

Schulich School of Law, Dalhousie University

Schulich Law Scholars

Articles, Book Chapters, & Popular Press

Faculty Scholarship

2017

Federalism and Health Care in Canada: A Troubled Romance?

Colleen M. M. Flood

William Lahey Prof.

Bryan P. Thomas

Follow this and additional works at: https://digitalcommons.schulichlaw.dal.ca/scholarly_works



Part of the [Administrative Law Commons](#), [Comparative and Foreign Law Commons](#), [Constitutional Law Commons](#), and the [Health Law and Policy Commons](#)

Federalism and Health Care in Canada: A Troubled Romance?

Colleen Flood, William Lahey & Bryan Thomas

Forthcoming in *The Oxford Handbook of the Canadian Constitution*, 2017

DRAFT VERSION – NOT FOR CITATION

1. Introduction

Canada's efforts to offer a modern health care system to its people are shaped, complicated, and in many ways hindered, by interpretations of federal/provincial divisions of power laid out in the *Constitution Act, 1867* (the 1867 Act). Given its vintage, the 1867 Act has relatively little to say *directly* with respect to the health sector, which has since Confederation evolved into an enormously important area of the economy and of government activity. Consequently, the courts are forced to interpret more general provisions as to who governs with respect to the delivery and financing of health care and with respect to health more broadly.

With respect to the *delivery* of health care, Canada's ten provinces have been interpreted to have primary jurisdiction, owing to two provisions of the 1867 Act. First, in the only direct mention of health care in the 1867 Act, provinces are assigned jurisdiction over the "establishment, maintenance, and management of hospitals, asylums, charities and eleemosynary institutions."¹ Second, the provinces are assigned general jurisdiction over 'property and civil rights,' which has been interpreted as providing broad

· Colleen M. Flood is the Inaugural Director of the University of Ottawa, Centre for Health Law, Policy and Ethics and is a Professor and University of Ottawa Research Chair in Health Law & Policy; William Lahey is a Professor at Dalhousie's Schulich School of Law and President of University of King's College; Bryan Thomas is a Research Associate with the University of Ottawa Centre for Health Law, Policy and Ethics. The authors would like to thank David Rodriguez for superb research assistance.

¹ *Constitution Act, 1867* (UK), 30 & 31 Vict, c 3, s 92(7), reprinted in RSC 1985, Appendix II, No 5. s. 92(7) (*Constitution Act*); Originally enacted in the UK as the British North America Act 1867 (30 & 31 Vict c 3).

authority to regulate professional services—including the specific services of doctors, nurses, and other health professionals.²

By contrast, jurisdiction over the *financing* of health care and over health more broadly is divided. Court rulings from the 1930s found that the provinces have broad authority under their jurisdiction over property and civil rights to enact programs of social insurance, including health insurance.³ Subsequent rulings, however, recognized a federal “spending power,” allowing the federal government to fund social insurance programs through financial grants to the provinces, and influence the design of those programs through the attachment of conditions.⁴ Some dispute the legal validity of the federal spending power, as it has no explicit basis in constitutional text.⁵ Notwithstanding, the spending power is recognized by Court of Appeal⁶ and Supreme Court of Canada jurisprudence and has played a critical and longstanding role in Canadian federalism—particularly in health care, as explained below in our discussion of the *Canada Health Act (CHA)*.⁷

The federal Parliament has other important powers it can use to govern in relation to health and to health care, including its criminal law powers, its powers and duties in relation to Aboriginal people, its power

² See e.g., *Landers v N.B. Dental Society* (1957) 7 DLR (2d) 583 (N.B.C.A.) [affirming provincial powers to regulate the practice of dentistry].

³ See *Canada (Attorney General) v Ontario (Attorney General)*, [1934] ExCR 25, [1934] 3 DLR 483; *Reference re Employment and Social Insurance Act*, [1936] SCR 427, [1936] SCJ No 30 (S.C.C.); *Reference re Employment and Social Insurance Act*, [1937] AC 355 (J.C.P.C.) (affirming S.C.C.). The amendment of the Constitution that reversed these rulings as regards the specific issue of unemployment insurance (but not the general holding that schemes of social insurance were provincial) came in 1940, through the British North America Act, 1940 (3-4 Geo VI c 36) (renamed Constitution Act, 1940 by Constitution Act, 1982), which added s 91(2A), “Unemployment Insurance”, to enumerated federal powers.

⁴ *YMHA Jewish Community Centre of Winnipeg Inc. v Brown* [1989] 1 SCR 1532; *Reference Re Canada Assistance Plan (B.C.)*, [1991] 2 S.C.R. 525. For a more detailed discussion of the federal spending power, see below and the Chapter by Kong in this Handbook.

⁵ See Andrew Petter, “Federalism and the Myth of the Federal Spending Power” [1989] 68 Can Bar Rev 448.

⁶ *Winterhaven Stables Limited v. Canada (Attorney General)*, 1988 ABCA 334; *Syndicat national des employés de l’aluminium d’Arvida Inc. v Canada (Attorney General)* 2006 QCCA 1453.,

⁷ RSC 1985, c C-6 (hereinafter *CHA*)

over patents, and its (arguably under-utilized) power to regulate in pursuit of “peace, order and good government”. Using these powers, the federal order of government has made significant inroads into various facets of health care—including establishing the conditions for a national medicare scheme; regulating the approval of pharmaceuticals and medical devices; and enacting criminal law provisions in areas like assisted human reproduction, abortion, narcotics and so on. With respect to public health, it has also, for example, regulated the sale and advertizing of tobacco and acted—insufficiently, as we discuss below—to track and prevent the spread of contagious diseases across borders.

Below, we first describe in greater detail the ways in which the provinces have exercised jurisdiction in health (section 2, below), before turning to the federal role (section 3). We discuss how, in some cases, the courts have rebuked federal assertions of power, particularly the use of its criminal law powers, as an intrusion into provincial terrain (e.g., the regulation of IVF). We will also discuss some areas where the federal government could (and arguably should) exert greater regulatory muscle – such as in the area of infectious disease control.

We conclude with some general reflections on the troubled romance between federalism and health care, and how this contributes to a number of ongoing policy challenges. The federal government’s role in health care is often portrayed as residual to that of the provinces, although as we will argue the federal authorities potentially have a far greater potential range of powers under the Constitution than is generally acknowledged or employed. The inability to track responsibility for health care, as between the federal and provincial governments, leaves a gap in accountability and results in political inertia in the face of mounting problems. In our conclusion, we analyze how federalism could be better employed to modernize Canadian health care. There is a need for bold federalism in health care, of the sort that spurred the creation of Medicare in the 1950s and 1960s, when federal-provincial cooperation expanded Saskatchewan’s experiment with universal coverage into a national program of seminal importance to Canadians. To use the metaphor of our title, there is a need to work past the ‘troubled romance’ that now characterizes federal-provincial relations in health care, to forge a vibrant and durable partnership adaptive to the 21st century.

2. Exercises of Provincial Jurisdiction in Health Care

To understand the limits upon direct federal action in health care, one must understand the extent to which health care has been interpreted to date as falling under provincial jurisdiction. For example, while the federal government can operate quarantine and military hospitals and health care facilities for Aboriginal Canadians,⁸ the establishment, governance, regulation and funding of hospitals and health care facilities falls under provincial jurisdiction. Health care providers, whether working in hospitals or in the community, and whether in the public or private system, generally operate under provincial jurisdiction. Similarly, health insurance, like other kinds of insurance, is within provincial jurisdiction, whether it is private insurance purchased in the market or public insurance provided by government..

Nonetheless, it is important to acknowledge, as the Supreme Court of Canada has, that health is a diffuse field of legislative responsibility in which Parliament and provincial legislatures can both pass valid laws.⁹ For example, with respect to jurisdiction over prescription drugs, although provinces have authority over medicine and other prescribing professions, the federal government has the ability to regulate safety and approval of new drugs for general distribution and the price of prescription drugs still under patent.¹⁰ The porousness of federal/provincial jurisdiction over health was nicely explained by Chief Justice McLachlin in *Canada v. PHS Community Services Society*, responding in this instance to an argument with respect to interjurisdictional immunity:

[t]he federal role in the domain of health makes it impossible to precisely define what falls in or out of the proposed provincial “core”. Overlapping federal jurisdiction and the sheer size and diversity of provincial health power render daunting the task of drawing a bright line around a protected provincial core of health where federal legislation may not tread.¹¹

⁸ See *Constitution Act*, ss 91(7), (11), (24).

