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Pandemics and Pandemonium: Constitutional Jurisdiction Over Public Health

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PANDEMICS AND PANDEMONIUM: CONSTITUTIONAL JURISDICTION OVER PUBLIC HEALTH

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Abstract

It has long been accepted that the provinces have general jurisdiction over healthcare. But many aspects of public health – the branch concerned with the welfare of populations – can be argued to lend themselves to federal involvement. This was recently illustrated in 2003 when SARS, a previously unknown disease, arrived in Toronto and wreaked havoc on the local public health system. The epidemic highlighted numerous shortcomings within Ontario's system and caused us to question those of the other provinces. Not surprisingly, the federal government quickly came under heavy pressure to take leadership and action in respect of public health. In response, we received the Public Health Agency of Canada (PHAC). However, the agency's full mandate is unclear at the time of this paper, and as yet it is without an enabling statute.

This article is concerned with the extent, if any, of the constitutional jurisdiction for federal involvement in public health. It will use hypothetical federal legislation regarding infectious disease control to evaluate the possible heads of power for such involvement: Peace, Order and Good Government; Criminal Law; the Spending Power; and Quarantine and Marine Hospitals. The author will then review the long-held bases for provincial jurisdiction: Municipal Institutions; Hospitals; Property and Civil Rights; and Matters of a Local or Private Nature. Throughout the paper, the author makes reference to public health's constant struggle to balance individual rights with the welfare of the larger community. The author observes that there is a great deal of variation among the provinces in how they have chosen to balance

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these interests, and suggests that this variation can be attributed to the societal and cultural differences among the provinces. The author concludes by asserting that when a subject matter not only implicates provincial heads of power but plays heavily upon local values, there is excellent reason to leave primary jurisdiction with the provinces in all but extreme cases, despite the arguments which could be made for federal jurisdiction.

Introduction

In a recent article in the Canadian Journal of Public Health, the claim is made that:

> [A] government's fundamental role is to preserve the security of its citizenry, and as such it must be structured in a way that ensures that the health of its population is protected.[1]

But, in a federal state such as ours, which level of government is to act for this purpose? If this fundamental role applies to both the provincial and federal governments, what are the constitutional sources of power that grant the authority needed to fulfil that role? And if jurisdiction is to be shared between these two levels of government, how should it be assigned so as to respect federalism? Viewed through the lens of public health, these questions are as increasingly relevant as they are evasive of resolution.

Although a province's receipt of federal funding for healthcare is contingent upon its compliance with the federal *Canada Health Act*,[2] provinces have retained wide discretion over the provision of healthcare and health services. The provinces enjoy jurisdiction over health insurance programs,[3] the regulation of health professionals,[4] hospitals and similar institutions,[5] and the provision (and in some cases, enforcement) of treatment.[6] The provincial legislative landscape includes mental health, the protection and management of health information, hospitals, nursing homes and other care facilities, and the focus of this article,

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1 Kumanan Wilson, "The complexities of multi-level governance in public health" (2004) 95(6) Can. J. Public Health 409 at 409.

2 R.S.C. 1985, c. C-6 [*Canada Health Act*].

3 *Eldridge v. British Columbia (A.G.)*, [1997] 3 S.C.R. 624 at 646, 151 D.L.R. (4th) 577 [*Eldridge* cited to S.C.R.].

4 See Linette McNamara, Erin Nelson & Brent Windwick, "Regulation of Health Care Professionals" in Jocelyn Downie, Timothy Caulfield & Colleen M. Flood, eds., *Canadian Health Law and Policy*, 2nd ed. (Toronto: Butterworths, 2002) at 55.

5 *Constitution Act, 1867* (U.K.), 30 & 31 Vict., c. 3, reprinted in R.S.C. 1985, App. II, No. 5 at s. 92(7) [*Constitution Act*].

6 See *e.g. Schneider v. British Columbia*, [1982] 2 S.C.R. 112, 139 D.L.R. (3d) 417 [*Schneider* cited to S.C.R.]; *Fawcett v. Ontario (A.G.)*, [1964] S.C.R. 625, 45 D.L.R. (2d) 579 [*Fawcett* cited to S.C.R.].

public health. This discussion will centre on public health legislation addressing the management and control of infectious disease which, until now, has been left to the provinces and has never been seriously questioned from a constitutional division of powers perspective.[7]

However, a shift may be underway. In March 2003, a previously unknown respiratory illness appeared in Toronto and quickly began to terrorize both the public and the public health system.[8] The illness was soon coined "SARS," or Severe Acute Respiratory Syndrome. The months that followed saw 44 deaths and 438 probable and suspect cases of the disease in Canada.[9] Remarkably, the outbreak remained confined within Ontario. However, the chaos it created within that province highlighted the larger, more systemic weaknesses of public health in Canada generally. For example, Ontario's experience brought to light problems such as:

> [A] lack of surge capacity in the clinical and public health systems; difficulties with timely access to laboratory testing and results; absence of protocols for data or information sharing among levels of government; uncertainties about data ownership; inadequate capacity for epidemiologic investigation of the outbreak; lack of coordinated business processes across institutions and jurisdictions for outbreak management and emergency response; inadequacies in institutional outbreak management protocols, infection control, and infectious disease surveillance; and weak links between public health and the personal health services system, including primary care, institutions, and home care.[10]

As observed by the National Advisory Committee on SARS and Public Health, it is likely that other provinces would have faced similar

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[7] Although there has been at least one *Charter* challenge to such legislation. See *Toronto (City, Medical Officer of Health) v. Deakin*, [2002] O.J. No. 2777 (QL) (challenging the detention and treatment provisions of *Ontario's Health Protection and Promotion Act*, R.S.O. 1990, c. H-7).

[8] See especially The National Advisory Committee on SARS and Public Health, "Learning from SARS - Renewal of Public Health in Canada" (Ottawa: Health Canada, October 2003) [Learning from SARS]; World Health Organization, Communicable Disease Surveillance & Response (CSR), "Severe Acute Respiratory Syndrome (SARS)," online: <http://www.who.int/csr/sars/en>.

[9] Learning from SARS, *ibid*. at 20.

[10] *Ibid*. at 1.

issues had the outbreak not been contained.[11] Had the epidemic spread, these intra-provincial shortcomings would have been greatly compounded by numerous inter-jurisdictional problems. These problems include uncertainty as to federal and provincial responsibilities during a health crisis and the inadequate means of collaborative decision-making and action among the provinces.[12]

In response to these problems, considerable pressure was placed upon the federal government to create a national public health agency[13] and by September 2004, the agency's Chief Public Health Officer had been appointed.[14] One year earlier at the Conference of Federal, Provincial and Territorial (FPT) Ministers of Health, the participants agreed upon the necessity of inter-jurisdictional collaboration in enhancing the national public health infrastructure, and thus began the blueprint for the Pan-Canadian Public Health Network (PCPHN).[15] Although the Public Health Agency of Canada (PHAC) is currently without an enabling statute[16] and the PCPHN is still in its early stages, it is clear that the PCPHN was created to enable truly national consultation and engagement with regard to activities of the PHAC.[17] However, the federal

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[11] *Ibid*. at 20.

[12] *Ibid*. at 19.

[13] See *e.g.* Learning from SARS, *supra* note 8; The Honourable Mr. Justice Archie Campbell, "The SARS Commission Interim Report, SARS and Public Health in Ontario" (April 15, 2004) [Campbell Commission, Interim Report].

[14] Public Health Agency of Canada, News Release, "Government of Canada Appoints First Chief Public Health Officer to Head Public Health Agency Of Canada" (24 September 2004), online: <http://www.phac-aspc.gc.ca/media/nr-rp/2004/phac_nr_e.html>.

[15] Health Canada, News Release, "Conference of Federal/Provincial/Territorial Ministers of Health Halifax, Nova Scotia - September 4, 2003" (4 September 2003), online: <http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2003/2003_67_e.html>.

[16] Bill C-75, *An Act respecting the establishment of the Public Health Agency of Canada and amending certain Acts*, 1st Sess., 38th Parl., 2004-2005 received its first reading on November 16, 2005 but the session ended before the bill completed the legislative process.

[17] Health Canada, "Frequently asked questions: Chief Public Health Officer of Canada/Public Health Agency of Canada" (September 2004), online: <http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2004/2004_47bk3_e.html>; Working Group on a Public Health Agency for Canada, "Report: A Public Health Agency for Canada" (2004), online: <http://www.phac-aspc.gc.ca/publicat/phawg-aspgt-noseworthy/index.html#toc>.

status of the Agency raises the question as to Parliament's constitutional jurisdiction over public health. With respect to the agency's potential role in facilitating inter-provincial cooperation, the same question arises and the boundaries of each level of government's jurisdiction must be considered.

For the purposes of this discussion, a distinction is made between: (a) public health activities concerned primarily with the prevention and treatment of disease at the individual level, with a view to the welfare of both individuals and the public at large; and (b) the regulation of certain activities and industries with a view to protecting the public from broad-based harms such as radiation, environmental pollution, tobacco, and unsafe food and drugs. The first of these is addressed almost exclusively by provincial public health statutes, while the second has been dealt with by both levels of government and, not surprisingly, has been the source of much constitutional litigation. It is the first conception of public health with which this article is concerned.

