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Constitutional Jurisdiction Over Health and Health Care Services in Canada

by

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The views expressed herein are solely those of the author and do not necessarily reflect those of the Commission on the Future of Health Care in Canada.

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Highlights

This paper examines the various questions related to the origin and exercise of constitutional jurisdiction over health care in Canada. In particular it examines four questions.

What are the constitutional bases for the federal and provincial roles in the provision of health care in Canada?

Most agree that although provincial governments have a firm jurisdictional basis for the delivery of health care services, the increasing overlap and expanding scope of services means that the federal government has become a major player in the area, and that it has a constitutional basis for doing so.

What is the constitutional basis for the exercise of the federal spending power as it relates to health?

Most agree that health is a matter of provincial jurisdiction, but also agree that the federal government can make transfer payments to provinces for health care purposes and attach conditions to those transfers, even if they appear to invade provincial jurisdiction. Some think that this power may be on shaky ground.

Does the Charter of Rights and Freedoms affect the distribution of jurisdiction with respect to health care and the delivery of health care?

In a formal sense the answer is no. However, the potential to influence or enhance the exercise of jurisdiction is another matter. It is conceivable that the Charter might influence the role of the federal government.

Insofar as Canadian health policy increasingly involves broader definitions of “health” each year, how might the interrelationship of broader parameters and overlapping jurisdictions affect health care policy in the future?

The paper concludes that economic powers will play an increasingly important role in health care because of globalization, economic powers like the power over patents, possible privatization, and finally, the important fiscal role that the federal government maintains in the funding of health care.

Executive Summary

This paper examines the various questions related to the origin and exercise of constitutional jurisdiction over health care in Canada. In particular it examines four questions.

What are the constitutional bases for the federal and provincial roles in the provision of health care in Canada? The answer to this question raises some interesting issues. Actual heads of jurisdiction have changed little since the original *British North America Act* was adopted. However, judicial interpretation of some of those provisions has altered their ambit significantly. During the same period, both orders of government have increased their overall involvement in general social matters, including health care. As a result, although provincial governments have a firm jurisdictional basis for the delivery of health care services, the increasing overlap and expanding scope of services means that the federal government has become a major player in the area.

Given the recent history of constitutional amendment in Canada, there is little likelihood of amendments that would either clarify the current heads of power, or add new jurisdiction to the federal or provincial governments. It may be that the courts might reinterpret some existing powers in an effort to remedy a specific problem, but they would be loath to cast a broad net into such a sea of overlapping jurisdiction. As a result, we can anticipate that changes will occur, if at all, by way of practice or agreement.

What is the constitutional basis for the exercise of the federal spending power as it relates to health? The answer to this question also provides some interesting insights. The common conception is that health care is a matter of provincial jurisdiction. The actual situation is more complex. The second common conception is that the federal government is on firm ground using its spending power in the area of health care. Put differently, most agree that health is a matter of provincial jurisdiction but also agree that the federal government can make transfer payments to provinces for health care purposes and attach conditions to those transfers, even if they appear to invade provincial jurisdiction. Provinces agree to this only because they want to keep federal funding. Although most constitutional experts agree that the federal government can dispose of its property in any way it sees fit, some, like Dale Gibson, think that this power may be on shaky ground.

Since the *Canada Health Act* is the main instrument of federal involvement, it is interesting that Gibson thinks that this act may be assailable if it is defended solely as an exercise in the disposition of property. He believes that it can be defended under the Peace, Order and Good Government (POGG) clause on the “national aspect” dimension. He may or may not be right, but it would be far better if the two orders of government could jointly agree on the principles involved and enshrine it in an agreement that carried with it a mutually agreeable dispute settlement mechanism. It remains to be seen if the recent agreement on the Social Union Framework Agreement (SUFA) will serve to help bridge this gap.

Does the Charter of Rights and Freedoms affect the distribution of jurisdiction with respect to health care and the delivery of health care? This question deals with the impact of the Charter on jurisdiction in the area of health care. Specifically, does the Charter affect the

distribution of jurisdiction with respect to health care in Canada? In this paper the question is interpreted to mean, “can the Charter be used to alter jurisdiction in health care.” In a formal sense the answer is no. However, the potential to influence or enhance the exercise of jurisdiction is another matter. It is conceivable that the Charter, primarily through Section 6, Mobility Rights, and Section 15, Equality rights, might influence the role of the federal government. The kind of arguments made by Gibson that portability, for example, might be justified under POGG, could certainly be applied to Sections 6 and 15 as well.

Insofar as Canadian health policy increasingly involves broader definitions of “health” each year, how might the interrelationship of broader parameters and overlapping jurisdictions affect health care policy in the future? This question four asks us to speculate on broadening definitions of health and how that might relate to the economic powers of the federal government. These were broad questions that are only partially addressed in this paper. The paper concludes that economic powers will play an increasingly important role in health care because of globalization, power over patents, possible privatization, and finally, the important fiscal role that the federal government maintains in the funding of health care.

Overall the paper concludes that it is unlikely that there will be formal constitutional change in the area of health care. It is also probable that the courts will tread carefully in this area as well. If there is change needed in the exercise of jurisdiction, it will probably be brought about by political agreement, enshrined in some form of semi-permanent contract or arrangement.

Introduction

This paper examines the various questions related to the origin and exercise of constitutional jurisdiction over health care in Canada. In particular it examines four questions that are of importance for the future of publicly funded health care. These questions are:

What are the constitutional bases for the federal and provincial roles in the provision of health care in Canada?

What is the constitutional basis for the exercise of the federal spending power as it relates to health?

Does the Charter of Rights and Freedoms affect the distribution of jurisdiction with respect to health care and the delivery of health care?

Insofar as Canadian health policy increasingly involves broader definitions of “health” each year, how might the interrelationship of broader parameters and overlapping jurisdictions affect health care policy and the discharge of responsibilities for the delivery of health care in the future? In particular, how do various jurisdictional responsibilities for economic matters affect health policy?

In order to answer these questions, this paper is divided into four parts. Part I outlines the historical development of constitutional jurisdiction over health care in Canada. This development has been characterized by two long-term trends. First, important heads of power that might have been relevant to health care have taken on different meanings from those anticipated in 1867. This has occurred largely as a result of judicial interpretation. Second, the exercise of federal and provincial jurisdiction has changed profoundly in response to changing conceptions of the role of the state over the period 1867-2002. Despite this complexity, there is a discernible body of case law and convention to guide us in examining the present situation.

Part II of the paper looks specifically at the federal spending power and its impact on health care policy development and delivery of health care services in Canada. The federal spending power provides the basis for much of federal involvement in the policy areas of the social safety net in Canada. The ability to give or withhold funding for specific programs has been a potent force in shaping all areas of social policy. In health care, it forms the basis for the *Canada Health Act*, which seeks to provide “national standards” for Medicare.

Part III deals with one of the most interesting points that has emerged in this debate, the impact, if any, of the Canadian Charter of Rights and Freedoms (the Charter) on the matter of the provision of health care services. Discussion in this area has usually revolved about the right to equality in the provision of care. Specifically, do people have some form of “charter right” to health care? To date the courts have resisted interpretations of equality rights that guarantee equality of condition as a public right, but they have not tolerated discriminatory treatment of individuals or groups in the provision of care. As well, they have resisted using place of residence as a basis for insisting on equality of condition or service. However, the law in this regard is evolving. This paper deals with a more precise question, however. That is, does the

Charter affect jurisdiction over health care in Canada? The answer to this question is easier to determine.

