

Constitutional Jurisdiction Over Health in Canada

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I. Introduction

Health and health care reform remain at the forefront of current social and political debate in Canada. Recent governmental and non-governmental studies alike have recommended greater collaboration and cooperation between federal and provincial/territorial governments in order to increase the coherence of Canadian health policy and to better ensure the long term viability of the health care system. In its 1997 *Final Report*, for instance, the National Forum on Health identified a “strong federal/provincial/territorial partnership” as a key principle for health care renewal.¹ In its 1999 review of federal support for health care delivery, the Auditor General of Canada urged the federal government and the provinces to “build on the Social Union Framework Agreement and work together to avoid and resolve disputes over the interpretation of the *Canada Health Act*.”² Most recently a task force of prominent health care experts brought together by the IRPP,³ recommended that the now “dysfunctional” federal-provincial relationship in the area of health be abandoned in favour of a “renewed partnership” between the federal government and the provinces.⁴

In response to these and broader calls for urgent joint action on the health care front, the Prime Minister and Premiers ended their September 11, 2000 First Ministers’ meeting with the announcement of a new federal-provincial “health renewal agreement”, providing for a \$23.4 billion increase in federal health transfers over five years in exchange for better reporting by the provinces on health care system performance and outcomes.⁵ Essential to reaching consensus among the

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¹National Forum on Health, *Canada Health Action: Building on the Legacy – Final Report of the National Forum on Health* (Ottawa: Minister of Public Works and Government Services, 1997) at 20.

²Auditor General of Canada, *Report of the Auditor General of Canada to the House of Commons, 1999 – Chapter 29: Federal Support of Health Care Delivery* (Ottawa; Minister of Public Works and Government Services Canada, 1999) at 29-19.

³Institute for Research on Public Policy Task Force, *Recommendations to First Ministers* (Montreal: Institute for Research on Public Policy, 2000). The IRPP task force members include former federal health minister Monique Bégin, former Québec health minister Claude Forget, and Henry Friesen, former president of the Medical Research Council of Canada, among others.

⁴In the view of the task force “Canadians now witness almost daily childish, sterile bickering between the two levels of government as to who-paid-how-much-for-what-when”; *ibid.* at 29; P. Adams, “Stop Bickering, Health Panel Says” *The Globe and Mail* (8 September 2000) A1.

⁵Government of Canada, Privy Council Office, News Release 800-038/004, “First Ministers Meeting Communiqué on Health” (11 September 2000).

First Ministers, according to the media,⁶ was the inclusion in the agreement of a preamble stating that “Nothing in this document shall be construed to derogate from the respective governments’ jurisdictions” and that all elements of the agreement “shall be interpreted in full respect of each government’s jurisdiction.”⁷ The object of the following paper is to review the current state of the law relating to the division of powers over health in Canada, in order to describe the “respective governments’ jurisdictions” to which the new federal-provincial health agreement so emphatically refers.

While Canadian governments at all levels are now extensively involved in health protection and promotion and in the regulation and delivery of health care services, at the time of Confederation, however, health care was not considered a matter of national importance but was seen primarily as an issue of private or local interest. In the event of illness, most people were dependent on their families and neighbours for care within the home. What little institutionalized health care did exist in 1867 was organized and delivered largely by local charities and religious groups rather than by the state.⁸ As a consequence, the *Constitution Act, 1867*⁹ does not include “health” as a specific head of federal or provincial legislative responsibility. As Justice Estey explained in *Schneider v. R*:

“[H]ealth” is not a matter which is subject to specific constitutional assignment but instead is an amorphous topic which can be addressed by valid federal or provincial legislation, depending in the circumstances of each case on the nature or scope of the health problem in question.¹⁰

In the absence of an express grant of legislative authority under the *Constitution Act, 1867*, Parliament has relied primarily on its spending and criminal law powers as a basis of federal action in relation to health. The provinces have intervened broadly in the health care field by virtue of their jurisdiction over “hospitals”, “property and civil rights”, and matters of a “local or private nature” in the province. The first part of the paper will review the source and scope of federal jurisdiction over health; the second part of the paper will examine the basis and limits of provincial legislative authority in this area.

⁶P. Adams, “Desperate Diplomacy Delivers Last-minute Deal” *The Globe and Mail* (12 September 2000) A1.

⁷Privy Council Office, “First Ministers Meeting Communiqué on Health”, *supra* note 5.

⁸See generally D. Guest, *The Emergence of Social Security in Canada*, 2d ed. (Vancouver: University of British Columbia Press, 1985) at 9-17; H. Lessard, “The Construction of Health Care and the Ideology of the Private in Canadian Constitutional Law” (1993) 2 Ann. Health Law 121 at 123-26.

⁹*Constitution Act, 1867* (U.K.), 30 & 31 Vict., c. 3, reprinted in R.S.C. 1985, App. II, No. 5.

¹⁰*Schneider v. R.* [1982] 2 S.C.R. 112 at 142; see also *Eldridge v. British Columbia (A.G.)*, [1997] 3 S.C.R. 624 at 646-47.

A. Federal Jurisdiction over Health

1. The Federal Spending Power

The federal spending power, or Parliament's power to spend money raised through taxation and otherwise dispose of public property, inferred from sections 91(1A), 91(3) and 106¹¹ of the *Constitution Act, 1867*, provides the basis for considerable federal activity in the field of health, including for the most significant piece of federal health legislation – the *Canada Health Act*.¹²

The federal government's exercise of its spending power in the area of health was reviewed by the Alberta Court of Appeal in *Winterhaven Stables Ltd. v. Canada (A.G.)*,¹³ a constitutional challenge to a number of federal spending statutes prompted by the enactment of the *Canada Health Act* in 1984. In his decision for the Alberta Court of Appeal, Justice Irving agreed with the appellant that federal financial incentives under the *Canada Health Act*, the *Canada Assistance Plan*¹⁴ and other federal spending legislation created substantial pressure on the provinces to participate in national shared-cost programs such as medicare. However, Justice Irving held that the federal government was not acting beyond its jurisdiction when it imposed conditions on its transfers to the provinces. Rather, he concluded that such conditions created "legitimate national standards", and that the existence of federal shared-cost programs, such as the national health insurance scheme established under the *Canada Health Act*, was explicitly recognized under section 36 of the *Constitution Act, 1982*.¹⁵ The constitutional validity of such federal spending was confirmed by the Supreme Court of Canada in its 1991 decision in *Reference Re Canada Assistance Plan*¹⁶ and reaffirmed, with regard to the *Canada Health Act* in particular, in the Court's recent decision in *Eldridge v. British Columbia (A.G.)*.¹⁷

¹¹Section 91(1A) grants Parliament the power to legislate in relation to "the public debt and property"; section 91(3) grants Parliament the power to legislate in relation to "the raising of money by any mode or system of taxation"; and section 106 sets out Parliament's power to appropriate funds for federal purposes.

¹²R.S.C. 1985, c. C-6. See generally D. Gibson, "The *Canada Health Act* and the Constitution" (1996) 4 Health L. J. 1; J. Maziade, "L'imposition du ticket modérateur dans le système de santé des provinces: qui décide? Le gouvernement fédéral ou le gouvernement provincial?" (1995) 26 R.D.U.S. 134.

¹³(1988), 53 D.L.R. (4th) 413 (Alta. C.A.), leave to appeal to S.C.C. refused 55 D.L.R. (4th) viii.

¹⁴R.S.C. 1985, c. C-1.

¹⁵*Winterhaven Stables v. Canada (A.G.)*, *supra* note 13 at 433-34. Section 36 sets out a commitment by the federal and provincial governments to: "promoting equal opportunities for the well-being of Canadians;" "furthering economic development to reduce disparity of opportunities;" and "providing essential public services of reasonable quality to all Canadians."

¹⁶[1991] 1 S.C.R. 525 at 567.

¹⁷*Supra* note 10 at 647. The *Eldridge* case involved a successful challenge, under section 15 of the *Canadian Charter of Rights and Freedoms*, to British Columbia's failure to provide sign language interpretation services for the deaf under the province's health and hospital insurance regime. For a discussion of the *Eldridge* case see M. Jackman, "Giving Real Effect to Equality: *Eldridge v. B.C.*

The *Canada Health Act* represents a classic exercise of the federal spending power.¹⁸ The *Act* establishes a number of conditions which the provinces must meet in order to be eligible for federal cash contributions towards provincial health insurance costs, pursuant to Canada Health and Social Transfer provisions of the *Federal Provincial Fiscal Arrangements Act*.¹⁹ These conditions, set out under section 7 of the *Canada Health Act*, include the requirements that provincial health insurance plans be comprehensive, universal, portable, publicly administered, and accessible.²⁰ Because compliance with the terms and conditions of the *Act* is entirely voluntary (the only penalty being the withholding of federal funds), the legislation is constitutionally unobjectionable.

