

THE CHA AND BEYOND THE ROLE OF LEGISLATION IN NATIONAL REFORM IN HEALTH CARE

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SUMMARY

This paper is centred on the use of legislation as *a tool of public action* in health policy. We suggest that, as with the Canada Health Act (CHA) of 1984, this option should be considered to direct future reform efforts and pursue our collective aims of health and wellness.

The CHA is the legislative expression of the federal government's exercise of its spending power, serving to consolidate key national agreements governing the circumstances under which the federal government contributes to the costs of medically necessary health services delivered by the provinces and territories.

Two features of the CHA merit highlighting. The first is that its core provisions — in particular, the five criteria often referred to as Canada's "national standards" for health care — were not new or original to the CHA. The CHA was nonetheless an important step in the development of Canada's health system because it enshrined together, in one statute, longstanding commitments. A second feature of the CHA worth highlighting is that it does not stand alone. The CHA is one of 13 statutes across the country, including one in each province and territory, that serve together to establish the basic legal infrastructure of Canada's health insurance system.

The CHA's powers to make regulations and issue policy interpretation letters offer important potential to achieve needed health system reforms without needing to "open" the act. Even where these powers are unrestricted by an express requirement for consultation with the provinces and territories,

however, this would undoubtedly be required, given the fundamentally consensual nature of the CHA.

Finally, the federal government's legislative options are not limited to the CHA. Jurisdiction over health and health care in Canada is *shared* between the federal and provincial and territorial governments. The various federal powers with health aspects allocated by the Constitution Act, 1867 are significant, including the residual "federal health power" to make laws "for the peace, order and good government of Canada" It therefore makes good sense to consider federal policy objectives in the health domain with regard for the full spectrum of federal legislative competence.

GENERAL INTRODUCTION

In 2017, the federal government took a new approach to that taken in the early 2000s to move forward on health system priorities. The government worked with the provinces and territories (PTs) to identify shared health priorities for federal investments, develop common areas of action within these priorities through an FPT framework, and then negotiated bilateral agreements with each PT. COVID-19 has highlighted the need for resilient health care systems that will continue to meet the needs of Canadians today and in the future.

It is in this context that in April 2021, the School of Public Policy convened a group of health policy experts to develop research papers on various aspects of the evolution of health care in consultation with Health Canada. These experts have a diverse range of perspectives on issues related to Canadian health systems. Health Canada was consulted on the list of topics, but the orientation of each paper, the methodology, as well as the substance of the recommendations were left entirely to the discretion of the authors.

We are proud to share the result of this process. Each paper in this series of eight was subject to the intense scrutiny, and discussed extensively following detailed roundtable presentations. Two eminent health policy experts were also asked to conduct a careful double-blind review of the papers, with a special focus on rigor, readability, and relevance. We believe these policy briefs offer a rare combination of original thinking, deep subject expertise, and technical feasibility: a perfect balance between the very practical needs of the end users of the research and the independent and innovative spirit that pervades all the work originating from the School of Public Policy.

INTRODUCTION

At least since the late 1980s, mature welfare states such as Canada have faced restricted capacity for fiscal expansion — hence the relative scarcity of bold social policy initiatives and the repeated exhortations from politicians and public bureaucrats to do more, or better, with less (Klein and O’Higgins 1988). The COVID-19 pandemic has opened the way for a radical change of direction. Even more than the global financial crisis of 2007–08, which forced the then Conservative government in Ottawa to embrace public spending and budget deficits, the public health crisis triggered a steep decline in economic activity, employment and trade. In turn, it warranted prompt and decisive action by the federal government, even though the long-term fiscal outcome of a broad package of expensive measures was viewed by some as questionable (Office of the Parliamentary Budget Officer 2021). New social programs responsive to the impacts of the pandemic, and the inequalities it has laid bare, were the order of the day.

It must be said that the current federal Liberal government was first elected in 2015 with a clear mandate for policy expansion. Prime Minister Justin Trudeau was adamant that his government would run substantial deficits in support of new public programs and infrastructure spending. In that sense, his approach to the pandemic-induced recession can be seen as a continuation, albeit on a much larger scale, of an overall economic vision. Yet, context is everything in public policy. The delicate balance that Canadian social policy rests upon relies on elements that are utterly sensitive to the economic situation and the ensuing perception of unmet or emerging social needs — more so in times of crisis. It just so happens that the pandemic has revealed disturbing socioeconomic and ethnocultural disparities in areas of social policy in which governments will now be expected to act decisively. Ottawa has set the tone with its pandemic support programs and subsidies. It might be possible to build on this momentum in the future, either directly, with new national programs, or indirectly, by supporting provincial initiatives of the same nature.

This paper is centered on the use of legislation by the federal government as a *tool of public action* in health policy. Payments — sometimes called “chequebook” government — and messaging, too often presented as the only policy instruments available to Ottawa to make its mark, can only go so far (Hood 1983). The legislative process can be slow and cumbersome, which may be unattractive in times of emergency. Yet, if the federal government is serious about leadership in the health and social policy sector, whether in the form of responsible stewardship of existing programs or policy expansion in new areas, it cannot dispense with a review of the range of legal instruments and provisions at its disposal. It may also be time to consider adding to the arsenal of existing laws and regulations, to give shape and structure to new commitments.

