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# INTERGOVERNMENTAL CONSULTATIONS ON HEALTH: TOWARD A NATIONAL FRAMEWORK ON REPRODUCTIVE TECHNOLOGIES

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# INTERGOVERNMENTAL CONSULTATIONS ON HEALTH: TOWARD A NATIONAL FRAMEWORK ON REPRODUCTIVE TECHNOLOGIES

> Federalism in health care is a fearsome and foggy bog, an inky reservoir surrounded by slow-footed constitutional guardians; fed by the erratic springs of federal spending power; seething with undercurrents of tax points and transfers; and fiercely contested by the conspiracy-minded battalions of intergovernmental affairs.(1)

## BACKGROUND

Intergovernmental consultations on health are commonplace but complicated. Although the subject of reproductive technologies raises its own complexities and concerns, the federal government's effort to develop a national framework presented multiple difficulties. As with virtually every aspect of health care, federal involvement in this matter involves ongoing debate. While successive federal health ministers assert the commitment to a strong federal presence, they are aware that provincial health ministers may challenge any action as an intrusion into an area of provincial control.

The jurisdictional concerns of both federal and provincial-territorial governments were the starting point for the final report of the Royal Commission on New Reproductive Technologies (RCNRT), released in 1993. The Commission emphasized that reproductive technologies "raise issues of a magnitude and importance that not only warrant but *require* a national response."(2) It rejected the subdividing of reproductive technologies into component parts to be addressed by provincial legislatures and self-governing professional bodies on a province-by-province or institution-by-institution basis. It advocated federal regulation "under

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(1) Steven Lewis, "The bog, the fog, the future: 5 strategies for renewing federalism in health care," *Canadian Medical Association Journal*, vo1. 166, no. 11, 28 May 2002.

(2) Royal Commission on New Reproductive Technologies, *Proceed with Care: Final Report*, Ottawa, Government Services Canada, 1993, p. 18 (emphasis in original).

the national concern branch of the peace, order and good government power, as well as under the criminal law, trade and commerce, spending and other relevant federal constitutional powers."(3)

While joint discussions between the federal and provincial-territorial governments began immediately after the Royal Commission reported, they were taking place in an atmosphere unfavourable to swift resolution. By the second half of the 1990s, intergovernmental consultations in the health and social areas were characterized by competition and conflict. Restraints on fiscal transfers, culminating in the consolidation of major social transfers into the Canada Health and Social Transfer (CHST) in 1995, heightened provincial dissent against unilateral federal regulatory and program actions.

The ratification of the Social Union Framework Agreement (SUFA) in 1999 by all governments except Quebec signalled a new approach.(4) Explicit in SUFA was a commitment to joint priority-setting and prior notice by the federal government of new initiatives. The federal and provincial governments were experimenting with more flexible forms of federalism, but they were still engaged in an unresolved struggle over who should make the rules in the health arena.(5) Health Canada, as the key federal negotiator on reproductive technologies, regularly encountered challenges from many provincial counterparts about the appropriate role for the federal government in setting nationwide standards. Some individual provinces and territories had moved to regulate particular aspects, and the result was a patchwork of laws and practices with many holes.

This paper focuses on the dynamics of the cross-jurisdictional divide, and federal efforts to facilitate coordination and consensus in areas related to reproductive and genetic technologies. It also provides some assessments of intergovernmental processes, with reference to potential roles for parliamentarians.

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(3) *Ibid.*

(4) *A Framework to Improve the Social Union for Canadians*, An Agreement between the Government of Canada and the Governments of the Provinces and Territories, 4 February 1999, http://socialunion.gc.ca/news/020499_e.html.

(5) Antonia Maioni, "The Social Union and Health Care," *Policy Options*, vol. 21, April 2000, pp. 39-41; Robert Asselin, *The Canadian Social Union: Questions About the Division of Powers and Fiscal Federalism*, PRB 00-31E, Parliamentary Research Branch, Library of Parliament, Ottawa, January 2001.