Aside from the *Canada Health Act*, the spending power provides the constitutional basis for a number of federal health promotion and health research-related initiatives, primarily under the aegis of Health Canada,²¹ such as the National AIDS Strategy,²² the Canadian Institute for Health Information and the Canadian Institutes for Health Research.²³ Federal health spending also takes place through the income tax system, most notably through the individual medical expense deduction under the federal *Income Tax Act*.²⁴

(A.G.) and *Vriend v. Alberta*" (1998) 4 Rev. of Constitutional Studies 352.

¹⁸For a discussion of the history and functioning of the *Canada Health Act* see, M.G. Taylor, *Health Insurance and Canadian Public Policy* (Montreal: McGill-Queen's University Press, 1987); A. Crichton & D. Hsu, *Canada's Health Care System: Its Funding and Organization* (Ottawa: Canadian Hospital Association Press, 1990); Canadian Bar Association Task Force on Health Care, *What's Law Got to do With It? Health Care Reform in Canada* (Ottawa: Canadian Bar Association, 1994).

¹⁹R.S.C. 1985, c. F-8. For a recent description of the structure of federal funding under the *Canada Health Act* see Auditor General of Canada, *Report of the Auditor General of Canada to the House of Commons, 1999 – Chapter 29: Federal Support of Health Care Delivery*, *supra* note 2.

²⁰For a review of the conditions under the *Canada Health Act* and their enforcement, see C.M. Flood, "The Structure and Dynamics of Canada's Health Care System" in J. Downie & T. Caulfield, eds., *Canadian Health Law and Policy* (Toronto: Butterworths, 1999) at 18-29; S. Choudhry, "The Enforcement of the Canada Health Act" (1996) 41 McGill L. J. 461.

²¹Within Health Canada, the Health Protection Branch conducts intramural research in the areas of environmental health, food safety, and the safety of drugs and other related products. The Laboratory Centre for Disease Control, also located in the Health Protection Branch, conducts research in disease identification, prevention and control; online: Health Canada <www.ch-sc.gc.ca/english/about.htm> (date accessed: 22 February 2000).

²²See generally Health Canada, *National AIDS Strategy Progress Report 1996-97* (Ottawa: Health Canada, 1997); Health Canada, *Towards a Canadian Strategy on HIV/AIDS* (Ottawa: Health Canada, September 1997).

²³A newly created federal research agency, replacing the former Medical Research Council of Canada, the Canadian Institutes for Health Research is responsible for funding clinical and basic science research as well as social science research related to health. Its budget of \$402 million in 2000-2001 is projected to rise to \$533 million in 2001-2002; online: Canadian Institute for Health Research <www.cihr.ca/about_cihr/who_we_are/fold_e.shtml> (date accessed: 15 June 2000).

²⁴R.S.C. 1985 (5th supp.), c.1, s. 118.2.

2. The Federal Criminal Law Power

The courts have granted Parliament a large degree of latitude in the exercise of its criminal law power under section 91(27) of the *Constitution Act, 1867*.²⁵ As Justice Estey explained in *Scowby v. Glendinning*: “The terms of s. 91(27) of the Constitution must be read as assigning to Parliament exclusive jurisdiction over criminal law in the widest sense of the term.”²⁶ While the exercise of the federal criminal law power cannot amount to a disguised attempt to regulate matters unrelated to the criminal law,²⁷ the courts have held that federal legislation enacted pursuant to the criminal law power can be preventive or punitive,²⁸ can include dispensations and exemptions,²⁹ can determine the extent of blameworthiness,³⁰ can provide for functionally related civil remedies,³¹ and can create new crimes.³² So, for example, in *R. v. Cossman’s Furniture (1972) Ltd.* the Manitoba Court of Appeal ruled that provisions of the federal *Hazardous Products Act*³³ regulating infant cribs were directed at ensuring the security and health of infants, and so were a valid exercise of the federal criminal law power.³⁴ In *R. v. Wetmore*, the Supreme Court of Canada held that the provisions of the federal *Food and Drugs Act*³⁵ relating to the safety of food,³⁶ drugs and medical devices, were supportable under the criminal law power, inasmuch as they were directed at protecting the “physical health and safety of the public.”³⁷ In its 1988 decision in *R. v. Morgentaler*,³⁸ the

²⁵Section 91(27) grants Parliament the power to legislate in relation to “the criminal law, except the constitution of courts of criminal jurisdiction, but including the procedure of criminal matters.” Section 91(27) provides the constitutional basis for the federal Criminal Code, R.S.C. 1985, c. C-46.

²⁶[1986] 2 S.C.R. 226 at 238. The prevailing test for determining the validity of legislation enacted under the criminal law power was put forward by Justice Rand in *Reference Re s. 5(a) of the Dairy Industry Act (Margarine Reference)*, [1949] S.C.R. 1 at 49-50, in the following terms:

A crime is an act which the law, with appropriate penal sanctions, forbids; but as prohibitions are not enacted in a vacuum, we can properly look for some evil or injurious or undesirable effect upon the public against which the law is directed ... Is the prohibition then enacted with a view to a public purpose which can support it as being in relation to the criminal law? Public peace, order, security, health, morality: these are the ordinary though not exclusive ends served by that law.

²⁷*Reference Re s. 5(a) of the Dairy Industry Act, ibid*; *A.G. Ontario v. Reciprocal Insurers*, [1924] A.C. 328 (P.C.).

²⁸*R. v. Swain*, [1991] 1 S.C.R. 933 at 999.

²⁹*Morgentaler v. R.*, [1976] 1 S.C.R. 616 at 627; *R. v. Furtney*, [1991] 3 S.C.R. 89 at 106-7.

³⁰*R. v. Hydro Quebec*, [1997] 3 S.C.R. 213 at para. 120.

³¹*R. v. Zelensky*, [1978] 2 S.C.R. 940.

³²*Proprietary Articles Trade Association v. Attorney-General for Canada*, [1931] A.C. 310 (P.C.) at 323-24; *Goodyear Tire and Rubber Co. v. The Queen*, [1956] S.C.R. 303 at 311.

³³R.S.C. 1985, c. H-3.

³⁴(1976), 73 D.L.R. (3d) 312 (Man. C.A.) at 314-15.

³⁵R.S.C. 1985, c. F-27.

³⁶The criminal law power as a basis for federal regulation of food adulteration in the interests of protecting public health was discussed in *Standard Sausage Co. v. Lee*, [1933] 4 D.L.R. 501 (B.C.C.A.) at 506-7; and in *Berryland Canning Co. v. The Queen*, [1974] 1 F.C. 91 (T.D.).

³⁷[1983] 2 S.C.R. 284 at 288. In his judgment for the Court, and in contrast to Justice Estey’s reasoning in the earlier case of *Labatt Breweries v. A.G. Canada*, [1980] 1 S.C.R. 914, Chief Justice Laskin suggests, at 288-89, that comprehensive regulation of the pharmaceutical industry could also be upheld

Supreme Court held that the federal government had jurisdiction to enact therapeutic abortion provisions under the federal *Criminal Code*, although the Court went on to find that the abortion provisions violated the *Canadian Charter of Rights and Freedoms*, and declared them unconstitutional on that basis.³⁹

The scope of the federal criminal law power in relation to health was addressed in depth by the Supreme Court in its decision in *RJR-MacDonald Inc. v. Canada (A.G.)*,⁴⁰ a case involving the constitutionality of the federal *Tobacco Products Control Act*⁴¹ under the *Constitution Act, 1867* and under the *Charter*.⁴² The *Act*, which prohibited tobacco advertising and promotional activities and the sale of tobacco products in packages which did not display the requisite health warnings, was challenged by the RJR-MacDonald and Imperial Tobacco companies as an attempt to regulate advertising – a matter of provincial jurisdiction under section 92(13). In its decision in the case, the Québec Superior Court agreed with the tobacco manufacturers' characterization of the *Act*, and struck it down.⁴³ On appeal,⁴⁴ the Québec Court of Appeal found that the *Tobacco Products Control Act* was not a legitimate exercise of the federal criminal law power, but decided that it could be upheld under the federal peace, order and good government power.⁴⁵ On the issue of the *Act's* validity as criminal law the Court of Appeal found that, while Parliament was clearly seeking to protect public health, neither the activities directly prohibited by the *Act* nor smoking itself were matters having a sufficient "affinity with some traditional criminal law concern."⁴⁶

Rendering the majority decision for the Supreme Court of Canada on the division of powers issue, Justice La Forest declined to address the question whether the *Tobacco Products Control Act* could be justified under the federal peace, order and good government power, and found instead that the *Act* was a valid exercise of

under the federal trade and commerce power; see N. Finkelstein, "Constitutional Law - Section 91(2) of the Constitution Act, 1867 - Competition Legislation" (1984) 62 Can. Bar Rev. 183 at 194-95.