A simple yet compelling reason to use legislation to achieve policy objectives in the context of health and social policy reform is that legislation both engages and fulfils the rule of law, a fundamental principle of our Constitution. As explained by the Supreme Court of Canada, the rule of law means at least two things: first, it means that people (government officials as well as private individuals) should be ruled by the law and obey it; and second, it refers to the creation and maintenance of positive laws so that

people are able to be guided by them.¹ At a more practical level, and in the context of health policy, use of legislation — of laws — serves three interrelated purposes:

1. It provides *transparency*. This includes transparency as to Canada's effort to fulfill important obligations to its citizens, including the shared obligation of federal, provincial, and territorial governments under Section 36.1(c) of the Canadian Charter of Rights and Freedoms to "provid(e) essential public services of reasonable quality to all Canadians" and, under international human rights instruments ratified by Canada, to deliver "a standard of living adequate for the health and well-being ... including ... medical care" (UDHR 1948; ICESCR 1966). It also includes transparency as to Canadians' basic entitlements from the health-care system (Forest 2007).
2. Legislation also provides *permanence*. Unlike intergovernmental agreements, legislation can only be changed by representatives elected by the Canadian public following the democratic procedures that govern our federal Parliament and the legislatures of provinces and territories.
3. Finally, legislation provides increased scope for *accountability*. Unlike the details of intergovernmental agreements, which may or may not be made public, legislation is by its very nature public and necessarily exposed to potential for public scrutiny and challenge. The potential to challenge legislation is also greater since — access to the courts being another essential element of the rule of law² — a citizen can more readily challenge legislation in the courts than challenge an intergovernmental agreement to which he or she is not a party.

The question may legitimately be asked whether the enforcement of existing legislative provisions — such as those that ensure that the basic values underlying public health care are respected — should not have priority over any new policy commitments and, further, any new legislation. In other words, couldn't we first make sure that the house is on safe ground before adding to its already complex architecture? This is, in fact, a false dichotomy. As we shall suggest, some of the new problems we face, such as those arising from the digitalization of medicine for example, could possibly be addressed using existing legal instruments. Yet, in other cases, there is much to gain from federal legislative initiatives that could underpin and supplement new policy engagements.

THE CONTEXT

It is the case in any federal state that a crisis would be experienced somewhat differently by national and subnational governments, depending on the distribution of duties and powers and, consequently, of resources. But in Canada, the problem may even be more acute. This is because in social matters, such as health or family law

¹ Re Manitoba Language Rights, 1985 CanLII 33 (SCC), [1985] 1 SCR 721, paras 59–60; Re Resolution to Amend the Constitution, 1981 CanLII 25 (SCC), [1981] 1 S.C.R. 753, pp.805–806.

² Trial Lawyers Association of British Columbia v. British Columbia (Attorney General), 2014 SCC 59 (CanLII), [2014] 3 SCR 31, para 38.

or old-age pensions, legislative competence is not as clearly stated as it could be in the Constitution, with much room for interpretation (Gaudreault-Desbiens and Poirier 2017). Governments often muddled through such crises in the past, sometimes acting unilaterally and other times acting in a more co-operative manner, guided by changing moods in public opinion or the fiscal needs of the moment, rather than any specific constitutional doctrine. In the end, however, essential changes in the assignment of policy responsibilities among jurisdictions may have followed, with lasting effects on the operations of the federation. It is to be expected that the COVID-19 crisis will have this sort of impact in Canada, as we can see already with the new federal initiative on child care.

The child care example is also telling, because it is symptomatic of a recent transformation in the federal approach to social-policy expansion. It looks as if province-specific initiatives or adjustments, instead of hard-negotiated “national accords,” have become the preferred approach to policy change (McIntosh and DeCorby 2021). It is probably easier to identify and agree upon shared goals and outcomes through a succession of bilateral federal-provincial negotiations held in confidence — something that was nearly unthinkable a couple of decades ago — than through multilateral conversations. In the past, formal (and sometimes public) discussions among policy leaders at the federal and provincial level provided the groundwork for the establishment of social programs such as pensions and publicly funded health care. When the then newly elected Liberal government in 2015 insisted that it ought to reach a new health accord with the provinces and territories, marking a real break with 10 years of Conservative indifference, observers were convinced that nothing but “a single deal” would do. Anything else would “screw up standards, targets and get way too complicated” (Solomon 2016).

Yet, yesterday’s certainties and assumptions fell apart when New Brunswick concluded a bilateral health accord with Ottawa in December 2016, initiating a process with the 12 other provinces and territories that ended in August 2017 with an agreement with Manitoba. One-on-one conversations had seemingly replaced the former lengthy process in which Ottawa would seek to rally the provinces and territories around a common program of national dimensions, explicitly guided by core principles and values. To be fair, no bilateral agreement took place without some commitment to common policy objectives, and conversely, information exchanges and policy coordination in multilateral settings were to continue as in the past. However, since the circumstances and the preferences of each provincial or territorial partner dictated in large part the design of the new programs, there was also less room for national standards or even for comparable performance indicators.

Five years later, it is not clear that this approach — tailored to the needs and wants of each provincial or territorial partner — is less (or indeed *more*) effective than previous multilateral accords at producing expected results or reforms. Obviously, time will tell. Whether bilateral or multilateral, however, absent a well-developed set of “tools of government” embedded in legislation, political arrangements tend to encourage

asymmetry in the federation (beyond the well-known case of Quebec³). By contrast, national agreements of the more distant past were also followed by the deployment of a battery of policy instruments, including transfers, fiscal measures, and new institutions — all of which contributed to enshrining new programs in the fabric of society and the conscience of the public.