⁹ *Schneider v British Columbia*, [1982] 2 SCR 112, [1982] SCJ No 64.

¹⁰ *Patent Act*, RSC 1985, c P-4, ss 79-103.

¹¹ *Canada (Attorney General) v PHS Community Services Society*, [2011] SCC 44, [2011] 3 SCR 134 [68] (hereinafter PHS).

3. Exercises of Federal Power in Health Care: Successes, Failures, and Works-in-Progress

In this section we proceed through relevant federal powers and explain their role in Canadian health care. In some cases, the federal government has made forays into a given area of health care only to be pushed back by the courts — either because the move treaded on provincial jurisdiction, or due to conflicts with the *Charter of Rights and Freedoms*.¹² We start with the federal spending power, which despite its contested nature lies at the foundation of Canada's public health care system (Medicare).

A. The federal Spending Power and the foundations of Medicare

a. How the spending power is applied to health care

The federal government flexes its implied 'spending power' through provisions of the *CHA*,¹³ which employs a carrot and stick approach to incentivize provinces to comply with national standards in their respective public insurance plans (see detailed discussion below). In theory, if provinces do not comply with *CHA* criteria (e.g., related to preventing out-of-pocket billing of patients at point-of-service), the federal government can in future years withhold funding from the offending province.¹⁴

In reality, direct enforcement of the *CHA* by the federal government (e.g. withholding dollars from transfers to the provinces as a result of non-compliance) rarely happens. The federal government's political leverage (and perhaps political will) to enforce the *CHA* has likely diminished as a result of the rapid decline in the amount of federal health transfers, from 50% of the total cost in 1968 to an estimated 15.5% in 2015.¹⁵ Growth in health care expenditures, combined with an imperative to lower taxation

¹² Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

¹³ *CHA* (n 5)..

¹⁴ Gregory Marchildon and Haizhen Mou, 'A Needs-Based Allocation Formula for Canada Health Transfer' (2015) 40(3) *Can Pub Pol'y* 209 (hereinafter Marchildon).

¹⁵ Department of Finance Canada, "Federal Support to Provinces and Territories" (Department of Finance Canada 2016) <www.fin.gc.ca/fedprov/mtp-eng.asp> accessed 27 June 2016; Canadian Institute for Health Information, "National Health Expenditure Trends, 1975 to 2015" (CIHI 2016) 6, <<https://www.cihi.ca/en/spending-and-health-workforce/spending/national-health-expenditure-trends>> accessed 27 June 2016(CIHI NHEX 2015).

rates, have resulted in some provinces seeing their share of expenditures on health care absorb nearly 50% of total governmental spending,¹⁶ further diminishing the federal government's capacity to influence system reform.

Nonetheless, past federal governments have attempted to use negotiations over annual health transfers as an opportunity to buy real system change. For example, in 2000, 2003 and 2004, the federal government and most of the provinces, along with the territories, agreed to non-enforceable political accords under which the federal government committed to a decade of substantial increases in its health transfers to the provinces in exchange for promises to achieve or adopt certain basic reforms in their respective systems. The core outcome was to be the implementation of wait time benchmarks for five specified services (and the development and implementation of benchmarks for others). Other promises dealt with 24/7 access to multidisciplinary primary care teams, universal availability of catastrophic drug coverage, the development and implementation of a national pharmaceutical strategy and a national system of electronic health records. Responsibility for reporting on progress was given to the Health Council of Canada¹⁷ — a pale imitation of the strong, independent oversight and coordinating body recommended by Commissioner Romanow in his Royal Commission report on the Future of Medicare.¹⁸

Like the parallel Kelowna Accord, which promised significant action on First Nation health, the accords were, at best, “soft law”. They stressed respect for the jurisdiction of the provinces over health care and emphasized that provinces would be accountable to their residents, not to the federal government or to each other. So, it was perhaps unsurprising that although the federal money flowed, reform came unevenly, if at all. As Romanow and others have charged, the accords bought federal-provincial peace

¹⁶ Canadian Institute for Health Information, ‘How do the provinces and territories compare?’ (CIHI 2014) <https://www.cihi.ca/en/spending-and-health-workforce/spending/health-spending-data/nhex-infographic-how-do-the-provinces>> accessed 27 June 2016.

¹⁷ The Health Council of Canada was defunded and closed in 2014 by the Harper federal government on the rationale that the ten-year health accord started in 2004 had been completed. Steve Rennie, ‘Tory government will end funding of body that oversees Canada’s health accord’ (The Toronto Star, 2013) <https://www.thestar.com/news/canada/2013/04/16/tory_government_will_end_funding_of_body_that_oversees_canadas_health_accord.html> accessed 27 June 2016.

¹⁸ Roy J Romanow, *Building on Values: The Future of Health Care in Canada* (Commission on the Future of Health Care in Canada 2002) <<http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf>> accessed 27 June 2016.

but not change that benefited patients.¹⁹ Although this may have been predictable given their softness, it was foreordained once responsibility for their administration shifted in 2007 from the Chretien/Martin government, which at least asserted a federal role in health care, to the Harper government, which did not. Indeed, the latter would go on to recalculate the formula for the health transfer as a flat per capita amount, pegged to GDP growth – meaning that (e.g.) provinces with older populations receive no special assistance, significantly undermining national solidarity in the project of medicare.²⁰ The Kelowna Accord dealing with funding for Aboriginal peoples in Canada fared worse: it was simply disowned by the Harper government.²¹

b. Constitutional Challenges to the Implied Spending Power

Though not explicitly enumerated in the constitutional text, the spending power is derived partly from the federal authorities section 91 powers to raise revenues “by any mode or system of taxation.” It has been suggested that the power garners additional support from the federal Parliament’s section 91A powers related to “public debt and property” and its section 102 authority to make payments out of the Consolidated Revenue Fund.²²

The federal government’s use of the spending power to influence areas nominally under provincial jurisdiction has been subject to constitutional challenge. Thus, in *Winterhaven Stables Ltd. v. Canada (Attorney General)*,²³ the appellants argued that the spending power was being used, through legislation such as the *CHA*, to ‘coerce’ provinces into participating in federal programs, usurping their jurisdiction. In the health care context specifically, the case raises the example of Canadian restrictions on two-tier care, with the appellant contending that, “...Parliament cannot directly prohibit extra-billing (over and

¹⁹ See The Honourable Kelvin K Ogilvie and The Honourable Art Eggleton, ‘Time for Transformative Change: A Review of the 2004 Health Accord’ (Canada, Parliament, Standing Senate Committee on Social Affairs, Science and Technology, 2012)

<www.parl.gc.ca/content/sen/committee/411/soci/rep/rep07mar12-e.pdf> accessed 27 June 2016 82.

²⁰ Marchildon (n 11).

²¹ Christopher Alcantara and Zac Spicer, ‘Learning from the Kelowna Accord’ (Policy Options 2015) <<http://policyoptions.irpp.org/magazines/clearing-the-air/alcantara-spicer/>> accessed 27 June 2016.

²² Constitutional Law Group, *Canadian Constitutional Law* (4th ed.) at 469.

²³ 1988 ABCA 334 (CanLII) <<http://canlii.ca/t/2dmzv>> accessed on 27 June 2016, 53 DLR (4th) 413 (*Winterhaven*).

above health care payments) by doctors, so it cannot achieve the same end by the conditions attached to funding.”²⁴ The court rejected this argument on grounds that the federal authorities had not used “legislative force” to achieve their ends—provinces could refuse to accept the conditions of the *CHA*, and “there would be no effect on matters within provincial jurisdiction.”²⁵ Subsequently, in *Reference Re Canada Assistance Plan*,²⁶ the province of Manitoba argued that a federal spending ceiling on the Canada Assistance Plan program was an unconstitutional interference with the provinces’ jurisdiction over social services.²⁷ The argument was rejected along similar lines to *Winterhaven*, with Justice Sopinka writing for a majority of the Supreme Court that, “[t]he simple withholding of federal money which had previously been granted to fund a matter within provincial jurisdiction does not amount to the regulation of that matter.”²⁸

Moreover, in various *Charter* challenges concerning access to health goods and services, the Supreme Court of Canada has relied on the *CHA* for guidance in interpreting provincial health insurance acts, seeming to embrace the idea that health care is an area of federal/provincial cooperation.²⁹ Canadian legal scholars appear by and large to accept the spending power’s constitutionality.³⁰ It is unclear whether *at some point* the strings attached to federal financial inducements become so irresistible as to be coercive.

