

The Enforcement of Multi-Tiered Dispute Resolution Clauses in International Contracts.

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Multi-tiered dispute resolution clauses encourage parties to seek a consensual solution to contractual disputes, while providing a binding dispute resolution process such as arbitration as a backstop. However, these clauses raise important enforcement issues. Although at common law it has been held that agreements to negotiate are unenforceable, a good case can be made for distinguishing ADR clauses requiring negotiations and mediation from unenforceable agreements to agree. While the matter involve negotiations to settle the terms of a contract, the former require the parties to participate in a defined process regardless of the outcome. Few Canadian courts have considered what remedies may be available for failing to comply with the initial steps of a multi-tiered ADR clause, or indeed the question of whether the arbitral tribunal rather than the court should decide enforceability and compliance issues. In such circumstances, appropriate drafting is imperative for such clauses to be effective.

Les clauses escalatoires de résolution des différends encouragent les parties à rechercher une solution amiable à leurs différends contractuels, tout en prévoyant en dernier ressort une procédure contraignante comme l'arbitrage. Ces clauses soulèvent des problèmes importants quant à leur exécution. En common law, une entente par laquelle les parties s'obligent à conclure un contrat n'est pas exécutoire. Or, il convient de distinguer une telle entente — qui concernent une négociation dont l'objet est la conclusion des modalités d'un contrat — des étapes préliminaires d'une clause escalatoire, dont l'objet est d'obliger les parties à participer à un processus de négociation et de médiation, sans égard à son résultat. La jurisprudence canadienne offre peu d'exemples des mesures de redressement disponibles advenant le non-respect d'une clause escalatoire et elle ne donne pas non plus de solution à la question de savoir s'il revient à l'arbitre plutôt qu'au tribunal de statuer sur la question du caractère exécutoire de la clause ou encore pour disposer de l'allégation qu'une partie a fait défaut d'en respecter les termes. Dans de telles circonstances, il est impératif que de telles clauses soient l'objet d'une rédaction adéquate.

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It is increasingly common in the United States, Canada and elsewhere for commercial parties to include multi-tiered dispute resolution clauses in international contracts. Multi-tiered clauses, sometimes referred to as "step clauses" or "issue escalation clauses", might include some or all of the following "tiers":

- Discussion, consultation or negotiation by representatives of the parties;
- mediation or conciliation;
- expert determination or valuation;
- arbitration.

Multi-tiered clauses encourage parties to seek a consensual, conciliatory solution to contractual disputes while providing a backstop in the form of a binding dispute resolution process such as arbitration if the consensual approach fails.

Multi-tiered clauses raise several important enforcement issues which can be exploited to defeat the intended purpose of providing the parties with a quick and cost effective dispute resolution process. These issues include the following:

- Is an agreement to negotiate enforceable?
- Where an independent agreement to negotiate is not enforceable, can the initial steps of a multi-tiered dispute resolution clause, such as the obligation to negotiate or mediate a dispute, nevertheless be enforced?
- Who should decide – the court or the arbitral tribunal – whether the agreement to negotiate or mediate is enforceable or has been breached?
- What are the remedies for breach of the clause?

1. The Enforceability of Agreements to Negotiate

The traditional position at common law is that agreements to negotiate are unenforceable because they are inherently too uncertain. In *Walford v. Miles*,² the House of Lords held that agreements to negotiate are too uncertain to create binding obligations and that, at common law, the existence of a duty to negotiate in good faith is "repugnant" to the adversarial positions of parties negotiating towards an agreement.

² [1992] 2 A.C. 128 (H.L.) See also *Courtney & Fairbairn Ltd. v. Tolaini Bros. (Hotels) Ltd.*, [1975] 1 All E.R. 716 (C.A.).

The courts of Canadian common law provinces have consistently applied the reasoning of these leading English authorities.³ However, in a recent decision in which the Supreme Court of Canada refused to extend the laws of negligence into the conduct of negotiations, the Court indicated that the question of whether there is a duty to negotiate in good faith might be considered by the Court in the future.⁴

In contrast with the position in the Canadian common law provinces, there is no philosophical or legal obstacle in Quebec law to enforcing duties to negotiate. While very few decisions have dealt with the issue, learned authors take the position that courts should have no difficulty enforcing a contractual obligation to negotiate in good faith as may be found, for instance, in a preliminary agreement such as a letter of intent.⁵ Indeed, the parties' legal obligation to act in good faith in relation to both the formation and performance of their contracts is expressly enshrined in the Quebec Civil Code.⁶

While the question is not fully settled, the modern view emerging in the U.S. seems to be that agreements to negotiate are enforceable if the terms are sufficiently definite.⁷ The key distinction between agreements to agree, which are not enforceable, and agreements to negotiate, which are, lies in the nature of the obligation:

³ See e.g. *L.C.D.H. Audio Visual Ltd. v. I.S.T.S. Verbatim Ltd.* (1988), 40 B.L.R. 128 (Ont. H.C.J.); *Cedar Group Inc. v. Stelco Inc.*, [1995] O.J. No. 3998 at paras. 3-6 (Gen. Div.) (Q.L.), aff'd [1996] O.J. No. 3974 (C.A.) (Q.L.); *Mannpar Enterprises Ltd. v. Canada* (1999), 173 D.L.R. (4th) 243 at 263-264 (B.C.C.A.); *EdperBrascan Corp. v. 117373 Canada Ltd.*, [2000] O.J. No. 4012 (Sup. Ct. J.) (Q.L.).

⁴ *Martel Building Ltd. v. Canada*, [2000] 2 S.C.R. 860 at para. 73 (*per* Iacobucci and Major JJ.).

⁵ J.L. Baudouin & P.G. Jobin, *Les Obligations*, 5th ed. (Cowansville, Qc.: Yvon Blais, 1998) at paras. 91-95; see also J. Talpis, "Enforcement of Agreements to Mediate International Disputes and Mediated Agreements in Québec Private International Law" in J.-L. Baudouin, ed., *Médiation et modes alternatifs de règlement des conflits: aspects nationaux et internationaux* (Cowansville, Qc.: Yvon Blais, 1997) 299; F. Heleine "L'obligabilité des clauses de médiation et des transactions en résultant en droit interne québécois" in *ibid.*, 275.

⁶ Art. 1375 C.C.Q.: "The parties shall conduct themselves in good faith both at the time the obligation is created and at the time it is performed or extinguished."

⁷ See e.g. *Howtek Inc. v. Relisys*, 958 F. Supp. 46 (D. N.H. 1996); *Copeland v. Baskin Robbins U.S.A.*, 96 Cal. App. 4th 1251 at 1259 (2002) [hereinafter *Copeland*]. See also *Teachers Insurance and Annuity Association of America v. Tribune Company*, 670 F. Supp. 491 (S.D.N.Y. 1987); E.A. Farnsworth, "Precontractual Liability and Preliminary Agreements: Fair Dealing and Failed Negotiations" (1987) Colum. L. Rev. 217 at 266-270 (seminal article). Like Canada, the United States is a federal state of which the states are political sub-units. Since contract law is generally governed by state law, some caution is required in making general statements about U.S. contract and dispute resolution law, as it may vary from state to state.

- Under agreements to agree, the obligation is to settle the terms of an agreement and a breach would consist of the parties failing to reach agreed terms. Such agreements are generally unenforceable, although the courts recognize the same exception as in Canada where the agreement provides some definite measure of the parties' performance.
- In the case of agreements to negotiate, on the other hand, the parties' obligation is to participate in a process. That process is to negotiate or to negotiate in good faith.⁸ In an enforceable agreement to negotiate, failure to reach agreement on substantive contractual terms is not in issue.

In Australia, another common law jurisdiction historically based on English common law, the courts have drawn a distinction between agreements to agree, which are unenforceable, and agreements to participate in a dispute resolution process, which the courts have held are enforceable.⁹ In France and Germany, the position seems to be that agreements to negotiate are enforceable.¹⁰

As can be seen, legal systems adopt different approaches to independent agreements to negotiate. The uncertainty surrounding their enforceability in certain jurisdictions must be borne in mind when considering the inclusion of multi-tiered clauses in international contracts.

II. *The Enforceability of the Initial Steps in Multi-Tiered Clauses*

In both Canada and the United States, there is a strong public policy in favour of alternative dispute resolution. This is reflected in legislation in both countries enforcing ADR. Statutes oust the courts' jurisdiction over disputes that are properly the subject of arbitration clauses. In addition, many statutes require parties to participate in preliminary proceedings in civil court actions such as case conferences, conciliation or mediation. However, legislation does not typically address the enforceability of the preliminary steps of a multi-tiered dispute resolution clause in a direct fashion.

On both sides of the Canada-U.S. border, courts have enforced multi-tiered dispute resolution clauses. They have stayed or dismissed court actions and they have refused to compel arbitrations because the parties had failed

⁸ In California, for example, a covenant of good faith and fair dealing is implied in every contract (*Copeland, ibid*).

⁹ See e.g. *Hooper Bailie Associated Ltd v. Natcon Group Pty Ltd* (1992), 28 N.S.W.L.R. 194 (S.C.); *Aiton Australia Pty Ltd v. Transfield Pty Ltd*, [1999] N.S.W.S.C. 997. See also M. Pryles, "Multi-Tiered Dispute Resolution Clauses" (2001) 18:2 J. of Int'l Arb. 156. ¹

¹⁰ J. Fry, "Enforcement of Multi-Tiered Dispute Resolution Clauses: France" (Oct. 2001) Arb. & ADR 14; R.H. Kreindler & S. Beruti, "Enforcement of Multi-Tiered Dispute Resolution Clauses: Germany" (Oct. 2001) Arb. & ADR 16.

to comply with the preliminary steps of their dispute resolution bargain. Courts have also given positive effect to multi-tiered clauses by mandating performance of the agreed dispute resolution process.

Few Canadian cases directly address the enforceability of non-binding dispute resolution processes. In a recent Nova Scotia case, *Canada (A. G.) v. Marineserve.MG Inc.*,¹¹ the court enforced a three-tiered dispute resolution clause that required the successive steps of negotiation, mediation and binding arbitration. The first step contemplated a meeting attended by senior representatives with decision-making authority at which the parties would engage in good faith negotiations. If the negotiations did not result in a resolution, the parties were required to submit the dispute to mediation and, failing settlement at that stage, to binding arbitration.

The plaintiff began court proceedings which the defendants sought to stay. The defendants also sought an order directing the parties to follow the contractual dispute resolution process. The court granted the stay and issued the requested order, enforcing the ADR clause in full, including the negotiation stage. Finding the parties "bound by the procedure pursuant to their contract", the court ordered the parties to "follow the path of their own choosing" and start with the first step: "a good faith meeting attended by senior individuals with decision-making authority..."¹² The court thus implicitly confirmed the enforceability of an agreement to negotiate, albeit without discussing the issue.

In another case, the Ontario Court (General Division) considered a two-tiered dispute resolution clause in a contract between a truck manufacturer and a dealer.¹³ The first step involved the manufacturer or its general counsel reviewing the dispute at the dealer's written request. The review was not binding. The second step, if invoked by the dealer, required binding mediation. The dealer applied to the court for a mandatory order compelling the manufacturer to participate in the mediation and to name a mediator. The court granted the application but ordered the parties to submit only to binding mediation. The court did not require them to first engage in the non-binding review, nor did it discuss its enforceability. In the court's opinion, the parties' intransigence would make that step futile. However, it is implicit that the court thought it could have made such an order but exercised its discretion not to do so in the circumstances.

Based on the authorities to date, only one of which enforced a multi-tiered clause in its entirety, it remains unclear whether courts in Canadian common law provinces will enforce the negotiation and mediation steps in multi-tiered dispute resolution clauses. On the one hand, the courts recognize the strong public policy in favor of ADR in Canada. On the other hand,

¹¹ [2002] N.S.J. No. 256 (S.C. (T.D.) in chambers) (QL) [hereinafter *Marineserve.MG*].

¹² *Ibid.* at paras. 37-38.

¹³ *Toronto Truck Centre Ltd. v. Volvo Trucks Canada Inc.* (1998), 163 D.L.R. (4th) 740 (Ont. Gen. Div.).

agreements to negotiate are unenforceable under Canadian common law principles.

In the author's view, a good case can be made for distinguishing ADR clauses requiring negotiation and mediation from unenforceable agreements to agree. The cases concerning independent agreements to agree involve negotiations to settle the terms of a contract. A clause mandating non-binding ADR steps, on the other hand, requires the parties to participate in a defined process regardless of the outcome.

The distinction recently made by Australian courts between agreements to agree, which are unenforceable, and agreements to participate in a dispute resolution process, which are enforceable, is persuasive.¹⁴ Given the policy climate in favour of ADR, it can be safely predicted that Canadian courts in common law provinces will enforce the initial steps of a multi-tiered dispute resolution clause.

The Quebec courts' willingness to enforce a duty to discuss a dispute in good faith is illustrated by the Quebec Superior Court's decision in *Bridgepoint International (Canada) Inc. v. Ericsson Canada Inc.*¹⁵ In that case, the first tier of a dispute resolution clause required the parties to submit any dispute in writing to a "coordinating team" for discussion and resolution. The clause required the coordinating team to discuss the dispute in good faith. If the coordinating team was unable to resolve the dispute, either party could request the appointment of a conciliator. If the matter was still unsettled after the conciliator reported to the coordinating team, either party could submit the dispute to final and binding arbitration.

The plaintiff commenced a court action without first engaging in the dispute resolution process. The defendant asked the court to refer the parties to final and binding arbitration. The court noted that dispute resolution clauses should be interpreted "in a liberal way".¹⁶ The court went on to dismiss the action without prejudice and it enforced the first ADR step, ordering the parties to submit the dispute to the coordinating team for good faith discussion. The court explained that this first step set in motion a dispute resolution process that would culminate in binding arbitration only if one of the parties chose to carry the dispute resolution process forward. If neither party requested conciliation, arbitration would not ensue and either party could then begin a court action.

A second example may be found in a comment of Mr. Justice Chaput of the Quebec Superior Court in *In re: Peachtree Network Inc.* rendered on June 20, 2002.¹⁷ In that case, the Superior Court held that the bankruptcy court had exclusive jurisdiction over the dispute despite the existence of a valid

¹⁴ *Supra* note 9.