Finally, and most interestingly, the definition of what constitutes a “health” matter continues to expand. Whereas 30 years ago a health matter was generally thought of in curative terms that involved a doctor and a hospital, that definition has broadened considerably. Determinants of health now include such things as genetic factors, lifestyle, social and economic status, occupational and environmental conditions, and even race or gender. This part of the paper will explore the constitutional implications that flow from this kind of broad definition. While it may be useful to aggregate policy into clusters, it becomes problematic when constitutional powers are not distributed in a way that facilitates these kinds of aggregations.

The paper concludes by summarizing its descriptive and analytical findings. As well, it provides some suggestions on constitutional interpretations and directions that might be useful in shaping future policy in this area.

I Health Care and the Constitution

Any examination of constitutional powers with regard to health care in Canada must be based upon the recognition of several important considerations. First, “health care” is not a head of power in the Canadian Constitution in the same way that banking, buoys, or Sable Island is. The common perception is that health care is a matter of provincial jurisdiction. Such a statement is at best misleading. As Peter Hogg, one of Canada’s preeminent constitutional experts says:

Health is not a single matter assigned by the Canadian constitution exclusively to one level of government. Like inflation, and the environment, health is an ‘amorphous topic’ which is distributed to the federal parliament or the provincial legislatures depending on the purpose and effect of the particular health measure at issue. (Hogg 1998, 445)

Why then is there a perception that the provinces have exclusive jurisdiction in this important social area? Part of the misunderstanding arises from the fact that section 92(7) assigns exclusive provincial control over hospitals and psychiatric institutions. Insofar as health care was concerned in 1867, it was thought of in terms of disease and hospitals. More will be said about this later.

The second important matter to be considered has to do with the evolution of the federal system in Canada. More precisely, the exercise of various constitutional powers by the federal and provincial governments in Canada has been altered profoundly by two important events. The first has been the growth of the involvement of the state in the lives of all Canadians. The second is the way that judicial interpretation and conventional usage have altered the original intentions of those who drafted the *British North America Act*.

Taking the second point first, it is important for our discussion to understand that exclusive provincial power over what has become such an important matter, as health care could not have been anticipated by the “fathers of Confederation.” As Donald Smiley pointed out:

The Confederation settlement contemplated a centralized federal system. Most of what were then regarded as the major functions of government were vested in the Dominion. (Smiley 1980, 19)

Insofar as this distribution of power is concerned, many federal heads of power that were thought to be important in 1867 have come to be restricted by judicial interpretation. These include most importantly the general power (Peace, Order and Good Government [POGG]) and the trade and commerce power. In contrast, specific heads of provincial power were interpreted more broadly to enhance the provincial role and jurisdiction. In particular this was the case with the interpretation of Section 92(13), Property and Civil Rights. The Privy Council in Great Britain, through its disposition of appeal cases primarily during the period 1892-1930, effectively turned 92(13) into a broad provincial residual clause.¹ There is not time in this paper to review the role of judicial interpretation in constitutional development in Canada. It is important to point out, however, that such a process of interpretation could be expected where constitutional sections are

either ambiguous or potentially susceptible to broad interpretation. Whyte and Lederman put this dilemma very well in their landmark books on constitutional law in Canada.

The danger is this, that some of the categories of federal power and those of provincial power are capable of very broadly extended ranges of meaning. If one of these concepts of federal power should be given a broadly extended meaning, and also priority over any competing provincial concept, then federal power would come close to eliminating provincial power. The converse could happen just as easily, with the federal power suffering virtual eclipse. (Whyte and Lederman 1977, 4-10)

Thus it is not only important to understand the actual heads of power with regard to health care, but also how they interrelate with other heads of power, how they have changed, and why.

This brings us to the second matter involved with this point. The roles of the federal and provincial governments, and the exercise of their jurisdiction, have changed in response to changing conceptions about the role of government in society. In 1867, matters like education, health care, family care and control, and most of what we now consider social services, were all considered private, charitable or religious matters. These services, insofar as they existed, were not generally thought to be included in the responsibilities of the state, except in a then very limited regulatory manner. The conceptions and expectations about the role of government in this area changed profoundly during the 20th century, especially after the Great Depression. Canadians demanded that the state ensure that many basic social services in society be guaranteed by entrusting them to government. This raised the question of what government, federal or provincial, ought to be responsible for these services, and concomitantly, the relationship between them. As Bakvis and Skogstad point out in their recent book on federalism, it has made for interesting times.

Despite occasionally turbulent relations between governments, and despite the high degree of centralization, the Canadian federation has successfully faced several major policy challenges. These challenges include those related to the construction of the post-war social safety net, including Medicare. . . . (Bakvis and Skogstad 2001, 4)

The most crucial questions involved capacity and power. The lesson of the depression was that the provinces had the constitutional power with regard to matters like unemployment, pensions, and social services, but lacked the fiscal capacity to cope with the problems. By contrast, the federal government had the plenary taxing power and the fiscal capacity, but no constitutional jurisdiction in relation to these costly areas of social welfare. This led to intense pressure from Canadians for the federal government to get involved in areas of provincial responsibility. Some provinces resisted this pressure, but fought a losing battle.

A rising tide of political sentiment ran in the opposite direction. From the 1930's through the end of the 1950's the centralist perspective was the dynamic initiating force in Canadian constitutional politics. Centralism was never stronger than during this quarter century. (Russell 1993, 62)

For the most part this centralization did not involve specific constitutional amendment. Instead, the federal government found new ways to become involved, primarily as we will see, through

the use of the spending power. The desire of Canadians for social services served to legitimate the involvement of the federal government in areas of what were previously considered provincial responsibility. This is an important point. No federal government could resist the chance to secure political credit for ensuring that there was no return to the deprivation of the 1930s. The small matter of jurisdiction could be overlooked in the circumstances. Thus, together with the increasing complexity and expansion of health care delivery, crucial political imperatives dictated that both orders of government become involved in a profound way in this area.

With this background we can now turn to the explicit heads of constitutional power involved in health care.

Provincial Powers

92(7) – The Establishment, Maintenance, and Management of Hospitals, Asylums, Charities, and Eleemosynary Institutions In and For the Province, Other Than Marine Hospitals.

This section constitutes one of the central sources of provincial jurisdiction in the area of health care. By natural implication, the regulation of personnel, and functions associated with these institutions broadens the ambit of jurisdiction. Originally these institutions were under the control of private and religious groups. The fact that most are now owned by the government makes their control a matter of government proprietorship also. It should be noted that there are major exceptions to the above. The first is marine hospitals, which are explicitly mentioned in 91(11) and hospitals and care in federal territories and defense establishments.

92(10) – Local Works and Undertakings. . .

This section could be used to bolster provincial control since most hospitals are not parts of interprovincial enterprises. However, many health care delivery organizations, such as nursing homes, are now both private and national in scope, and might be susceptible to federal regulation through competition legislation, or by virtue of the fact that they are economic enterprises that are covered by treaties such as NAFTA.

92(13) – Property and Civil Rights in the Province

This section, aside from the fact that it has received wide ambit in judicial interpretation, is the basis by which the provinces regulate labour relations and the professions involved in the health care field.

92(16) – Generally All Matters of a Merely Local or Private Nature in the Province

This section is similar to Section 92(10) but involves private matters as well. This would bolster the provincial power to regulate religious health care delivery agencies.

93 – In and for each province the Legislature may exclusively make laws in relation to education...

This section allows the provinces to regulate the education and training of all health care delivery personnel. It also allows them, in conjunction with section 92(13), to establish self-regulating professions and registration procedures in the field.

95 – In each Province the legislature may make laws in relation to. . . immigration. . . .

This is a concurrent power with the federal government and provincial laws may not be “repugnant” to federal laws. Immigration has been important in some provinces attempting to cope with a lack of domestic health care personnel by bringing immigrants into the province.