As regards the health system in particular, the federal government's National Health Grants program, initiated in 1948, was credited with strengthening the foundations for the national system of health insurance established by means of interlocking federal and provincial/territorial statutes (Hall 1964).

At the time of the second Hall Commission in 1979–80, moreover, it was doubtful that Canadians could continue to access hospital and medical services on uniform terms and conditions for very long, despite the achievements of previous decades. The 1984 Canada Health Act (CHA) was a strong gesture, symbolic and powerful at the same time; a next-generation legislative effort to correct the course and affirm the national dimensions of the health-care system. Of course, conflicts over health care between the federal government and the provinces and territories did not stop after the CHA was enacted, but those conflicts were essentially concerned with funding, rather than with the core egalitarian values expressed by medicare.

After close to 50 years, it is legitimate to ask whether the CHA is still relevant and effective, particularly as it relates to the newest health accords. Can the CHA, in its present form, help preserve and provide a sense of common purpose to the current reform agenda? Yet, it is also clear that without the safeguards provided by the CHA, notably its role in affirming that health care should and would remain free at point of service, Canadian health policy priorities would be very different from what they are now, without the same prospects of expanded scope and more social justice.

It may still be advisable not to put all our eggs in the CHA basket, so to speak, and to look at the possibility of using other federal legislative instruments, including but not limited to well-established areas of jurisdiction. The CHA itself was the third act in a play that started in 1957 with the Hospital Insurance and Diagnostic Services Act (HIDS), followed in 1966 by the Medical Care Act (MCA). It might be time for another chapter in the history of medicare to be written, with a "companion legislation" covering sectors such as long-term care, pharmaceuticals or Indigenous health. Finally, provinces could also be encouraged to develop and eventually adopt complementary or "interlocking" legislation. This is a practice of longstanding precedent in Canada, as demonstrated by the complementary health insurance laws adopted by the

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Although Quebec is sometimes described as having "opted out" of the federal-provincial cost-sharing arrangements for health care, implying that it is not subject to Canada Health Act requirements, this description is inaccurate. On Nov. 1, 1970, Quebec entered into an agreement with the federal government to enable it to gradually assume full responsibility for the delivery of health-care services. The making of this agreement was authorized by Section 3 of the Established Programs (Interim Arrangements) Act, R.S.C. 1970, c.E-8, repealed S.C. 1976-77, c.10, s.48. It required Quebec to undertake to continue to operate its health-care system in accordance with the federal Hospital Insurance and Diagnostic Services Act (1957) and Medical Care Act (1966). The Federal-Provincial Fiscal Arrangements Act and Established Programs Financing Act (1977), S.C. 1976-77, c.10, which altered the formulas for federal contributions to medicare and ceded additional tax room to Quebec based on its prior agreement with the federal government, contained a similar provision (Section 32(2)).

provinces and territories to give practical effect to the CHA criteria (and before the CHA it happened with the HIDS and MCA). It is also a practice developed considerably within the EU in recent decades, and we can learn from this experience (Garrett 1995; Martinico 2016).

THE CHA

The CHA is the legislative expression of the federal government's exercise of its spending power, consolidating key national agreements governing the circumstances under which the federal government contributes to the costs of medically necessary health services delivered by the provinces and territories.

While controversial in the eyes of some, it appears settled as matter of Canadian constitutional law that the federal government may indeed use its spending power to impose conditions regarding the provincial and territorial expenditure of funds, even if those conditions relate to matters otherwise outside the federal government's legislative competence. This includes "in respect of insured health services and extended health care services" (the CHA's full legislative title).⁴

Two features of the CHA merit discussion before reviewing its operative provisions.

The first is that the CHA's core provisions — in particular, the five criteria often referred to as Canada's "national standards" for health care — were not new or original to the CHA. The CHA was nonetheless an important step in the development of Canada's health system because it enshrined together, in one statute, longstanding commitments pertaining to its constituent elements that had evolved over time and were reflected in two separate federal laws: the HIDS and the MCA. Under these earlier federal laws, the federal government had agreed to contribute 50 per cent of the provinces' yearly costs of basic insured health services, and the provinces agreed to insure basic hospital and medical services for their residents meeting five specified conditions: universality, comprehensiveness, accessibility, portability and public administration.⁵ In 1977, the 50/50 cost-matching formula was replaced with block funding provided by the federal government through tax transfers and cash payments, and with the federal and provincial governments reaffirming their commitment to those five conditions.

By the early 1980s, a lack of precision in the definition of "accessibility" had resulted in the introduction of direct charges to patients in some provinces — "user charges" by hospitals and "extra-billing" by physicians. The federal government considered these charges to undermine the essential commitment of universal health insurance: that "necessary insured hospital and medical services must be available (and) accessible to all residents of Canada regardless of the financial circumstances" (Bégin 1988). Further and crucial dimensions of the CHA — that *were* new — included its articulation

⁴ Winterhaven Stables Limited v. Canada (Attorney General) (1988), 53 D.L.R. (4th) 413 (Alta. C.A.), 1988 ABCA 334 (CanLII), leave to appeal to S.C.C. denied at 55 D.L.R.(4th) vii; cited with approval in Reference Re Canada Assistance Plan (B.C.), 1991 CanLII 74 (SCC), [1991] 2 S.C.R. 525, p. 567 and Canada Mortgage and Housing Corp. v. Iness, 70 O.R. (3d) 148, 2004 CanLII 15104 (ON CA), paras 28-34, leave to appeal to S.C.C. denied.