In this article I will illustrate that the unique qualities of public health demand a complex, and sometimes unusual, division of powers analysis. Furthermore, I will argue that this uniqueness poses several challenges to a traditional conception of federalism. Given that the driving force behind current federal efforts in public health is the issue of infectious diseases,[18] this topic will be my main focus. As such, I will employ hypothetical federal legislation respecting disease management and control. Following a comprehensive analysis of potential sources of federal power to support such legislation, there will be a brief discussion of the basis for the virtually unquestioned provincial jurisdiction over matters of health. The article concludes with the finding that, notwithstanding the strong constitutional arguments for federal jurisdiction, there are equally important yet unwritten principles that are only consistent with the provinces retaining primary responsibility over public health and infectious disease control.

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[18] The term "infectious disease" is perhaps best defined by way of example, as it encompasses a wide variety of infections with little in common but for their communicable nature. Illustrations of these diseases include tuberculosis, HIV, smallpox and measles; sexually transmitted infections such as gonorrhoea and chlamydia; and also more commonplace infections such as chickenpox and influenza. The terms "infectious" and "communicable" will be used interchangeably in this article, consistent with their use in provincial public health legislation.

I. The Need For A Constitutional Analysis Of Public Health Jurisdiction

Whereas constitutional jurisdiction over health has been the theme of considerable academic discourse[19] and judicial comment,[20] it was not included as a distinct subject matter capable of federal or provincial assignment in 1867. This is likely because health may have been assumed to be a personal matter as between an individual and her doctor, attracting the responsibility of the provinces only in the event of an emergency and otherwise leaving each municipality to address issues such as sanitation and disease control.[21]

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[19] See *e.g.* M. Jackman, "Constitutional Jurisdiction Over Health in Canada" (2000) 8 Health L.J. 95 [Jackman]; André Braën, "Discussion Paper No. 2: Health and the Distribution of Powers in Canada" (Ottawa: Commission on the Future of Health Care in Canada, July 2002) [Braën]; D. Gibson, "The Canada Health Act and the Constitution" (1996) Health L.J. 1. Public health has received considerably less attention; see *e.g.* "Chapter 9: Some Legal and Ethical Issues Raised by SARS and Infectious Diseases in Canada", in Learning from SARS, *supra* note 8; R.T. McKall, "Constitutional Jurisdiction Over Public Health" (1976) 6 Man. L. J. 317.

[20] See *e.g. Eldridge*, *supra* note 3 (provision of services); *Schneider*, *supra* note 6 (detention and treatment of heroin addicts); *Fawcett*, *supra* note 6 (mental health legislation). As early as 1886, the division of powers with respect to health was judicially considered; interestingly enough, it was in the context of public health: *Rinfret v. Pope*, [1886] 12 Q L.R. 303 (Que. CA).

[21] *Report of the Royal Commission on Dominion-Provincial Relations*, Book II: Recommendations (Ottawa, E. Cloutier, Queen's Printer, 1940) at 32-35 [*Rowell-Sirois Report*]. In explaining the relative inattention given to health in the *Constitution Act, 1867*, the Commission wrote the following:

> In 1867 the administration of public health was still in a very primitive stage, the assumption being that health was a private matter and state assistance to protect or improve the health of the citizen was highly exceptional and tolerable only in emergencies such as epidemics, or for purposes of ensuring elementary sanitation in urban communities. Such public health activities as the state did undertake were almost wholly a function of local and municipal governments. It is not strange, therefore, that the British North America Act does not expressly allocate jurisdiction in public health, except that marine hospitals and quarantine (presumably ship quarantine) were assigned to the Dominion, while the province was given jurisdiction over other hospitals, asylums, charities and eleemosynary institutions. But the province was assigned jurisdiction over "generally all matters of a merely local or private nature in

While it remains true that public health is addressed at the municipal and provincial levels, the urbanization and economic interdependence of modern Canada creates novel threats to health and brands of public health emergencies of previously unimaginable scope. It is no longer sufficient to treat public health as if it were capable of the compartmentalization that applied in 1867. Not only do contemporary threats such as SARS, West Nile Virus, pandemic flu (such as the Avian Flu) and the spectre of bioterrorism suggest the desirability of a more national approach to public health, in some instances federal action may be constitutionally required.

Upon first inspection, a division of powers analysis of public health may present as purely academic. Indeed, if the recent proclamations[22] of commitment to federal-provincial cooperation are any indication, perhaps we are unlikely to see any government-initiated constitutional challenges in this area. At this point, however, it is important to accurately identify the constitutional significance of cooperation between governments. It has been held, for example, that constitutional jurisdiction cannot be obtained by a consensual transfer from one government to another.[23]

By contrast, the Supreme Court of Canada has also consistently alluded to the relevance and value of cooperation between the federal and provincial governments. For example, in *Kitkatla Band v. British Columbia (Minister of Small Business, Tourism and Culture)*[24] the federal Attorney General intervened in support of the province, arguing that the impugned provincial legislation was in fact intra vires. Writing for the Court, LeBel J. held that:

> the Province", and it is probable that this power was deemed to cover health matters, while the power over "municipal institutions" provided a convenient means for dealing with such matters.

[22] Health Canada, News Release, "Ministers of Health Announce Creation of the Pan-Canadian Public Health Network and Name Council Membership" (22 April 2005), online: <http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2005/2005_26_e.html>; Health Canada, News Release, "A 10-year plan to strengthen health care" (16 September 2004), online: <http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index_e.html>.

[23] *Nova Scotia (Attorney General) v. Canada (Attorney General)*, [1950] 4 D.L.R. 369, [1951] S.C.R. 31 at 40.

[24] [2002] 2 S.C.R. 146, 210 D.L.R. (4th) 577 [*Kitkatla* cited to S.C.R.].

> [W]hile this is not determinative of the issue…it does invite the Court to exercise caution before it finds that the impugned provisions of the Act are *ultra vires* the province.[25]

Thus, a cooperative atmosphere between the federal and provincial governments will not preclude a finding that one has subject matter jurisdiction to the exclusion of the other, but it will be one factor for consideration.

The above points are particularly important when we look to the identities of potential constitutional litigants. Experience has shown that it is more likely that a division of powers analysis will arise in the context of a larger rights-based challenge to public health legislation brought by an individual, rather than an inter-governmental challenge. In such a case, inter-governmental cooperation is likely to be irrelevant to the challenger, and the division of powers issue will inevitably be before the court.

In so far as the PHAC may offer logistical support and additional resources for provincial efforts, federal leadership in public health is relatively unproblematic from a division of powers perspective. However, at present, the full scope of the Agency's activities remains unarticulated and, possibly, undecided. Additionally, there is the federalism-inspired risk that attempts to secure federal-provincial cooperation will be unsuccessful, despite the work of the PCPHN.[26] Such a failure might provide an incentive for a more assertive – in other words, legislative – approach by the federal government.

At this point in the discussion it becomes crucial to appreciate that among the thirteen provincial and territorial jurisdictions in Canada,

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[25] *Ibid.* at 180. This practice was recently confirmed in *Rothmans, Benson & Hedges Inc. v. Saskatchewan*, [2005] 1 S.C.R. 188, 250 D.L.R. (4th) 411.

[26] While cooperative efforts might fail where one or more jurisdictions cannot agree, perhaps the more prominent concerns should be those of timeliness and inaction. For example, the 1999 Auditor General's report called for the creation of a national public health surveillance network, to be led by Health Canada. Three years later, the 2002 Report observed that limited progress had been made on most areas of the project, including the creation of data-sharing agreements with the provinces. See Auditor General of Canada, 1999 Report of the Auditor General of Canada, "Chapter 14 — National Health Surveillance: Diseases and Injuries," online: <http://www.oag-bvg.gc.ca/domino/reports.nsf/html/9914ce.html>; Auditor General of Canada, 2002 Status Report, "Health Canada — National Health Surveillance," online: <http://www.oag-bvg.gc.ca/domino/reports.nsf/html/20020902ce.html>.

there exist vastly different approaches to numerous elements of public health,[27] and to a certain extent these variations likely reflect important differences in history and culture between the provinces. Should Parliament's leadership be perceived as an intrusion into provincial jurisdiction, or in the event that a province is unwilling to yield on a particular issue, public health may present a veritable constitutional battleground. Furthermore, as stated above, it is always open for an individual litigant to question the constitutionality of one government's legislation in the context of a larger action. Regardless of how the challenge arises, a court will have to ascertain the constitutional validity of an impugned law for compliance with the division of powers.

1. Public Health as a Subject Matter

Public health can be distinguished from health, generally, on the basis of their respective 'clients'. While health (or 'medicine') focuses on individuals, public health is concerned with the communal well-being. This distinction is somewhat superficial as individual health has obvious implications for the collective interest, and the collective well-being represents the aggregate health status of individuals. However, the distinction becomes clearer when we look to the specific example of infectious disease. An infection begins at the level of the individual, but the threat of widespread transmission requires that broader-based measures be taken to prevent, manage and control that disease from causing greater harm within the community. The inherently public nature of infectious disease certainly creates a strong incentive for federal involvement; however, the corresponding provincial interest in respect of individual health and protecting their own communities is both supported by logic and manifested in long-standing provincial public health legislation and practice.