These are the major provincial constitutional powers over health care. They are supplemented by the general power over provincial public lands and assets, as well as the provincial taxation power.

Federal Powers

Section 91 – The most important powers in this section have been the enumerated heads, which we will examine below. It is worth noting, however, that the residual or general power remains. Despite the fact that it was restricted by judicial interpretation in the period up to 1930, some think it possible that it could be important in the future. Indeed, the Supreme Court has several times indicated that it remains a possible potent source of federal power.² The most often cited examples of “national concern” usually involve health matters.

There are however, cases where uniformity of law throughout the country is not merely desirable but essential, in the sense that the problem ‘is beyond the power of the provinces to deal with.’ . . . The often-cited case of an epidemic of pestilence is a good example. The failure by one province to take preventative measures would probably lead to the spreading of disease into those provinces, which had taken preventative measures. (Hogg 1998, 415)

The recent events after September 11, 2001, and the attacks in the United States, have led the national government to look at health measures designed to combat the release of deadly diseases such as smallpox. As well the federal government has acted to stockpile needed drugs to cope with something like the mailing of envelopes with deadly anthrax bacterial spores in them. No one would dispute that these are health measures, but they are generated from security and national defense concerns.

91(2) – The Regulation of Trade and Commerce

This head of power was thought in 1867 to be one of the most important. Given the economic expectations associated with Confederation, and the anticipated role of the federal government in this area, it was a reasonable expectation. However, judicial review of this section in relation to

section 92(13) led to the diminution of the federal power over trade and commerce. There is too little time in this paper to fully explore the constitutional changes and debates involved in this matter. However, one aspect is crucial, the regulation of international trade and commerce.

How is this related to health care and the delivery of health care services? For the most part it relates to the production and trade in health care related goods and services. Most of the products relevant to the delivery of health care such as machines, drugs, tools, and construction of facilities, are produced in the private sector. Quite often they are imported from another country. They are treated no differently than other products that are produced or traded. As well, many of the services related to health care delivery, such as training programs, are also undertaken by the private sector, often with manuals or procedures developed in other countries and sold in Canada. In short, the economic aspect of health care is both international and subject to regulation by the federal government.

This is especially true when it comes to comprehensive international agreements. In agreements like NAFTA general regulations about trade and trade practices are put in place, even though the implementation of those regulations may trench on an area of provincial jurisdiction. Thus obligations in the field of health care may result from general trade agreements, despite the fact that health care delivery is largely a provincial responsibility.³ We will explore this more fully later in this paper.

91(9) – *Beacons, Buoys, Lighthouses and Sable Island*

Since the federal government was given exclusive jurisdiction over Sable Island, all health care related matters on the island come under federal jurisdiction.

91 (11) – *Quarantine and the Establishment and Maintenance of Marine Hospitals*

The federal government has exclusive jurisdiction over marine hospitals in Canada. As well, it has the health-related power of quarantine.

91(22) – *Patents of Invention and Discovery*

This power has had a major impact on health care in Canada. Patents allow the individual or corporation to claim the exclusive right to manufacture and profit from “inventions.” This is particularly important with regard to drugs that are now used extensively in the prevention and treatment of illness. The cost of these drugs has risen dramatically in the last two decades, in part because Canada, along with other governments in the developed world, has extended the time of patent protection. In Canada it was lengthened from 7 years to 21 years. The effect of this has been to preclude generic manufactures from providing cheaper copies of the patented products, usually until after their effectiveness has been superseded by newer patented drugs.

91 (24) – *Indians and Land Reserved for Indians*

Initially this power included all health matters for “Indian” people (excluding Metis in most cases). This is now not the case. The matter of health care and the delivery of health care services for “Indians” is a matter of ongoing negotiation between federal, provincial, and First Nations governments. First Nations generally want to deliver their own services wherever possible. However, they believe that the federal government is responsible for the cost of this care under treaty obligation. For its part, the federal government has now restricted its fiscal role to First Nations people on reserves. Provincial governments have now unwillingly assumed the cost of health care for all Aboriginal peoples off reserves.⁴

91(27) – *The Criminal law. . .*

The criminal law power is intimately associated with matters of health care. By using its power to declare something a crime the federal government has the power to restrict or expand many health activities. Current examples that illustrate this are: the criminalization or decriminalization of such procedures as abortion, cloning, genetic research on embryos, and sperm banks. As well the use of certain foods and drugs can be made illegal or restricted. For example, marijuana can be used for medicinal as well as recreational purposes. By classifying it as illegal, the use of this substance for health purposes is restricted.

92(10c) – *The Power to Declare Works. . .*

Federal power in this area results from its declaration of a “work.” As a result, such as in the uranium area, the federal government becomes responsible for labour relations, work safety, and health issues, all of which would normally be under provincial jurisdiction. Thus, if the political will were present, any hospital or group of hospitals could be declared to be a work for the general advantage of Canada by Parliament.

Federal Territories

The territories of Yukon, Northwest Territories, and Nunuvut are all ultimately under federal jurisdiction, since their own jurisdiction is delegated from Parliament. Although the three jurisdictions have various legislative bodies and treaty arrangements that govern the delivery of health care services, ultimately constitutional power in these areas is with the federal government.

International Treaties

It is possible for the federal government to intrude on or frustrate provincial jurisdiction through the power to sign international treaties. In other federal countries, this power is virtually unchecked.⁵ In Canada the situation is somewhat more complex. The constitutional power to implement treaties originally resided in Section 132 of the *Constitution Act*. It allowed the

federal parliament to implement treaties signed on behalf of the empire.⁶ However, in a landmark decision rendered in 1937, the Judicial Committee of the Privy Council declared this section to be exhausted as a result of the fact that treaties had ceased to be treaties of the empire. It rejected the idea that the federal parliament would automatically have the right under Section 91 to intrude on areas of provincial jurisdiction to implement the provisions of international treaties. This has left Canada with a “bifurcated treaty power.” Simply put, if the federal government signs a treaty in an area of provincial jurisdiction, it means that the provincial legislature must implement the provisions of the treaty in its area of jurisdiction. It may or may not do so. Since 1937, the Supreme Court of Canada has “nibbled” around the edges of this decision, but never reversed it.⁷

This has meant that economic treaties such as the FTA and NAFTA, which obviously have implications for health care, have yet to be tested. It could be that the Supreme Court may find that the power exercised over international trade by the federal government can incidentally trench on the provincial power over the delivery of health care. This would be especially relevant in the matter of private sector hospitals, etc.

The above is not an exhaustive list of specific powers, or the discussion about them. However, it does touch on most of the relevant major heads of power. Of equal interest for this paper are areas that are either ambiguous or that overlap.

Unassigned or Ambiguous Jurisdiction

As with any constitutional document, powers assigned to governments at one time often become redundant or inapplicable in another time. This has been especially true in Canada in the last century as the political and social roles of the federal and provincial governments have changed dramatically. Sometimes these ambiguities have been directly remedied through judicial decision or constitutional amendment. For example, neither the radio nor the airplane was contemplated in 1867. The question of regulation of these devices and activities associated with them became a question in the early 20th century. The courts resolved both matters in 1930, assigning jurisdiction for both to the federal government in Canada.⁸ No one contemplated the need for a national unemployment insurance scheme in 1867, but the savage depression of the 1930s made it a social necessity. The problem was solved by assigning the matter to the federal government by amending the *British North America Act* in 1940. The same was true for pensions in 1951, although the provincial governments retained paramountcy in that case.⁹

Not all matters have been so easy to categorize, however. In some cases both federal and provincial legislatures have legitimate and pressing concerns. The question of the environment is an example. Both the Parliament of Canada and the provincial legislatures have dealt with “environmental” matters when they thought it necessary. In part this is because the “environmental matters” are not easily classifiable. They may involve a number of jurisdictional heads. For example, air pollution can be thought to be a matter involving natural resources if it comes from the operation of a mine, or water pollution can be a fisheries matter if it involves the rivers emptying into the ocean. It can be a local matter if it involves one lake, a federal matter if it affects inland streams, or an international matter if involves the Great Lakes. The type, extent,

and time of the matter all affect the exercise of jurisdiction. Finally, the matter of politics also enters into the equation. It may be politically desirable for one order or the other to be seen to be doing something about a particular issue or problem at any given time. The environment is only one example. Matters like communications, intellectual property, and others could be said to fit into this category.