³⁸[1988] 1 S.C.R. 30.

³⁹For a review of this aspect of the case see S. Rodgers, "State Intervention in the Lives of Pregnant Women" in J. Downie & T. Caulfield, eds., *Canadian Health Law and Policy*, supra note 20 at 278-80.

⁴⁰[1995] 3 S.C.R. 199 [hereinafter *RJR-MacDonald*].

⁴¹S.C. 1988, c. 20.

⁴²As discussed below, a majority of the Supreme Court of Canada held that the *Tobacco Products Control Act* was a valid exercise of the criminal law power, but found that it interfered with freedom of expression under section 2(b) of the *Charter* and could not be justified under section 1. For an analysis of this aspect of the case, see R. Cunningham, "R.J.R.-MacDonald Inc. v. Canada (A.G.): Reflections from the Perspective of Health" (1995) 40 McGill L. J. 229; R. Moon, "RJR MacDonald v. Canada on the Freedom to Advertise" (1995) 7 Constitutional Forum 1.

⁴³*Imperial Tobacco Ltd. c. Canada (Procureur Général)*, [1991] R.J.Q. 2260 (Sup. Ct).

⁴⁴*Canada (Procureur général) c. R.J.R.-MacDonald Inc.*, [1993] R.J.Q. 375 (C.A.).

⁴⁵See the discussion on the peace, order and good government power in Part 3, below.

⁴⁶*Canada (Procureur général) c. R.J.R.-MacDonald Inc.*, supra note 44 at 410, citing *Reference Re s. 5(a) of the Dairy Industry Act*, supra note 26.

the federal criminal law power.⁴⁷ Justice La Forest described Parliament's criminal law jurisdiction over matters of health in the following terms: "The scope of the federal power to create criminal legislation with respect to health matters is broad, and is circumscribed only by the requirements that the legislation must contain a prohibition accompanied by a penal sanction and must be directed at a legitimate public health evil."⁴⁸ In Justice La Forest's view, the federal government's purpose in enacting the *Tobacco Products Control Act* was the reduction of tobacco consumption and the protection of public health. Since the legislation was directed at a public health evil: smoking, and contained prohibitions accompanied by penal sanctions,⁴⁹ Justice La Forest concluded that the *Act* fell squarely within section 91(27).

In coming to this conclusion Justice La Forest rejected the arguments, advanced by the tobacco companies and supported by Justice Major in his dissenting opinion,⁵⁰ that the *Act* was not valid criminal law because it prohibited conduct which was not of traditional criminal law concern; that tobacco advertising and promotion could not be criminalized when the underlying activity (smoking) remained legal; and that, in view of the various exemptions which it contained, the *Act* was more properly characterized as regulatory rather than criminal in nature.⁵¹ Responding to these objections, Justice La Forest argued that the fact that smoking and tobacco advertising were not illegal in the past in no way precluded Parliament from criminalizing either of the activities today;⁵² that in attempting to address tobacco's harmful health effects, Parliament was free to choose the legislative method it deemed most feasible;⁵³ and that the exemptions set out under the *Act* did not detract from the criminal nature of the legislation, but rather, helped to clarify the contours of the new crime – "the advertisement and promotion of tobacco products offered for sale in Canada."⁵⁴

Following its decision in *RJR-MacDonald*, the Supreme Court confirmed Parliament's ability to rely on its criminal law power to justify broader forms of health regulation in *R. v. Hydro-Québec*.⁵⁵ The case involved a challenge by Hydro-Québec to the regulation of PCBs under the *Canadian Environmental Protection*

⁴⁷*RJR-MacDonald*, *supra* note 40 at 267. For an analysis of this aspect of the case, see A.C. Hutchinson & D. Schneiderman, "Smoking Guns: The Federal Government Confronts the Tobacco and Gun Lobbies" (1995) 7 Constitutional Forum 16.

⁴⁸*RJR-MacDonald*, *ibid.* at 246.

⁴⁹The penalties under the *Act* ranged from \$2,000 to \$100,000 in fines and from six months to two years imprisonment; *Tobacco Products Control Act*, *supra* note 41 ss. 18, 19.

⁵⁰*RJR-MacDonald*, *supra* note 40 at 361-64.

⁵¹*Ibid.* at 258-67.

⁵²*Ibid.* at 260-61.

⁵³*Ibid.* at 263.

⁵⁴*Ibid.* at 266.

⁵⁵*Supra* note 30. For a comment on the *Hydro-Québec* case, see J. Leclair, "The Supreme Court, the Environment, and the Construction of National Identity: *R. v. Hydro-Québec*" (1998) 4 Review of Constitutional Studies 372.

Act. In rejecting Hydro-Québec's claim that the environmental controls contained in the *Act* touched upon matters of provincial jurisdiction, Justice La Forest asserted that the goal of protecting human health supported federal regulation of toxic substances under the criminal law power.

The Supreme Court's reasoning in *RJR-MacDonald* and in *Hydro-Québec* provides considerable scope for future federal legislation aimed at controlling activities which put human health at risk, including those which have historically been perceived as entirely legitimate in nature. As Justice La Forest's decision makes clear, the federal government may not only exercise its criminal law power in emerging areas of public health concern, it may also invoke section 91(27) in support of regulatory schemes which, like the *Tobacco Products Control Act*, are relatively detailed and complex in their structure, penalties and scope. In this regard, the *RJR-MacDonald* decision represents an important departure from the earlier view⁵⁶ that legislation of a regulatory rather than more strictly prohibitive form could not be justified under section 91(27). By allowing for a regulatory approach to public health issues under section 91(27), the decision significantly expands the potential for federal reliance on the criminal law power in the area of health.

3. The Peace, Order and Good Government Power

The federal peace, order and good government (POGG) power is a residual power found in the opening paragraph of section 91 of the *Constitution Act, 1867*.⁵⁷ The courts have identified two situations in which the peace, order and good government power will support federal legislative action. First, under the "emergency" branch of the peace, order and good government power, Parliament may adopt temporary legislation dealing with matters of national urgency.⁵⁸ In *Toronto Electric Commissioners v. Snider*⁵⁹ and in *Attorney General for Ontario*

⁵⁶*R. v. Hauser*, [1979] 1 S.C.R. 984 at 999; *RJR-MacDonald*, *supra* note 40 at 364, Major J.

⁵⁷The preamble of section 91 provides that: "It shall be lawful for the Queen, by and with the advice and consent of the Senate and House of Commons, to make laws for the peace, order and good government 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."

⁵⁸In his judgment in *Reference Re Anti-Inflation Act*, [1976] 2 S.C.R. 373 at 436, Justice Ritchie described the circumstances which would warrant federal reliance on the national emergency branch of the peace, order and good government power as follows:

In my opinion such conditions exist where there can be said to be an urgent and critical situation adversely affecting all Canadians and being of such proportions as to transcend the authority vested in the Legislatures of the Provinces and thus presenting an emergency which can only be effectively dealt with by Parliament ... The authority of Parliament in this regard is, in my opinion, limited to dealing with critical conditions and the necessity to which they give rise and must perforce be confided to legislation of a temporary character.