## INITIATING WORK ON A NATIONAL FRAMEWORK (1993-1996)

### A. Response to the Royal Commission

Efforts to respond to the Royal Commission's work and to build the required national governmental consensus began relatively quickly after the release of the RCNRT report. In the fall of 1994, the then Minister of Health, Diane Marleau, noted that the engagement of provincial governments in a joint approach to the reproductive technologies issue was "one of my first acts in office."(6) Following the standard approach, the issue was sent to an intergovernmental working group and was put on the agenda of a federal, provincial and territorial health ministers' meeting. Thus, from 1993 to 1996, until the first legislation was introduced in Parliament, Health Canada coordinated a Federal-Provincial-Territorial Working Group on Reproductive and Genetic Technologies (RGT) established to advise the deputy ministers of health. In addition, less than six months after the release of the RCNRT report, federal, provincial and territorial ministers indicated that they would begin a detailed review of the recommendations, assessment of costs and identification of areas for collaboration.(7)

### B. Voluntary National Moratorium

By July 1995, however, when announcing a voluntary moratorium on specific reproductive and genetic technologies and practices, the federal health minister provided a general indication of the complexities of consultations in a shared jurisdictional area. She noted that, in a meeting held only weeks earlier, provincial and territorial ministers of health had agreed to support the voluntary moratorium.(8) She also observed that the ministers were willing to work with the federal government on a permanent management regime as part of a comprehensive approach, but gave no indication of the process to be employed or of any progress toward this goal. At the same time, to cover other jurisdictional aspects, the Minister of

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(6) Diane Marleau, Minister of Health, Speech, "Canadian Bioethics Society, 6th Annual Conference," 26 November 1994, p. 1.

(7) Canadian Intergovernmental Conference Secretariat, Press Release, "Synopsis of Health Ministers Discussions," Ottawa, 9 February 1994.

(8) Health Canada, Speaking Notes for the Honourable Diane Marleau, Minister of Health, "News conference announcing a voluntary moratorium on new reproductive and genetic technologies," National Press Theatre, Ottawa, 27 July 1995.

Justice was enlisted to write to provincial and territorial attorneys general to express support for the moratorium and to raise concerns about the role of lawyers as agents or brokers in commercial surrogacy arrangements.

### C. First Legislative Proposal (Bill C-47)

Within the year, the federal government indicated its willingness to take legislative action, albeit limited, of its own accord. In June 1996, David Dingwall, the then Minister of Health, introduced Bill C-47, the Human Reproductive and Genetic Technologies Act, based on federal criminal law powers.(9) The Bill aimed only to prohibit 13 human reproductive and genetic technology practices and did not address the call for a national regulatory regime encompassing a regulatory structure, regulations, licensing, and compliance mechanisms. In proposing the legislation, the federal government deliberately excluded areas where the provincial role was dominant, leaving unresolved the issue of overlap with provincial areas of jurisdiction such as health services and health practitioners.

### D. Toward a Regulatory Framework

In this period of heightened tensions between governments, consultations proceeded cautiously, and federal proposals built in ways for provinces to protect their authority. Further consultations with provinces and interested groups were to be based on the proposed regulatory framework outlined in *New Reproductive and Genetic Technologies: Setting Boundaries, Enhancing Health,* a departmental discussion document released at the same time as the legislation.(10) This document emphasized the federal desire to collaborate with the provinces and territories. For the first time, it specified that future legislation would include a provision for equivalency agreements between the federal government and any province or territory. This meant that, except for absolute prohibitions, the federal regulatory controls could be suspended and replaced by provincial controls substantially the same as, but not necessarily identical to, the federal ones.

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(9) Health Canada, News Release, "Comprehensive National Policy on Management of New Reproductive and Genetic Technologies Proposed," 14 June 1996.

(10) Health Canada, *New Reproductive and Genetic Technologies: Setting Boundaries, Enhancing Health*, Ottawa, June 1996, http://www.hc-sc.gc.ca/english/protection//reproduction/nrgt/index.htm.

Also for the first time, the document pointed to the separation of the genetic technologies from the reproductive technologies. The proposed legislation, Bill C-47, dealt with prohibitions on sex selection and germ-line therapy. Issues concerning the availability, application and appropriateness of prenatal diagnosis and genetic screening, however, were considered to "fall largely within the ambit of" medical practice and thus to come under provincial and territorial jurisdiction.(11) The federal government proposed that a consensus conference be convened to examine some of the relevant issues. It seemed that agreement was to be sought outside the established avenue of federal-provincial-territorial advisory committees and was perhaps to be found in the realm of medical professionals and their organizations.

