical Care Act. The Act was designed to encourage the remaining provinces to introduce schemes like Saskatchewan's. It established federal cost-sharing transfers to the provinces for medical care insurance schemes that met the criteria of universality, public administration, comprehensiveness and portability. It was established with the goal of ensuring that all Canadians had access to core hospital and physician services on the basis of need, rather than ability to pay. By 1972, all the provinces had signed on and a universal national health insurance plan was in place.

Finally, in 1984, in response to concerns that "extra billing" by physicians and "user fees" charged by hospitals and clinics were impeding equitable access, the federal

178 See, e.g., The Charity Aid Act, Ontario Statutes, 1874, 37 Vict., ch. 33.
180 For a historical overview, see Marchildon, supra note 1 at 19-25. For a richer history, see CAROLYN HUGHES TUOHY, ACCIDENTAL LOGICS: THE DYNAMICS OF CHANGE IN THE HEALTH CARE ARENA IN THE UNITED STATES, BRITAIN, AND CANADA 49 (1999).
181 Tuohy, id. at 53.
182 Id. at 56.
183 EMMETT M. HALL ET AL., THE ROYAL COMMISSION ON HEALTH SERVICES (Queen's Printer and Controller of Stationery, Ottawa, Ont, Canada, 1964).
184 For an analysis of the meaning of these principles, see Colleen M Flood & Sujit Choudhry, *Modernizing the Canada Health Act*, in ROMANOW PAPERS: THE GOVERNANCE OF HEALTH CARE IN CANADA 346, 348.
government passed the Canada Health Act (CHA). The CHA prohibited provinces from introducing extra charges by deducting them dollar-for-dollar from the province's share of the federal government transfer. In support of the prohibition on user fees and extra billing, the CHA also added a fifth funding condition in addition to public administration, comprehensiveness, universality, portability — accessibility. Finally, provinces either prohibited or created disincentives for private insurance for publicly insured hospital and physician services in order to discourage the development of parallel private systems.

Thus, the original design of Medicare, on its face, made no changes to delivery of physician and hospital services, but simply underwrote a portion of what already existed. Distribution of covered hospital and physician services would remain determined by individual professional judgments about medical necessity. Other individual health services — home care, physical therapy, prescription drugs — could be funded and administered at provincial discretion, and provinces might require co-payment. Public Health would likewise fall outside the CHA funding scheme. Provinces and territories could continue to regulate public health through provincial and territorial Public Health Acts and through specialized branches of each one's ministry of health, and programs would be funded out of provincial and territorial budgets without federal constraint.

Under this basic structure, which remains in place today, Canada's health system as a whole cannot fairly be described as nationalized, socialized, or a "command and control" system, nor can it fairly be described as comprehensive. Rather, it is more appropriately understood as a "single payer" system for a core set of universal public services, statutorily defined, at the outset and still, as hospital and physician services.

The decision not to change the design of service delivery but rather to underwrite its costs meant that the scope of covered services would, in the years to follow, be adjusted through multiple provincial-level accommodations with professional bodies. As a consequence, the scope of public coverage of health care in Canada has been described as

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185 Canada Health Act, R.S.C. 1985, c. C-6, §20. (Can.).
186 Id. §7.
187 Colleen M. Flood & Tom Archibald, supra note 3.
188 Public health can be defined as the science and art of promoting health through broad population-level initiatives. See C.-E. A. Winslow, The Untilled Fields of Public Health, 51 SCIENCE 23 (1920).
189 The federal government does, however, affect health policy through spending.
190 The "comprehensiveness" criterion at §7 of the CHA is largely defined out of meaning. Section 9 provides, "In order to satisfy the criterion respecting comprehensiveness, the health care insurance plan of a province must insure all insured health services . . ."; See Romanow Report, supra note 172, at 62-63 (noting that "This is not how the average person would define comprehensive. . . [but that [d]espite this, comprehensiveness should be retained as a principle, not so much as a description of existing coverage under the Canada Health Act but as a continuing goal. It should be redefined to mean that, as financial resources permit and as the health care system changes, the definition of comprehensiveness (and of services insured under provincial plans) should continue to evolve.
191 Carolyn Hughes Tuohy, The Costs Of Constraint And Prospects For Health Care Reform In Canada, 21 HEALTH AFF. 32, 35-36 (2002). (setting out three ways of understanding the "political icon" that is Canadian Medicare: a "traditional delivery system for physician and hospital services, underwritten by public funding"; "exclusive universal public financing of physician and hospital services"; and "exclusive universal public finance for a core set of services," and arguing that understanding carries with it different prospects for reform, with the first conception being most restrictive, and the last being most liberal.)
driven neither by markets, nor hierarchy, but more by "collegiality" – the government "pays the bills and leaves those in medicine to practice their profession."\textsuperscript{192}

But the passage of time brought new challenges and ideas around health, medical care, and insurance that fundamentally tested the vision of Medicare rooted in the 1960s. Individual physician discretion could no longer play the predominant role in determining the volume and mix of services. Shifts in governance of health care distribution in the last two decades have been shaped largely by two forces: concerns about cost containment, and the increasing perceived importance of health interventions outside of hospital and physician services.

\textbf{IV. Costs and the scope of services: redefining the Medicare basket}

As discussed, a key part of the original single-payer bargain was that individual physicians maintained professional control over clinical decisionmaking. Per-service fees were regulated according to "fee schedules" typically negotiated at the provincial level between provincial governments and provincial medical associations, but physicians were largely permitted to determine who to treat, how much, and how.\textsuperscript{193} It was generally assumed that only medically necessary services would be billed to provincial plans, and that the definition of medical necessity could be managed at the doctor-patient level.\textsuperscript{194} In 1999, Tuohy called it "one of the puzzles of the Canadian case" that despite highly developed databases of both medical and hospital services generated through physician and hospital billing, there was little government involvement in monitoring or reviewing the mix, volume and distribution of hospital and physician services.\textsuperscript{195} But rising health care costs and waves of funding reductions driven by federal deficit-cutting in the 1980s and 1990s\textsuperscript{196} eventually led to more government involvement in rationing health care services.

From Medicare's inception in the 1960s until significant cuts in the 1990s, costs were kept in check largely without resort to restricting services available under the public plan. At the hospital level, costs were constrained early on when provinces replaced fee-per-item payments with global budgets provided to each hospital. These budgets were based on historic spending, with increases driven mainly by provincial fiscal considerations.\textsuperscript{197} Occasionally, ministries of health, with input from professional associations, might negotiate with individual hospitals to fund new treatments on an ad hoc basis,\textsuperscript{198} but global budgets were considered relatively successful at keeping costs down. Government played a very limited role in determining which services would be

\textsuperscript{193} TUOHY, supra note 180, at 205.
\textsuperscript{194} id. at 205-206.
\textsuperscript{195} id. at 224-25.
\textsuperscript{196} id. at 90-93.
\textsuperscript{197} id. at 212.
\textsuperscript{198} id. at 218.
considered medically necessary as individual hospitals determined their own allocation of services within their budget.\textsuperscript{199}

Government efforts to limit costs associated with physician services likewise at first avoided engaging with the basket of covered services. Initially, fee schedule negotiations between governments and medical associations addressed the fee per physician service rather than the relative value of items listed on the fee schedule or the scope of services covered, which had evidently changed little since the early days of Medicare.\textsuperscript{200} Occasionally, there were additions or deletions from the fee schedule, generally at the initiative of medical associations with little substantive government involvement. Costs were primarily controlled by caps on physicians' billing or by legislative limits on the flow of physicians entering the profession or establishing themselves in a given province or area, generally after some negotiation between provincial ministries of health and professional associations.\textsuperscript{201}

By this point, the tradition of negotiation between the medical profession and provincial ministries of health was well entrenched, and health care in Canada could reasonably be described as "co-managed" between government and professional bodies.\textsuperscript{202} Government set broad budgetary parameters, and the medical profession determined distribution mainly at the point of care.\textsuperscript{203} Evans and colleagues explain the logic: Canadian public insurers, unlike, for example, private insurers in the United States, had no administrative overhead, no costs for estimating risk status to determine what to cover, cheaper claims processing (not to mention marketing costs and shareholder premiums).\textsuperscript{204} Physicians, for their part, tended to express satisfaction with their level of clinical autonomy, avoiding problems like inadequate resources and rationing in the UK, and inadequate coverage and corporate dominance in the US. The trade-off was lower gross incomes.\textsuperscript{205}

But by the 1990s, significant financial pressures would come to bear on the Canadian health care system, creating a new climate for reform. In 1987, Canada had the second-highest level of per capita health spending in the world.\textsuperscript{206} An economic recession began in 1990. By 1993, federal and provincial deficits reached a record-breaking 65 billion Canadian dollars.\textsuperscript{207} The federal government responded by freezing social and health transfers, and in 1995, it actually cut transfers to the province for the first time.\textsuperscript{208} In this environment, real per capita health spending declined sharply from 1992 to 1996.