Of greater concern perhaps, are matters that require federal and provincial governments to coordinate their areas of jurisdiction to deal with a particular issue. For example, in the matter of inflation the primary powers are federal, but the exercise of provincial jurisdiction with regard to spending and borrowing is very important. In a modern interconnected and complex society it is almost impossible to have watertight jurisdictional compartments. This is certainly the case with regard to health care and the delivery of health care services. Even without the exercise of the spending power by the federal government, which will be discussed below, health care is an area where constitutional coordination is required. Thus, while it is useful to know the specific areas of jurisdiction, such knowledge alone gives you no sense of the actual exercise of power by the two orders of government. Other matters, as discussed below, become equally important.

II Health and the Federal Spending Power

For the purposes of this paper, we will assume that much of the history and detail involved with this issue is already known to the reader. The crucial elements revolve about the matter of the federal use (or non-use) of its ability to raise and spend revenue in Canada, and its impact on provincial legislatures and governments when it does so.

The term “spending power” requires some definition in order to ensure that we deal with it in a precise manner. There are many ways that a government can use its power to “spend.” The first and most obvious use of the federal spending power involves the expenditure of monies on projects and services within the federal jurisdiction. These can include direct payments to individuals or corporations for goods or services. As well, the federal government expends monies on various programs that are within the federal jurisdiction. This includes the expense of the public service in managing these programs.

The federal government also makes direct payments to individuals for a variety of purposes. There is nothing to restrict the federal government in these payments. The only question may revolve about the purpose involved, or the qualifications to receive the payment. The purpose may be something that is offered or regulated by the provinces. For example, there is nothing to prevent the federal government from giving cash bursaries to students attending educational institutions, or from providing research grants to university faculty engaged in research at a provincial university.

The federal government may also use its taxing power as part of the spending power. We have all heard of the term “tax expenditures.” This usually means revenue forgone by not exercising or transferring certain taxes, in Canada, most often to the provinces. These are considered as real expenditures and their transfer is often referred to by federal ministers when talking about their “share” of the cost of programs like Medicare.

Another way to use the spending power is to transfer monies to other governments in Canada. In the case of the federal government, this application has a long and honourable history. Many of the crucial arrangements and debates in 1867 involved the level of Dominion payments to the new provinces, division of property, and assumption of debts. Several parts of the original *British North America Act* refer specifically to such arrangements.¹⁰ This has continued to be the case, and has often been the subject of federal-provincial conferences. Transfer payments, as they are now called, are intimately bound up with shared cost programs, the spending power, and federal/provincial questions about jurisdiction.¹¹

Debate about the use of the spending power usually revolves around questions about its use in areas of provincial jurisdiction. The general arguments in this case are also well known. In the post-WWII era the Liberal federal government sought to establish a number of social programs in Canada. The motivation for this move is a matter of some discussion. Some argue that it was simply the product of electoral concerns, a move to the left by the Liberals to blunt the rise of the CCF. Others have argued that it was the result of the need to legitimate the capitalist economic system, to prevent a move toward socialism. For example, Garth Stevenson has argued this point of view in his works on Canadian federalism.

Generally speaking, however, conditional grants [by the federal government] have been mainly devoted to legitimization, precisely because the provinces cannot be relied upon to spend money in this field of policy without substantial incentives, and in some cases actual coercion.

It would be wrong, however, to overestimate the federal enthusiasm for spending on legitimization. . . . By accepting only partial financial responsibility and leaving provinces to assume the rest, the federal government purchases the political benefits (or avoids the political cost of inaction), at minimum expense to its treasury. (Stevenson 1982, 157 and 158)

Others explain the rise of shared cost programs as a reaction by the state to the unreformed federal system, as a way to circumvent an unusable constitutional system.

Historically the fiscal arrangements for social policy have served various purposes, all of which can be related to the handling of social policy in the Constitution. At times, the purpose has been to bridge the vertical ‘fiscal gap’ caused by the constitutional allocation or mismatch of revenues and expenditures, while at other times the desire has been to assist the poorer provinces in such a way that all parts of the country are able to offer comparable levels of public services. Sometimes the intent is to convince provinces to establish programs that might otherwise not have been developed sufficiently or even introduced. . . . Lastly, national unity has been the object of the arrangements. In this form, the arrangements amount to ‘bonds of nationhood’ forged out of a sense among Canadians that they share common services with each other. (Barker 1998, 145)

Whatever the motivation, the outcome was that over 100 shared cost programs were established after WWII, the best known of which were in the health care field. The constitutionality of this use of the spending power has caused considerable debate.

Generally arguments against federal involvement in shared cost programs involve two matters. The first is that by its use of the spending power the federal government skews provincial priorities. By offering federal dollars for certain programs in the area of provincial jurisdiction it ensures that others, not funded by the federal government, will be relegated to a lower priority. Insofar as the area of health care is concerned, this was an initial argument when the federal government first attempted to induce the provinces to establish a national Medicare system. No province now seriously argues against a Medicare system, but there is considerable debate about the lack of adequate federal financing, and consequently its role in determining the shape and priorities of the system.

The centre of debate in the last two decades, however, has concerned the use of the federal spending power in order to “enforce” certain health care goals outlined in the *Canada Health Act* (CHA). These “principles” are public administration, comprehensiveness, universality, portability, and accessibility. If a provincial system does not meet these criteria it is liable to lose some or all of the federal funding designated for health care delivery.

There are, therefore, two important questions involved. Is it constitutional for the federal government to use its spending power in the area of health care? Second, is it constitutional for the federal government to impose conditions upon provinces like those in the CHA?

While there are still many who argue against a positive answer to the first question, the majority of scholars support the kind of interpretation outlined by Peter Hogg.

It seems to me that the better view of the law is that the federal parliament may spend or lend its funds to any government or institution or individual it chooses, for any purpose it chooses; and that it may attach to any grant or loan any conditions it chooses, including conditions it could not directly legislate. There is a distinction in my view, between compulsory regulation, which can obviously only be accomplished by legislation enacted within the limits of legislative power, and spending or loaning or contracting, which either imposes no obligations on the recipient (as in the case of family allowances) or obligations which are voluntarily assumed. . . . (Hogg 1998, 157)

He supports this view in two ways. First he refers to Parliament's power under sections 91(3), the power to levy taxes, and 91(1A) to legislate in regard to public property, and 106, the right to appropriate federal funds. Second, he refers to the judgement of the Supreme Court in *Re Canada Assistance Plan* in which Justice Sopinka wrote the following for the unanimous decision.

The written argument for the Attorney General of Manitoba was that the legislation 'amounts to' regulation of a matter outside of federal authority. I disagree. The Agreement under the Plan set up an open-ended cost-sharing scheme which left it to British Columbia to decide what programmes it would establish and fund. The simple withholding of federal money which had previously been granted to fund a matter within provincial jurisdiction does not amount to regulation of the matter. (Hogg 1998, 158)¹²

Hogg is supported in his view by many other scholars. In particular Martha Jackson, writing in the *Health Law Journal*, outlines exhaustively the arguments and cases supporting the legitimacy of the federal government's role in health care. For example, she reviews the criminal law power involving environmental cases.