²⁴ *Ibid* [20].

²⁵ *Ibid*.

²⁶ [1991] 2 SCR 525 (hereinafter *Re Canada Assistance Plan*).

²⁷ The Canada Assistance Plan was introduced in 1966 as a cost-sharing arrangement for social assistance programs. It entitles provinces to federal funding on the condition of providing social assistance without provincial or territorial residency requirements. In 1995 the program was combined with the Established Programs Financing to create the Canada Health and Social Transfer program. This combined program has since been split into the Canada Social Transfer and Canada Health Transfer. Department of Finance Canada, ‘History of Health and Social Transfers’ (Department of Finance Canada 2014) <<https://www.fin.gc.ca/fedprov/his-eng.asp>> accessed 27 June 2016.

²⁸ *Re Canada Assistance Plan*, above (n 26)[92].

²⁹ *Eldridge v British Columbia (Attorney General)*, [1997] 3 SCR 624, 31; *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*, 2004 SCC 78, [2004] 3 SCR 657, 1.

³⁰ Peter W Hogg (ed), *Constitutional Law of Canada* (2015 Student Edition, Carswell 2015) 6-16 - 6-22, 32-4; William Lahey, “The Legal Framework for Intergovernmental Health Care Governance: Making the Most of Limited Options” in Katherine Fierlbeck and William Lahey, *Health Care Federalism in Canada: Critical Junctures and Critical Perspectives* (McGill-Queen’s University Press) 75-77. Constitutional experts in Quebec are on the whole more skeptical. See, e.g., Brun, Brouillet & Tremblay, *Droit constitutionnel* (4th ed Yvon Blais, 2002) and Marc-André Turcotte, *Le pouvoir fédéral de dépenser* (Yvon Blais, 2015).

A majority of the US Supreme Court embraced this view for the first time in its history in 2012, as it rejected the US federal government's efforts to expand Medicaid eligibility on grounds that the massive financial stake used to incentivize state participation crossed the line from encouragement into coercion.³¹

B. The Canada Health Act (*CHA*) and Challenges to It

In theory, to receive federal transfer payments for health care, the provinces must comply with five program criteria set out in the *CHA*:

- (i) public administration;
- (ii) comprehensiveness;
- (iii) universality;
- (iv) portability; and
- (v) accessibility.³²

The requirement of *public administration* refers to the insurance system for medically necessary care, but does not preclude private *delivery* of health care services, as is often mistakenly believed. In fact, most Canadian physicians operate as independent for-profit businesses, billing government on a fee-for-service basis. The principle of *comprehensiveness* requires that a province's public insurance scheme cover "all insured health services provided by hospitals, medical practitioners or dentists."³³ However, given that the *CHA* defines all "insured services" as being "medical necessary" physician services and "medically required" hospitals services but defines neither term, it is effectively left to each province to determine the basket of health services actually insured.³⁴ The principle of *universality* requires that all insured persons receive uniform coverage. This would appear to preclude, for example, means testing for public coverage.

³¹ *National Federation of Independent Business v. Sebelius*, 132 S. Ct. 2566 (2012); Nicole Huberfeld, Elizabeth Weeks Leonard and Kevin Outterson, 'Plunging Into Endless Difficulties: Medicaid and Coercion in *National Federation of Independent Businesses v Sebelius* (2013) 93 BUL Rev 1 <http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2128760> accessed 27 June 2016.

³² *CHA* (n 5)

³³ *Ibid* s 9.

³⁴ Colleen M Flood, Mark Bernard Stabile and Carolyn Hughes Tuohy, 'What Is In and Out of Medicare? Who Decides?' in Colleen M Flood (ed), *Just Medicare: What's In, What's Out, How We Decide* (University of Toronto Press 2006).

The principle of *portability* ensures that Canadians retain coverage when moving from one province to another. Lastly, the principle of *accessibility* requires reasonable access on uniform terms and conditions. In furtherance of accessibility, the *CHA* also specifically forbids employment of user fees (requiring that patients make an out-of-pocket payment at point of service) and extra billing (physicians charging an additional fee above the amount paid by the public insurer), which might block people of limited means from making use of Medicare or otherwise cause inequalities of access. Arguably, the criteria of accessibility is violated by long wait times in the public system, though this has not been strongly tested by the federal government or in the courts.³⁵

The *CHA* has undoubtedly played a critical role in establishing a core of public finance for important health care services and ensuring redistribution from the wealthy to the poor, and from the healthy to the sick.³⁶ However, it is showing its age and needs modernization.³⁷ Drafted to protect a system of public health in the 1960s, the *CHA* focuses entirely on health care delivered by physicians and in hospitals.³⁸ This has meant, for example, that the *CHA* does nothing to ensure public coverage for the growing spending on pharmaceuticals in community settings or spending on long-term care. Health care has increasingly shifted out of hospitals and to different kinds of health care providers apart from physicians, eroding the public system in a process dubbed ‘passive privatization’. We return to the question of how to expand and modernize public health insurance in our conclusion.

Apart from the need to expand, there is also a problem of actually *enforcing* the present provisions of the *CHA*. The broad provisions of the *CHA* mean the federal government has wide and virtually unreviewable discretion as to whether or not a province has complied with any of its criteria and then, further, whether to penalize a province. On both fronts, federal governments over the decades have taken

³⁵ William Lahey, ‘Medicare and the Law: Contours of an Evolving Relationship’ in, Jocelyn Downie, Tim Caulfield and Colleen M Flood (eds), *Canadian Health Law and Policy* (Lexis 2011) 43.

³⁶ Canadian Institute of Health Information, ‘Lifetime Distributional Effects of Publicly Financed Health Care in Canada’ (CIHI 2013) <https://secure.cihi.ca/free_products/Lifetime_Distributional_Effects_AiB_EN.pdf> accessed 27 June 2016.

³⁷ Colleen M Flood & Bryan Thomas, ‘Modernizing the Canada Health Act’ (2017) 39 Dal LJ [forthcoming].

³⁸ See *CHA* (n 5) s 2 for the definition of “insured services.”

a lenient if not a permissive approach to enforcement. The *CHA* does, however, have a stronger in-built mechanism for enforcing the ban on extra-billing and user fees: for every dollar patients or private insurers are billed for medically necessary care, the federal government *must* withhold a dollar from the transfer payment to the relevant province. However, this still leaves space for interpretation— for example, as to whether private clinics could charge a facility fee directly to patients or their insurers to cover the costs of running the clinic, and then separately bill the public system for the cost of the physician service. To clarify this practice, then federal Minister of Health Diane Marleau wrote to all provincial and territorial ministers of health on 6 January 1995, to announce that when a province pays the physician fee for a medically necessary service delivered at a private clinic, it must also pay the facility fee or have the sum treated as a user charge and deducted from their transfer payment.³⁹ More recently, even these more robust and ostensibly mandatory provisions of the *CHA* have fallen away, with anecdotal evidence of little or no enforcement through the last ten years under a Conservative federal government which viewed health care as solely a matter of provincial jurisdictions. Into this void, private clinics have sprung up across the country, often only thinly disguising the fact that they are offering medically necessary care in contravention of the *CHA*.⁴⁰

To be clear, the *CHA* does not itself entrench direct rights to health or health care for Canadians. As indicated, where a province for example violates the criteria of accessibility by allowing extra billing, the federal government must respond by withholding a portion of transfer payments. However, on a plain reading, the *CHA* does not issue *citizens* a right to challenge their provincial government's noncompliance with the five principles.⁴¹ Canadian patients have nevertheless found legal avenues for pursuing access to health care through litigation – for example, by launching mass tort claims, requesting administrative

³⁹ See Canada, Health Canada, *Canada Health Act Annual Report 2014-2015* (Health Canada 2015) <www.hc-sc.gc.ca/hcs-sss/alt_formats/pdf/pubs/cha-ics/2015-cha-lcs-ar-ra-eng.pdf> accessed 27 June 2016, 71s 7 the page number? If so it should probably come after Health Canada 2015 above

⁴⁰ See Kate McNamara, 'Alberta government to investigate private medical clinic in Calgary' (CBC News 2016) <www.cbc.ca/news/canada/calgary/copeman-clinic-investigation-alberta-government-1.3603242> accessed 27 June 2016; Kate McNamara, 'Both province and patients pay for tests a Copeman Clinic' (CBC News 2016) <www.cbc.ca/news/canada/calgary/private-healthcare-copeman-overtesting-billing-1.3589748> accessed 27 June 2016; Kate McNamara, 'Copeman clinic, doctors battle over how private health care should be delivered' (CBC News 2016) <www.cbc.ca/news/canada/calgary/copeman-nedelmann-calgary-clinic-lawsuit-1.3530149> accessed 27 June 2016.

