

Federalism and Public Health Law in Canada: Opportunities and Unanswered Questions

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Public health renewal has emerged as a central policy issue in this country and has, at least for a moment, overcome the shadow of its health care cousin. This attention has been largely precipitated by the re-emergence of new infectious threats such as Mad Cow disease, West Nile virus and, most notably, Severe Acute Respiratory Syndrome (SARS). SARS revealed important limitations to this country's emergency response capacity and the health and economic implications of these limitations.¹ Consequently, several national initiatives to revamp the public health system have been launched including the creation of a new public health agency, the appointment of a national public health officer and the acceleration of the health protection legislative renewal process.

SARS exposed the critical need for better intergovernmental cooperation if public health programs are to be truly effective. Unfortunately, however, intergovernmental relations during the response to SARS were less than optimal.² A number of factors help to explain the troubled response, but one issue has clearly stood out – the question of unclear jurisdictional responsibilities for public health. In attempting to resolve this problem, legislative options have been considered. However, by and large, governments have chosen political alternatives that centre on establishing effective collaborative federalism solutions.

In exploring the various options for restructuring Canada's public health system, policy makers must carefully consider both legislative and intergovernmental issues. Indeed, there is an important interplay between the law and federalism in

public health, and several questions related to legal matters need to be clearly answered before effective public health policy can be formulated. This article will explore some of these issues and examine the variety of legislative options available to the federal government. The authors of this article have familiarity in public policy formulation and specifically the development of public health policy. The legal questions we put forth are those we believe remain unresolved and for which resolution would be important for the development of effective future policy. We encourage legal academics to address and expand upon some of the issues we raise.

Defining Public Health

To begin a discussion of the legal issues in public health it is first important to define what the term means. Perhaps the most important distinction between health care and public health is the population to which care is being delivered. Health care is viewed primarily as being directed at the level of the individual – specific health interventions are prescribed according to the specific physiological or mental needs of a particular person. Public health, conversely, is primarily designed to improve the health of the population in general. The Institute of Medicine has defined public health as:

what we, as a society, do collectively to assure the conditions for people to be healthy. This requires that continuing and emerging threats to



the health of the public be successfully countered. These threats include immediate crises, such as the AIDS epidemic; enduring problems, such as injuries and chronic illness; and growing challenges, such as the aging of our population and the toxic by-products of a modern economy, transmitted through air, water, soil, or food. These and many other problems raise in common the need to protect the nation's health through effective, organized, and sustained efforts led by the public sector.³

According to the U.K. Acheson report, public health's primary responsibilities include⁴ "the surveillance of the health of a population, the identification of its health needs, the fostering of policies which promote health, and the evaluation of health services." The Public Health Agency of Canada provides the following definition of public health: "the science and art of promoting health, preventing disease, prolonging life and improving quality of life through organized efforts of society."⁵

The Agency further defines the essential functions of public health to include health protection, health surveillance, disease and injury prevention, population health assessment and health promotion.

Based on the variety of definitions provided, public health activities can be divided into three major categories: 1) health protection, which includes activities by the government to protect the public from harm including harms from hazardous products and disease; 2) health promotion, which is directed at promoting healthy behaviour among members of the general population, including smoking cessation activities and improving physical fitness; and, 3) health surveillance, which monitors outbreaks, disease trends and risk factors for disease. Much of the discussion related to public health reform has focussed on the disease prevention component of health protection and health surveillance as it complements this function.

Summary of The Canadian Public Health Reform Process in Response to SARS

In considering its response to SARS and the general issue of public health reform, Canada was largely influenced by the experience in the United States. The U.S. is a few years ahead of Canada in evaluating the need for public health reform largely because of initiatives introduced after the terrorist attacks of September 11, 2001 and the subsequent anthrax attacks over the fall of that same year.⁶ The American constitution provides state legislatures with primary responsibility for public health, and several recent court decisions have limited federal involvement in domestic matters, which could apply to public health.⁷ The federal government in the United States has exercised a legislative role in public health through related areas of jurisdiction such as environmental protection; how-

ever, limits have been placed on this legislative authority particularly because it can create excessive costs at the level of state and local governments.⁸ After the anthrax attacks, which exposed the lack of effective public health infrastructure and the consequences of this when responding to a public health outbreak, Washington identified mechanisms by which it could play a greater role in public health. Along with introducing legislation relating to issues of national security, the federal government also relied on its taxing and funding power.⁹ In particular, the American federal government expanded funding to the U.S. Centers for Disease Control. The CDC in turn promoted desired public health programs by providing direct conditional grants to the states in exchange for them providing specific services. Interestingly, the U.S. CDC does not have the authority to involve itself in public health outbreaks without state approval. However, the CDC has used its reputation and position as an opinion leader to formulate a model emergency act for states to use.¹⁰

