

Commission on the
Future of Health Care
in Canada



Commission sur
l'avenir des soins de santé
au Canada

DISCUSSION PAPER NO.2

Health and the Distribution of Powers in Canada

by

André Braën

University of Ottawa



July 2002

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 study deals with the constitutional distribution of powers in the area of health services. It analyses the applicable provisions in Canada's Constitution as well as their interpretation by the courts. By describing the state of the law relating to health, it seeks to inform the Commission on the Future of Health Care in Canada about the legal principles underlying federal and provincial intervention in the field of public health and to enable the Commission to provide the federal government with recommendations on the policies and measures needed to ensure the long-term sustainability of a universally accessible, publicly financed system of health care.

Executive Summary

The constant rise in health care costs, the development of medical research and technology, and the expectations of an ageing population are shaking the Canadian health care system and jeopardizing its universality and public funding mechanism. The Commission on the Future of Health Care in Canada has been charged with recommending to the federal government the measures needed to ensure this system's sustainability and development. Constitutionally speaking, both levels of government, each in its respective jurisdictional areas, are authorized to take action in the field of public health. The present study describes the state of the law relating to the constitutional justification for such intervention.

Before proceeding with the actual analysis of the applicable rules of law, our study stresses the difficulties inherent in defining its main theme, namely health, and their impact on the distribution of powers. It also discusses the principles used by the courts to interpret constitutional texts and examines the consequences that the *Canadian Charter of Rights and Freedoms* might have in this field. Under Canadian constitutional law, it is the provinces which have primary authorization to intervene in the field of health care. Traditionally, this is an area that very early on was considered to be a matter of a merely local and private nature. The establishment of a system based on insurance (hospitalization, medical) also calls into play provincial jurisdiction in the area of property and civil rights. These principles are analysed in the second portion of our study. Other powers specifically set out in the *Constitution Act, 1867*, also enable the provinces to consolidate their authority with regard to the establishment and maintenance of hospitals, education or medical professions. But the Parliament of Canada also plays a significant public health role, and that is the focus of the third part of our study. Parliament intervenes mainly through its criminal law jurisdiction, but also through specific powers such as those pertaining to quarantine and marine hospitals, interprovincial and international trade, patents and copyrights or through its jurisdiction relating to peace, order and good government. It was mainly by virtue of its spending power that the federal government had a large hand in implementing a free, universal health care system. Our study therefore analyses the parameters and limitations pertaining to the exercise of this power. Last, it presents a comparative analysis of applicable systems in other federations.

Thus, the Canadian Constitution authorizes both levels of government to intervene in the field of health care, although it does assign the provinces primary responsibility in this matter. That is the current state of the law; it is a situation that cries out for consultation and cooperation – not competition – between the two levels of government. If the role of these governments must be amended, it is a task best left to the politicians, as the law in this field is merely a reflection of their decisions.

Introduction

A - Health Services in Canada

1. When the Canadian union was formed in 1867, health care was primarily the concern of religious or charitable organizations and individuals. It was only gradually, and in particular after World War II, that the role of the State – both federally and provincially – began to expand in the field of social health. With the cost of health services on the rise, governments appeared to be a good way to provide Canada with a system of publicly accessible health services. Today, the implementation and especially the maintenance of a viable and accessible public system of quality health care remains a priority for Canadian society. Against the backdrop of an ageing population, rapidly escalating costs, the remarkable growth of scientific research and medical technology, and rising expectations, crucial questions are being raised. They deal with the search for sufficient and sustainable funding, the availability and universality of care and the development of the human resources involved therein.
2. In Canada, federal and provincial governments are important actors in this field. Needing to reflect on the various issues involved and determined to play an important role, the federal government established the Commission on the Future of Health Care in Canada. The Commission's mandate is to recommend to the Canadian government the policies and measures needed to ensure the long-term viability of a publicly funded, universally accessible health care system. However, this exercise must take into account the distribution of powers and jurisdiction in Canada. Accordingly, four main research themes were identified by the Commission: (a) Canadian values; (b) viability; (c) cooperation among the main public and private stakeholders in the field of health; and (d) management of change.

B - Mandate

3. This was the context in which we were invited to prepare a study on the constitutional distribution of powers in the area of health and health services. The objective of our study is to inform the Commission about the legal principles underlying the role of each level of government in this area and about their development and transformation. Generally, this involves verifying the historical and legal origins of the assignment and distribution of powers among the various levels of government in Canada in the field of health. Specifically, we are required to verify (a) the constitutional bases of both the provincial and federal roles in the area of health; (b) the constitutional basis of the federal spending power as it relates to health; (c) the effect, if any, which the *Charter of Rights and Freedoms* has on the distribution of powers; and (d) changes in the role played by both the federal and provincial governments in the field of health. For comparative purposes, we are also being asked to touch on the situation in other federations.¹

C - Plan and Methodology

4. Canadian constitutional law, and in particular the *Constitution Act, 1867*, distributes legislative authority between the Parliament of Canada and the legislature of each province. Generally, it is the provinces which play the primary role in the field of health services. Thus we will analyse the constitutional provisions that authorize this role before considering those that form the basis of the federal role. In Canada, the courts are the guardians of the constitutional order. Consequently, our analysis of the constitutional enactments will take into account the judicial decisions rendered in this field. Last, we will consider the situation in other federations. But to begin with, we will take a detailed look at the difficulties in defining our subject, namely “health,” and the consequences from a legal analysis standpoint. We will also examine the historical context in which Canada’s public health care system developed and, for introductory purposes, the principal rules of interpretation that should be adopted concerning the constitutional enactments. Finally, we will look at the impact that the *Canadian Charter* might have in the field of assignment of powers.

I - Constitutional Distribution of Powers

A - Difficulties Defining Our Terms

5. The Canadian Constitution assigns, exclusively in most cases, to the Parliament of Canada or the legislature of a province the authority to make laws in all matters coming within the classes of subjects enumerated therein.² The constitutional assignment of authority for health was not, as such, covered by a specific provision. In fact, nowhere in the Constitution is there mention of the authority to make laws in the matter of “health,” “health services” or “health care.” The word “health,” as defined in *The Canadian Oxford*, refers to *the state of being well in body or mind or a person’s mental or physical condition*.³ In French the word “santé” is also defined in relation to the state of being well in body and mind.⁴
6. This amorphous nature of “health” was not lost on the Supreme Court of Canada in *Schneider v. the Queen*.⁵

In sum “health” is not a matter which is subject to specific constitutional assignment but instead is an amorphous topic which can be addressed by valid federal or provincial legislation, depending in the circumstances of each case on the nature or scope of the health problem in question.⁶

It is easy to see that actions taken in the public realm that could affect or change human welfare or equilibrium, either directly or indirectly, can take an infinite number of forms and rest on disparate constitutional foundations. For example, a measure aimed primarily at protecting the environment could ultimately have an impact on this welfare. As we will see, several federal initiatives in the field of public health are based first and foremost on the authority of the Canadian Parliament in the field of... criminal law. In short, health has many facets, which can fall under different areas of jurisdiction. In this study, we will confine ourselves, from a content standpoint, to the contemporary conception of a public health care system, be it in terms of the structure of health care institutions or the provision of health services.