## CONTINUING TO SEEK NATIONAL CONSENSUS (1997-2000)

### A. Beyond SUFA

The proposed legislation died on the *Order Paper* when the election was called in 1997, with no evidence of progress on inter-jurisdictional concerns. That same year, the provincial and territorial first ministers agreed to initiate a process that eventually led to the Social Union Framework Agreement with the federal government in 1999. Now, even more than in previous years, the federal government was committed to collaborating on setting priorities and establishing new cost-shared programs. This process also accentuated a trend for provincial positioning on actions seen as intrusive. Quebec did not sign the Agreement, arguing against any arrangement that implied a federal role in what Quebec saw as exclusive provincial policy jurisdictions and that did not provide for an unconditional provincial right to opt out of new federally initiated programs.(12) In the same year that SUFA was signed, Allan Rock (the then Minister of Health) and the Government of Canada "signalled an interest in moving the RGT agenda forward and stakeholder meetings commenced."(13) Although the news release from the September 1999 Federal-Provincial-Territorial Health Ministers Conference contained no mention of any related discussions or resulting actions, the issue of reproductive and genetic technologies was reportedly on the meeting agenda.(14)

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(11) *Ibid.*

(12) Jack Stilborn, *Intergovernmental Relations – Social Union Issues*, PRB 99-37E, Parliamentary Research Branch, Library of Parliament, Ottawa, December 1999.

(13) Health Canada, *Reproductive and Genetic Technologies Overview Paper*, "Preface," Ottawa, 1999, http://www.hc-sc.gc.ca/english/protection/reproduction/rgt/overview.htm.

(14) Canadian Intergovernmental Conference Secretariat, News Release, "F/P/T Health Ministers Take Action on Key Health Issues," Annual Conference of Federal-Provincial-Territorial Ministers of Health, Charlottetown, Prince Edward Island, 16 September 1999.

## B. Overview of Broader Legislation

With guidance from an Advisory Committee to the Deputy Minister, a Health Canada document, *Reproductive and Genetic Technologies Overview Paper*, laid out the case for revised legislation broader than the 1996 prohibitions. It emphasized that the health measures under scrutiny required pan-Canadian standards and coordination, and that any planned federal actions were based on the criminal law power. It noted, however, that this proposed legislation touched on standards of clinical practice and the operation of health services – areas under provincial jurisdiction. Given the possible linkages with provincial-territorial activities, as well as to be consistent with the Social Union Framework Agreement, federal, provincial and territorial discussions at all levels (ministers, deputy ministers, and other officials) had commenced.

## C. Case for Equivalency Agreements

Equivalency agreements with provinces were a favoured way to proceed. Health Canada pointed out the need for certain "flexibilities" in the legislative process to ensure that maximum use was made of existing capacities in provincial-territorial jurisdictions, such as professional colleges and accreditation bodies, and to provide an option for the provinces and territories to exercise a regulatory role through equivalency agreements.(15) The equivalency agreements would allow a province or territory to "legislate standards equivalent to the federal law for any or all of the controlled activities, privacy and reporting of health information pertaining to controlled activities, and investigation and enforcement of its legislation."(16) Thus, where both levels of government agreed that a province had equivalent legislation, the federal government would withdraw the application of the federal law where a province regulated one or more controlled activities. In addition to federal-provincial equivalency agreements, the Health Canada report stressed the need to take provincial and territorial interests into account through the incorporation of any relevant standards and through agreements on enforcement.

(15) Health Canada, *Overview Paper*, Section 2.3.

(16) *Ibid.*, Section 5.2.3.

## D. Consensus on Sexual and Reproductive Health

Less controversial intergovernmental developments in 1999 centred around a framework on sexual and reproductive health based on input from federal, provincial and territorial governments and from non-government organizations.(17) This was an attempt to respond to the Royal Commission's call for a coherent, coordinated approach for promoting sexual and reproductive health and thereby preventing infertility. A report on consultations held in 1999 provided a common base for public information and communication and for collaborative policy and programs on issues pertinent to preventing infertility. Health Canada had already worked with other levels of government to develop Canadian guidelines for sexual health education.(18) The Royal Commission saw such guidelines as a crucial step toward preventing infertility associated with sexually transmitted diseases, and it pushed for more active endorsement and ongoing assessment.(19)

The RCNRT had also emphasized the need for a coherent and comprehensive response to other factors that might put fertility at risk, such as reproductive hazards in the environment and the workplace. Efforts were apparently made within the government bureaucracy, but the matter never achieved status on the agendas of federal-provincial-territorial meetings. Although the first phase of framework discussions with provincial officials and non-governmental organizations had been completed by 1996, additional national consultations did not develop consensus on guiding principles until 1999. By 2002, directions for an active national strategy were still unresolved.(20)

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(17) Health Canada, *Report from Consultations on a Framework for Sexual and Reproductive Health*, Ottawa, 1999, http://www.hc-sc.gc.ca/hppb/srh/pubs/report/text_only.html.