⁵⁹[1925] A.C. 396 (P.C.) at 412.

v. *Canada Temperance Foundation*,⁶⁰ the Privy Council referred to an epidemic as an example of a situation which might warrant federal intervention under the emergency power. As Viscount Simon explained:

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.⁶¹

In addition to emergency situations, under the “national concern” branch of the peace, order and good government power, Parliament can regulate matters going beyond local or provincial interest, which are inherently the “concern of the Dominion as a whole.”⁶²

In *R. v. Schneider*, Justice Laskin made reference to a national concern based field of federal health jurisdiction under the peace, order and good government power “directed to the protection of national welfare.”⁶³ In his decision in the *Schneider* case Justice Estey described this federal dimension of health as follows: “[F]ederal legislation in relation to “health” can be supported where the dimension of the problem is national rather than local in nature ... or where the health concern arises in the context of a public wrong and the response is a criminal prohibition.”⁶⁴ The most recent, comprehensive review of the peace, order and good government power is found in *R. v. Crown Zellerbach Canada Ltd.*,⁶⁵ in which the Supreme Court of Canada upheld federal regulation of marine pollution as a matter of national concern. In his judgment for a majority of the Court, Justice Le Dain argued that, for a matter to qualify for federal intervention under the national concern doctrine: “it must have a singleness, distinctiveness and indivisibility that clearly distinguishes it from matters of provincial concern and a scale of impact on provincial jurisdiction that is reconcilable with the fundamental distribution of legislative power under the Constitution.”⁶⁶ In determining whether these requirements had been met, Justice La Forest held that the effect on extra-provincial

⁶⁰[1946] A.C. 193 (P.C.).

⁶¹*Ibid.* at 207-8.

⁶²*Ibid.*; *R. v. Crown Zellerbach Canada Ltd.*, [1988] 1 S.C.R. 401 [hereinafter *Crown Zellerbach*].

⁶³*R. v. Schneider*, *supra* note 10 at 114.

⁶⁴*Ibid.* at 141; see also *Reference Re s. 5(a) of the Dairy Industry Act*, *supra* note 26 at 78, where Justice Estey characterized the federal *Dairy Industry Act* as legitimate public health legislation under the peace, order and good government power.

⁶⁵*Crown Zellerbach*, *supra* note 62.

⁶⁶*Ibid.* at 432.

interests of a province's failure to deal effectively with the intra-provincial aspects of the matter in question would be of particular relevance.⁶⁷

The criteria put forward by Justice Le Dain in the *Crown Zellerbach* case were applied by the Québec Court of Appeal in its ruling on the constitutionality of the *Tobacco Products Control Act* in the *RJR-MacDonald* case.⁶⁸ As discussed above, the tobacco manufacturers challenged the federal *Act* on the grounds that its true object was the regulation of tobacco advertising, a matter of exclusive provincial jurisdiction. Like the Supreme Court of Canada, the Québec Court of Appeal rejected this characterization of the federal legislation, arguing instead that the object of the *Act* was the control of tobacco advertising in the interests of protecting public health.⁶⁹ Speaking for a majority of the Court of Appeal on the division of powers issue, Justice Brossard emphasized that, in keeping with the Supreme Court's reasoning in *Crown Zellerbach*, a simple desire to achieve legislative uniformity, or a concern about the possibility of a legislative patchwork absent federal intervention, were not sufficient to justify reliance on the peace, order and good government power.⁷⁰ However, Justice Brossard found that, in the broader context of public health, smoking and tobacco advertising were matters of national concern which met the criteria put forward by Justice La Forest in *Crown Zellerbach*, in terms of the distinct and uniform nature of the health problems created.⁷¹ Justice Brossard argued further that, while the provinces were capable of adopting similar legislation, a failure by one province to legislate with regard to tobacco advertising would compromise the interests of residents elsewhere, since such advertising would necessarily spill over into other provinces. On that basis the Québec Court of Appeal concluded that federal intervention in this area of public health was necessary and justifiable under the peace, order and good government power.⁷²

As discussed earlier, in his decision for the Supreme Court of Canada in the *RJR-MacDonald* case, Justice La Forest declined to address the issue of whether the *Tobacco Products Control Act* could be upheld under the peace, order and good government power, but instead relied on the federal criminal law power. In the Supreme Court's recent decision in *R. v. Hydro-Québec*,⁷³ Justice La Forest again held that it was unnecessary to decide whether the peace, order and good government power could support federal regulation of PCB's and other environmental contaminants under the *Canadian Environmental Protection Act*,

⁶⁷*Ibid.*

⁶⁸*Canada (Procureur général) c. R.J.R.MacDonald Inc.*, *supra* note 44. For a comment on the Court of Appeal decision see J. Leclair, "La théorie des dimensions nationales: une boîte à phantasmes: *Canada (Procureur général) c. R.J.R.-MacDonald Inc.*" (1993) 72 Can. Bar Rev. 524.

⁶⁹*Canada v. R.J.R.-Macdonald Inc.*, *ibid.* at 381-82.

⁷⁰*Ibid.* at 387-88.

⁷¹*Ibid.* at 415.

⁷²*Ibid.* at 388-89.

⁷³*Supra* note 30.

since he considered the federal legislation to be justified under the criminal law power. Justice La Forest did, however, caution against a too ready reliance on the peace, order and good government power, out of concern that this could radically alter the existing division of powers between the federal government and the provinces.⁷⁴

The Supreme Court's decision in the *Schneider* case suggests that the federal government has the power to regulate matters of national health and welfare, *per se*, under the peace, order and good government power.⁷⁵ The *Crown Zellerbach* decision also leaves room for the argument that particular issues of national public health are susceptible to federal regulation under the peace, order and good government power, provided they meet the specific criteria set out by Justice Le Dain in the case. However, the Supreme Court's reasoning in the *RJR-MacDonald* and *Hydro-Québec* decisions make it far more likely that the federal government will invoke its criminal, rather than the peace, order and good government, power as a basis for future federal intervention in the field of health. For instance, while the Royal Commission on New Reproductive Technologies (NRT) relied heavily on the peace, order and good government power in support of its recommendations for extensive federal intervention in the field of NRTs,⁷⁶ the legislation subsequently proposed by the federal government to regulate new reproductive and genetic technologies was grounded almost exclusively in the criminal law power.⁷⁷

⁷⁴For their part, the dissenting judges in the *Hydro-Québec* case rejected both the criminal law and the peace, order and good government powers as a basis for the *Canadian Environmental Protection Act*; *ibid.* at 244-266.

⁷⁵For an argument that the peace, order and good government power also provides constitutional support for the *Canada Health Act*, see Gibson, "The *Canada Health Act* and the Constitution", *supra* note 12 at 20-30.

⁷⁶Royal Commission on New Reproductive Technologies, *Proceed With Care: Final Report of the Royal Commission on New Reproductive Technologies*, Vol. 1 (Ottawa: Minister of Government Services Canada, 1993) at 19-22; see also M. Jackman, "The Constitution and the Regulation of New Reproductive Technologies" in *Overview of Legal Issues in New Reproductive Technologies*, Vol. 3 of the Research Studies of the Royal Commission on New Reproductive Technologies (Ottawa: Minister of Supply and Services Canada, 1993). For a critique of the argument that the peace, order and good government power can support federal regulation of NRTs, see P. Healy, "Statutory Prohibitions and the Regulation of New Reproductive Technologies under Federal Law in Canada" (1995) 40 McGill L.J. 905 at 915-19.

⁷⁷Bill C-47, *Human Reproductive and Genetic Technologies Act*, 2nd Sess., 35th Parl., 1996; see also Government of Canada, *New Reproductive and Genetic Technologies: Setting Boundaries, Enhancing Health* (Ottawa: Minister of Supply and Services Canada, 1996); Health Canada, *Reproductive and Genetic Technologies Overview Paper (Working Draft)* (Ottawa: Health Canada, December, 1999) at 19; R. Mykitiuk & A. Wallrap, "Regulating Reproductive Technologies in Canada" in *Canadian Health Law and Policy*, *supra* note 20 at 315-19.