\textsuperscript{199} See Marchildon, supra note 1, at 96.
\textsuperscript{200} Tuohy, supra note 180, at 213.
\textsuperscript{201} See generally Morris L. Barer, Jonathan Lomas & Claudia Sammartin, Re-Minding our Ps and Qs: Medical Cost Controls in Canada, 15 Health Aff. 216 (1996).
\textsuperscript{203} Tuohy, supra note 180, at 231.
\textsuperscript{204} See id. at 573.
\textsuperscript{205} Id. at 232.
\textsuperscript{207} Tuohy, supra note 191, at 33.
\textsuperscript{208} Marchildon, supra note 1, at 106.
Then rather suddenly, austerity was abandoned and spending rebounded rather quickly, so that spending in 2000 was actually 9 per cent higher in 1995-adjusted dollars than it had been in 1992.209 Tuohy observes that the 30 billion dollars were saved during the period of austerity came at a great political cost: federal-provincial wrangling over health care dollars and "an atmosphere of crisis that shook public confidence in the health care system and in government's ability to manage it."

A. De-listing

A number of reforms resulted from concerns over sustainability that dominated the 1990s. First, the concept of "de-listing" – i.e., limiting the scope of physician services covered under the fee schedule by deeming some to be "medically unnecessary" – began to gain popularity among members of the medical profession.211 De-listing, as a form of privatization, could both reduce government spending and provide physicians with extra income from non-insured items. Provincial governments and medical associations began more detailed and explicit negotiation over coverage of specific items. In Ontario, for example, a Physician Services Committee (PSC) was established through a profession-government agreement in 1997, to assume primary responsibility for reviewing utilization of resources to determine which would be eligible for public coverage in accordance with undefined principles of "tightening" and "modernization."212

Along with the more prominent government role in determining the contents of the "Medicare basket" came public and academic concern about the processes of listing and delisting services. Ontario's PSC, for example, comprised of five members appointed by the Ontario Medical Association and five Ministry appointees, has been criticized for its lack of transparency, accountability, and public participation in relation to the principles and values that guide coverage determinations, and for determinations themselves.213 Flood and Erdman note that although the original agreement between the ministry and the profession establishing the PSC suggested an open process for listing and de-listing, in practice reasons for covering or denying coverage for particular services have tended not to be given, and processes for decisionmaking are closed. The public is forced to rely on the Ministry to represent the larger public interest.214 There is little room in such approaches for stakeholder values to enter into determinations of what is

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209 Tuohy, supra note 191, at 33-34.
210 Id. at 34. (noting that "the proportion of Canadians in a cross-national survey, reporting the view that the health care system needed only minor changes, plunged from 56 percent to 20 percent between 1988 and 1998 and did not rebound with increased public investment"); citing Robert J. Blendon et al., Inequalities In Health Care: A Five-Country Survey, 21 HEALTH AFFAIRS 182 (2002).
211 Tuohy, supra note 180, at 237.
212 Ontario Medical Association – Ministry of Health and Long Term Care Comprehensive Agreement 1997-2000 (December 1996) (available via www.oma.org). "Medical Directors" – senior bureaucrats within provincial and territorial ministries of health – may also approve requests to funding for particular treatments not included in the fee schedule, but their role has been limited. See Mona Awad, Julia Abelion & Colleen M. Flood, The Boundaries of Canadian Medicare: The Role of Medical Directors and Public Participation in Decision Making 12.
213 Flood, Tuohy & Stable, supra note 5, at 19.
funded and what is not funded, or to be sure whether decisions were based on cost-benefit analysis in relation to health outcomes, political factors, or the interests of physician groups.215

B. Early hospital restructuring: experiments with performance measurement

In the hospital sector, provinces pursued twin avenues of reform in response to fiscal constraint: explicit cost-cutting through hospital closings and consolidations, and structural reorganization designed to integrate services across the health continuum, generally through regionalization of health governance within provinces. These reforms ushered in a new focus on performance measurement and coordination of health interventions that had previously been absent.

In one early response to cuts in hospitals’ global budgets in the 1990s, Ontario and Alberta experimented with “case-based funding formulas.” The idea was to project, for a given case, expected costs of treating similar cases based on comparisons with peers and then to measure actual costs of treatment. In Ontario, institutions with average cost per weighted case below the mean of their peers would receive additional funding from an “equity fund” to bring them up to the group mean. In Alberta, funds would be redistributed from the less efficient “losers” to the more efficient “winners.”216 Case-based funding thus operated with the twin goals of rewarding efficiency and improving equity in the sense of giving each hospital its fair share of funding.

Although the projects raised concerns around hospitals “gaming” the system, and although the experiments were ultimately overshadowed by hospital restructuring efforts in the mid-1990s, they did elevate the prominence of certain themes in hospital resource allocation. First, they increased the perceived need for fair and transparent processes for funding, tied to performance. In Ontario, hospitals were satisfied with the collaborative policy approach for setting up case-based funding, resulting in greater acceptance of the policy, while actors in Alberta hospitals perceived a government “hidden agenda.”217 Second, hospitals accepted the idea that attention to outcomes and comparisons between groups were an important and fair way to determine appropriate allocations, even as they disputed the appropriateness of some comparators. But perhaps most importantly, these projects elevated the role of information-generation as a regulatory tool.218 In both provinces, ministries of health used information generated through case-based funding to establish provincial targets under hospital restructuring for expected resource use and utilization patterns.219

215 See Hogan, supra notes 36 to 57 and accompanying text (demonstrating judicial reluctance to address lack of transparency and consultation in decision to de-list gender reassignment surgery).
216 Vandana Bhata, Susan West & Mita Giacomini, Equity in Case-Based Funding: A Case Study of Meanings and Messages in Hospital Funding Policy (1996).
217 Id. at 42.
218 Id. at 42-43.
219 Id. at 43. (“The new focus on generating projected and real costs linked to particular case profiles “may have been as influential in restructuring the hospital system as the funding reforms themselves.”) See also Tuohy, supra note 180, at 213 (references omitted). “One effect of the experiments with case-based
C. A major structural shift: Regionalization

The major structural change in management of hospital services came through regionalization, which has been described as "the most sweeping structural reform since Medicare, and became a coast-to-coast program in 1971."\(^{220}\) Regionalization can be understood broadly as the transfer of power and authority for health care policymaking and priority-setting to sub-provincial regional bodies that are largely at arm's length from government.\(^ {221}\)

In the late 1980s and early 1990s, each province established a task force or commission of inquiry to deal with the new period of economic restraint.\(^ {222}\) All reflected a similar set of general goals. Many were about efficiency: better health outcomes with less overall spending. Others addressed broader political concerns like increasing accountability of decision-makers and enhanced citizen participation. Suggested directions for achieving those goals included a shift from institutionally-based to community-based care, a focus on a broader range of health determinants beyond the health care delivery system, making room for the representation of a variety of interests in the health field in health policy planning, and the integration of services across the continuum of care.\(^ {223}\) Regionalization of health care was the favored structural approach for achieving these reforms, and was adopted from the late 1980s and through the 1990s in every province\(^ {224}\) but Ontario (which finally adopted a form of regionalization in the mid-2000s).\(^ {225}\)

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hospital funding formulas was, as happened in the United States and the United Kingdom, to accelerate the development of information systems in individual hospitals and in provincial governments. Information so generated was brought to bear in the hospital restructuring exercises.”