⁴¹ Cf Sujit Choudhry, 'The Enforcement of the Canada Health Act' (1996) 41 McGill LJ 462 .

reviews, and bringing constitutional challenges. In the last-mentioned scenario, the courts are being used to launch attacks on provincial laws enacted to limit the private sale of medically necessary care. Depending on the province, these laws ban private health insurance for services covered by Medicare, forbid physicians from charging patients more than the public tariff they receive (extra billing), and require physicians who wish to practice privately to opt out of the public system entirely.⁴² These kinds of provincial laws have been largely successful in discouraging the emergence of a parallel private payment system of medicine in Canada but are now under sustained constitutional attack in a number of provinces on the basis that they violate the security of the person of those who would be able and willing to pay for faster access to medical care than is available to them under the public system. One such challenge has succeeded at the Supreme Court of Canada level, leading to the partial overturn of a Quebec law banning private insurance for medically necessary care.⁴³ Thus, counter-intuitively, the Charter and human rights legislation are being used to attack a Canadian social program that is, more than any other, based on a commitment to equity.⁴⁴

These *Charter* challenges do not directly threaten the federal government's use of the spending power to create – or expand – a national medicare scheme. But it may be a genuine conundrum, how Canada will maintain a single-payer system on a national scale if the courts overturn provincial statutes now in place. Meanwhile, because of the failure of the *CHA* to cover important areas of care like prescription drugs outside of hospitals and because of the reluctance of the Federal government to enforce the *CHA* against provinces, the system is being increasingly privatized contrary to the Act's clear intent.

C. Other Uses of the Spending Power: Existing and Potential

⁴² Colleen M Flood and Tom Archibald, 'The Illegality of Private Health Care in Canada' (2001) 61CMAJ825, 825–830 ; See Colleen M Flood and Amanda Haugan, 'Is Canada Odd? A Comparison of European and Canadian Approaches to Choice and Regulation of the Public/Private Divide in Health Care' (2010) 5 Health Econ Pol'y & L 319 for a comparative overview of regulation of the public/private divide.

⁴³ *Chaoulli v Quebec (Attorney General)*, 2005 SCC 35, [2005] 1 SCR 791.

⁴⁴ Colleen M Flood, 'Litigating Health Rights in Canada: A White Knight for Equity' in Colleen M Flood, Aeyal Gross (eds), *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge University Press 2014).

In addition to the *CHA*, the federal spending powers are also used in pursuit of diverse health purposes including: health research; health information; health promotion and disease prevention and control; and other various health care initiatives undertaken in cooperation with the provinces.⁴⁵

Both in these specific applications and in its core role in cost-sharing provincial health insurance, the federal spending power clearly has played a critical role in giving Canada the semblance of a national health care system. At the same time, the weak enforcement of the minimalist and narrow requirements of the *CHA*, discussed above, and the failure of three broader health accords, cast doubt on the potential for real reform *in the health care system* if the spending power is applied as it has been in the past. Something is required beyond narrowly-targeted and weakly-administered efforts to get each province to meet and maintain basic national standards or to achieve basic outcomes. This is a topic we return to in the conclusion.

D. First Nations & Inuit People

We have just discussed the general structure and financing of Medicare. For some populations, such as prisoners in federal institutions and members of the military, health care falls directly under federal jurisdiction. Here we focus on First Nations and Inuit People – arguably the most contentious group, because the federal Parliament has jurisdiction relating to “Indians”, and provincial legislatures have jurisdiction more broadly with respect to health care, but neither level of government wants to take responsibility for the poor state of Aboriginal health, or admit of constitutional duties with respect thereto.

a. Historical perspective on First Nations health⁴⁶

⁴⁵ *Canadian Institutes of Health Research Act*, SC 2006, c 6, ss 4, 5; *Public Health Agency of Canada Act*, SC 2006, c 5, preamble.

⁴⁶ We are indebted in this section to the research of Allison Nesbit and her excellent paper, ‘Targeting High Rates of First Nations Youth Suicide: Exploring a Positive Right to Government-Funded Mental Health Care Services’ (2016) (copy on file with authors) (hereinafter *First Nations Child*).

Aboriginal peoples enjoyed relatively good states of health prior to the arrival of European settlers in Canada, who carried with them diseases that decimated Indigenous populations.⁴⁷ Subsequent colonization further detrimentally affected the health of First Nations, who were forced off resource and agriculturally rich land and onto small plots of reserve land, usually in remote areas with a high population density⁴⁸ and relatively poor access to health care services.⁴⁹ Conditions on many reserves continue to this day to be described as “third world”, with insufficient access to clean drinking water, poor sanitation, food insecurity, and inadequate shelter.⁵⁰ Aboriginal health was further threatened as a result of government assimilation policies: “The colonization of Indigenous Peoples ... [has been recognized] as a fundamental underlying health determinant.”⁵¹

The process of colonization and the resulting negative impact on health is exemplified by the policy of forcibly taking Aboriginal children from their families and incarcerating them in residential schools. Residential schools, which existed in Canada from the late 19th century until the late 1960s (although some remained until the 1990s), institutionalized more than 150,000 Aboriginal children. The policy goal was to entirely isolate the children from their Aboriginal culture, and assimilate them into the predominantly European culture that Canada wanted to recreate.⁵² Subjected, at a minimum, to complete repression of their language and culture and, in some cases, physical and sexual abuse, generations suffered and continue to suffer the ill-effects, including a persistent gap in health outcomes compared to

⁴⁷First Nations Health Authority, *Our History, Our Health* (First Nations Health Authority 2016) <www.fnha.ca/wellness/our-history-our-health> accessed on 27 June 2016.

⁴⁸ Truth and Reconciliation Commission of Canada, *Canada's Residential Schools: The History, Part 1 Origins to 1939, Final Report of the Truth and Reconciliation Commission of Canada, vol 1* (Ottawa, McGill-Queen's University Press 2015) 3.

⁴⁹ Canada, Royal Commission on Aboriginal Peoples, *Report of the Royal Commission on Aboriginal Peoples*, Vol 1, Part 2 (Communication Group 1996) 396-400.

⁵⁰Ben Spurr, ‘First Nations chief blames ‘Third World’ living conditions for fatal fire on reserve’ (The Toronto Star 2016) <<http://www.thestar.com/news/canada/2016/03/31/chief-blames-third-world-living-conditions-on-first-nations-reserve-for-fatal-fire.html>> accessed 27 June 2016.

⁵¹ International Symposium on the Social Determinants of Indigenous Health, ‘Social Determinants and Indigenous Health: The International Experience and its policy implications’ (World Health Organization 2007) <http://www.who.int/social_determinants/resources/indigenous_health_adelaide_report_07.pdf> accessed 27 June 2016, 2.

⁵² Norah Keilland and Tonina Simeone, , *Current Issues in Mental Health in Canada: The Mental Health of First Nations and Inuit Communities*, by, (Ottawa, Publication No 2014-02-E 6, Library of Parliament, Parliamentary Information and Research Service, Legal and Social Affairs Division 2014).

the rest-of-Canada and galloping rates of mental illness for both themselves and their children.⁵³

Nationwide, First Nations youth are seven times more likely to commit suicide in comparison to the non-First Nations youth population of Canada.⁵⁴ Within Northern Ontario, some First Nations have a suicide rate that is 50 times the Canadian average for children under 15 years.⁵⁵

b. Current Division of Powers Problem Negatively Affects First Nations' Health

As mentioned, the *Constitution Act, 1867* is not explicit on whether the federal or provincial governments have jurisdiction over health care. Section 92(7) is the only constitutional provision that explicitly defines a branch of health care as a provincial matter, but it is restricted to the “[m]anagement of [h]ospitals”.⁵⁶ Nevertheless, through judicial interpretation, health care has primarily (though not exclusively) been assigned to provincial jurisdiction. As stated in *R v Schneider*, “[the] view that the general jurisdiction over health matters is provincial ... has prevailed and is ... not seriously questioned.”⁵⁷ However, the issue of Aboriginal health is further complicated as section 91(24) assigns “Indians” to federal jurisdiction.⁵⁸ Thus, whilst both levels of government may provide health care to Aboriginal peoples, it is yet to be determined whether either level of government *must* do so. It speaks volumes that with respect to Aboriginal health, both levels of government have sought to avoid rather than assume responsibilities in this area.

