HEALTH POLICY IN ARGENTINA AND CANADA: AN EXCEPTION TO THE RULE OF DEFERENCE?

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Abstract: Both Argentina and Canada have increasingly engaged in litigation regarding fundamental rights and freedoms. Canada has seen exponential judicialization of rights since the adoption of the Charter in 1982. Likewise, Argentine courts were dramatically affected by the overwhelming constitutional reform process of 1994 and in particular by the overbearing presence of Inter-American Court of Human Rights positions. However, in the social and economic realm, caution has generally prevailed. Argentina avoided a full-scale confrontation with the Executive over social security mobility rights. Canada has been traditionally deferential to Executive and Parliament wishes in the economic and social fields. In spite of these trends, one particular area of adjudication stands out. Health policy is an exception to deference and institutional compromise. Both the Argentine Supreme Court and the Canadian Supreme Court are eager to explore new ways to make health provisions effective, despite different institutional setups and political climates: Canada is a Westminster-type parliamentary democracy, while Argentina is heavily presidential. Deference seems to play a smaller role when vital, life-and-death issues are at stake. Health policy provides an interesting case study where classical notions of division of power and the pervarding role of administrative agencies are abandoned in favor of a new spectrum of judicial options that may include cooperation with other political actors in town.

Keywords: health policy; litigation regarding; judicialization.

1 Introductory remarks

Argentina and Canada share some common denominators: both are large, sparsely-populated countries, with rather young political histories and federal struc-

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tures which combine both central and peripheral CUs (Constituent Units) levels of governance. Both polities are instead dissimilar in terms of economic performance and types of government. Canada is the tenth largest economy in the world, and functions as a Westminster-type parliamentary democracy. Argentina is heavily presidential (some observers contend that it happens to be even hyper-presidential) and still developing, after recurrent economic crises cycles (1975, 1989, 2001) of hyper--inflation and recession.

As a larger phenomenon, the "Rights Revolution" which pervaded political andlegal discourse in the late 20th. and early 21st. centuries everywhere has also heavily impacted on both nations, albeit in their own particular ways. Canada entered the "constitutionalization" of rights stage when it adopted the Charter of Fundamental Rights and Freedoms in 1982, as Epp argues (1998, p. 171, griffon added):

> The source for Canada's dramatic rights revolution, it is commonly believed, is the Canadian Charter of Rights and Freedoms. In addition to creating a host of new constitutional rights, the Charter authorized judges to overturn administrative practices *and laws* that are found to be inconsistent with its principles. Moreover, the Canadian Supreme Court has responded: the Court's agenda is now dominated by rights cases, and the Court has developed a rich body of law that applies and expands the rights promised by the Charter.

Andrew Stark (1982, p. 150) observes that:

> Some scholars now refer to the charter as the third pillar of Canadian government. This is an apt description, not only because it accurately conveys the prominence the charter has gained in the company of the two more venerable pillars – the parliamentary system and the federal structure – but also because the charter was meant to act as a counterweight to them. Because the charter protects citizens' rights, it is widely held to have introduced Canada's first constitutional limitation on the supremacy of Parliament at the federal and the provincial levels. And because the rights in question are universal, that is, applicable equally to all Canadians, the charter is widely held to have introduced a pan-Canadian set of values that move against the centrifugal forces of a federal state. In this counter federalizing vein, it is often said that the charter has begun to supplant Canadians' traditional regional and linguistic identifications. That is, it has superimposed on the old, federally based divisions a new set of pan-Canadian attachments based on gender, religion, race, and age.

Parliamentary supremacy, thus, lagged behind. As Janet Hiebert (2002, p. 218) puts it:

> Excessive reliance on judicial wisdom to resolve contentious social conflicts [may] lead representative institutions to renege on their responsibility to make responsible decisions about how to reconcile competing legislative purposes with the values espoused in the Charter.

