Inspiring Analogies: From Access to Healthcare to Access to Justice

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INTRODUCTION

When they write about access to justice, authors sometimes draw analogies with initiatives implemented in the healthcare system. For instance, the position of "nurse practitioners" has inspired the idea of "legal technicians", who would perform some acts currently reserved to lawyers without having the same type of training (Sen, 2019, pp. 138–140). The widespread practice of annual visits to the doctor and to the dentist has inspired the idea of periodic legal checkups (Brown & Dauer, 1994; Winn, 1986, p. 134). More broadly, the focus on health prevention has inspired calls to shift the focus from litigation to legal prevention (Horvath, 1998; Lawton & Sandel, 2014, p. 37; Susskind, 2019, ch. 6). The ability of healthcare professionals to work in interdisciplinary teams has prompted calls for greater interdisciplinarity in legal matters as well (Lawton & Sandel, 2014, p. 36). And the list goes on.

These sporadic analogies suggest that there is something intuitively similar between access to healthcare and access to justice. They also show that strategies developed in the healthcare system can provide much-needed inspiration to find new paths of access to justice. However, these analogies are often made without explaining why and to what extent the healthcare system is an appropriate source of inspiration for the justice system. If we want these analogies to hold, we need to show that the two systems are truly comparable, beyond mere intuition.

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The first objective of this chapter is to justify the analogy by providing a more comprehensive and systematic comparison of the two systems, focusing more precisely on the features that influence the delivery of services. This comparison confirms that the healthcare and justice systems are sufficiently similar for the former to inspire the latter. It also shows that health and justice issues are often intertwined, and therefore that users could benefit from a better integration of the two systems. However, important differences — such as the existence of legal persons and the correlativity of most legal issues — must be considered when transferring a solution from the healthcare system to the justice system. Such a transfer must also be tailored to the specific context of the jurisdiction in which it is undertaken.

The second objective of this chapter is to encourage scholars and activists to look to the healthcare system as a source of inspiration in the quest for access to justice. The last part of the chapter provides examples of healthcare solutions that could provide interesting new paths of access to justice. But first, the next section provides an overview of the analogical method that will be used to compare the two systems.

ANALOGICAL METHOD

The central question in this chapter is whether solutions implemented to increase access to healthcare can inspire new solutions for access to justice. This question can be reframed as one of analogy: is the healthcare system analogous enough to the justice system to suggest that solutions used in the former may be appropriate in the latter? The answer to this question is guided by a set of principles which together constitute the analogical method.

Analogies are central to everyday reasoning. They allow us to find "the solution to [a new] problem by reference to another similar problem and its solution" (Weinreb, 2016, p. 4). More precisely, an analogy transfers knowledge acquired in a familiar situation (the *source* analog) to a new situation (the *target* analog) which is sufficiently similar to the source for that prior knowledge to be relevant. The key to that process is the identification of relevant similarities between the source and the target.

Various theories in cognitive sciences and philosophy, among others, have sought to explain what makes a similarity relevant to an analogy. The structure-mapping theory describes this process as "establishing a *structural* alignment between two representations based on their common relational structure" (Gentner & Maravilla, 2018, p. 187). This means that similarities are relevant not because the elements of the source match those of the target in a one-to-one correspondence (e.g. two objects are of the same colour), but most importantly because these elements play the same functional role and are similarly related within their respective systems (e.g. the colour of both objects have the same function) (Gentner & Maravilla, 2018, p. 187; Juthe, 2005, p. 5; Perelman, 1982, pp. 114–115).

When a structural mapping is correct, inferences can plausibly be drawn from the source to the target (Gentner & Maravilla, 2018, p. 189). However, analogies can quickly become "slippery and likely to mislead" (Weinreb, 2016, p. 4) if they do not rely on an accurate mapping — for instance if two relations are said to be comparable when they are not — or if the similarities identified are irrelevant to the inference that the analogy is meant to support (Juthe, 2005, p. 4). To take a simple example, if I know that rebooting my computer makes it work again when it freezes, I might apply the same strategy to my printer and reboot it if it refuses to print. The structural mapping between the two objects plausibly supports this analogy, because the booting process plays the same functional role in both.[1] However, it would be incorrect to draw the same analogy based on the fact that both objects are black, because their colour has no bearing on the way they work; this analogy would lead to the conclusion that all non-functioning black objects need to be rebooted, which is obviously incorrect. In short, analogies must be built upon relevant features and relations in order to be persuasive and useful.

Even then, analogies rarely support conclusive arguments. They are primarily used as a heuristic tool in order to generate hypotheses about the target (see e.g. Perelman, 1982, p. 115). For example, the analogy between my computer and my printer, even if plausible, cannot lead me to conclude with certainty that the printer will work if rebooted. The analogical process allows me to generate this hypothesis, but I will need to test it in order to reach a definitive conclusion. Various other factors that cannot be captured by the analogy might influence the extent to which the inference proves true. Beyond their role in generating hypotheses, analogies

are also used as rhetorical devices, because the link they establish with similar notions that the audience already understands and accepts often enhances the clarity and persuasiveness of an explanation or argument (Perelman, 1982, pp. 116, 119).

Within these limits, analogies are used in a number of contexts. For our purposes, they are particularly helpful in choice situations, i.e. when confronted to "both an unsatisfied goal and a set of alternative ways to satisfy that goal" (Markman & Moreau, 2001, p. 363). In such a situation, analogies assist in choosing among different options, but they also contribute to expanding the set of available options. When they are drawn "from reasonably close domains", analogies can in fact provide very specific ideas and options (Markman & Moreau, 2001, pp. 368, 373).

Access to justice is also a choice situation, in which decision-makers must choose among various options in order to increase access. An analogy with the healthcare system is helpful to deal with this choice, but only within the limits established above. First, the analogy cannot prove that the solutions used in the healthcare system will work in the justice system, but it can spur creativity and inspire new paths of access to justice. Second, the inquiry must focus on features that are relevant to service delivery in each system, and not on similarities that are irrelevant for that purpose.

The scope of any analogy must also be carefully circumscribed. This chapter focuses on services that allow persons to prevent, contain, and resolve legal or health issues. These services include, for instance, public education, consultations with professionals, mediation, arbitration, court services and medical treatments. This clarification is important because the access to justice agenda is much broader and can include for instance greater access to law-making institutions (Macdonald, 2005, p. 23). However, it would be difficult to include these institutions in the analogy, because there is no direct equivalent to law-making institutions in the healthcare system. Indeed, a significant difference between the two systems is that the principles and rules governing legal outcomes are determined by humans, while the outcome of medical issues is ultimately governed by natural factors. The closest analogy would be for example if someone were calling for patients to have greater access to the processes by which treatment protocols are designed. Even then, treatment protocols are not exactly analogous to laws. For that reason, the analogy

developed in the next section focuses on services provided to prevent, contain, and resolve health or legal issues.