In many ways, SARS was Canada's equivalent to the 2001 anthrax attacks in the United States in that it has mobilized the movement towards more federal involvement in public

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health. In both the U.S. and Canada each of these events presented a policy opportunity that policy entrepreneurs exploited.¹¹ The David Naylor report into the SARS crisis was the first released in response to the management of the outbreak and outlined several recommendations for improving public health capacity in Canada. The report explicitly described the need for a stronger federal presence in public health through the creation of an arm's length national public health agency and the investment of increased federal money into public health.¹² As part of its work, the commission considered a centralized model in which the federal government, through legislative mechanisms or strong financial coercion, would direct provincial/territorial or local public health activities. This option was rejected, however, due to potential intergovernmental conflict this could create and the recognition of the importance for intergovernmental cooperation in public health.¹³ Instead the report suggested that Canada adopt a U.S. CDC style model in which a new federal agency would work "collaboratively" with the provinces and regions. This federal agency would provide seed funding to provinces/territories and regions to encourage the development of desired public health programs.

The SARS report also considered the use of federal legislation to achieve desired public health policy goals. In particular, the report referred to the ongoing review of health protection legislation and the development of a new health protection act. The report recognized that the new Act had to be acceptable to all orders of government, in particular provincial and local governments who would have to carry out many of the activities specified in the Act. However, the report also recognized the ultimate importance of such legislation to ensure uniform minimum approaches to public health across the country and that the federal government prepare default legislation in the event that intergovernmental consensus could not be achieved.¹⁴

Since the release of the SARS report and several other reports, all of which called for a more coordinated approach to public health, Ottawa has taken several steps to act on some of the key elements Dr. Naylor outlined. These include the announcement of a Minister of State for public health,

the creation of a new federal agency, the Public Health Agency of Canada (PHAC), and the announcement of a new Canadian public health officer. The new federal public health agency is headquartered in Winnipeg and Ottawa and reports ultimately to the Minister of Health. The new public health agency is intended to be *the* federal focal point on all issues related to public health – from promoting healthy living strategies for individual Canadians to establishing national emergency plans to address catastrophic public health threats. In addition to establishing itself and its new role, PHAC has two key roles to play. The first is to collaborate with provinces, territories and other stakeholders to establish Canada's core long-term public health initiatives. Included here are the development of the Pan-Canadian Public Health Strategy and Network, and the improvement of Canada's plans for public health emergency response and preparedness. The second key role is to develop pan-Canadian integrated and disease-specific strategies for chronic disease and healthy living

as well as strategies for infectious diseases. Public health legislative renewal is also underway, including the creation of implementation legislation for the new Agency.¹⁵ As the new agency moves out with its new mandate and responsibilities, thus far it appears that provinces and territories are willing to cooperate under federal leadership. In the September 13-15, 2004 First Ministers' Meeting, federal/provincial/territorial (FPT) ministers recognized the critical nature of public health efforts and committed to a national approach to public health including outlining a ten-year action plan.¹⁶ As well, on April 22, 2005 F/P/T ministers responsible for health announced the long-awaited creation of the Pan-Canadian Public Health Network whose mandate is to "serve as a forum for multilateral intergovernmental collaboration on public health issues while respecting jurisdictional responsibilities in public health."¹⁷

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Intergovernmental Options in Considering Public Health Reform

Federalism is a form of government in which centralized rule is combined with regional government and no order of government is necessarily subordinate to the other. This is in



contrast to a unitary state where regional governments are subordinate to the central authority or confederations in which the central authority is subordinate to the regional governments.¹⁸ Canada is a federal state with several specific qualities that make it unique. Canada was the first country to combine federalism with parliamentary government. While Canada has a bicameral system, it is the only federation without an effective second chamber. Arguably this has contributed to the greater emphasis on executive federalism as, in the absence of a second chamber representing the regions, provincial/territorial representation in policy matters is primarily via F/P/T meetings. Also importantly, Canada is a federation with two disproportionately large provinces and a large minority group primarily residing in one of the provinces. The Constitution of the country has some level of asymmetry to address issues related to the latter fact. From the perspective of legislative authority, Canada could be viewed as a relatively decentralized federation.¹⁹