⁵ Preserving Universal Medicare, published by the authority of the Honourable Monique Bégin, Minister of National Health and Welfare, 1983 (Minister of Supplies and Services Canada 1983), pp.8-10.

of more precise definitions for the five existing conditions. Specifically, the “national standards,” its imposition of clear prohibitions against user charges and extra-billing, and its creation of a more nuanced approach to enforcement, one that did not require the prior “all-or-nothing” approach by the federal government, which had effectively precluded the imposition of any sanctions in response to provincial or territorial default.

A second feature of the CHA worth highlighting is that it does not stand alone. The CHA is one of 13 statutes across the country, including one in each province and territory, that serve together to establish the basic legal infrastructure of Canada’s health insurance system. This feature, also, is not new. It is a longstanding element of Canada’s medicare compact, central to the HIDS as first introduced in 1957.⁶ Indeed, the use of interlocking federal-provincial statutes to provide a system of health insurance for Canadians appears to date back to a 1943 recommendation from a House of Commons committee as a means of resolving the constitutional challenge presented by provincial responsibilities for health in the context of demands for federal action (Hall 1964).⁷

KEY COMPONENTS OF THE CHA

The following are key components of the CHA:

a. Preamble, title and statements of purpose

The CHA’s preamble, long and short titles, and express statements of policy and purpose (sections 1, 3 and 4) articulate broad policy objectives: “to protect, promote and restore the physical and mental well-being of residents of Canada” and “facilitate reasonable access to health services without financial or other barriers,” while working in “cooperative partnership with governments” with regard for Canada’s division of legislative powers.

b. Application and exclusions

The CHA provides for insured health services to residents of provinces and territories, but excludes certain categories from its definition of “insured persons”: non-residents, members of the Canadian Forces and prisoners of federal penitentiaries.⁸

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Hospital Insurance and Diagnostic Services Act, 1957, S.C. 1957, c.28:

“3(1) Subject to this Act, the Minister may, with the approval of the Governor in Council, enter into an agreement with any province to provide for the payment by Canada to the province of contributions in respect of the cost of insured services incurred by the province pursuant to provincial law.

(2) The provincial law referred to in this Act is a law of the province that

(a) makes provision for the furnishing by hospitals of insured services upon uniform terms and conditions to residents of the province under the conditions specified in this Act and the regulations; ...”

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The use of interlocking federal/provincial/territorial legislation as a means of protecting and promoting the public’s health reaches back even earlier, to the Canada Temperance Act, the federal legislation enacted to protect the public health by requiring uniform legislation in all provinces to restrict the traffic in alcohol and promote temperance. *Russell v. The Queen* (1882), 7 App. Cas. 829 (PC); *AG Ont. v. AG Can. (Local Prohibition)*, [1896] AC 348 (PC); and *AG Ontario v. Canada Temperance Federation*, [1946] A.C. 193 (PC).

⁸

CHA: Section 2 definitions of “insured person” and “resident”; and 11(1)(a)

c. *Program criteria*

The five conditions underlying the former HIDS and MCA are now the CHA's "program criteria," mandated by Section 7 of the act and often referred to as its "national standards":

- Public administration (Section 8): Requires provincial and territorial health insurance plans to be administered and operated on a non-profit basis by a public authority in accordance with three requirements.⁹ Consistent with the original HIDS, the CHA defines "health insurance plan" in Section 2 to mean "a plan or plans *established by the law of the province* to provide for insured health services" (emphasis added).¹⁰
- Comprehensiveness (Section 9): Requires all "insured health services" provided by hospitals, medical practitioners and dentists to be covered by provincial health insurance plans. The term "insured health services" and its constituent elements ("hospital services," "physician services" and "surgical-dental services") are all defined in Section 2 of the act.

For "hospital services," the CHA provides a defined list of services that must be provided for in-patients and out-patients "if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability." Specified services are excluded.¹¹

For "physician services," "any medically required services rendered by medical practitioners" must be covered, but there is no defined list. All three CHA policy interpretation letters issued by federal ministers of health to date confirm that *all* medically necessary services provided by physicians must be covered. The policy interpretation letter issued in 1985 by then federal health and welfare minister Jake Epp communicates the further view that "provinces, along with medical professionals, have the prerogative and responsibility for interpreting what physician services are medically necessary" (Health Canada 2021).

Although the CHA includes many references to "extended health services," its operative provisions do not require any such services to be delivered as "insured health services."¹²

⁹ (1) Non-profit administration and operation by a public authority appointed by the provinces and territories; (2) the public authority must be responsible to them; and the public authority must be subject to audit. CHA, s.8(1)

¹⁰ See also the CHA's statement of purpose in Section 4: "The purpose of this Act is to establish criteria and conditions in respect of insured health services and extended health care services *provided under provincial law* that must be met before a full cash contribution may be made" (emphasis added).

¹¹ Services excluded from CHA coverage are:

- Services provided by "hospitals or institutions primarily for the mentally disordered" and "nursing home intermediate care service or adult residential care service, or comparable services for children" (excluded from the Section 2 definition of "hospital"); and
- Health services to which persons are entitled to and eligible for under any other federal statute or under any provincial statute relating to workers' compensation (excluded from the Section 2 definition of "insured health services").

¹² CHA, ss.2, 4, 13(b) and 22(1)(b); "Extended health services" include: nursing home intermediate care; adult residential care; home care; and ambulatory care services.