ANALOGY BETWEEN THE HEALTHCARE AND JUSTICE SYSTEMS

The similarities and differences that are relevant to the delivery of services in both systems fall under three categories: the problems to be addressed and the idea of remedy (a), the professionalization of services (b), and the involvement of the state (c).[2]

PROBLEMS TO BE ADDRESSED AND REMEDIES

At a very general level, the healthcare and justice systems both seek to prevent, contain and resolve problems. Of course, other institutions and social actors also address problems their own way; for example, social workers address problematic personal or social situations, and political institutions tackle broader social issues. However, the particular problems with which healthcare and justice are concerned share a number of more specific features.

It is telling, first, that the words "injury", "harm", and "remedy" are used in both domains: we speak, for instance, of a broken arm as an injury that causes physical harm just as we speak of the resulting loss of income as an injury that causes pecuniary harm. As its etymology indicates, the word "injury" — which comes from the latin *injūria*, literally "not right" — expresses a deviation from the norm, from a "right" situation. Indeed, in most cases where people seek access to healthcare or justice, it is because they have identified that something is "not right" in their situation, and because they seek a remedy for the harm suffered.

Of course, injuries do not exhaust the scope of problems that either the healthcare system or the justice system seek to address: the former treats diseases and illnesses as well, and the latter also serves to distribute social benefits.[3] That said, illnesses and diseases also deviate from a "right" situation and generally cause harm, and the wrongful denial of a legal benefit can be conceived as an injury that causes harm as well. For that reason, the notions of "injury", "harm", and "remedy" provide a helpful starting point to conceptualize the problems with which both systems are concerned, namely situations that are "not right" and that generally cause some harm for which those affected seek a remedy.

In both systems, these problems fall on a spectrum from the most detectable to the most undetectable. A patient will readily identify a broken arm as an injury, while a cancer will often remain undetectable — at least in its initial stages — because symptoms are absent or imperceptible. Similarly, the loss of revenue resulting from a car accident caused by another person will readily be identified as a legal injury by most people, while the deprivation of a benefit to which a person is entitled under the law may not be perceived as a problem if that person is not aware of the benefit. Concretely, this means that the identification of potential problems is a threshold issue for both the healthcare system and the justice system.[4] This is why, in both systems, efforts of public education have sought to raise public awareness. This is also why annual visits to the doctor are recommended and why, as mentioned in the introduction, some authors put forward the analogous idea of legal checkups.

The problems tackled by each system are also affected by the passage of time in similar ways. On the one hand, many injuries, diseases or illnesses will worsen over time if left untreated, just as many legal injuries will deteriorate if left unaddressed. For instance, a cancer will generally grow if untreated, just like the situation of a person will likely worsen if they are wrongfully evicted from their apartment and cannot reclaim it. On the other hand, some problems naturally stabilize over time. A healthy person will generally be able to fight a cold or a flu in a matter of days, without having recourse to the healthcare system. Similarly, some legal problems will be resolved without the help of the justice system; for instance, a debt may be paid off voluntarily, or a potential legal liability may be extinguished by a limitations statute. When developing and providing services, both systems must be cognizant of the ways in which time affects the issues that they have to address.

One way in which both systems reflect the importance of time is in the prioritization of their services. In both systems, factors such as the impact of time and the potential consequences of inaction determine the order in which each problem should be addressed. The problems that have greater consequences and are likely to deteriorate will often be treated with a greater level of urgency. For example, a patient rushed into an emergency room with a heart attack will generally be treated before someone with a broken arm or a cold. Similarly, someone who was wrongfully evicted from her apartment and seeks an interim order to reclaim it will

generally be heard more quickly than a consumer claiming damages for a broken appliance. In practice, this means that both systems need to have a mechanism to triage the patients and potential litigants who access their services.

A further similarity between both systems is the fact that they provide remedies but are unable to guarantee outcomes (Weale, 2016, p. 46). Health professionals may give their best effort and try every treatment possible, but there are ailments which are simply incurable. Similarly, even with the best lawyers, paralegals, and judges, outcomes cannot be guaranteed to any potential litigant. Thus, in both systems, access is not defined by outcomes but rather by the ability to receive quality services. Both systems must be aware of their own limits when they develop and provide services, and the expectations of patients and potential litigants must be managed accordingly.

One last similarity that I will point out here is the fact that both systems address and remedy problems suffered by a *person*. In the healthcare system, this reflects the fact that health issues are related in one way or another to the body or mind and are therefore suffered by an individual. Of course, a situation may cause harm to a whole collectivity: for example, a chemical plant may emit particles in the air and cause harm to an entire neighbourhood. However, the harm will still be suffered and treated individually by the healthcare system. The same can be said for the justice system. Of course, a plant polluting the air might be liable to every member of a collectivity, but once again each affected person will conceptually have an individual claim. Mechanisms for assembling claims, such as joint trials and class actions, generally rely on the existence of a cause of action for each member of the class, even if these individual claims are ultimately aggregated.[5] Similarly, the outcome of a legal claim might have a collective impact — if it invalidates a law or prohibits some type of harmful activity, for example — but in these cases as well, the plaintiff will usually be required to have an individual claim.

That being said, some interventions — mostly preventive ones — target communities and have collective outcomes. The whole field of public health is focused on interventions that improve the general health of the population, for instance through public education or measures tailored to protect everyone from communicable diseases (see e.g. Laverack, 2019,

p. 1).[6] Similarly, efforts of legal education and prevention such as encouragements to draft up wills or to prepare advance instructions for end of life care have an undeniable collective impact (Weale, 2016, p. 44).

A significant difference between the two systems, however, is the existence of *legal* persons in the justice system. Corporations, organizations, and the like, can suffer legal injuries and make corresponding claims, even if they are fictional creatures of the law. In contrast, the healthcare system is not concerned with legal persons, since they are unable to suffer health problems. This difference must be kept in mind when designing modes of service delivery in the justice system, for the place of legal persons has no equivalent in the healthcare system and the solutions developed therein do not take them into account.

Another important difference is the correlativity or adversarial nature of legal problems. Legal claims are usually made against another person or entity, whereas health problems only involve the person who is injured or harmed. To put it simply, the person responsible for breaking my arm will not be involved in the medical treatment of my injury, but she will become legally involved if I make a claim against her for the fallout of that injury. This correlative aspect is important when designing modes of service delivery, because while healthcare services are essentially concerned with the interests of the person under their care, the justice system must also take into account the interests of the person(s) against which the claim is made.

This correlativity also gives rise to a division between legal services that advise people on their options and support them in arguing their case (e.g. lawyers), and those which provide a neutral dispute resolution service (e.g. mediation, arbitration, courts). While patients who consult a health professional will often receive simultaneously advice on their options as well as a treatment to resolve the issue, the correlativity of legal issues requires having recourse to a neutral third party to consider the interests involved and take care of the "treatment" portion of the services.[7] This separation of services must be considered when transferring a solution from the healthcare system to the justice system.