Each province currently employs a variety of public health practices as set out in their respective statutes and as implemented by regional

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[27] See *e.g.* Elaine Gibson, "Provincial/Territorial Public Health and Emergency Laws" (Presentation to Health Canada's Public Health Workshop on Quarantine and Legal Preparedness for Public Health Emergency, September 2004) [unpublished]; Jennifer L. Schulz, "Public Health Law" in Barney Sneiderman, John C. Irvine & Philip H. Osborne, *Canadian Medical Law: An Introduction for Physicians, Nurses and other Health Care Professionals*, 3rd ed. (Toronto: Carswell, 2003) [Schulz].

health authorities.[28] With respect to infectious disease, every province requires its physicians to report to their public health authority any cases of enumerated infectious diseases. In some provinces, this duty extends to others such as school teachers, and still other provinces require reporting by any individual who suspects the presence of an infectious disease in another person. Many provinces require that an infected individual's familial and sexual contacts be notified in respect of certain diseases, while others leave reporting to the discretion of the physician or are altogether silent on the matter. Once the presence of disease has been confirmed, the imposition of treatment will depend upon the province: treatment may be ordered by a medical health officer acting alone or as supported by a court order, or treatment may be at the election of the individual provided that they take necessary precautions such as isolation to minimize the risk of infecting others. Confidentiality provisions with respect to an individual's health status may afford nearly impermeable protections in some provinces while in others identifying personal information can be released to the public where it is believed necessary for the protection of the public.

This overview of public health activities is not intended to be exhaustive, but rather to provide the reader with a sense of current provincial powers and practices. Additionally, it points to the existence of gaps and inconsistencies as between the provinces in terms of how they manage disease within their own boundaries. These differences, while compatible with federalist principles,[29] may attract the scrutiny of those contemplating federal public health initiatives. As such, they will inform the hypothetical legislation and provide the starting point for a division of powers analysis.

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[28] See generally Schulz, *ibid.*, for the examples discussed here.

[29] See Peter W. Hogg, *Constitutional Law of Canada*, 2005 Student Edition (Toronto: Carswell, 2005) at ss. 52.9(d), 52.16 [Hogg]. As noted by Hogg, there is no constitutional requirement for uniform legislation among the provinces. Differential treatment that is only the result of legislative variation among the provinces will not amount to a violation of equality rights under section 15(1) of the *Charter*, as this would run contrary to the very notion of federalism.

2. The Hypothetical Legislation

This discussion will employ fictitious yet plausible federal legislation respecting highly communicable diseases. It imagines that in anticipation of newly emerging (or re-emerging) infectious diseases, Parliament has created a *Public Health Protection Act*. This umbrella legislation authorizes the Minister of Health, using criteria enumerated in the statute, to identify those infectious diseases that pose a threat to the national public health and to impose particular measures for their prevention and control. The application of the *Act* would be limited to virulent diseases with the potential to spread widely, such as SARS or the diseases addressed by the World Health Organization's *International Health Regulations*.[30] It may also include less-threatening diseases appearing in unusual clinical forms and/or frequency, such as a pandemic flu or a particular strain of infectious disease that has become resistant to all available antibiotics.

Once a disease has been recognized by the Minister, the preventative and responsive measures would be quite broad and may include: compulsory vaccination, mandatory reporting by the infected individual and others, obligatory testing for exposed individuals, the compulsion of personal health information as between the provinces and the PHAC, quarantine and isolation provisions and mandatory treatment. The PHAC, with the assistance of the PCPHN, would be responsible for advising the Minister on the development of these criteria and response measures and additionally, would make recommendations for a cooperative inter-governmental approach to infectious disease management.[31] Finally, the use of penalties including fines and, in some cases,

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[30] World Health Organization, "*International Health Regulations (1969)*," (Geneva: World Health Organization, 2003) [IHRs]. These regulations apply to cholera, plague and yellow fever. In May 2005, the World Health Organization approved a new set of regulations intended to address a wider variety of international public health threats, but they are not yet in force: see World Health Organization, News Release, "World Health Assembly adopts new International Health Regulations" (23 May 2005), online: <http://www.who.int/mediacentre/news/releases/2005/pr_wha03/en/index.html>.

[31] In these respects, the fictitious *Act* would resemble the structure of the *Canadian Environmental Protection Act, 1999*, S.C. 1999, c. 33, and its creation of a National Advisory Committee for the purpose of assisting the Minister of the Environment in making regulations with respect to the identification, control and management of

imprisonment, would be available for the purposes of securing compliance with the *Act*.[32]

II. Locating Federal Public Health Legislation Within the Division of Powers

This section will evaluate the following heads of power as possible sources of jurisdiction for federal public health legislation: Peace, Order and Good Government, the Criminal Law, the Spending Power, and the authority over Quarantine and Marine Hospitals. While there are other heads of power which may assist in supporting public health activities, such as Trade and Commerce[33] or the Treaty-Making power,[34] neither would provide an adequate basis for enacting a statute such as the *Public Health Protection Act*.

1. Peace, Order and Good Government

The residual power to legislate in relation to "peace, order and good government" (hereinafter POGG) was given to Parliament by the preamble of s. 91 of the *Constitution Act*.[35] Due to its residual nature, this power is generally reserved for consideration until the more explicit federal heads of power have been examined. However, it will be considered first here as the discussion will provide a better foundation from which to assess the other possible sources of power.

The jurisprudence recognizes two dimensions of POGG: the National Concern branch and the Emergency branch.[36] Both will be discussed briefly and then examined in the context of public health.

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toxic substances.

[32] This is consistent with provincial public health legislation, which generally creates numerous offences and corresponding penalties. The frequency with which these offences are prosecuted, however, is unknown and is likely worthy of scepticism.

[33] *Constitution Act*, *supra* note 5 at s. 91(2).

[34] As confirmed in *Re Regulation and Control of Radio Communication* [1932] A.C. 304, 2 D.L.R. 81.

[35] *Constitution Act*, *supra* note 5.

[36] See especially *R. v. Malmo-Levine; R. v. Caine*, [2003] 3 S.C.R. 571, 233 D.L.R.

i. The National Concern Branch

In *R. v. Crown Zellerbach Canada Ltd.*,[37] the Supreme Court confirmed the existence of the National Concern branch of POGG. The diverse range of topics upheld under this branch includes aeronautics,[38] the creation of a national capital region,[39] marine pollution,[40] and atomic energy.[41]

The Court in *Crown Zellerbach* provided the factors to be considered in applying the doctrine:

> For a matter to qualify as a matter of National Concern in either sense it must have a *singleness, distinctiveness, and indivisibility* that distinguishes it from matters of provincial concern and a scale of impact on provincial jurisdiction that is reconcilable with the fundamental distribution of legislative power under the Constitution.
>
> In determining whether a matter has attained the required degree of singleness, distinctiveness and indivisibility that clearly distinguishes it from matter of provincial concern it is relevant to consider what would be the effect on extra-provincial interests of a provincial failure to deal effectively with the control or regulation of the intra-provincial aspects of the matter.[42]

The scenario of an epidemic has been frequently invoked in the POGG jurisprudence as an example of a matter concerning the nation as a whole.[43] Under the Emergency branch I will consider the prospect of

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(4th) 415 at para. 69 [*Malmo-Levine* cited to S.C.R.]. Additionally, some case law suggests a possible third dimension of POGG, referred to as the 'gap' branch by Professor Hogg, *supra* note 29, s. 17.2. However, it will not be discussed here as it has not been expressly recognized by the jurisprudence and thus, it is unlikely that Parliament would rely upon it as the source of its jurisdiction over public health.

37 [1988] 1 S.C.R. 401, 49 D.L.R. (4th) 161 [*Crown Zellerbach* cited to S.C.R.].

38 *Johannesson v. West St. Paul*, [1952] 1 S.C.R. 292, 4 D.L.R. 609.

39 *Munro v. Canada (National Capital Commission)*, [1966] S.C.R. 663, 57 D.L.R. (2d) 753.

40 *Crown Zellerbach*, *supra* note 37.

41 *Ontario Hydro v. Ontario (Labour Relations Board)*, [1993] 3 S.C.R. 327, 107 D.L.R. (4th) 457.

42 *Crown Zellerbach*, *supra* note 37 at 432 [emphasis added].