(18) Expert Interdisciplinary Advisory Committee on Sexually Transmitted Diseases in Children and Youth and the Federal-Provincial-Territorial Working Group on Adolescent Reproductive Health, *Canadian Guidelines for Sexual Health Education*, Health Canada, Ottawa, 1994, http://www.hc-sc.gc.ca/hpb/lcdc/publicat/sheguide/pref_e.html.

(19) Royal Commission on New Reproductive Technologies, *Proceed with Care: Final Report*, p. 218.

(20) Health Canada, *New Reproductive and Genetic Technologies: Setting Boundaries, Enhancing Health*, p. 35; also see Planned Parenthood Federation of Canada, "Hot Issues – Call for Action," web site on the national strategy for sexual and reproductive health, http://www.ppfc.ca/issues/action.htm.

### E. *Workbook* for Legislating Reproductive Technologies

To further facilitate broad consultations on reproductive technologies with the provinces and territories, and to make the process more open to other stakeholder groups, Health Canada in February 2000 released a *Workbook* on issues and related questions associated with the proposed legislation.(21) Again there was an emphasis on flexibility and a need to "respect provincial and territorial desires for 'opting-out' of the regulatory regime through equivalency agreements." For the provinces and territories, the *Workbook* had specific questions: "Are you considering the possibility of entering into an enforcement agreement with the federal government? What level of interest might you have in an equivalency agreement, now or in the future? Have you done any regulatory work in any of the proposed areas? Could your work be used as a model or template for future regulatory work?" While Health Canada acknowledged the need to consult and to build on existing provincial efforts, it also advocated federal public policy leadership in this area. Increasingly, scientific possibilities and medical practices had moved beyond the scope of and with greater speed than the provincial legislatures.

### F. Provincial *Feedback* on the Proposed Federal Approach

The follow-up to this endeavour, the *Feedback Report*, was prepared within a few months and highlighted provincial apprehension about federal encroachment.(22) In February and March 2000, Health Canada officials had met with provincial and territorial colleagues to gain a fuller understanding of provincial, territorial and stakeholder views on the proposed federal approach to reproductive and genetic technologies. In response, provinces and territories acknowledged the need for federal leadership in this field. However, while some supported the introduction of prohibitions as an area appropriate for federal action, the development of regulations was seen as an area of provincial responsibility. Quebec officials, in particular, were clear that "from their perspective, federal regulations in the field of RGTs were not warranted." They pointed out that the Quebec government had already introduced measures in this area, including amendments to the Civil Code and regulatory development. However, they recognized

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(21) Health Canada, *Workbook for Purposes of Discussion Only – Issues and Related Questions*, Ottawa, February 2000, http://www.hc-sc.gc.ca/english/protection/reproduction/rgt/workbook.htm.

(22) Health Canada, *Feedback Report – Discussions and Written Comments on Proposed Federal RGTs Legislation*, Ottawa, June 2000, http://www.hc-sc.gc.ca/english/protection/reproduction/rgt/feedback_report.htm.

that "RGTs are an issue without geo-political borders" and wanted to make certain that "their standards and regulations mesh with those developed in other provinces and territories, as well as internationally."(23)

This acknowledgement that intergovernmental cooperation was essential to ensure harmonization of standards and regulations was the area of greatest agreement. But the acknowledgement was tinged with concern, particularly in provinces where there were relevant legislative and/or regulatory developments. The provinces' fears related to the potential effect that "federal legislation might have on their health care system, existing laws (e.g., Privacy Act, Human Tissues Gift Act) and policies (e.g., research guidelines)."(24) Many provinces and territories requested more time to consider the full impact of the proposed measures on their own laws and policies, and wanted sufficient advance notice to be able to prepare adequately for consultations on the legislation itself. The need for a clear delineation between federal and provincial or territorial roles was noted specifically "with respect to RGT procedures, research, therapies, transgenics and transactions." The provinces and territories "suggested that a distinction be made between regulations for research and safety purposes (a federal area) and those for service provision (a provincial responsibility)."(25)