In theory, powers are divided into “watertight” compartments in the Canadian constitution as “[e]ach list of classes of subjects in s. 91 or s. 92 of the *Constitution Act, 1867* is exclusive to the Parliament or Legislature to which it is assigned.”²⁰ However, in reality there are multiple policy areas in which jurisdictional overlap occurs and may even be considered desirable. In general, the federal government has a variety of mechanisms by which it can involve itself in provincial matters. These include legislation in those areas in which it has constitutional authority and intergovernmental agreements and spending power (including both grants and contracts) in those areas in which it does not have clear authority.²¹ Out of the use or lack of use of these mechanisms arise a variety of intergovernmental relations. Federal unilateral relations describe relationships in which the federal government has the ability to coerce provincial action in areas of provincial jurisdiction through the use of tied funding or legislation targeted at a related area. Collaborative relations can be created through the use of intergovernmental agreements in which no order of government has dominance over the other; however, the two orders of government are dependent on each other for the achievement of policy goals. In the event that no mechanism exists for interaction between the federal and provincial governments, the relationship is described as disentangled.²² One alternative intergovernmental relationship, referred to as a confederal relationship, could exist if the provinces enter into intergovernmental agreements with each other and exclude the federal government.²³

The emerging approach to public health reform is clearly based on a collaborative model and designed to replace a largely disentangled model. The model described in the SARS report is for federal involvement in public health via seed funding on a project-by-project basis, as opposed to a large conditional block grant²⁴. This latter approach was not considered appropriate because of the potentially coercive nature of the arrangement and the likelihood that the large sums of money involved in such grants could become politicized. While the collaborative approach seems to be the preferred starting point, such approaches have been shown to not necessarily be effective in other public health domains such as health surveillance and environmental harmonization.²⁵ In theory the prospect exists for the federal government to act in a more unilateral manner. This would be primarily predicated on their willingness to proceed with federal legislation as a primary tool for achieving desired policy goals. Such an approach, however, brings with it its own set of problems.

Jurisdictional Issues in Public Health

In considering legislative options to a greater federal role in public health several questions arise. These include establishing clearly the constitutional responsibilities of the different orders of governments, identifying the extent of federal legislative authority, and determining what mechanisms exist for the federal government to enforce their legislative mandates.

Like so many policy issues in Canada, jurisdictional responsibility for public health is not absolutely clear; however, some attempts have been made to untangle the ball of yarn.²⁶ Responsibility for public health is not explicitly stated in the Constitution. Primary provincial responsibility for public health legislation is derived from section 92(13) of the *Constitution Act*, which gives the provinces responsibility for property and civil rights and from the power they are given over matters of a local or private nature in the province (section 92(16)).²⁷ This authority and subsequent legal interpretations have given provincial legislatures the authority to pass public health legislation. The federal government has involved itself in public health via use of its powers over criminal law (Section 91(27)), power to quarantine (section 91(11)) and power to regulate trade and commerce of an interprovincial or international nature (section 91(2)). The federal government also has available to it the option of using its spending power, either by providing conditional



funding for public health programs or by entering into legal contracts to develop public health initiatives.

The federal government also derives power to implement public health policy from two additional areas in the constitution. By virtue of its treaty making power, the federal government can enter into international agreements and other international initiatives in public health. However, any international agreement that the federal government enters into that touches on a matter of provincial jurisdiction would require enabling legislation at the provincial level. The federal government also potentially has power under the “peace, order and good government power”, (POGG) found in the preamble of section 91 of the *Constitution Act, 1867*, which allows it to pass legislation to regulate matters of national health and welfare. In sum, the federal government has found innovative ways to use its powers in an effort to implement its public health agenda. Nevertheless, these approaches have sometimes led to less than optimal results in terms of effectiveness.