4. Aboriginal Health

Under section 91(24) of the *Constitution Act, 1867*, Parliament has constitutional authority over “Indians, and Lands reserved for the Indians”.⁷⁸ The federal *Indian Act*⁷⁹ and the *Indian Health Regulations*⁸⁰ deal directly with the delivery of health services to status Indians living on reserves.⁸¹ The scope of federal responsibility for Aboriginal health is, however, a matter of ongoing debate between Aboriginal groups, the federal, and provincial governments, particularly as regards off-reserve health and services for Métis and non-status Indians.⁸² Aboriginal groups characterize the provision of health services by the federal government as a treaty right. A direct reference to the obligations of the federal Crown in this regard is found in *Treaty No. 6*, signed in 1876 between the federal government and the Cree of Central Alberta and Saskatchewan. *Treaty No. 6* provides, in relevant part:

That a medicine chest shall be kept at the house of each Indian agent for the use and benefit of the Indians at the direction of such agent. That in the event hereafter of the Indians comprised within this treaty being overtaken by any pestilence, or by a general famine, the Queen, on being satisfied and certified thereof by Her Indian Agent or Agents, will grant ... assistance of such character or to such extent as the Chief Superintendent of Indian Affairs shall deem necessary and sufficient to relieve the Indians from the calamity ... befallen them.⁸³

The significance of the *Treaty No. 6* “medicine chest” clause in terms of the federal government’s obligations to provide health services to treaty Indians was addressed by the Saskatchewan Court of Appeal in the 1971 case of *R. v.*

⁷⁸In its decision in *Re Esquimos*, [1939] S.C.R. 104, the Supreme Court interpreted section 91(24) to include Inuit. Métis people have long argued that they should also be included within the term “Indian” under section 91(24).

⁷⁹R.S.C. 1985, c. I-6. The *Indian Act* was first enacted in 1876, and substantially revised in 1951. See generally J. Woodward, *Native Law*, looseleaf (Toronto: Carswell, 1989).

⁸⁰*Indian Health Regulations*, C.R.C., c. 955 (1978).

⁸¹For an account of the evolution of the delivery of health services to Aboriginal people in Canada, see G. Graham-Cumming, “Health of the Original Canadians, 1867-1967” (1967) 23 *Med. Serv. J. Can.* 115; T.K. Young, “Indian Health Services in Canada: A Sociohistorical Perspective” (1984) 18 *Soc. Sc. & Med.* 257; Canadian Medical Association, *Bridging the Gap: Promoting Health and Healing for Aboriginal Peoples in Canada* (Ottawa: The Canadian Medical Association, 1994) at 49-55. For a general overview of Aboriginal health issues, see Medical Services Branch, Health Canada, *Aboriginal Health in Canada* (Ottawa: Medical Services Branch, Health Canada, 1994); H.L. MacMillan *et al.*, “Aboriginal health” (1996) 155 *C.M.A. J.* 1569.

⁸²See Royal Commission on Aboriginal Peoples, *Gathering Strength: Volume 3 of the Report of the Royal Commission on Aboriginal Peoples* (Ottawa: Supply and Services Canada, 1996) at 247-53; Canadian Medical Association, *Bridging the Gap: Promoting Health and Healing for Aboriginal Peoples in Canada*, *ibid.* at 24.

⁸³See generally P.A. Barkwell, “The Medicine Chest Clause in Treaty No. 6” (1981) 4 *C.N.L.R.* 1.

Swimmer.⁸⁴ The Respondent, a status Indian living off-reserve in Saskatchewan, was charged with failure to pay the province's medical and hospital insurance premiums. At trial, the judge found that, as a beneficiary of *Treaty No. 6*, the Respondent was entitled to receive all medical services, including medicine, drugs, medical supplies and hospital care free of charge, and was therefore exempt from paying provincial health insurance premiums. In his decision for the Saskatchewan Court of Appeal, Justice Culliton rejected this interpretation of the *Treaty*, arguing that:

The clause itself does not give to the Indian an unrestricted right to the use and benefits of the "medicine chest" but such rights as are given are subject to the direction of the Indian agent ... I can find nothing historically, or in any dictionary definition, or in any legal pronouncement, that would justify the conclusion that the Indians, in seeking and accepting the crown's obligation to provide a 'medicine chest' had in contemplation provision of all medical services, including hospital care.⁸⁵

Justice Culliton concluded that *Treaty No. 6* did not impose an obligation on the federal government to provide medical and hospital services to all Indians, nor did any federal legislation. On that basis he found that the respondent was subject to the provisions of the Saskatchewan *Hospitalization Act* and the *Medical Care Insurance Act*, and so obliged to pay the provincial premiums provided for under the legislation.⁸⁶

The Manitoba Court of Appeal came to a similar conclusion, that status Indians in Manitoba were subject to that province's *Hospital Services Insurance Act*, in its decision in *Manitoba Hospital Commission v. Klein and Spence*.⁸⁷ In that case the Respondent argued that, while she was an "insured person" within the meaning of the Manitoba hospital insurance legislation, Indians had traditionally been supplied with hospital services free of charge by the federal government, and thus could not be expected to pay for such services under provincial legislation. The Court of Appeal rejected this argument on the grounds that the *Hospital Services Insurance Act* was a law of general application within the meaning of section 88 of the *Indian Act*,⁸⁸ and thus applied to all residents of the province, including Indians. On that basis, the Court of Appeal concluded that the Respondent was liable for payment for any hospital care which she received.⁸⁹

⁸⁴[1971] 1 W.W.R. 756 (Sask. C.A.).

⁸⁵*Ibid.* at 759-60.

⁸⁶*Ibid.* at 760.

⁸⁷(1969), 70 W.W.R. 79 (Man. C.A.).

⁸⁸Section 88 of the *Indian Act* provides that: "Subject to the terms of any treaty and any other Act of the Parliament of Canada, all laws of general application from time to time in force in any province are applicable to and in respect of Indians in the province, except to the extent that such laws are inconsistent with this Act..."

⁸⁹*Manitoba Hospital Commission*, *supra* note 87 at 80.

Beyond the health and hospital insurance context, provincial health legislation was also found to apply to Indians in the 1907 case of *R. v. Hill*.⁹⁰ There the Ontario Court of Appeal held that an Ontario law which restricted the practice of medicine to licensed physicians applied equally to Indians, and found the aboriginal defendant guilty of the unauthorized practice of medicine. More recently, in *Westbank First Nation v. British Columbia (Labour Relations Board)*,⁹¹ the B.C. Supreme Court held that labour relations in a long-term care facility owned and operated on behalf of the Westbank First Nation in British Columbia were a matter of provincial rather than federal jurisdiction. The Court came to that conclusion on the basis that less than a third of the residents of the home were First Nations patients, and that the mandate of the home was to provide intermediate care to a much wider population. However, the Federal Court of Canada came to the opposite conclusion with regard to jurisdiction over labour relations in an aboriginal alcohol rehabilitation facility in its decision in *Sagkeeng Alcohol Rehab Centre Inc. v. Abraham*.⁹² The Court held that labour relations at the Sagkeeng Alcohol Rehab Centre, located on the Fort Alexander Reserve in Manitoba and funded by Health Canada under the National Native Alcohol and Drug Abuse Program, were a matter of federal jurisdiction under section 91(24). In Justice Rothstein's view:

The fact that the rehabilitation centre is organized and operated primarily for Indians, governed solely by Indians, that its facilities and services are intended primarily for Indians, that its staff are specially trained under the [National Native Alcohol and Drug Abuse Program] and receive First Nations training, and that its rehabilitation program, curriculum and materials are designed for Indians, all serve to identify the inherent "Indianness" of the centre and link it to Indians.⁹³

While the federal government now provides status Indians living on and off reserve access to general health and hospital care through provincial health insurance regimes, the Medical Services Branch of Health Canada continues to directly deliver other public health services in Aboriginal communities,⁹⁴ including health promotion, immunization, dental health, and drug and alcohol prevention and treatment programs. The Medical Services Branch also provides a range of non-insured health benefits to status Indians, such as drugs, eyeglasses and transportation, as well as operating a small number of hospitals in remote areas. In 1988, the federal government established a program to facilitate the transfer of

⁹⁰(1907), 15 O.L.R. 406 (C.A.).

⁹¹[1997] B.C.J. No. 2410 (S.C.).

⁹²[1994] 3 F.C. 449 (T.D.).

⁹³*Ibid.* at 459-60.