B - Historical and Legislative Background

7. Although the State has long been involved in certain public health issues (the elimination of epidemics, for example), in 1867 its activities in the field of health care proper were limited and undertaken in concert with religious or charitable organizations.⁷ The *Constitution Act, 1867*, is a reflection of the times, to wit its provisions that the provinces have authority over “the establishment, maintenance, and management of hospitals, asylums, charities, and eleemosynary institutions in and for the province, other than marine hospitals”⁸ and that the federal government has authority over “quarantine and the establishment and maintenance of marine

- hospitals.”⁹ Personal health was seen by society, and therefore politicians, as a purely private matter.¹⁰
8. It was only as mindsets began to change that the State gradually stepped in to adopt social measures, and that the idea for a health insurance program began to form in Canada’s political consciousness.¹¹ During World War II, a proposal for a provincial health insurance plan subsidized by the Dominion was put forth but rejected. A federal cost-sharing plan in this field was also rejected in 1945.¹² It was not until 1957 that the Canadian Parliament passed the *Hospital Insurance and Diagnostic Services Act*.¹³ By 1961, all the provinces had climbed aboard with their own hospital insurance plan. In response to the Royal Commission on Health Services,¹⁴ Parliament passed the *Medical Care Act* in 1966.¹⁵ Clearly, the purpose of both Acts was to share between the two levels of government the costs of implementing a public hospitalization and medical care plan.
 9. Thus the federal government acted as a catalyst for the implementation in Canada of provincial health services plans, intervening through direct programs or, more often, transfer programs and conditional grants. It was within this system that the provinces put in place their public health care plans.¹⁶ The cost-sharing formula was amended a few times.¹⁷ In 1984, the *Canada Health Act (CHA)*¹⁸ merged the 1957 legislation on hospital insurance with the 1966 legislation on medical care. The CHA listed the eligibility criteria that provincial plans needed to meet in order to qualify for federal grant money, namely: public administration; comprehensiveness; universality; portability; and accessibility.¹⁹ Subsequently, financial difficulties led the federal government to slash its financial contribution to the provincial plans. It should be pointed out that in moulding the provincial health care plans, the federal government did not alter the constitutional assignment or distribution of powers, and that it carved out for itself an active and very important role in this field.²⁰

C - Principles of Interpretation

10. The constitutional provisions dealing with distribution of powers are in and of themselves insufficient and too imprecise to allow a determination of the tasks that might fall to each level of government in the field of health. They must be supplemented with the decisions rendered by the courts that had to interpret them. Indeed, in the final analysis it is the courts that are called on to interpret a legislative or constitutional provision and assign it meaning, content and scope. In terms of distribution of powers, the courts have endeavoured to verify the true nature of legislative provisions whose validity was contested from a constitutional standpoint. To do so, they have set out a number of principles that we should touch on.²¹
11. First, the constitutional provisions governing distribution of powers, in particular sections 91 and 92 of the *Constitution Act, 1867*, must be interpreted in the light of the federative intent underlying Canada’s political and legal system. Second, these provisions must not be interpreted literally and in isolation, but in relation to one

another by means of a correlative interpretation. It is the entire body of legislative jurisdiction which is distributed in this manner through the Constitution, and consequently any matter can be governed by one or the other level of government. In theory, the jurisdiction assigned to a level of government is exclusive to that level and cannot be encroached on by the other, whether the incumbent government has exercised it or not.²² There are, however, limits to this principle. A question can have two facets, with one coming under federal jurisdiction and the other provincial. In addition, while exercising its powers in a valid manner, one legislature can produce an incidental affect on a matter that falls under the jurisdiction of the other. At the same time as the distribution of legislative jurisdiction was explicitly set out, the distribution of the ensuing executive powers was also set out, implicitly.²³

12. In order to confirm that a statute is valid in terms of division of powers, the courts examine its true nature. By analysing the actual objectives pursued by the statute under challenge and by taking into account – where appropriate but not necessarily – the effects it produces, the courts seek to verify the question to which the statute pertains and to identify which level of government holds the jurisdiction. If there is incompatibility between two constitutionally valid statutes, one federal and the other provincial, the federal statute prevails.

D - Impact of the *Canadian Charter*

13. The *Canadian Charter* guarantees the rights and freedoms set out therein. Exceptions to and limits on these rights and freedoms are possible only to the extent permitted.²⁴ Legislators as well as the federal and provincial governments are bound by it in all areas coming under their jurisdiction. On this level, the main effect of the *Canadian Charter* is to limit State sovereignty. That is why the federal or provincial State, in the exercise of its legislative and executive functions, cannot undermine it. Since it is a constitutional enactment, it applies to matters of both federal and provincial jurisdiction. Consequently, the distribution of powers between the two levels of government has no effect on the *Canadian Charter*, since the latter has no effect on the distribution of powers. One could not, for example, invoke the equality rights set out in section 15 of the *Canadian Charter* to contest before the courts a distinction that might exist between two provincial schemes.²⁵ Indeed, the *Canadian Charter* cannot be invoked in such a way as to amend the distribution of powers.²⁶
14. So we see that the *Canadian Charter* limits legislators' sovereignty and does not affect the distribution of powers as such. But it is in the exercise of these powers that its effects are felt. Thus a legislative measure or the exercise of jurisdiction by a government entity may be challenged from the standpoint of its compatibility with the *Canadian Charter*. As in any other sector of activity, challenges based on the *Canadian Charter* can be the subject of legal proceedings. In terms of content, the *Canadian Charter* does not confer on individuals any right to health.²⁷ But other provisions can be invoked. For example, the Supreme Court of Canada in *Eldridge v. British Columbia (A.G.)*²⁸ ruled that a hospital, even if it is a private organization,²⁹

controlled by the provincial government and implementing the policies of this government, must comply with the *Canadian Charter* and can be required on the basis of the equality rights set out in section 15 to offer sign language interpretation services to its patients who are hard of hearing. Similarly, if the federal government offers services to the public in the field of health, in so doing it must comply with section 20 of the *Canadian Charter* and make them accessible in both official languages. In its negotiations with the provinces on the public health care system and in accordance with the principle of linguistic duality (sec. 16 of the *Canadian Charter*) and its commitments under the *Official Languages Act*,³⁰ it must take all necessary measures in this regard to enhance the vitality of the official languages wherever they are found.