⁵³ Truth and Reconciliation Commission of Canada, *Canada's Residential Schools: The History, Part 1 Origins to 1939, Final Report of the Truth and Reconciliation Commission of Canada*, Vol 1 (Ottawa, McGill-Queen's University Press 2015) 152.

⁵⁴ Laura Eggertson, ‘Aboriginal youth suicide rises in Northern Ontario’ (2015) 187:11 CMAJ 335, 355ff>. First Nations females from ages 1-19 years are five times more likely to commit suicide versus non-First Nations females; PA Peters, LN Oliver and DE Kohen, ‘Mortality among children and youth in high-percentage First Nations identity areas, 2000-2002 and 2005-2007’ (2013) 13:2424 Rural and Remote Health 7 <www.rrh.org.au/publishedarticles/article_print_2424.pdf> accessed 27 June 2016

⁵⁵ DPRA Canada, ‘North West Local Health Integration Network Aboriginal Health Programs and Services Analysis & Strategies: Final Report’ (DPRA 2010) <www.northwestlhinc.on.ca/resources/~media/sites/nw/uploadedfiles/Home_Page/Report_and_Publications/NW%20LHIN%20Aboriginal%20Health%20Programs%20and%20Services%20Analysis%20and%20Strategy.pdf> accessed 27 June 2016, 25.

⁵⁶ *Constitution Act, 1867* (n 1).

⁵⁷ *Schneider v The Queen* [1982] 2 SCR 112, 137, 139 DLR (3d) 417.

⁵⁸ *Constitution Act, 1867* (n 1) s 91(24). Indians under this provision refer to Aboriginal peoples, First Nations, Inuit and Métis.)

The Federal government has interpreted its responsibility under section 91(24) to apply only to individuals registered as “Indians” under the *Indian Act* and to Inuit peoples.⁵⁹ The recent Supreme Court of Canada victory for Canada’s Metis peoples, establishing their status as “Indians” under the Constitution, confirms the doubtfulness of this self-serving restriction.⁶⁰ What remains is the insistence of Health Canada (the Federal government department) that the health benefits it delivers to Aboriginal peoples are discretionary, humanitarian efforts. In other words, the Federal government claims that it is the provincial governments’ constitutional responsibility to provide health care to First Nations persons as part of their public health insurance schemes:⁶¹ to the extent the Federal government provides services to First Nations peoples, it purports to do so on a discretionary basis and cannot be required to do so under section 91(24).⁶² Needless to say First Nations’ peoples dispute this characterization.

One of the major health care initiatives launched by the federal government is the Non-Insured Health Benefits (NIHB) program, which provides a portion of Aboriginal peoples with select medically necessary health-related goods and services that are not covered by provincial or privately-held medical plans.⁶³ This includes pharmacy benefits, dental services, medical transport, and eye and vision services. The NIHB accounts for nearly half of Health Canada’s expenditures for First Nations and Inuit health, with pharmacy costs alone making up nearly half of that amount.⁶⁴

⁵⁹ Constance MacIntosh, ‘Indigenous Peoples and Health Law and Policy: Responsibilities and Obligations’ in Jocelyn Downie, Timothy Caulfield and Colleen M Flood(eds), *Canadian Health Law and Policy 4th Edition* (Markham, LexisNexis 2011) 587-588 (hereinafter *Indigenous Peoples*).

⁶⁰ *Daniels v Canada (Indian Affairs and Northern Development)*, 2016 SCC 12 (CanLII),

⁶¹ Kelly A Macdonald and Kylie Walman, ‘Jordan’s Principle: A Child First Approach to Jurisdictional Issues’ in First Nations Child & Family Caring Society of Canada, *WEN: DE - We are Coming to the Light of Day* (First Nations Child & Family Caring Society of Canada 2005) <<https://fncaringsociety.com/sites/default/files/docs/WendeReport.pdf>> accessed 27 June 2016,90.

⁶² Romanow, ‘The Future of Health Care in Canada’ (n 15) 212; Indigenous Peoples (n 55).

⁶³ The NHIB assumes that Aboriginal peoples who are accepted by the federal government as coming within federal jurisdiction are eligible persons under provincially and territorially administered medicare programs. This is consistent with the definition of “resident” found in the Canada Health Act, which includes Aboriginal persons. The effect is that provinces and territories must ensure Aboriginal people who live within their territory to satisfy the universality criteria of their eligibility for federal health transfers under the Act.

⁶⁴ Canada, Health Canada, *Non-Insured Health Benefits Program: Annual Report 2008/2009* (Ottawa, Health Canada 2010) 17

Aboriginal peoples may find themselves slipping through the cracks, as both federal and provincial governments look to avoid financial responsibility. In 1999, a First Nations boy named Jordan was born in Manitoba with complex medical needs, and hospitalized at birth. Although he could have been cared for in his home/community he eventually died in hospital at 5 years of age, as neither the federal government (Health Canada) nor the Manitoba provincial government were willing to take responsibility for the costs involved in moving him from hospital. Although this case resulted in an agreement that Aboriginal children would not be subjected to these kind of jurisdictional disputes—“Jordan’s Principle” — it seems that such disputes continue to arise.⁶⁵

Canada’s abysmal approach to First Nations’ peoples has drawn international attention. The United Nations has called on Canada to “implement and reinforce its existing programmes and policies to supply basic needs to indigenous peoples.”⁶⁶ The most hopeful response to this jurisdictional quagmire has come in the form of devolution: the passage of financial and governance authorities from federal and provincial and territorial governments to First Nations bands themselves. Although not without its own concerns -- passage of authority without sufficient resources may only allow Bands to “self-administer their own misery”-- devolution potentially allows Aboriginal peoples the autonomy to craft health care systems that better reflect their own needs and culture. The British Columbian Tripartite Agreement marks the most comprehensive Aboriginal health self-governance agreement to date. It was signed on 13 October 2011 by the First Nations Health Society, the province of British Columbia (BC), and the federal government. Pursuant to this agreement, the federal government transferred all of its responsibilities, resources and infrastructure for Aboriginal health in BC to a new First Nations Health Authority. While BC’s regional health authorities will continue to provide acute care to Aboriginal people, the First Nation Health Authority will be responsible for on-reserve programs, including primary care and public health initiatives. In total, the federal government is to transfer about \$380 million per year to Aboriginal communities under the Tripartite Agreement, with the province of BC contributing an additional \$83

⁶⁵*Pictou Landing Band Council v Canada (Attorney General)*, [2013] FC 342, [2013] 3 CNLR 371.

⁶⁶ United Nations Human Rights Committee, *Concluding observations on the sixth periodic report of Canada* (International Covenant on Civil and Political Rights 2015) <www.refworld.org/docid/5645a16f4.html> accessed 27 June 2016.

million.⁶⁷ The new governance agreement ultimately marks an attempt to close the disparities that exist between First Nations and other British Columbians in, *inter alia*, the area of health, by increasing the capacity of First Nations communities to provide primary health care and by empowering them to take a much more active role in the formulation of Aboriginal health policy.⁶⁸

Apart from devolution of responsibility there are also signs that courts are growing far more willing to order action on the part of governments vis-à-vis their responsibilities to Aboriginal peoples. The case law demonstrates that Canadian courts and tribunals have begun to recognize the importance of Aboriginal rights and the protection these groups deserve.⁶⁹ Thus courts may in the future be more willing to demand positive action by Canadian governments when it comes to the provision of adequate health and health care services to Aboriginal Canadians than they have been relative to Canadians more generally.

E. Criminal Law Power

Section 91(27) of the *Constitution Act*, 1867 confers on the federal Parliament the exclusive power to legislate in relation to the criminal law. The Supreme Court of Canada has found this power to be plenary and broadly defined in scope; further, the Court has emphasized that the definition of a crime is not frozen in time nor confined to a fixed domain of activity. At first blush, such a broad jurisdiction could be used to achieve almost any regulatory purpose— which would lead to intolerable intrusions into provincial

⁶⁷ Lauren Vogel, 'BC First Nations to run own health system' (2011) 183(17) CMAJ E1227.

⁶⁸ The Supreme Court has broadly endorsed this approach of 'cooperative federalism' in the context of delivering child welfare services to Aboriginal children and families in British Columbia. See *NIL/TU, O Child and Family Services Society v B.C. Government and Service Employees' Union* [2010] 2 SCR 696 [42] (Abella J), (LeBel, Deschamps, Charron, Rothstein and Cromwell JJ concurring).