Kava as a Case Example

In areas of public health in which the federal government has chosen to use a legislative approach, which is primarily in the field of health protection, questions remain as to what is the effective ability of the federal government to enforce its mandate. An example of this potential dilemma of federal regulations can be found in the regulation of natural health products. Under the *Food and Drugs Act*, the federal government has the authority to pass regulations governing the sale of pharmaceuticals, which includes non-prescription pharmaceuticals such as natural health products.²⁸ Ottawa has used its authority in this regard to protect the public from potential harm associated with the use of the health product kava. Kava is a substance that has been widely used in certain parts of Asia as an anxiolytic agent. The agent has also been used in North America as an alternative medicine product, and evidence exists for its efficacy as an anxiolytic.²⁹ However, in initial European case reports, evidence emerged that some kava-containing products may be associated with a serious form of toxicity affecting the liver. In response to preliminary information on this potential

adverse event, Health Canada issued an advisory in January 2002 recommending consumers not use any products containing this substance.³⁰ Further case reports soon emerged about Canadians who had ingested the substance and developed the liver disease. In response, Health Canada stated that kava was a non-prescription pharmaceutical product and proceeded to issue a stop sale order on the product in August 2002.³¹

In reviewing the federal response to the potential risks associated with kava, the limitations of federal regulatory power become evident.³² While not specifically set out in the Constitution, the courts have held that federal authority over health protection matters is largely derived from the federal power over criminal matters.³³ Accordingly, regulation of conventional drugs, as a matter of health protection, is set out under the federal *Food and Drugs Act*. Presumably, based on this Act, Health Canada had the authority to make its

stop-sale order regarding kava, which stated that “there is insufficient evidence to support their safe use” and further stated that “Health Canada now considers products containing kava to be drugs and has determined there are no acceptable food uses for kava”.³⁴ Two field studies auditing the practices of health food stores in Toronto evaluated the effectiveness of both the initial advisory and the subsequent stop-sale order and found important shortcomings. The first study, conducted after the advisory was issued, found that 22 of 34 (65%) of stores recommended kava as a treatment for anxiety. Only nine of the 22 stores mentioned the potential safety concerns although three of these stated that the information on risk was not accurate.³⁵ The second study found that two months after the stop-sale order, 17 (57%) of 30 stores continued to sell kava.³⁶ These results demonstrate real practical issues in the federal government’s ability to enforce its regulations.

The *Food and Drugs Act* specifically provides the federal government with the powers it needs to enforce the *Act* through the creation of federal inspectors (section 22). The inspectors have the authority to enter into areas that they reasonably believe may house a suspected compound and seize or inspect substances. The Act states that any individual

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who “contravenes any of the provisions of the Act or of the regulations made under this Part is guilty of an offence and liable”. Penalty provisions range from a fine of \$500 or three months imprisonment for a first offence to \$5,000 or three years in prison for a conviction. However the results of the field studies demonstrate practical limitations of the federal government’s ability to enforce their own legislation. In particular, it demonstrated their inability to effectively audit all health food store practices to ensure compliance with federal safety standards. The federal government theoretically could rely on provinces to enforce the legislation. However, it is uncertain if they have any legislative means to force provincial or local governments to assist them in enforcing their mandates, and doing so would incur large costs on the other orders of government. Ideally, however, obtaining such cooperation could greatly assist in ensuring that safety standards are adhered to and the public remains protected from potentially harmful substances.

The Blood System as an Alternate Model

One option for a more effective federal regulatory approach is to combine legislation with intergovernmental agreements. The blood system provides an example of the effectiveness of this option. In response to the tragedy of transfusion transmission of hepatitis C and HIV, F/P/T officials in 1996 initiated plans for the development of a new blood system.³⁷ The allocation of governmental responsibilities was described in a Memorandum of Understanding.³⁸ This intergovernmental agreement stated that regulatory authority for the safety of blood products resides with the federal government under the *Food and Drugs Act*. The federal government has the authority to enact regulations governing the introduction of safety measures to ensure that the blood supply remains safe. Delivery of transfusion services is fundamentally a provincial/territorial responsibility that is administered by Canadian Blood Services, a not-for-profit corporation. Funding of the blood system is also a provincial/territorial responsibility. The allocation of responsibilities and the existence of an intergovernmental agreement has allowed for the creation of an effective blood system, which has regained the trust of Canadians.³⁹ However, it has also created a situation in which the federal government can adopt legislation that creates costs at a provincial/territorial level. Such unfunded mandates can and have produced intergovernmental conflict and can exist as long as the current MOU exists.⁴⁰ An interim review identified this as an important consideration that needed to be addressed by all parties.