II - Constitutional Basis of the Provincial Role

A - General Remarks

15. When it comes to health, the provinces man the front lines. If the constitutional enactments did not assign specific authority for health, it was because in 1867 health was seen as a private matter.³¹ Consequently, public authorities intervened in this area only on an exceptional basis in response to emergencies caused by epidemics or by the need to undertake rudimentary public health measures in urban areas. Most of the time, these measures were ordered by city councillors. The *Constitution Act, 1867*, seemed to reflect this reality when some of its provisions assigned the province jurisdiction for hospitals (subsection 92(7)), matters of a local nature (subs. 92(16)) and municipal institutions (subs. 92(8)).³² In fact, it was in making reference to these provisions that right from the start, case law gave a very liberal interpretation to the provincial jurisdiction over health.³³ Thus “all matters concerning public health, with the exception of quarantine stations and marine hospitals, are within the exclusive purview of provincial legislation.”³⁴

B - Relevant Provisions

16. Today, the exercise of provincial jurisdiction over health care is a multifaceted undertaking, with all the facets pertaining to various classes of subjects listed in the *Constitution Act, 1867*. The most important are those which give the provinces exclusive authority to make laws in the following areas:
- “the establishment, maintenance, and management of hospitals, asylums, charities, and eleemosynary institutions in and for the province, other than marine hospitals” (subs. 92(7));
 - “generally all matters of a merely local or private nature in the province” (subs. 92(16));
 - “property and civil rights in the province” (subs. 92(13)); and
 - “education” (sec. 93).

Taken individually or together, these provisions are seen as assigning the provinces primary authority for health, in the form of hospital or health care services, the practice of medicine, training of health professionals and regulation of their profession, hospital and health insurance, and occupational health.³⁵

- *Establishment and Management of Hospitals*

17. Subsection 92(7) assigns the provinces specific jurisdiction over the establishment and administrative organization of the hospital system.³⁶ The public or private nature of an institution is of no import here; it is the provinces that determine their vocation and services. The only limit explicitly mentioned in this provision has to do with marine hospitals. The reason for this exception is that subsection 91(11) assigns the

Parliament of Canada exclusive authority for quarantine and the establishment and maintenance of marine hospitals. It is on the basis of this jurisdiction that the courts have, among other things, confirmed the provinces' authority to make laws on detention of mentally ill persons,³⁷ establishment of hospital therapeutic abortion committees³⁸ and the right to strike and labour relations within a hospital.³⁹

- *Matters of a Strictly Local or Private Nature*

18. Some argue that subsection 92(16) is the basis on which the provinces are recognized as having general if not extensive jurisdiction over public health.⁴⁰ Indeed, it seems that health itself can be seen on the whole as a strictly local matter. If that is the case, it should be pointed out that such jurisdiction, as general as it is, cannot extend to the classes of subjects assigned exclusively to the federal domain.⁴¹ In any event, in *Schneider v. the Queen*⁴² the Supreme Court of Canada upheld the constitutional validity of a British Columbia statute imposing drug treatment, basing its decision on, among other things, subsection 92(16). Drug dependency constitutes a local matter even though, seen in a different light, it could come under criminal law.

- *Property and Civil Rights*

19. It has already been determined that, from a constitutional standpoint, Canada's Parliament could not institute an unemployment insurance plan.⁴³ This program involves insurance and affected employers' and employees' civil rights. Consequently, subsection 92(13) was invoked to allow the provinces to establish a contributory health plan, be it a hospital, medical or drug insurance scheme, and to define its terms and conditions. In 1977, the Supreme Court of Canada upheld the provinces' authority to establish a compulsory, universal automobile insurance plan, basing its ruling on subsection 92(13).⁴⁴ This applies as well to health insurance.⁴⁵ Also, the courts ruled very early on that because they are based on contracts, trade and commerce within a province constitute a matter of private law coming under provincial jurisdiction, pursuant to subsection 92(13).⁴⁶ The provinces can, therefore, intervene in all the stages of the production and marketing of a product, and can also control its quality and quantity. For our purposes, this provincial jurisdiction comes into play for food products, drugs and other health products.⁴⁷ But this authority is limited by the principle of extra-territoriality, which opens the door to federal intervention.⁴⁸ Last and in a general sense, private law comes under provincial jurisdiction in accordance with subsection 92(13). Consequently, relations between a patient and a physician or with another health professional, and between a patient or physician and a hospital constitute a matter coming under provincial authority, as do most questions of liability in contract and tort. The same is true of the establishment, regulation and control of health professions, in particular the practice of medicine, as well as professional discipline and, in a general sense, the field of labour relations.⁴⁹

- *Education*

20. Section 93 of the *Constitution Act, 1867*, assigned the provinces exclusive authority to make laws in the area of education. Thus university programs, diploma oversight and proficiency tests in the field of health are all matters coming under provincial authority.⁵⁰ This authority also affords the provinces a role in the field of research.
- *Other Powers*
21. A province's ability to intervene in the field of health is not limited to the specific jurisdictions already listed. In constitutional law, the exercise of its powers is also valid to the extent that such exercise can be tied in with any other area of jurisdiction explicitly set out in section 92.⁵¹ Accordingly, it was judged that under subsection 92(9) a province can impose a mandatory registration procedure for health professionals⁵² or assign professional associations the authority to impose fines and other penalties under subsection 92(15).⁵³ Its powers in the area of agriculture⁵⁴ (sec. 95), direct taxation (subs. 92(2)) or prisons and reformatories (subs. 92(15)) also afford it an incidental role in health.⁵⁵

III - Constitutional Basis of the Federal Role

A - General Remarks

22. From a constitutional standpoint, we can see that health has been viewed by and large as a general envelope for which the provinces have primary responsibility. Today, however, the federal government is also very active in this area. It was when the Parliament of Canada began to get involved in social measures that the courts were called on to identify the constitutional basis for this intervention and to specify its limitations.⁵⁶ Except for an area of jurisdiction explicitly enumerated, federal authority over health matters generally derives from a triple source, namely Parliament's authority to legislate in the area of criminal law, the federal government's spending power and perhaps its authority to ensure peace, order and good government.⁵⁷ For its part, the doctrine examines this question mainly to verify whether Parliament, from a constitutional standpoint and as the architect of a pan-Canadian public health care scheme, can compel the provinces to comply with national standards that it, itself, sets.⁵⁸