¹⁵ [2001] Q.J. No. 2470 (Sup. Ct.) (QL) [hereinafter *Bridgepoint*].

¹⁶ *Ibid.* at para. 10.

¹⁷ REJB 2002-33077 (Sup. Ct.).

arbitration agreement. In *obiter*, the court commented that the motion to have the parties referred to arbitration was in any event premature since the dispute resolution clause provided for a conciliation procedure prior to arbitration. Whether the parties would ever reach arbitration was therefore hypothetical.

Unlike in Canada, there are many U.S. cases in which courts have enforced non-binding ADR processes either under arbitration acts or pursuant to general contract law principles.

In the U.S., arbitration is subject to two statutory regimes, one federal and the other at the state level. The *Federal Arbitration Act* ("FAA") governs arbitrations relating to transactions involving interstate commerce. Most states have also adopted arbitration statutes, which apply to the extent the state legislation does not conflict with federal law.

Some courts have interpreted the definition of arbitration in the FAA to include non-binding processes such as negotiation or mediation. A striking example is the case of *CB Richard Ellis, Inc. v. American Environmental Waste Management*,¹⁸ in which the District Court for the Eastern District of New York held that a mandatory mediation step in a multi-tiered clause was covered by the FAA and this, even though the ultimate dispute resolution method provided for in the clause was litigation, not arbitration. In a more recent case, *Allied Sanitation, Inc. v. Waste Management Holdings, Inc.*,¹⁹ the court further extended the FAA's application by concluding that a first-step "ADR negotiation procedure" was included in the FAA definition of arbitration. The court held that the "concept of arbitration plausibly embraces all contractual dispute resolution mechanisms, consistent with Congress's design to foster alternative means to resolving litigation".²⁰

The courts have also enforced the initial stages of multi-tiered clauses by relying on general contract law principles. For example, in *DeValk Lincoln Mercury, Inc. v. Ford Motor Company*,²¹ involving an agreement to submit disputes to a policy board for mediation as a condition precedent to pursuing any other legal remedies, the plaintiff tried to negotiate with the defendant but did not initiate mediation. The plaintiff started court proceedings which were dismissed by summary judgment, later affirmed by the Seventh Circuit Court of Appeals. The court held that because mediation was a condition precedent to other legal remedies, the parties had to comply strictly with the mediation clause before starting litigation.

¹⁸ 1998 U.S. Dist. Lexis 200064 (E.D.N.Y. December 4, 1998) [hereinafter *CB Richard Ellis*]. See also *AMF Inc. v. Brunswick Corp.* 621 F. Supp. 456 (E.D.N.Y. 1985) at 459 [hereinafter *AMF*].

¹⁹ 97 F. Supp. 2d 320 (E.D.N.Y. 2000) [hereinafter *Allied Sanitation*].

²⁰ *Ibid.* at 327, citing *CB Richard Ellis*, *supra* note 18 and *AMF*, *supra* note 18.

²¹ 811 F.2d 326 (7th Cir. 1987) [hereinafter *De Valk*].

To date, the case law indicates that U.S. courts are prepared to enforce non-binding ADR processes, whether they stand on their own or precede other binding or non-binding processes in a multi-tiered clause.

Until very recently, the same could not be said in respect of England. In *Halifax Financial Services Ltd. v. Intuitive Systems Ltd.*,²² McKinnon J. declined to stay court proceedings in order to allow the parties to participate in a mediation, as provided in the three-tiered clause included in their contract. Judge McKinnon drew a distinction between "determinative procedures", such as arbitration, binding expert valuation and third-party certification, and "non-determinative procedures", such as negotiation, mediation, expert appraisal and non-binding rulings from a mediator.²³ The Court held that only in respect of determinative procedures can the *Channel Tunnel* case²⁴ be applied to stay proceedings instituted in breach of a dispute resolution clause. In *Channel Tunnel*, the House of Lords considered its jurisdiction to stay an action as a means of enforcing the process set out in a two-tiered clause. The first step of the clause required the parties to submit their dispute to an expert panel for binding decision. If either party wished to have the expert decision reconsidered, that party was required to submit the matter to ICC arbitration. The court considered whether or not the multi-tiered clause was an arbitration agreement, even though the first step did not involve arbitration. Lord Mustill expressed the view that, on balance, the clause likely was an arbitration agreement and so the court could grant a stay of the action pursuant to the English arbitration statute. However, it was not necessary for the court to found its jurisdiction in the arbitration statute because the court also had the inherent jurisdiction to stay the action. Lord Mustill noted that "those who make agreements for the resolution of disputes must show good cause for departing from them". In contrast to *Halifax Financial*, in *Cable & Wireless plc v. IBM United Kingdom Ltd.*,²⁵ the English High Court (Commercial Court) enforced a dispute resolution clause requiring "an Alternative Dispute Resolution (ADR) procedure as recommended to the Parties by the Centre for Dispute Resolution." Colman J adjourned the litigation proceedings on the basis that the parties intended that litigation be a last resort, that the ADR clause was more than a simple agreement to negotiate, and that there were good policy reasons for enforcing the clause. It is to be noted that the clause was declared to be enforceable even though a "non-determinative procedure" (to use the language in *Halifax Financial*) such as mediation was contemplated as part of the ADR procedure. The important consideration, according to Colman J, was that

²² [1999] 1 All E. R. (Comm) 303 (Q.B.) [hereinafter *Halifax Financial*]. See also *Paul Smith Ltd. v. H&S International Holding Inc.*, [1991] 2 Lloyd's L.R. 127, holding that a clause providing that the parties should strive to settle any dispute amicably, failing which it should be referred to ICC arbitration, did not create enforceable legal obligations.

²³ *Ibid.* at 5.

²⁴ *Channel Tunnel Group v. Balfour Beatty Ltd.*, [1993] 1 All E.R. 664 (H.L.) [hereinafter *Channel Tunnel*].

²⁵ [2002] EWHC 2059 (Comm), [2002] 2 ALL E.R. (Comm) 277 (Oct. 11, 2002)

"the obligation to mediate was expressed in unqualified and mandatory terms".

In France, the better view seems to be that courts are likely to enforce the mediation or conciliation tiers in multi-tiered clauses,²⁶ even though there remains some uncertainty in the case law.²⁷ There are some decisions suggesting that German courts would also be willing to enforce negotiation or mediation tiers in multi-tiered clauses.²⁸

III. Authority to Decide Enforceability and Compliance Issues

Some argue that all enforceability and compliance issues raised in connection with the obligation to negotiate or mediate of multi-tiered clauses should be decided by the arbitrators, rather than the courts, on the ground that the arbitral tribunal is competent to decide on its own competence under the widely-accepted theory of competence/competence. There is case law supporting this position in the United States and commentators have expressed the same view in respect of France and Germany. In the United States, the position appears to be that, unless the parties have agreed otherwise, the question of whether a dispute falls within the scope of an arbitration agreement (an issue that American jurists refer to as "substantive arbitrability") is one for the courts to decide, while issues of "procedural arbitrability", that is, of whether conditions precedent to the obligation to arbitrate have been complied with, should be referred to the arbitrators.²⁹

IV. Remedies

Very few Canadian courts have considered the remedies which may be available for failing to comply with the initial steps of a multi-tiered ADR clause. Without engaging in any discussion of theory, the Quebec Superior Court in *Bridgepoint* and the Nova Scotia Supreme Court in *Marineserve.MG* ordered the parties to comply with the clause by staying the court action pending compliance (*Marineserve.MG*) or dismissing the action without prejudice (*Bridgepoint*).

²⁶ Cass. civ. 2^e, 6 July 2000, Rev. arb. 2001 (no. 4) *Société Polyclinique des Fleurs c/ Peyrin*, and comment by C. Jarrosson, 749.

²⁷ See the two decisions of the 1^{re} Chambre civile of the Cour de cassation discussed by Jarrosson, *ibid*.

²⁸ See Kreindler & Berruti, *supra* note 10 at 17.

²⁹ See K. Scanlon, "Multi-Step Dispute Resolution Clauses in Business-to-Business Agreements", paper presented at the IBA Conference in Durban, South Africa, on October 22, 2002 (unpublished). As pointed out by Scanlon, that is the position adopted in s. 6 of the *Revised Uniform Arbitration Act* (2000), which reads as follows: "(c) An Arbitrator shall decide whether a condition precedent to arbitrability has been fulfilled and whether a contract containing a valid agreement to arbitrate is enforceable."

While House of Lords decisions are not binding in Canada, they are highly persuasive in the courts of the Canadian common law provinces. Accordingly, and subject to the distinction made in *Halifax Financial* between "determinative" and "non-determinative" procedures, the *Channel Tunnel* case provides authority in Canadian common law provinces for the courts' inherent jurisdiction to stay an action which has been commenced before the plaintiff complies with a multi-tiered ADR clause.

Damages were not sought or considered in the reported cases. An award of damages would be unlikely due to the speculative nature of the outcome of non-binding pre-arbitral processes. It has been suggested that the parties could provide in the ADR clause for liquidated damages as a genuine pre-estimate of damage in the event of a breach,³⁰ but this approach has not been tested in the Canadian courts.

U.S. courts have enforced multi-tiered or other non-binding ADR clauses by a variety of remedies, including:

staying court proceedings until ADR processes have been exhausted,³¹

- ordering submission of the dispute to the ADR process,³² enjoining a party from prematurely invoking an arbitration clause,³³ or
- refusing to enforce an arbitration clause where the preliminary ADR process did not occur³⁴ and
- staying litigation until a multi-tiered "ADR process" is completed, without distinguishing between, for example, a preliminary ADR process and arbitration.³⁵

³⁰ L. Boule & K. Kelly, *Mediation: Principles, Process, Practice* (Toronto & Vancouver: Butterworths, 2000) at 291.

³¹ See e.g. *BAE Automated Systems v. Morse Diesel International, Inc.*, 2001 U.S. Dist. LEXIS 6682 (S.D.N.Y. May 22, 2001 [hereinafter *BAE*]). The FAA grants federal courts the power to stay actions pending arbitration and to compel arbitration (see 9 U.S.C. ss. 3-4) but *BAE* is not an FAA case.

³² See e.g. *Haertl Wolff Parker, Inc. v. Howard S. Wright Construction Co.*, 1989 U.S. Dist. LEXIS 14756 (D. Or. December 4, 1989) [hereinafter *Haertl*]. See also *AMF*, *supra* note 18. As noted above, the FAA allows the court to compel arbitration (s. 4). The decision in *AMF* in which the court ordered the defendant to submit the dispute for a non-binding advisory opinion, was based on both the FAA and common law.

³³ See e.g. *Semco, LLC v. Ellicott Machine Corporation International*, 1999 U.S. Dist. LEXIS 10710 (E.D. La. July 9, 1999) [hereinafter *Semco*].

³⁴ See e.g. *Kemiron Atlantic, Inc. v. Aguakem International Inc.*, 290 F.3d 1287 (11th Cir. 2002) [hereinafter *Kemiron*]; and *HIM Portland, LLC v. DeVito Builders, Inc.*, 2002 U.S. Dist. LEXIS 13960 (D.C. Me., July 26, 2002) [hereinafter *HIM Portland*] (applying *Kemiron*).

³⁵ See e.g. *Griffin Trading Company v. Checkers, Simon & Rosner, LLP*, 250 B.R. 667 (Bankr., N.D. Ill. 2000) [hereinafter *Griffin*]; *Bishop v. We Care Hair Development Corp.*, 316

The courts have stayed litigation primarily under the FAA or similar state legislation, which require that court proceedings be stayed pending arbitration,³⁶ or under contract law principles.³⁷ Contract law principles have also been invoked to grant specific performance, ordering the parties to engage in the ADR process. The courts typically suspend or dismiss the court action without prejudice to the parties' ability to resume court proceedings if the ADR process fails to settle their dispute.³⁸

In at least two cases, *Kemiron* and *HIM Portland*, the court refused to stay court proceedings pending arbitration because the parties had failed to trigger mediation which was a condition precedent to arbitration.³⁹ In *Kemiron*, the plaintiff terminated a requirements contract for non-payment and commenced litigation against the buyer for breach of contract. The defendant, relying on the dispute resolution clause in the contract, moved to stay the action pending arbitration. The clause provided for disputes to be first subject to negotiations, to be followed, failing settlement, by mediation (upon notice of either party requesting same) and then arbitration (upon further notice requesting same). Neither party had given a notice of mediation or arbitration.

The court denied the stay and held that for there to be a duty to arbitrate the parties had first to mediate their dispute and then one party must give notice of a desire to arbitrate. On appeal, the 11th Circuit Court of Appeals affirmed the judgment, noting that the arbitration agreement, by the plain language of the dispute resolution clause, was subject to conditions precedent that had not been complied with. The court added: "The FAA's policy in favor of arbitration does not operate without regard to the wishes of the contracting parties."

The practical outcome in *Kemiron* was therefore that, by their failure to comply with the mediation step of the applicable dispute resolution clause, the parties were deprived not only of the benefit of the mediation step in the clause, but also of the arbitral forum they had selected as the ultimate dispute resolution tier for any dispute.

Ill. App. 3d 1182 (2000); *Design Benefit Plans v. Enright*, 940 F. Supp. 200 (N.D. Ill. 1996) [hereinafter *Design*].

³⁶ FAA, ss. 3-4. See e.g. *CB Richard Ellis*, *supra* note 18; *Cecala v. Moore*, 982 F. Supp. 609 (N.D. Ill. 1997) [hereinafter *Cecala*]; *Design*, *ibid.*; *Griffin*, *ibid.*; *Bankers Insurance United States v. Bankers Insurance Company*, 245 F.3d 315 (4th Cir. 2001) [hereinafter *Bankers*].

³⁷ See e.g. *BAE*, *supra* note 31.

³⁸ See e.g. *Haertl*, *supra* note 32.

³⁹ *Kemiron*, *supra* note 34 and *HIM Portland*, *supra* note 34. See also *DeValk*, *supra* note 21 (where mediation was a condition precedent to litigation, substantial performance by attempting to negotiate a settlement was insufficient and strict compliance with the mediation clause was required).

It is uncertain whether U.S. courts would award damages for breach of the preliminary ADR stages in multi-tiered clauses. The courts have generally refused to award expectation damages for breach of agreements to negotiate because an obligation to negotiate does not include an obligation to come to terms.⁴⁰ This reasoning may be applied to the breach of preliminary stages in multi-tiered ADR clauses.