\(^{221}\) Flood, Sinclair and Erdman, *supra* note 177, at 173. See also Lewis & Kouri, *ibid* at 14 (defining regionalization in Canada by four key features: each region occupies a sub-provincial territory; authority is devolved from provinces rather than self-created; at the same time, regionalization consolidates authority previously distributed among many programs and communities; and each regional authority is responsible for a broad range of services, including things like community care, long-term residential care, acute hospital care, and often extending to other things like mental health and addictions, public health and health promotion.)


\(^{223}\) TUOHY, *supra* note 180, at 97.


\(^{225}\) For a description of the Ontario experience, see Bob Gardner, LOCAL HEALTH INTEGRATION NETWORKS: POTENTIAL, CHALLENGES AND POLICY DIRECTIONS (2006), http://wellenleyinstitute.com/files/LHINs_PCh_Paper2.pdf (last viewed May 10, 2011). See also B.
Regionalization was expected to help in a number of ways. As discussed, government had begun funding health services largely by underwriting existing institutions and agencies – and in Saskatchewan, for example, those institutions amounted to 435 health boards for a population of only one million people drawing on government funds. Because funding was based mainly on historical practice, the system as a whole remained unresponsive to changing demands and circumstances. Consolidating accountability within regional health boards was expected to allow resources to move more fluidly in response to local needs. It was also expected to contribute to the vertical integration of services – "consolidating facilities and providers across the continuum of care into a single administrative organization capable of improving the coordination and continuity of health care services including prevention, public health, and health promotion activities." Under existing systems, institutions had neither the ability nor the motivation to make rational decisions about deploying resources from one "silo" care to another. Regionalization would allow home care to be proportionately expanded as hospital beds were reduced, for example; and a given "silo" would no longer benefit from offloading responsibilities to other actors represented in the regional health authority's budget. It was envisioned that increased reporting of spending, projected and actual health outcomes and wait times – as would be necessary for re-distributing funding within regions – would result in more direct accountability to local citizens and make funding less conventionally politicized and less dominated by professional interests. It would resolve what Colleen Flood has called the conflict of interest problem if governments both manage health care distribution and set broad policy goals. Other ostensible benefits include increased service quality and reliance on evidence-based practice, as well as increased spaces for public participation that come along with local participation, though the extent to which devolution by itself facilitates these results has been questioned. Finally, and less optimistically, regionalization can be understood as a way to contain discontent and conflict as service expectations seem increasingly to exceed what governments are prepared to pay for.

Unsurprisingly, regionalization has not fully lived up to its promise. The most oft-cited obstacle is the failure of most regions to situate full fiscal responsibility for all services within a given region. A broad conception of the social determinants of health

MOLOUGHNEY, A DISCUSSION PAPER ON PUBLIC HEALTH, LOCAL HEALTH INTEGRATION NETWORKS, AND REGIONAL HEALTH AUTHORITIES (2010) (criticizing the Ontario regional structure for failing to include authority over public health, and for failing to eliminate hospital boards).
226 Steven Lewis & Denise Kouri, supra note 220, at 15.
227 Marchildon, supra note 1, at 107.
228 See Flood, Sinclair, & Erdman, supra note 177, at 176.
229 Lewis & Kouri, supra note 220, at 15-20.
230 Flood, Sinclair, & Erdman, supra note 177, at 174. (D)evolution helps to install a series of checks and balances . . . [allowing governments to] monitor the performance of subsidiary agencies that manage the health care system, rather than attempt to fulfill simultaneously conflicting roles of regulator, manager and purchaser."
231 See Lomas, supra note 192, at 819; Flood, Sinclair, and Erdman, supra note 177. Lewis & Kouri, supra note 220, at 16.
232 Lomas, supra note 192, at 818.
233 Flood, Sinclair & Erdman, supra note 177, at 193; Lomas, supra note 192, at 823-824; Lewis & Kouri, supra note 220, at 20-23.MOLOUGHNEY, supra note 225.
would suggest a very wide range of community services be included within an RHA budget. But even the two most important cost elements in a region’s existing health care system – remuneration for physicians and drug plans outside hospitals have not been devolved to regional authorities. Physician remuneration remains governed by profession-province arrangements, such as through the Ontario’s Physician Services Committee described above, and coverage of pharmaceuticals remain subject to technocratic cost-benefit analysis with little consideration of relationships with other services or public values. Community services and home care services have likewise tended not to be included in RHA authority. Lomas blames the long history of political accommodation for this situation.

In addition, the benefits of regionalization may be squandered through lack of RHA independence from provincial government. Though the power held by RHAs varies from province to province, Flood and Archibald note a number of common constraints on RHA authority: members are appointed at pleasure and can be dismissed at any time. Ministers can issue binding directives to RHAs and withhold funds for non-compliance. Ministries retain the power to plan and fund additional services beyond those funded by the RHA, and RHAs cannot contract with private clinics nor make by-laws without Ministerial approval. Authors have also noted that despite the rhetoric of devolution, many RHAs were in practice subject to substantial provincial control. Limits on RHA independence risk perpetuating existing professional dominance over provincial decisionmaking, to the detriment of the evidence-based, participatory, and accountable promise of regionalization. While there might be some place for provincial control – for example should powerful local interests dominate RHA decisionmaking illegitimately, as will be discussed below – the potential benefits of regionalization are squandered with regionalization is in name only.

In addition, the promise of needs-based funding has not been fully borne out. Some provinces explicitly opted to maintain funding based on historical and political factors. In Ontario, commentators have blamed capture by medical interests with less to gain from investment in “upstream” factors like social determinants of health. In Newfoundland and Labrador, governments feared technocratic needs assessment might limit flexibility to assign funds based on concerns not reflected in the formula. And, as discussed further below, even where there were the official policies requiring each RHA

235 Lewis & Kouri, supra note 220, at 25.
236 Id. at 25.
237 Id.
238 Lomas, supra note 192, at 820.
241 See Part V, infra.
242 McIntosh, supra note 224.
243 Id. at 57.
to submit a plan documenting how it anticipates meeting the needs of its population, in most cases "this year's plan is last year's plan slightly twigged to reflect updated information."244 Part of the problem may lie in the technical challenge of drawing up formulas for determining relative need that extend beyond age and gender adjusted population counts.245 and the fear that such formulas might become so complex that they shut out stakeholder participation.246 But the difficulties associated with implementing needs-based funding also suggest that it may be impossible to depoliticize allocation decisions within regions.247

Instead, the goals of regionalization and rationalization might be better understood not as de-politicizing but modifying the political environment in which the decisions are made. Regionalization and needs-based assessment may not ever have offered a complete technocratic solution to balancing a move away from hospital and physician based care and toward prevention, health promotion, and other upstream investments, much less to the broader problem of spending wisely and fairly. Instead, their promise lies in setting the stage for more transparent allocation, and, much like the new approach to human rights set out above, opening up new kinds of spaces for democratic accountability and participation beyond the ordinary political process. Understanding whether the ostensible shifts toward evidence-based distribution through regional consolidation have indeed opened up such new spaces, particularly for marginalized groups, in determining the distribution of health care resources in Canada requires an examination of the accountability frameworks that have accompanied the move toward regionalized governance.

D. Accountability frameworks

Regionalization both consolidated and devolved authority at once. As such, it traded off some opportunities for local participation in multiple small boards of health care institutions for the promise of rationalization across institutions. The question is the extent to which regionalization has afforded opportunities for more meaningful accountability to citizens of the kind envisaged under new conceptions in human right to health – opportunities for participation created through information-generation, and new spaces for participatory deployment of that information.