- Universality (Section 10): Requires all insured persons in a province or territory to be entitled to insured health services within the province on uniform terms and conditions.
- Portability (Section 11): Establishes requirements to enable residents to move within Canada without jeopardizing their entitlement to insured health services and provides limited entitlement to coverage outside Canada.¹³
- Accessibility (Section 12): Requires each province and territory to provide insured health services on a basis that provides reasonable access, including freedom from charges — “extra-billing,” “user charges” or otherwise.¹⁴

d. Conditions

Two conditions must be met for a province or territory to qualify for a full cash contribution from the federal government (sections 5 and 13): (1) it must provide the federal minister of health with information as required by regulation for purposes of the act (implicitly, to monitor compliance); and (2) it must give recognition to the Canada Health Transfer in public documents, advertising and promotional material relating to insured health services and extended health services.

e. Regulations and policy interpretation letters

The federal government can make CHA regulations (Section 22) in four listed categories: (a) to further define “extended health services”; (b) to exclude services from the definition of “hospital services”; (c) to prescribe the information to be provided by provinces and territories under Section 13(a) of the act; and (d) to prescribe how provinces and territories must give recognition to federal funding. The first two categories require agreement from the provinces and territories; the second two requires that the provinces and territories be consulted.

These regulation-making powers are provided as an *inclusive* rather than *exhaustive* list, meaning that the federal government arguably has a broader inchoate power to make regulations to administer the CHA and to carry its purposes and provisions into effect (Côté 2000).¹⁵

To date, only one regulation has been passed under the CHA: the Extra-billing and User Charges Information Regulations, unamended since enactment in 1986.

¹³

Inside Canada, residents should not be subject to out-of-pocket costs or charges for necessary hospital and physician services, and providers should be assured reasonable levels of payment; outside Canada, they should receive reasonable indemnification for necessary hospital/physician emergency services or referred services unavailable in their province/territory or a neighbouring one. Epp interpretation letter, June 18, 1985, Canada Health Act Annual Report 2019–2020, p.293.

¹⁴

“Extra-billing” is defined by the CHA to mean the billing of patients by physicians or dentists for an amount in addition to that paid by the provincial health insurance plan for insured health services; “user charges” means charges to patients for insured health services not payable directly or indirectly by the provincial health insurance plan. CHA, s.2.

¹⁵

CHA, s.22(1): “... the Governor in Council may make regulations for the administration of this Act and for carrying its purposes and provisions into effect, including, without restricting the generality of the foregoing ...” (emphasis added).

Three federal ministers of health have issued policy interpretation letters to their counterparts, setting out the federal position on key CHA matters. The minister's authority to do so flows reasonably as an ancillary power to her express powers to enforce its requirements.¹⁶

Of note, to date:

- In 1985, then minister Epp set out his intentions regarding the CHA's interpretation and enforcement. Regarding the provision of information contemplated by the act, he emphasized his intention "to make as few regulations as possible and only if absolutely necessary," relying instead "on the goodwill of Ministers ... to provide necessary information voluntarily for purposes of administering the Act and reporting to Parliament." Epp stated his commitment to "maintaining and improving national data systems on a collaborative and co-operative basis" (Health Canada 2021). In a subsequent 2018 interpretation letter, then health minister Ginette Petipas Taylor signalled her intention to strengthen and standardize provincial and territorial reporting.
- In 1995 and 2018, then ministers Diane Marleau and Petipas Taylor, respectively, addressed patient charges by private clinics, emphasizing that: (1) all medically necessary physician and hospital services (including diagnostic services) must be covered by provincial and territorial health insurance plans; and (2) the status of a medically necessary service under the CHA does not change simply because the service is delivered in a private clinic rather than a hospital; all must be provided as publicly insured services free of charge to the patient (Health Canada 2021).

f. Amendments

The CHA has been amended on five separate occasions. The only substantive amendment to date rendered members of the RCMP "insured persons" under the act.

g. Accountability and enforcement

The CHA provides three possible mechanisms for accountability and enforcement. First, and arguably the most important, is the federal government's authority to withhold some or all of a cash transfer to remedy default under the act. As noted above, one of the CHA's core objectives was to provide less drastic automatic¹⁷

¹⁶ For example, CHA, sections 13, 14, 16–21, 23. The federal Interpretation Act provides in Section 31(2): "Where power is given to a person, officer or functionary to do or enforce the doing of any act or thing, all such powers as are necessary to enable the person, officer or functionary to do or enforce the doing of the act or thing are deemed to be also given."

¹⁷ The automatic penalties relate to extra-billing and user charges. Any such charges must be reported by each province or territory to the federal government, and the federal government must, in turn, deduct the estimated total of such charges from the cash contribution to which each province would otherwise be entitled. CHA, ss.2, 18–21, 13(a) and 22(1)(c); Extra-billing and User Charges Information Regulations, SOR/86-259, s.5, Appendix 2.

and discretionary¹⁸ penalties than existed under the former HIDS, to be more easily engaged if and as necessary.

The second mechanism for accountability and enforcement is the CHA's requirement that the federal minister of health prepare and submit an annual report to Parliament, "respecting the administration and operation of (the) Act ..." (Section 23). This requirement provides some transparency to the public as regards compliance with CHA criteria and conditions and the adequacy of corresponding federal enforcement activity, and for comparisons of the provincial and territorial health systems.