On June 24, 2002 the United Nations Commission on International Trade Law (UNCITRAL) adopted the UNCITRAL Model Law on International Commercial Conciliation. Article 13 of the Model Law provides that where the parties have agreed to conciliate and have expressly undertaken not to initiate during a specified period of time or until a specified event has occurred arbitral or judicial proceedings with respect to an existing or future dispute, such undertaking shall be given effect by the arbitral tribunal or the court until the terms of the undertaking have been complied with, except to the extent necessary for a party, in its opinion, to preserve its rights.

Words Matter

The cases reviewed in this article illustrate the importance of appropriate drafting. Sample clauses may be consulted and should be adapted to fit the relevant circumstances.⁴¹

By way of example only, parties should ensure that time periods are provided for in respect of each ADR step, with clear, non-subjective triggers (such as a written notice) to determine the starting point of these time periods. Consideration may also be given to addressing such issues as the availability of interim or conservatory measures from a court of competent jurisdiction even if the negotiation or mediation stages have not been exhausted. Depending on the applicable law, one may also wish to avoid using standards (such as good faith) that are suspect under certain legal systems.

The goal of effecting the speedy, economical and final resolution of international disputes is reflected in the wide use of multi-tiered ADR clauses in international transactions. Attaining this goal, however, can be problematic if the parties are not careful to ensure that such clauses are enforceable in the relevant jurisdictions: these include the seat of the ADR process and the other jurisdictions in which either party is likely to face litigation that might be commenced in breach of the clause.

⁴⁰ See e.g. *Goodstein Construction Corp. v. New York (City of)*, 80 N.Y. 2d 366, 590 N.Y. Supp. 2d 425, 604 N.E. 2d 1356 (N.Y. Ct. App. 1991). But compare with *Venture Associates Corp. v. Zenith Data Systems Corp.*, 96 F.3d 275 (7th Cir. 1996).

⁴¹ See, among others, *CPR Drafter's Deskbook for Dispute Resolution Clauses* (New York, NY: CPR Institute, 2002) and P. D. Friedland, *Arbitration Clauses for International Contracts*, Juris Publishing, Inc., 2000.

Auton and Evidence-Based Decision-Making: Medicare in the Courts.Donna Greschner¹ and Steven Lewis²

I. Introduction

If hard cases make bad law, then *Auton* (*Guardian ad litem* of) *v. British Columbia (Attorney General)*³ poses serious risks. It is the first case in which an appellate court upheld a lower court's decision that *Charter*⁴ rights require a provincial government to pay for a specific health treatment.⁵ *Auton* is a very hard case: the petitioners' circumstances are compelling, if not heartbreaking; the scientific evidence is elusive and contested; and the implications of a decision in either direction are potentially profound. In this commentary we examine the claims made in *Auton* and elements of the judicial reasoning that led to the decision to expand the scope of publicly funded health treatment. We are interested in developing an approach to *Charter* litigation that will not only affirm individuals' rights, but also will improve health care decision making for everyone. This task engages evidentiary questions about medical treatments and health care policies. Indeed, such questions will be at the centre of *Charter* actions that challenge health care decisions. In our view, in this case the evidence did not support the highly interventionist order.

II. The Context

Autism spectrum disorder (ASD), which includes autism, is a mysterious neurological ailment.⁶ Its symptoms usually begin to appear around the age of two. Persons with ASD have impaired abilities to communicate or interact socially with other people, and they engage in repetitive, often dangerous, behaviour. Intensive behavioural intervention (IBI) seems to ameliorate some symptoms for some children, if started at a very young age.⁷ IBI

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³ *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, (2002) 6 B.C.L.R. (4th) 201 (C.A.) [*Auton* (CA)].

⁴ *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c.11 [*Charter*].

⁵ *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, (2000) 78 B.C.L.R. (3d) 55 (B.C.S.C.) [*Auton* #2].

⁶ For convenience, we refer to autism and ASD interchangeably.

⁷ L. McGahan, *Behavioural Interventions for Preschool Children with Autism* (Ottawa: Canadian Coordinating Office for Health Technology Assessment, 2001) [McGahan] at viii, defines behavioural intervention as "behaviourally based therapy developed to improve the

usually requires trained therapists who work with children on a one-to-one basis, often at the child's home. One type of IBI is Lovaas Autism Treatment (LAT).⁸

In British Columbia, a group of parents with children who have ASD lobbied unsuccessfully the provincial government to fund LAT. The parents believe that LAT is the only hope for mitigating their children's condition. LAT is expensive, costing between \$45,000 and \$60,000 per year for each child, and it is controversial.⁹ They wanted IBI, specifically LAT, recognized as a medically necessary service and, accordingly, covered under the province's medical insurance plan. The government refused to pay for LAT, informing a number of parents in 1998 that it was not "in a resource position"¹⁰ to respond to funding requests. Four parents¹¹ initiated a *Charter* action, arguing that the denial of funding for LAT violated their children's s.15 equality rights and s.7 rights to liberty and security of the person. In addition to seeking a declaration about the rights violations, they sought an order of mandamus requiring the Crown to pay for past and future LAT for their children.¹²

In the Supreme Court of British Columbia, Madame Justice Allan issued a declaration that the government's failure to provide effective treatment for young children with autism violated their rights to equality guaranteed under s.15 of the *Charter*, and could not be justified under s.1.¹³ She directed the government to fund IBI for children with autism who were between the ages of two and six, approximately.¹⁴ Furthermore, after noting that the four infant

symptoms associated with autism" and at 11-13 she lists a number of different behavioural intervention options. The Autism Society of America, online: <http://www.autism-society.org>. provides information about various treatments, including behavioural and communication approaches (such as Applied Behavioural Analysis, Floor Time, and Social Stories), biomedical and dietary treatments, and complementary approaches (such as music, art, and animal therapies).

⁸ The treatment is named for its pioneer, Ivar Lovaas. See, e.g., O. Ivar Lovaas, "The Development of a Treatment-Research Project for Developmentally Disabled and Autistic Children" (1993) 26. J. Appl. Behav. Anal. 617; J.J. McEachin, T. Smith & O. Ivar Lovaas, "Long-term Outcome for Children With Autism Who Received Early Intensive Behavioral Treatment" (1993) 97 Am. J. Ment. Retard. 359, especially at 373-91.

⁹ The controversy about LAT involves, *inter alia*, outcome claims and exclusivity. McGahan, *supra* note 7 at 10, 13-14, briefly describes contested issues.

¹⁰ *Auton* #2, *supra* note 5 at para. 6.

¹¹ The parents unsuccessfully attempted a class action: *Auton* (*Guardian ad litem* of) v. *British Columbia* (*Attorney General*), (1999) 32 C.P.C. (4th) 305 (B.C.S.C.) [*Auton* #1].

¹² *Auton* #2, *supra* note 5 at para. 8.

¹³ *Auton* (*Guardian ad litem* of) v. *British Columbia* (*Attorney General*), (2001) 84 B.C.L.R. (3d) 259 (B.C.S.C.) [*Auton* #3]. Justice Allan did not order LAT, noting in *Auton* #2, *ibid.* at para 157, that "the Court has no jurisdiction to specifically order Lovaas therapy."

¹⁴ *Ibid.* at para. 65. While the order of relief in para. 65 does not specify that funding of IBI is limited to children between the ages of two and six, Justice Allan clearly intended this limit. At para. 37 she noted that the most compelling argument for publicly funded IBI is to

petitioners were ages six or older, and thus unlikely to benefit from the order in spite of the costs incurred by their parents in providing LAT at their own expense, she awarded monetary damages of \$20,000 to each of the four adult petitioners.¹⁵ In October 2002, the British Columbia Court of Appeal upheld her ruling about the constitutional violation, but varied the remedy by ordering the government to fund LAT treatment for the four infant petitioners.¹⁶ Its decision is under appeal to the Supreme Court of Canada.¹⁷

The *Auton* judgments are important for several related reasons. First, the financial stakes in this litigation are significant. Although the judgments do not estimate the annual cost of providing IBI therapy in British Columbia, it is clear that the cost will be many millions of dollars.¹⁸ An order of this magnitude greatly exceeds the amount mandated by Supreme Court of Canada in *Eldridge v. B.C.*, its first *Charter*-based health care decision.¹⁹ Furthermore, the cost will rise with greater public awareness of the service and more vigorous case finding. While the incidence and prevalence of autism and ASD are not definitively known, the diagnosis rates appear to have increased over time.²⁰ To put this amount in perspective, consider that the British Columbia Minister of Child and Family Services in 1999-2000

treat the condition during the "window of opportunity" between the ages of two and six. As well, at para. 42 she refused to determine whether the government would breach its constitutional obligations if it did not accommodate children with autism after they reach school age.

¹⁵ *Ibid.* at para. 64.

¹⁶ *Auton (CA)*, *supra* note 3 at para. 92.

¹⁷ *Ibid.*, leave to appeal granted, [2002] S.C.C.A. No. 510 (QL).

¹⁸ According to *Auton* #2, *supra* note 5 at para. 56, the British Columbia Ministry of Children and Families served 1274 children and youth with autism from its 1999/2000 budget. Diagnosis usually doesn't occur before the age of two, and youth is defined as being under the age of 18. For the sake of calculation, assume that these children's ages are evenly distributed between two and eighteen, so that one-quarter of these children are between the ages of two and six (318 children). If assessment panels recommend IBI treatment as expensive as LAT, which costs \$45,000 to \$60,000 per year, the government's liability is on the order of \$14 to \$19 million annually, in British Columbia alone, based on a conservative estimate of the number of children, ages 2-6, who would seek treatment.

¹⁹ *Eldridge v. British Columbia (A.G.)*, [1997] 3 S.C.R. 624, [Eldridge] (government ordered to pay for sign language interpreters for deaf patients, a service that was estimated to cost approximately \$150,000/year in British Columbia). Even taking into account that this estimated cost was far too low (see C. Manfredi & A. Maioni, "Courts and Health Policy: Judicial Policy Making and Publicly Funded Health Care in Canada" (2002) 27 J. of Health Pol. 213 [Manfredi & Maioni], at 229), the amount would still be negligible compared to the annual cost of funding IBI.

²⁰ The medical literature reveals considerable controversy about the prevalence of ASD, whether it has increased over time, and why. For a succinct overview of these and other complicated issues, see E. Fombonne, "The Prevalence of Autism" (2003) 289 J. Amer. Med. Assoc. 87 [Fombonne] (the best current estimate for the prevalence rate for ASD and related disorders, such as Asperger disorder and 'pervasive developmental disorder-not otherwise specified,' is approximately 60 cases per 10,000 children; he concludes that "there is good

had to provide services for approximately 12,000 children with special needs with a budget of only \$62 million dollars, or \$5,000 per capita.²¹ By virtue of the potential amount of the court order, and the order's skewing of the resources otherwise allocated to children with special needs, the judgments are highly interventionist.

Second, and importantly, the approach in the *Auton* judgments may influence judicial involvement in health care policies more generally. Canada has a mixed system of health care, with considerable public financing and mostly private, non-profit delivery. One of the most significant and controversial policy debates is whether to change, and to what extent, the mix between public and private financing. Thus far, even though the *Charter* of Rights and Freedoms permits challenges to governmental decisions about health care services, courts have not played a large role in determining these and other questions of health care policy. Other than mostly early and now likely temporary victories of doctors in opposing restrictions on entitlement to provincial billing numbers,²² successful *Charter* challenges to health care policies have been few in number and small in impact.²³ Only one case about health care funding, *Eldridge v. B.C.*, has reached the Supreme Court of Canada, and it involved equal access to existing health care services for Deaf patients, not the larger question about including new treatments within the scope of insured services.²⁴ For the most part, judges have hesitated to wade into the turbulent waters of health care policy, and have deferred to governments' choices in delivering health care services.²⁵ However, more litigation is inevitable and it has the potential to affect the structure of health services and the scope of coverage.²⁶ In *Charter* cases of the latter type where plaintiffs win, courts will be ordering governments to spend health care dollars in particular ways. Such orders, as *Auton* vividly illustrates, expand the scope of coverage by mandating new service types. They will change the mix of public and private financing, one case at a time. Money is

evidence to support that higher prevalence rates reflect changes in diagnostic practices, improved identification and availability of services, and other similar factors." *Ibid.* at 88). See also L. Dales *et al.*, "Time trends in autism and in MMR immunization coverage in California" (2001) 285(9) J. Amer. Med. Assoc. 1183; L. Wing and D. Potter, "The Epidemiology of Autistic Spectrum Disorders: Is the Prevalence Rising?" (2002) 8 Ment. Retard. Dev. Disabil. Res. Rev. 151. ²¹ These figures come from *Auton* #2, *supra* note 5 at para. 56. (The Ministry was also allocated an additional \$28 million for special needs day care). Using the estimates calculated in note 18, *supra*, 316 children would receive between 22 – 30% of the entire non-day care budget for children with special needs. ²² See *Re Mia and Medical Services Commission of B.C.* (1985) 17 D.L.R. (4th) 385 (B.C.S.C.) and *Wilson v. British Columbia (Medical Services Commission)* (1988) 53 D.L.R. (4th) 171 (B.C.C.A.), in which doctors argued successfully that billing policies infringed their mobility rights. The interpretation of mobility rights that produced these victories was rejected by the Supreme Court of Canada in a non-health care case (*Canadian Egg Marketing Agency v. Richardson*, [1998] 3 S.C.R. 157), and most recently by the New Brunswick Court of Appeal in another doctors' challenge to billing policies (*Rombaut v. New Brunswick (Minister of Health and Community Services)*, (2001) 250 N.B.R. (2d) 258 (C.A.)). ²³ For a review of *Charter* cases

on the table, and lots of it. So, too, since health care resources are not unlimited, is equity.

The judicial approach to health care policies will be tested quite quickly. Litigation about funding treatment for autistic children is underway in several provinces.²⁷ Although the treatment programs in other provinces may differ from British Columbia's, the result and reasoning in *Auton* will influence the jurisprudence. In addition, *Charter* challenges to several other health care policies are proceeding or can be expected in the near future.²⁸ The parents' success in *Auton* is likely to lead other patients to press for a greater share of resources. With many cases possible in the wake of *Auton*, it becomes important that courts grapple properly with *Charter* claims about health care policies and the attendant evidentiary questions. Close scrutiny of the judicial reasoning in *Auton* will foster this objective.