It is true that some legal situations may appear to be non-correlative; for example, someone may petition a court to invalidate a will or to confirm the

adoption of a child and no one may be taking the opposite side. However, the recourse to a court is usually imposed in these situations, even if they present no dispute at all, because they call for the careful consideration of other interests that could be at stake, for instance the child's interest or those of other people who could have rights in the estate. There is thus some level of correlativity — although not necessarily adversity — even in these apparently one-sided situations. There are few situations, if any, in which legal problems will not present a correlative aspect that has to be taken into account by the justice system. Similarly, legal assistance provided outside the court system will often entail some level of correlativity; advice given by lawyers or others will often need to consider the interests of third parties and the impact on their client's situation.

The problems tackled by both systems are similar in at least two other ways, which the next two subsections explore. First, the resolution of health and legal problems generally entails a level of complexity that partly explains the professionalization of services in both systems. Second, the importance of the problems addressed by each system leads in both cases to a significant involvement of the state in the delivery of services.

COMPLEXITY AND THE PROFESSIONALIZATION OF SERVICES

The healthcare and justice systems are both highly professionalized. The definition of "professions" is contested (Burns, 2019, pp. 43–45), but I am referring here to the fact that actors in each system perform reserved acts and, in order to do so, are required to have specific academic qualifications, be registered, and subject themselves to mechanisms aimed at ensuring their competence and professionalism, whether through governmental institutions or through self-regulating professional bodies.[8]

Physicians and lawyers immediately come to mind as examples of professionals practicing in each system. Like other professionals, they need to complete specific training, internships and/or examinations to enter their profession, and they then acquire the right to perform specific acts which other members of the public are prohibited from performing.[9] Both systems are replete with other professionals who are subject to similar requirements and who also have their own reserved acts. In the healthcare system, we may think of nurses, pharmacists, dentists, ophthalmologists, and many other specialties. In the justice system, other professionals

include paralegals and court stenographers for instance, although the number of legal professions is generally lower than the number of health-care professions (Weale, 2016, p. 45).

The correlativity of legal issues and the resulting division between advising services and dispute resolution services calls for an important distinction. Decision-makers, including judges, mediators and arbitrators, are rarely required to be members of a professional body *per se*. However, judges are generally drawn from the ranks of professional bodies or from a specific judicial training, which ensures a specific level of qualification, and they generally remain subject to disciplinary bodies.[10]

The professionalization of healthcare and justice contrasts with other public services, for instance the education system, in which teachers are seldom governed by a self-regulating licensing body.[11] The reasons advanced for the professionalization of healthcare and justice are tied to the idea that the public needs to be protected due to the complexity of the acts performed and the magnitude of their potential consequences.[13] In other words, professionalization results from the observation "that none of us has enough specialist knowledge to cope with our daily challenges" in these areas (Susskind & Susskind, 2015, p. 3). For similar reasons, the availability of professional services is often viewed as an essential part of quality care and quality justice (Dmytraczenko & Almeida, 2015, p. 152).

This official narrative around the reasons for which professions are established and maintained is challenged by some social scientists who view professionalization as a much more complex phenomenon that is contingent on historical events and other factors (Burns, 2019, pp. 75–76). This challenge leads to the same types of debates in both systems regarding the types of professionals who should be allowed to perform some acts, and whether some acts might be deregulated and left to non-professionals as well.

In that sense, there has been a tendency in the healthcare system to rethink the way in which acts are allocated among different types of professionals. Acts that were at some point reserved to physicians — for instance renewing prescriptions or prescribing some drugs — have now been opened up to pharmacists in some jurisdictions, although primarily in North America and to a lesser extent in Latin America (Alvarez-Risco &

Del-Aguila-Arcentales, 2019; Brown & Seoane-Vazquez, 2019).[14] The creation of the position of "nurse practitioners" in some countries has allowed these nurses to perform acts that were previously exclusively reserved to physicians, although again this tendency seems more prevalent in North America than in Latin America (Oldenburger et al., 2017). These trends result from a recognition that some acts might be performed by many types of professionals, and that increasing the number of people who perform them increases access.

This tendency has also been observed in the justice system, but to a much lesser extent. Some countries have broadened the scope of acts that paralegals are allowed to perform, chipping away at the lawyers' exclusive sphere of activity. This diversification of the types of professionals allowed to perform some legal acts has been said to increase access to justice (see e.g. Trabucco, 2018). Yet, lawyers in many jurisdictions still have a very broad sphere of protected activity. This might be an area where greater inspiration could be drawn from the healthcare system.

IMPORTANCE AND INVOLVEMENT OF THE PUBLIC

A further similarity is the fact that the state is generally involved in both healthcare and justice: each jurisdiction has its own public dispute resolution system, and most countries have a public healthcare system as well. The existence of a public justice system is almost a defining feature of states, since it is essential to the enforcement of laws: "the state's obligation to ensure justice [arises] as an essential element in its own purpose and functioning" (Weale, 2016, p. 51). Beyond dispute resolution, the state is also often involved in the delivery of legal advising services, primarily through legal aid schemes, although the scope of these programs varies across jurisdictions. In healthcare, states generally maintain public institutions — hospitals, clinics — and fund at least a portion of the services provided to the public, for instance through a public insurance scheme. The reasons for public investment in legal and healthcare services are multiple: some see them as fundamental rights, others as public goods, and yet others as sectors in which the market has failed (Weale, 2016, p. 42). Central to these reasons is an acknowledgment, first, that both health and justice are of crucial importance for the population, and second, that public involvement is essential to secure affordable access.

The importance of health and justice is recognized in myriad legal instruments. In the Americas, most states are parties to conventions that recognize health and justice as human rights. The *American Convention on Human Rights* guarantees the right to a fair trial in both criminal and civil matters (1969, s. 8(1)), while the *Protocol of San Salvador* guarantees the right to health, as "the enjoyment of the highest level of physical, mental and social well-being" (*Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights [Protocol of San Salvador]*, 1988, s. 10; see also the *International Covenant on Economic, Social and Cultural Rights*, 1966, s. 12). This recognition of health as a human right has also been implemented in many state constitutions, although this implementation is not universal.

Characterizing health and justice as human rights entails a promise "to advance an egalitarian approach to distributive justice in allocating [...] resources" which supports "public finance and access [...] on the basis of need as opposed to ability to pay" (Flood & Gross, 2014, p. 452, discussing healthcare but equally applicable to the justice system). The involvement of the public in both systems rests at least partly on an observation that the private sector is unable to ensure access on the basis of need. Left to market forces and treated as commodities, health and justice often entail significant costs at the point of access — especially when the professionalization of these services results in restrictions on the supply side — while "the removal of financial barriers at point of need is central to the successful securing of access for all but the most wealthy" (Weale, 2016, p. 45; see also Flood & Gross, 2014, p. 453).