⁶⁹ For example, in *McIvor v Canada (Registrar of Indian and Northern Affairs)*, [2009] BCCA 153, 165-166, 306 DLR (4th), 190 CRR (2d) (*McIvor*), the B.C.C.A. forced the Federal government to amend the *Indian Act* to eliminate discrimination against wives and children of non-status Indians. The Canadian Human Rights Tribunal has found that the Federal Government discriminated against on-reserve First Nations children in failing to provide equal social assistance funding for children living on reserves, in comparison to off-reserve children. *First Nations Child and Family Caring Society of Canada et al. v. Attorney General of Canada (for the Minister of Indian and Northern Affairs Canada)*, 2016 CHRT 2. The complainants are now seeking to have the decision enforced by the Federal Court. Kristy Kirkup, "Trudeau government on notice in First Nations child welfare dispute" *The Toronto Star* (20 September 2016), online: <www.thestar.com>.

domains. Thus the courts have established tests for ascertaining whether a law is a valid exercise of the criminal law power, requiring that it “contain a prohibition accompanied by a penal sanction and must be directed at a legitimate public health evil.”⁷⁰ Legislation that attempts to disguise a regulatory purpose as a prohibition runs the risk of being overturned.⁷¹

There are a host of issues in health care where the federal authorities have asserted their power to enact criminal law. For example, doctors and hospitals providing care under provincial jurisdiction can only use drugs and medical devices that have been licensed by federal regulators. Another example is federal tobacco control, including laws which impose advertising restrictions on tobacco companies and which work in combination with provincial laws, (e.g., Nova Scotia’s requiring that retailers keep cigarettes “under an opaque front counter,” out of customer’s view). Federal advertising restrictions have been upheld by the Supreme Court as valid criminal law on the basis that “it is difficult to conceive what Parliament’s purpose could have been in enacting this legislation apart from the reduction of tobacco consumption and the protection of public health.”⁷² Further, the Court found that Parliament’s choice to prohibit tobacco *advertising* (rather than tobacco consumption) was not an attempt to colourably intrude on provincial jurisdiction, as the choice was driven by the reality that widespread use of tobacco made a direct ban on consumption simply impractical.⁷³

There are however prominent examples of federal forays into health and health care based on the criminal law power being turned back by the courts, on grounds that they infringe *Charter* rights. Examples

⁷⁰ *RJR-MacDonald Inc. v Canada (Attorney General)*, [1995] 3 SCR 199 [267], 111 DLR (4th) 385 (*RJR*),.

⁷¹ *Reference re Assisted Human Reproduction Act*, [2010] 3 SCR 457

⁷² *Ibid* [33].

⁷³ In *RJR* (n 71), the Supreme Court went on to find that the restrictions on brand advertising violated free speech rights under the *Charter*. A majority of the Court also found that the violation could not be justified, due to the federal government’s failure to show the legislation’s limitations on advertising were reasonably necessary to achieving the legislation’s objective of reducing tobacco consumption. This very disappointing result was largely reversed in the subsequent case of *Canada (Attorney General) v. JTI-Macdonald Corp.* 2007 SCC 30, where the court viewed the array of international evidence presented as now sustaining the government’s approach to regulation. Very recently, the newly-minted Liberal federal government announced plans to introduce laws requiring plain packaging of all tobacco products. These laws are sure to result in further challenges to the authority of Parliament to use its criminal law powers to control the harms which tobacco poses to public health.

include cases striking down *Criminal Code* provisions imposing bureaucratic restrictions on access to abortion,⁷⁴ restrictions on the use of medical marijuana,⁷⁵ and a Ministerial decision to revoke a previously granted exemption of a safe injection site from criminal prohibitions on possession contained in the *Controlled Drugs and Substances Act*.⁷⁶ Arguably, these cases show that criminal law can be a very blunt tool with which to regulate public health and health care. This no doubt limits the extent and manner of its possible use, particularly as a means of regulating health care financing and delivery. It also suggests that those subjected to this kind of regulation can be expected to challenge the federal Parliament's constitutional authority to regulate them under criminal law. But challenges also occur because the provinces (frequently Quebec) believe the federal government is intruding into their areas of jurisdiction, even in cases where the challenging province itself has failed to sufficiently regulate an area.

This last point is illustrated by the fate of the federal government's attempt to regulate in the field of assisted human reproduction (AHR). In 2004, the federal Parliament passed legislation regulating diverse aspects of AHR. The *Assisted Human Reproduction Act (AHRA)*⁷⁷ broadly divided AHR technologies and therapies into two baskets—*controlling* some and altogether *prohibiting* others. Sensing an intrusion into provincial jurisdiction, Quebec asked the Quebec Court of Appeal to decide whether certain provisions of the *AHRA* dealing with “controlled activities,” such as IVF, were *ultra vires* federal jurisdiction. The Attorney General of Quebec argued these provisions were an attempt to regulate medical practice, an area that has historically fallen within provincial jurisdiction under ss. 92(13) and 92(16) of the *Constitution Act, 1867*.⁷⁸ The Attorney General of Canada defended the impugned provisions as a valid use of the federal criminal law power under s. 91(27) of the *Constitution Act, 1867*.⁷⁹

In a 4–4–1 split decision released in December 2010, the Court ruled in part for Quebec, striking down the provisions that empowered the federal Assisted Human Reproductive Agency to license and regulate

⁷⁴ *R. v Morgentaler*, [1988] 1 SCR 30, 63 OR (2d) 281.

⁷⁵ *Allard v Canada*, 2014 FC 280 (CanLII), 451 FTR 45.

⁷⁶ PHS *supra* n 11.

⁷⁷ *Assisted Human Reproduction Act*, SC 2004, c 2 (*Assisted Reproduction*).

⁷⁸ *Reference Re Assisted Human Reproduction Act*, 2010 SCC 61 [7], [327]. Sub-s 92(16) of the *Constitution Act, 1867* confers authority over “local matters” on provincial legislatures.

⁷⁹ *Ibid* [6], [327].

the practice of IVF.⁸⁰ Relying substantially on the recommendations of the Baird Commission, which had prompted the legislation, Justices LeBel and Deschamps found the pith and substance of these provisions to be regulatory in joint reasons for judgment that Justices Abella and Rothstein concurred with and that Justice Cromwell agreed with in the result.⁸¹ They argued that these provisions of the Act did not target either a harm or a moral evil within the criminal law power and that to find otherwise would make the criminal power too broad and too encroaching on provincial jurisdiction over the practice of medicine.⁸² For the impugned provisions, no moral evil or harm had been identified; indeed, the Baird Commission considered the “controlled” activities beneficial.⁸³

The Supreme Court essentially ruled that the regulation of the delivery of IVF services lies primarily in the hands of the provinces and that the federal authorities could not regulate using its criminal law powers, even in the absence of provincial action. Further, Justices LeBel and Deschamps were unmoved by the federal government’s argument that a federal scheme was required in light of the difficulty the provinces would face in creating a uniform national scheme through coordinated legislative action.

Few would contest that, absent an overriding federal jurisdiction based on the criminal law power, it does lie within the power of provinces to regulate the provision of IVF services. Until recently however, none had taken up this challenge, making a national consensus that would see harmonization of such regulations across the country a very remote possibility. The first child conceived through *in vitro* fertilization was born in 1978, the first Canadian child in 1983.⁸⁴ It took twenty-one years for the federal authorities to attempt (unsuccessfully) to regulate the practice through the *AHRA*. In 2010, Quebec

⁸⁰ Colleen M Flood and Bryan Thomas, ‘Regulatory Failure: The Case of the Private-For-Profit IVF Sector’ in T Lemmens, C Milne and I Lee (eds), *Legal, Ethical and Policy Challenges of Assisted Human Reproduction* (Toronto, University of Toronto Press 2015) 438-475 (Regulatory Failure).

⁸¹ *Ibid* [227], [327].

⁸² *Ibid* [236], [238], [243], [327].

⁸³ *Ibid* [250], [327]. The Act’s “prohibited” activities, set out in sub-ss 5-7 were not challenged and therefore remain in force. These include human cloning, screening for sex for non-medical purposes, permanently altering the genome of an embryo so that the alterations would be passed down to descendants, creating chimeras or animal hybrids, paying surrogates or intermediaries to a surrogacy contract, using a surrogate mother under the age of twenty-one, and the sale of gamete material: *Assisted Reproduction* (n 76) ss 5–7.