43 See *e.g. Toronto Electric Commissioners v. Snider*, [1925] A.C. 396 at 412, 2

temporary legislation enacted for combating an existing emergency, but under the National Concern branch the discussion need not be so constrained. Consistent with the principle that full subject matter jurisdiction will be granted to Parliament where the matter satisfies the *Crown Zellerbach* factors,[44] there is a case to be made that federal legislation respecting infectious disease need not be limited to purely reactive measures, but may also provide for the prevention of disease outbreaks. Indeed, in *Ontario (A.G.) v. Canada Temperance Federation* the Privy Council held that:

> [T]o legislate for prevention appears to be on the same basis as legislation for cure. A pestilence has been given as an example of a subject so affecting, or which might so affect, the whole Dominion that it would justify legislation by the Parliament of Canada as a mater concerning the order and good government of the Dominion. *It would seem to follow that if the Parliament could legislate when there was an actual epidemic it could do so to prevent one occurring and also to prevent it happening again.*[45]

Thus, the case law alone provides a strong foundation for advancing infectious disease control under the National Concern branch. At the same time, it has never been seriously disputed that the provinces can legislate in respect to public health, including the prevention and control of disease. Indeed, the public health statutes of most provinces include broad provisions for combating public health crises such as epidemics.[46] But, as witnessed during the SARS outbreak of 2003, the definition of "epidemic" or "health emergency" may vary from one health authority to another, just as the assignment of such a designation may be laden with local politics.[47] Faced with the lack of distinction between public

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D.L.R. 5; *Ontario (A.G.) v. Canada Temperance Federation*, [1946] A.C. 193 at 205, 207, 2 D.L.R. 1 [*Canada Temperance*]; *Labatt Brewing Co. v. Canada*, [1980] 1 S.C.R. 914 at 934, 110 D.L.R. (3d) 594.

44 *Crown Zellerbach*, *supra* note 37 at 433.

45 *Canada Temperance*, *supra* note 43 at 207 [emphasis added].

46 See *e.g.* Saskatchewan's *Public Health Act, 1994*, S.S. 1994, c. P-37.1, s. 45.

47 China was widely criticized for under-reporting the severity of the epidemic in its early stages, both to its own citizens and to the international community. There was speculation that the under-reporting was part of larger efforts to ensure political and civil stability as the national legislatures opened for their next session. See *e.g.* Time Asia, "How Bad Is It? Beijing has come clean, but the litmus test of China's

health practice and a public health emergency, where then might the POGG power crystallize on the basis of National Concern?

Returning to the relevant factors in *Crown Zellerbach*, the jurisprudence makes it clear that neither health nor public health generally, will be a matter capable of attaining such "singleness" or "distinctiveness". Indeed, in *Schneider v. The Queen*, Estey J.[48] held that:

> '[H]ealth' is not a matter which is subject to specific constitutional assignment but instead is an amorphous topic which can be addressed by valid federal or provincial legislation, depending in the circumstances of each case on the nature or scope of the health problem in question.[49]

It follows that the National Concern doctrine will only be available, if at all, in limited circumstances and for very specific public health purposes. However, even the oft-cited example of an epidemic may require further refining before it would attract such its application. Whereas it is easy to imagine how an infectious disease could quickly become a matter of extra-provincial concern, the "distinctiveness" requirement and its focus on striking an appropriate balance of powers may pose the real challenge to federal legislation in this area.

Environmental pollution may provide a useful analogy to disease control, and the case law on that topic offers guidance on the distinctiveness inquiry. In *R. v. Hydro-Québec*,[50] several provisions of the *Canadian Environmental Protection Act* were challenged as being *ultra vires* the federal government. The sections in issue purported to regulate the release of substances that could harm the environment or present a danger to human health. The four-member minority declined to uphold the provisions under the criminal law power and moved on to the National Concern test under POGG.[51] On the issue of distinctiveness, Lamer and

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new openness is Shanghai," (28 April 2003) online: <http://www.time.com/time/asia/covers/501030505/story.html>; Time Asia, "Beijing's SARS Attack: Doctor and party member insists there are many more cases than officials will admit," (8 April 2003) online: <http://www.time.com/time/asia/news/daily/0,9754,441615,00.html>.

48 Concurring with the majority.

49 *Schneider, supra* note 6 at 142.

50 [1997] 3 S.C.R. 213, 151 D.L.R. (4th) 32 [*Hydro-Québec* cited to S.C.R.].

51 The five-member majority upheld the Act as a valid exercise of the criminal law power and thus, declined to consider it under POGG.

Iacobucci JJ.[52] held the *Act*'s definition of "toxic substances" to be "an all-encompassing definition with no clear limits,"[53] thus failing to meet the distinctiveness requirement.

In *Crown Zellerbach*, the issue was the application of the *Ocean Dumping Control Act* to marine pollution in intra-provincial marine waters. Upholding the *Act* under POGG, the four-member majority concluded that pollution of marine waters by the dumping of substances was sufficiently distinct from other forms of water pollution. One of the reasons for this finding was the difficulty in ascertaining the boundaries between intra-provincial and extra-provincial marine waters; it was argued that this difficulty "creates an unacceptable degree of uncertainty for the application of regulatory and penal provisions."[54] The minority, however, held that marine pollution was incapable of the requisite distinctiveness because environmental pollution in general is "all-pervasive" and furthermore, because of the difficulty in determining the boundaries between marine and fresh water (to which the impugned provisions did not apply).[55]

At this point it is important to make a distinction between the true pith and substance of the legislation and the means selected for addressing its subject matter. It is the subject matter that must be "distinct," not the means employed to address it. Thus, although the hypothetical legislation may contemplate a vast array of disease-control measures, the distinctiveness of the subject matter itself will not suffer as a consequence. Furthermore, the Supreme Court has held that the pith and substance of the legislation cannot be challenged on the basis that there are alternative, more effective means of achieving that purpose.[56] Thus, the wisdom of Parliament will not be questioned when it comes to the methods it chooses for the management and control of infectious disease.

On the other hand, the legal effect of the legislation may assist in illustrating its pith and substance, and thus, may be relevant to the distinctiveness inquiry. As held by McLachlin C.J. in *Ward v. Canada (Attorney General)*:

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52 Sopinka and Major JJ. concurring.

53 *Hydro-Québec*, *supra* note 50 at 260.

54 *Crown Zellerbach*, *supra* note 37 at 437.

55 *Crown Zellerbach*, *supra* note 37 at 455, 457.

56 [2002] 1 S.C.R. 569, 210 D.L.R. (4th) 42 at 582 [*Ward* cited to S.C.R.].

> The legal effect refers to how the law will affect rights and liabilities, and is also helpful in illuminating the core meaning of the law[…]. The effects can also reveal whether a law is "colourable", i.e. does the law in form appear to address something within the legislature's jurisdiction, but in substance deal with a matter outside that jurisdiction?[57]

There can be no doubt that federal public health legislation will affect legal rights that are usually reserved for regulation by the provinces. For example, more stringent reporting requirements imposed upon physicians and other health care providers will impact the confidential nature of the patient-provider relationship. Quarantine and isolation provisions may affect the legal relationship as between employers and their employees who are subjected to orders under such provisions. However the Supreme Court has held that:

> '[I]mpact' with nothing more is clearly not enough to find that a statute encroaches upon the jurisdiction of the other level of government.[58]

Therefore, short of an allegation that the federal law is colourable in such a way that it attempts to regulate a provincial matter, the intra-provincial effects will not compromise the validity of the federal law.

The reasoning in the pollution cases illustrates the distinction between pith and substance and legislative means. In *Crown Zellerbach*, for example, the disagreement between the majority and the dissent arose over whether marine pollution was a sufficiently distinct subject matter. The fact that regulation of marine pollution under the *Ocean Dumping Control Act* would involve the regulation of provincial activity such as construction and municipal activity did not compromise the distinctiveness of the issue; it simply provided an incentive for the appellant corporation to challenge the *Act*. In *Hydro-Québec*, the minority was troubled by the impugned legislation's broad conception of "toxic substances" as a subject matter; their analysis was not concerned with the proposed means of regulating those substances, regardless of how far-reaching those means might have been. Thus, the expansive gamut

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[57] *Ibid.* at 579.

[58] *Reference Re Canada Assistance Plan (B.C.)*, [1991] 2 S.C.R. 525 at 567, 83 D.L.R. (4th) 297 [*CAP Reference* cited to S.C.R.].

of measures that might be taken in respect of preventing or controlling a specific disease does not compromise the distinctiveness of the subject matter. The distinctiveness must be found in the matter to be prevented or controlled.

Generally speaking, "communicable disease" captures a vast range of infections from chickenpox to smallpox, from salmonella poisoning to tuberculosis, from gonorrhoea to HIV. In other words, the definition of "communicable disease" may suffer from the same absence of ascertainable outer limits as did "toxic substances" in the view of the dissenting judges in *Hydro-Québec*. Accordingly, there is a strong case for making federal public health legislation such as the hypothetical *PHPA* applicable only to specific diseases or circumstances (such as an unusually sizeable outbreak of an otherwise less worrisome disease) and furthermore, for providing clear and meaningful criteria for determining which diseases or circumstances will trigger its application.

In assessing the distinctiveness of infectious disease:

> [I]t is relevant to consider what would be the effect on extra-provincial interests of a provincial failure to deal effectively with the control or regulation of the intra-provincial aspects of the matter.[59]

Often referred to as the "provincial inability test," this factor tells us that the mere desirability of uniform legislation will not suffice, despite the national importance of the subject matter. The relevant concern is not a question of legislative capacity or the adequacy of provincial resources, but whether the intra-provincial efforts of one province in this regard would be compromised by the legislative choices or inaction on the part of another. The provincial inability test will only be satisfied if the failure by one province to adequately deal with the subject matter would lead to harm for the other provinces that had taken steps to address the matter.