The third possible mechanism for accountability and enforcement is the potential for litigation grounded in the CHA. While often cited in cases seeking improved or expanded access to health services, however, the CHA is generally characterized by courts as contextual and secondary to the provincial and territorial legislation governing health insurance plans that give rise (or not) to residents' actual entitlements.¹⁹

h. In summary

The CHA does provide scope for reforms that are legislative in nature.

The act could be amended. Before choosing this path, however, the very deliberate — almost surgical — strategy that informed development of the CHA warrants careful reflection:

“... Even non-essential stylistic corrections could give the impression that everything was renegotiable. That was a sure route to disaster; the whole medicare system could fall apart under contradictory and often selfish pressures. We simply wanted to clarify the basic conditions and reformulate the penalties accordingly, to consolidate what already existed; no more, no less.”
(Bégin 1988)

The powers to make regulations and issue policy interpretation letters also offer important potential to achieve needed health system reforms without needing to “open” the CHA. Even where these powers are unrestricted by an express requirement for consultation with the provinces and territories however, consultation would undoubtedly be required. This is due to the fundamentally consensual nature of the CHA as grounded in the spending power and reinforced by policy interpretation letters

¹⁸ The discretionary penalties, more challenging, relate to the federal minister of health's determination whether the health-care insurance program of a province or territory fails to meet one or more of the agreed-upon program criteria established by sections 7-12 of the CHA. Before imposing any such penalty, the minister must give a notice of concern and engage in related consultation with the affected province. CHA, ss.14-17.

¹⁹ For example: *Elder Advocates of Alberta Society v. Alberta*, 2018 ABQB 37.

to date (Health Canada 2021), the 1999 Social Union Framework Agreement and the 2002 CHA Dispute Avoidance and Resolution Process.²⁰

THE FEDERAL HEALTH POWERS

The federal government's legislative options are not limited to the CHA. Jurisdiction over health and health care in Canada is *shared* between the federal and provincial and territorial governments:

“Health is not a subject specifically dealt with in the *Constitution Act* either in 1867 or by way of subsequent amendment. ... ‘health’ is an amorphous topic which can be addressed by valid federal or provincial legislation, depending in the circumstances of each case on the nature of the health problem in question.”²¹

The broad range of powers that provinces and territories have to legislate on health-related matters provides them with primary legislative competence and responsibilities for health-care delivery. This includes such matters as hospital and health-care services, the practice of medicine, the education and regulation of health professionals, occupational health, and the control of infectious disease and other hazards at the local level.²²

Federal powers to legislate on health-related matters as allocated by the Constitution Act, 1867 are also significant, and fall into five main categories:

- (1) Section 91(11), Quarantine and the establishment and maintenance of marine hospitals, relied upon to date to provide federal jurisdiction over the control of infectious disease at international borders, although arguably broader in scope (e.g., National Advisory Committee on SARS and Public Health 2003).
- (2) Section 91(27), The federal criminal law power, interpreted to provide federal jurisdiction over health matters, “where the health concern arises in the context

²⁰

In the Social Union Framework Agreement dated Feb. 4, 1999 (SUFA), the federal, provincial and territorial governments (except Quebec) agreed to consult and collaborate regarding new and existing initiatives supported by federal funding transfers (e.g., articles 4-6) and to work collaboratively to avoid and resolve intergovernmental disputes regarding CHA interpretation (article 6). By letter, dated April 2, 2002, A. Anne McLellan, then federal minister of health, committed the federal government to a CHA Dispute Avoidance and Resolution Process (DAR), while confirming the federal minister's final authority to interpret and enforce the CHA. In September 2004, the first ministers formalized this 2002 agreement. Canada Health Act Annual Report 2019-2020, pp.305-309.

²¹

Schneider v. R., [1982] 2 SCR 112, 1982 CanLII 26 (SCC), pp.141-142; cited with approval in Carter v. Canada (Attorney General), [2015] 1 SCR 331, [2015] 1 SCR 331, para 53.

²²

Provincial jurisdiction over health matters is derived from the following powers allocated by the Constitution Act, 1867: Section 92(7) Establishment, maintenance, and management of hospitals, asylums, charities and eleemosynary charitable institutions in and for the province (other than marine hospitals); Section 92(13) Property and civil rights in the province; Section 92(16) Matters of a local or private nature in the province; and Section 93, Education. The territories' jurisdiction over health matters is essentially the same as that of the provinces, and is received from a statutory delegation of legislative competence originally allocated to the federal government. S.4 of the Constitution Act, 1871, 34-35 Vict., c.28 (U.K.); Yukon Act, S.C. 2002, c.7, as amended, s.18(1)(j), (s), (x); Northwest Territories Act, S.C. 2014, c. 2, s. 2, as amended, s.18(1)(j), (s), (x); and Nunavut Act, S.C. 1993, c. 28, as amended, s.23(1)(h), (l), (v).

of a public wrong and the response is a criminal prohibition.”²³ Examples include: tobacco consumption; dangerous and adulterated food and drug products; medical devices; and illegal drugs.