⁸⁴ Canadian Press, ‘First Test-Tube Babies Born in Canada Turn 25’ (CTV News 2007), <www.ctvnews.ca/first-test-tube-babies-born-in-canada-turn-25-1.234615> accessed 27 June 2016.

became the first province to directly regulate IVF, twenty-seven years after the technology's appearance in Canada. To date, most provinces in Canada resemble Ontario in eschewing direct regulation of the IVF sector, taking instead a light and indirect approach. This "light" regulatory approach is especially problematic given the safety, quality, and consumer concerns arising from the delivery of IVF services in the context of private, for-profit clinics.⁸⁵

The broader implications of the ruling in the *AHRA* reference should not be overstated. There was no majority consensus on the reason for the ruling. Four judges would have upheld the impugned provisions of the AHRA on reasoning which agreed with the federal government's argument -- that criminal legislation was required in order to ensure uniform regulation in an emerging field of health technology which raised fundamental questions about the limits which society should place on technological manipulation of human reproduction. Moreover, the newly enacted federal legislation on medically assisted dying,⁸⁶ replacing laws struck down on *Charter* grounds in the *Carter* decision, shows that there is both jurisdictional competency and wide support for federal criminal law in some critical areas of medical practice.⁸⁷ Nevertheless, the fate of the AHRA shows how conflicts over division of power can limit optimal health care governance on issues of great importance to Canadians.

F. Peace, Order & Good Government

Under existing case law, Parliament's residual jurisdiction under section 91 of the Constitution Act, 1867 to make laws for the "peace, order and good government of Canada," could conceivably authorize federal laws on or affecting health care in three situations. First, where a "gap" is found to exist in the jurisdiction over health care otherwise assigned to one of the two levels of government. Second, where an emergency situation of sufficient magnitude arises, requiring temporary federal encroachment on provincial jurisdiction. Third, where federal legislation addresses an aspect of health care, which would normally be within provincial jurisdiction, but which is found to have become a matter of "national concern".

⁸⁵ Regulatory Failure (n74)

⁸⁶ *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* S.C. 2016, c. 3.

⁸⁷ *Carter v Canada (Attorney General)*, 2015 SCC 5, [2015] 1 SCR 331.

Federal jurisdiction based on a gap in the jurisdiction over health care otherwise conferred seems a remote possibility, given the capacious interpretation of existing jurisdictional categories (e.g., the provinces' power to regulate health professionals, grounded in jurisdiction over 'property and civil rights'). The emergency branch will remain a vital ground for federal action: recent events, including the SARS outbreak in 2003 and the 2009 H1N1 flu pandemic, have demonstrated the importance of the federal role in ensuring readiness for and management of public health emergencies, including by exercising temporary authority over health care personnel, resources and systems otherwise under provincial and territorial jurisdiction. A key concern here is the persistent unwillingness of the federal government to fully and proactively play its assigned role, apparently for fear of upsetting the provinces, and perhaps to avoid or limit its financial commitments. There have, for example, been sustained calls for the federal authorities to make more assertive use of their POGG powers to assist with the surveillance and reporting of infectious diseases.⁸⁸ Surveillance is crucial to limiting the spread of infectious disease across borders, both international and interprovincial. The existing reporting system, such as it is, relies on voluntary federal/provincial/territorial cooperation. Experience to date suggests that this strategy of 'cooperative federalism' leads to breakdowns and unclear accountability, with Justice Archie Campbell complaining in the SARS Commission report of a "lack of any federal-provincial machinery of agreements and protocols to ensure cooperation."⁸⁹ To date—even in the wake of these rattling disease outbreaks and subsequent damning reports—only the province of Ontario has entered into a voluntary agreement with the Public Health Agency of Canada to exchange information on epidemic outbreaks. These failings put Canadians at greater risk and invite sanctions under international law; Canada was subject to travel warnings by the WHO during the SARS crisis, suffering over a billion dollars in lost tourism and trade.

⁸⁸ Sina A. Muscati, "POGG as a Basis for Federal Jurisdiction over Public Health Surveillance," (2007) 16 *Constitutional Forum* 41; Keri Gammon, "Pandemics and Pandemonium: Constitutional Jurisdiction over Public Health" (2006) 15 *Dalhousie J Legal S* 1; Amir Attaran & Kumanan Wilson, "A Legal and Epidemiological Justification for Federal Authority in Public Health Emergencies" (2007) 52 *McGill LJ* 381; Amir Attaran & Elvina C. Chow, "Why Canada is Very Dangerously Unprepared for Epidemic Diseases: A Legal and Constitutional Diagnosis" (2011) 5 *Journal of Parliamentary and Political Law* 287.

⁸⁹ *The Sars Commission Interim Report: SARS and Public Health in Ontario* (15 April 2004) (Commissioner: The Honourable Justice Archie Campbell) at 66, online: The SARS Commission <http://www.sarscommission.ca/report/Interim_Report.pdf>.

This is one of several emerging challenges where Canada lags behind other countries due to its disjointed health governance. For example, antimicrobial resistance is another area where the stakes are incalculably high – recent estimates are that, by 2050, superbugs will kill more people globally than currently die of cancer⁹⁰— while the response by both levels of government has been slow and ineffectual. The key components of a response are well understood, and crucially involve careful stewardship of the existing cache of antimicrobials; currently, they are profligately overprescribed to patients and pumped into agricultural animals. As with infectious disease control, this issue demands national and indeed global coordination - yet key levers of governance (e.g., the regulation of prescribing practices) fall under provincial jurisdiction. Solutions to this problem, bringing forward concerted action by the various sectors of government involved (e.g., health, environment, agriculture) have scarcely been conceptualized, let alone set on a path to implementation.⁹¹

The “national concern” branch of the “POGG power” seems to at first blush offer the greatest prospects for use in the health sector. Regular comparisons between the Canadian system and that of other countries by the Commonwealth Fund show that the performance of the Canadian system is objectively a matter of national concern: in these comparisons, Canada has always ranked behind the United Kingdom, the Netherlands, Germany, Denmark, Australia and New Zealand in health system performance and ahead of only the United States.⁹² However to be satisfy the “national concern” test set out by the courts, one must meet more than its common-sense definition.

The leading case on what constitutes a “national concern” for the purposes of POGG is *Crown Zellerbach*.⁹³ There, the Court said a matter of national concern must have “a singleness, distinctiveness

⁹⁰ Jim O’Neil, ‘Foreword by Jim O’Neil’ in Review on Antimicrobial Resistance, *Tackling Drug-Resistant Infections Globally: Final Report and Recommendations* (Review on Antimicrobial Resistance 2016) <<http://amr-review.org/Publications> > accessed 29 June 2016, 1.

⁹¹ Bryan Thomas and Colleen Flood, ‘Why aren’t we doing more about superbugs and over-prescribing?’ (Policy Options 2016) <policyoptions.irpp.org/2016/03/29/arent-superbugs-prescribing/> accessed 27 June 2016.

⁹² Canadian Institute for Health Information, ‘How Canada Compares: Results From the Commonwealth Fund 2015 International Health Policy Survey of Primary Care Physicians’ (CIHI 2016) <<https://www.cihi.ca/en/health-system-performance/performance-reporting/international/commonwealth-fund-survey-2015>> accessed 27 June 2016, 6-22.

⁹³ *R v Crown Zellerbach*, [1988] 1 SCR 401, 49 DLR (4th) 161 (*Zellerbach*).

and indivisibility that clearly 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.”⁹⁴ This is typically referred to as the distinctiveness requirement. The Court further stated that in determining if a matter has the required degree of singleness, distinctiveness and indivisibility that clearly distinguishes it from matters of provincial concern, courts should “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.”⁹⁵ This is typically referenced as the provincial inability requirement.

Together, these two requirements set a very high threshold for establishing federal jurisdiction under the national concern branch of POGG. This reflects the underlying judicial concern that federal jurisdiction based on POGG, unlike jurisdiction based on an enumerated power such as criminal law, gives Parliament “exclusive jurisdiction of a plenary nature to legislate in relation to that matter, including its intra-provincial aspects”.⁹⁶ In other words, federal jurisdiction based on POGG is not, unlike other less-expansive federal jurisdiction based on enumerated powers, subject to the double aspect doctrine, which allows provincial jurisdiction on provincial aspects of the same matter to operate, subject to federal paramountcy. It also reflects the difference between the national concern and emergency branches of POGG: whereas the latter where triggered confers only a temporary jurisdiction on Parliament, the national concern branch provides a constitutional basis for what is necessarily legislation of a permanent nature. In these respects, there is judicial concern that applying the national concern branch has greater potential to reduce the jurisdiction of the provinces and to alter the fundamental balance of federalism between the Federal government and the provinces. Thus the general approach of the courts with respect to this power is illustrated in *Ontario Hydro*, where the Supreme Court of Canada held that laws made under POGG must be “carefully described to respect and give effect to” the powers of the provinces.⁹⁷

⁹⁴ Ibid [33]

⁹⁵ *Ontario Hydro* (n 87) [431-32].