B - Relevant Provisions

- *Quarantine and Marine Hospitals*
23. Subsection 91(11) assigns Parliament exclusive authority to make laws concerning "quarantine and the establishment and maintenance of marine hospitals." This explicit exception to provincial jurisdiction in this area⁵⁹ is attributable to the fact that primary jurisdiction in marine matters was assigned to Parliament, particularly for navigation and the merchant marine (subs. 91(10)) and the naval service (subs. 91(7)).
- *Criminal Law*
24. Subsection 91(27) assigns Parliament exclusive authority to legislate with regard to "the criminal law, except the constitution of courts of criminal jurisdiction, but including the procedure in criminal matters." This assignment must be viewed in its broadest sense.⁶⁰ The definition of criminal law is not rooted to a specific era or field; it evolves. The only characteristic common to all crimes is that they are prohibited and liable to sanction.⁶¹ This jurisdictional assignment authorizes Parliament to prohibit, for either preventive or punitive purposes,⁶² any act or behaviour and to impose sanctions for an offence. It can proclaim new crimes.⁶³ But because a crime cannot be proclaimed in a void, it must be associated with situations deemed undesirable. In criminal law, federal statutes must not only decree a prohibition and sanctions, but they must also pursue an objective which is in the public realm and generally recognized in criminal law. In this regard, the Supreme Court of Canada has already defined a public objective as being – and the list is not exhaustive – public

- peace, order, safety, *health* and morality.⁶⁴ Last, federal legislation must not constitute a specious encroachment upon provincial jurisdiction. Disguised legislation is not allowed under Canadian constitutional law.⁶⁵
25. From a constitutional standpoint, health occupies a grey area. Both Parliament and the provinces can intervene within their respective jurisdictions – hence the importance of highlighting the plenary nature of the jurisdiction that Parliament exercises in criminal law. It was determined that pursuant to this jurisdiction, Parliament may prohibit or control the manufacture, sale and distribution of products posing a public health risk. Parliament may impose labelling and packaging requirements for hazardous products and warnings on cigarette packages.⁶⁶ Federal legislation on food and drugs is perfectly valid,⁶⁷ just as it is on narcotics.⁶⁸ Parliament is also authorized to criminalize abortion⁶⁹ and to ban the sale of furniture considered hazardous for children.⁷⁰ It can make it illegal to produce and sell hazardous products and therefore prohibit certain substances in food products.⁷¹ But it may not impose standards on food composition, as this does not involve public health.⁷² Similarly, the prohibition on the sale of margarine was not aimed at protecting public health; rather, this measure was aimed at protecting the dairy industry.⁷³ To sum up, if its jurisdiction in criminal law enables the federal government to play a significant role in public health protection, this single area of jurisdiction has little impact on the implementation and maintenance of a public health care scheme.
- *Spending Power*
26. Generally, one level of government may spend in areas coming under the jurisdiction of the other. This can be likened to an owner exercising his power to dispose of his property as he sees fit. But in so doing and from a constitutional standpoint, it must not attempt to control or regulate those areas that come under the other's jurisdiction.⁷⁴ In the area of health, the federal government played a key role in implementing a public health care plan in all the provinces. To that end, it availed itself of its spending power. There is no explicit provision for this in the constitutional enactments. Rather, it derives from the manner in which these are interpreted, particularly the provisions of the *Constitution Act, 1867*, which deal with federal taxation power (subs. 91(3)), the authority to make laws with regard to public property (subs. 91(1A)) and the power to appropriate federal funds (sec. 106).⁷⁵
27. Federal legislation, which provides for the allocation of funds in provincial areas through transfer or grant programs, sometimes contains conditions that must be observed by the provinces if they wish to receive this funding. To avoid regional disparities, lawmakers have often inserted into this legislation what is now called “national standards.” In order to be constitutionally valid, the conditions must not alter the true substance of the statute or be tantamount to regulations governing a matter which comes under provincial jurisdiction. A province that enacts a law in

- order to conform to these standards is considered to be doing so of its own volition, since there is nothing obliging the province to do so from a legal standpoint.⁷⁶
28. But can the contents of these conditions or “national standards” alter the true nature of the federal statute in question and thus constitute a disguised attempt at regulating an area of provincial jurisdiction? As we know, the *Canada Health Act*⁷⁷ contains conditions to which the provinces must adhere if they wish to remain eligible for federal funds. This legislation has never been challenged in the courts – one can understand why, from the provinces’ viewpoint. But seen in a different light, the Supreme Court of Canada has already ruled that the simple withholding of funds by federal authorities in the event that a province fails to abide by the conditions prescribed in the federal statute does not in and of itself amount to regulating a provincial matter.⁷⁸ In *Winterhaven Stables Ltd. v. A.G. Canada*,⁷⁹ the Alberta Court of Appeal ruled that pursuant to its spending power, Parliament may impose conditions while exercising this power, even if this creates pressure on the provinces to adapt their legislation accordingly. This does not amount to regulating a provincial matter. It was also stated that a distinction must be made in this field between the power to make laws and the power to enter into contracts. In the latter case, nothing would prevent the federal authorities from setting the conditions they want in an agreement or contract to which the provinces remain free to adhere.⁸⁰
29. In any case, federal activity in the field of health care is a clear affirmation of federal spending power. Obviously, the exercise of this power is generating enormous tension within the Canadian federal system. On the one hand, the Canadian government is acting on its commitment in section 36 of the *Canadian Charter* to provide all Canadians with reasonably comparable levels of public services at reasonably comparable levels of taxation. On the other hand, the provincial governments are demanding the right to fully exercise their sovereignty in this area. In this regard, a province does not really have the choice of accepting or refusing the conditions unilaterally put forth by the federal authorities. If a province refuses to participate in a federal initiative aimed at, say, implementing a new program, the taxpayers of that province would pay (through their federal taxes) for the program to be implemented in the participating provinces without being able to reap the benefits themselves. Thus the federal government’s ability to use its spending power to influence provincial schemes and impose so-called national standards depends in large part on its financial wherewithal; this influence is likely to diminish in step with the decrease in federal transfers to the provinces... especially since a province may hesitate to implement a federal proposal, even a generously funded one, in the knowledge that a few years down the road the federal authorities may unilaterally decide to terminate their payments to the province. It should be pointed out that a disadvantage of such a system is that it creates some confusion in terms of accountability. Since maintaining existing programs and their quality depends on both provincial and federal funding, it becomes difficult to determine who is responsible for what, and when difficulties do arise, the two levels of government take turns passing the buck to one another.