## TAKING NATIONAL ACTION (2001-2003)

### A. Draft Proposals to Parliament

Having tested the intergovernmental waters, and knowing the potential for public controversy on various elements associated with regulating reproductive technologies, the federal government opened up the issue to parliamentary scrutiny. Based on the efforts to build a national consensus, a document titled *Proposals for Legislation Governing Assisted Human Reproduction* (essentially a draft of the legislation) was tabled in Parliament in May 2001 for study by the House of Commons Standing Committee on Health. Allan Rock, the then Minister of Health, indicated that the federal government was ready to move to the comprehensive approach advocated by the RCNRT.(26) To meet provincial concerns, the *Proposals* included

(23) *Ibid.*

(24) *Ibid.*

(25) *Ibid.*

(26) Health Canada, News Release, "Rock launches review of draft legislation on assisted human reproduction to ban human cloning and regulate related research," Ottawa, 3 May 2001; available with accompanying documents at: http://www.hc-sc.gc.ca/english/media/releases/2001/2001_44e.htm.

several mechanisms to enhance coordination and harmonization across all jurisdictions. Thus, they provided the authority to enter into enforcement agreements with the provinces. They also outlined equivalency arrangements where, if certain conditions were fulfilled, provincial provisions could replace particular parts of the federal legislation. In addition, they made it clear that the provinces and the territories would be engaged as participants in any development of regulations. As many of the controlled areas related to the practice of medicine, the proposals stated that if a province wanted to pass legislation in respect of those controlled activities, it would have the legislative authority to do so.

Genetic technologies, with the exception of those to be legislatively prohibited, were again largely absent from the discussion surrounding the proposed legislation which, by now, was directed to assisted human reproduction. Prior to the September 2001 federal-provincial-territorial health ministers meeting that focused on genetic testing in relation to the broader health system, Health Canada commissioned a series of papers to review and analyze current trends in relation to genetic testing for late-onset diseases. The particular paper touching on jurisdictional issues noted the need for careful regulatory frameworks to standardize personnel training, laboratories, quality control requirements, and product safety.(27) At the health ministers' meeting, there was a call for continual assessment of genetic testing, of its appropriate role within the publicly funded health system, and of patent and proprietary issues. Ministers "directed their deputies to collaborate on a work plan to manage implications for the health system over the short and longer term." However, they issued no immediate call for a uniform regulatory approach.(28)

## B. Health Committee Considerations

Parliamentary committee study revealed strong support for a pan-Canadian regulatory approach but questions about the way equivalency agreements might work. In addition to examining the draft proposals for legislation, the House of Commons Standing Committee on Health provided advice on options for a possible national regulatory body that would govern the implementation of the legislation and monitor developments. When it tabled

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(27) Christine Jamieson, *Genetic Testing for Late Onset Diseases: In-depth Thematic Analysis of Policy and Jurisdictional Issues*, Health Policy Working Paper Series, September 2001, p. 18.

(28) Health Canada, News Release, "Health Ministers move forward on improving health care in Canada," Federal-Provincial-Territorial Health Ministers' Meeting, September 2001, http://www.hc-sc.gc.ca/english/media/releases/2001/2001_103e.html.

its report in December 2001, the Standing Committee requested that comprehensive legislation be introduced on a priority basis.(29)

On the question of equivalency agreements, the Committee heard general apprehensions that they would undermine the establishment of a strong, national regulatory regime for assisted human reproduction. Even though the Committee had serious reservations about equivalency agreements, members accepted that these agreements could be a necessary tool in advancing cooperative federalism. However, it asked for a number of safeguards, including: accountability of the federal health minister; public consultation; opportunities for parliamentarians to make recommendations; agreements to be made publicly available; and others. In various dissenting opinions, members called for a federal-provincial-territorial conference to address the specific issue of reproductive technologies, and expressed concerns about infringement on provincial jurisdictions in health and social areas.

### C. Continued Concerns With Comprehensive Legislation (Bill C-56, later Bill C-13)

When the comprehensive legislation was finally introduced on 9 May 2002, further reassurances about intergovernmental collaboration were offered. In speaking about Bill C-56, An Act Respecting Assisted Human Reproduction, Health Minister Anne McLellan emphasized that regulations would be developed by Health Canada in consultation with provincial and territorial governments.(30) The bill incorporated many, but not all, of the Committee's recommendations on equivalency agreements. In establishing the independent agency requested by the Committee, the proposed legislation added provisions for a federal and a provincial governmental observer to oversee issues of mutual concern with the agency's Board of Directors. However, the bill ignored the Committee's calls for greater public and parliamentary consultation and reporting.