⁹⁶ Ibid [433].

⁹⁷ *Ontario Hydro v Ontario (Labour Relations Board)*, [1993] 3 SCR 327 [328], 107 DLR (4th) 457 (*Ontario Hydro*).

The consequence for health care is that the federal government has little jurisdiction to legislate directly on health care on the basis that it is a matter of national concern. Instead, it is limited to acting indirectly by making conditional grants to the provinces or to regulating aspects of health care that fall within its power to make laws on other subjects, such as the criminal law. A broader approach would require a federal government to challenge the restrictiveness of the national concern branch of POGG by asserting jurisdiction under over aspects of health about which the rationale for federal jurisdiction is strong and the consequences of splintered provincial jurisdiction demonstrably serious. For example, building on the soft jurisdiction it already exercises by operating the Canadian Institute for Health Information, the Federal authorities could assert jurisdiction over monitoring, evaluating and reporting on health system performance. More broadly, building on the jurisdictions it already exercises over pharmaceuticals and the growing national importance of pharmaceuticals in health care, the federal authorities might assert jurisdiction to launch national pharmacare.⁹⁸ In the latter regard, it can plausibly be argued that without a single purchaser of prescription drugs, Canada cannot ever achieve the price and cost savings and meet access goals as has been the case in many other developed countries. Further, in the absence of one pan-Canadian formulary and where provinces negotiate separately with large global providers of prescription drugs, this results in “whip-sawing,” where provinces buckle under public pressure to fund drugs covered in other provinces.

These remain theoretical possibilities: to date federal authorities have been unwilling to assert jurisdiction in health care under the national concern branch of POGG, due to the power’s uncertain but generally restrictive boundaries and a political unwillingness to test those boundaries.

G. Conclusion

The credibility of future reform strategies based on the spending power first requires federal insistence that provinces satisfy existing CHA conditions, preventing for example the privatization of medically necessary physician services. Second, as a quid pro quo, the provinces must be assured of a meaningful and predictable level of cost-sharing based on an evidence-based and transparent funding formula, built

⁹⁸ Roy Romanow and Greg Marchildon, ‘The time has come for universal pharmacare’ (The Toronto Star 2015) < <https://www.thestar.com/opinion/commentary/2015/10/29/the-time-has-come-for-universal-pharmacare.html> > accessed 27 June 2016.

with provincial input, which honours the Constitution's concern for equalizing the capacity of the provinces to provide comparable services at comparable costs.⁹⁹ A third critical ingredient would be measures, including institutional arrangements, which build independence, objectivity and transparency into the measurement and evaluation of provincial compliance with program criteria. This is vital, among other things, to avoiding a repeat of the past decade's failings, where the Federal government has paid lip service to the CHA while allowing it to fizzle into obsolescence through lack of enforcement. A fair and objective dispute resolution process through a neutral institution is another key ingredient – having the Federal government as the umpire of the *CHA* when it is one of the players is clearly insufficient to ensure fair enforcement.

But these reforms alone are insufficient, as true modernization requires expansion of the public system. For example, universal health insurance for prescription drugs is a glaring gap: Canada is the only country in the world with a universal health insurance program that does not include prescription drugs.¹⁰⁰ The lack of universal pharmacare results in severe access problems; to cite just one data point, an estimated 830 patients in Ontario under the age of 65 die each year for want of access to something as basic as insulin.¹⁰¹ Without federal support, our provincial systems tend to regress to a US-style insurance system, insuring the elderly (or least the poor elderly) and those on social assistance, and leaving the rest of the system to private insurance and out-of-pocket payments. This messy mix of public and private insurers and heavy reliance on patients paying for treatment themselves is not only inequitable but inefficient, as it leads to higher drug prices. In a recent CIHI study, Canada's per capita drug spending ranked second only to the U.S. among 7 comparator countries (CIHI, 2013).

There are essentially three constitutional options to help modernize Medicare by expansion to community-based pharmaceuticals. First, the federal government could assert authority under the POGG power to achieve reform, but as we discussed earlier, there is great reluctance on the part of both the federal government and the courts to liberalize this head of power. Second, the provinces could agree to

⁹⁹ *Constitution Act* (n 1) s 36.

¹⁰⁰ Steven G Morgan and others, 'Estimated cost of universal public coverage of prescription drugs in Canada' (2015) 187 *CMAJ* 491.

¹⁰¹ Gillian L Booth and others, 'Universal Drug Coverage and Socioeconomic Disparities in Major Diabetes Outcomes' (2012) 35 *Diabetes Care* 2257.

delegate administrative responsibilities for pharmaceuticals to a pan-Canadian agency, funded by the federal government;¹⁰² this is a real prospect given the increasing fiscal burden experienced by the provinces with respect to their pharmaceutical plans even for the limited populations covered.¹⁰³ The third option is the most familiar and arguably most feasible: it is for the federal government to use its spending power to give each province financial incentives to offer universal insurance for a core range of medically necessary drugs to all of its citizens. Here, the eligibility of each province should depend not only on its own pharmacare plan but also on its participation in the pan-Canadian governance schemes which are needed to ensure the affordability of universal pharmacare and the safety and efficacy of the drugs it funds. These schemes would include coordinated health technology assessment processes, collective bulk purchasing, optimal use of generics, and a national system of post-market surveillance, monitoring and evaluation—overcoming the jurisdictional divide which currently exists between federal licensing for drug safety and provincial regulation, monitoring and evaluation of their use.

It is clear the need for coordinated and cooperative health system governance, which transcends provincial boundaries, goes beyond pharmacare. The reasons include the constrained capacity of the smaller provinces and the common interest of all provinces – and their residents – in consolidation of purchasing power for human resources and other inputs, minimization of duplication and maximization of value derived from the large-scale investments required in areas such as information technology. More generally, there is a common interest in a more deliberate harnessing of federalism’s potential for policy experimentation and learning across jurisdictional boundaries. There is, in other words, a need to rekindle the romance that once enabled bold action on health care within Canadian federalism. Aboriginal health, human resource planning, health professional regulation, electronic health information systems, health technology assessment and system-level quality assurance are all areas of modern health system

¹⁰² Full-fledged delegation of legislative powers was declared unconstitutional by the Supreme Court of Canada in *General of Nova Scotia v. Attorney General of Canada*, [1951] S.C.R. 31. However, it is open to the provinces to delegate administrative responsibility for a national arms-length agency, as is done for example with Canadian Blood Services.

¹⁰³ Aidan Hollis, ‘Opinion: Time to end haphazard pharmacare coverage’ (Edmonton Journal 2015) <<http://edmontonjournal.com/news/politics/opinion-time-to-end-haphazard-pharmacare-coverage>> accessed 29 June 2016.

governance which could benefit from more coordinated and cooperative action by provinces and territories.

Various pan-Canadian initiatives show glimmers of hope for renewed health care federalism -- many focused on specific diseases or on specific aspects of health care governance. More to the point, the provinces and territories have used the Council of the Federation as a forum to coordinate action on a number of specific reform priorities, ostensibly to fill the void created by the federal government's abandonment of the field over the past decade during the tenure of the last Conservative government. Individually and collectively, these initiatives are encouraging, as are the handful of federally funded supporting institutions, such as the Canadian Patient Safety Institute and the Canadian Institute for Health Information. They are however not big enough, durable enough, or sufficiently integrated to achieve fundamental reform. They are unlikely, in other words, to amount to more than the sum of their parts.

What is missing is what has been missing for decades: a general plan of sustained and integrated reform through coordination and cooperation among provinces and territories, with the active participation of the federal government, flexing not only its spending power but its full array of governance assets—its jurisdiction over aboriginal health, large dimensions of public health, health research, drug and medical devices licensing and a number of the broader determinants of health, such as age-related income security. The accords of the first decade of this century were a vague and inadequate attempt to lay the foundations for such a plan and process of reform. Fresh efforts at righting this troubled romance must link eligibility for federal funding to ongoing participation in a process of reform, to achieve lasting transparency and accountability of a sort lacking in the health accords of the past.