Most RHA legislation provides only modestly for citizen involvement. Board members are appointed rather than elected248 and only two provinces provide for

245 See, e.g., McIntosh, supra note 224.
246 Hurley, supra note 244.
247 Id. (stating that in retrospect the optimism around needs-based funding coupled with regionalization was unfounded, and that this "perhaps should have been obvious when one reflects how difficult reallocation is within fully integrated, hierarchical organizations, much less a regional health authority with far more muted power.")
248 See FLOOD & ARCHIBALD, supra note 239, at 25.
community involvement in those appointments.\textsuperscript{249} The noteworthy example here is Quebec. In line with a far more developed participatory approach to regional health care governance, Quebec’s RHA legislation contains extensive provisions ensuring that boards represent numerous stakeholders: positions on the board are allotted to stakeholder groups including labor organizations, community organizations, medical professionals and “socio-economic organizations.” The Minister fills these positions from lists provided by each group.\textsuperscript{250} Moreover, the lists are required to “tend toward gender equity.”\textsuperscript{251}

In most provinces, citizen participation is encouraged more through open RHA planning processes, consultation with legislatively-created community bodies, and information-forcing. Legislation in most provinces requires that RHAs conduct regular open meetings where public reports are tabled and public submissions are heard.\textsuperscript{252} Duties to consult the public in devising annual health plans, however, are generally more rare: Quebec and New Brunswick are the only provinces requiring public consultation, and Quebec’s consultation requirements are far more specific.\textsuperscript{253}

The primary route for citizen participation in RHA planning is what Flood and Archibald call Community Health Councils\textsuperscript{254}—bodies created in RHA legislation and designed to act as liaisons between citizens and RHA boards. In some provinces, these bodies play a “very limited advisory role, acting as a kind of advocacy vehicle for citizens’ concerns.”\textsuperscript{255} In other jurisdictions, they are more powerful. For example, the Quebec CHC, known as the “people’s forum” nominates RHA board members and, by law, plays an active role in devising RHA plans.\textsuperscript{256} Little appears to be known,

\textsuperscript{249} E.g., The Nova Scotia Health Authorities Act, S.N.S. 2000, c. 6 [hereinafter Nova Scotia Health Authorities Act]; §11 requires that two thirds of board members be appointed from among persons nominated by community health boards, which are in turn elected by communities under the Regional and Community Health Boards Act s. 8(3). Quebec’s legislation carefully circumscribes Ministerial board appointment: one member must be selected from lists provided by each of a number of stakeholder groups, including community organizations, labor organizations, and “socio-economic organizations.” An Act Respecting Health and Social Services, R.S.Q., c. S-4.2 [hereinafter Quebec Act Respecting Health and Social Services].

\textsuperscript{250} Quebec Act Respecting Health and Social Services, \textit{id.}

\textsuperscript{251} \textit{id.} §397.0.1

\textsuperscript{252} See FLOOD & ARCHIBALD, \textit{supra} note 239 at 23.

\textsuperscript{253} Quebec Act Respecting Health and Social Services, \textit{supra} note 249, at §343.1; Regional Health Authorities Act, SNB 2002, c R-5.05 [hereinafter New Brunswick Regional Health Authorities Act] at §33(1); \textit{Compare} other provincial legislation, in which duties to consult are framed permissively and subjectively: RHAs consult when they consider it appropriate with groups they see fit to consult with. See, for example, the Manitoba Regional Health Authorities Act, CCSM c R34, §24(2) (“In the course of preparing a proposed regional health plan, the regional health authority shall consult with such persons, including municipalities, Indian Bands, and government departments and agencies, as the regional health authority considers appropriate.”)

\textsuperscript{254} Flood & Archibald, \textit{supra} note 239 at 25.

\textsuperscript{255} \textit{id.} at 25. See Nova Scotia Health Authorities Act, \textit{supra} note 249, at §§45, 48 and 49; Manitoba’s District Health Advisory Council’s mandate is very vaguely defined as “to advise and assist the board of the regional health authority. Manitoba Regional Health Authorities Act, \textit{supra} note 253, at §25(1).

\textsuperscript{256} Quebec Act Respecting Health and Social Services, \textit{supra} note 249, at §346.1 (“For the purpose of preparing the strategic plan, an agency must obtain the opinion of the people's forum, call on the participation of the institutions and community organizations of its region, and ensure the collaboration of
however, about the extent to which participation through CHCs is meaningful as opposed to superficial.\textsuperscript{257}

The most significant accountability-related achievement in regionalization is the explosion it generated in terms of improved transparency through reporting. Working within broad provincially-set parameters, RHAs must typically develop and publicize a regional plan setting out how it will meet its statutory obligations to provide for the health needs of the population.\textsuperscript{258} Legislation varies in the detail it requires of its plans: some of the more elaborate require RHAs to set out anticipated methods of measuring performance in delivery and administration of health services.\textsuperscript{260}

As for reporting requirements themselves, each RHA is statutorily required to report publicly on the extent to which its plans are met through some combination of financial reports, audited statements, and, most novel in this context, indicators of the health status of the population and the efficacy of the RHA basket of services.\textsuperscript{261} In the stakeholders in other sectors of activity that have an impact on health services and social services.” The “people’s forum” defined at §343.1, is a body established in each region to “[set] up different modes of consultation of the population on issues regarding health and well-being,” and to “[make] recommendations on the means to put in place so as to improve satisfaction of the population as regards available health and social services and to better respond to the needs in terms of service organization.”\textsuperscript{257} Flood & Archibald, supra note 239, at 27.

\textsuperscript{258} See, e.g., New Brunswick Regional Health Authorities Act, supra note 253 at §6(1) (setting out guidelines for the development of the provincial health plan); Regional Health Services Act, SS 2002, c R-8.2, [hereinafter Saskatchewan Regional Health Services Act], at §4 (affirming that the minister (i.e., the provincial government) is responsible for overall strategic direction, including, \textit{inter alia}, the establishment of goals, objectives, performance measures and targets, and development of methodologies for resource allocation).

\textsuperscript{259} See, e.g., New Brunswick Regional Health Authorities Act, \textit{id} §32(1); Health and Community Services Act, SNL 1995, c. P-37.1, §§16; 21(1) [hereinafter Newfoundland and Labrador Health and Community Services Act] Manitoba Regional Health Authorities Act, \textit{supra} note 253, at §§24(1) and 24(3); Saskatchewan Regional Health Services Act, \textit{id}, at §51; Regional Health Authorities Act, RSA 2000, c R-10, §9(1) [hereinafter Alberta Regional Health Authorities Act]; Health Authorities Act, RSBC 1996, c. 180 [hereinafter British Columbia Health Authorities Act] at §5 (1)(a); Quebec’s legislation requires RHAs to set out multi-year strategic plans supplemented by an annual “management and accountability agreement” negotiated between the provincial government and the RHA: Quebec Act Respecting Health and Social Services, \textit{supra}, note 249, §§346.1, 350,385.1-385.3. Statutory duties of RHAs vary from province to province. The Quebec Act Respecting Health and Social Services at §340 lists RHA duties including allocating budgets, ensuring public participation, ensuring efficient distribution of resources, assessing the results of the implementation of its strategic plan, and carrying out any other mandate entrusted to it by the minister. \textit{Supra} note 249. Responsibilities of RHAs in New Brunswick’s legislation are simpler: determining needs, setting priorities and allocating resources: New Brunswick Regional Health Authorities Act, \textit{supra} note 253, at §30). See similarly, the Nova Scotia Health Authorities Act, \textit{supra} note 249, at §§19 and 20.

\textsuperscript{260} Flood, Sinclair, & Erdman, \textit{supra} note 177, at 194. See e.g., New Brunswick Regional Health Authorities Act, \textit{supra} note 253, at §32(1). Alberta Regional Health Authorities Act, \textit{id}, at §9 (4)(a); Quebec Act Respecting Health and Social Services, \textit{id}, at §285.2(3).

\textsuperscript{261} The detail with which legislation prescribes the content of reports varies. In Alberta, for example, annual reports must contain audited financial information, senior management and board remuneration, and “other performance information required by regulation,” Alberta Regional Health Authorities Act, \textit{supra} note 259, at §9 (4)(a), §14(2)(b). Manitoba legislation specifies that annual reports shall contain, in addition to financial statements, the health services provided, their costs, and a “report respecting the health status of the population and the effectiveness of the health services provided or funded by the regional health
addition, as permitted in most RHA legislation that places a premium on flexibility of objects and modes of assessment, RHAs increasingly negotiate additional accountability beyond what is explicitly set out in statutes through "performance agreements" with the provinces, followed by reports on progress toward achievement. The combined result has been a massive shift toward the use of targets or benchmarks, followed by statistical indicators on things like population health, service usage, wait times, and other aspects of system effectiveness. Flood and Archibald have described this as a "significant improvement on what provincial governments were historically prepared to divulge to citizens.