Third, the *Auton* litigation engages an even more far-reaching question of how governments can make health care policy decisions in a manner that best conforms to *Charter* values. The Canadian health care system has many touted virtues, not least of which are freedom of choice for patients, low overhead costs, and relative efficiency, with overall costs about half of those in the United States, consuming 4% less of our GDP. From the standpoint of ensuring quality and measuring performance, however, the Canadian system is information poor. Costing information is typically aggregated rather than case-specific. Undisciplined by the need to retain or expand market share and/or keep premiums low while providing high quality care, the system focuses on volumes and access. The strongest predictor of budgetary allocations in the upcoming year is the pattern from this year. There is little value-for-money assessment, and new resources tend to be spent to address

that concern the health care system, see Commission on the Future of Health Care in Canada, *How Will the Charter of Rights and Freedoms and Evolving Jurisprudence Affect Health Care Costs?: Discussion Paper No. 20* by Donna Greschner (Saskatoon: Commission on the Future of Health Care in Canada, 2002) [Greschner] online: Health Canada http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/20_Greschner_E.pdf; B. Berger, "Using the *Charter* to Cure Health Care: Panacea or Placebo?" (2003) 8 Rev. Const. Studies 20. ²⁴ *Eldridge*, *supra* note 19. Note as well that the Supreme Court denied leave to appeal in *Cameron v. Nova Scotia (Attorney General)*, (1999) 240 N.S.R. (2d) 1 (C.A.) [Cameron] (exclusion of in vitro fertilization from public funding does not violate the *Charter*; leave to appeal to the Supreme Court of Canada denied, [1999] S.C.C.A. No. 531 (QL)).

²⁵ See Greschner, *supra* note 23 at 2-5.

²⁶ See Manfredi & Maioni, *supra* note 19, for an insightful critique of the effects of litigation on health care policies.

²⁷ *Deskin v. Ontario*; *Wynberg v. Ontario* (2003) #00-CV-184608CM (Ont. Sup. Ct.) (*Charter* challenge at trial during summer of 2002 to the age criterion for publicly funded early intervention treatment of children with autism); *Clough (Litigation guardian of) v. Ontario*, [2003] O.J. No.1074 (Ont. Sup. Ct.) (QL) (request for interim relief of continued IBI funding for children with autism denied); *Lowrey (Litigation guardian of) v. Ontario*, [2003] O.J. No.1197 (Ont. Sup. Ct.) (QL) (request for interim relief of continued IBI for child with autism granted).

the interests of various groups, such as clinicians, people with a particular illness or condition, communities wanting a larger share of the pie, and other advocates. Despite the appearance of coherence and corporate-style management, clinical decision-making is highly decentralized, with autonomous clinicians deciding what services their patients need. Systematic performance measurement, oversight, and review are just emerging in Canadian health care. There is little scrutiny of practitioners' decision-making, with the consequence that enormous variations in practice go, if not unremarked, habitually unremedied.²⁹

This "muddling through" approach may produce both good care and generally acceptable use of resources, but when called to account for particular decisions it appears porous at best. By and large, there is no "science" of resource allocation, nor is there yet a uniform process for determining the relative value or cost-effectiveness of existing services, or proposed new programs. Several emerging approaches to budget-making promise greater articulation and precision, but none has yet been implemented on a wide scale in Canada.³⁰ In short, too often decisions about funding particular health care services are historically based, ad hoc, opaque, and lacking a scientific foundation.³¹

For the past decade, however, efforts have been underway to improve health care decision-making. "Evidence-based decision-making" or "evidence-based medicine" is a relatively recent development in health care whose origins are significantly Canadian.³² Its core notion is the idea that

²⁸ *Chaoulli c. Quebec (Procureur général)*, [2002] R.J.Q. 1205 (C.A.) (QL), leave to appeal to S.C.C. granted, [2002] C.S.C.R. no. 280 (QL) (ban on private health insurance not a violation of s. 7); and litigation similar to *Shulman v. College of Audiologists and Speech Language Pathologists of Ontario*, (2001) 155 O.A.C. 171 (Ont. Sup. Ct.) (government's decisions to stop insuring cost of hearing aid evaluations and attach conditions to physicians' payment for diagnostic hearing tests does not violate s.15).

²⁹ See e.g. V. Goel et al., eds, *Patterns of Health Care in Ontario: The ICES Practice Atlas*, 2d ed. (Ottawa: Canadian Medical Association, 1996).

³⁰ See C. Mitton & C. Donaldson "Setting Priorities in Canadian Regional Health Authorities: a Survey of Key decision Makers" (2002) 60 *Health Policy* 39.

³¹ See Saskatchewan, Commission on Medicare, *Caring for Medicare: Sustaining a Quality System* (Regina: Commission on Medicare, 2001) (Commissioner: Kenneth J. Fyke) online: Saskatchewan Health

http://www.health.gov.sk.ca/info_center_pub_commission_on_medicare-bw.pdf. [Fyke Report], especially at 43-54, 72-74.

³² Already a vast literature exists on these subjects. For an overview of the basic concepts and their application, see e.g. Guyatt, Cairns, John et al., "Evidence-based Medicine" (1992) 268 *J. Amer. Med. Assoc.* 2420; and S. Findlay, ed., *Reducing Medical Errors and Improving Patient Safety: Success Stories from the Front Lines of Medicine* (Washington, D.C.: National Coalition on Health Care, Boston: Institute for Healthcare Improvement, 2000) online: National Coalition of Health Care http://www.nchc.org/releases/medical_errors.pdf. For an example of concerns, see N. Black & A. Donald, "Evidence Based Policy: Proceed with Care" (2001) 323 *Brit. Med. J.* 275.

systematically accumulated scientific evidence, rather than tradition, hunch, anecdote, or peer pressure, should guide medical practice. Similarly, health care professionals have embraced the theory of continuous quality improvement, with a dual focus on error identification and management, and performance measurement and enhancement. Both approaches, which are connected but not identical, rely on good information systems and analytical reports that link resources and processes to outcomes. Moreover, several recent, influential reports on health care reforms have stressed the critical importance of evidence-based decision-making,³³ and with their clout, its time may have come. The Health Accord, signed by First Ministers in February 2003, undertakes to establish a new Health Council that may facilitate systemic changes in the health care system.³⁴

In principle, evidence-based decision-making is a good thing, and ought to be encouraged throughout the health care system. There are obvious similarities between evidence-based decision-making in the health care sector and the standards of legal reasoning – outcomes based only on relevant evidence – that are expected of courts. In *Charter* litigation more specifically, s.1's dictate of demonstrable justification³⁵ resembles evidence-based decision-making and may, indeed, even mandate it. In this comment we cannot explore fully these similarities and the differences. Rather, we are interested in how *Charter* litigation can promote evidence-based decision-making in health care.

Our analysis of the *Auton* judgments rests on several propositions. First, government departments are better equipped than courts to manage complex programs and use resources effectively. They may not always make the best use of available data and expertise, but they have far more of it than judges do, and more practice at using it. Moreover, they have the major advantage of perspective: they not only can, but must, look at the entire system. In the context of health care, they must consider the needs of all patients, compare the sometimes incommensurable, and make often tragic trade-offs. In contrast, courts run a higher risk of telescopic vision: focussing on the case

³³ See National Forum on Health, *Canada Health Action: Building on the Legacy* (Ottawa: National Forum on Health, 1997), especially Volume 1, section 3; online: Health Canada http://www.hc-sc.gc.ca/english/care/health_forum/forum_e.htm [National Forum on Health] (one author, Steven Lewis, was a member of the Forum); Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada – Final Report* (Saskatoon: Commission on the Future of Health Care in Canada, 2002) (Commissioner: Roy J. Romanow), online: Commission on the Future of Health Care in Canada <http://www.healthcarecommission.ca> [Romanow Report], especially pp. 75-90, 137-57; and Fyke Report, *supra* note 31.

³⁴ First Ministers' Meeting, 2003 *First Ministers' Accord on Health Care Renewal*, Doc. 800-039 (Ottawa: 5 February 2003), online: Canadian Intergovernmental Conference Secretariat, Conference Information for 2003 http://www.scics.gc.ca/pdf/800039004_e.pdf.

³⁵ Section 1 places the onus on governments to demonstrate their justifications for limiting rights; demonstration usually requires evidence.

before them magnifies that case, and removes other needs and problems from their field of vision.³⁶

Second, as we have stated, health care decisions should be evidence-based. At a minimum, this requires transparency – the reasons for funding one treatment but not another should be open to scrutiny.³⁷ Third, courts can usefully signal problems with programs and governmental decision making.³⁸ One major advantage of courts as decision makers is their obligation to justify their decisions with arguments and evidence, which together comprise their reasons. They can also require other decision makers to give reasons for decisions; in *Charter* litigation, this is the role of s.1. Consequently, by mandating and scrutinizing reasons for health care decisions taken by professionals in the field, constitutional challenges and court decisions have the potential to improve the health care system, which would inure to the benefit of patients, both as rights-holders and as taxpayers. On the other hand, court decisions also have the potential to wreak serious havoc on the health care system. Our analysis aims to ensure that the former occurs, not the latter.

III. *The Judgments*

A. The Decision of the B.C. Supreme Court

In the Supreme Court of British Columbia, Justice Allan dealt with the matter in three stages. First, she heard an application to certify a class action on behalf of all autistic children and their parents who were denied funding for LAT. She dismissed the application,³⁹ and subsequently four parents and their children became named petitioners in the lawsuit. Second, Justice Allan dealt with the liability issue, which she heard by way of summary motion. She held that the government's failure to fund IBI treatment, when it funded other necessary health treatment under its medicare program, violated the children's equality rights, and could not be justified under s.1 of the *Charter*. Third, in a separate hearing, she dealt with remedies. The plaintiffs sought a declaration that the government pay for future LAT for so long as it is

³⁶ Telescopic vision (the distant object you peruse in a telescope becomes much larger, but you see nothing else) is not unique to adjudication of health care policies; it is one reason for the judicial minimalism advocated by legal scholars such as C. Sunstein, *One Case At A Time: Judicial Minimalism on the Supreme Court* (Cambridge: Harvard University Press, 1999).

³⁷ Transparency is a key feature of evidence-based decision-making and is a precondition for greater accountability.

³⁸ See M. M. Mello, "Policing Medicaid and Medicare Managed Care: The Role of Courts and Administrative Agencies" (2002) 27 J. Health Pol. 465.

³⁹ *Auton #1*, *supra* note 11. However, the government acknowledged that a declaration that it was in breach of its obligations to the petitioners would mean it was in breach of its obligations to autistic children generally: *Auton #3*, *supra* note 13 at para. 9.

recommended by a medical practitioner or psychologist. Justice Allan refused to issue this declaration, instead directing the government to “fund early intensive behavioural therapy for children with autism, including autism spectrum disorder.”⁴⁰ She noted that the government was establishing a provincial centre for autism, which would provide IBI to autistic children under the age of six, after diagnosis and assessment by a multi-disciplinary team.⁴¹ According to Justice Allan, courts “cannot dictate what treatment programs should or should not be implemented, nor can it dictate how limited financial resources should be allocated.”⁴² In addition, she refused to order the government to pay for the LAT received in the past by the infant petitioners, but did award \$20,000.00 in monetary damages to each of the four adult petitioners.⁴³

During the second stage at the Supreme Court, the parties agreed on several points with respect to treating autistic children. There is a window of opportunity in autism for treating and obtaining “in some cases”⁴⁴ significant results: the earlier that IBI begins after diagnosis at an early age, the better the prognosis. “Current research has established, with some certainty, the efficacy of early intervention in assisting *many* children to achieve significant social and educational gains (emphasis added).”⁴⁵ Moreover, the expert witnesses agreed that there are no effective competing therapies for children with autistic disorders. Notice that the parties did not agree, and the trial judge made no findings, about the proportion of cases that would benefit from IBI, and the extent of the benefit (known as effect size in the medical literature). We do not know if the treatment is effective for only a small minority of children with ASD, or most of them. The judge uses imprecise words – “in some cases” and “many children” – in describing the agreed-upon success rate.

Justice Allan also made a critical ruling about the four child petitioners: “I am satisfied on the basis of admissible evidence that the infant petitioners made significant gains *as a result of* the Lovaas Autism Treatment they received (emphasis added).”⁴⁶ The admissible evidence, however, appeared to have been only the affidavits of the parents. Each parent described the effects of LAT as “dramatic,”⁴⁷ with each child making substantial progress while receiving the treatment. Letters from the children’s doctors outlining their patients’ advancements were attached as exhibits to the parents’ affidavits, but these letters were not admissible evidence.⁴⁸

⁴⁰ *Auton* #3, *ibid.* at para. 65.

⁴¹ *Ibid.* at para.22.

⁴² *Ibid.* at para. 27.

⁴³ *Ibid.* at para. 64.

⁴⁴ *Auton* #2, *supra* note 5 at para. 51.

⁴⁵ *Ibid.* at para. 52.

⁴⁶ *Ibid.* at para. 18.

⁴⁷ *Ibid.* at para. 14.

⁴⁸ *Ibid.* at para. 18.

B. The Decision of the Court of Appeal

The government appealed Justice Allan's decision that s. 15 had been violated, and that the violation could not be upheld under s. 1. The petitioners cross-appealed, arguing that the government not only breached the children's s. 15 rights, but also their s. 7 rights. In addition, they cross-appealed with respect to remedies, arguing that the trial judge's order should have directed funding for all future LAT whenever it is recommended by a medical practitioner or psychologist, and that the monetary damages were insufficient. The Court of Appeal asked for and received submissions about its *parens patriae* jurisdiction.⁴⁹ In the end, it upheld Justice Allan's decision, but varied the remedy.⁵⁰

(1) Section 15

The Court of Appeal, in line with the lower court, followed the basic steps for s. 15 claims that the Supreme Court of Canada established in its major decision, *Law v. Canada*.⁵¹ The steps are threefold. First, does the law distinguish between the claimants and a comparator group, or fail to take into account the claimant's already disadvantaged position? Second, is the differential treatment based on one or more of the enumerated or analogous grounds? Third, does the differential treatment discriminate in a substantive sense?