Following its decision in RJR-MacDonald, the Supreme Court confirmed Parliament's ability to rely on its criminal law power to justify broader forms of health regulation in R. v. Hydro Quebec. (f.#55) The case involved a challenge by Hydro-Quebec to the regulation of PCBs under the Canadian Environmental Protection Act. In rejecting Hydro-Quebec's claim that the environmental controls contained in the Act touched upon matters of provincial jurisdiction, Justice La Forest asserted that the goal of protecting human health supported federal regulation of toxic substances under the criminal law power. The Supreme Court's reasoning in RJR-MacDonald and in Hydro-Quebec provides considerable scope for future federal legislation aimed at controlling activities which put human health at risk, including those which have historically been perceived as entirely legitimate in nature. As Justice La Forest's decision makes clear, the federal government may not only exercise its criminal law

power in emerging areas of public health concern, it may also invoke section 91(27) in support of regulatory schemes which, like the Tobacco Products Control Act, are relatively detailed and complex in their structure, penalties and scope. In this regard, the RJR-MacDonald decision represents an important departure from the earlier view (f.#56) that legislation of a regulatory rather than more strictly prohibitive form could not be justified under section 91(27). By allowing for a regulatory approach to public health issues under section 91(27), the decision significantly expands the potential for federal reliance on the criminal law power in the area of health. (Jackman 2000, f55 and 56)

She concludes that *“The need for cooperation between the federal government and the provinces in the area of health is therefore as much a matter of constitutional law as it is of sound health policy.”* (Jackman 2000, f142)

If Hogg and Jackman are categorical in this matter, some others are not. In an excellent article on this issue, Dale Gibson, Belzburg Fellow at the University of Alberta Law School worries that the justifications put forward by Hogg and others are not sufficient.

Two important cautions should be noted, however. First the power may not be quite as sweeping as some of the pronouncements [like those of Hogg] seem to suggest. Although some of those statements quoted above seem to indicate that the federal spending power provides limitless justification for conditional federal fiscal initiatives in provincial fields, the historical pattern of Canadian constitutional interpretation, which has maintained a rough balance between federal and provincial powers, strongly suggests that if such initiatives threatened to alter that balance the courts would interfere. The second (and related) caution is that the customary theoretical legal basis for exercising the federal spending power in provincial fields is open to considerable question when scrutinized in terms of long-standing general principles of Canadian constitutional law. These two matters are related since, as will be seen, the customary rationale for the federal spending power offers very limited scope for federal involvement. . . . Leaving these legal doubts unresolved may not be wise. (Gibson 1996, 7)

Gibson outlines his concerns in some detail. He concentrates in particular on legal justifications that rely on Section 91(1A), Public Debt and Property. He reviews the argument used by most in favour of this broad power, which concludes that monies raised by the federal government are really property, and that the federal government is allowed to dispose of its property in any way that it desires. In the case of the *Canada Health Act*, therefore, it is really an act about federal property, and not health care.

He goes on to argue that this approach has two “Achilles heels.” First, there is doubt as to the ability of the federal authority to raise money for provincial purposes, and second, there is a legal requirement that legislation authorizing spending be in “pith and substance” really about the disposal of federal property and not some other purpose. The second is potentially most telling. In examining the *Canada Health Act*, no reasonable person would conclude that it is only about the distribution of federal property. Several parts of the Act make specific reference to health objectives and requirements. However, the Act could still survive if it was deemed to have a dual aspect. Again, Gibson notes that such a conclusion is by no means guaranteed. In particular, he

cites the Supreme Court decision on the Canada Assistance Plan. (Gibson 1996, 10) He concludes by saying:

In light of this uncertainty, those who support federal health care initiatives under the Canada Health Act and other uses of the federal 'spending power' would be well advised, as a safeguard against the possibility that the 'property' rationale will eventually succumb to siege, to explore alternative rationales. (Gibson 1996, 16)

In the remainder of his paper Gibson provides a cogent and well-argued case that acts like the *Canada Health Act* can be justified under Section 91, the Peace Order and Good Government clause (POGG). In particular, he stresses that “national dimension” aspect of several judicial decisions involving POGG.

While the applicability of the POGG power to federal legislation relating to health has never been determined conclusively, the Supreme Court of Canada has suggested that the power has a role to play in that field, [Margarine Reference, 1985] and in 1993 the Quebec court of Appeal held that federal legislation restricting tobacco advertising could be justified by POGG. (Gibson 1996, 17 and 18)

Gibson's arguments are compelling, if not conclusive, especially as they relate to some elements of the CHA such as portability, one of the five principles in the Act.

Gibson wrote his article before the negotiation and agreement of the nine provinces and the federal government to the Social Union Framework Agreement (SUFA). This agreement obligates all governments to respect the principles in the CHA. It is possible that this agreement could bolster the legal case that the requirements of the CHA are justiciable.¹³

We are left, therefore, with the uneasy feeling that the present constitutional justifications of the *Canada Health Act* are assailable, while other justifications, such as those proposed by Gibson, are not yet accepted.

Recent initiatives by the government of Alberta in response to the provincial study on the health care system headed up by former Deputy Prime Minister Don Mazankowski may serve as the catalyst for some judicial activity in this regard. The provincial government appears poised to privatize parts of the hospital system, and to de-list some services. It is possible that this could be construed as a violation of the principles of the CHA. Preliminary reaction by the federal government is cautious, with no indication that the federal government might penalize the province of Alberta for these proposed actions. This approach is not shared by many in the province itself, or by some of the opposition parties in Parliament. The lack of federal response raises a corollary question, however. Should the federal Cabinet not act to penalize the province of Alberta, is that the end of the matter? The answer by at least one scholar is that this is not the case. He argues in a lengthy article that the courts could be asked to force the federal government to enforce the legislation, to penalize the province. In particular, this action could be taken by individuals seeking to enforce the principle of the Act. Should such a court decision be forthcoming, the federal government would be forced to act or change the legislation. (Choudhry 1996, 462-509)

In the final analysis, at least in the near future, the constitutional status of the CHA may not be of great consequence. All governments have shown a distinct lack of appetite for a judicial challenge to its requirements. This is true even of the PQ government in Quebec. However, the continuing reduction of the federal fiscal role in health care may yet prove to be the catalyst for legal action. The outcome of that action would not, as Gibson has indicated, be a foregone conclusion.

III The Charter of Rights and Freedoms and Health Care Jurisdiction

This section deals with the impact, if any, of the Charter of rights and Freedoms on the matter of the provision of health care services. Discussion about the Charter and health care usually addresses the question of whether or not there is a justifiable right to equality of health care, or some minimum standard of publicly provided health care, in Canada. Specifically, do people have some form of “charter right” to health care?¹⁴ As always, the law in this regard is evolving, and a charter challenge is not out of the question. However, this paper deals with a more precise question. That is, does the Charter affect jurisdiction over health care in Canada?

There are several ways to conceptualize this question. The first would be; has the Charter transferred jurisdiction over health care in any meaningful way between the two orders of government? The short answer to this question is no. Insofar as provincial or federal jurisdiction over health care is concerned, the courts have not used the Charter to re-allocate power or powers as a result of interpretation of the Charter. It is difficult to conceive of this happening, except in the instance where one order of government refused to exercise its jurisdiction, causing a breach of a Charter right. For example, if the federal government refused to use the power to quarantine at all in specific regions of the country, section 15 might be invoked to ensure “equality” of treatment. We are on slippery ground here however.