Although regionalization addresses only some parts of health care distribution in Canada, the move reconstructed the discourse around health care reform at all levels of government. It refocused the debate away from the thorny issue of spending, and toward the importance of regional decisionmaking, the use of comparable indicators, benchmarks set based on scientific evidence, local experience, and public consultation. These values are explicitly reflected, for example, in the 2004 Ten-Year Plan to Strengthen Health Care in Canada, in which the federal, provincial and territorial first ministers (i.e., the Prime Minister and the Premiers of each province) agreed to address issues around access to health care and wait times in key health areas. In addition, the move toward

authority." Manitoba Regional Health Authorities Act, supra note 253, at §38(2). In Nova Scotia, the legislation is more open-ended: district health authorities are required to provide financial statement and "such information as is required by the Minister for the purpose of monitoring and evaluation of the quality, accessibility and comprehensiveness of health services." Nova Scotia Health Authorities Act, supra note 249, at §21(1)(c).

Saskatchewan Regional Health Services Act, supra note 258, at §54(2); British Columbia Health Authorities Act, supra note 259, at §7(2); Newfoundland and Labrador Health and Community Services Act, supra note 259, at §24.

Performance agreements are becoming an increasingly common tool in the public sector for governments to set the course for agencies without micromanaging their work. See Mark Considine, The End of the Line? Accountable Governance in the Age of Networks, Partnerships, and Joined-Up Services, 15 GOVERNANCE 21-40, 22 (2002). These are most prominently used in British Columbia and Quebec, where they are becoming increasingly elaborate. Quebec's legislation explicitly requires the use of performance agreements and consequent reporting: §385.7 requires that the annual report measure results against the plan in the management and accountability agreement. In addition, legislation requires each RHA to report on the reliability of the data and the monitoring mechanisms. (Quebec Act Respecting Health and Social Services, supra note 249, at §385.7). British Columbia consolidates its RHA reports and publishes them on the Ministry of Health website at http://www.health.gov.bc.ca/sossec/publications.html.

The British Columbia Ministry of Health Services describes the purpose of reports pursuant to performance agreements as "an opportunity to compare the performance of health authorities relative to each other, Ministry expectations, and to provide the public with ongoing information on the impact of redesign on patient services." REPORT ON HEALTH AUTHORITY PERFORMANCE AGREEMENTS 2002/2003, 6, http://www.health.gov.bc.ca/sossec/pdf/haagreement0203.pdf.

FLOOD AND ARCHIBALD, supra note 239 at 25.

Id. at 25. See Manitoba Regional Health Authorities Act, supra note 253, § 38(2); Quebec Act Respecting Health and Social Services, supra note 249, § 346.

The plan states, "First Ministers agree to collect and provide meaningful information to Canadians on progress made in reducing wait times, as follows:"

- Each jurisdiction agrees to establish comparable indicators of access to health care professionals, diagnostic and treatment procedures with a report to their citizens to be developed by all jurisdictions by December 31, 2005.
provincial regionalization prompted the federal government to consolidate Statistics Canada with a number of other health data management infrastructures to establish the Canadian Institute of Health Information, which "has grown into one of the world's premier health information agencies with extensive databases on health spending, services and human resources." 268

V. Appraisal: The new right to health and new governance in Canadian health care

Changes to Canada's systems of health care governance in the last two decades share a number of common features with procedural approaches to the right to health reflected in the turn toward monitoring-of-monitoring by the CESCR as well as in academic literature expounding upon the content of the right to health. 269 Regionalization is neither necessary nor sufficient for equitable, non-discriminatory, transparent, participatory, progressive decisions about which health and related services to provide, nor to ensure, for example, that those services are availability, accessibility, acceptability and of good quality. 270

Nonetheless, the move toward regionalization, accompanied as it has been by preoccupations over ensuring accountability, participation, and evidence-based policy, appears notably friendly to new conceptions of human rights and the right to health described above. Like the human rights approaches, it begins by recognizing the disproportionate emphasis on curative over social and structural determinants of health. 271 It seeks to dis-entrench structures that support an anachronistic reliance on curative models, and move away from arbitrary, inefficient and ineffective allocation decisions by coordinating services 272 and opening up priority-setting to flexible, transparent, accountable and participatory local-level decisionmaking. Participation is sought through representative local boards and public reporting. Transparency and accountability are likewise pursued through public plans for progress toward legislatively-bounded goals, mandatory reporting including indicators, benchmarks, and

- Evidence-based benchmarks for medically acceptable wait times starting with cancer, heart, diagnostic imaging procedures, joint replacements, and sight restoration will be established by December 31, 2005 through a process to be developed by Federal, Provincial and Territorial Ministers of Health.
- Multi-year targets to achieve priority benchmarks will be established by each jurisdiction by December 31, 2007.
- Provinces and territories will report annually to their citizens on their progress in meeting their multi-year wait time targets.
- The Canadian Institute for Health Information will report on progress on wait times across jurisdictions.


268 MARCHILDON, supra note 1, at 109.

269 See supra Part II.

270 See, e.g., Lomas, supra note 192, at 819. See also Hunt and Backman, supra note 124, at 42-50.

271 See infra note 287 and accompanying text.

272 Hunt & Backman, supra note 124, at 47-48.
comparative data indicating progress toward those benchmarks. Through orchestration — including comparison of targets and means of achieving progress toward those targets — it might promote continual improvement by revealing progress over time.\textsuperscript{273}

At the same time, context is important. Canada’s new institutions for managing health care distribution were not designed as, nor do they fully reflect, a proceduralist, participation-oriented, human rights-based approach to determining distribution of health care resources in Canada. Politically, these changes were motivated by concerns about service integration, cost containment, and communicating accountability to an increasingly dissatisfied public. They were also justified publicly with reference to their value for citizen engagement.\textsuperscript{274} Conceptually, they draw more on changing ideas about regulatory law that have become prominent since the early 1990s, known collectively as “new governance”\textsuperscript{275} than they do on human rights.\textsuperscript{276}

New governance, which has been described as a “darling child” of regulators and academics,\textsuperscript{277} is usually understood an alternative set of organizing principles that emerged in response to criticisms of bureaucratic command-and-control regulatory model that dominated most western welfare states since the New Deal.\textsuperscript{278} Lester Salomon suggests that it has become the dominant model of modern government.\textsuperscript{279}

The field of new governance is diverse.\textsuperscript{280} However, its general orientation can be understood by noting a few key organizing tenets. There is a preference for situating decisionmaking close to the community level.\textsuperscript{281} Fixed rules, imposed hierarchically, are abandoned in order to allow local administrators to direct their own actions through goal-directed measures combined with performance indicators. Collaboration and participation of all stakeholders, including non-state actors is sought. According to new governance approaches, this collaboration expected both to improve decisionmaking and to retain the democratic legitimacy lost through the loosening of government authority by providing information through performance indicators and protecting opportunities for

\textsuperscript{273} See supra notes 118 to 126 and accompanying text (setting out the theory that appropriate procedural requirements might drive progressive realization).

\textsuperscript{274} Lomas, supra note 192 (noting the empowerment rhetoric that came along with regionalization, but doubting whether community participation was ever necessary to the central vision of regionalization, and suggesting that empowerment was bound to take a backseat to cost-cutting goals).


\textsuperscript{277} Melish, supra note 87 at, 31.

\textsuperscript{278} Lobel, supra note 275, at 357. But see Amy J. Cohen, Governance Legalism: Hayek and Sabel on Reason and Rules, Organization and Law, 2010 WISCONSIN LAW REVIEW 357, 378 (asserting that that “new governance emerged as much as a response to deregulation and privatization as to socialist planning”).


\textsuperscript{280} For an excellent and thorough summary, see Lobel, supra note 275.