With respect to the first step, the Court of Appeal rejected the government's argument that the appropriate comparator group was all members of the medicare plan, none of whom has all his or her health care needs covered by the plan.⁵² Instead, it agreed with Justice Allan that the appropriate comparator groups were other children and adults with mental disabilities. In comparing autistic children to each comparator group, the Court concluded that their treatment was different. Justice Allan in the lower court had found that IBI was "the only effective treatment"⁵³ for

⁴⁹ *Auton (CA)*, *supra* note 3 at para. 8.

⁵⁰ The majority opinion was written by Justice Saunders and joined by Justice Hall. In a separate opinion, Justice Lambert concurred with Justice Saunders with respect to the violation of s. 15, but dissented in part on the question of remedy. Although the lower court had declined to deal with the s. 7 claim because it could decide the case under s. 15, in the Court of Appeal, *ibid.* at paras 68-74, Justice Saunders offered a brief opinion, disagreeing with the petitioners' argument that the government's failure to fund LAT violated s. 7 rights to liberty and security. In her view, the right to liberty concerns either physical liberty or an irreducible sphere of personal autonomy, circumstances that do not result from the governmental decisions in this case. Further, she held that even if the circumstances could violate the right to security, the under inclusiveness of the health care system would not violate a principle of fundamental justice.

⁵¹ *Law v. Canada (Minister of Employment and Immigration)*, [1999] 1 S.C.R. 497 (SCC).

⁵² *Auton (CA)*, *supra* note 3 at para. 30-32.

⁵³ *Ibid.* at para. 37.

children with ASD, and the Court of Appeal accepted her assessment that IBI was "necessary medical care."⁵⁴ According to the Court of Appeal, the government provided necessary medical care for non-autistic children but not for autistic children. In addition, the government provided treatment and rehabilitative therapies for adults with mental disabilities, but not to children with autism.⁵⁵ The latter constituted differential treatment on the basis of disability: "to say that these children do not receive the only treatment they greatly need is to say that they are treated differently from other children."⁵⁶ With these rulings of age and disability differentials in the first step, the answer to the second stage – whether the plaintiffs were denied treatment on the basis of an enumerated ground – was affirmative.⁵⁷

The third step of an equality analysis asks whether the differential treatment constituted discrimination "in a substantive sense." Here again, the government argued that since the health care system did not serve every health care need, the failure to fund IBI treatment for autistic children was not discriminatory.⁵⁸ The Court again rejected that argument, pointed to several factors that showed substantive discrimination: the failure to treat autism would condemn these children to an adult life of isolation and institutionalization; the denied treatment holds a "realistic prospect"⁵⁹ of improving their condition; no other effective treatment was available; and other serious and less serious conditions were treated by state-funded programs.⁶⁰ Unlike complainants in other cases, who were not as disadvantaged as other people receiving more treatment, here the complainants were "greatly disadvantaged with the prospect that without treatment, they are likely to remain so for the rest of their lives."⁶¹ The Court concluded that the failure to fund treatment for autistic children confirmed that "the community was less interested in their plight than the plight of other children needing medical care and adults needing mental health therapy."⁶² Accordingly, it upheld the ruling that the denial of funding violated s.15 of the *Charter*.

(ii) Section 1

Both the Supreme Court and the Court of Appeal began their discussion of section 1 with references to the classic framework established in *Oakes*.⁶³ Briefly, the *Oakes* test has two parts: first, the government must show that it

⁵⁴ *Ibid.*

⁵⁵ *Ibid.* at para. 41.

⁵⁶ *Ibid.* at para. 40.

⁵⁷ *Ibid.* at para. 44.

⁵⁸ *Ibid.* at para. 46.

⁵⁹ *Ibid.* at para. 49.

⁶⁰ *Ibid.*

⁶¹ *Ibid.*

⁶² *Ibid.* at para 51.

⁶³ *R. v. Oakes*, [1986] 1 S.C.R. 103.

has a pressing and substantial objective in limiting a right; and second, it must show that it has violated the right in a proportionate manner. The latter part has three components: (1) the violation must be rationally connected to the aim of the legislation; (2) the violation must minimally impair the right; and (3) the deleterious effects of the violation must not outweigh the salutary effects of the objective.

At the Supreme Court, Justice Allan had ruled that excluding treatment for autistic children undermined the primary objective of the law, namely to provide universal health care,⁶⁴ and that this exclusion was not a minimal impairment. She dismissed the government's arguments that ordering treatment would direct resources away from other children, or that it would lead to a checkerboard effect in the medicare system.

In the Court of Appeal, the government argued that upholding the court order would start the courts down a very slippery slope of intervening in a vast array of health care policies. In its view, courts should not be involved in allocating scarce resources on a case by case basis because it would thwart the goal of a comprehensive and systematic basis for health care decisions. In response, Justice Saunders said the order would not open a Pandora's Box of judicial micro-management of health care services because this order dealt with the needs of children. She noted that people who cannot care for themselves, such as children and adults with mental incapacity, are protected by the courts' ancient *parens patriae* jurisdiction. For Justice Saunders, the fact that the patients are children raised the bar very high for government: "the underlying thesis that the law works for the protection and advantage of children strongly argues against finding s. 1 justification for the discriminatory administration of the health care scheme at issue in this case."⁶⁵ To bolster the courts' special jurisdiction over children, Justice Saunders referred to modern international conventions about children, noting that these conventions have moral force in assessing s. 1 considerations, even when the impugned measure lies within provincial competence. In this case, since the international commitment did not support the impugned measure (i.e. no funding of IBI treatment), it weighed against justification under s. 1.⁶⁶

The specific steps in the *Oakes* analysis were dealt with very briefly and somewhat cryptically. Justice Saunders accepted the importance of the overall objectives of "advancing health care and developing a rational administrative scheme by which to determine the respective priorities of medical treatments and aspects of health care."⁶⁷ However, in her view, denying funding or effective treatment for autism was not a governmental objective, but rather was the result of the low priority assigned to treating autistic children or "overlooking their dominant health care need

⁶⁴ *Auton* #2, *supra* note 5 at para 151.

⁶⁵ *Auton* (CA), *supra* note 3 at para. 61.

⁶⁶ *Ibid.* at para. 64.

⁶⁷ *Ibid.* at para. 65.

altogether.”⁶⁸ Ruling for the petitioners would not undermine the health care scheme, or render the government’s choices of funding less certain, for two reasons. First, the case involved funding treatment for children, who have a “significant place”⁶⁹ in the law’s priorities. As well, it involved special factors, namely the “immediate need of the children, the potential benefit to them and the community, and the terrible consequences for such children who do not receive treatment when young enough to benefit from it.”⁷⁰ She concluded that the government had not proved a rational connection between the objective and the measures, or proportionality between the deleterious and salutary effects.

(iii) Remedies

In the Court of Appeal the petitioners argued that the lower court should have specified LAT, not IBI generally, and that it should not have contemplated age limits on the treatment. The Court of Appeal refused to specify LAT or order treatment beyond the age of six for all children with ASD. However, Justice Saunders also noted that the age of six might be too “crisp”⁷¹ and she directed that any disputes about the duration of treatment should be decided through an appropriate dispute resolution process or, if no process existed, before the Supreme Court of British Columbia.⁷²

In addition, the Court directed the government to fund treatment “in the nature in which they had been receiving” for the four child plaintiffs,⁷³ and to continue that funding until a qualified medical practitioners opine that the treatment will not give “further significant benefit.”⁷⁴ Since these four children had received LAT, the order entitles them to receive LAT in the future. The Court gave no reason to ignore the age limit of six with respect to these four children. Justice Saunders also upheld the symbolic award of \$20,000 for each of the four parents. Consequently, the four infant petitioners obtained more benefits from the litigation, and more fully funded treatment, than other children with autism.

⁶⁸ *Ibid.*

⁶⁹ *Ibid.*

⁷⁰ *Ibid.*

⁷¹ *Ibid.* at para. 90. Presumably, she was referring to children who reach six early in the year, but would be without services until September, when they start school and thus have access to school-based services.

⁷² *Ibid.*

⁷³ *Ibid.* at para. 92

⁷⁴ *Ibid.*

IV. *The Courts' Reasoning: Difficulties and Implications*

A. *Health Care Services and the Canada Health Act*

The *Canada Health Act* (CHA)⁷⁵ and its provincial complements are pivotal to this litigation. Since the petitioners' claim is a typical 'scope of coverage' case, seeking expansion of publicly funded health services to include IBI for children with ASD, it challenges the constitutionality of the statutory medicare scheme. The judgments raise several important, general points about medicare's principles, definitions, and limits.

First, the judgments appear confused about which principle of the *CHA* and complementary provincial legislation was at play in the litigation.⁷⁶ In the lower court, Justice Allan stated that the primary objective of the medicare legislation was to provide universal health care,⁷⁷ thus inferring that the government was violating the principle of universality by not funding LAT. The Court of Appeal also describes the issue as the failure to provide treatment "in the context of a universal program."⁷⁸ But this litigation does not engage the principle of universality. Under s.10 of the *CHA*, universality means that 100% of qualified provincial residents are entitled to receive insured health services.⁷⁹ British Columbia's program meets this criterion, as its counsel pointed out in noting that children with autism are entitled to all insured services in the same manner as other residents.⁸⁰ Rather, since the plaintiffs were asking for IBI to be funded by the government, thus in effect seeking expansion of insured health services, they were invoking the principle of comprehensiveness.⁸¹ To put the matter another way, the case is about seeking a bigger share of the resource pie; it does not engage basic questions about citizenship, the fundamental value captured by the principle of universality.⁸² In our view, focusing on the

⁷⁵ R.S.C. 1985, c. C-6. [CHA].

⁷⁶ *The Medicare Protection Act*, R.S.B.C. 1996, c.286, repeats the CHA's five principles (public administration, comprehensiveness, universality, portability, and accessibility) in its preamble.

⁷⁷ *Auton #2*, *supra* note 5 at para. 151.

⁷⁸ *Auton (CA)*, *supra* note 3 at para. 59.

⁷⁹ *Supra* note 74, s.10. Canada's principle of universality accords with the view of the World Health Organization: "Universal coverage means coverage for all, not coverage of everything." See The World Health Organization, *World Health Report 1999: Making a Difference* (Geneva: World Health Organization, 1999) at 43.

⁸⁰ *Auton #2*, *supra* note 5 at para. 133-34. The Crown made this point in the course of distinguishing *Eldridge*, *supra* note 19. It could also be noted that *Eldridge* involved the principle of accessibility, not comprehensiveness or universality.

⁸¹ For a description and discussion of the CHA's principles, see Commission on the Future of Health Care in Canada, *Strengthening the Foundations: Modernizing the Canada Health Act: Discussion Paper No. 13* by ©. Flood and S. Choudhry (Saskatoon: Commission on the Future of Health Care in Canada, 2002), online: National Library of Canada http://collection.nlc-bnc.ca/100/200/301/pc0-bcp/commissions-ef/future_health_care-ef/discussion_paper-e/no13/13_e.pdf [Flood and Choudhry].

⁸² Notions of citizenship and belonging are at the heart of s.15 (see Donna Greschner,

wrong principle played a subtle but critical role in the courts' reasoning. Using the lens of universality made the exclusion of funding for LAT look like an omission that struck at the very heart of medicare, Canada's most cherished social program. By contrast, if the courts had viewed the litigation through the lens of comprehensiveness, they would have seen the petitioners, not standing alone outside of medicare's protection, but jostling with numerous other groups of patients pressing for expansion of insured services.

The principle of comprehensiveness has never meant coverage for every treatment or service that improves health. Since at least passage of the CHA, many beneficial and highly effective health services, such as prescription drugs, have not been insured. This is not unusual or surprising. Unless publicly funded health care has an unlimited budget, every medicare system must have a method of distinguishing between those health services provided at public expense, and those that it leaves to an individual's own resources to finance. In Canada, comprehensiveness, which means insured health services, has been generally demarcated in the CHA as medically necessary services that are delivered in a hospital or by a physician.⁸³ The source of the treatment is the major litmus test of insurability. The treatment for which the petitioners sought public funding, LAT, did not meet either criterion, as it is delivered by therapists outside of hospitals. Nevertheless, in the lower court Justice Allan ruled that IBI was a "medically necessary service," accepting one expert's broad definition of medical treatment as "whatever cures or ameliorates illness."⁸⁴ Since British Columbia's legislation permits the Minister of Health to prescribe a profession or occupation as a "health care profession" for insurance purposes, the Minister could bring therapists who deliver LAT under medicare. Accordingly, Justice Allan held that nothing in the legislation precludes the delivery of IBI within the province's medicare scheme.⁸⁵

"The Purpose of Canadian Equality Rights" (2002) 6 Rev. Const. St. 291). Allocative decisions, such as the scope of funding under medicare, can raise questions of distributive justice that are integral to citizenship. For the reasons outlined in Part IV of this comment, we do not conclude that *Auton* is such a case.

⁸³ CHA, *supra* note 75, s.2 and 9: Comprehensiveness covers insured health services, which are defined as hospital services, physician services, surgical-dental services (surgical dental procedures performed in a hospital), and, where the law of the province permits, services rendered by other health care practitioners; hospital services are defined as "medically necessary" ones and physician services as "medically required" ones, but these two phrases themselves are not defined.

⁸⁴ *Auton* #2, *supra* note 5 at para. 102.

⁸⁵ *Ibid.* at paras. 103, 109. If B.C.'s legislation had *not* given the Minister the power to designate health care practitioners for insurance purposes (a power that s.9 of the CHA does not require as a condition of federal funding), the constitutional validity of the CHA's criteria would have been squarely before the courts. In that circumstance, bringing IBI under medicare's umbrella would have required judicial rewriting of the CHA and the provincial legislation, which might have resulted in more sustained discussion of the ramifications of erasing those criteria.