If the Charter has not been used to do this, is there the potential for the Charter to be used to alter jurisdiction, or to enhance the jurisdiction of one order or the other? The answer is less than clear, but it is not difficult to conceive of how this might occur. For example, Dr. Marcia Rioux, in a book by Margaret E. A. Sommerville, outlines the basis for such an occurrence.

As an absolute minimum, any health policy must conform not only to the five recognized principles of the Canada Health Act, but also to meet the standards of the constitutional guarantee of equality rights. . . the acceptable bases for determining access to scarce resources must now be viewed in terms of the legal standards found in the Constitution and the Charter of Rights and Freedoms. (Rioux 1999, 144 and 145)

She goes on to cite cases where provincial governments were required to amend treatment or practices to conform to the equality guarantee of the Charter, section 15. That is, equal access to treatment was not being afforded to a recognizable group, in the most recent case, to those who are deaf in British Columbia. She concludes by emphasizing that the equality section must be used to ensure that no discrimination is allowed as between individuals or groups. She implicitly accepts the notion that equal health care access is a right of citizenship. (Rioux 1999, 144 and 145)¹⁵

Superficially this has little to do with jurisdiction. She does not speak to the question of equality as between provinces or the need for the power over health care to be transferred to the federal government in order to ensure equality. However, when wedded to some of the notions presented in the Gibson article cited above, it is easy to see how this could be the case. Gibson argued that the CHA could be supported by the POGG power in section 91. In particular, he

noted that the portability section of the CHA could be justified as a “national concern” and therefore supported by 91.

The goal of the portability criterion is obviously to ensure (to the extent that federal and provincial contributions are capable of doing so) that everyone who resides somewhere in Canada is free to exercise his or her right . . . to move about the country at will, without jeopardizing his or her access to satisfactory public health care benefits. The contention that legislation in support of such a goal has a national dimension is rooted, again, in the fact that no single province could achieve it. . . . Only the Parliament of Canada has the constitutional authority to ensure the portability of health care benefits for all Canadians. (Gibson 1996, 22)

The argument is clearly about equality of access. Curiously, however, Gibson supports this argument only with reference to Section 6 of the Charter, the Mobility Rights section, and not by reference to Section 15, Equality Rights. It seems that this argument could also be made.

The combination of 6 and 15 in the Gibson argument gives us a scenario where the jurisdiction of the provinces could be altered and/or reduced by the application of the Charter in order to ensure equality of access between the provinces. In this case, the federal government would legislate portability under POGG, using the argument of national dimension and Sections 6 and 15 of the Charter. Gibson goes on to speculate that universality and comprehensiveness could also be supported, albeit with less guarantee of success in case of a legal challenge. (Gibson 1996, 23) Such an enhancement of federal jurisdiction in this scenario would profoundly affect the jurisdictional balance in health care.

The possibility of using Section 6, Mobility Rights, to enhance the right of the federal government to legislate in the area of health care has already been noted above. Again, the existence of intergovernmental agreements like SUFA and the Agreement on Internal Trade (AIT) might be used to bolster the case.

The need for brevity in this article means that we have only scratched the surface of this subject. We can conclude by saying that it is likely that the Charter will be used to ensure equality of access in the area of health care in the future. Indeed, it may even be used to guarantee the system itself.

The Interrelationship of Definitions of Health and Constitutional Jurisdiction

This section attempts to answer the questions that surround definitions of health, health care and health care services, and jurisdictional responsibilities. More specifically, since definitions of what constitutes “health” have become more encompassing as we move away from the acute and chronic care model and toward the “wellness” or “preventative” model, does this have implications for the interrelationship of constitutional jurisdiction and jurisdictions that will come into play in the regulation and delivery of these increasingly broad services? Even more specifically, what role will economic powers play in the future in the area of health?

One way to reduce the scope and complexity of these questions is to focus on one or two major issues. Another way is to look at what has shaped broad trends in federal-provincial relationships during the past several decades and attempt to extrapolate future trends in the area of health care in particular from those broad trends. The first approach might select, for example, the issue of privatization and examine how major moves in this area might affect jurisdiction. The second approach might look at the role of the federal government in health care as an indicator of its commitment to the equity goals that have characterized federal government involvement in programmes that are largely in areas of provincial jurisdiction. In this section we will take the second approach, and blend in issues like privatization where relevant.

We looked briefly above at the conditions involved in the creation of a social program like Medicare after WWII. There was a broad social consensus that such a programme was needed, and the fiscal capacity of the federal government to initiate and sustain such a programme. Both consensus and capacity remained until the latter part of the 20th century. Harvey Lazar describes this interrelationship very well.

Until the late 1970's or early 1980's, Canadian fiscal federalism had a 'mission statement.' Its sense of purpose mirrored the broader postwar consensus about the role the state could play, through programs of redistribution and macroeconomic stabilization, in building a fair and compassionate society and a prosperous and stable economy. In turn this consensus was predicated on the idea that there was a latent sense of Canadian political nationhood, which could be mobilized in pursuit of these noble goals. (Lazar 2000, 4)¹⁶

For the most part, this “mission” was accomplished without formal jurisdictional change. It was undertaken and installed through various informal federal-provincial mechanisms of accommodation. These have at different times been called cooperative federalism, collaborative federalism, executive federalism and accommodative federalism, and recently flexible federalism. Results were achieved largely through negotiation and federal-provincial agreement. In other words, conventional practice altered formal jurisdictional capacity.

That process began to break down in the last two decades. Under fiscal and other pressures, both orders of government began to make unilateral decisions that had serious implications for the other order. The consensus on process was the first casualty of fiscal pressure, especially after the Liberal party took over government in 1993. As a result, the system lost both some of its sense of purpose and its sense of process. In health care this, coupled with other factors, produced a crisis of funding and services, which led to a crisis of confidence and disagreement about the principles of Medicare.

This process was compounded by the emergence of genuine ideological differences between the governing parties of the provinces, and, in some cases, the federal government. In Alberta and Ontario, Progressive Conservative governments were not only committed to fiscal integrity, they were committed to reducing the role of government, including its role in health care. This brought them into conflict with some other provinces, like Saskatchewan, and with the federal

government. The result was more pressure yet on the post-war consensus about social programmes, with the expected fragmentation of programme and purpose.

At the same time, there have been broad pressures in the other direction. Lazar, in the same article noted above outlines these pressures.

If the federal and provincial governments were operating in watertight compartments, this [trends toward unilateralism and loss of a sense of mission] might not matter much. But the forces of global and continental integration are increasing interdependence among economies and politics. For functional reasons, therefore, they are making intergovernmental collaboration a growing necessity for an ever-broadening range of issues not only across international borders, but also for governments within Canada. For that collaboration to be effective, however, the various governments have to have a minimum level of trust for one another. The ‘rules of the game’ must entail a measure of predictability about the behaviour of the partners. (Lazar 2000, 5)

Where, then, are these countervailing trends headed? Part of the answer lies in assessing how ever-broadening definitions of health, together with increasing economic globalization and integration, will integrate with the now re-emerging fiscal pressures that have fragmented the sense of national purpose described by Lazar.

Definitions of Health

As noted earlier in the paper, conceptions of what constitutes health and health care services have changed dramatically since the time of confederation. Indeed they have changed more dramatically in the last three decades than at any time in between. We now conceive of “health” in broader social terms, indicating that we understand that disease and its implications arise in a more holistic sense from everyday life and being. Many of the recent commissions studying health in the past two years have taken pains to point this out.