⁹⁴The federal Department of Indian Affairs oversaw the delivery of Indian health services, from its inception in 1880, until this responsibility was taken over by the Department of Health and Welfare in 1945. The Medical Services Branch was created within the Department of Health and Welfare in 1962, with the specific mandate of providing health services to status Indians and Inuits; see T.K. Young, "Indian Health Services in Canada: A Sociohistorical Perspective", *supra* note 81.

responsibility for Indian health programs from Health Canada to Aboriginal communities,⁹⁵ and in 1998 the department reported that 170 such agreements had been signed, covering 282 of the 631 First Nations and Inuit Communities in Canada.⁹⁶

5. Other Constitutional Basis for Federal Health Regulation

Section 91(11) of the *Constitution Act, 1867* grants Parliament the power to legislate in relation to “quarantine and the establishment and maintenance of marine hospitals” – the basis for the federal *Quarantine Act*.⁹⁷ Under section 91(7) of the *Constitution Act, 1867*, Parliament has constitutional authority over the “militia, military and naval service, and defence”. Section 91(25) provides for federal jurisdiction over “naturalization and aliens”. Section 91(28) provides for federal power over “the establishment, maintenance and management of penitentiaries”. Pursuant to these provisions the federal government provides health services to members of the Canadian armed forces and veterans, to members of the Royal Canadian Mounted Police, to immigrants and refugees at certain stages of the immigration process, and to inmates in federal penitentiaries. Under section 91(22) of the *Constitution Act, 1867*, Parliament has jurisdiction over “patents of invention and discovery”. Section 91(22), along with Parliament’s criminal law power under section 91(27), provides the constitutional basis for federal regulation of the pricing of patented medicines by the Patented Medicine Prices Review Board, established under the *Patent Act*.⁹⁸

The federal treaty-making power, a prerogative power belonging to the federal executive, provides the basis for a range of federal health-related initiatives in the international area.⁹⁹ While the power to ratify international treaties is a federal one, in its decision in the 1937 *Labour Conventions Reference*, the Privy Council held that jurisdiction to implement such agreements is divided between Parliament and the provincial legislatures according to the subject matter of the treaty in question.¹⁰⁰ The Supreme Court of Canada has since suggested that this decision may be open to review, and that Parliament may be empowered to enact treaty-

⁹⁵See Medical Services Branch, Health Canada, *Transfer of Health Services* (Ottawa: Medical Services Branch, Health Canada, 1994); Health and Welfare Canada, *Health Status of Canadian Indians and Inuit - 1990* (Ottawa: Minister of Supply and Services Canada, 1991) at 8-9.

⁹⁶See Health Canada, *Performance Report for the period ending March 31, 1998* (Ottawa: Ministry of Public Works and Government Services Canada, 1998) at 35; see also Health Canada, *Performance Report for the period ending March 31, 1999* (Ottawa: Ministry of Public Works and Government Services Canada, 1999) at 63-71.

⁹⁷R.S.C. 1985, c. Q-1.

⁹⁸R.S.C. 1985, c. P-4.

⁹⁹For a discussion of the source and scope of the federal treaty making power, see generally, P.W. Hogg, *Constitutional Law of Canada*, 4th ed., looseleaf (Scarborough, Ont.: Carswell, 1997) at 11.2-11.5.

¹⁰⁰*A.G. Canada v. A.G. Ontario (Labour Conventions Reference)*, [1937] A.C. 326 (P.C.) at 351.

implementing legislation in areas otherwise of provincial concern.¹⁰¹ However, in the *Schneider* case, the Supreme Court emphasized that, assuming Parliament does have such power, its exercise “must be manifested in the implementing legislation and not be left to inference.”¹⁰²

The federal government has ratified several international agreements touching upon matters of health. For example Article 12(1) of the *International Covenant on Economic, Social and Cultural Rights (ICESCR)*,¹⁰³ ratified by Canada in 1978, recognizes “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” Article 12(2)(d) of the *ICESCR* sets out States parties’ obligations to take all steps necessary for “the creation of conditions which would assure to all medical service and medical attention in the event of sickness.” In similar terms, Article 24 of the *Convention on the Rights of the Child*, ratified by Canada in 1992, guarantees children the right to “the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health.”¹⁰⁴ The Canadian government also participates in international health research and health promotion initiatives through domestic and international organizations, such as the Canadian International Development Agency and the World Health Organization.

B. Provincial Jurisdiction over Health

As described at the outset of the paper, individual and public health were considered by the drafters of the 1867 *Constitution* to be matters of local rather than national concern. While “health” is not an expressly enumerated subject under section 91 or 92 of the *Constitution Act, 1867*, section 92(7) grants the provinces exclusive jurisdiction in relation to the establishment, maintenance and management of hospitals. Section 92(13) and section 92(16) provide for provincial jurisdiction over “property and civil rights” and “local or private” matters in the province. Taken together, these provisions give the provinces primary constitutional responsibility for health care and health care services in Canada.

1. Hospitals

Section 92(7) grants the provinces legislative authority in relation to “the establishment, maintenance, and management of hospitals, charities and eleemosynary institutions in and for the province, other than marine hospitals.”

¹⁰¹*MacDonald v. Vapour Canada Ltd.*, [1977] 2 S.C.R. 134 at 162-72. For a discussion of this issue see R. Sullivan, “Jurisdiction to Negotiate and Implement Free Trade Agreements in Canada: Calling the Provincial Bluff” (1987) 24 U.W.O.L. Rev. 63.

¹⁰²*Supra* note 10 at 135.

¹⁰³*International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, Can. T.S. 1976 No. 46.

¹⁰⁴*Convention on the Rights of the Child*, 20 November 1989, Can. T.S. 1992 No. 3.

Provincial jurisdiction under section 91(7) extends to all aspects of the operation of public and privately owned health care facilities within the province, including acute and chronic care hospitals, psychiatric institutions, nursing homes, and other health care facilities. So for instance, in *Fawcett v. Attorney General for Ontario*, the Supreme Court of Canada held that provisions of the Ontario *Mental Hospitals Act*, allowing for the involuntary confinement of persons declared to be mentally ill was justifiable under section 92(7) and did not impinge upon the federal criminal law power.¹⁰⁵ Similarly, in *Carruthers v. Therapeutic Abortion Committees* the Federal Court of Appeal held that, since the regulation and control of hospitals was clearly a provincial matter, the appointment of therapeutic abortion committees also fell within provincial jurisdiction, even though such committees were granted decision-making powers under the therapeutic abortion provisions of the federal *Criminal Code*.¹⁰⁶

Provincial legislation enacted pursuant to section 92(7) governs the establishment and management of public hospitals, including provincially owned psychiatric institutions. Provincial legislation also regulates the administration of privately owned facilities such as private diagnostic clinics and nursing homes. Provincial laws touch upon such diverse matters as hospital funding, licensing, maintenance and inspections; governing structures and management procedures; treatment standards and practices; the rights of patients and hospital workers; staffing requirements, including physician privileges; and the creation, retention and confidentiality of hospital health records.

2. Property and Civil Rights and Matters of a Local or Private Nature

Section 92(13) of the *Constitution Act, 1867*, empowers the provinces to legislate with respect to “property and civil rights in the province” and section 92(16) authorizes provincial regulation of “generally all matters of a merely local or private nature in the province.” The property and civil rights power supports provincial regulation of most legal relationships between individuals, including those traditionally governed by civil and common law property, contract and tort law principles.¹⁰⁷ Together with the provincial power over hospitals under section 92(7), sections 92(13) and (16) have been read by the courts as granting the provinces primary constitutional authority over matters of public and individual health. As Justice Dickson put it in *Schneider*: “Th[e] view that the general

¹⁰⁵[1964] S.C.R. 625 at 630.

¹⁰⁶(1983), 6 D.L.R. (4th) 57 (F.C.A.) at 63-64.