This leads us into our second point about the courts' handling of the CHA. In essence, the courts brushed aside the CHA's two primary criteria for insured services (hospital or physician delivery) as constitutionally impermissible without sufficient consideration of the profound consequences of extending coverage to health services regardless of their source. For example, since all prescription drugs are medically necessary services under the courts' definition, provinces without pharmacare programs are violating *Charter* rights. Indeed, with the *Auton* reasoning, Canadians will acquire fully comprehensive medicare, which they have never had before, through litigation. Such a system, however, would require an unlimited budget.⁸⁶ While the CHA criteria for insured medical services do not draw a perfect line (no line ever does), erasing the line ought to be accompanied by careful scrutiny of replacement criteria and the cost of extending medicare's ambit upon implementing those criteria.⁸⁷

Third, it is troubling that no attention is paid to the antecedent issue of distinguishing health services from educational and social services. Justice Allan considered the issue "to be primarily a health issue,"⁸⁸ not education or social services, but does not elaborate on the reasons for reaching that conclusion. This is unfortunate. At first glance, IBI looks more like educational services than medical services. It is delivered by trained therapists, in much the same manner as educational services are delivered to other special needs children in schools. Moreover, the treatment does not "cure"⁸⁹ the children, but ameliorates behavioural symptoms; the goal is to teach children skills and behaviour that more closely approximate the behaviour of children without the condition. Granted, there are difficult questions about the line between medical and educational services. Our point is that, at a minimum, it seems reasonable to investigate more fully whether IBI is more akin to an educational service.

The question of whether IBI treatment is a medical, educational, or, for that matter, a social service is important because the categorization is critical to the constitutional analysis. It determines, for the purposes of the s.15 claim, the comparator groups. To illustrate, if IBI is seen as medical treatment, then the petitioners' claim for funding is compared against the funding given to other patients. The health care system is by common understanding Canada's most valued social program and as a consequence is

⁸⁶ The lower court's standard of "whatever cures or ameliorates illness" is much too broad to usefully demarcate insured from non-insured health services; with that standard, the health care budget could easily swallow all of a government's resources.

⁸⁷ Flood and Choudhry, *supra* note 81 at 9-11, in their excellent discussion of the CHA principles, propose a process for determining insured services, one that rests on evidence of effectiveness for medical treatments. Their proposal would give primacy to evidence-based decision-making in health care.

⁸⁸ *Auton* #2, *supra* note 5 at para. 88; see also para. 153.

⁸⁹ In *Auton* #2, *ibid.* at paras. 31 and 45, the court accepts that LAT is not a "cure"; presumably, very young children who receive it during the "window of opportunity" are not cured, but instead have the highest likelihood of benefitting from it.

very generously funded. Medicare, its biggest plank, covers a wide, but not limitless, array of medical services for every citizen from birth to death. Plaintiffs will have a better chance of showing that they are disadvantaged if they compare themselves to groups of patients in the relatively well-paved corridors of Canadian medical care. By contrast, if the service is classified as educational, then the plaintiffs' treatment is compared to that of other pupils. Public education is not quite so richly endowed. It is only universal for people between the ages of five and nineteen; teachers are employees, not paid on a fee-for-service basis; and a host of educational programs that would dramatically benefit children are offered sporadically, if at all. An even smaller share of public resources is usually directed toward social services; moreover, its standards for entitlement are much stiffer, and the range of competing needs is even more basic. If IBI therapy is defined as a health care service and competing for dollars on the relatively rich playing field of health care, an obligation to fund would emerge more readily. However, what is discriminatory in health care might be less so under education or social services. In short, it would presumptively be better for plaintiffs to approach the s.15 analysis as patients, not as pupils or poor people. When programs raise important issues of equity, as this one does, the analysis should address these categorization questions. Otherwise, resources will be skewed toward those groups who have the good fortune of fitting their claims into the richest programs.

B. Evidentiary Questions

In this case the evidence was not compelling. At the centre of the petitioners' arguments were four children with autism who had received, or were receiving, LAT. We have noted that the lower court appeared to base its finding that these four children improved *as a result of* LAT solely on the affidavits of the parents.⁹⁰ It seems odd, to say the least, that such a critical finding of fact about a controversial and complex matter (i.e. the effectiveness of a treatment for specific individuals) could be based exclusively on the non-expert opinion of a party to the litigation. In fairness to Justice Allan, perhaps there was other admissible evidence that established a causal connection between the treatment and improvement in the children's condition. However, if there was, it was not highlighted in the judgment.

If one accepts that the children improved over time, and that they improved while receiving LAT, such anecdotal evidence is questionable on two counts, both of which are important to describe because they will arise in future cases about health care funding for specific treatments. First, the children may have improved anyway, in which case there is a classic confusion of correlation with causation. Second, the four cases in question may have constituted a small sub-group, quite unrepresentative of the

⁹⁰ See text to notes 46-47, *supra*.

general population of children with autism, who apparently benefited where many others would not.⁹¹

Scientific studies about the effectiveness of specific treatments are designed to address questions such as these. For instance, if well-designed scientific studies cumulatively show that a particular health treatment ameliorates an illness in, say, 70 per cent of cases (and there is no improvement in similar cases not so treated), it is reasonable to conclude that the treatment caused the improvement. For this reason, the scientific studies introduced in the lower court about the effectiveness of LAT were relevant, at least with respect to any remedy that included an order specifying LAT. In the lower court, after spending twenty paragraphs summarizing the contested scientific evidence about LAT, Justice Allan said that she did not need to "descend further into the ongoing debate"⁹² in the medical and scientific journals about LAT because she had concluded that the Court could not direct the government to provide LAT specifically. However, at the Court of Appeal, these questions regained their immediate relevance because that Court ordered the government to provide LAT for the four child petitioners. In the absence of any judicial finding about LAT's effectiveness based on scientific studies, the Court's remedy was based on the parents' affidavits, which, as we have noted, is a shaky evidentiary foundation for an interventionist ruling.

It is also important to highlight that the courts did not assess the overall effectiveness rate of IBI generally. As we have pointed out, the effectiveness rate is described in general language: "some children" and "many cases"⁹³ by the lower court and a "realistic prospect"⁹⁴ by the Court of Appeal. This omission is unfortunate because the effectiveness rate plays, or ought to have played, a central role in the *Charter* analysis. Surely it makes a difference to policy decisions about funding if the success rate of treatment is 5% or 50%. A low effectiveness rate would explain, if not justify, the government's unwillingness to fund LAT, the IBI treatment requested by the parents, especially in light of its financial obligations to other special needs children and patients.

In the lower court, Justice Allan describes the IBI programs that other provinces, such as Alberta and Ontario, have introduced to treat children with ASD.⁹⁵ Can the fact that other provinces provide IBI for children with ASD constitute evidence of sufficient effectiveness to justify the public expense? In other words, is it reasonable for courts to conclude that funding of a treatment in other provinces is sufficient evidence of effectiveness for the

⁹¹ This is exactly one contentious point about the Lovaas study – whether the children in his study were representative.

⁹² *Auton* #2, *supra* note 5 at para. 50.

⁹³ *Ibid.* at paras. 51-52.

⁹⁴ *Auton* (CA), *supra* note 3 at para. 49.

⁹⁵ *Auton* #2, *supra* note 5 at paras. 69-83. The judgment begins, in para.1, by quoting from an Ontario government report about its program.

purpose of grounding a *Charter* claim? The conceivable defense of this approach would be that assessing the effectiveness of health treatment is expensive and often time-consuming, and it is cost-effective to consider determinations made by provinces.

If the objective is a better health care system for everyone, courts should not blithely accept the mere fact of funding programs in other provinces as conclusive evidence that a treatment is cost-effective. Many programs are introduced for various political reasons, and their effectiveness may not withstand close scrutiny. Indeed, according to one Canadian expert, Dr. Eric Fombonne, treatment for autism falls into this category. In a recent article, he states that one important research question involves exploring the link between social policy favouring substantial funding and weak empirical evidence.

Finally, the current social context seems to exert a stronger influence on the debate than the scientific arguments. Although claims about an epidemic of autism and about its putative causes have the most weak empirical support, the subsequent controversy has put autism on the public agenda. In recent years, children with autism, their families, and professionals involved in their care and in research have seen welcome and legitimate increases in public funding. Yet, ironically, what has triggered substantial social policy changes in autism appears to have little connection with the state of the science. Whether this will continue to be the case in the future remains to be seen, but further consideration should be given to how and to why the least evidence-based claims have achieved such impressive changes in funding policy.⁹⁶

In our view, instead of accepting the existence of programs elsewhere as evidence of effectiveness, courts should ask for the basis on which programs were introduced. Doing so is consistent with, and would support, acceptance of evidence-based decision-making. As we have noted, one advantage of courts is that they can require governments to give reasons for decisions. Ergo, they can ask for the reasons why programs were introduced in other provinces. Doing so will assist in implementing evidence-based decision-making, and perhaps arrest the political domino effect in health care services (by this we mean that an expensive service, such as MRI, is introduced in one province and quickly becomes the focus of political lobbying in other provinces.)⁹⁷

⁹⁶ Fombonne, *supra* note 20 at 88-89.

⁹⁷ Without close scrutiny of the evidentiary basis for other provinces' programs, court orders will generate a similar domino effect. If funding for treatment in other provinces is, by itself, a persuasive reason to order government funding, court orders will generate a 'forced march to the top'. It is not an accident that the two provincial programs that receive the most attention in *Auton* are in the two wealthiest provinces, Ontario and Alberta. If there is to be a forced march to the top, its prod should be cogent evidence, not successful political lobbying. Without such cogent evidence, provinces should be free to establish their own priorities with their limited resources; for instance, Fetal Alcohol Syndrome and Fetal Alcohol Effects (FAS/FAE) is more prevalent in some provinces than others.

The plaintiffs also had an easy time because the lower court found that IBI was the only effective treatment for ASD.⁹⁸ Thus, the case is unusual because there were no arguments about the relative effectiveness of the preferred treatment (IBI in this case) as compared to other treatments for the same condition, which is one of the critical health care decisions that must be made daily.

C. *The Section 15 Analysis*

We have noted in Part IV (A) the significance of whether IBI is classified as medical, educational or social services for the purposes of selecting the comparator group in s.15 analysis. Assuming that the appropriate funding program is health care, further questions arise about the courts' selection of the comparator group for s.15 analysis. It is not obviously compelling why the comparator group is restricted to non-autistic children, and adults with mental disabilities, when the government's health care system is charged with providing all medically necessary services *for the entire population*. The government argued, quite properly in our view, that the appropriate comparator group was all members of the Medical Services Plan (i.e. all eligible residents of the province).⁹⁹ It pointed out that other members of this group do not have all of their health care needs covered by medicare.¹⁰⁰ In other words, the government's argument began with the reality that the health care system is not, and never has been, comprehensive, in the sense of addressing all medical needs all of the time. As a consequence of scarce resources, frequently governments do not fund effective treatment (e.g. most prescription drugs, hearing aids) because of policy decisions that most people should pay for the treatment themselves. Sometimes they do not fund treatment because it is ineffective, or its effectiveness does not justify the expense.

If courts want to encourage governments to implement more evidence-based decision-making, and rationality across the board in its health policy decisions, it would follow that assessing claims of discrimination should take account of the entire system of health care because that is what a government will be assessing when it makes allocative decisions.¹⁰¹ We hasten to add, of course, that accepting the government's comparator group would not lead

⁹⁸ In this comment we do not take issue with the trial judge's finding that IBI is the only effective treatment. However, it is worth noting that the medical literature discusses other treatments, including other forms of early interventions. McGahan, *supra* note 7 at p. iv, calls for "improved research methods to provide more reliable evidence of therapeutic effectiveness" and comparison of "the value of early intensive behavioural therapy to other early interventions for autism."

⁹⁹ *Auton (CA)*, *supra* note 3 at para. 32, Justice Saunders stated that the comparator group of all patients was too broad to permit adequate comparison.

¹⁰⁰ *Ibid.* at para. 30.

¹⁰¹ In defense of the courts' acceptance of these comparator groups, it must be noted that in the leading *Law* decision, *supra* note 51, the Supreme Court states that an equality analysis

inexorably to a government victory. Rather, in light of the non-comprehensive nature of public funding for health care, the appropriate question would be whether this group of patients (children with ASD) is being denied a health service as effective as the health services provided at public expense to patients with other conditions. Once again, to belabour the point, the effectiveness rate becomes critical.

Even if one accepts the narrow comparator groups used by the courts, there are difficulties with the judgements. The courts do not refer to any evidence that patients within these two groups (other children; adults with mental disabilities) were receiving a health care service whose scientific underpinnings and general effectiveness were as contested as LAT or IBI more generally. Both courts appear to assume that people in the two comparator groups are receiving, at full public expense, treatments as effective, or less effective, than LAT or other forms of IBI. This may well be the case, but one would expect evidence for this point. The Court of Appeal refers to the fact that "other serious, and indeed less serious conditions are treated" as evidence of discrimination,¹⁰² but this is insufficient by itself.¹⁰³ What must also be addressed is the effectiveness rate of the treatment, not solely the seriousness of the condition. To take an obvious example, cancer is a serious condition, but few would advocate public funding of laetrile treatment for cancer patients, since it is dubious treatment with no proven effectiveness.

This leads into our second point. When courts approach claims for expanding the scope of insured health services, their findings of discrimination need to incorporate more clearly several vital aspects about medical treatments. In deciding to fund treatments, officials in the health system apply, or should apply, three tests: a) is there a need?; b) is the need addressable by therapies that are known to be within the usual bounds of effectiveness?; and c) is the cost of those therapies acceptable?¹⁰⁴ For the purposes of upholding the discrimination claim in this case, the judicial reasoning concentrated heavily on the first test— is there a need? With respect to the second test, the lower court accepted the questionable evidence of effectiveness for the four infant petitioners, and dealt with the expert

should usually use comparator groups chosen by the plaintiffs. We wonder whether this presumption is sustainable in the health care context, where the government must allocate health care resources amongst a population that, by definition, needs health services, and thus possesses a disability in constitutional terms. The comparison will always be between groups of plaintiffs with disabilities, and given the enormous variability of conditions and treatments, it will always be possible for plaintiffs to propose comparator groups that place the government's action in the most unfavourable light.

¹⁰² *Supra* note 3 at para 49.