High tech medicine and emergency room dramas may get all of the media attention, but a quiet revolution has been taking place at the other end of the health system that is just as important. The evidence from around the world is clear. When it comes to improving health, high tech care takes a back seat to primary health services. The ‘miracles of modern medicine’ are not limited to drugs and surgery. Research on heart disease and diabetes, for example, demonstrates that years can be added to people’s lives by healthy lifestyles, early intervention, monitoring and health management-simple everyday health measures. (Fyke 2001, 9)

The Commission goes further to say that the “health effects of poverty and inequality are becoming more evident, particularly in the case of aboriginal people.” (Fyke 2001, 12)

Lifestyles, poverty, inequality, drugs, high tech equipment, and the equity goals of accessibility, and comprehensiveness, all make for a complex multi-faceted system that does not fit neatly into the constitutional categories of 1867. It is clear, however, that as the definitions of

health change and expand, they bring with them new ideas on what to do, and in many cases, how to do it more efficiently. Thus promotion of health prevention measures is justified not only on the grounds that it will keep people healthier, but that it will do it cheaper. The old maxim “an ounce of prevention is worth a pound of cure” is at the heart of much of the reform of Medicare and health care in general in Canada. Yet, despite cost savings, there is still the need to deal with rapidly expanding and costly health care measures in the existing system, while investing in new approaches that will ultimately save money. In other words, we need to invest now, to save later. The first part of this equation is what has caused so much consternation in the past 10 years.

It is obvious that how you define health, health care services, and even medical necessity all have profound implications for federal provincial relations. If, as suggested in the Mazankowski Report in Alberta, certain medical services are removed from the list of covered services, it will undoubtedly cause at least discussion with the federal government, if not confrontation. But will it affect constitutional jurisdiction, the subject of this paper? The answer is probably that it could, although this answer is hardly satisfactory. The most obvious way that this could happen would be through a court challenge involving the *Canada Health Act*, or even a Charter challenge, as discussed earlier in this paper. If such a challenge were successful, it could alter the jurisdiction of the provinces or the federal government. The more likely outcome, however, is that such definitional changes will alter federal provincial discussion and agreement.

Cost Containment, Federalism, and Jurisdiction

Given the widening definitions of health, it is inevitable that there will be increasing overlap with the federal government as the economic decisions of that government impact on health care. We saw this happen in the period after 1993. The federal government cut back massively in transfer payments in all programs, including health. According to studies, when adjusted for inflation, public spending on health care declined by 1.1 percent from 1992 to 1997. This brought the national share of the GDP spent on health care down from 10.2 to 9.2 percent. As one study said, “This absolute decline is unprecedented.” (Rachlis et al. 2001, 6) The immediate impact of this was, as noted above, to increase unilateralism. The consensus on both role and process virtually collapsed. The now conventional ability of the federal government to shape the health care system by using its spending power was challenged and remains in question.

Another impact of fiscal retrenchment was to increase the amount of private spending in the system. In the same time period noted above, 1992 to 1997, private spending, principally on drugs, dentistry, and related private sector institutional care, rose by 16.4 percent. (Rachlis et al. 2001, 6) This has an impact on jurisdiction as well. Take drugs as an example. We noted above that the power over patents has meant that the federal government has an enormous impact on health care development and expenditures. These are largely private commercial enterprises whose product is tested, patented, and regulated by the federal government. The period of patent protection is a direct result of international agreements on patent protection. As individuals increasingly pay for their own drugs, these become significant private transactions, unregulated by provincial governments. The same is true of private home care services, like those provided by corporations like the Extendicare Company, an international corporation that provides institutional care to the elderly. The federal government has considerable jurisdictional control

over these services through taxation, and control of interprovincial economic activities. Should the privatization of direct health care delivery continue, the federal government would undoubtedly acquire more jurisdictional influence through the increasing control it will have through its economic jurisdiction over international treaties, patents, etc.

Globalization and Health Care

At its simplest we know that globalization will have a similar impact on health to that in other economic and social areas. It will bring with it access to greater and more complex systems and knowledge, the production of the goods and services for health related activities will probably become global in origin, and the ability for smaller national and sub-national governments to control these international organizations will become increasingly problematic. How, if at all, might this influence jurisdiction in health care? There are many who put forward the “end of territory” thesis, which proposes that through the process of international integration territorial governments will lose real and legal sovereignty to international organizations. In this process, the nation-state will become increasingly irrelevant as social and economic activities are organized on an international basis. By implication, so will sub-national governments.

Most believe that this approach is overly simplistic. The complexity of the interrelationship of social economic and political actions is not as deterministic as this thesis would have us believe. In an excellent article on this subject, Michael Keating points out some of the problems with the end of territory approach.

We need to be careful about the ‘end of territory’ thesis. One cannot reason directly from functional re-structuring or economic processes to political power and governing institutions, without giving an independent role to politics, a role which varies from one case to another. . . . Yet today, in the face of all of the forces apparently undermining the territorial basis for politics and government, the territorial principle for organizing government is not only surviving but extending. So, as in the past, we are seeing not the end of territory but its transformation and reinvention in new forms. (Keating 1999, 15)

Keating goes on to note that the new territorial politics will be characterized by four features, competition, context, complexity, and asymmetry. For our discussion of jurisdiction the most important of these are complexity and asymmetry. Complexity means that the link between territory and function, identity, and institutions becomes complicated and variable. In particular, political accountability becomes blurred and innovation is less likely to occur. Asymmetry may also be one of the results of complexity, as the interrelationship of politics and complexity means that “one size” is unlikely to fit all. If we accept the argument of Keating and others, politics and territory will still matter in the future, but in a different and more complex way. Thus the argument of Lazar, that globalization will increase interdependence and blur jurisdictional lines even further in the future is probably correct.

How will governments respond to this blurring and asymmetry and what might be the form of their response? We can quite likely rule out formal constitutional change. Given the history of

constitutional amendment in Canada during the last 20 years, and the continuing strong role of the PQ in Quebec, the possibility of some comprehensive new arrangements is just not “on” as they say.

More probably we will see two contradictory directions, especially in the health care field. First, given the current fiscal arrangements, and the expectation that governments are again going to cut spending, we can expect to see more unilateral moves. What has happened in Alberta and British Columbia in the past few months will probably be replicated in other provinces. This will lead to the possibility that some of these changes might be challenged by the federal government as violations of the CHA. While this is not a certainty, the actions of some provinces make it more of a possibility. Second, if provincial governments proceed with major privatization initiatives the federal government’s role through its economic powers over international trade might be enhanced. For example, private hospitals and other institutions might be covered by provisions of NAFTA. Unilateral moves by the federal government could lead to friction, as control over these institutions in different provinces becomes a matter of economic as well as health interest.

Another response, given globalization and the increasing importance of economic powers to the health field, may be that the federal and provincial governments will seek to extend the model of SUFA specifically to the field of health care. A comprehensive federal provincial accord in the field of health, akin to the AIT or the SUFA, would certainly be preferable to formal amendment or continued confrontation. This might allow for some more specific matters to be included in the agreement. Whether or not Quebec could be brought into such an arrangement is problematic to say the least.

Finally, given the economic role of the federal government, there is the possibility that the courts might be used by individuals, companies or governments to “smooth out” complex jurisdictional overlap. Such challenges might arise from particular interest groups or private companies seeking to attain specific goals.

Much depends on how the federal government perceives its role in the field of health in the future. Recent initiatives stemming from September 11 seem to indicate that there is little chance that the federal government will enhance its fiscal role in the field in the near future. If it remains determined to put security, fiscal, and economic objectives ahead of matters like health care, it is likely that there will be further decentralization of control in the field of health. This could raise questions of equity and concern about national standards. Conversely, as noted above, the federal government’s economic role, and the increasing complexity stemming from the influence of globalization, might force the federal government to re-evaluate its role and the tools it might use to ensure that it has a role in the future.