In the case of healthcare, this concern for equality is reflected in the push of many countries towards universal health coverage, that is, "ensuring that all people can obtain the services they need without suffering financial hardship" (Báscolo et al., 2018; Dmytraczenko & Almeida, 2015, p. 1). While universal coverage is far from being achieved, it has gained momentum in recent years, notably with the adoption of resolutions at the World Health Organization (2004) and the United Nations (2002).[15] Many countries have also developed programs targeted at specific populations in order to reduce pre-existing inequities in access to care (Houghton et al., 2020). Indeed, people affected by poverty, geographic isolation, precarity or lack of work, poor education, or lower socio-economic backgrounds tend to detect health issues less quickly and to have a more limited access to the

services they need, resulting in a worse health status (Acuña et al., 2014, pp. 128–129; Dmytraczenko & Almeida, 2015, p. 1; Levy & Janke, 2016).

Similar socio-economic factors also have a detrimental impact on access to justice. Barriers to access include geographic isolation, lack of work, poor education, as well as lower socio-economic backgrounds (Currie, 2007b, p. 2; Macdonald, 1990, 1992, pp. 300–301). The access to justice movement, in a sense, is similar to the movement towards universal health coverage in its concern for achieving equal access to quality legal services, regardless of the ability to pay (see e.g. O'Connor, 1993, p. 929). However, an important distinction must be drawn between advising services and dispute resolution services. While public courts have generally been relatively affordable with manageable court fees, access to professional services and to representation by lawyers is still largely inequitable. It is also in that area that countries fail to provide coverage that is as extensive as in health care, with legal aid programs reserved for the poorest segments of society. Some authors have suggested that the commitment to equality in the justice system should justify the establishment of mechanisms for distributing legal resources more equally, as it does in the healthcare system (Wilmot-Smith, 2019, pp. 98–105). This is perhaps an area where the healthcare system could inspire the justice system, the analogy generating ideas such as a single-payer universal legal insurance scheme.

It is important to note that while the state is heavily involved in healthcare and justice, private options are usually offered alongside the public system. For instance, private health clinics offer services similar to those offered in the public system, as do arbitrators in relation to dispute resolution. With respect to legal advice, lawyers are in majority part of the private sector, with a portion of lawyers being employed by the state and often another portion being paid through legal aid schemes. Similar situations exist in the healthcare system: depending on the country, health professionals are employed by the state, work privately, or are private providers paid through a public insurance scheme. The public-private divide and its implications for access must be considered when designing services in both systems.

Finally, like many other public goods, health and justice face resource constraints as soon as they are provided by the state. In the face of such constraints, the state must set priorities and choose the principles that will

guide the distribution of resources (Weale, 2016, pp. 46–47). As previously described, both systems treat in priority those situations in which the passage of time has a deteriorating effect and where the consequences are potentially significant. Beyond this order of priority, the guiding principle that usually determines the delivery of services in both cases is equality (for healthcare, see e.g. Flood, 2000, p. 27; for justice, see e.g. Wilmot-Smith, 2019).

BEYOND COMPARISONS: THE INTERRELATIONSHIP BETWEEN HEALTH AND JUSTICE

As the previous analysis shows, the healthcare and justice systems share many similar features that must be considered when designing modes of service delivery: the problems that they have to address are similar in many ways, their complexity leads to some degree of professionalization, and their importance justifies the involvement of the state, at least to some extent. But in addition to being comparable, health and justice are also intertwined in many cases.

On the one hand, health problems may lead to legal issues, especially when they are not promptly treated. Consider the example provided above of a person breaking her arm. This physical injury is first and foremost a health problem, but it might quickly lead to legal issues: if the responsibility for the incident can be attributed to someone else, the injured person might want to claim damages for medical costs, moral harm, and perhaps for any wage lost during the recovery period. But the legal effects of this injury might be more pernicious as well. If the injured person loses her income for a few weeks, she may not be able to pay her mortgage, which will give rise to debt-related legal issues. Or she may be unable to pay rent, which will lead to housing-related legal issues. Research has shown, in fact, that health problems often give rise to a number of legal issues (Currie, 2007a; Nobleman, 2014).

On the other hand, legal issues are also a factor contributing to the emergence of health problems. Consider the situation of a person who is trying to recover a large debt before the courts. The inability to access that money in the meantime might impair that person's ability to pay for basic needs such as food and shelter, which will affect her health. The litigation process itself often takes its mental and physical toll on litigants. Research

has shown that legal issues do have a detrimental impact on the health of many litigants (Nobleman, 2014; Pleasence et al., 2008).

This link between justice and health has implications for the design of modes of service delivery in both systems. While both systems often operate in silos, they should perhaps more frequently combine their services to offer a more holistic approach to a person's problems, which may have both legal and health implications. In that same vein, scholars in the United States have called for the healthcare community to take legal issues more seriously as a determinant of health, and for the legal community to consider health issues as a central component for the achievement of justice (see e.g. Lawton & Sandel, 2014, p. 33).

DRAWING INSPIRATION FROM THE HEALTHCARE SYSTEM

By now, it should be clear that there is a close relationship between health and justice and that it is possible to draw on modes of service delivery developed in the healthcare system to inspire innovation in the quest for access to justice. The objective of this last section is to provide a glimpse into potential solutions that the analogy between health and justice can reveal. Of course, there are many more examples, and my hope is that others will find it useful to discover these examples, analyze them, and apply them within their own legal system.

It is important, first, to make a caveat. The comparison between the general features of the healthcare and justice systems provided in this chapter applies in most jurisdictions, because of its conceptual nature. Most healthcare and justice systems address similar problems, with some degree of professionalization and public investment. However, when we move from this abstract comparison to the concrete design of modes of service delivery, a series of other factors come into play which depend on the particular country or region at issue. For that reason, a solution implemented in Guatemala's healthcare system, for example, will be more plausibly suited to Guatemala's justice system than to the justice system of another country. Analogies between the services implemented in different jurisdictions are also helpful to spur creativity, but their relevance is limited by the fact that contextual factors might differ between these jurisdictions.

Having made this caveat, I will explore examples of innovations in the healthcare system that could be transferred to the legal system. I have already discussed the division of labour between different types of professionals, which the healthcare system appears to achieve better than the justice system, as well as the degree of involvement of the state in the delivery of services, which is also higher in the healthcare system. I will explore two further aspects: the decentralization of services (a) and the single-window approach (b).

DECENTRALIZATION: COMMUNITY CLINICS AND HOME CARE

In some countries, healthcare services are much more decentralized than the dispute resolution services provided by the justice system. This decentralization has generally had a positive impact on the accessibility of healthcare services, which suggests that the justice system could also seek to decentralize its dispute resolution services in order to increase access to justice.