¹⁰³ Moreover, it may also be the case that other serious neurological conditions do not receive funding to ameliorate behavioural symptoms. For instance, treatment programs for young offenders with FAS/FAE have been unavailable in at least one province: *R. v. L.E.K.*, (2000) 203 Sask. R. 273 (C.A.) at para. 51.

testimony about effectiveness rates for LAT quite cursorily. The troubling feature of the reasoning is the implicit finding that it is discriminatory for governments not to spend money to alleviate suffering, without more careful attention to the effectiveness of the treatment for the group as a whole. The effectiveness rate was critical in this situation; medical science may simply not be sufficiently advanced to respond effectively to the condition. On these facts, the Court of Appeal's conclusion that non-funding indicates that "the community is less interested in their [autistic children's] plight"¹⁰⁵ seems like a harsh indictment to infer from the facts. The community may be as interested in their plight as it is with other victims, but medical science may not offer much hope of alleviating that particular plight.

It is important to note here the differences between this case and the facts of the leading Supreme Court decision, *Eldridge*.¹⁰⁶ In that case, the government argued that its failure to fund sign language interpreters for deaf patients was not discriminatory because deaf patients were receiving exactly the same health services as other patients, and their condition (deafness) created the discrimination, i.e. their inability to take advantage of service providers who used the spoken word. The Court rejected this argument, saying that this was an impoverished vision of equality. We agree with this conclusion. The *Eldridge* plaintiffs were asking for the same services as all other patients, and the government was properly obligated to accommodate their disability so that they could enjoy those services. In the language of the CHA, the case involved the principle of accessibility. By contrast, the *Auton* plaintiffs are asking for health services to ameliorate their disability. The equivalent request in *Eldridge* would have been if the deaf patients had asked to have their deafness treated so that they would no longer be deaf. That is emphatically what they were not asking for; rather they wanted changes in the social circumstances of delivering health services to recognize, accept, and accommodate their deafness.¹⁰⁷

In *Eldridge*, the Supreme Court articulated what has come to be called the social model of disability. Under this approach the disability, or the nature of the condition, is not the problem; rather, the problem is society's response to it, specifically a prejudicial or exclusionary response grounded in negative stereotypes about disabled people.¹⁰⁸ Society has a duty to accommodate

¹⁰⁴ Under s.15, the Court of Appeal did not deal with the third test (is the cost of the therapies acceptable?), although this is understandable since the question of costs is usually reserved for the s. 1 analysis.

¹⁰⁵ *Supra* note 3 at para. 51. The failure to fund IBI and its variant LAT may not indicate "less interest" but result, rather, from a calculation that the benefits of the treatment, given its controversial effectiveness rate, do not outweigh the costs, in light of the needs of other special needs children and other patients, whom communities must consider in allocating resources.

¹⁰⁶ *Supra* note 19.

¹⁰⁷ The *Auton* facts are more closely analogous to the facts in *Cameron*, *supra* note 24, where plaintiffs were seeking funding to help alleviate their infertility.

¹⁰⁸ See also *Granovsky v. Canada (Minister of Employment and Immigration)*, [2000] 1 S.C.R. 703.

people with disabilities as far as reasonably possible so that they can lead lives rich with opportunities despite the disabilities. The social disability model is essential to protecting the dignity of persons with disabilities, and including them as full members of the community. However, in the health care context when plaintiffs seek services to remove the disability altogether, or ameliorate the symptoms of a disabling condition, the social model of disability may need fine-tuning.¹⁰⁹ Some disabilities are permanent and untreatable, while for others, medical science does offer considerable hope. In deciding whether to fund treatments that attempt to cure illnesses or ameliorate symptoms, questions about the nature of the condition, the effectiveness of treatment, and its cost are important factors for governments to consider.¹¹⁰

D. The Section 1 Analysis

Given the large amounts of money at issue here, and the questions of equity with respect to other patients when this amount of money is directed toward one group, one would expect careful attention to the *Oakes* factors. However, neither court attempted to quantify in either clinical or economic terms the cost-effectiveness for IBI. Strikingly, the judgments contain no cost-benefit analysis of the expected benefits of the treatment in terms of cost per quality-adjusted life-year (QALY), disability-adjusted life year, or other commonly used metric. In the lower court, Justice Allan said that the cost of paying for effective treatment “may well be more than offset by the savings achieved by...[the costs associated with]a life of isolation and institutionalization.”¹¹¹ Whether this is the case, rather than *may* be the case, depends on the effectiveness rate.¹¹² The Court of Appeal’s cost-benefit

¹⁰⁹ P. Carver, “Disability and the Allocation of Health Care Resources: The Case of Connor Auton” (2001) 12 *Health Ethics Today* 6. online: *Health Ethics*, <http://www.ualberta.ca/bioethic/HETVol12No1/page6.html>.

¹¹⁰ To use a simple example, short-sightedness is a medical condition that needs treatment. Corrective lenses are almost 100% effective in ameliorating the disability associated with the condition. A government can legitimately decide that it will not pay, either fully or in part, for corrective lens because more serious conditions deserve funding. Nor, with serious conditions, do governments need to take a flyer on whatever medical intervention might possibly remove the disability. For a discussion of factors in ‘scope of coverage’ claims, see B. von Tigerstrom, “Human Rights and Health Care Reforms: A Canadian Perspective” in T. Caulfield and B. von Tigerstrom, eds., *Health Care Reform & the Law in Canada: Meeting the Challenge* (Edmonton: University of Alberta Press, 2002) 157 at 166-77.

¹¹¹ *Supra* note 5 at para. 147. We agree that long-term costs must be considered throughout the health care system. Indeed, placing more emphasis on reducing long-term costs would significantly alter spending priorities; for one thing, more resources would shift into preventative programs, such as prenatal care and preschool programs for poor families. For a general discussion of ways of improving population health, see the Fyke Report, *supra* note 31 at 35-42.

¹¹² In *Auton* #2, *supra* note 5 at para. 145, Justice Allan noted that “it is not possible to

analysis is shorter, consisting of references to the individuals' and the community's benefit if treatment is provided, and the terrible consequences if it is not.¹¹³

Instead of a careful assessment of s. 1 factors, the Court of Appeal invoked its *parens patriae* jurisdiction to uphold the lower court's decision that the government had not satisfied its s. 1 burden. This manoeuvre gave the Court an ostensible response to the fears of opening Pandora's Box if it intervened in health care funding: because the treatment was for children, the Court could distinguish the case as unusual. However, this manoeuvre was problematic for two reasons.

First, the Court of Appeal did not provide an evidentiary basis for giving special protection to children in the area of health care policies. While current information and evaluation systems may make it difficult to prove with hard numbers whether the needs of children receive discriminatory or preferential treatment in the health care system,¹¹⁴ the visible signs suggest that children are not disadvantaged within the health care system, but privileged. For instance, even though children are usually healthy, there are dedicated children's hospitals in most major urban centres in the country. By contrast, the elderly are obviously the sickest part of the population (and quite properly receive a huge amount of resources), but there are almost no geriatric acute care hospitals designed especially for their needs. As well, in spite of the huge concentration of need among the elderly, in 2002 there were only 183 geriatricians in Canada, as compared to 2095 pediatricians. Adults, but not usually children, frequently wait for a long time for elective surgical procedures. Furthermore, while children may not be able to advocate for themselves, they usually have two powerful allies: their parents, and a general societal bias in favour of youth. Overall, the Court's implicit assumption that sick children are disadvantaged and need its special *parens patriae* jurisdiction to ensure receipt of a fair share of health care resources seems, at best, counter-intuitive.

The Court might have stood on stronger ground had it stressed only that these children were suffering a mental disability. At least with respect to people with mental disabilities, an assertion of vulnerability is not counter-intuitive. While there are specialized hospitals for people with mental illnesses, there are also long waiting lists for access to children's mental health services, particularly for teenagers.¹¹⁵ Further examination may well show that children with mental disabilities generally receive a

estimate accurately the additional immediate costs of a treatment program or the inevitable savings in the long run." This is correct, but it is possible to offer reasonable estimates if one has the success rate for treatments.

¹¹³ *Auton (CA)*, *supra* note 3 at para. 65.

¹¹⁴ Proof would be difficult, but not impossible, because health care dollars are not categorized in this way.

¹¹⁵ See e.g. Gina Browne *et al.*, "The Current Status of Mental Health Services for School-Aged Children and Youth in Ontario" (McMaster University, System Linked Research

disproportionately smaller share of health care resources. However, even if one limits the inquiry to children with mental disabilities, that does not by itself justify exercising the *parens patriae* jurisdiction for children with ASD. A further evidentiary base would be necessary, as it may also be the case that children with ASD receive a disproportionately larger share of resources than other children with mental disabilities. One area that invites inspection is treatment for children with FAS/FAE, who often, due to the causes of their condition, do not have parents fighting on their behalf.¹¹⁶

Second, one practical result of the Court's approach is that it creates no incentive for governments and their agencies to improve the transparency, and rationality of health care decision making. What would be the point of using a clear and comprehensive system of setting priorities in health care if courts will bring into play vague principles? We believe that the courts missed an opportunity to signal governments about the importance of justifying their decision-making more thoroughly and transparently, which consequently would improve the health care system overall. Recall that with respect to justifications under s.1, the government argued the following:

the choice made by those administering health care services in the province was a rational allocation of resources, i.e. reasonable and demonstrably justified. ...a decision in favour of the petitioners will impel the necessarily complex administrative choices required to be made in the course of balancing the myriad and competing demands for health care, into the courts for decision on the allocation of scarce resources on a case by case basis, rather than on a comprehensive and systematic basis.¹¹⁷

In our view, at this point the Court should have said to the government – “okay, show us how you made this necessarily complex decision. Articulate the factors that you took into account, and the administrative choices that you made. Since you are asserting that decision making is ‘comprehensive and systematic,’ show us the comprehensive system that you use.” In short, the Court would accept the government's assertion about having rationally allocated its resources on a “comprehensive and systematic basis”, and reply with three words: where's the proof? In the absence of such proof, the

Unit: 2001) online : McMaster University http://www.fhs.mcmaster.ca/slru/paper/Current_Status_of_Mental_Health.pdf.

¹¹⁶ Children with FAS/FAE have been exposed to alcohol *in utero*. They are more likely to have mothers with addiction problems, and appear more likely to be the subject of child protection orders. One Saskatchewan study found that only 25.6 % of children with FAS/FAE lived with their biological parents when last seen at a provincial child development centre: B.F. Habbick *et al.*, “Foetal Alcohol Syndrome in Saskatchewan: Unchanged Incidence in a 20-year Period” (1996) 87 Can. J. Public Health 204. Many of the children are Aboriginal; E.A. Loney *et al.*, “Hospital Utilization of Saskatchewan People with Fetal Alcohol Syndrome” (1998) 89 Can. J. Public Health 333, found that 88% of hospitalized people with FAS/FAE were Aboriginal.

¹¹⁷ *Auton (CA)*, *supra* note 3 at para. 56.

government's burden under s.1 would not be met.¹¹⁸ With this approach, the Court would be asking the government to *illuminate* its decision-making system as a necessary part of its s.1 defense, to prove the comprehensive and systematic basis of decision making rather than assert it.

This response would have signalled to government the importance of developing more defensible methods of health care decision-making. Assuming the government had picked up the gauntlet, the Court's prod would have furthered the aim of shedding light on the decision process. Moreover, a response along these lines may be required by the *Oakes* test, which is designed to illuminate the factors that a government took into account in deciding to limit a right. The different parts of the *Oakes* test demand that a government discloses its process of decision-making; the two-stage test requires articulation of means, ends, and consequences of decisions.

E. Remedies

The litigation raised difficult remedial questions. Justice Allan recognized the interventionist nature of ordering governments to provide a particular health treatment. She refused to specify that the government provide LAT, saying that the treatment choice must remain with governments. However, one aspect of the Court of Appeal's remedial order is problematic from an evidentiary perspective.

The Court of Appeal ruled that the four infant petitioners were to receive LAT, at full public expense, until medical practitioners determined that the treatment was no longer of significant benefit to them.¹¹⁹ It is remarkable that the Court ignored the age limit on IBI for these four plaintiffs. Given that trained therapists are a scarce resource, its order means that the four plaintiffs are at the front of the line for treatment, and receive it well past the time allotted for other children with ASD, even if those other children would benefit more than the four plaintiffs. Surely such an untoward result would need compelling justification, but the Court does not give any cogent reason for favouring these four plaintiffs.

The Court's failure to address the likely 'wait time' problem with ordering LAT for four children well past the critical treatment age is not a trivial point. Health care personnel are frequently in short supply, especially in specialized fields. This is one cause of longer-than-desirable wait times; trained personnel are a scarce resource, and there must be a method of

¹¹⁸ In this particular case, if evidence about the "comprehensive system" was not already before the Court, it could have asked counsel to provide it, in a manner similar to the Court of Appeal's request for submissions on the *parens patriae* jurisdiction (*ibid.* at para. 8). More generally, if the Court had said "prove it" in this case, it would have been signaling governments to develop comprehensive systems for future cases.

¹¹⁹ *Ibid.* at para. 92

allocating them. With IBI, how to allocate trained therapists among children with ASD is a central question. Requiring funding IBI for children older than six will have, at least in the short term, a potentially disastrous effect on IBI for younger children. Generally, unless the supply of trained therapists meets or exceeds the demand, any extension of the right to fully funded IBI is a reallocation of the service.

Earlier we stated that governmental decisions about health care services should be transparent and based on the best available evidence, just as judicial decisions have publicized reasons and are based on evidence. Unfortunately, the Court of Appeal's decision to exempt these four plaintiffs from the age limit does not meet this standard, but falls prey to the dangers of telescopic vision. The Court focuses on the four petitioners before it and does not see the larger context, even within the segment of the health care field that pertains to autism. In addition, it ignores a key evidentiary point, namely that the treatment's effectiveness (whatever the rate might be) diminishes precipitously after a certain age. Hence there are two flaws: one, privileging the four children without considering the possible impact on other children with ASD; and two, mandating an essentially open-ended duration for expensive treatment when the window of opportunity is narrow.

This portion of the Court's reasoning takes us back to our opening comment about how hard cases can make bad law. One reason why cases are hard is because they arouse people's emotions. When suffering individuals are before the court, judges will want to give comfort to them, and in order to do so, they articulate rules or order remedies that may not do justice to a larger group; hence, the hard case has made bad law. We hearken back to the dangers encapsulated by this maxim because these cases will be common in the health care field. Sympathetic plaintiffs will be the norm. Empathy for the individuals in court needs to be tempered with empathetic appreciation of those people who are not in court, but who will be negatively affected by the decision's consequences. Otherwise, health care resources run the risk of being skewed unfairly toward those individuals with the financial, social and familial resources to pursue litigation.