Nevertheless, it must be noted that the Charter provided a way out of excessive judicialization (unless democratic or mobility rights were at stake) in the notwithstanding clause' of section 33:

> (1) Parliament or the legislature of a province may expressly declare in an Act of Parliament or of the legislature, as the case may be, that the Act or a provision thereof shall operate notwithstanding a provision included in section 2 or sections 7 to 15 of this Charter. (2) An Act or a provision of an Act in respect of which a declaration made under this section is in effect shall have such operation as it would have but for the provision of this Charter referred to in the declaration. (3) A declaration made under subsection (1) shall cease to have effect five years after it comes into force or on such earlier date as may be specified in the declaration. (4) Parliament or the legislature of a province may re-enact a declaration made under subsection (1). (5) Subsection (3) applies in respect of a re-enactment made under subsection (4).

Sub-national squabbles were also present during this process, as Peter Russell (1994, p. 8) duly noted:

> The most powerful effort to counter Quebec nationalism was Pierre Trudeau's constitutional program which by codifying individual civil and linguistic rights on a pan-Canadian basis aimed at weaning the Quebecois away from a preoccupation with their collective survival as a distinct French-speaking society in North America.

As Erdos (2010, p. 83, griffon added) apty summarizes,

> The political origins of the *Charter* arose from the federal political elite's need to find a centripetal symbol and institution to counter the threats to the Canadian federal system emanating from a new and destabilizing form of nationalism which had emerged in the province of Québec.

However, the record in this aspect is somehow mixed, to say the least Ishiyama Smithey (1996, p. 100):

> The Charter was also promoted as a document that would pull Canadians together because it secured full national independence from Britain and created common rights and liberties. It was hoped that uniform rights would pacify separatists in Quebec by satisfaying francophone demands for the protection of both Canadian cultures. Instead, through two subsequent rounds of constitutional reconsideration, Canadians seem more divided into interests groups and regions than they did before 1982. The Supreme Court's interpretation of the Charter has contributed greatly to the failure to achieve greater unity.

Argentina, by contrast, has a rich tradition of rights entrenchment which goes back to 1853, when the original Constitution was adopted (i.e., Articles 14, 16, 17, 18 and 19) after decades of civilian strife (1816-1852) following independence from Spain. However, it has a spotty record on judicial compliance. Moreover, the vast constitutional reform undertaken in 1994 awarded "constitutional rank" to several international human rights treaties, spawning new, more sophisticated and complex

strategic public litigation. This constitutional revision process regrettably failed in Argentina to specifically include an explicit right to health provision (CARNOTA, 1996, p. 2966). However, both the 1982 Canadian Charter (Article 15, section 1) and the Argentine Constitution revamped in 1994 (Article 75, section 23) give enhanced protection to aged and disabled people on equality grounds.

Inevitably, "rights talk" embedded in "New Constitutionalism" leads to greater judicialization. Some authors even argue about the existence of a "juristocracy", meaning a new political order (HIRSCHL, 2004) that emphasizes judge-made policy making in detriment of democratic processes triggered by periodical elections. Clasically, the S.C.C. increasingly adopted an "activist" role in rights adjudication, closely following the trajectory of its Southern neighbor during the Warren and early Burger years.

Judicial activism was evident from the start. Van Loon and Whittington wrote (1987, p. 266) that:

> The experiences of the first four years of the Charter of Rights indicate that the judiciary is willing to take a more activist role, particularly with respect to procedural rights in criminal matters and with respect to the determination of "reasonableness" under section 1.

Argentine courts were historically deferent to the political branches of government, since Civil Law tradition mandates that legal application is a strict mechanical operation and judicial interference becomes minimal (Montesquieu used to say that judges were the "mouth of the law"). However, the new C.S.J.N. which began to emerge during Néstor Kirchner's first years at the presidency (2003-2007) has been prone to call itself "activist" and adopt a more prominent role in the decision-making process, even starting a "dialogue" with the Congress and the President, similar to the relationship between European political actors and Constitutional Courts.