During Second Reading in the House of Commons, although most of the debate was taken up with the issue of embryonic stem cell research, concerns arose about federal-

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(29) House of Commons Standing Committee on Health, *Assisted Human Reproduction: Building Families*, Ottawa, December 2001, http://www.parl.gc.ca/InfoComDoc/37/1/HEAL/Studies/Reports/healrp01/08-rap-e.htm#SECTION%209.

(30) Health Canada, News Release, "Government introduces Legislation on Assisted Human Reproduction including the creation of a Regulatory Agency," http://www.hc-sc.gc.ca/english/media/releases/2002/2002_34.htm.

provincial relations.(31) Various members suggested that: a voting provincial member be on the Board of Directors; more rigorous provincial control over practices and research be allowed under equivalency agreements; the federal government bring reproductive technology under provincial public non-profit sectors; and the provinces be involved in the drafting as well as the implementation of the regulations. In October 2002, the Bloc Québécois proposed that the bill (now reintroduced as Bill C-13) be split to avoid federal encroachments.(32) The criminalization of certain practices such as human cloning was to be separated from the clinical activities falling under provincial jurisdiction. Referring to the existence of no fewer than 10 relevant Quebec laws, regulations and guiding principles, the Bloc's communiqué indicated that the establishment of a federal regulatory agency was ignoring the knowledge and expertise acquired by the province. In December 2002, when clause-by-clause consideration of Bill C-13 took place in the Standing Committee on Health, none of the sections relevant to intergovernmental processes were amended. The Senate will have its first opportunity to assess the legislation in early 2003.

## ASSESSING NATIONAL INTERGOVERNMENTAL CONSULTATIONS

Reproductive technologies were seen by the Royal Commission as an issue encompassing national health care concerns and successive federal health ministers agreed. Accordingly, intergovernmental consultations became a requirement for moving forward and served several purposes. Aside from the obvious interdependence of governments and the need for coordination, the consultations were one avenue for increasing awareness of other jurisdictional activities and a method of keeping all parties informed at the same level. By pointing out areas of jurisdictional concern, they allowed governments to think about and agree on areas where harmonization could be beneficial to counter the potential patchwork of health practices. They also provided a forum for putting forward requests for new funding in areas of shared jurisdiction.

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(31) House of Commons, *Hansard Debates*, Number 188, 21 May 2002; Rob Merrifield (Yellowhead, Canadian Alliance), Réal Ménard (Hochelaga-Maisonneuve, BQ) and Judy Wasylycia-Leis (Winnipeg North Centre, NDP) were key commentators on the federal-provincial elements.

(32) Le Bloc Québécois, *Communiqué*, "Le Bloc Québécois propose de scinder le projet de loi sur la reproduction assistée pour éviter les empiètements fédéraux," 17 October 2002, http://209.104.82.226/archivage/com_Ménard_projet_de_loi_C-56.pdf.

The preceding overview has highlighted several matters pertinent to intergovernmental consultations on health generally and to reproductive technologies specifically. The following sections assess the significance of equivalency agreements, committee formats, jurisdictional boundaries and transparency with respect to intergovernmental processes. In doing so, they also suggest various roles for parliamentarians in mediating possible outcomes.

## A. Initiating Equivalency Agreements

Discussions about equivalency agreements were taking place by the mid-1990s, and provisions were included in the legislation on reproductive technologies. Thus far, general experience with equivalency agreements is limited. The best-known legislative source for equivalency agreements is found in the *Canadian Environmental Protection Act*. However, when the Commissioner of the Environment and Sustainable Development reported in 1999, only one equivalency agreement had been negotiated, the Agreement on the Equivalency of Federal and Alberta Regulations for the Control of Toxic Substances, and its effect had not been evaluated.(33) In 1997, the *Tobacco Act* allowed the Minister of Health to enter into equivalency agreements with a province, but as of 2002 none had been signed.

Questions about the implementation and effectiveness of equivalency agreements are multiple. They include confusion about the meaning of equivalent (does it mean identical measures or measures leading to the same results); the criteria for the establishment of such agreements (what are the objectives and how are they audited); the requirements for resources and technical capacity (how many inspectors are needed, are computer systems for reporting needed); and the presence of provisions for whistleblower protection and citizen enforcement (do all jurisdictions have laws).(34)

The 1999 report of the Commissioner of the Environment and Sustainable Development pointed directly to the need for effective accountability and a requirement that accomplishments be communicated to Canadians through Parliament: "To demonstrate the

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(33) Commissioner of the Environment and Sustainable Development, *Streamlining Environmental Protection through Federal-Provincial Agreements*, Ottawa, 1999, http://www.oag-bvg.gc.ca/domino/reports.nsf/html/c905ce.html.