- (3) Enumerated powers that are not health-specific but are understood to carry an important health aspect. For example: the census and statistics (Section 91(6)); members of the Canadian Forces, veterans and the RCMP (Section 91(7)); Indigenous populations including First Nations, the Inuit, Métis and non-status Indians (Section 91(24)); refugee claimants (Section 91(25)) and prisoners of federal penitentiaries (Section 91(28)). Similarly,

“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 or to monitor and control the price at which medicines are sold. Parliament’s jurisdiction over interprovincial and international trade (subs. 91(2)) enables the federal government to oversee exchanges of medical technology and of hospital equipment.” (Braën 2004)

- (4) Introductory language to Section 91 of the Constitution Act, 1867 provides the power “to make laws for the peace, order and good government (POGG) of Canada, in relation to all matters not coming within the classes of subjects by this Act assigned exclusively to the legislatures of the provinces” POGG operates as a separate grant of federal legislative competence.
- (5) The federal spending power, to spend funds raised through federal taxes, including by transfer of funds to provincial and territorial governments, is inferred from three enumerated federal powers: the right to “(raise) money by any mode or system of taxation” (Section 91(3)); the right to appropriate federal funds (Section 106); and the power to legislate in relation to “the public debt and property” (Section 91(1A)).²⁴ A grant of federal funds (e.g., to a province or territory) may be conditional, requiring the receiving government to adhere to agreed-upon conditions in exchange for the transfer of funds.

When considering primary sources of jurisdiction to support federal intervention to protect the public’s health, the criminal law power and POGG are the usual candidates.

The criminal law power presents a potentially significant limitation given its requirement for a proper criminal law purpose, i.e., the prohibition of “conduct that

²³ Reference re Assisted Human Reproduction Act, 2010 SCC 61 (CanLII), [2010] 3 SCR 457, paras 41 and 230–233.

²⁴ YMHA Jewish Community Centre of Winnipeg Inc. v. Brown, [1989] 1 S.C.R. 1532, 1989 CanLII 53 (SCC), [1989] 1 S.C.R. 1532, p.1548; Eldridge v. British Columbia (Attorney General), [1997] 3 S.C.R. 624, paras 24–25, citing Reference Re Canada Assistance Plan (B.C.), [1991] 2 S.C.R. 525, 1991 CanLII 74 (SCC), p.567.

is reprehensible or represents a serious risk to morality, safety or public health.”²⁵ The promotion of positive health measures or beneficial medical practices in and of itself — for example, by setting national standards to provide access to medically necessary health services of similar quality for all Canadians regardless of their financial circumstances — would be unlikely to qualify as a proper federal criminal law purpose.²⁶

Where the federal criminal law power leaves off, however, it is at least arguable that POGG may engage to provide federal jurisdiction to make laws that promote positive health measures and/or beneficial practices in health-care delivery — matters that might otherwise be seen to entrench upon provincial and territorial jurisdiction. This argument (more fully developed in Stoltz 2018) is based on longstanding authority that POGG provides residual federal power to legislate to protect the public health on the basis of national concern,²⁷ coupled with the proposition that “protection of the public health” need not (and should not) be narrowly defined. Considered in context, this residual “federal health power”²⁸ may provide the constitutional space — and, arguably, a *mandate* — for the federal government to enact legislation with reforms aimed at ensuring the continued existence and relevance of a national health system capable of delivering timely services of reasonable quality to all Canadians based on need rather than the ability to pay. Even in the current constitutional context of modern co-operative federalism that accommodates and encourages intergovernmental co-operative efforts, however, the threshold for engaging the POGG national-concern doctrine is high and would require exceptionally strong justification.²⁹

ASYMMETRY AND CENTRALISM IN CANADIAN HEALTH CARE

It is safe to say that the CHA and other federal laws and policies have already played a major role in maintaining the cohesion and unity of provincial and territorial health plans. Let there be no mistake: the provinces and territories play a key role in most aspects of Canadian health policy, in large measure, as we have seen, because of their primary legislative competence for health-care delivery. But as a result, depending on where one lives in Canada, the experience of health care at point of service may

²⁵ To come within the federal power under Section 91(27), a criminal law must satisfy three requirements: (1) a prohibition; (2) backed by a penalty; and (3) with a criminal law purpose. Reference re Assisted Human Reproduction Act, paras 35 and 230–234.

²⁶ This was the result reached in Reference re Assisted Human Reproduction Act (paras 38, 64 and 232), for example.

²⁷ I.e., “where the problem is national rather than local in nature,” as summarized in the passage from *Schneider v. R* (cited in footnote 21, above). While application of the POGG national concern doctrine is not limited to matters of health, its origins — interestingly — lie in the Privy Council’s consideration of three cases challenging federal legislation (the Canada Temperance Act) enacted to protect the public health by requiring uniform legislation in all provinces to restrict the traffic in alcohol and promote temperance. *Russell v. The Queen* (1882), 7 App. Cas. 829 (PC); *AG Ont. v. AG Can. (Local Prohibition)*, [1896] AC 348 (PC); and *AG Ontario v. Canada Temperance Federation*, [1946] A.C. 193 (PC).

²⁸ In *Labatt Breweries of Canada Ltd. v. Attorney General of Canada*, [1980] 1 SCR 914, 1979 CanLII 190 (SCC), a majority of the Supreme Court of Canada characterized the POGG national concern doctrine as “the federal health power” (p.934).

²⁹ *References re Greenhouse Gas Pollution Pricing Act*, 2021 SCC 11 (CanLII).

be different, including eligibility rules for some treatments, clinical pathways, and social support during or after receiving care. Given the differences among provinces and territories in terms of demographics, political culture, fiscal resources and policy capacity, this degree of asymmetry — and, consequently, the variation in the shape and organization of health services — cannot come as surprise.