2 Civil Law vs. Common Law, Federal vs. Provincial

Lately, in many parts of the world, there has been adoption of new rights, such as education and health-care. As Elkins, Ginsburg and Melton (2010, p. 28) point out:

> Technological innovation works by addition as well as substraction. In addition to weeding out irrelevant rights and institutions, designers writing replacement documents have the opportunity to implant others. Nowhere is this more obvious than in the area of rights. […] Second and third generation rights, the positive rights, are now included in international covenants as well as most national constitutions. […] [W]e can observe the adoption of three more rights: freedom of speech, the right to education and the right to health care.

As mentioned, health care has not been specifically included neither in the 1982 Canadian Charter nor in the 1994 Argentine constitutional revision process,

antidiscrimination clauses aside. However, adoption in both countries of the 1948 Universal Declaration of Human Rights and the 1966 U. N. International Convenant on Economic, Social and Cultural Rights had relevant implications for health law development. Argentina has traditionally linked health care to the right to life, as befits a heavily Roman Catholic country. Canada has used the "equalrights" yardstick when dealing with health. In spite of actual textual footing, both the Argentine Supreme Court (C.S.J.N.) and the Supreme Court of Canada have frequently dealt with health. Even the United States Supreme Court (U.S.S.C.) is currently conducting hearings on "Obamacare", a key decision expected to be released in late June 2012.

In Canada, health care is a social policy that lies within provincial jurisdiction (MANFREDI; MAIONI, 2002), which led many to contend that increasing judicialization further erodes federalism. Palley, Pomey and Forest (2011, p. 80) argue in their essay about health care in Québec and Ontario that in Canada:

> [T]he health care delivery system is primary the responsibility of provinces. We consider this sub-national Canadian health care system study to be important internationally, as an aggregate of national studies that use a comparative framework contributes to the international comparative health policy literature through an accumulation of case by case studies.

By contrast, Argentina has devised a so-called "concurrent" (CARNOTA, 2010a) system regarding health matters, in which both national and CUs level of governments theoretically are engaged. All Argentine 24 sub-national constitutions include health provisions (CARNOTA, 2011), usually more generous than regulations stemming from the federal level of government. In real terms, however, the latter always gets the upper hand, since it has widespread control of financing through revenue--sharing and other, even more discretional programs (such as "ATN", National Treasury grants) that at the end of the day weaken provincial strength.

Health legislation has been labeled in Argentina as "fragmentary" (MADES; GARAY, 2011, p. 122), a rather startling assertion to be made in a Civil Law context:

> Health legislation was enacted during different historical periods of our past, under democratic governments and under unconstitutional governments; under different political, economical, social and cultural conditions (Welfare State – state interventionism – dictatorships – strong and weak democratic governments – development prone administrations – economic neoliberalism – unorthodox economic policiesauthoritarian and conservative culture – openess culture and recognition of minorities and vulnerable groups, and is embedded with these values).

In 1998, when Argentina began to consolidate its legislation, health was not even considered an autonomous legal field. This mistake was corrected when legal consolidation was re-started in late 2010.

Legislative fragmentation in Argentina mirrors its health system. It is composed basically of three pillars: Social Security health benefits; public health sector and private health sector benefits. These three components, however, have not always been adequately integrated as a whole. Assymetries abound, as fragmentation shows up in three different areas: the rights front; the territorial front and the regulatory front.

The twenty-third Argentine Provinces – plus the City of Buenos Aires which enjoys a special "autonomous" status since the 1994 constitutional reform – show very different realities as far as health care is concerned. Far-way provinces located in the Northwestern part of the country or in Patagonia pale in comparison to big, urban provinces such as Buenos Aires, Córdoba or Santa Fe.