A concern is that compliance with Health Canada regulations often has cost implications that must be absorbed by the provinces/territories. Some costs are direct such as the \$35 per bag increase in the cost of blood bags when universal leukoreduction was mandated. Other costs are indirect such as the staff time involved in writing and revising SOPs and dealing with Health Canada on SOP changes. As CBS and the Corporate Members strive to predict and control rising costs, they must find a way to take the impact of the regulatory environment into account. Each party has a role to play in this. When the regulator dictates operational changes, CBS should provide an analysis that describes the costs, benefits and risks of the change, identifies the fit with international best practices, identifies alternatives, and highlights the implications for CBS. This analysis should be shared with the Members and the Provincial/Territorial Contacts. If the Members have concerns about implementing the change from either a cost, benefit or risk perspective, they should initiate dialogue with the regulator to address these concerns.⁴¹

The potential for such “unfunded mandates” to exist in blood safety arises at least partly from the existence of a Memorandum of Understanding formalizing federal and provincial powers as they specifically apply to blood safety. Importantly, under the MOU, any province/territory can withdraw by giving one years notice, a situation that may arise if provinces/territories no longer find the costs being imposed upon them acceptable. Again it remains uncertain if the federal government could still expect provinces/territories to implement and fund their regulations in the absence of a MOU.

The Extent of Federal Powers – Emergency Response

Perhaps the most important outstanding question on the extent of federal powers in public health pertains to emergency response capacity for infectious outbreaks, which provides an example of where a more powerful federal role may be desirable. As it stands, the federal government has developed a complex relationship with provinces and territories in order to provide a smooth and coordinated pan-Canadian emergency response to any future public



health crisis, particularly those that surpass the capacity of any individual province/territory. However, the question remains as to whether the federal government has the legislative tools to enforce its will in the event of major disagreement with one or more provinces. Currently the federal government's emergency response to infectious threats is framed primarily by two pieces of legislation: the *Emergencies Act* and its companion piece the *Emergency Preparedness Act*. Of these, the *Emergencies Act* is the only legislation that provides the federal government with sufficient authority to act unilaterally to manage an infectious threat.⁴² However, since its proclamation, the Act has never been used, including for the management of SARS. There are several potential explanations for this related to the wording of the Act and the implications of its use. Its implementation would require the declaration of a national emergency and there is a stigma associated with this that may impede this declaration. Further limiting its use in public health is the requirement, under the Act, for two provinces to be affected before the federal government has the authority to act unilaterally in provincial jurisdiction.⁴³ The companion *Emergencies Preparedness Act* does not provide authority for the federal government to act unilaterally but rather simply provides a mandate for it to act in collaboration with provinces to coordinate preparations for eventual emergencies.⁴⁴

The current legislative framework creates unnecessary and arguably dangerous obstacles to this nation's ability to respond to a public health infectious threat. Evidence for this was provided in the national response to manage SARS. SARS emerged initially as a local threat and under provincial jurisdiction. The federal government did not have the legislative tools available to it to intervene and was thus reliant upon provincial cooperation. As a result, the federal government was unable to demand the transmission of information and data in order to have complete understanding of what was occurring at the ground level. At the same time, the WHO's mandate to interact only with the federal government created a scenario in which adequate outbreak communication could not occur. This requirement for cooperation provided some deficits in communication, and inter-

governmental communication was identified by World Health Organization officials as a major shortcoming of Canada's response.⁴⁵ The WHO's inadequate knowledge of the local response to SARS also may have contributed to the imposition of a travel advisory on Toronto.⁴⁶

This current arrangement is clearly problematic. Primarily the outbreak was initially confined to one province, which would have precluded unilateral federal action under the *Emergencies Act*. This clause is understandable when defining

appropriate response to emergencies such as natural disasters. However, the limitations of the clause when it relates to infectious threats were evidenced by the existence of SARS in multiple countries, clearly demonstrating the ability of the pathogen to cross borders. There were important implications of the lack of clear federal involvement in the early stages of the outbreak. Recognizing some of these legislative obstacles, the SARS report stated:

a related concern is lack of clarity about jurisdiction when a health threat affects multiple provinces. The federal *Emergencies Act* (R.S. 1985, c. 22 (4th Supp.)) confers very wide powers on the federal government and can only be invoked in the face of a truly grave national threat. The federal government otherwise has uncertain authority in the face of a multi-provincial outbreak. This situation is particularly problematic as the World Health Organization (WHO) moves to establish International Health Regulations that set expectations of member states as regarding surveillance, reporting and outbreak management. We recommend that consideration be given to a federal health emergencies act to be activated in lockstep with provincial emergency plans in the event of a pan-Canadian health emergency.⁴⁷