Those cases that have satisfied the test to date centred on issues such as aeronautics, atomic energy and marine pollution. Given the nature of these subject matters, little serious discussion of the provincial inability test was required. As a result, relatively little guidance exists as to the lower threshold of provincial inability.

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[59] *Crown Zellerbach*, *supra* note 37 at 432.

Hogg, however, suggests that an epidemic is likely to satisfy the test. He observes that:

> [T]he failure of one province to take preventative measures would probably lead to the spreading of disease into those provinces which had taken preventative measures.[60]

Such a claim has immediate appeal, even if we have seen examples to the contrary. For example, during the SARS crisis of 2003, other provinces were relatively fortunate in that the outbreak remained localized to Ontario. Under such strain, the shortcomings of its public health system were brought to light and severely criticized.[61] Considering these shortcomings, the fact that the epidemic did not spread beyond the provincial borders was perhaps due largely to luck, for the simple fact remains: pathogens, like pollution, do not respect borders. Should one province fail to adequately address infectious disease control within in own population, the movement of cross-border traffic and even goods could quickly transport the disease to other regions which had previously avoided such an outbreak by adopting strict preventative measures.

The National Concern doctrine also requires "that the scale of federal intrusion upon provincial authority must be reconcilable with the constitutional division of powers."[62] This principle qualifies the broad label of "National Concern" and assists in setting the parameters of a federal regime. The above analysis suggests that legislation such as the hypothetical *PHPA* would be supportable under this branch, but there are several qualities of public health which make the division of powers reconciliation difficult. First, since Confederation public health has been dealt with almost exclusively by the provinces and, in that time, comprehensive legislation and authoritative bodies have been established in each jurisdiction. Federal initiatives will likely have to rely upon the existing public health infrastructure of each province for their successful execution. Secondly, the difficulty in separating everyday public health practice from federal activities with nation-wide importance poses practical problems in determining when the respective boundaries are being overstepped. Finally, where public health practice is most successful at

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60 Hogg, *supra* note 29 at ss. 17.3(b).

61 See especially Campbell Commission, Interim Report, *supra* note 13.

62 *Crown Zellerbach*, *supra* note 37 at 432.

preventing and controlling disease, it is arguably very private in nature, and inextricably linked to the provincially-regulated practitioner-patient relationship, health insurance and hospitals. Assuming for the sake of argument that federal legislation could satisfy the other requirements under the National Concern branch, the real challenge may arise in minimizing its impact upon the long-standing provincial jurisdiction over public health.

Finally, it is important to remember even without an attempt by Parliament to legislate in this area, a challenge to existing provincial public health laws may result in a finding that the subject matter is truly an inter-provincial concern and thus, within the exclusive legislative purview of Parliament. For example, in *Inter-provincial Co-op Ltd v. Manitoba*[63] the majority held that the provincial legislation that attempted to control and remedy intra-provincial harm resulting from extra-provincial pollution was *ultra vires*. Although the federal government was not a party to the case, the Court declared that Parliament had exclusive authority over the subject matter under their residual power.

ii. The Emergency Branch

Rendered a near-fiction by earlier decisions of the Privy Council,[64] POGG's Emergency branch of was revitalized by the Supreme Court in the *Anti-Inflation Reference*.[65] The reasoning of the Supreme Court in this case illustrates the difference between this branch and the National Concern branch. In *Anti-Inflation*, despite the fact that the all-pervasive nature of 'inflation' would not likely meet the distinctiveness requirement under National Concern, the statute was upheld as valid emergency legislation by seven of the nine judges, as reflected in two separate judgments.[66]

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[63] [1976] 1 S.C.R. 477, 53 D.L.R. (3d) 321 [*Inter-provincial Co-op* cited to S.C.R.].

[64] Save for during times of war and the immediate post-war periods, the Privy Council was unwilling to uphold federal legislation under this branch. For a discussion on this point, see Hogg, *supra* note 29 at 17.4(a)-(b).

[65] [1976] 2 S.C.R. 373, 68 D.L.R. (3d) 452 [*Anti-Inflation Reference* cited to S.C.R.].

[66] Laskin C.J. writing for Judson, Spence and Dickson JJ and Ritchie J. writing for Martland and Pigeon JJ.

Both sets of reasons affirm that the term "emergency" in this sense need not be limited to times of war, but the legislation must be temporary in nature. It was made clear that courts should not inquire into the actual existence of an emergency but, in a more deferential approach, should focus on whether Parliament had a rational basis for finding that an emergency existed.[67] Further, Parliament will not have the onus of establishing the rational basis; rather, the responsibility will be on the party challenging the legislation to prove its absence.[68]

The issue that split the Court is illustrative of the breadth afforded to the definition of "emergency" in this judgment. Despite the considerable expert evidence advanced to discount the existence of an economic crisis and the relative paucity of supporting or rebuttal evidence advanced by the federal government, the Court did not split on the "rational basis" consideration. This may very well mark the height of deference afforded to Parliament by the Court. Rather, the dissenting reasons concern Parliament's failure to make an explicit declaration that it was legislating under its residual emergency powers. On this issue, Beetz J. wrote:

> Parliament cannot enter the normally forbidden area of provincial jurisdiction unless it gives an unmistakable signal that it is acting pursuant to its extraordinary power. Such a signal is not conclusive to support the legitimacy of the action of Parliament but its absence is fatal.[69]

The reasoning of the majority in *Anti-Inflation* and the Court's strong deference to Parliament suggest that a federal law enacted for the sole purpose of combating an epidemic would be *intra vires* Parliament. However, given the hesitation of the dissenting judges in the same case, Parliament would be wise to explicitly invoke the Emergency power as the basis for subject matter jurisdiction.[70] However, it must be remem-

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67 *Anti-Inflation Reference*, *supra* note 65 at 425.

68 Martland and Pigeon JJ. concurring. The reasons of Laskin C.J. are more elusive on this point, although they have since been interpreted to place the same onus on the challenging party.

69 *Anti-Inflation Reference*, *supra* note 65 at 463.

70 The political ramifications of making such a declaration are outside the scope of this discussion, but it is recognized that there may be hesitation on the part of elected officials to employ such potentially panic-inducing terminology such as "public health emergency".

bered that such a finding amounts to only a temporary suspension of the division of powers. If the subject matter of disease control is otherwise within provincial jurisdiction, upon the conclusion of the epidemic such jurisdiction will revert back to the provinces. Thus, for sources of federal jurisdiction on an ongoing basis, the National Concern branch is the more attractive option under POGG.

However, given that the courts have been cautious in their application of the National Concern branch, as well as the deference shown to Parliament in *Anti-Inflation* with respect to the finding of a *bona fide* emergency, Parliament may be wise to make use of this branch. This route would be particularly attractive should Parliament wish to have only temporary management of disease control. For example, contemporary concerns such as SARS or Avian Flu may lend themselves to federal jurisdiction so long as they remain relatively new threats. The necessarily temporary nature of Emergency legislation requires that Parliament re-visit the subject matter at a later date and, if continued jurisdiction is desirable at that time, requires that a factual foundation be provided to support permanent legislation.

2. Criminal Law Power

In *RJR-MacDonald Inc. v. Canada (A.G.)*[71] the Supreme Court reviewed the federal criminal law power and its application in the health context. The requirements were succinctly produced by La Forest J.[72] after declining to consider POGG as the jurisdictional basis for the impugned *Tobacco Products Control Act*:

> [T]he scope of the federal power to create criminal legislation with respect to health matters is broad, and is circumscribed only by the requirements that the legislation must contain a prohibition accompanied by a penal sanction and must be directed at a legitimate public health evil.[73]

These requirements - a legitimate public purpose, and one or more prohibitions supported by a penalty - will be discussed below.

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71 [1995] 3 S.C.R. 199, 127 D.L.R. (4th) 1 [*RJR-MacDonald* cited to S.C.R.].

72 Writing for the majority on the division of powers issue.

73 *RJR-MacDonald*, *supra* note 71 at 246.

Short work can be made of establishing a valid public purpose behind legislation aimed at the control of infectious diseases. It has been held that "[p]ublic peace, order, security, health, morality: these are the ordinary though not exclusive ends served by that law,"[74] and disease control could easily be argued as serving several of these purposes and infectious diseases surely amount to a public health evil.

The reasoning in *Schneider*[75] is illustrative of the difference between a health-related purpose and a public health purpose. In that case, British Columbia sought to uphold provincial legislation providing for the detention and treatment of heroin addicts. In challenging the law's validity, the Appellant argued that such measures were in pith and substance criminal law, and thus were *ultra vires* the province. Although the statute was ultimately upheld as a valid exercise of provincial power pursuant to s. 92(16), the case can be distinguished on the basis that the law was directed towards the rehabilitation of the individual rather than the protection of the community at large. The societal dangers of heroin addiction are quite different than the threats posed by infectious disease. As measures taken in respect of such diseases are aimed at safeguarding the welfare of the greater community, laws that call for such measures are likely to have the requisite public purpose to be upheld as valid criminal law.