(34) Canadian Institute for Environmental Law and Policy, *It's Still About Our Health*, A Submission on the CEPA Review, 1996, http://www.cielap.org/infocent/research/health.html.

performance achieved and the lessons learned, the information reported to Parliament on the agreements needs to be meaningful, complete, timely, reliable and understandable."[35] Parliamentarians have expressed similar concerns, asking that elected representatives have an opportunity to study draft agreements and a summary of the comments from a public consultation. They have also questioned whether equivalency agreements could work against more rigorous control by provinces; for example, a province might want to impose stricter rules on embryonic stem cell research or reimbursement of donor expenses than those proposed by the federal government.

### B. Engaging Federal-Provincial-Territorial Advisory Committees

Consultations among governments on health issues may take various formats, but particular weight is given to those that take place in recognized intergovernmental advisory committees or their working groups. One study of inter-jurisdictional structures and approaches has suggested three variables that influence the structure and subject matter of federal-provincial-territorial advisory committees: conceptualization of the issue; dominance of professionals; and intergovernmental politics.[36] All these variables may have influenced and helped to diffuse the debate on reproductive technologies. Discussion of the subject was limited in both advisory committees and working groups after the mid-1990s. Without openness in the visible structures and access to agendas, the issue was shaped by ideas emanating from officials and organized interests rather than the broader political sphere.

Getting the attention of governments seems to have been particularly problematic in the case of infertility prevention and genetic technologies, two areas seen by the RCNRT as having national significance. Prior to the 1993 RCNRT report, infertility prevention was linked to a large extent with initiatives on sexual and reproductive health being addressed by a federal-provincial-territorial Advisory Committee on Community Health. The RCNRT report called for a coherent and comprehensive national response to the issue of infertility prevention. It also recommended that genetic technologies related to assisted human reproduction, such as prenatal diagnosis and genetic alteration, be subject to national licensing, monitoring, information

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(35) Commissioner of the Environment and Sustainable Development, 1999, para. 5.79.

(36) Lindsey McKay, *Changing Approaches to Health: The History of a Federal-Provincial-Territorial Advisory Committee*, Canadian Policy Research Network, Ottawa, 2001, http://www.cprn.com/cprn.html.

collection, and overall regulations. Following the release of the RCNRT report, however, neither issue appeared to receive significant attention from any federal-provincial-territorial advisory committee, and they remained unresolved when the latest bill on assisted human reproduction was introduced in 2002. Parliamentarians have not filled this gap with any extensive debate on either subject.

One reason for the lack of federal-provincial-territorial attention to infertility prevention may have been the change in approach from the earlier Advisory Committee on Community Health to the Population Health Advisory Committee formed at the time of the RCNRT report.(37) Where the earlier advisory committee had studied a specific target group, focusing on adolescent sexual and reproductive health, with a view to developing national strategies for health promotion, subsequent efforts focused on broader determinants of health and health goals for the overall Canadian population. Changes to the structure of the committee, to ideas about appropriate areas of study and to the interests supporting the ideas closed a possible intergovernmental avenue for discussion. Subsequent action on developing a national strategy for reproductive health has taken place outside the intergovernmental forums and within non-governmental organizations in individual provinces where there is "considerable interest in the issues, but no clear and coherent focal point for action, coordination or facilitation."(38)

With regard to genetic technologies, Health Canada appeared to generate background research and direct an external expert advisory group without any parallel work by any federal-provincial-territorial advisory committee or related working group.(39) Although the RCNRT saw genetics as a health care issue of national interest, the 2001 ministerial discussion indicated that genetics was primarily related to provision of health services, clinical practice and public funding, aspects generally viewed as areas of provincial and professional authority.

### C. Protecting Jurisdictions

With the reproductive technologies consultations, as with other health-related issues over the last decade, provincial governments proceeded very carefully before committing

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(37) *Ibid.*

(38) Planned Parenthood and the Pro-Choice Network, *Workshop on the Framework for Sexual and Reproductive Health*, Sydney, B.C., 2001, http://www.prochoiceactionnetwork-canada.org/workshop-report.html.