We can conclude that the increasingly comprehensive definitions of what constitutes a health matter, together with globalization, privatization, and the reduction of the fiscal role of the federal government will probably cause friction and disorder in health care matters. The result may not be a diminished role for the federal government but a changed one. The shape of that role is not entirely clear, but international agreements will ensure that the role remains important.

IV General Conclusions

This study set out to answer four questions. They were:

What are the constitutional bases for the federal and provincial roles in the provision of health care in Canada?

What is the constitutional basis for the exercise of the federal spending power as it relates to health?

Does the Charter of Rights and Freedoms affect the distribution of jurisdiction with respect to health care and the delivery of health care?

Insofar as Canadian health policy increasingly involves broader definitions of “health” each year, how might the interrelationship of broader parameters and overlapping jurisdictions affect health care policy and the discharge of responsibilities for the delivery of health care in the future? In particular, how do various jurisdictional responsibilities for economic matters affect health policy?

The answer to the first question has raised some interesting issues. Actual heads of jurisdiction have changed little since the original BNA Act was adopted. However, judicial interpretation of some of those provisions has altered their ambit significantly. During the same period, both orders of government have increased their overall involvement in general social matters, including health care. As a result, although provincial governments have a firm jurisdictional basis for the delivery of health care services, the increasing overlap and expanding scope of services means that the federal government has become a major player in the area.

Given the recent history of constitutional amendment in Canada there is little likelihood of amendments that would either clarify the current heads of power, or add new jurisdiction to the federal or provincial governments. It may be that the courts might reinterpret some existing powers in an effort to remedy a specific problem, but they would be loath to cast a broad net into such a sea of overlapping jurisdiction. As a result, we can anticipate that changes will occur, if at all, by way of practice or agreement.

The answer to our second question has also provided some interesting insights. As noted above, the common conception is that health care is a matter of provincial jurisdiction. We have demonstrated that the actual situation is more complex than that simple understanding. The second common conception is that the federal government is on firm ground using its spending power in the area of health care. Put differently, most agree that health is a matter of provincial jurisdiction, but also agree that the federal government can make transfer payments to provinces for health care purposes and attach conditions to those transfers, even if they appear to invade provincial jurisdiction. Provinces agree to this only because they want to keep federal funding. Although most constitutional experts agree that the federal government can dispose of its property in any way it sees fit, some, like Dale Gibson, think that this power may be on shaky ground.

Since the *Canada Health Act* is the main instrument of federal involvement, it is interesting that Gibson thinks that this Act may be assailable if it is defended solely as an exercise in the disposition of property. He believes that it can be defended under POGG on the “national aspect” dimension. He may or may not be right, but it would be far better if the two orders of government could jointly agree on the principles involved and enshrine it in an agreement that carried with it a mutually agreeable dispute settlement mechanism. Unfortunately, this is unlikely to happen without some agreement on long-term funding.

Question three dealt with the impact of the Charter on jurisdiction in the area of health care. Specifically, does the Charter affect the distribution of jurisdiction with respect to health care in Canada? We interpreted this to mean can the Charter be used to alter jurisdiction in health care. In a formal sense the answer is no. However, the potential to influence or enhance the exercise of jurisdiction is another matter. It is conceivable that the Charter, primarily through Section 6, Mobility Rights, and Section 15, Equality rights, might influence the role of the federal government. The kind of arguments made by Gibson that portability, for example, might be justified under POGG, could certainly be applied to Sections 6 and 15 as well.

Finally, question four asked us to speculate on broadening definitions of health and how that might relate to the economic powers of the federal government. These were broad questions that were only partially addressed in this paper. We concluded that economic powers would play an increasingly important role in health care because of globalization, economic powers like the power over patents, possible privatization, and finally, the important fiscal role that the federal government maintains in the funding of health care.

It is unlikely that there will be formal constitutional change in the area of health care. It is also probable that the courts will tread carefully in this area as well. If there is change needed in the exercise of jurisdiction, it will have to be brought about by political agreement, enshrined in some form of semi-permanent contract or arrangement. However, as one famous baseball person noted, making predictions is difficult, especially about the future.

Notes

- 1 There are many good texts that discuss this matter. In particular, Smiley cited above, Stevenson, and Meekison, all cited in the bibliography.
- 2 In particular see Hogg (1988), p. 407-433, for a discussion of the “branch,” “gap” and “emergency” explanations of POGG. It would be worth noting as well, that the Supreme Court has had an expanding view of federal legislative power under POGG (see *R. v. Crown Zellerbach Canada Ltd.*) and has stressed the incapacity of the provinces to regulate effectively in some areas.
- 3 This is not as clear a federal power as this discussion might indicate.
- 4 For a good discussion of this see the *Report of the Royal Commission On Aboriginal Peoples, Volume 3*, especially p. 107-177.
- 5 In the United States, the Supreme Court has given the U.S. Congress virtually unfettered power to implement international treaties in areas of state jurisdiction.
- 6 Section 132 reads: *The Parliament and Government of Canada shall have all Powers necessary or proper for performing the Obligations of Canada or of any Province thereof, as part of the British Empire, towards Foreign Countries, arising under Treaties between the Empire and such Foreign Countries.*
- 7 For a discussion of this decision and other related documents, see Howard Leeson and Wilfred Vanderelst (1973). Since 1937, as a result of the Labour Conventions Case, the federal parliament has lacked the ability to legislate obligations under international treaties that fall into areas of provincial jurisdiction. However, recent decisions by the Supreme Court of Canada, such as *Vapour Canada Ltd. [1977] 2 SCR 134* in 1974, *R. v. Crown Zellerbach Canada Ltd.* in 1988, and *General Motors v. National City Leasing* in 1989 have all indicated that the federal government may be given more latitude under POGG to implement treaties in the future.
- 8 See Radio and Aeronautics cases, 1930.
- 9 There are a number of good articles on the events of the 1930s and the impact on Canadian federalism. The most eloquent portrayals of the problem are found in the Rowell-Sirois Commission itself, especially the Saskatchewan submission. Other articles are Martha Fletcher’s article “Judicial Review and the Division of Powers,” and Bora Laskin, “Reflections on the Canadian Constitution,” both in Peter Meekison’s *Canadian Federalism: Myth or Reality* (1968). A more recent article by Gerald Baier, entitled “Judicial Review and Canadian Federalism,” in the Bakvis/Skogstad volume (2001) is also good.
- 10 See sections 112, 118, 119, 142, and the Third and Fourth Schedules.
- 11 Once again there are several good sources for this discussion. In particular Banting (1987; 1998) and Lazar (2000), cited in the Bibliography, have done considerable work on the evolution of the spending power in Canada.
- 12 In this case, Hogg reveals that he was counsel for the federal government in this matter.

- 13 In fact, the federal government and nine provinces agreed to a dispute settlement procedure this Spring.
- 14 Interestingly, a corollary question is also being asked. That is, can the Charter be used to ensure the right to choose private care?
- 15 We may know more about this when the Supreme Court of Canada decides the Lavigne case from Quebec.
- 16 Professor Lazar's statement, while broadly true, fails to capture the regional commitment to this state of condition and the role of the federal government. In some provinces like Quebec, or some regions like western Canada, there was more or less commitment at different times.

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Terms

Accessibility: Requires reasonable access unimpeded by financial or other barriers to medically necessary hospital and physician services for residents, and reasonable compensation for both physicians and hospitals.

Comprehensiveness: Requires that all medically necessary services provided by hospitals and doctors be insured.

Portability: Requires that coverage be maintained when a resident moves or travels within Canada or travels outside the country (coverage outside Canada is restricted to the coverage the resident has in his/her own province).

Public administration: Requires that the administration of the insurance plan of a province be carried out on a non-profit basis by a public authority.

Universality: Requires that all residents of the province be entitled to public health insurance coverage.