- *Peace, Order and Good Government*
30. The introductory portion of section 91 of the *Constitution Act, 1867*, authorizes the Parliament of Canada “to make laws for the peace, order, and good government of Canada.” Because the distribution of powers is comprehensive, this authority to make laws for peace, order and good government is exercised in respect of all matters not coming within the classes of subjects assigned exclusively to the provinces or enumerated in section 91.⁸¹ This authority has been interpreted by case law to comprise two elements. The first empowers Parliament to legislate in situations of emergency or national crisis. By its very nature, this authority can be exercised only on a temporary basis.⁸² The other element involves Parliament’s ability to make laws on any matter that is in the interest of the federation as a whole. This is where the doctrine of national dimensions or national concern comes in.
 31. In *R. v. Crown Zellerbach Canada Ltd.*,⁸³ the Supreme Court of Canada spelled out this theory of national interest.
 1. The national concern doctrine [...] is separate and distinct from the national emergency doctrine...;
 2. [The national concern doctrine] applies to both new matters which did not exist at Confederation and to matters which, although originally matters of a local or private nature in a province, have since, in the absence of national emergency, become matters of national concern;
 3. For a matter to qualify as a matter of national concern in either sense it must have a singleness, distinctiveness and indivisibility that clearly distinguishes it from matters of provincial concern and a scale of impact on provincial jurisdiction that is reconcilable with the fundamental distribution of legislative power under the Constitution;
 4. In determining whether a matter has the requisite singleness, distinctiveness and indivisibility, it is relevant to consider what would be the effect on extra-provincial interests of a provincial failure to deal effectively with the control or regulation of the intra-provincial aspects of the matter.⁸⁴
 32. Thus the mere fact that a matter is of importance to the Canadian population as a whole does not necessarily mean that it has a national dimension or make it a national concern. The mere fact that health insurance is perceived as a Canadian value does not alter its nature, from a constitutional standpoint. In *A.G. Canada v. A.G. Ontario*,⁸⁵ the federal authorities’ argument that unemployment insurance had attained a national dimension was not upheld.⁸⁶ The merely local or private nature of health constitutes an important basis for provincial intervention in this area.⁸⁷ But health also comprises aspects that come under federal authority.⁸⁸ Do certain aspects of the public health care system, in particular national standards governing public administration, comprehensiveness, universality, portability and accessibility, constitute a matter possessing a singleness, distinctiveness and indivisibility that make it distinct from provincial powers in this area? More important, can a province’s failure or inability to deal effectively with these aspects inside its territory have an adverse effect on extra-provincial interests? Some say that by virtue of this authority, the Parliament of Canada could indeed intervene in such areas as AIDS,

abortion, smoking or foreigners' access to the medical profession.⁸⁹ But all these aspects have no bearing on the actual nature of today's health care system. The usefulness of the discussion lies, of course, in providing a basis for federal intervention without federal authorities necessarily having to use their spending power.

- *Other Powers*

33. As in the case of a province, the federal government's ability to intervene in health matters also remains possible to the extent that such intervention can be associated with another area of jurisdiction expressly assigned to the Parliament of Canada by the *Constitution Act, 1867*. Thus it is by virtue of their authority with regard to the militia, military and naval service, and defence (subs. 91(7)) that the federal authorities established and maintain veterans' hospitals. Parliament's exclusive jurisdiction over patents of invention and discovery (subs. 91(22)) and copyrights (subs. 91(23)) enables federal authorities to intervene in the area of scientific research and, more specifically, biomedical, genetic and pharmaceutical research. Parliament's jurisdiction over interprovincial and international trade enables the federal government to oversee exchanges of medical technology and of hospital equipment. In the area of agriculture and immigration-related health matters, federal legislation prevails (sec. 95). In businesses that come under its jurisdiction, Parliament can regulate health and safety matters as well as labour relations (subs. 92(10)).⁹⁰ The *Constitution Act, 1871*, enables it to exercise provincial health powers in federal territories.⁹¹ Last, Parliament's authority with respect to Indians, and lands reserved for the Indians (subs. 91(24)), certainly enables federal authorities to deal with Aboriginal health matters.⁹² Curiously, federal authorities consider Aboriginal health matters to fall under provincial responsibility.⁹³

IV - Health in Other Federations

34. Contrary to unitary systems, a federal system distributes the exercise of internal sovereignty between a central State and member States. This model is adopted by a State because it constitutes a form of government adapted to its specific needs and characteristics. How have other federations gone about the task of distributing powers in the area of health? In this regard, the Canadian system is but one model among others, and all variations remain possible. Our purpose here is not to systematically review the manner in which other federal systems operate in this field. Rather, and for purposes of comparison, we would like to touch on and summarize a few experiences in other countries that might be of interest to Canada, in view of their level of economic development, their population and territory, and their proximity and influence.

A - Australia

35. At the time of confederation in 1867 and influenced in this regard by the United States, where the same thinking prevailed, Canada's population looked on health care as a private matter. During the same period, Australia took the opposite position. It was very receptive to European ideas in this field, which held that health care was a personal right. Thus public access to health care and hospitals seemed to go without saying. At a time when most Canadian hospitals were private and many were managed by religious communities, Australia already had a public hospital network.⁹⁴
36. In the beginning, it was the federated States rather than the federal State which dispensed health services to the public. Responsibility for health stemmed from the residual jurisdiction vested in the federated States under the Australian constitution, which assigned the federal State only the authority for quarantine. But the federal State's interest in promoting social measures led it to create a federal ministry of health in 1921 and to become more involved in setting health policy. It seems that the relationship between the two levels of government has been a collaborative one, all the more so since, unlike the Canadian provinces, the federated States are far more dependent on the central State for funding. Similarly, while Canada's politicians were concerned about removing financial barriers to access to health care, Australia was firmly committed to developing the actual provision of health services.⁹⁵
37. An amendment to the constitution in 1943 specifically authorizes the federal State to adopt measures relating to pharmaceuticals, disease, and hospital, medical and dental services. Today both levels of government are concurrently and actively involved in the field of health, often in concert with local communities. Australia has a universal system of health benefits (Medicare) guaranteeing residents access to medical care and drugs at a reasonable cost, as well as free access to hospital care. Three-quarters of hospitals are public and their services are complemented by a network of private clinics. It is the federal State, with its exclusive authority to levy taxes, which funds

the bulk of the system through a general tax and an income-related deduction for health insurance.⁹⁶

B - United States

38. The health care system in this country is relatively complex. It involves both the public sector, comprising the federal State, member States and local communities, and the private sector, comprising insurance carriers and individual plans. Health care is dispensed locally within a loosely structured system. There is a free market when it comes to hospital services. There is no health planning at the federal level, although several reforms have been put forth with a view to controlling rising costs and improving accessibility to care. At the member States level, the role of the public authorities appears modest and is often limited to overseeing projects to create hospitals or health care centres. Most hospitals are managed by private, not-for-profit institutions, but some are owned by private for-profit corporations or public authorities.⁹⁷
39. The United States does not have a general health insurance system. The public sector offers Medicare, a universal, national health insurance plan for seniors and persons with disabilities. The federal government manages this scheme, which serves about 13 percent of the population. It is financed through a formula combining pay deductions, federal funds and premiums. The public sector also operates Medicaid. This health insurance program is aimed at the disadvantaged and serves about 10 percent of the population. Funding comes from the federal government and the federated States. Federal funding varies according to the federated State's wealth (between 50 and 83 percent of the total). Medicaid is managed by the federated States, but this is done in accordance with federal guidelines on categories of recipients and the range of services covered. The federal authorities, the federated States and the local communities also subsidize health care centres or hospitals for those most in need, or reimburse the institutions dispensing the care. But the vast majority of the public has recourse to the programs run by the private sector.⁹⁸