That said, we should not exaggerate the situation. The truth is nuanced. First, asymmetry is present in all health systems because of determining factors such as location, social class, gender, race or ethnicity, and Canada is no exception. From certain angles, there might even be more variation *within* a particular provincial health system (between central and remote areas, for example) than *between* two provinces. Second, and importantly, despite marginal differences between provincial health plans, the Canadian health system provides citizens with a common core of services and benefits that is quite close to the notion of *universal health coverage* as defined by the United Nations: “the promotive, preventive, curative, rehabilitative and palliative health services they need, of sufficient quality to be effective, while also ensuring that the use of these services does not expose the user to financial hardship” (Glassman et al. 2016).

Third, while the health system is not always doing its best (in comparison with other countries), it does seriously attempt to inject some degree of equity in the way people are treated and decisions are taken once they have accessed public health services, to counteract the negative effects of some major social determinants (Shortt and Shaw 2003; Van Doorslaer et al. 2006; Hurley and Grignon 2006). When made visible to public opinion, departures from that principle — for example, queue-jumping for surgery or unfair treatment of vulnerable patients — are almost always a source of scandal and, in some cases, public anger. It can be argued that those strong (and understandable) reactions are in good part inspired by a set of norms that were sustained through the direct and indirect effects of federal health-care funding, following a lengthy social process of consensus-building and with the core commitment to universal health insurance for medically necessary health care ultimately enshrined in legislation — the CHA and its predecessors together with interlocking provincial and territorial laws.

Various attempts have been made by scholars working on federalism to give shape to the idea that the continuum between centralization and decentralization could not do justice to the complex arrangements that characterize the relationships between a national or general government and the constituent subnational units — in Canada, the federal government on the one hand and the provinces and territories on the other. The debate extends far beyond the scope of the present paper (Watts 1998). Suffice it to say that it is not enough to claim that Canada is “one of the world’s most decentralized federations” (Simeon 1986; Bakvis and Skogstad 2002; Lecours 2019). Health care in Canada is a domain in which the provinces like to affirm their “exclusive jurisdiction,” and many experts opine that Canada possesses “thirteen somewhat distinctive provincial or territorial health systems” (Naylor, Boozary and Adams 2020). Even here, however, the centrifugal forces of policy and administrative differentiation are nonetheless held in check by the combination of laws, policies, institutions, and

interests that are dedicated to a national agenda of social welfare defined and/or imposed by Ottawa (Forest 2015).

Theorists of federalism might conclude that Canadian provinces and territories have jealously preserved and exercised their *right to act* in health care, hence the asymmetry; but that their *right to decide*, under the constraint of social norms, legal obligations and conditional funding, is at least in part shared with their other partners within the federation including, first and foremost, the federal government (Biela et al. 2011). The Canadian health-care system should not be reduced to a single dimension of policy variation, marked by the high degree of decentralization that is observed in the organization and administration of each provincial and territorial system. It is a fundamental tenet of public health whose services must be adapted to local needs and conditions. At the same time, it is possible to contemplate a set of core values that can uniformly inform health policy decisions, whether through some expression in legislation or engagement of other mechanisms and practices such as federal grants.

Given the long history of the CHA and its predecessors, there is no doubt that federal legislation can be used in Canada to maintain or improve upon the existing national norms and standards that ground our health-care system, or to establish new ones. “Opening” the CHA for amendment to achieve this is certainly an option. Over the years, for example, it has been suggested to change its preamble to make room for a more generous and progressive vision of health, in keeping with such changes as in the U.K.’s constituent legislation for the National Health Service (Bégin and Forest 2008) or, more recently, to affirm principles such as anti-racism (Kirkup 2020). Proposals have also been made from time to time to bring under the act other programs or sectors, such as mental health, long term care or prescription drugs. The Commission on the Future of Health Care in Canada has recommended to establish accountability as a sixth criteria, distinct from public administration (Romanow 2002).

But these initiatives, however well-intentioned, risk a difficult path and uncertain outcome. The former federal minister who championed the CHA’s creation and oversaw that legislative process from beginning to end sounds an important cautionary note: it is a path fraught with the risk of giving the impression that everything is renegotiable, “a sure route to disaster” and the potential undoing of the longstanding national medicare compact initiated with the HIDS in 1957, itself the product of many years of provincial experimentation and innovation.

Safer alternative courses to achieve needed reforms may lie (depending upon the issue) in the CHA’s existing potential for regulations and/or policy interpretation letters. These subsidiary legislative instruments might prove sufficient to address such matters, for example, as the need for more fulsome data and supporting information pertaining to the national health workforce, to strengthen reporting and health system planning (Bourgeault 2021). To take another example, they could ensure that, like insured health services provided in private clinics, the virtual care Canadians have had access to during the COVID-19 pandemic continues to be provided as an insured service: that the medical necessity of service does not change based on venue or modality (Jamieson 2021). Even where the power to engage these instruments may be unrestricted by any

express requirement for consultation with the provinces and territories however, there is no doubt that consultation would be required, for reasons explained above.

Moreover — and importantly — the federal government’s legislative options are not limited to the CHA. Consideration should also be given to the alternative possibility of new legislation, grounded in the federal spending power or other federal powers to legislate on health-related matters, and perhaps mirroring the organic development over time of the Canadian health system at the national level. Indeed, new “companion” legislation to achieve reform in areas such as mental health, long-term care or pharmacare might fairly be characterized as a fourth cornerstone to the medicare legislative compact, entirely in keeping with the 1957 Hospital Insurance and Diagnostic Services Act, the 1966 Medical Services Act and — most recently — the 1984 Canada Health Act.

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