As in many countries, health protection has evolved in Canada as an integral part of a wide array of administrative regulations. Theoretically, deference should prevail. However, health constitutes a sensitive matter: the system, providing Canadians with free doctors' services that are paid for by taxes, has generally been supported by the public, and is broadly identified with the Canadian national character (KRAUSS, 2012).

3 Sub-national and supra-national dialogue

Canadian health policy is basically a provincial responsibility, as previously noted. By contrast, Argentina involves its three different levels of government – even local government – in its health policy-making process, as in other federal systems like Brazil (AITH, 2011, p. 33). Needless to say, federal governments always find its way to meddle in health issues, even in Canada (ADAM; BERGERON; BONNARD, 2010, p. 23):

> After World War II, the federal government, with its larger fiscal resources, was able to become increasingly active in provincial jurisdictions through the use of conditional grants to the provinces. In this way, the federal government played a major role in building the welfare state, even though health care, education and social services are, in principle, provincial responsibilities. This "federal spending power" is not explicitly provided for in the Constitution, but numerous authors support its validity.

As a result,

> The functioning of Canadian federalism in the area of health care delivery is characterized by a dynamic relationship between national fiscal power and the constitutional responsibility of the provinces to provide health care to its residents. This relationship is a stipulation of the initial Canadian Constitution, the British North American Act of 1867, and the more recent Constitution of 1982. Under the Canada Health Act of 1987, in order for the provinces to receive full federal financial contributions, provincial programs must provide for the delivery of required health services. They must also meet criteria of public (non profit) administration, comprehensiveness, universality, portability, and

> accesibility for all necessary health care services. Provincial "extra billing" and user charges are not permitted for these services (PALLEY; POMEY; FOREST, 2011, p. 81).

Canadian legislation offers particular features (VAN LOON; WHITTINGTON, 1987, p. 270) in this respect:

> Thus, for example, the Canada Health Act states that if provinces are to receive federal transfers to cover hospital and medical services, their programs must feature universal coverage of their population; must be available to everyone under equal terms and conditions, and, therefore, must be free of any barriers to access, such as extra-billing by doctors; must be portable from province to province; must be publicly administered, and must cover a comprehensive range of services.

As the Menem government (1989-1999) ushered in liberalization policies in Argentina, health services (for instance, hospitals) were "devolved" to provinces.

Only 1 out of 121 hospitals remained in national hands. However, despite some efforts at increased inter-governmental coordination within the Federal Health Council (Cofema) at the start of the century, centralization has continued to run unabated, mainly as a result of fiscal federalism imbalances.

4 Easing threshold requirements

Judicial review is generally seen as a "last resort" option, following the "avoidance doctrine" established in U.S.S.C. Justice Brandeis' concurrence in "Ashwander v. Tennessee Valley Authority" (297 U.S. 288, 345 (1936). Accordingly, both the U.S.S.C. and the C.S.J.N. have developed considerable threshold requirements, i.e. standing-to-sue and other procedural hurdles effectively restricting unlimited access to courts.

In general terms, the S.C.C.

> [I]s not a constitutional court and most of the Charter appeals that it hears arise in the course of appeals from criminal cases. The Court has recognized a limited form of public interest standing if there is no other way for a directly affected person to challenge the constitutionality of the legislation, and courts have exercised their discretion to decide constitutional issues even when the dispute is otherwise moot on a similar basis (ROACH, 2011, p. 319).

In this way, the right to abortion rose in Canada from a challenge to a criminal code provision (*R.v. Morgentaler,* [1988] 1 S.C.R.30). Recently, the C.S.J.N. did so similarly in Argentina (*F, A.L.,* sentenced on March 13, 2012).

Asociación Benghalensis[1] conferred in Argentina standing-to-sue status within an injuctionary context to eight NGOs devoted to fighting AIDS. These NGOs contended that existing legislation[2] primarily compelled the federal government to assure

[1] C.S.J.N. *Fallos*: 323: 1339 (June 1, 2000).