The next requirement from *RJR-McDonald* is that the law must create one or more prohibitions directed towards the public purpose, in this case, control of an infectious disease. For examples of prohibitions that might be included in our hypothetical legislation, we can look to existing provincial public health statutes, where prohibitions include: the failure by a health professional to report to the local public health authority in respect of a notifiable disease, the failure by an individual to follow isolation or quarantine orders, and more generally, the failure by an individual to comply with the precautionary measures ordered by a public health official, such as notification of family members and contacts of one's infectious status.[76]

The third requirement of a valid criminal law is that a penalty must attach to any prohibitions. The imposition of a fine or prison term for

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[74] *Reference re: Dairy Industry Act (Canada) s. 5(a)*, [1949] S.C.R. 1 at 50, 1 D.L.R. 433, aff'd [1951] A.C. 179.

[75] *Schneider, supra* note 6.

[76] See generally Schulz, *supra* note 27.

non-compliance is typical of both criminal law and existing provincial public health legislation.[77] However, Parliament could hardly criminalize the mere status of having an infectious disease, and short of deliberate transmission or the failure to comply with preventative measures ordered by public health officials, it would present an administrative nightmare[78] to criminalize the spreading of disease from one individual to another. Instead, public health laws often seek to prohibit and/or enforce conduct that appears to be ancillary to disease control, such as the required reporting of notifiable diseases by health care professionals to the local public health authority for surveillance purposes. It was held in *RJR-McDonald* that such an approach – the criminalizing of ancillary activity without criminalizing the underlying activity itself – does not necessarily compromise the criminal nature of the law.[79] Given this reasoning, Parliament would have wide latitude in selecting the measures to be used in combating and managing infectious disease.

Where a federal law that claims to be criminal in nature has the effect of creating a regulatory scheme allowing for exemptions and the exercise of administrative discretion, that law may face a constitutional challenge on the basis that it does not create a true prohibition and thus, is not a valid criminal law.[80] This becomes important when drafting federal public health legislation, in that existing provincial public health statutes include numerous exemptions and often authorize the exercise of discretion by public health officials in enforcing the statutory provisions. For example, Manitoba's *Public Health Act* allows individuals with an infectious disease to be exempted from a treatment order where

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[77] Although it is unclear as to how often, if at all, the penalties are imposed for the purpose of enforcing provincial public health efforts. In fact, many of the penalty provisions appear to be outdated, providing in some cases for very limited fines in consequence of some of the more serious offences under these acts. For example, s. 34 of Newfoundland's *Communicable Diseases Act* (R.S.N.L. 1990, c. C-26) provides that:

> [A] person wilfully committing a breach of this Act shall be subject to a penalty not exceeding $100, or in default of payment, to imprisonment for a period not exceeding 30 days, or to both a fine and imprisonment.

[78] Not to mention ripe grounds for a *Charter* challenge.

[79] *RJR-MacDonald*, *supra* note 71 at 258.

[80] See e.g. *Reference re: Firearms Act (Can.)*, [2000] 1 S.C.R. 783, 185 D.L.R. (4th) 577 [*Firearms Reference* cited to S.C.R.]; *Hydro-Québec*, *supra* note 50.

they oppose such treatment on religious grounds.[81] Under the Ontario *Health Protection and Promotion Act*, physicians have broad discretion in the types of directives they provide to patients suffering from an infectious disease, and non-compliance with those directives constitutes an offence under the *Act*.[82] Similar exemptions and discretion may be included in federal public health legislation, and it may very well resemble a regulatory scheme. However, if the primary *raison d'être* behind federal jurisdiction in this area is the highly virulent nature of particular diseases and the need for a common, standardized approach to their control, one would expect that such exemptions and discretion would be more circumscribed than in general provincial public health legislation.

In any event, federal legislation in this area is bound to be complex and is likely to appear regulatory in nature. The reasons in the *Firearms Reference* provide guidance as to drafting criminal law of this sort. In that case, the Court held that "[t]he fact that the [Firearms] Act is complex does not necessarily detract from its criminal nature."[83] Despite the allowance for administrative discretion in the registration of firearms and the licensing of their users, the Court found that the discretion was not overly broad, and it was sufficiently informed by the *Act*. Indeed, even if a statute gives full discretion to the responsible Minister, that is not necessarily enough to take the statute out of the criminal domain.[84]

3. The Spending Power

Although not an explicit head of power under s. 91, the federal spending power in s. 36 of the *Constitution Act, 1982*[85] affords Parliament the

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81 C.C.S.M., c. P210 at s. 32.

82 R.S.O. 1990, c. H.7 at ss. 22, 100.

83 *Firearms Reference, supra* note 80 at 805-806.

84 As was the case with the legislation in *Hydro-Québec*, *supra* note 50.

85 Being Schedule B to the *Canada Act* 1982 (U.K.), 1982, c. 11 [*Constitution Act, 1982*]. Section 36 provides:
36(1) Without altering the legislative authority of Parliament or of the provincial legislatures, or the rights of any of them with respect to the exercise of their legislative authority, Parliament and the legislatures, together with the government of Canada and the provincial governments, are committed to
(a) promoting equal opportunities for the well-being of Canadians; (b) furthering

opportunity to influence many provincial activities. Through the use of conditional grants, Parliament can provide incentives to the provinces to exercise their constitutional powers in accordance with federally-determined standards. The *Canada Health Act* operates in this manner, providing for transfer payments to the provinces on the condition that their provincial health insurance programs comply with the five criteria outlined in the *Act*.[86]

The *Canada Health Act* and several other acts were challenged in *Winterhaven Stables v. Canada* under the claim that they were statutes in relation to exclusively provincial matters and thus, were *ultra vires* Parliament. The Alberta Court of Appeal adopted the reasons of the trial judge in holding that:

> Parliament…is entitled to spend the money that it raises through proper exercise of its taxing power in the manner that it chooses to authorize. It can impose conditions on such disposition so long as the conditions do not amount in fact to a regulation or control of a matter outside federal authority.[87]

Although the sheer size of the grant or the province's palpable need for the funds may appear to blur the line between incentive and coercion, the case law suggests that the courts will not look behind the legislation to question whether the province had a real choice as to whether to accept a conditional grant.[88] Provided that the grant is not a colourable attempt by Parliament to regulate a matter falling exclusively within provincial jurisdiction, the courts will not interfere. For example, in *Winterhaven*, the Court held that the purpose of the impugned statutes was "the allocation of federal funds to assist the provinces in providing

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economic development to reduce disparity in opportunities; and
(c) providing essential public services of reasonable quality to all Canadians.
(2) Parliament and the government of Canada are committed to the principle of making equalization payments to ensure that provincial governments have sufficient revenues to provide reasonably comparable levels of public services at reasonably comparable levels of taxation.

86 *Canada Health Act, supra* note 2 at s. 7. The criteria laid out in s. 7 include: public administration, comprehensiveness, universality, portability, and accessibility.

87 (1988), 53 D.L.R. (4th) 413 (Alta. C.A.) at 434 [*Winterhaven*].

88 See *e.g. Winterhaven*, *supra* note 87; *CAP Reference*, *supra* note 58.

services"[89] and found that this was consistent with the history of cost-shared programmes as expressly contemplated in section 36.

A recent article by discusses the federal spending power as a means of implementing national public health standards as designed by PHAC at the provincial level.[90] Indeed, s. 36 of the *Constitution Act, 1982* appears to support federal spending with respect to public health. What remains unclear is whether or not the federal government can impose conditions upon such a grant absent explicit constitutional jurisdiction with respect to public health. While the jurisprudence does not openly contemplate any such requirement before the creation of a conditional grant, such a requirement may be understood from the qualification that the conditions "do not amount in fact to a regulation or control of a matter outside federal authority."[91] However, more likely is the case that this qualifier functions to provide a limit on the degree of federal involvement, rather demanding federal jurisdiction over the subject matter involved.

The value of invoking the spending power to achieve national disease-control standards is also its weakness. By affording the provinces a choice as to whether to accept a conditional grant from the PHAC, their jurisdiction over basic health matters is respected. They can choose not to adopt the federal condition and instead employ their own legislation. The possibility that one or more provinces would choose that option would provide considerable incentive for federal-provincial collaboration in creating the conditions in an effort to achieve the buy-in of the provinces. However, if one province should refuse to agree to the conditions, the value of the national scheme is compromised.[92] This could be

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89 *Winterhaven*, *supra* note 87 at 433.

90 Kumanan Wilson, "A Canadian Agency for Public Health: Could it Work?" (2004) 170(2) Canadian Medical Association Journal 222. The article does not discuss what these standards would look like, but for the purposes of this article they are contemplated as the measures specified in the hypothetical legislation (e.g., standardized reporting requirements, treatment provisions, vaccination programs, etc.). Dr. Wilson discusses the recommendations contained in Learning from SARS (*supra* note 8), namely, that if a more collaborative approach as between the federal and provincial governments should fail, Parliament could resort to its spending power and/or federal legislation for the purpose of achieving the PHAC's national standards at the provincial level.

91 *Winterhaven*, *supra* note 87.