The question arises as to whether the federal government has the authority to involve itself unilaterally in the management of infectious outbreaks, which while initially confined to one province, are either international in etiology or have

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characteristics that suggest transmission across provincial borders as being an important concern. The federal government could again rely on its powers over criminal law to do so. Alternatively, the national concern branch of the POGG clause may provide the federal government with such power. This clause can be utilized for issues in which intra and extra provincial implications of the issues are linked, provinces are not able to regulate effectively on their own, and failure of one province to regulate would affect the health of residents of other provinces⁴⁸ Infectious disease outbreaks could be argued as meeting these three criteria, particularly at early stages of the outbreak where the nature of the pathogen is not known. The emergencies branch of POGG could also be utilized to implement federal regulation. A previous ruling used an infectious epidemic as an example of a condition in which this clause could apply.

A pestilence has been given as an example of a subject so affecting, or which might so affect, the whole Dominion that it would justify legislation by the Parliament of Canada as a matter concerning the order and good government of the Dominion. It would seem to follow that if the parliament could legislate when there was an actual epidemic it could also do so to prevent one occurring and also to prevent it happening again.⁴⁹

Thus there appears to be at least an opportunity for the federal government to have the constitutional authority to pass legislation that would allow greater federal involvement at the early stages of infections outbreaks. Of course the government would have to clearly define what powers it needs and wants to have (recognizing that the ability to act would carry with it certain obligations that the federal government may actually not desire). At a minimum, the ability to mandate a certain level of data transfer would appear to be a reasonable first step. Such measures would ensure the federal government would have the ability to monitor the outbreak accurately, communicate with adjacent provinces about the potential risk of the outbreak to them, and communicate with neighbouring countries and appropriate international organizations. This would also be an important step given the development of new international health regulations that will require such levels of data collection.⁵⁰ It is important to recognize that such legislation has the potential to create substantial costs at the provincial level, particularly if the necessary infrastructure for data collection does not exist. Thus the moral obligation would return to the federal government to assist in this venture. This coupled with the

uncertain ability of the federal government to force provincial cooperation would bring us back to a more collaborative strategy, but one that perhaps could more easily be encouraged with the threat of legislation as a back-up.

Conclusion

We have hoped to illustrate the importance of intergovernmental cooperation in public health and the opportunities and limitations of legislative options. To assist policymakers in developing public health strategies, answers are needed to a list of important legal and legislative questions. There remains some uncertainty about the ability of the federal government to enforce legislative mandates in the absence of intergovernmental agreements. Also needing clarification is the extent to which the national concern and emergency branches of POGG could be used to justify legislation that allows unilateral federal actions in the presence of a public health emergency that emerges in one province. However, despite these remaining uncertainties, some important messages emerge from our examination. While the federal government has substantial authority to involve itself in public health, and potentially has additional unexploited constitutional powers to do so, the actual effectiveness of such authority would require a degree of provincial cooperation. This could be enhanced through the use of intergovernmental agreements or funding arrangements. Thus any approach to public health will likely have to combine components of strong federal approaches with clearly collaborative strategies.

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11. George Avery, "Bioterrorism, Fear, and Public Health Reform: Matching a Policy Solution to the Wrong Window" (2004) 64 *Public Administration Review* 275.
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13. *Supra* at 165. The report specifically stated:

A federal (legislative) model would be the most efficient way to achieve national uniformity in national public health rules, but has drawbacks that we have already indicated. Unless its terms were closely aligned to the collaborative mechanisms set out elsewhere in this report, and unless it carried with it a funding mechanism, a federal model would run the risk of imposing unfunded federal mandates, and spark substantial opposition from provinces. From a policy standpoint, federal uniformity may come at the expense of provincial innovation and experimentation. The measures already set out in the Committee's report should allow the federal government and its provincial/territorial partners to stitch together existing uncoordinated local, provincial and federal public health systems into a national system, with attendant harmonization of existing provincial and local public health rules. A federally-imposed system might instead be viewed as a necessary last resort if collaborative and consensus-building mechanisms fail.
14. *Supra* note 12 at 170, the report specifically states:

The need for federal legislation could be vitiating not only by the piecemeal assembly of a system of national rules through mechanisms described, but by intergovernmental initiatives to upgrade and harmonize legislation. To that end, we believe the federal government should embark on a time-limited intergovernmental initiative with a view to renewal of the legislative framework for disease surveillance and outbreak management in Canada, ideally extending to broader health emergencies from the latter as a starting point. Only if these initiatives fail to produce a national system of public health norms and rules would we recommend that the federal government move towards legislation along the lines of the "federal default" provision set out above. Our assumption is that many provinces will be in agreement with the thrust of these legislative reforms and the goal of creating a national system, and that the default legislation would therefore apply only to those provinces.
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<http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2005/2005_26_e.html>.