\textsuperscript{281} Id. at 345.
input. Incentives, including pressure from stakeholders armed with performance evaluation, are expected to generate the adoption of best practices and the continual improvement of the system.\textsuperscript{282}

Some underlying instincts of the new governance models are clearly reflected in developments in models of Canadian health care,\textsuperscript{283} and, as discussed above, in many of the elements in the move toward procedurally-based human conceptions of human rights. But the change in Canada has been a partial one, and it does not conform to all the key prescriptions of either model. Canada’s program of regionalization, even with its focus on transparency, accountability, and participation might better be described as “new governance-esque.”\textsuperscript{284} With reference to a number of key ongoing areas of tension within and between new governance and new proceduralist conceptions of the right to health reflected among right to health scholars and UN bodies, the following sections will evaluate the extent to which the shift in health care administration in Canada meets, challenges, and informs the shift toward proceduralism in the right to health.

A. Wholism

Perhaps the most common critique of Canada’s move toward regionalization is that it is not comprehensive enough. Only a small portion of health-affecting areas have been devolved to regional or local authorities for rationalization and integration through ostensibly open, participatory,\textsuperscript{285} accountability-oriented governance. The most obvious gap is authority over physician services and pharmaceuticals, two areas that are dominated by powerful private interests. In addition, the fact that many provinces continue to maintain separate funding streams and governance structures for mental health and addictions, public health, and health promotion,\textsuperscript{286} not to mention the only limited coordination in some regions with community and social services, raises similar concerns. A regionalized project that is purportedly dedicated to moving resources where they are most needed to improve health outcomes should be able to accommodate moving resources across the fullest possible range of determinants of those outcomes.

It appears to run contrary to prescriptions of new governance for some health-affecting services to remain non-transparent, non-participatory, non-accountable and dominated by professional interests – as has been the case with questions around the scope of physician services included in the Medicare basket.\textsuperscript{287} New governance seeks to “push control further into organizational structures, inscribing it in systems that can be

\textsuperscript{282} Id. at 371-404.
\textsuperscript{283} See supra note 276.
\textsuperscript{284} Cohen, supra note 278, at 379.
\textsuperscript{285} For a critique of the adequacy of participatory dimensions of Canada’s regionalized health governance structures, see infra notes 319-321 and accompanying text.
\textsuperscript{286} Lewis & Kouri, supra note 220, at 14.
\textsuperscript{287} See e.g., Wendy A. Bach, Governance, Accountability, and the New Poverty Agenda, 2010 WJS. L. REV. 239, 286-287. (criticizing a purported new governance poverty project for “not provid[ing] data on questions that those who designed the experiments are not willing to ask” and lamenting that “we will look at the positive effect of some government benefit programs but will [ignore other hardships affecting the goals of the program.]”)
audited."\textsuperscript{288} Indeed, Carolyn Tuohy has suggested that though the rise of new governance ideas in structures of Canadian health care are placing the existing model under strain, Canada remains fundamentally "the preeminent example of a governmental role in a health care arena premised on principal-agent relationships," in which both patients and governments essentially allocate priority-setting to medical professionals.\textsuperscript{289}

The limited scope of rationalization also undermines the promise that regional governance, accompanied by benchmarking, participation, and accountability structures, will drive progressive realization of the right to health.\textsuperscript{290} Recall the argument that governments, in their role as monitors or "accountability managers", are increasingly expected ensure as part of their right to health obligations that policy decisions are reasonable, transparent, evidence-based, participatory, and geared toward the needs of the most marginalized, and that such processes will themselves contribute to progressive realization.\textsuperscript{291} Scholars and have also emphasized the need to move away from overly curative models of health,\textsuperscript{292} consistent with the CESCR's requirement of equitable resource allocation\textsuperscript{293} and its emphasis on social determinants.\textsuperscript{294}

Regionalized governance promises to facilitate the movement of resources "upstream" by placing allocation decisions in a context where relative importance of social determinants and preventative measures can be fairly weighed and re-weighed against competing demands in relation to measurable health-related outcomes. Regionalized decisionmaking is not the only way to achieve such a goal, and nothing in the ICESCR, General Comment 14,\textsuperscript{295} or scholarly interpretations of the international human right to health prescribes the level at which allocation decisions are to be taken. However, to the extent that regionalized governance organized along principles of transparent, participatory, evidence-based allocation, benchmarked and measured in relation to locally-set goals, purports to drive that reallocation, the exclusion of key areas of physician services and pharmaceuticals is unfortunate.

\textsuperscript{289}Id. at 205. (contrasting Canada's traditional, predominantly principal-agent model with new governance arrangements).
\textsuperscript{290}See supra notes 118-126 and accompanying text.
\textsuperscript{291}See supra at Part III.
\textsuperscript{292}Hunt & Backman, supra note 124, at 42 (defining the integrative project of human rights in the following terms: "As a recent WHO publication observes, 'health systems and services are mainly focused on disease rather than on the person as a whole, whose body and mind are linked and who needs to be treated with dignity and respect...' [Therefore] health care and health systems must embrace a more holistic, people-centered approach"] citing WORLD HEALTH ORGANIZATION, PEOPLE AT THE CENTRE OF HEALTH CARE V, VII (2007). See also Norman Daniels, Equity and Health: Toward a Broader Bioethics Agenda 36 THE HASTINGS CENTER REPORT 22 (2006) (suggesting that the human right to health can and should drive resources away from curative approaches and toward social determinants of health).
\textsuperscript{293}See General Comment 14, supra note 16 at ¶52 (identifying misallocation and failure to take steps such as identification of indicators and benchmarks as violations).
\textsuperscript{294}General Comment No. 14, supra note 16 at ¶11 (emphasizing the importance of underlying determinants of health in addition to curative health care)
\textsuperscript{295}Id. (emphasizing the importance of participatory decisionmaking at community, national and international levels, but without going so far as to prescribe levels at which allocation decisions are made.)
The shift in governance across Canada, however, may be its infancy. From a human rights perspective, regionalized processes that are limited in scope might be understood as a step in a state’s progressive path toward more comprehensive rationalization. Moreover, faithful understanding of social determinants suggests that their discovery can only be understood as a constant process that evolves and changes as cultures and societies change.  

From the perspective of the CESCR, however, ensuring equitable distribution and adopting a national health plan that is evidence-based and addresses the health concerns of the whole population are core obligations. A core procedural obligation to orient a health system so that it is capable of emphasizing social determinants equitably relative to generally curative physician services renders the continued exclusion of physician services from regional rationalization hard to defend from a human rights perspective. A regionalized model that is at least capable of expanding to address a full range of factors affecting health would institutionally accommodate the shared key insight of new governance and of the proceduralist orientation in right to health: the “unknowingness” that prevents any regulator or norm consolidator from taking into account all relevant considerations.

There is of course a risk of overextending the scope of what health authorities are required to consider. This is a key criticism of broad conceptions of human rights. The more factors go into reports, indicators and benchmarks, the greater the risk that the spaces opened for democratic participation will be too complex for stakeholders to navigate. However, the concern both from the perspectives of both the right to health, and a political orientation committed to fair distribution of health resource based on need

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296 In Quebec’s case, perhaps it is in its adolescence. Quebec first began its regionalization process in 1988; by 2004, Quebec’s regionalized system explicitly adopted an upstream-oriented population health approach with the goal of “managing a continuum of interventions aimed at developing and maintaining the population’s health and optimizing individuals’ personal and social autonomy,” in part by seeking to “reduce social inequalities which constitute an obstacle to well-being and health.” David Levine, *A Healthcare Revolution: Quebec’s New Model of Healthcare*, 8 *HEALTHCARE* Q. 38, 39-40 (2005). (David Levine was president and CEO of the Montreal Regional Health Authority). Placing authority for priority-setting squarely outside of provincial government, Quebec’s most recent iteration of the regional model further devolves authority to local “Health and Social Service Centers “to conduct an inventory of all health-affecting resources in a region currently and to analyze gaps across the continuum of care” and to allocate budgetary resources locally. *Id.*


298 General Comment No.14, *supra* note 16, ¶¶ 43(e), (f). The indeterminacy of social determinants, and their inclusion within core obligations, further calls into question the hard distinction between the minimum core and the progressive periphery in conceptions of ESCRs. *See supra* notes 153 and accompanying text.