Consider the example of the Canadian province of Quebec. The justice system is organized hierarchically: the Court of Appeal is at its apex;[16] the Superior Court and the Court of Quebec both have jurisdiction in the whole province; municipal courts have jurisdiction over minor penal offences and some municipal civil cases in their locality; and administrative tribunals are in charge of most administrative disputes (*Act respecting municipal courts*; *Courts of Justice Act* (Quebec), ss. 1-2, 18, 51-52, 138). As we go down this pyramid, the number of physical locations for each tribunal generally increases. With some exceptions, the Court of Appeal only sits in two locations — Montréal and Quebec City — while the Superior Court and the Court of Quebec sit in approximately 55 locations (Justice Quebec, 2017). There are currently 89 municipal courts in Quebec (Cours municipales du Quebec, 2017), while administrative tribunals usually sit in a limited number of locations due to their specialized mandate.[17]

The healthcare system is similarly organized in different levels of services. Cases requiring a high degree of specialization are usually dealt with in large hospitals, which are often affiliated with universities (Ministère de la Santé et des Services sociaux, 2017, p. 5). Other serious cases and those requiring some level of specialization are treated in other hospitals, while minor cases are treated in medical clinics and Local Community Services

Centres (CLSCs) (Ministère de la Santé et des Services sociaux, 2017, pp. 7, 9). Specialized resources provide rehabilitation services, services to youth, and services to the elderly (Ministère de la Santé et des Services sociaux, 2017, p. 7). The number of locations where people are able to access treatment is greater at all levels than in the justice system: there are seven university hospitals at the apex, around 110 hospitals in total, more than 150 CLSC locations (Ministère de la Santé et des Services sociaux, 2020) and hundreds of medical clinics.

More important however is the geographical proximity of those services to the population. The greater number of access points in the healthcare system means that a person who has a minor health problem will generally be able to see a professional in her city and even sometimes in her neighbourhood, and to obtain treatment for a range of ailments. For a more serious problem, a hospital and specialized resources are likely to be available in the same region. In contrast, the same person will often have no dispute resolution mechanism in her city — except in larger ones — which means that she will have to travel sometimes significant distances to access dispute resolution services.

As we have seen before, geographical proximity is an important factor in access to healthcare and justice, and the lack of proximity can easily become a barrier (Macdonald, 1990, pp. 300–301). This barrier is even more significant because it is often coupled with other factors affecting access to justice "such as living in an Aboriginal community or older age" (Hughes, 2013, p. 15). Requiring people to have access to transportation to access justice might pose a problem "particularly for those who do not have their own car whether it is because they cannot afford it, have never learned to drive, have reached an age where they find driving more difficult or are no longer permitted to drive" (Hughes, 2013, p. 16).

By contrast, legal advising services are often more readily accessible and more geographically dispersed, with lawyers having their own private practice in small villages or towns. These services are valuable as they allow people to obtain legal advice close to where they live, and as they also allow for the informal resolution of a number of disputes through direct negotiation. However, they do not provide dispute resolution services in the same way as medical clinics provide both advice and a range of direct treatments. Therefore, while legal advice might be geographically access-

ible in many jurisdictions, the same is often not true for dispute resolution mechanisms and especially for mechanisms provided by the state.

One potential solution is to follow other countries which have developed local mechanisms of dispute resolution in an effort to decentralize their justice system. To take but one example, Colombia has created the position of community justices of the peace in application of article 247 of its Political Constitution of 1991, which states that "*la ley podrá crear jueces de paz encargados de resolver en equidad conflictos individuales y comunitarios*" (the law may create justices of the peace charged with resolving in equity individual and community conflicts). While the jurisdiction of these justices is limited both in monetary terms and with regards to the types of disputes they may adjudicate, they provide a first point of access to justice in many communities, with 537 of them across Colombia in 2018 (Consejo Superior de la Judicatura de la República de Colombia, 2018, p. 43). There are justices of the peace in other jurisdictions as well, but in Quebec for example they exercise their functions in criminal and penal matters only, and still within the points of service designated for other courts, which means that they do not increase the geographical accessibility of legal services.

The healthcare system in Quebec also adopts another solution to bring healthcare services closer to people's homes, namely home care. For certain types of chronic ailments or situations of invalidity, the Quebec Government provides professional services to admissible patients directly at their home (Ministère de la Santé et des Services sociaux, 2003). All legal services are perhaps not amenable to this mode of delivery, but it could be explored in some cases. With respect to dispute resolution, could we think of community judges meeting in someone's home to resolve their dispute with a neighbour or with their landlord? With respect to legal advising services, could we think of lawyers paid by the state being available to meet people at their home and provide them advice on everyday legal issues? These are merely hypotheses generated by the analogy with healthcare services, but they could merit further exploration.

In addition to providing services that would be more accessible geographically, the decentralization of legal services could be an occasion to strengthen the link between justice and health and to foster a holistic approach to users' problems. For instance, CLSCs across the province

of Quebec already provide services in multiple health and social services disciplines. They could perhaps also host decentralized legal services. One could think, for instance, of judges or lawyers providing services in those CLSCs. This potential combination of multiple services in the same place leads us to the second innovation in healthcare which could inspire the justice system: the single-window model.

SINGLE-WINDOW MODEL AND TRIAGE MECHANISMS

A challenge that faces both the healthcare and justice systems is the large number of institutions they host, each with their own specific functions. For potential patients or litigants, it is sometimes difficult to identify precisely the institution to which they should turn. The challenge, then, is to direct them as efficiently as possible to the right resource.

Each institution generally has its triage area. Hospitals — and especially their emergency rooms — triage patients to determine the order in which they should be seen by a doctor; medical clinics also have their triage mechanisms; and courts and tribunals have clerks to administratively manage cases. However, these institutional triage mechanisms do not have the role of redirecting patients or litigants to the appropriate resources outside of their respective institutions.

In the Quebec healthcare system, various primary care services have been implemented to resolve this issue. For example, Info-Santé is a service available by phone 24 hours a day, every day, which gives professional opinions on minor health problems and redirects people to the appropriate resources for further treatment (Government of Quebec, 2020). The line functions as a single-window service — a one-stop shop — for all health services in the province.

In the Quebec justice system, no similar public help line exists to direct people to the proper services or to give them advice on minor legal issues. The closest services are those provided by Community Justice Centres, non-profit organizations who offer free legal information to individuals in ten locations and refer them to other legal resources according to their needs (Réseau des Centres de justice de proximité du Quebec, 2020). Many community legal clinics also provide the same type of information. However, those services are generally not offered by

phone, are primarily available during business hours, and do not always provide legal advice.

Single-window services are not unheard of in other justice systems. In Ontario, unified family courts are available in 25 locations, which allows people to access a single court for all their family issues instead of having to petition either the Ontario Court of Justice or the Superior Court of Justice based on the nature of their issue (*Courts of Justice Act* (Ontario), s. 21.1; Ministry of the Attorney General of Ontario, 2019). While this service does not address issues other than family-related ones, it implements the single-window approach in a more limited way.