92 As discussed above under POGG, specifically the National Concern branch's

a very real danger with respect to conditions around mandatory treatment given that some provinces take a very libertarian approach to such issues.[93] Furthermore, as the provincial public health infrastructure is long-standing and well-established, the availability of additional federal funding for public health may not be sufficiently compelling to the provinces such that they will acquiesce to the attached conditions if they oppose them. Federal funding may prove more attractive with respect to costly novel programs which exist in few, if any, jurisdictions. However, if the purpose of the funding is to supplement existing provincial programs while securing compliance with newly drafted federal standards, the persuasive value of that funding may be considerably less, particularly when it comes to the larger provinces. For these reasons, the importance of the federal spending power is limited with respect to enacting national public health standards.

4. Quarantine and Marine Hospitals

As mentioned above, Parliament has jurisdiction over "Quarantine and Marine Hospitals."[94] This power is manifested in the *Quarantine Act*,[95] which provides for the detection and management of certain infectious diseases at international points of entry and departure. While the health powers under the *Act* extend to the reporting of personal health information, health assessment of individuals, disease testing, quarantine, isolation and treatment, the reference in s. 91(11) to marine hospitals appears to limit its application to international border traffic (with the primary focus on incoming travellers), rather than recognizing a generally ap-

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provincial inability test.

93 For example, under the Quebec *Public Health Act* (R.S.Q., c. S-2.2) the only disease for which treatment can be mandated is tuberculosis (although individuals suffering from other diseases may be required to remain in isolation). By contrast, Saskatchewan's *Public Health Act, 1994,* (S.S. 1994, c. P-37.1) allows a medical health officer to order the treatment of an individual where the officer considers it necessary to decrease or eliminate the health risk presented by an infectious disease.

94 *Constitution Act*, *supra* note 5 at s. 91(11).

95 R.S.C. 1985, c. Q-1. This legislation will be replaced by Bill C-12, *An Act to prevent the introduction and spread of communicable diseases*, 1st Sess., 38th Parl. (assented to on May 12, 2005) once the accompanying quarantine regulations have been completed and approved.

plicable federal public health power. Furthermore, the quarantine power is perhaps a necessary but limited corollary of Parliament's immigration power[96] and the resulting authority over national borders. Thus, despite the fact that the federal quarantine power is the only explicit constitutional reference to public health, its presence in s. 91 provides little assistance in the broader discussion of public health and its proper jurisdictional assignment.

II. Public Health has Traditionally Been Under Provincial Jurisdiction

In *Schneider*, Dickson J.[97] held that:

> [T]his view that the general jurisdiction over health matters is provincial (allowing for a limited federal jurisdiction either ancillary to the express heads of power in s. 91 or the emergency power under peace, order and good government) has prevailed and is now not seriously questioned.[98]

As the primary focus of this article has been to examine the counter-arguments of this view with respect to public health, it is now necessary to examine its foundational underpinnings. However, the provincial heads of power, particularly those with which we are concerned here, have not received the same type of analytical treatment by the courts as we have seen for the federal heads of power. For example, there is neither a 'test' nor prescribed indicia for determining whether a matter is one of a "local and private nature," under s. 92(16). Similarly, "property and civil rights"[99] simply encompass easily recognizable matters such as tort law, contracts and the regulation of professional relationships. Thus, in responding to the federal arguments above, the discussion focuses on the conceptual rather than legal arguments for provincial jurisdiction over the control of infectious disease. Municipal Institutions will be considered first, in light of their historical role in public health leadership. Consistent with the jurisprudence, Hospitals, Property and

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96 *Constitution Act*, *supra* note 5 at s. 91(25).

97 As he then was, writing for the Court.

98 *Schneider*, *supra* note 6 at 137.

99 *Constitution Act*, *supra* note 5 at s. 92(13).

Civil Rights and Matters of a Local or Private Nature will be addressed together.

1. Municipal Institutions

The provinces were given authority to legislate in relation to "Municipal Institutions in the Province" by s. 92(8) of the *Constitution Act* and, since prior to Confederation, municipalities have taken responsibility for numerous public health matters.[100] Indeed, even today municipal public health authorities are the 'front line' for combating epidemics and other public health threats. While s. 92(8) does not provide a foundation upon which the provinces can legislate directly with respect to public health, the argument for provincial jurisdiction over such matters is supported by the long-standing role of municipalities as the first line of public health defence, and the constitutional relationship between the municipalities and their province.

The constitutional authority for such municipal and thus, provincial, responsibility was confirmed in several early cases. For example, municipal by-laws directed at infectious disease control were upheld as valid exercises of provincial jurisdiction.[101] In a slightly different approach, an earlier case found that the inherent responsibility of municipalities with respect to public health activities gave the provinces jurisdiction over public health by way of s. 92(8).[102] In a more recent case, a municipal by-law prohibiting close-contact dancing in adult entertainment parlours was upheld as a valid exercise of municipal and provincial authority to legislation in relation to public health.[103] In that case, the city of Toronto claimed its by-law was directed towards the health risks posed by close-contact dancing to both exotic dancers and patrons. The applicant challenged the law on the grounds that it sought

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[100] See generally *Rowell-Sirois Report*, *supra* note 21 at 32-34; Jackman, *supra* note 19 at 115; Learning from SARS, *supra* note 8 at 2, 19, 49-51.

[101] *Re George Bowack*, [1892] B.C.J. No. 33 (S.C.) (QL); *Canadian Pacific Navigation Co. v. Vancouver (City)*, [1892] B.C.J. No. 27 (S.C.) (QL).

[102] *La Municipalité St. Louis du Mile End c. La Cité de Montréal* (1885), 2 M.L.R. (S.C.) 218.

[103] *Re Ontario Adult Entertainment Bar Association and Municipality of Metropolitan Toronto*, 26 O.R. (3d) 257 (Gen. Div.), aff'd (1997), 35 O.R. (3d) 161 (C.A.), leave to appeal to S.C.C. refused, [1997] S.C.C.A. No. 594 (QL).

to regulate morality and was thus criminal law, and *ultra vires* the municipality. The Ontario Provincial Court held that any element of morality was merely ancillary to the broader purposes of protecting health and preventing crime in licensed entertainment establishments, both of which were held to be valid municipal and provincial objectives.

The principles in these cases are consistent with the basic logic regarding the role of the local community in managing threats to its citizens. A municipality is the best positioned to know its residents, identify risks as they arise, and respond in the manner best-suited to that community's unique needs and culture. Furthermore, people are likely to rely first and foremost on their closest level of government to protect them from such risks.

2. Hospitals, Property and Civil Rights, Matters of a Local or Private Nature

Taken together, these three sections are thought to give the provinces primary jurisdiction over health and public health.[104] As alluded to in the Introduction, these provisions have been held to ground a nearly exclusive provincial power to legislate in relation to health and health care. However, for public health purposes, the former two provisions are arguably less pertinent than is the jurisdiction over local and private matters. The power to legislate in relation to "the establishment, maintenance and management of hospitals, charities and eleemosynary institutions in and for the province"[105] relates primarily to issues such as funding and other administrative matters related to the governance of hospitals and similar institutions.[106] This power is also thought to include subjects such as patient rights and treatment standards,[107] both of which are relevant to public health practice. However, the broader community-based concerns of infectious disease control can be argued to transport the subject away from the hospital power and ground it in s. 92(16), with patient rights and treatment standards being corollary to the subject matter. Likewise, while the regulation of relationships

104 See *e.g. Schneider*, *supra* note 6.

105 *Constitution Act*, *supra* note 5 at s. 92(7).

106 See generally Jackman, *supra* note 19 at 110-111.

107 *Supra* note 19 at 110-111.

between health professionals and their patients, and provincial health insurance schemes, both of which fall under s. 92(13), are implicated in the public health system, property and civil rights does not ground general provincial efforts aimed at infectious disease management.

In a discussion paper prepared for the Commission on the Future of Health Care in Canada, André Braën suggests that "health itself can be seen on the whole as a strictly local matter"[108] and thus, granted to the provinces under s. 92(16). This proposition is supported by the case law. For example, the majority in *Schneider* relied upon that section to uphold provincial legislation providing for the detention and treatment of heroin addicts. In *R. v. Morgentaler*[109] the Supreme Court confirmed that view, holding that "[s]ection 92(16) also gives [the provinces] general jurisdiction over health matters within the province."[110]

Despite the generous provincial allowance under that section, in *Morgentaler* the Court found Nova Scotia's provisions restricting abortion services to be criminal law in pith and substance. Review of extrinsic evidence such as the transcripts of legislative debates revealed that the legislation was directed at preventing the "perceived public harm or evil" of private abortion clinics.[111] In delineating the difference between the criminal law power and provincial jurisdiction over health, Sopinka J. wrote:

> [I]f the central concern of the present legislation were medical treatment of unwanted pregnancies and the safety and security of the pregnant woman, not the restriction of abortion services with a view to safeguarding the public interest or interdicting a public harm, the legislation would arguably be valid health law enacted pursuant to the province's general health jurisdiction.[112]

This reasoning might be viewed as supporting the criminal law power for legislating with respect to communicable disease control. To be sure, public health is concerned with reducing public harm, and the measures taken with respect to individuals may be seen as ancillary to

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108 Braën, *supra* note 19 at 8.