¹⁰⁷See generally *Citizens Insurance Company of Canada v. Parsons* (1882), 7 A.C. 96 (P.C.); *Toronto Electric Commissioners v. Snider*, [1925] A.C. 396 (P.C.). Pursuant to section 92(13), the provinces have enacted consumer protection, employment standards, and occupational health and safety legislation. Workers' compensation regimes have also been put in place in all provinces to deal with employment related illness and injuries. Under sections 92(13) and (16) the provinces have adopted wide ranging family and social welfare legislation, which have a direct bearing on individual and community health.

jurisdiction over health matters is provincial...has prevailed and is now not seriously questioned.”¹⁰⁸ *Schneider* itself involved a constitutional challenge to the British Columbia *Heroin Treatment Act*.¹⁰⁹ The appellant argued that, by authorizing the involuntary detention of heroin addicts for treatment, the B.C. legislation attempted to regulate narcotics, a matter of exclusive federal jurisdiction. The Supreme Court disagreed with this characterization of the *Act*. In the Court’s view, the provincial legislation was not intended to be punitive. Rather, the Court found that provisions allowing for the examination, apprehension and detention of drug addicts were part of a valid provincial scheme for medical treatment of drug addiction as a public health problem.¹¹⁰

Apart from specific addiction treatment legislation of the type challenged in the *Schneider* case, broader mental health statutes have been adopted in all provinces to govern the treatment of persons suffering from mental illnesses.¹¹¹ Laws dealing specifically with issues of capacity and consent exist in some provinces, and all provinces have adopted laws to provide for judicial guardianship of persons who are deemed to be mentally incompetent.¹¹² Legislation also exists in all provinces empowering coroners or medical examiners to investigate unnatural or unexplained deaths, including deaths in the health care setting.¹¹³ Public health acts and related regulations have been enacted in all provinces and territories, granting medical health officers and other provincial health authorities the power to deal with the prevention, treatment and control of communicable diseases, such as tuberculosis and sexually transmitted diseases, including AIDS.¹¹⁴

Another important dimension of the provinces’ legislative jurisdiction over health is the power to regulate health professions and practices, notably the accreditation, training,¹¹⁵ licensing and discipline¹¹⁶ of physicians, nurses and other

¹⁰⁸ *R. v. Schneider*, *supra* note 10 at 137.

¹⁰⁹ R.S.B.C. 1978, c. 24.

¹¹⁰ See also *R. v. Lenart*, [1999] 39 O.R. (3d) 55 (C.A.) where the remand for psychiatric assessment provisions of the Ontario *Mental Health Act* were found by the Ontario Court of Appeal not to infringe upon the federal criminal law power; and *Alberta v. K.B.*, [2000] A.J. No. 876 (Alta. Prov. Ct.), where provisions of Alberta’s *Protection of Children Involved in Prostitution Act*, allowing for the involuntary detention of child prostitutes in “protective safehouses”, were found to have a legitimate provincial public health objective.

¹¹¹ See H.S. Savage & C. McKague, *Mental Health Law in Canada* (Toronto: Butterworths, 1987).

¹¹² See H.A. Kaiser, “Mental Disability Law” in *Canadian Health Law and Policy*, *supra* note 20 at 217; G.B. Robertson, *Mental Disability and the Law in Canada*, 2d ed. (Toronto: Carswell, 1994).

¹¹³ For a comprehensive review of the coroner inquest system, see C. Granger, *Canadian Coroner Law* (Toronto: Carswell, 1984).

¹¹⁴ See generally J. Schultz, “Public Health Law” in B. Sneiderman, J.C. Irvine & P.H. Osborne, *Canadian Medical Law*, 2d ed. (Toronto: Carswell, 1995) at 237-50.

¹¹⁵ Together with sections 92(13) and (16), section 93 of the *Constitution Act, 1867*, which grants the provinces exclusive legislative authority over education, supports provincial oversight over health and medical education and training.

¹¹⁶ See generally L. McNamara & E. Nelson, “Regulation of Health Care Professionals” in *Canadian Health Law and Policy*, *supra* note 20 at 51-81.

health care providers, and the definition of medical and non-medical practices. In *Landers v. N.B. Dental Society*,¹¹⁷ for instance, the New Brunswick Court of Appeal rejected the argument that provisions of the *New Brunswick Dental Act*, defining “dentistry” and “dental surgery”, and penalizing those performing such work without a license, amounted to an improper provincial exercise of the federal criminal law power. Instead the Court held that the province had jurisdiction to enact the legislation as a matter of property and civil rights under section 92(13), and that such legislation was enforceable by fine or penalty, pursuant to section 92(15).¹¹⁸

In addition to the regulation of health training, accreditation, and practices, health insurance is also a matter of provincial jurisdiction.¹¹⁹ As Justice Rinfret declared in the 1936 *Unemployment Insurance Reference*, in striking down the federal government’s initial efforts to establish a national unemployment insurance scheme in the 1930s: “Insurance of all sorts, including insurance against unemployment and health insurance, have always been recognized as being exclusively provincial matters under the head “Property and Civil Rights” or under the head “Matters of a merely local or private nature in the Province.”¹²⁰ Thus, while the federal government contributes substantial funds to provincial health insurance plans pursuant to the *Canada Health Act*, the health insurance regimes themselves are administered by the provinces.

Although the provinces have wide powers in the field of health, the courts have found a number of provincial attempts to regulate abortion under guise of health care legislation to be unconstitutional. For example, in *Reference Re Freedom of Informed Choice (Abortions) Act*, the Saskatchewan Court of Appeal held that the province could not make it an offence to perform an abortion without the prior written consent of a pregnant woman’s husband or parents, because the law’s objective was to stiffen criminal law in relation to abortions – a matter for exclusive federal jurisdiction.¹²¹ After the 1988 *R. v. Morgentaler* decision,¹²² in which the Supreme Court of Canada struck down the therapeutic abortion provisions under section 251 of the *Criminal Code* on the grounds that they violated section 7 of the *Charter*, several provinces attempted to introduce new restrictions

¹¹⁷(1957), 7 D.L.R. (2d) 583 (N.B.C.A.).

¹¹⁸*Ibid.* at 587-88.

¹¹⁹*Eldridge v. British Columbia (A.G.)*, *supra* note 10 at 646.

¹²⁰*Reference Re Employment and Social Insurance Act*, [1936] S.C.R. 427 at 451. The Privy Council, in *A.G. Canada v. A.G. Ontario (Reference Re Employment and Social Insurance Act)*, [1937] A.C. 355 (P.C.), confirmed the Supreme Court of Canada’s decision that the proposed federal unemployment insurance scheme was not a legitimate exercise of the federal spending power but rather interfered with provincial jurisdiction over property and civil rights. These decisions prompted a 1940 constitutional amendment transferring jurisdiction over unemployment insurance to the federal government, under section 91(2A).

¹²¹(1986), 25 D.L.R. (4th) 751 (Sask. C.A.) at 753.

¹²²*Supra* note 38.

on access to abortion services.¹²³ In its 1993 *R. v. Morgentaler* decision,¹²⁴ the Supreme Court reviewed the constitutionality of one such attempt: Nova Scotia's *Medical Services Act* and related regulations, which prohibited the performance of abortions outside provincially approved hospitals, and denied health insurance coverage for such abortions. Doctor Henry Morgentaler opened a free standing abortion clinic in Halifax and was charged under the *Act*. In defending the legislation, the province maintained that the *Act* was designed to prevent the privatization of health services, to ensure high-quality health care, and to rationalize the delivery of medical services in the interest of containing public costs.¹²⁵ In delivering his judgment for the Supreme Court, Justice Sopinka summarized the basis and scope of provincial health jurisdiction as follows:

The provinces have general legislative jurisdiction over hospitals by virtue of s. 92(7) of the *Constitution Act, 1867*, and over the medical profession and the practice of medicine by virtue of ss. 92(13) and (16). Section 92(16) also gives them general jurisdiction over health matters within the province.¹²⁶

Having reviewed the legislative history of the *Medical Services Act*, however, Justice Sopinka rejected the province's characterization of the legislation as relating to health, and found instead that it attempted to control abortion and to suppress abortion clinics as a public evil, a matter beyond provincial jurisdiction.¹²⁷ As Justice Sopinka put it: "The primary objective of the legislation was to prohibit abortions outside hospitals as socially undesirable conduct, and any concern with the safety and security of pregnant women or with health care policy, hospitals or the regulation of the medical profession was merely ancillary."¹²⁸ On that basis, Justice Sopinka held that the legislation was unconstitutional.¹²⁹ The requirement imposed by Justice Sopinka in the *Morgentaler* case, that provincial legislation be designed first and foremost to protect and promote individual and public health, rather than to deal with questions of crime or morality, is the only significant restriction on the provinces' health jurisdiction.

¹²³See generally S. Rodgers, "State Intervention in the Lives of Pregnant Women" in *Canadian Health Law and Policy*, *supra* note 20 at 283-84.

¹²⁴[1993] 3 S.C.R. 463; for a comment on the case see M.L. McConnell, "Abortion – Provincial Legislation – Control Over Health Care: *R. v. Morgentaler*" (1994) 73 Can. Bar Rev. 417.

¹²⁵*R. v. Morgentaler*, *ibid.* at 505.