[2] Argentine law number 23.798.

full distribution of AIDS medicine irrespective of provincial responsibility. This ample standard was followed in subsequent cases, like in *Maria, Flavia*[3] (decided on October 10, 2007). Furthermore, the C.S.J.N. emphasized that the National Ministry of Health and Social Services had a "coordinating role" over HMOs and provincial health authorities (*Campodónico de Beviacqua*[4], decided on October 24, 2000). In many cases, the Argentine Supreme Court and federal lower courts seem to favor injuctions (*amparos*) as a preferred vehicle for right to health claims to be channeled over ordinary – and slower – remedies (CARNOTA, 2008). Substantially, it stressed the relevance affirmative action targeted at vulnerable groups such as children, protected by specific international conventional law.

5 Calculating economic costs and reaping political benefits

Health cases provide judges with the golden opportunity of relatively low cost (in Argentina, if compared to, for instance, Social Security mobility, health adjudication is cheaper) and high-profile, symbolic litigation. In 2009, the C.S.J.N. created a special unit empowered to study the potential costs of massive litigation[5], with no real bite. Health adjudication allows judges high visibility in life-and-death issues where minor squabbles (i.e., choice of venue; threshold requirements) tend to be minimized for the "greater good" (for instance, the opportunity to save lives). The former Menem Court in Argentina (1990-2003) tried to legitimize itself with cases such as *Asociacion Benghalensis,* to no avail. This Court, which served under Presidents Menem, De la Rúa and Duhalde, had been attacked by the media as an "automatic-majority Court", since it vigorously supported all of Menem's controversial economic liberalization policies sponsored by the IMF-led "Washington consensus". Health seemed for the Court, at the beginning of the century, as a good starting point to reconcile itself with society. The subsequent Court, presided over by Ricardo Lorenzetti, further expanded the "human rights agenda" as its own legitimization strategy (CARNOTA, 2010b).

Consequently, the new C.S.J.N. which began to take shape after Néstor Kirchner became the country's President in May 2003 adopted an even more aggressive "internationalist" stance by quoting in decisions all International Law materials available; began an aggressive p.r. policy involving the Internet and social networks; issued transparency guidelines such as banning *ex parte* arguments and allowing for *amicus curiae* briefs; and promoted social rights, mainly in the labor law area. Health cases continued to have an impact within the C.S.J.N.'s docket, as *F.,A.L.* regarding "non-criminalized" abortion eloquently show.

In *Chaoulli*[6]*,* the S.C.C. struck down Quebec legislation banning private medical insurance. Dr. Jacques Chaoulli, a Montreal doctor, argued his own case through

[3] C.S.J.N. *Fallos*: 330: 4647.

[4] C.S.J.N. *Fallos*: 323: 3229.

[5] *Acordada nº 36.*

[6] S.C.C., *Chaoulli v. Quebec* [2005] 1 S.C.R. 791.

two Quebec provincial courts, together with his patient George Zeliotis, who was forced to wait a year for hip replacement while impeded from private treatment.

Canada has avoided the transformation of its health care system into a two--tier scheme, like France, Switzerland and Germany. The S.C.C. in *Chaoulli* stopped short of declaring the unconstitutionality of the country's health coverage, but paved the way for greater judicialization as it struck down section of two Quebec provincial laws that banned residents from purchasing private insurance for medical and hospital services supposedly rendered by the national system. The S.C.C. found that this legislation breached section 1 of the Quebec Charter of Human Rights and Freedoms[7] which guarantees "liberty, safety and security". As Flood and Zimmerman say (2007, p. 42, griffon added):

> Although the *Chaoulli* decision deals with the right to be free from government interference when purchasing *private* insurance (a negative right), it establishes the connection between deprivations of the basic necessities of life and fundamental rights.