109 [1993] 3 S.C.R. 463, 107 D.L.R. (4th) 537 [*Morgentaler* cited to S.C.R.].

110 *Ibid*. at 505.

111 *Ibid*. at 512.

112 *Ibid*. at 491.

that broader public purpose. However, the "public interest" and "public harm" referred to by Sopinka J. in that case reflected the deeply moral nature of the abortion debate. Infectious disease, on the other hand, does not generally include an element of morality. The public interest in controlling disease is not only much clearer and less controversial in infectious disease, but the public interest of safeguarding the community could be argued to fit squarely within the provincial concerns under s. 92(16).

In *Schneider*, the Court found British Columbia's *Heroin Treatment Act* to be within the jurisdiction conferred by s. 92(16). For Dickson J., it was an important finding that heroin addiction had not reached the level of national concern, and furthermore, he found that the failure by one province to provide adequate treatment programs would not result in harm to the other provinces.[113] Instead, in adopting the findings of an earlier report he held that "narcotic addiction is […] a physiological condition necessitating both medical and social intervention. This intervention is necessarily provincial."[114]

With respect to infectious disease control, the potential for extra-provincial harm is very real. Thus, the dialogue of a jurisdictional dispute is likely to amount to "national concern" versus "local and private matter." However, the provinces have the benefit of strong conceptual arguments under s. 92(16). The communicable nature of a disease should not be permitted to obscure the fact that the disease still exists at the level of the individual, and that it is combated in part by medical intervention on an individual basis. While in public health law the concern for the individual is frequently subordinated to the concern for community welfare, such subordination in constitutional law should be less tolerable, and even suspect. To deny legislative jurisdiction from the province because an individual is being treated or quarantined for the benefit of the community would undermine our conception of dignity and would further disenfranchise the individual from their community. It would also deny the reality of our health care system; individuals are treated by our health system as ends in themselves, even where certain measures taken in respect of an individual will serve a utilitarian purpose. Despite the measures imposed upon the infected individual, they are still afforded

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113 *Schneider, supra* note 6 at 131-32.

114 *Supra* note 6 at 131.

procedural protections and rights, and are provided with medical services specific to their needs.

An outbreak of disease may quickly escalate into more than a merely local matter. However, as discussed above, the management of an outbreak is perhaps best addressed by the locality, whether in the early stages outbreak or during a widespread epidemic. The fact that inter-jurisdictional cooperation is very desirable in such an emergency should not detract from the reality that local public health units will be called upon to provide the first line of defence, even if they are asked to do so in accordance with nationally-designed standards of practice.

4. The Importance of a Cooperative Approach to Public Health

The SARS crisis of 2003 provided a long overdue wake-up call. Although the Canadian experience was primarily localized within one province, jurisdictional issues arose nonetheless. For example, when it came to personal health information, municipalities, the province of Ontario and Health Canada disagreed as to the obligations and constraints upon each level of government when it came to sharing that information with the others.

A robust public health system requires a concerted national effort. But national effort does not necessarily mean federal jurisdiction; it requires cooperation and leadership. The federal government, through PHAC and the PCPHN, can employ cooperative approaches in addressing the problems within the existing provincial public health framework. Some of these problems may result from differences among the provincial approaches to public health, and others may be the result of confusion over jurisdiction (as seen with the SARS example in the context of information sharing).

When it comes to activities such as the reporting and sharing of public health information (such as personal health information), federal jurisdiction may be required by the National Concern branch of POGG to ensure that the PHAC can effectively identify threats, track the evolution of outbreaks, coordinate a national response, share meaningful data with the international community and provide accurate and comprehensive surveillance data for conducting public health research. But when

it comes to other public health activities – those related directly to prevention, control and management of communicable disease – inter-provincial differences in approach may not always be fatal to the efficacy of larger public health efforts. More significantly, these differences are illustrative of an important but unwritten constitutional principle – that of democracy.

Notwithstanding the strong arguments for federal jurisdiction, perhaps the best counter-argument is as follows. The ability of local government to identify and respond to the needs of its community is unmatched by the federal government. This argument is particularly applicable to public health practice where the interests, autonomy and liberty of the individual must be reconciled with the collective interest of their local community. The practical benefits of local jurisdiction in the American context have been noted:

> States and localities are closer to the people and understand better threats to their health. Because they are closer to the community, they can adapt prevention strategies to meet the needs of localities. States also are better placed to 'experiment' with solutions to complex health problems. By permitting states to act as laboratories for innovative health policies, the federalist system can, in theory, sort out effective from less effective interventions.[115]

The conceptual appeal of this approach was also articulated in the *Rowell-Sirois Report* and, seventy years later, there is no reason to believe that these observations no longer apply:

> [T]here are pronounced regional differences in Canada in social philosophy which are bound to affect public health legislation. Centralization of jurisdiction might not, therefore, conduce to progressive action in public health or to national unity in general.[116]

The holdings in *Rio Hotel Ltd. v. New Brunswick (Liquor Licensing Board)*[117] and *Siemens v. Manitoba (Attorney General)*[118] show a will-

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[115] Lawrence O. Gostin, "Public Health Theory and Practice in the Constitutional Design" (2001) 11 Health Matrix 265 at 287.

[116] *Rowell-Sirois Report*, *supra* note 21 at 34.

[117] [1987] 2 S.C.R. 59, 44 D.L.R. (4th) 663 [*Rio Hotel* cited to S.C.R.].

[118] [2003] 1 S.C.R. 6, 221 D.L.R. (4th) 90 [*Siemens* cited to S.C.R.].

ingness by the Supreme Court to uphold the role of local governments in responding to regional "social philosophy," even if the response appears to encroach upon the federal criminal law power. In *Rio Hotel*, New Brunswick had enacted legislation regulating nude entertainment in establishments licensed to serve alcohol. Rio challenged the law as an attempt to legislate morality, thereby making it criminal law. To be sure, the *Criminal Code* includes prohibitions similar subject matter as was dealt with by the provincial legislation. In holding the law to be a valid exercise of provincial power under ss. 92(13) and 92(16), the Court assigned it a very narrow purpose, finding that it was simply aimed at regulating the forms of entertainment which licensed establishments could use in their marketing efforts.[119] While the reasons do not directly address the democratic importance of allowing provinces to legislate under s. 92(16) in a way which reflects the values of the local community, such reasoning can be inferred from the majority's decision to uphold the law under the non-controversial licensing power in s. 92(13) when there was clearly a deeper thread of morality running through the legislation.

Similarly, in *Siemens*, the Supreme Court upheld provincial legislation allowing for binding municipal plebiscites with respect to banning Video Lottery Terminals (VLTs), despite the fact that gaming is also a matter addressed under the *Criminal Code*. Major J., writing for the Court, held that:

> [T]he purpose of the VLT Act as a whole seems to be, quite simply, to allow municipalities to express, by binding plebiscite, whether they wish VLTs to be permitted or prohibited within their communities,[120]

and that such a purpose was *intra vires* the province, again under ss. 92(13) and 92(16). The Court held that there were many valid reasons for which a municipality might wish to ban VLTs, and even if moral considerations arise in these reasons, this will not invalidate the law and render it criminal in nature.[121]

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119 *Rio Hotel, supra* note 117 at 65.

120 *Siemens, supra* note 118 at 21.

121 *Supra* note 118 at 25.

Conclusion

As discussed above, infectious disease control is not concerned with morality. But the reasons in *Rio Hotel* and *Siemens* are nonetheless applicable here. In short, local needs, values and customs will often elude the federal government, which does not have an effective means of identifying these local needs and responding to them. In contrast, the local and provincial governments are likely to be seized of such mechanisms and therefore must be accorded deference in their legislative decisions, even if they appear to be addressing an otherwise federal subject matter.

Granted, sometimes these local needs, values and customs will be immaterial to the exercise of proper jurisdiction. For example, the criminal law will apply without exception across Canada; one province cannot amend certain provisions as applied to them because their local culture is in disagreement with the federal approach. But when a subject matter not only implicates provincial heads of power but plays heavily upon these local values, there is excellent reason to leave primary jurisdiction with the provinces, despite the strength of arguments under federal powers such as POGG or the criminal law.

In extreme cases, such as where one province fails to act altogether in respect of a public health emergency, federal jurisdiction may be required if only on a temporary basis. But with respect to regional differences in public health legislation, such differences should not be dogmatically impugned and subjected to standardization. Differences in approach do not suggest that provinces have abdicated their responsibility or in any way compromised their ability to protect the health of their citizenry. On the contrary, the very fact of these differences suggests that provincial and municipal governments have acted based on the needs and values of their communities, thereby fulfilling their responsibility to protect health and, at the same time, preserving local democracy and the relationship between an individual and their local community. In assessing arguments for federal jurisdiction over public health, the unique position and abilities of the other governments must be kept at the forefront of the discussion. Such an approach will likely conclude that in all but extreme circumstances, the provinces must not be divested of primary jurisdiction over public health.