(39) See working papers prepared by the Applied Research and Analysis Directorate, and references to the work of the Expert Working Group on Genetic Testing of Late Onset Disease and other initiatives in the *Health Policy Research Bulletin*, vol. 1, issue 2, http://www.hc-sc.gc.ca/iacb-dgiac/arad-draa/english/publications/publicindex1.html.

themselves to a pan-Canadian approach. Although federalism and intergovernmental consultations are commonly described as collaborative, provincial governments may choose to be observers in the process but not participants in the eventual outcome. In particular, it has been noted that: "Shared visions, agreements, agendas, objectives, consultations, outcome indicators and progress reports regularly come out, usually with a footnote stating that the Government of Quebec shares 'essentially the same concerns' but 'does not intend to adhere to the federal-provincial-territorial approach' and is not included in the analysis or in the stated positions."(40)

This phenomenon continues in the case of reproductive technologies legislation, as with larger agreements such as the Social Union. Although Health Canada's consultation process on reproductive technologies tried to be supportive of provincial variation, the legislation covering both prohibited and controlled areas of assisted human reproduction is seen by the provinces as intrusive. Although the federal government claims a firm base in federal criminal law power, the regulatory aspects of the legislation are viewed as interfering with the provincial authority with respect to social and medical aspects of infertility and intervention technologies.

During the consultations among officials, Quebec was not alone in pointing out that the legislation had implications for existing provincial laws and policies on privacy, physicians, or research, and in arguing that federal regulations must distinguish between those for safety and those for service provision. At the parliamentary level, Bloc Québécois members announced support for the Quebec health minister's view that the regulatory aspects go too far; in particular, that they encroach on Civil Code provisions, on ministerial powers and on professional practices. Although the cost of the proposed regulatory agency has been mentioned, the question of opting out with federal funding to provide an equivalent regulatory program with similar objectives and accountability has not been raised publicly.

### D. Opening the Deliberations

It has been observed that intergovernmental decision-making often becomes "a competitive constitutional match at the expense of the problem under consideration."(41) On reproductive technologies, the federal government issued continual public assurances that the

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(40) Alain Noel, "Without Quebec: Collaborative Federalism with a Footnote?" *Policy Matters*, vol. 1, no. 2, March 2001, p. 4.

(41) D. Angus and M. Bégin, "Governance in Health Care: Dysfunctions and Challenges," in *Governance in the 21st Century*, Proceedings of a symposium held in November 1999 under the auspices of the Royal Society of Canada, Ottawa, 2000, p. 182.

provinces and territories had been consulted regularly while revealing little about the nature or extent of such joint deliberations. Commentators have noted the highly politicized, non-transparent and centralized nature of current federal, provincial and territorial consultations where officials rather than politicians have dominated.(42)

Press releases from various meetings involving federal, provincial and territorial ministers and deputy ministers contain little or no reference to reproductive technologies. Ministerial statements and announcements suggest that ministers of health were more involved in debates about issues such as the *Canada Health Act* and the sustainability of the health care system; justice ministers with subjects such as organized crime and young offenders; and status of women ministers with economic indicators. At the departmental level, most documentation suggests that detailed consultations took place among various officials, and that such activities may have been concentrated at mid-levels rather than at senior levels in the departments of health, justice and the status of women.

Engaging Parliament is suggested as one way to unfetter intergovernmental consultations by simultaneously activating "arenas of bargaining and partisan discussion – including not only formal intergovernmental conferences, but also the national parliament, national or provincial inquiries and other 'open' forums."(43) More recently, this proposal was reiterated as "a need to find better ways to incorporate consultation with affected groups" and "to find better ways to involve legislatures in monitoring and debating intergovernmental issues."(44) To date, the federal Parliament's role in the intergovernmental aspects of reproductive technologies has been constrained by factors such as availability of time and of knowledgeable witnesses. Although provincial representatives seldom appear as witnesses before committees, parties such as the Alliance and the Bloc with a clearer base in certain provinces continue to raise issues pertinent to provincial jurisdiction. Improved methods for parliamentary participation are unlikely to take effect before the reproductive technologies legislation is finalized, but they may be possible with concerted effort on the part of parliamentarians before the three-year review called for in the legislation.

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(42) Alain Noel, Christopher Dunn *et al.*, "Assessing the Social Union Framework Agreement, Redux," *Policy Options*, vol. 21, May 2000, pp. 42-51.

(43) Martin Painter, "Intergovernmental Relations in Canada: An Institutional Analysis," *Canadian Journal of Political Science*, vol. 24, no. 2, June 1991, p. 285.

(44) Richard Simeon, "Recent Trends in Federalism and Intergovernmental Relations in Canada: Lessons for the UK?" *The Round Table*, vol. 354, April 2000, p. 242.