C - Belgium

40. Unitary at the time of its founding in 1831, Belgium became a highly decentralized State following recent constitutional reforms. It has a federal system that comprises, in addition to the federal government, three cultural communities (French, Flemish and German-speaking) and three regions (Flemish, Walloon and Brussels-Capital). The constitution assigns the regions mainly economic powers; the regions are also involved in health and safety policies. The communities have exclusive jurisdiction over cultural matters, including education, and "personal matters" – the latter being matters closely linked with an individual's life within his or her community.⁹⁹

41. “Personal matters” encompass hospital and social services, which are organized and managed by the communities. The communities apply health policy, which comprises care delivery measures, health education and preventive medicine activities and services. Individuals are required to join a mutual company, which reimburses the cost of services. But the federal government plays a very important role in the field of health through its financial support, public health initiatives and, above all, regulation of access to and exercise of health professions.¹⁰⁰

Conclusion

42. From a constitutional standpoint, primary responsibility for health services and care belongs to the provinces. The main reason for this is that the current public system is modelled after the insurance sector, a matter of ownership and civil rights in the provinces, and also because from very early on health was seen as a local or private matter. The creation and structuring of hospitals and health care centres, education, health professions, coverage of insured services, allocation and distribution of financial and medical resources... these are all sectors for provincial intervention. And it would appear that this is how it should be, to the extent that a province, on account of its proximity with the population, is well acquainted with their real needs and seems to be the level of government most able to meet these needs.
43. But health, in view of the realities involved, definitely has elements that come under federal authority. The Canadian government intervenes in this field by means of specific powers. Its criminal law authority and, in particular, its spending power enable it to play an important role. While this spending power has not been challenged in the courts, it is nevertheless a source of tension. And although the *Canadian Charter* does not confer any right of access to health care, the fact remains that as things stand today, the Canadian public believes it has this right. In our opinion, the fact that access to health care constitutes a value in the eyes of Canadian society does not necessarily make it a matter of national concern, thereby opening the door to federal intervention in the interest of peace, order and good government. Clearly, however, the federal authorities – if only because of their commitments – have an important role to play in this field.
44. The public health care system is in the midst of a crisis. Increasingly, the decisions that must be taken in this regard involve governments' social policies and their financial situation. The rules of law can be used to identify who does what. They cannot, however, solve the problems currently plaguing the health care system. As in other federations, it is through a process of consultation and negotiations, rather than unilateralism, that the federal and provincial governments make their decisions. Is this not the true spirit of federalism? Thus it is through political action that any development concerning the role played by each level of government in this field must take shape. When all is said and done, the law is simply a reflection of the agreements reached in this field, and any proposal in this regard oversteps the strictly legal boundaries of the present study.

Notes

1. According to the terms of our mandate.
2. *Constitution Act, 1867*, sec. 91 and 92.
3. See *The Canadian Oxford* (1998).
4. See *Petit Robert*, tenth edition.
5. [1982] 2 S.C.R. 112.
6. *Ibid.*, p. 142 (J. Estey).
7. See: *What's Law Got To Do with It?* Report of the Task Force on Health Care, Canadian Bar Association, 1994, p. 2-14; Swartz, D., *The Politics of Reform: Public Health Insurance in Canada*, (1993) 23 (2) Int. J. of Health Services, 219; Lajoie, A. and Molinari, P.A., *Le partage constitutionnel des compétences en matière de santé*, (1978) 56 Canadian Bar Review, 579.
8. Subs. 92(7).
9. Subs. 91(11).
10. *What's Law Got To Do with It?* Report of the Task Force on Health Care, *supra*, note 7, p. 3.
11. *Ibid.* As early as 1919, the Liberal Party of Canada included this element in its political program. See also: Taylor, M.G., *Health Insurance and Canadian Public Policy*, 2 ed., (Kingston and Montreal: McGill-Queen's University Press, 1987).
12. *Ibid.* It should be pointed out that at the instigation of their New Democratic governments, certain provinces, notably Saskatchewan, played a very major role in implementing a public health system. Hospital insurance was introduced in Saskatchewan in 1947. British Columbia followed suit in 1949.
13. S.C. 1957, c. 28.
14. See the *Report of the Royal Commission on Health Services*, Ottawa, Queen's Printer, 1964-65 (chairman: E. Hall).
15. S.C., 1966-67, c. 64.
16. Duperré, T., *La perspective fédérale/provinciale dans le système de santé et de services sociaux du Québec*, Commission d'enquête sur les services de santé et les services sociaux [Commission of Inquiry on Health Services and Social Services], Quebec City, August 1987, p. 2-3.
17. See the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act*, S.C. 1977, c. 10. This legislation was later amended in step with the decline in federal contributions.
18. R.S.C., c. C-6.

19. *Ibid.*, sec. 7-12.
20. *What's Law Got To Do with It?* Report of the Task Force on Health Care, *supra*, note 7, p. 12.
21. See: Brun, H. and Tremblay, G., *Droit constitutionnel*, 3rd ed., (Montreal: Ed. Yvon Blais, 1997) p. 457 to 475 and Hogg, P.W., *Constitutional Law in Canada*, Student Edition (Toronto: Carswell, 2001), p. 387-399.
22. Certain matters, like immigration and agriculture, were assigned to both levels of government, which have “concurrent” jurisdiction over these areas. If there is a conflict between a federal statute and a provincial one, the federal statute prevails. See section 95 of the *Constitution Act, 1867*.
23. It should be pointed out that federal or provincial lawmakers are authorized to delegate jurisdiction to an organization subordinate to the other level of government. This form of cooperation conforms to the spirit of federalism and was found to be constitutionally valid by the courts. See: *P.E.I. Potato Marketing Board v. H.B. Willis Inc.*, [1952] 2 S.C.R. 392; *Coughlin v. Ontario Highway Transport Board*, [1968] S.C.R. 569.
24. Section 33 of the *Canadian Charter* provides for an express declaration mechanism for exceptions to fundamental freedoms (sec. 2) or to legal and equality rights (secs. 7 to 15). Under section 1, the rights and freedoms set out in the *Canadian Charter* are subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.
25. Including the territories according to sec. 32 of the *Canadian Charter*. See *R. v. S.(S)*, [1990] 2 S.C.R. 254.
26. Brun, H. and Tremblay, G., *op. cit.*, *supra*, note 21, p. 886.
27. *What's Law Got To Do with It?* Report of the Task Force on Health Care, *supra*, note 7, p. 21-29.
28. (1997) 151 D.L.R. (4) 577.
29. Contrary to provincial charters of rights and freedoms, the *Canadian Charter* generally does not apply to private matters. See: *Douglas/Kwantlen Faculty Association v. Douglas College*, [1990] 3 S.C.R. 570.
30. S.C., 1988, c. 38. Section 41 states: “The Government of Canada is committed to (a) enhancing the vitality of the English and French linguistic minority communities in Canada and supporting and assisting their development; and (b) fostering the full recognition and use of both English and French in Canadian society.”
31. *Supra*, para. 7.
32. McKall, R.T., *Constitutional Jurisdiction Over Public Health*, (1975) 6 Manitoba Law Journal, 317, p. 317-318.
33. Lajoie, A. and Molinari, P.A., *op. cit.*, *supra*, note 7, p. 581-584.
34. *Rinfret v. Pope*, (1886) 12 Q.L.R. 303, p. 315. See also: *La municipalité du village de Saint-Louis du Mile-End v. Cité de Montréal*, (1886) 2 M.L.R. S.C. 218; *Re George Bowack*, (1892) 2 B.C.R. 216; *Canadian Pacific Navigation v. City of Vancouver*, (1892) 2 B.C.R. 193.