299 Cohen, *supra* note 278, at 361.

300 FLOOD & ARCHIBALD, *supra* note 239, at 28 (noting that in the context of RHA reporting “intelligibility is a problem. Clearly RHAs have incentives to portray performance in the most positive light, and the results are often lengthy, obtuse documents that contain, but do not effectively communicate to the public, key facts about performance”). *See also* Gráinne de Búrca, *New Governance and Experimentalism: An Introduction*, 2010 *Wis. L. REV.* 227 at 233, 235 (suggesting that experimentalism/new governance projects are most likely to be successful when interdependence across policymaking sites is strong, and proposing that governance systems adopt “the broadest possible degree of stakeholder participation *compatible with effective decision-making...*”)(Emphasis added).
rather than ability to pay, is that the historic focus on funding hospital and physician services operates at the expense of social determinants, which affect the marginalized the most. Placing social determinants on a level deliberative playing field may be the best way to ensure the process of identifying and ranking determinants (even as they remain potentially boundless) against traditional health services becomes possible in the context of ossified health care allocation structures.

B. Values

Regionalization projects in Canada’s provinces are not value-neutral. Accountability mechanisms contained within RHA legislation and associated ministerial requirements and performance agreements are required to serve provincially-set objectives, operating within the framework of the Canada Health Act. However, human rights, or even fundamental rights of equal access to health services, tend not to be set out in RHA legislation; rather, RHA goals tend to be at once vaguely and narrowly defined as protection and promotion of health, responsiveness of health services to need, and coordination.

What distinguishes the human rights project generally from the new governance project is its prior commitment to an explicit set of substantive norms grounded in a broad, integrated dignity-based human rights framework. So, for example, when human rights bodies turn toward proceduralism, they urge the use not only of health indicators, but of right-to-health indicators; they turn health impact assessments into right to health impact assessments. Human rights activists, scholars, and bodies express particular ideas about how participation and deliberation should be conducted (the CESC, for

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301 See, e.g., Alberta Regional Health Authorities Act, supra note 259, at § 5 ("... a regional health authority (a) shall (i) promote and protect the health of the population in the health region and work toward the prevention of disease and injury..."), Manitoba Regional Health Authorities Act, supra note 253, § 23(2)(h) (In carrying out its responsibilities, a regional health authority shall... ensure that health services are provided in a manner which is responsive to the needs of individuals and communities in the health region and which coordinates and integrates health services and facilities’). The exception here is Quebec, whose legislation reflects broad normativity centered around equitable distribution of services, ensuring autonomy, addressing marginalization, and individual rights. (Defining the object of the provincially set plan at § 1 as being to “maintain and improve the physical, mental and social capacity of persons to act in their community and to carry out the roles they intend to assume in a manner which is acceptable to themselves and to the groups to which they belong”; requiring, at §§ 3 (6) and (7) that the provincial-level health plan focus on, inter alia, “reducing the impact of problems which threaten the stability, fulfilment or autonomy of users” and “attaining comparable standards of health and welfare in the various strata of the population and in the various region”; setting guidelines for management of services at § 3, including that “(1) the person requiring services is the reason for the very existence of those services; (2) respect for the user and recognition of his rights and freedoms must inspire every act performed in his regard; (3) the user must be treated, in every intervention, with courtesy, fairness and understanding, and with respect for his dignity, autonomy, needs and safety; (4) the user must, as far as possible, play an active role in the care and services which concern him; (5) the user must be encouraged, through the provision of adequate information, to use services in a judicious manner...”)

302 See supra notes 123 to 133 and accompanying text (illustrating the distinction between health indicators and right to health indicators); See also HUNT & MACNAUGHTON, supra note 12- (illustrating the distinction between health impact assessment and right to health impact assessment).
example suggests special attention to the most vulnerable).\textsuperscript{303} They have developed ideas about how indicators should be selected (again, the CESC\textsuperscript{R} suggests attention to the most vulnerable groups,\textsuperscript{304} including women, children, adolescents, the elderly, and people with disabilities;\textsuperscript{305} Yamin advises indicators that might be most likely to drive progressive realization, selected through activism of human rights organizations.\textsuperscript{306}) As to substantive responses, human rights approaches assume a connection between health and, among other things, the availability of clean water, adequate sanitation, nutritious food, adequate shelter, education, a safe environment, availability of health-related information, freedom from discrimination outside of health care distribution, and access to rights-based adjudication of claims for violation of the right to health.\textsuperscript{307}

The question of whether and how deliberative processes can and should serve pre-defined normative ends has troubled new governance scholars.\textsuperscript{308} In general, governance approaches show a reluctance to "pick winners"\textsuperscript{309} in terms of policy choices, based on the idea that policy solutions should be selected through deliberative processes themselves.\textsuperscript{310} The theory is that deliberative approaches are preferable precisely because what best promotes health (or human dignity in relation to health) is elusive. In this way, they would appear hostile to the rich framework of predetermined values set out by the CESC\textsuperscript{R} and by some right to health scholars, though it might be more amenable to the very broadly framed goals contained in the ICESC\textsuperscript{R} itself.

However, the differences between new governance and human rights may, \textit{at the moment}, be somewhat smaller than they seem in the context of managing and evaluating the distribution of health care resources in Canada. Recall that the substantive content of the right beyond the minimum core has been, until recently, relatively underdeveloped, and that the determinacy of normative features residing within the substantive core has likewise been called into question.\textsuperscript{311} New procedurally-oriented human rights approaches seek to address these previously neglected broad indeterminate features like progressive realization using tools like indicators, benchmarks, and impact assessment. For a country like Canada, with a well-developed universal health care system, this means leaving much of the content of the right to health relegated to the deliberative sphere previously attracted little meaningful human rights scrutiny.\textsuperscript{312} Compared to distribution determined historically and/or by relatively opaque accommodation with medical professionals, proceduralist approaches to progressive, transparent, accountable priority-setting may be understood, like new governance, as a "reason-seeking, indeed law-seeking project."\textsuperscript{313}

\textsuperscript{303} General Comment No. 14, \textit{supra} note 16, at ¶43 (f).
\textsuperscript{304} General Comment No. 14, \textit{supra} note 16, at ¶49(c).
\textsuperscript{305} See Hunt & Backman, \textit{supra} note 124, at 44.
\textsuperscript{306} Yamin, \textit{Economic, Social and Cultural Rights}, \textit{supra} note 137 at 1210.
\textsuperscript{307} See generally, Hunt and Backman, \textit{supra} note 305.
\textsuperscript{308} Cohen, \textit{supra} note 278, at 382-387.
\textsuperscript{309} Id. at 383.
\textsuperscript{310} Id.
\textsuperscript{311} See \textit{supra} notes 112 to 120 and accompanying text.
\textsuperscript{312} See \textit{supra} Part I.
\textsuperscript{313} Cohen, \textit{supra} note 278, at 381 (arguing that new governance may appear neoliberal compared to
In addition, more recently, some new governance scholars have been prepared to explore the possibility that traditional top-down normativity might interact with, or frame, new governance approaches.\footnote{314} New governance scholars have been more likely to embrace hybridity with traditional substantive norms and structures that have been understood as related to a necessary precondition for democratic deliberation, such as when they make up for power imbalances and distributional justice problems getting in the way of meaningful participation.\footnote{315}

So, for example, existing anti-discrimination protections could remain in place and arbitrariness revealed through transparency or accountability requirements could inform and enrich existing decisionmaking of human rights institutions. Recall the Hogan case on de-listing of sex reassignment surgery.\footnote{316} Clear rubrics, set in advance, on how "tightening and modernization" was to take place would not only have made discriminatory decisionmaking less difficult to detect, but would also have discouraged it.

New governance scholars are unlikely to go so far as to suggest that particular normative outcomes – say, equitable distribution of all health care services based on need and not ability to pay, or even the full rationalization of care across the spectrum extending to all social determinants – ought to be imposed at the outset. This suggests that if new governance approaches (or new-governance-esque approaches), like regionalization, are to seek such ends, the normative commitment will need to be found within individual and community participants through the deliberative process.