It must be noted that the Québec government "chose not to invoke the 'notwithstanding' cause of Section 33 of the Charter, which allows provincial governments to override legal rulings that might undermine founding provincial principles" (PALLEY; POMMEY; FOREST, 2011, p. 85). Subsequent provincial legislation (i.e., Bill 33) has increased the role of private actors in Quebec's health care system. *Chaoulli* presents the "Obamacare" situation in reverse: while in Canada, the C.S.C. chided Quebec for *not allowing* for private insurance, the recent U.S. health care legislation has been attacked on the grounds of *compelling* people to buy insurance.

Eldridge[8] had previously provided the S.C.C. with an opportunity to play the health card. Roach (2011, p. 340) says about that decision that:

> The Court intervened around the edges of health-care policy in 1997 by holding that the failure to provide sign-language interpreters for deaf patients when they received medically necessary services violated equality rights under the Charter. In the result, the Court issued a declaration but suspened it for a six-month period to allow the government to devise a system to provide the needed interpretation. The Court also was influenced by evidence that the costs of complying with its ruling would not be great.

However, the most important ruling dealing with health care activism in Canada to date has been *Canada (A.G.) v. PHS Community Services* ([2011] 3 S.C.R.134), popularly known as the *Insite* case, decided on September 30, 2011.

There, the S.C.C. upheld the vality of a Vancouver safe-injection facility, despite the federal government's refusal to grant it an exemption from the Controlled Deugs and Substances Act. The Court upheld the federal capacity to enact criminal law. However, it found that the Ottawa position was arbitrary on Charter grounds (sections 1 and 7).

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[7] Canadian Provinces do not have a sub-national Constitution as the Argentines Provinces, the American States or the Mexican States do.

[8] S.C.C., *Eldridge v. B.C.* [1997] 3 S.C.R. 624.

6 Conclusions

Canada and Argentina tell different stories as far as health care is concerned.

The Argentine Supreme Court has looked up at international human rights documents when facing health issues, while its Canadian counterpart did not hesitate to invalidate sub-national legislation, as in *Chaoulli,* or federal guidelines, like in *Insite*. Health policy is now part of the whole "multi-level governance" game: supra-national, federal and sub-national politics all jump in, and courts do not hesitate to attempt at fixing boundaries.

POLÍTICA DE SAÚDE NA ARGENTINA E NO CANADÁ: UMA EXCEÇÃO À REGRA DE DEFERÊNCIA?

Resumo: A Argentina e o Canadá têm cada vez mais envolvidos em litígio sobre os direitos e as liberdades fundamentais. O Canadá tem vivido a judicialização exponencial de direitos desde a adoção da Carta, em 1982. Da mesma forma, os tribunais argentinos foram drasticamente afetados pelo processo de reforma constitucional de 1994 esmagadora e em particular pela presença dominadora da Corte Interamericana de Direitos Humanos posições. No entanto, nas esferas social e econômica, o cuidado tem geralmente prevaleceu. A Argentina evitou um confronto em larga escala com o Executivo sobre os direitos de mobilidade social de segurança. O Canadá tem sido tradicionalmente deferente para Executivo e Parlamento desejos nos domínios económico e social. Apesar dessas tendências, uma área particular de adjudicação se destaca. A política de saúde é uma exceção à deferência e ao compromisso institucional. Tanto a Corte Suprema da Argentina quanto o Supremo Tribunal canadense estão ansiosos para explorar novas maneiras de fazer provisões de saúde eficaz, apesar de diferentes configurações institucionais e climas políticos: o Canadá é uma democracia parlamentar de tipo Westminster, enquanto a Argentina é fortemente presidencial. A deferência parece desempenhar um papel menor quando questões de vida e morte estão em jogo. A política de saúde fornece um interessante estudo de caso, em que as noções clássicas de divisão do poder e do papel das agências administrativas *pervarding* são abandonadas em favor de um novo espectro de opções judiciais, que podem incluir a cooperação com outros atores políticos na cidade.

Palavras-chave: política de saúde; litígio relativo; judicialização.

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