35. Beaudoin, G.A., *La constitution du Canada*, (Montreal: Wilson & Lafleur, 1990), p. 509-512; Hogg, P.W., *op. cit., supra*, note 21, p. 463-464; Gibson, D., *The Canadian Health Act and the Constitution*, (1996) 4 Health Law Journal, p. 1-5; Jackman, M., *The Constitutional Basis for Federal Regulation of Health*, (1977) 5 Health Law Journal, 3, p. 4; McKall, R.T., *op. cit., supra*, note 32, p. 320-323; Brun, H. and Tremblay, G., *op. cit., supra*, note 21, p. 547; and in general see Lajoie, A. and Molinari, P.A., *op. cit., supra*, note 7.
36. *In re Shelly*, (1913) 4 W.W.R. 741.
37. *Fawcett v. A.G. of Ontario & A.G. of Canada* [1964] S.C.R. 625.
38. *Carruthers v. Therapeutic Abortion Committee*, (1983) 6 D.L.R. (4) 57.
39. *C.E. Jamieson and Co. v. A.G. Canada*, [1988] 1 F.C. 590; *Bell Canada v. Québec (C.S.S.T.)*, [1988] 1 S.C.R. 749. See also: *Alltrans Express Ltd. v. Worker's Compensation Board*, [1988] 1 S.C.R. 897; *C.N. v. Courtois*, [1988] 1 S.C.R. 868; *R. v. Hydro-Québec*, [1997] 3 S.C.R. 213.
40. Lajoie, A. and Molinari, P.A., *op. cit.*, note 7, p. 581 and 597; Hogg, P.W., *op. cit., supra*, note 21, p. 464.
41. Section 91 *in fine* states: "And any matter coming within any of the classes of subjects enumerated in this section shall not be deemed to come within the class of matters of a local or private nature comprised in the enumeration of the classes of subjects by this Act assigned exclusively to the legislatures of the provinces."
42. *Supra*, note 5. See also: *Reference re: Intoxicated Persons Detention Act (Manitoba)*, (1981) 1 W.W.R. 333.
43. *In the Matter of a Reference as to Whether the Parliament of Canada Had Legislative Jurisdiction to Enact the Employment and Social Insurance Act*, [1936] S.C.R. 427; *A.G. Canada v. A.G. Ontario*, (1937) A.C. 355. In 1940, the Constitution was amended by the addition of subsection 91(2A) on unemployment insurance. See the *Constitution Act, 1940*, 3-4 George VI, c. 81.
44. *Canadian Indemnity Co. v. A.G. British Columbia*, [1977] 2 S.C.R. 504.
45. Beaudoin, G.A., *op. cit., supra*, note 35, p. 510.
46. *Citizens Insurance Co. v. Parsons*, (1881) 7 A.C. 96.
47. *Reference: Validity of Section 5(A) of the Dairy Industry Act*, [1950] 4 D.L.R. 689. See also: *Labatt Breweries v. A.G. of Canada*, [1980] 1 S.C.R. 914.
48. Pursuant to the federal authority over regulation of trade and commerce, see subsection 91(2) of the *Constitution Act, 1867*. See also: Hogg, P.W., *op. cit., supra*, note 21, p. 489-502.
49. *Ex Parte Fairbain*, (1877) 18 N.B.R. 4; *Metherwell v. The Medical Council of British Columbia*, (1892) 2 B.C.R. 186; *Stinson v. College of Physicians & Surgeons (Ont.)*, (1911) 22 O.L.R. 627; *Hunt v. College of Physicians & Surgeons (Sask.)*, (1925) 3 W.W.R. 758; *R. v. Sirkis*, (1930) 2 W.W.R. 93; *Re Hayward*, (1934) O.R. 133; *Landers v. Dental Society (New Brunswick)*, (1957) 7 D.L.R. (2) 583 and in general: *Re Underwood McLellan Associated Ltd. & Ass. of Professional Engineers*, (1980) 103 D.L.R. (3) 268.