18. Ron Watts specifically defines federal political systems as

a broad category of political systems in which, by contrast to the single central source of authority in unitary systems, there are two (or more) levels of government which combine elements of shared-rule through common institutions and regional self-rule for the governments of the constituent units.

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20. Peter W. Hogg, *Constitutional Law of Canada*, Student ed., (Toronto: Thomson Carswell, 2003) at 397. [Hogg]
21. *SARS*, *supra* note 12 at 71.
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23. Thomas J. Courchene, "Assessing ACCESS. Towards a New Social Union" (paper presented at ACCESS: A Convention on the Canadian Economic and Social System October 1996) [unpublished].
24. Kumanan Wilson, "The Canadian Agency of Public Health. Could it Work?" (2004) 170 *Canadian Medical Association Journal* 222.
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However, subsequent Auditor General reports identified the failure of moving the project beyond the design stage; P. Faford, "Green Harmonization: the Success and Failure of Recent Environmental Intergovernmental Relations" in E.H. Lazar ed. *Canada: the State of the Federation 1997. Non-constitutional Renewal* (Kingston, Ont.: Institute of Intergovernmental Relations, Queen's University; 1998) 71.

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27. *Constitution Act*, 1867. U.K., 30&31 Victoria, c. 3, reprinted in R.S.C. 1985, App. II.
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29. M. Pittler & E. Ernst, "Efficacy of Kava Extract for Treating Anxiety: Systematic Review and Meta-analysis"(2000) 20:1 *Journal of Clinical Psychopharmacology* 83.
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33. Hogg, *supra* note 20, at 471, states: "It is well-established that food and drug legislation making illegal the manufacture or sale of dangerous products, adulterated products or misbranded products is within the criminal law power." See e.g. *R. v. Wetmore*, [1983] 2 S.C.R. 284.
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the Blood System in Canada, Ottawa: Canadian Government Publishing, 1997).

38. *Ibid.* at 1023.
39. Graham D. Sher “The Blood Supply System in Canada” (Paper presented to the Advisory Committee on Blood Safety and Availability, Washington D.C. January 2004). [unpublished].
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42. *Emergencies Act* (R.S.C. 1985, c. 22 (4th Supp.)).
43. *Ibid.* at s. 14 (2) which states:
The Governor in Council may not issue a declaration of a public welfare emergency where the direct effects of the emergency are confined to, or occur principally in, one province unless the lieutenant governor in council of the province has indicated to the Governor in Council that the emergency exceeds the capacity or authority of the province to deal with it.
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46. World Health Organization, News Release, Update 37, “Sever Acute Respiratory Syndrome (SARS) Multi-country outbreak” (23 April 2003). online: WHO <http://www.who.int/csr/don/2003_04_23/en/index.html>.
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48. Sujit Choudhry, “Recasting Social Canada: A Reconsideration of Federal Jurisdiction Over Social Policy” (2002) 52:3 U.T.L.J. 163. *Schneider v. R.* [1982] 2 S.C.R. 112 at 142 as quoted in Martha Jackman, “Constitutional Jurisdiction over Health in Canada” (2000) 8 Health L.J. 96. See also *Hogg, supra* note 20 at 446, where he notes: “It seems, therefore, that the most important element of national concern is a need for one national law which cannot realistically be satisfied by cooperative provincial action because the failure of one province to cooperate would carry with it adverse consequences for the residents of other provinces.”
49. *Attorney General for Ontario v. Canada Temperance Federation*, [1946] A.C. 193.
50. *Review and approval of proposed amendments to the Internatinal Health Regulations: draft revision*. World Health Organization, Intergovernmental Working Group on Revision of the International Health Regulations, Provisional agenda item 3. Online: <http://www.who.int/gb/ghs/pdf/A_IHR_IGWG_3-en.pdf>

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Deadlines:

February 15, August 15, October 15, 2006

Tel: 780.492.8343 email: hli@law.ualberta.ca