¹²⁶*Ibid.* at 490.

¹²⁷*Ibid.* at 512-13.

¹²⁸*Ibid.* at 513.

¹²⁹In *Morgentaler v. New Brunswick (A.G.)* (1995), 156 N.B.R. (2d) 205 (C.A.) the New Brunswick Court of Appeal also found that province's attempt to restrict access to abortion services unconstitutional, on the basis that the provincial legislation in question encroached upon the federal criminal law power.

3. Municipal Institutions

Section 92(8) grants the legislatures authority in relation to “municipal institutions in the province.” Inasmuch as health was historically deemed to be a matter of private or local concern, municipal governments were largely responsible for most government intervention which did occur in the field of health from Confederation until well into the twentieth century.¹³⁰ The scope of provincial, and hence municipal, authority over health pursuant to section 92(8) was described by the Québec Superior Court in its 1885 decision in *La Municipalité St. Louis du Mile End c. La Cité de Montréal* in the following terms:

La police sanitaire, les règlements sanitaires, l'érection de bâtisses pour isoler les malades pauvres, les soigner au dépens du public, de la ville ou du gouvernement de Québec, ou par la charité publique, qu'on décore ces bâtiments du nom hopitaux, hospices ou institutions ou maisons de charité -- tout cela est essentiellement local et municipal et tombe sous le corps de la juridiction locale.¹³¹

While many of the public health problems which municipalities were forced to deal with in the nineteenth century have been largely eradicated, or have become the responsibility of provincial governments, local governments remain active in the field of community health. Local or municipal health boards exist in most provinces, with a mandate to identify community health needs, participate in local health planning, and provide input to provincial ministries of health on local health issues. Municipal officers of health oversee public health programs and issues in many municipalities. In some larger cities, such as Toronto and Vancouver, municipal councils have focussed attention on particular public health issues, such as problems relating to drug addiction and communicable diseases.

One such effort, a city of Toronto by-law dealing with the public health risks of lap dancing, was the subject of constitutional challenge in *Ontario Adult Entertainment Bar Association v. Metropolitan Toronto (Municipality)*.¹³² The by-law, which was enacted after an earlier Ontario Provincial Court decision found that lap-dancing did not contravene the indecency provisions of the *Criminal Code*,¹³³ prohibited attendants in adult entertainment parlours from touching or having physical contact with patrons, and prohibited bar owners from allowing such contact under threat of fine or loss of their business license. In a decision, subsequently

¹³⁰See generally D. Guest, *The Emergence of Social Security in Canada*, *supra* note 8 at 25; R.T. McKall, “Constitutional Jurisdiction Over Public Health” (1976) 6 Man. L. J. 317.

¹³¹(1885), 2 M.L.R. (S.C.) 218 at 224; see also *Rinfret and Pope* (1886), 12 Q.L.R. 303 (Q.B.) at 315.

¹³²(1995), 26 O.R. (3d) 257 (Gen. Div.).

¹³³*R. v. Mara*, [1994] O.J. No. 264 (Prov. Ct.), *rev'd* 133 D.L.R. (4th) 201 (Ont. C.A.).

upheld by the Ontario Court of Appeal,¹³⁴ the Divisional Court rejected the Ontario Adult Entertainment Bar Association's argument that the Toronto by-law was designed primarily to legislate morality, and thus infringed upon the federal criminal law power. The Court found instead that the by-law was enacted to protect the health and safety of attendants in adult entertainment parlours, and to reduce the public health risks of close-contact dancing, as well as to prevent crime – all of which were valid provincial objectives.¹³⁵

4. Territorial Health

Pursuant to section 4 of the *Constitution Act, 1871*,¹³⁶ Parliament has legislative jurisdiction over the federal territories: the Northwest Territories, created in 1870;¹³⁷ the Yukon Territory, created in 1898;¹³⁸ and Nunavut, created on April 1st, 1999.¹³⁹ However, the federal government has delegated extensive powers to the elected Councils of the territories, including the power to enact territorial ordinances regulating most of the matters falling within provincial jurisdiction under section 92 of the *Constitution Act, 1867*.¹⁴⁰ In particular, section 16 of the *Northwest Territories Act* and section 17 of the *Yukon Territory Act* authorize the territorial Councils to legislate in relation to “property and civil rights” and “hospitals” within each territory. Section 23 of the *Nunavut Act* authorizes the territorial Legislature to make laws in relation to hospitals and to property and civil rights in Nunavut. In the Northwest Territories, the territorial government established its own hospital insurance program in 1960, and responsibility for the management and delivery of health services was transferred from the federal government to the Northwest Territories Department of Health and Social Services in 1988.¹⁴¹ In the Yukon Territory, responsibility for the delivery of health services and health insurance was transferred from the federal government to the Yukon Ministry of Health in 1997. Section 73 of the *Nunavut Act* provides for the transfer of health insurance and health care services from the Northwest Territories to Nunavut upon agreement between the two territories.

¹³⁴ *Ontario Adult Entertainment Bar Assn. v. Metropolitan Toronto (Municipality)* (1997), 151 D.L.R. (4th) 158 (Ont. C.A.).

¹³⁵ *Ontario Adult Entertainment Bar Assn. v. Metropolitan Toronto (Municipality)* (1995), 26 O.R. (3d) 257 at 271 (Div. Ct.).

¹³⁶ R.S.C. 1985, App. II, No. 11 (formerly the *British North America Act, 1871*).

¹³⁷ *Manitoba Act, 1870 (Can.)*, R.S.C. 1985, App. II, No. 8, s. 35.

¹³⁸ *Yukon Territory Act, 1898 (Can.)*, R.S.C., 1985, App. II, No. 19.

¹³⁹ *Nunavut Act*, S.C. 1998, c. 28.

¹⁴⁰ *Northwest Territories Act*, R.S.C. 1985, c. N-27, ss. 9, 16; *Yukon Act*, R.S.C. 1985, c. Y-2, ss. 9, 17.

¹⁴¹ See generally G. Weller, “The Devolution of Health Care to Canada’s North” in G. Dacks, ed., *Devolution and Constitutional Development in the Canadian North* (Ottawa: Carleton University Press, 1990) at 121-155.

Conclusion

As discussed in the first part of the paper, the federal spending power provides an important constitutional basis for federal intervention in the field of health. Through the provisions of the *Canada Health Act* and other forms of health spending, the federal government has achieved a considerable degree of control over the shape of the Canadian health care system, notwithstanding that direct regulation of health care services remains a matter of provincial jurisdiction. The Supreme Court of Canada's decision in *RJR-MacDonald* has significantly expanded the scope of the federal criminal law power as a basis for federal action, beyond control over hazardous products and drugs into emerging areas of environmental and reproductive health. The peace, order and good government power remains a potential source of federal jurisdiction in areas of urgent or national health concern, in accordance with the criteria set out in *Crown Zellerbach*. Finally, pursuant to its powers under section 91(24), the federal government has granted increasing powers to First Nations to regulate matters of Aboriginal health.

As discussed in the second part of the paper, the provinces possess primary constitutional authority over the design, management and delivery of health care services. Together with provincial jurisdiction over hospitals, the property and civil rights power under section 92(13) provides the basis for provincial regulation of health and hospital services, health records, health insurance, and the training, licensing and discipline of health professionals. Protection and promotion of public health at the local and municipal level are also a matter of provincial jurisdiction. In the case of the Yukon, Nunavut and Northwest Territories, Parliament has delegated health powers similar to those enjoyed by the provinces to the territorial governments.

Because "health" was not a matter of specific constitutional assignment under the *Constitution Act, 1867*, the current Canadian health care system has evolved as an inter-related mix of federal and provincial laws, regulations and programs. This is clearly reflected in the range of issues touched upon in the First Ministers' health renewal agreement. Among the matters addressed in the agreement are access to health care; health promotion, education and disease prevention; primary and emergency care; the supply of doctors, nurses and other health care personnel; home and community care services; pharmaceuticals management; health information and communications technology; and health equipment and infrastructure.¹⁴² Whether seen as discrete elements of the health care system, or taken together, these potential areas of health reform engage the constitutional jurisdiction of both levels of government. The need for cooperation between the federal government and the provinces in the area of health is therefore as much a matter of constitutional law as it is of sound health policy.

¹⁴²Privy Council Office, "First Ministers Meeting Communiqué on Health", *supra* note 5.