This is perhaps another area where the example of the healthcare system could provide inspiration for potential solutions of access to justice. One could explore, for example, the possibility of implementing a single-window service available to citizens to access legal services easily and quickly, and even to provide legal advice on minor issues.

CONCLUSION

Many authors instinctively draw from examples of solutions implemented in the healthcare system in order to advocate for innovative changes in their justice system. This chapter has shown that beyond intuition, this analogy also holds when the comparison between both systems is made in a more comprehensive and systematic way. Both systems address situations that are "not right" and cause harm to the person(s) concerned. The detectability of some of these problems is an issue for both systems, as is the passage of time. Both systems must prioritize cases according to the impact of time and their level of urgency, and they are unable to guarantee outcomes. And both systems provide services that are largely professionalized and in which the state is generally involved, at least to some extent. Beyond their comparability, health and justice are closely linked since health problems often lead to legal ones and vice versa.

The analogy has its limits. It is primarily helpful to generate hypotheses about potential solutions in the justice system, but these solutions still need to be further explored and tested. In addition, when transferring a solution from the healthcare system to the justice system, the latter's particularities must be taken into account. These are primarily the cor-

relative nature of most legal issues, which requires taking into account a broader array of interests and which gives rise to the distinction between advising services and dispute resolution services, as well as the fact that the justice system must concern itself with legal persons in addition to individuals. Furthermore, the comparison of concrete healthcare and justice institutions must be attuned to the specificities of each jurisdiction. Thus, solutions drawn from a jurisdiction's healthcare system are likely to be more appropriate in that jurisdiction's justice system than in another jurisdiction.

Within these limits, the analogy between both systems can provide much-needed inspiration. For example, the allocation of tasks between different professionals appears to be more efficient in the healthcare system than in the justice system; states appear to recognize more readily the consequences of an egalitarian framework on their involvement in the healthcare system than they do in the justice system; services are often more decentralized and thus more geographically accessible in the healthcare system than in the justice system; and the healthcare system appears to have more single-window services than the justice system. These are all areas where the healthcare system can inspire potential new modes of legal service delivery. My hope is that this general framework will provide a starting point to explore further the close interrelationship between healthcare and justice systems, and the wealth of initiatives that could be transferred from the former to the latter.

REFERENCES

Acuña, C., Marin, N., Mendoza, A., Emmerick, I. C. M., Luiza, V. L., & Azeredo, T. B. (2014). Determinantes sociales de la exclusión a los servicios de salud y a medicamentos en tres países de América Central. *Revista Panamerica de Salud Pública*, *35*(2), 128–135. https://doi.org/10665.2/8399

Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights [Protocol of San Salvador]. (November 17, 1988). OAS T.S. 69, 28 I.L.M. 156.

Alvarez-Risco, A., & Del-Aguila-Arcentales, S. (2019). Pharmaceutical care in Latin America. In F. Alves da Costa, J. W. F. van Mil, & A. Alvarez-Risco (Eds.), *The pharmacist guide to implementing pharmaceutical care* (pp. 183–190). Springer International Publishing. https://doi.org/10.1007/978-3-319-92576-9_16

American Convention on Human Rights. (November 22, 1969). 1114 U.N.T.S. 123. https://treaties.un.org/pages/showDetails.aspx?objid=08000002800f10e1

Báscolo, E., Houghton, N., & Del Riego, A. (2018). Lógicas de transformación de los sistemas de salud en América Latina y resultados en acceso y cobertura de salud. *Revista Panamericana de Salud Pública*, *42*(e126). https://doi.org/10.26633/RPSP.2018.126

Bou Malhab v. Diffusion Métromédia CMR inc., [2011] 1 SCR 214 (Supreme Court of Canada). http://canlii.ca/t/2frk1
Brown, L. M., & Dauer, E. A. (1994). Rx for 'legal health'. *Experience*, 5(2), 32–37.
Brown, L., & Seoane-Vazquez, E. (2019). Pharmaceutical care in North America. In F. Alves da Costa, J. W. F. van Mil, & A. Alvarez-Risco (Eds.), *The pharmacist guide to implementing pharmaceutical care* (pp. 145–158). Springer International Publishing. https://doi.org/10.1007/978-3-319-92576-9_13
Burns, E. A. (2019). *Theorising professions: A sociological introduction*. Palgrave Macmillan. https://doi.org/10.1007/978-3-030-27935-6
Congreso de los Estados Unidos de Colombia. (October 4, 2007). *Ley 1164 de 2007*. Diario Oficial no 46.771.
Congreso de los Estados Unidos de Colombia. (June 28, 2018). *Ley 1905 de 2018*. Diario Oficial nº 50.638.
Consejo Superior de la Judicatura de la República de Colombia. (2018). *Informe al Congreso de la República*. https://www.ramajudicial.gov.co/documents/1545778/5597675/Informe+al+Congreso+de+la+Rep%C3%BAblica+2018.pdf
Constitución Política de Colombia. (1991).
Cours municipales du Québec. (2017). *Liste des cours municipales*. http://www.tribunaux.qc.ca/c-municipales/FS-Liste.html
Currie, A. (2007a). Civil justice problems and the disability and health status of Canadians. *Journal of Law and Social Policy*, *21*, 31–48.
Currie, A. (2007b). *The legal problems of everyday life: The nature, extent and consequences of justiciable problems experienced by Canadians*. Department of Justice Canada.
Dittrich, R., Cubillos, L., Gostin, L., Chalkidou, K., & Li, R. (2016). The international right to health: What does it mean in legal practice and how can it affect priority setting for universal health coverage? *Health Systems & Reform*, *2*(1), 23–31. https://doi.org/10.1080/23288604.2016.1124167
Dmytraczenko, T., & Almeida, G. (Eds.). (2015). *Health care for all: Toward universal health coverage and equity in Latin America and the Caribbean: evidence from selected countries*. The World Bank Group. https://doi.org/10.1596/978-1-4648-0454-0
Felstiner, W. L. F., Abel, R. L., & Sarat, A. (1980). The emergence and transformation of disputes: Naming, blaming, claiming.... *Law & Society Review*, *15*(3), 631–654.
Flood, C. M. (2000). *International health care reform: A legal, economic, and political analysis*. Routledge.
Flood, C. M., & Gross, A. (Eds.). (2014). *The right to health at the public/private divide: A global comparative study*. Cambridge University Press. https://doi.org/10.1017/CBO9781139814768
García Villegas, M., & Ceballos Bedoya, M. A. (2019). *La profesión jurídica en Colombia: Falta de reglas y exceso de mercado*. Editorial Dejusticia. Retrieved from: https://www.dejusticia.org/publication/la-profesion-juridica-en-colombia/
Gentner, D., & Maravilla, F. (2018). Analogical reasoning. In L. J. Ball & V. A. Thompson (Eds.), *The Routledge international handbook of thinking and reasoning* (pp. 186–203). Routledge. https://doi.org/10.4324/9781315725697
Government of Québec. (2020). *Info-Santé 811*. https://www.quebec.ca/en/health/finding-a-resource/info-sante-811
Horvath, L. M. (1998). The legal checkup for the elderly: Diagnosing and preventing common legal illnesses. *Thomas M. Cooley Journal of Practical and Clinical Law*, *2*(1), 41–58.
Houghton, N., Bascolo, E., & Del Riego, A. (2020). Socioeconomic inequalities in access barriers to seeking health services in four Latin American countries. *Revista Panamericana de Salud Pública*, 44(e11). https://doi.org/10.26633/RPSP.2020.11
Hughes, P. (2013). Advancing access to justice through generic solutions: The risk of perpetuating exclusion. *Windsor Yearbook of Access to Justice*, *31*(1), 1–22.