50. *Metherwell v. The Medical Council of British Columbia*, *supra*, previous note.
51. Lajoie, A. and Molinari, P.A., *op. cit.*, *supra*, note 7, p. 600.
52. *Ex Parte Fairbain*, *supra*, note 49. Subsection 92(9) assigns the province authority over “shop, saloon, tavern, auctioneer, and other licences in order to the raising of a revenue for provincial, local, or municipal purposes.”
53. *Landers v. Dental Society (New Brunswick)*, *supra*, note 49. Subsection 92(15) assigns the province authority over “the imposition of punishment by fine, penalty, or imprisonment for enforcing any law of the province made in relation to any matter coming within any of the classes of subjects enumerated in this section.”
54. In the event of conflict, however, the provincial statute must yield to the federal statute.
55. See Beaudoin, G.A., *op. cit.*, *supra*, note 35, p. 510.
56. Lajoie, A. and Molinari, P.A., *op. cit.*, *supra*, note 7, p. 586 and ss.
57. *What’s Law Got To Do with It?* Report of the Task Force on Health Care, *supra*, note 7.
58. See *supra*, note 36. See also: Hogg, P.W., *op. cit.*, *supra*, note 21, p. 163-168.
59. *Supra*, para. 17.
60. *RJR-Macdonald Inc. v. Canada (A.G.)*, [1995] 3 S.C.R. 199; *Scowby v. Glendinning*, [1986] 2 S.C.R. 226; *A.G. for Ontario v. Hamilton Street Railway Co.*, (1930) A.C. 524.
61. *RJR-Macdonald Inc. v. Canada (A.G.)*, *supra*, previous note; *R. v. Zelensky*, [1978] 2 S.C.R. 940; *Proprietary Articles Trade Association v. A.G. of Canada*, (1931) A.C. 310.
62. *R. v. Swain*, [1991] 1 S.C.R. 933; *Morgentaler v. R.*, [1976] 1 S.C.R. 616; *R. v. Furtney* [1991] 3 S.C.R. 89.
63. *Goodyear Tire & Rubber Co. v. The Queen*, [1956] S.C.R. 303.
64. *Reference: Validity of Section 5(A) of the Dairy Industry Act*, *supra*, note 47; *R. v. Vaillancourt*, [1987] 2 S.C.R. 636; *R. v. Morgentaler*, [1993] 3 S.C.R. 463.
65. Brun, H. and Tremblay, G., *op. cit.*, *supra*, note 21, p. 503.
66. *RJR - MacDonald Inc. v. Canada (A.G.)*, *supra*, note 60.
67. *R. v. Wetmore*, [1983] 2 S.C.R. 284; *Standard Sausage Co. v. Lee*, (1934) 1 D.L.R. 706; *R. v. Perfection Creameries Ltd.*, (1939) 3 D.L.R. 185. See the *Food and Drugs Act*, now R.S.C., 1985, c. F-27.
68. *Ex Parte Wakaboyaski*, [1928] 49 C.C.C. 392; *Belleau v. Minister of National Health and Welfare*, (1948) R.C.E. 288. Contra: *R. v. Hauser*, [1979] 1 S.C.R. 984 in which the validity of the federal legislation was upheld on the basis of Parliament’s authority to make laws for peace, order and good government. Now see the *Controlled Drugs and Substances Act*, S.C., 1996, c. 19.

69. *Morgentaler v. R.*, *supra*, note 62; *R. v. Morgentaler*, [1988] 1 S.C.R. 30.
70. *R. v. Cossman's Furniture (1992) Ltd.*, (1976) 73 D.L.R. (3) 312.
71. *R. v. Wetmore*, [1983] 2 S.C.R. 284; *Standard Sausage Co. v. Lee*, *supra*, note 67; *Berryland Canning Co. v. The Queen*, [1974] F.C. 91.
72. *Labatt Breweries v. A.G. Canada*, *supra*, note 47.
73. *Reference: Validity of Section 5(A) of the Dairy Industry Act*, *supra*, note 47.
74. Brun, H. and Tremblay, G., *op. cit.*, *supra*, note 21, p. 443-444; Hogg, P.W., *op. cit.*, *supra*, note 21, p. 163-173. For example, in *Dunbar v. A.G. Saskatchewan*, (1984) 11 D.L.R. (4) 374, provincial legislative authorization for payment of \$1 million in international assistance was found to be valid.
75. See: Gibson, D., *op. cit.*, *supra*, note 35; Jackman, M., *op. cit.*, *supra*, note 35. See also in general: Lederman, W., *Some Forms and Limitations of Cooperative Federalism*, (1967) 45 Canadian Bar Review, 409; Driedger, E., *The Spending Power*, (1981) 7 Queen's Law Journal, 124; Magnet, J.E., *The Constitutional Distribution of Taxation Powers in Canada*, (1978) 10 Ottawa Law Review, 473. For an opposing viewpoint, see: Petter, A., *Federalism and the Myth of the Federal Spending Power*, (1989) 68 Canadian Bar Review, 448.
76. *Mercer v. A.G. for Canada*, (1971) 3 W.W.R. 375; *Central Mortgage & Housing Corp. v. Cooperative College Residence Inc.*, (1977) 71 D.L.R. (3) 183; *YMHA Jewish Community Centre v. Brown*, [1989] 1 S.C.R. 1532; *Finlay v. Canada*, [1986] 2 S.C.R. 607; *Re Canada Assistance Plan*, [1991] 2 S.C.R. 525.
77. *Supra*, note 18 and para. 9.
78. In *Re Canada Assistance Plan*, *supra*, note 76, British Columbia contested the reduction in federal funds for the wealthiest provinces in the fields of public assistance and social policy.
79. (1988) 53 D.L.R. (4) 413.
80. Hogg, P.W., *op. cit.*, *supra*, note 21, p. 166. See also Scott, F.R., *The Constitutional Background of Taxation Agreements* in "Essays on the Constitution," (Toronto: University of Toronto Press, 1977), p. 297 where the author states: "Generosity in Canada is not unconstitutional, making a gift is not the same as making a law."
81. Brun, H. and Tremblay, G., *op. cit.*, *supra*, note 21, p. 552-567; Hogg, P.W., *op. cit.*, *supra*, note 21, p. 421 and ss.
82. For an explanation of this authority and its exercise, see: *Reference Re Anti Inflation Act*, [1976] 2 S.C.R. 373.
83. [1988] 1 S.C.R. 401. At question was whether the Parliament of Canada could regulate the dumping of waste in provincial waters when it had not been proven that the said waste had a polluting effect on extra-provincial waters.
84. *Ibid.*, p. 431-432. (J. Le Dain).

85. *Supra*, note 43.
86. Unemployment insurance was found to be first and foremost a contractual matter coming under provincial authority in the area of property and civil rights.
87. *Supra*, para. 18.
88. *Supra*, para. 6.
89. Gibson, D., *op. cit.*, *supra*, note 35, p. 19-24; Jackman, M., *op. cit.*, *supra*, note 35, p. 8-11. See also: *What's Law Got To Do with It?* Report of the Task Force on Health Care, *supra*, note 7, p. 18-20. Contra: Lajoie, A. and Molinari, P.A., *op. cit.*, *supra*, note 7, p. 600-601.
90. *Bell Canada v. Québec (C.S.S.T.)*, *supra*, note 39.
91. Beaudoin, G.A., *op. cit.*, *supra*, note 35, p. 510.
92. *R. v. Swimmer*, (1971) 1 W.W.R. 756.
93. Indian and Northern Affairs Canada, "Indian Affairs in Canada and the United States," May 1, 2001, http://www.ainc-inac.gc.ca/pr/info/info122_e.html.
94. Gray, G., *Federalism and Health Policy, the Development of Health Systems in Canada and Australia*, (Toronto: University of Toronto Press, 1991), p. 26-49 for the background.
95. *Ibid.*, p. 50-52.
96. Organisation for Economic Co-operation and Development, *The Reform of Health Care Systems – a Review of Seventeen OECD Countries*, 1994, c. 6, p. 59-61.
97. *Ibid.*, c. 22, p. 343-347.
98. *Ibid.*
99. *Québec-Communauté française de Belgique : autonomie et spécificité dans le cadre d'un système fédéral* (under the direction of P. Patenaude) (Université de Sherbrooke: Wilson & Lafleur, 1991), p. 21-39.
100. *Ibid.*

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