For the moment, the normative assumptions of the Canadian population may line up with some of the broad goals associated with the full realization of the right to health. Roy Romanow, in his report, stated "[I]n their discussions with me, Canadians have been clear that they still strongly support the core values on which our health care system is premised – equity, fairness and solidarity. These values are tied to their understanding of citizenship."\footnote{317} To the extent that this sentiment drives experiments geared toward better horizontal integration of health care resources, for example, transparency, participation and accountability may drive the human rights goal of equitable distribution. Should human rights values in relation to progressive realization crystallize and separate from those concepts of progressive realization embraced by participants in new governance command-and-control governance, but that when it emerges as a response to an overweening free market, it serves a law-seeking function and shares more in common with liberalism. It is a "deliberate (but democratic) effort to try one's 'absolute best to decide what principles govern and apply them" (citing Duncan Kennedy, \textit{A Semiotics of Critique}, 22 CARDOZO L. REV. 1147, 1159 (2001) (providing a definition of liberalism)).


\footnote{316} \textit{Supra} notes 36-56 and accompanying text.

\footnote{317} Romanow Report, \textit{supra} note 172, at xvi.
projects, however, the goals of human rights and new governance might fail to align.\textsuperscript{318} Then the proceduralists may find their hopes that more information about the impacts of health processes and unfair or illegitimate exercises of power about health will drive reform dashed. This possibility presents an important challenge to the human rights reliance on proceduralism; human rights actors might be tempted to direct selection of indicators from above. I now turn to an examination of this possibility.

\section*{C. Hard and soft incentives}

Both new governance and human rights approaches place heavy emphasis on participation as a driver of more responsive allocation decisions in health care. But participation in Canadian RHAs has been weak. Processes themselves may not create room for meaningful participation, for example when uni-directional flows of information (typically from professionals to citizens) have stood in place of real deliberative exchange,\textsuperscript{319} or information presented was too technical or rushed through for participants to understand.\textsuperscript{320} Moreover, there is little evidence that citizen deliberators are actually listened to. Abelson has noted:

The limited experiences with deliberative methods in the health sector, to date, have suggested that the outcomes of deliberations are rarely, if ever, binding, and are often heavily ‘managed’ . . . by the health authority. Evaluations of deliberative processes in the health sector have identified concerns among public participants about what, if anything, would be done with their representations.\textsuperscript{321}

A related concern has been expressed over devolution in form rather than substance. To the extent that RHAs fail to operate independent of ministries,\textsuperscript{322} regionalization remains a hierarchically engineered exercise that does not live up to the promises of the “genuinely participatory, collaborative, reflexive governance.”\textsuperscript{323} From a human rights perspective, central organization is not by itself a problem. However, if local-level participation is rendered anemic by regional authorities lacking the ability to translate data into policy change, it fails to live up to both the promise that accountable and transparent processes when combined with participation of the most vulnerable, will ensure that interests of the powerful do not dominate the policy agenda.\textsuperscript{324}

\textsuperscript{318} One could imagine such a result in relation to, say, funding for palliative care, should deliberative processes disproportionately life-extending treatments over end-of-life care. See, e.g. Frank Brennan, \textit{Palliative Care as an International Human Right}, 33 J. PAIN SYMPTOM MGMT. 494 (2007).


\textsuperscript{320} Id. at 245.

\textsuperscript{321} Id. at 247.

\textsuperscript{322} See supra note 239-241 and accompanying text.

\textsuperscript{323} Id.

\textsuperscript{324} See General Comment No. 14, \textit{supra} note 16, ¶ 54 (The right of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral component of any policy, programme or strategy developed to discharge governmental obligations under article 12.
devolution in form only might shield government health rationing – with its history of domination by entrenched interests – under an illusion of democratic legitimacy participatory approaches provide.\textsuperscript{325} This recognition suggests that emerging proceduralist human rights approaches will need to develop concepts of transparency, equitable distribution, and participation with attention to risks that half-measures may not translate into policy changes.

Some problems can be addressed with improvements in design of consultations, and indicators should be developed to assess the extent to which there is “real” rather than “sham” participation. For both human rights and new proceduralist new governance approaches, open participation, transparency and accountability are not optional. Consultation requirements contained in RHA legislation should, on this view be clarified and they should be taken seriously by RHAs and, if necessary, on administrative review.\textsuperscript{326} New human rights approaches rely on procedural tools like transparency, participation and reporting requirements precisely in order to translate elusive, arguably “soft law” concepts like progressive realization into meaningful concrete, firm legal obligations.\textsuperscript{327} Likewise, despite new governance’s rejection of rule-based adjudicatory processes, it is friendly toward judicially ensured rights of participation, transparency and information, which are, in their view, more closely aligned with courts’ legitimate and capable role.\textsuperscript{328}

A more troubling problem however, is addressing power differences among participants. Left unassisted, those with the fewest resources are the least able to participate.\textsuperscript{329} Unstructured participation might result in the certain citizen voices being arguably disproportionately heard. So, for example, deliberative structures may be no better at addressing the fact that that expensive but cost-ineffective autism treatment\textsuperscript{330} has generated more support than cost-effective needle-exchange programs,\textsuperscript{331} even as provision of the latter have been considered part of states duties under the right to

Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health. Effective provision of health services can only be assured if people’s participation is secured by States.) See also Hunt & MacNaughton at 2049, (describing General Comment 14 as requiring “opportunities for as much participation as possible in health-related decision-making”).\textsuperscript{325} Lomas, supra note 192.

\textsuperscript{326} But see Hospital Employees’ Union v. Health Authorities (British Columbia) 2003 BCSC 778, ¶93 (acknowledging that legislation required open board meetings, finding a violation, but refusing to issue a formal declaration of the violation on the basis that it might “adversely impact on contracts that the boards entered into with innocent third parties.”)

\textsuperscript{327} Hunt & Backman, supra note 124, at 50.


\textsuperscript{329} C. Jim Frankish et al., Challenges of Citizen Participation in Regional Health Authorities, 54 SOC. SCI & MED. 1471 (2002).

\textsuperscript{330} Eric Fombonne, The Prevalence of Autism, 289 JAMA: THE JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 87, 89 (2003) (Ironically, what has triggered substantial social policy changes in autism appears to have little connection with the state of the evidence. . . . [F]urther consideration should be given to how and to why the least evidence-based claims have achieved impressive changes in funding policy.)

\textsuperscript{331} Franklin N. Laufer, Cost-effectiveness of syringe exchange as an HIV prevention strategy, 28 JAIDS 273 (2001).
health. Because choices in health cannot easily be reduced to a cost-benefit analysis, the fact that one substantive course is chosen over another cannot by itself indicate disproportionate wielding of power. A regional authority (invested with the full range of allocation authority) might legitimately favor good palliative care with no chance of prolonging life over cancer treatments with a remote likelihood of working. If deliberative processes are to avoid becoming naked cost-benefit analyses, space for such values should arguably be assured. When it relies on procedures like participation and accountable and transparent decision-making over traditional human rights tools like naming and shaming or litigation, the human rights project admits that it cannot determine with precision the relative values at stake.

As discussed above, new governance scholars are divided here. Some are friendly to normative goals in support of participation-enhancement. A commitment to real participatory deliberation requires attention to the full range of barriers to participation. The question then becomes, "What conditions are necessary for full participation?" This is where the new human rights approach can draw from its own rich tradition, including its capabilities-based definition of poverty that seeks to understand the full range of factors that stand in the way of meaningful self-governance. Unlike new governance which is generally hesitant about substantive normativity, human rights embraces new governance conceptions in a context of broad normative commitments, many of which are more completely defined than progressive realization of the right to health. Indeed, through the concepts of interdependence and indivisibility of human rights, a participatory human rights approach acknowledges that processes are embedded within contexts of inequality and dignitary harm, and offers a framework for addressing that context.

Conclusion: On directions

It is important to remember where we started. Human rights approaches have historically had little to say about the ossified and arguably regressive distribution of health resources in Canada. In turning toward the procedural, the right to health makes a modest step and a bold one. Modestly, it gives traction, without deciding, to concepts like "progressive realization" and the ultimately indeterminate "core obligations". More boldly, it locates the denial of the right to health squarely in the disenfranchisement and disempowerment of citizens from control over what affects their body. In doing so, the human right to health both delegitimizes professional and market capture and renews its own fundamental challenge of guaranteeing dignity-based self-realization.

332 See, e.g., Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, Mission to Sweden (28 February 2007) UN Doc No A/HRC/4/28/Add.2 ¶ 60-62 (suggesting that comprehensive harm reduction programs including needle exchange are required under the human rights approach to health).