International Covenant on Economic, Social and Cultural Rights. (December 16, 1966). 993 U.N.T.S. 3.

Justice Québec. (2017). *Find a courthouse*. https://www.justice.gouv.qc.ca/nous-joindre/trouver-un-palais-de-justice/

Juthe, A. (2005). Argument by analogy. *Argumentation*, *19*(1), 1–27. https://doi.org/10.1007/s10503-005-2314-9

Laverack, G. (2019). *Public health: Power, empowerment and professional practice* (4th ed.). Red Globe Press.

Lawton, E. M., & Sandel, M. (2014). Investing in legal prevention: Connecting access to civil justice and healthcare through medical-legal partnership. *Journal of Legal Medicine*, *35*(1), 29–39. https://doi.org/10.1080/01947648.2014.884430

Legislative Assembly of Ontario. *Courts of Justice Act*, R.S.O. 1990, c. C.43. https://www.ontario.ca/laws/statute/90c43

Legislative Assembly of Ontario. *Regulated Health Professions Act*, S.O. 1991, c. 18. https://www.ontario.ca/laws/statute/91r18

Levy, H., & Janke, A. (2016). Health literacy and access to care. *Journal of Health Communication*, *21*, 43–50. https://doi.org/10.1080/10810730.2015.1131776

Macdonald, R. A. (1990). Access to justice and law reform. *Windsor Yearbook of Access to Justice*, *10*, 287–337.

Macdonald, R. A. (1992). Theses on access to justice. *Canadian Journal of Law & Society*, *7*(2), 23–45. https://doi.org/10.1017/S0829320100002325

Macdonald, R. A. (2005). Access to justice in Canada today: Scope, scale and ambitions. In J. Bass, W. A. Bogart, & F. H. Zemans (Eds.), *Access to Justice for a New Century: The Way Forward* (pp. 19–112). Law Society of Upper Canada.

Markman, A. B., & Moreau, C. P. (2001). Analogy and analogical comparison in choice. In D. Gentner, K. J. Holyoak, & B. N. Kokinov (Eds.), *The analogical mind: Perspectives from cognitive science*. MIT Press.

Ministère de la Santé et des Services sociaux. (2003). *Chez soi : Le premier choix : La politique de soutien à domicile*. Gouvernement du Québec. Retrieved from: https://publications.msss.gouv.qc.ca/msss/document-001351/

Ministère de la Santé et des Services sociaux. (2017). *Le système de santé et de services sociaux au Québec en bref*. Gouvernement du Québec. Retrieved from: https://publications.msss.gouv.qc.ca/msss/document-000152/

Ministère de la Santé et des Services sociaux. (2020). *Liste des CLSC*. https://publications.msss.gouv.qc.ca/msss/fichiers/statistiques/decoupage-territorial/ListeCLSC.pdf

Ministry of the Attorney General of Ontario. (2019). *Ontario's Family Courts Structure: Family Law*. https://www.attorneygeneral.jus.gov.on.ca/english/family/famcourts.php

National Assembly of Québec. *Act respecting municipal courts*, C.Q.L.R., c. C-72.01. http://legisquebec.gouv.qc.ca/en/ShowDoc/cs/C-72.01

National Assembly of Québec. *Act respecting the Barreau du Québec*, C.Q.L.R., c. B-1. http://legisquebec.gouv.qc.ca/en/ShowDoc/cs/B-1

National Assembly of Québec. *Courts of Justice Act*, C.Q.L.R., c. T-16. http://legisquebec.gouv.qc.ca/en/showDoc/cs/T-16

National Assembly of Québec. *Pharmacy Act*, C.Q.L.R., c. P-10. http://legisquebec.gouv.qc.ca/en/ShowDoc/cs/P-10

National Assembly of Québec. *Professional Code*, C.Q.L.R., c. C-26. http://legisquebec.gouv.qc.ca/en/showdoc/cs/c-26

National Assembly of Québec. *Règlement sur les conditions et modalités de délivrance du permis et des certificats de spécialiste du Collège des médecins du Québec*, C.Q.L.R., c. M-9, r. 20.1. http://legisquebec.gouv.qc.ca/fr/ShowDoc/cr/M-9,%20r.%2020.1

Nobleman, R. L. (2014). Addressing access to justice as a social determinant of health. *Health Law Journal*, *21*, 49–74.