V. Toward Evidence-Based Decision-Making

Among the laudable ideals for health-care, eloquently repeated in every major health care review and report, are evidence-based decision-making, accountability, and value-for-money. Suppose we had a national or provincial system that put these principles into practice. There would be clear and transparent processes for evaluating the worth of both existing and proposed new services. There would be a constant culling of practices once thought useful on the basis of new evidence showing them to be ineffective. Efficiencies shown possible by sound research would swiftly become standard practice. Governing boards and senior managers would constantly monitor whether service patterns correspond to needs and equity concerns

are addressed. There would of course be gray areas and inevitable uncertainties, but principled vigilance would be standard practice.

In such a world, governments would present a much stronger defense of their decisions not to fund controversial treatments, such as LAT. Consider the situation in *Auton*. First, the evidence-based system would have assessed LAT using the same scientific and distributive principles applied to other resource allocation decisions. Hence the government's s.15 argument about non-discrimination would have inevitably been more robust. Second, s.1 would have been more central to the litigation, not least because the health care system would in effect be doing s.1-type analysis as a matter of course in conducting its business. The government could have sought to demonstrate that the decision to withhold funding for LAT or IBI was a reasonable abridgement of rights on two related grounds. First, the therapy has not firmly been established as effective on the basis of high-quality scientific trials—ideally randomized controlled studies, but failing these, large and well-controlled observational studies. Results of clinical trials are becoming available¹²⁰ but they are typically small (under 20 children in the treatment and control groups), the treatment modalities vary, and the reported improvements are not always easily interpretable.¹²¹ Second, even if the therapy is regarded as effective in some cases, the costs may be so disproportionate to the benefits as to be unsustainable given competing, and equally or more legitimate claims for resources and treatment. The government might conceivably have produced a list of proposed new technologies, programs and services for chronic conditions, which it had conscientiously and thoroughly evaluated, and assigned LAT a priority rating based on sound criteria.

All of this would have demonstrated government's (and its agencies') sensitivity to the spirit and provisions of the *Charter*, and a systematic, principled approach to resource allocation decision-making. These would constitute a far more impregnable bulwark against interest-based *Charter* challenges, and a less tempting conceptual and evidentiary void into which plaintiffs could persuade the courts to move. The courts' traditional deference rests, implicitly, on confidence in the decision-making processes of public

¹²⁰ See e.g. S. Eikeseth *et al.*, "Intensive behavioral treatment at school for 4- to 7-year-old children with autism: A 1-year comparison controlled study" (2002) 26(1) *Behav. Modif.* 49-68; J. Salt *et. al.*, "The Scottish Centre for Autism Preschool Treatment Programme. II: The Results of a Controlled Treatment Outcome Study" (2002) 6 *Autism* 33.

¹²¹ McGahan, *supra* note 7 at p. iv, summarized her findings as follows: "Though limited, findings of existing studies suggest that preschool children with autism exhibit cognitive and functional improvement when receiving behavioural intervention with applied behavioural analysis for approximately 20 hours per week or more. It is not clear, however, which subset of children with autism derive the most benefit, which components of therapy are integral to positive outcomes, whether similar benefits would be observed in older children with autism, whether there are definable long term functional benefits, or whether reported gains in IQ translate into happier people with greater functioning in the community."

bodies. In the *Auton* case, the courts must have found the decision-making apparatus sufficiently faulty to sustain a challenge that on the surface (i.e. on the basis of the plaintiff's evidence) is less than compelling.

The current situation in health care decision making, with its imperfect processes and politically charged decisions, can be fruitfully exploited by plaintiffs in the future to guard against the possibility of a damaging s.l defense by the government. They could emphasize that existing health care dollars can be spent more effectively by providing the treatment that they want, rather than providing other services. In *Auton*, the petitioners did make this argument: "[t]he petitioners also suggest that a great deal of the money spent by the government is misdirected."¹²² This line of argument could be strengthened by pointing out that some experts argue up to 30% of existing health care budgets could be saved and reallocated while improving quality,¹²³ and perhaps 50% of medical interventions lack a 'gold standard' evidentiary foundation.¹²⁴ Following this logic, plaintiffs can claim discrimination on the grounds that the evidence for controversial treatment, such as LAT, may be at least as strong as the evidence supporting a group of current practices known to be of uncertain value or even clearly wasteful.¹²⁵

¹²² *Auton* #2, *supra* note 5 at para 146.

¹²³ D.M. Berwick, *As Good As It Should Get: Making Health Care Better In The New Millennium* (Washington, DC: National Coalition on Health Care, 1998), online: Institute for Healthcare Improvement <http://www.ihl.org/newsandpublications/articles/ci0801asgoodas.asp>.

¹²⁴ This is of course hotly debated territory. The "gold standard" for medical evidence is the randomized controlled trial (RCT). Some research has attempted to quantify the proportion of medical practice based on RCT evidence. A Swedish study estimated about half of internal medicine was backed by RCT evidence, with higher proportions in cardiology and other circulatory diagnoses (A. Nordin-Johansson and K. Asplund, "Randomized controlled trials and consensus as a basis for interventions in internal medicine" (2000) 247 *J. Intern. Med.* 94). A study of a UK inpatient psychiatry ward found RCT support for 2/3 of the therapies: J.R. Geddes *et al.*, "What Proportion of Primary Psychiatric Interventions are Based on Evidence from Randomised Controlled Trials?" (1996) 5 *Quality Health Care* 215. A Hong Kong study (A.C. Hui *et al.*, "The practice of Evidence-Based Medicine in an Acute Medical Ward: Retrospective Study" (2000) 6 *Hong Kong Med. J.* 343) found half of the drug prescriptions for hospitalized patients were supported by RCT evidence. Intriguingly, a review of decision-making by a UK health authority (analogous to some extent to a Canadian Ministry of Health or health region) found that only a third of its decisions were supported by RCT evidence: P. Johnstone & P. Lacey, "Are Decisions by Purchasers in an English Health District Evidence-based?" (2002) 7 *J. Health Serv. Res. Policy* 166. Another study found no correlation between the strength of evidence underlying proposals for funding submitted to a UK health authority and final priority rankings: S. Dixon, A. Booth & K. Perrett, "The application of evidence-based priority setting in a District Health Authority" (1997) 19 *J. Public Health Med.* 307. However, many argue that the RCT standard is unrealistically stringent, not least because it would be unethical or otherwise unrealistic to use this methodology for every conceivable intervention, but also because it excludes from consideration important evidence derived from other methodologies.

¹²⁵ See e.g. R. Tamblin *et al.*, "Unnecessary Prescribing of NSAIDs [non-steroidal anti-

On this reasoning, providing the desired treatment, such as LAT, would not, in the end, require the government to spend new money because there are ample opportunities to finance it by reallocating money misspent elsewhere in the system on ineffective treatments. At the very least plaintiffs could argue that the disputed treatment falls within the normally accepted range of cost-effectiveness prevalent in the health care system.

This argument is available in future litigation, whether about funding for LAT or other controversial treatments, because of the general state of disorder within the health care house. That the courts in *Auton* accepted the discrimination argument and dismissed the s. 1 justification on a very modest body of evidence may suggest a level of judicial concern with and frustration about the transparency and, ultimately, defensibility of government policy-making and resource allocation. The prospect of similar decisions arising from such concerns should signal to governments that they need to accelerate the process of measuring what health care achieves, and prioritize expenditures more defensibly. Some recommendations of National Forum on Health, and the recently released Romanow Report, seek to promote this objective of evidence-based decision-making.¹²⁶ The risk of judicial intervention is another reason to pay heed to these proposals and others in a similar vein.

However, even in the absence of a comprehensive and transparent system of resource allocation, governments might be able to make a stronger case for the rationality of health care resource allocation practices. Cancer therapy protocols are often strongly science-based and subject to continuous evaluation and revision. Moreover, and germane to the issues in *Auton*, cancer control agencies do not as a rule approve therapies that have not undergone a rigorous clinical trials process. They certainly do not accept as conclusive evidence the results of a few case histories. Similarly, pharmacare programs must decide which drugs are to be covered and excluded in their formularies. The provincial formularies have scientific review committees and processes that assess the costs and benefits of new drugs, determine the conditions under which they should be publicly financed, and compare the cost-benefit ratios with those of other drugs. Assessing drugs is simply a species of therapeutic evaluation whose principles and methods could be extended to any health care intervention. Formulary decisions are often hotly contested by patients, physicians and manufacturers. Furthermore, governments sometimes reverse decisions based on cost-effectiveness analysis in response to political pressure (a prime example being the decision of many governments to supply beta- interferon for patients who suffer multiple sclerosis).¹²⁷ But at least the government is able to produce evidence of how it makes resource allocation decisions. It might reasonably

inflammatory drugs] and the Management of NSAID-related Gastropathy in Medical Practice" (1997) 127 *Annals of Internal Medicine* 429.

¹²⁶ National Forum on Health, *supra* note 33; Romanow Report, *supra* note 33.

¹²⁷ M.G. Brown *et al.*, "Cost-effectiveness of Interferon beta-1b in Slowing Multiple

be able to argue that these processes are applied, however imperfectly, elsewhere as well.

VI. Toward Better Law and Better Health Care

The current state of decision-making within the health care system leaves it vulnerable to claims of discrimination based on s. 15 of the *Charter*. In this case, the petitioners' claims did not have to reach a particularly high evidentiary standard. All they had to establish was that children with ASD were not receiving publicly funded treatment while other people with different conditions were receiving treatment. They did not have to prove the relative merits of LAT (or IBI generally) in the context of a highly developed system for determining what should be funded. In a system with finite resources and a virtually endless list of potential demands, choosing priorities becomes crucial, as the government noted. Unfortunately, with evidence-based decision-making not widely practiced across Canada, the prioritization process is largely invisible and an accumulation of historical decisions (and non-decisions) often unlinked by any discernible guiding rationale. In these circumstances the claim that a decision not to fund is justified on the basis of a carefully developed resource allocation scheme is unavailable. The result in *Auton* was that a less than irresistible force confronted an easily movable object. The courts had to weigh the plaintiffs' inconclusive evidence against the appellants' threadbare arsenal of justifications for the government's decisions. In light of what the courts had before them, it is understandable that they intervened and established a positive entitlement to some form of expensive IBI therapy. However, it is still regrettable. The judgment saddles the government with a potentially large current and future liability for provision of a service for which there is arguably no compelling evidence of reasonable rates of effectiveness.

In a world with a more orderly and transparent health care system, how would cases be argued and decided? First, health care decision-making would more closely approximate the tenets of evidence-based decision-making. In this regard, it would do well to take some lessons from legal reasoning and justification. The intellectual cornerstone of the law is the giving of reasons. Health care has been slow to explain the reasons for its decisions, not least because it is often difficult to locate the decision-maker (is it the government, the manager, the clinician?), but also because in the end, the reason may not be scientific or medical, but emotional, hopeful or political. If health care decision-makers want to avoid the courts usurping

Sclerosis Disability Progression: First Estimates" (2000) 16 Int. J. Technol Assess. Health Care 751. Note also that "first estimates" can be challenged; in this case, a subsequent study held that betaseron was about five times as cost-effective (measured by cost per QALY) than estimated by Brown *et al.*: see G. Kobelt *et al.*, "Cost-utility Analysis of Interferon beta-1B in Secondary Progressive Multiple Sclerosis Using Natural History Disease Data" (2002) 18 Int. J. Technol. Assess. Health Care 127.

their authority, they would do well to apply more stringent tests to their resource allocation decisions. Of course, one cannot expect algorithmic decision-making where uncertainty is inevitable and ethical issues abound. Nevertheless, health care decision-makers and the courts are united by a duty to seek distributive justice. If the courts are unconvinced that the stewards of health care are trying diligently to treat people fairly, based on principled and transparent decision-making, they will intervene. In the same manner, the courts' reasoning must also be defensible, and they will need to acquire the capacity to assess the relative merits of scientific evidence marshalled in support of competing claims.

Second, courts would engage in a comprehensive s. 1 analysis and argument. The presentation in *Auton* was cursory, and the courts' reasoning was skimpy and barely acknowledged the financial implications. Surely it is reasonable to expect that if the courts are to intervene, they must pay heed to the significance and meaning of s.1. It will not do to state, on the one hand, that the court agrees that health care leaders, not judges, should make health care decisions, and on the other hand to direct potentially huge amounts of money in various directions without having done the math or calculated with some precision the effectiveness of spending the money. Similarly, health care decision-makers would themselves have templates for assessing whether expected benefits are worth the costs, applying an implicit s. 1 test to their own priorities.

Third, assumptions about vulnerability to discrimination would be carefully examined and where possible, empirical evidence would be brought to bear to support them. We believe the Court of Appeal erred in invoking the *parens patriae* duty, partly because it did not seek to establish whether there was a predictable vulnerability among children to discriminatory treatment at the hands of the health care system. Furthermore, there must be a careful analysis of whether adverse consequences arise from genuine discrimination against certain classes of persons denied benefits that could reasonably be delivered, or from unfortunate variations in the capacity of scientific knowledge to meet people's needs. Nature and the state of science may conspire to disadvantage certain groups with respect to ameliorating their conditions; this ought not to be automatically conflated with discriminatory behaviour as defined by the *Charter*. As we have pointed out, it is one thing to identify a need, and another to be able to satisfy it; on top of this is a further question of "at what cost" in a world of finite resources and potentially infinite needs.

We share the government's concern about court cases producing negative effects on the health care system. If courts do not use standards that have as their goal the improvement of the system for everyone, judicial decisions risk responding only to patients with the loudest voices, the most effective advocates, or the deepest pockets to hire lawyers. *At the time, however, we share the courts' apparent concern about governments making health care decisions without adequate transparency and explanation. The*

risk of judicial intervention in specific funding areas, as troublesome as it is from an equity perspective, might well prod governments into speedier development of evidence-based decisions in health care. This would be a good thing for all Canadians. We hope that in the next case involving funding of controversial health treatment the courts will delve more deeply into the evidence of effectiveness, ask governments to justify their decisions on the basis of a transparent and comprehensive system of priorities, and consider more closely the difficult questions of implementing remedies in the world of wait times created by finite resources. Publicly funded health care as a basic entitlement of Canadians let alone as a right deserves no less.