O'Connor, K. (1993). Civil justice reform and prospects for change symposium: Reinventing civil litigation. *Brooklyn Law Review*, *59*(3), 917–930.
Oldenburger, D., De Bortoli Cassiani, S. H., Bryant-Lukosius, D., Valaitis, R. K., Baumann, A., Pulcini, J., & Martin-Misener, R. (2017). Implementation strategy for advanced practice nursing in primary health care in Latin America and the Caribbean. *Revista Panamericana de Salud Pública*, *41*(e40). https://doi.org/10.26633/rpsp.2017.40
Parliament of Canada. *Judges Act*, R.S.C. 1985, c. J-1.
Parliament of Canada. *Supreme Court Act*, R.S.C. 1985, c. S-26.
Perelman, C. (1982). *The realm of rhetoric*. University of Notre Dame Press.
Pleasence, P., Balmer, N. J., & Buck, A. (2008). The health cost of civil-law problems: Further evidence of links between civil-law problems and morbidity, and the consequential use of health services. *Journal of Empirical Legal Studies*, 5(2), 351–373. https://doi.org/10.1111/j.1740-1461.2008.00127.x
Presidente de la República de Colombia. (January 13, 1987). *Decreto 52 de 1987*. Diario Oficial no 37.755.
Presidente de la República de Colombia. (June 20, 2002). *Decreto 1278 de 2002*. Diario Oficial, no 44.840.
Presidente de la República de Colombia. (November 9, 2010). *Decreto 4192 de 2010*. Diario Oficial no 47.888.
Raz, J. (1979). *The authority of law: Essays on law and morality*. Oxford University Press. https://doi.org/10.1093/acprof:oso/9780198253457.001.0001
Réseau des Centres de justice de proximité du Québec. (2020). *Centres de justice de proximité: For easier access to justice*. https://www.justicedeproximite.qc.ca/en
Sen, G. (2019). Beyond the JD: How eliminating the legal profession's monopoly on legal services can address the access-to-justice crisis. *University of Pennsylvania Journal of Law and Social Change*, *22*(3), 121–148.
Susskind, R. (2019). *Online Courts and the Future of Justice*. Oxford University Press.
Susskind, R. E., & Susskind, D. (2015). *The future of the professions: How technology will transform the work of human experts* (1st ed.). Oxford University Press.
Trabucco, L. (2018). What are we waiting for? It's time to regulate paralegals in Canada. *Windsor Yearbook of Access to Justice*, *35*, 149–176. https://doi.org/10.22329/wyaj.v35i0.5277
Tribunal administratif des marchés financiers. (2020). *Mobility of the Tribunal*. https://tmf.gouv.qc.ca/en/hearings/mobilite-du-tribunal/
United Nations. (2002). *United Nations General Assembly Resolution A/67/L.36: Global Health and Foreign Policy*.
Weale, A. (2016). Principles of access: Comparing health and legal services. In E. Palmer, C. Tom, A. Guinchard, & Y. Marique (Eds.), *Access to Justice: Beyond the Policies and Politics of Austerity* (pp. 41–51). Hart Publishing. https://doi.org/10.5040/9781474203456
Weinreb, L. L. (2016). *Legal reason: The use of analogy in legal argument* (2nd ed.). Cambridge University Press. https://doi.org/10.1017/CBO9781316597774
Western Canadian Shopping Centres Inc. v. Dutton, [2001] 2 SCR 534 (Supreme Court of Canada). http://canlii.ca/t/520c
Wilmot-Smith, F. (2019). *Equal justice: Fair legal systems in an unfair world*. Harvard University Press. https://doi.org/10.4159/9780674243729
Winn, D. A. (1986). Preventive law, legal checkups, and the general practitioner. *Preventive Law Reporter*, 4(5), 132–136.
World Health Organization. (2004). *World Health Assembly Resolution WHA 64.9. Sustainable Health Financing Structures and Universal Coverage.*

ENDNOTES

1 Another way of viewing this analogy is as a form of deductive reasoning from a general rule that all electronics have a booting process that serves the same function. Some analogies, especially when they are relatively simple, can readily be expressed as examples of deduction, although the thought process that leads to the conclusion is different. Furthermore, in complex situations affected by many factors — for example finding the best paths of access to justice — a "general rule" may be difficult or even impossible to find, which makes analogies even more useful.

3 I do not pretend to provide a detailed and exhaustive comparison of all the relevant similarities and differences between the healthcare system and the justice system, but I see those discussed here as the most important in determining the modes of service delivery in both systems.

4 For one view of the main functions of the justice system (and law in general), see Raz (1979), ch. 9.

5 In the justice system, the model of "naming, blaming and claiming", while criticized for its incompleteness, identifies the issue of "naming" (i.e. identifying) legal problems as a threshold issue: Felstiner et al. (1980). Authors in the healthcare system similarly see the identification of health problems as an important issue: See e.g. Acuña et al. (2014).

6 For a general explanation of the history of class actions in the Commonwealth and of the conceptual requirement of an individual claim, see e.g. *Western Canadian Shopping Centres inc. v. Dutton* (2001). The Court also noted in *Bou Malhab v. Diffusion Métromédia CMR inc.* (2011, para. 54) that "the plaintiff must prove an injury shared by all members of the group so the court can infer that personal injury was sustained by each member" (emphasis added).

7 The COVID-19 pandemic most recently made very clear that the collective outcomes of public health measures are quite important.

8 This difference in the division of services was also pointed out by Wilmot-Smith (2019, pp. 91–92).

9 The exact requirements vary across jurisdictions. For example, Quebec lawyers are required to become members of the Quebec Bar and are subject to its disciplinary council (*Act respecting the Barreau du Québec*, ss. 45, 60, 128, 132), while Colombian lawyers are not required to be members of a *Colegio de Abogados* but have to pass an entry exam and remain subject to the disciplinary jurisdiction of the *Sala Disciplinaria del Consejo Superior de la Judicatura* (*Ley 1905 de 2018*; García Villegas & Ceballos Bedoya, 2019, pp. 21–22).

10 With respect to lawyers, see the examples of Quebec and Colombia, *ibid*. With respect to physicians, Quebec requires the completion of postdoctoral studies consisting in a series of internships and the completion of a final examination (*Règlement sur les conditions et modalités de délivrance du permis et des certificats de spécialiste du Collège des médecins du Québec*). Colombia requires physicians to complete a medical university degree and a "social service" (*Ley 1164 de 2007*, ss. 18, 33). Again, the requirements vary across jurisdictions.

11 For example, judges appointed by the Government of Canada must be members of at least ten years standing of the bar of a province and are subject to disciplinary inquiries by the Canadian Judicial Council (*Judges Act*, ss. 3, 60(2)). Similarly, most Colombian judges must have been lawyers for ten years prior to their appointment or follow the judicial training and selection process, and they are subject to the authority of a disciplinary body (*Constitución Política de Colombia*, 1991, ss. 232, 256; *Decreto 52 de 1987*).

12 Again, this depends on the jurisdiction. In Colombia, for instance, teachers are considered professionals and are subject to evaluations of their performance and conduct (*Decreto 1278 de 2002*).

13 In Quebec, for instance, the "principal function of each [professional] order shall be to ensure the protection of the public" (*Professional Code*, s. 23). In Ontario, "health professions are regulated and co-ordinated in the public interest" (*Regulated Health Professions Act*, s. 3). In Colombia, the *colegios profesionales del area de la salud* have "*la finalidad de promover la utilidad y el significado social de una profesion del area de la salud*" (i.e. their function is to promote the social utility and signification of their profession) (*Decreto 4192 de 2010*, art. 2o). It is worth noting that the complexity of healthcare issues largely results from natural factors that cannot be altered, whereas the complexity of legal problems derives in large part from the complexity of law, which is not immutable and can also be tackled in order to improve access to justice.

14 In Quebec, the adoption of Bill 41 in June 2015 allowed pharmacists to renew prescriptions, prescribe tests, some types of medications, adjust prescriptions, and administer medication in some circumstances: *Pharmacy Act*, s. 17.

15 Guaranteeing a right to health might however have the impact of prioritizing care for those who have the financial resources to petition the justice system and thus gain access to treatment that would otherwise have not been part of the choices made by the state in the course of its priority-setting exercise (Dittrich et al., 2016; Flood & Gross, 2014).

16 The Supreme Court of Canada has final jurisdiction over decisions of the Quebec Court of Appeal (*Supreme Court Act*, s. 37). However, only institutions located in the province are considered here.

17 The Tribunal administratif des marchés financiers, for instance, sits in Montréal but indicates that it is available to sit elsewhere in Quebec upon request (Tribunal administratif des marchés financiers, 2020).

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