

BILL 11, THE *CANADA HEALTH ACT* AND THE SOCIAL UNION: THE NEED FOR INSTITUTIONS[©]

BY SUJIT CHOUDHRY*

This article argues that the debate over the future of Medicare has been dominated by financial considerations at the expense of an examination of the place of supervisory institutions in the health care system. Supervisory institutions will be of central importance to the future of Medicare because any future system will include some national standards, which, to be effective, must be interpreted, applied and enforced by institutions of some kind. This article focuses on two specific institutional questions: the dismal record of federal enforcement of the existing national standards of the *Canada Health Act*, and the pressing need for dispute-settlement machinery under the *Social Union Framework* signed by Ottawa and nine provinces in 1999. The article also examines the compliance of Alberta's Bill 11 with the *Canada Health Act*.

Cet article fait valoir que le débat concernant l'avenir du régime d'assurance-maladie a été dominé par des préoccupations financières, aux dépens d'une examination du rôle joué par les institutions de contrôle dans le système de soins de santé. Ces institutions de contrôle assumeront un rôle central dans le régime d'assurance-maladie puisque l'avenir d'un tel système devra inclure des standards nationaux qui, pour être efficaces, devront être interprétés, appliqués et mis en vigueur par un type d'institution quelconque. Cet article vise deux questions institutionnelles spécifiques: le record déplorable de la mise en vigueur des standards nationaux existants en vertu de la *Loi canadienne sur la santé* par les autorités fédérales, ainsi que le besoin urgent d'instituer un mécanisme de résolution de conflit en vertu du cadre visant à améliorer l'union sociale pour les canadiens, signé par Ottawa et neuf provinces en 1999. L'article examine également la conformité du projet de loi 11 de l'Alberta à la *Loi canadienne sur la santé*.

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* Assistant Professor, Faculty of Law and Joint Centre for Bioethics, University of Toronto. An earlier version of this talk was presented at the Canadian Association of Law Teachers Annual Congress in May 2000. I thank Tim Caulfield for his invitation to speak at that event. In addition, I thank Amir Sperling for his excellent research assistance, Ira Parghi, Kent Roach, an anonymous reviewer, and the Editorial Board of the *Journal* (especially Bruce Ryder) for extremely helpful comments, and the Social Sciences and Humanities Research Council for financial support. This paper is the first part of larger project tentatively entitled "Recasting Social Canada: A Reconsideration of Federal Jurisdiction over Social Policy."

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I. INTRODUCTION: IN SEARCH OF INSTITUTIONS

Medicare has been a source of ongoing controversy between provincial governments, which separately administer the ten provincial health insurance schemes that constitute the Canadian health care system, and the federal government, which provides financial support to the provinces in exchange for compliance with the national standards spelled out in the *Canada Health Act*.¹ Indeed, this spring, two events thrust Medicare back onto the front pages and into the centre of the public policy agenda with renewed vigour. The first event was the passage of the federal budget.² Prompted by growing public concern regarding waiting lists and over-crowded emergency rooms, the federal government announced a one-time supplement to federal transfer payments to the provinces in the amount of \$2.5 billion. Instead of welcoming the new federal monies, however, the provinces were outraged, claiming that the federal initiative was grossly insufficient to deal with the fiscal crisis that has allegedly engulfed Medicare. Far from deflecting provincial criticism, the federal budget has had exactly the opposite effect of precipitating a new round of federal-provincial negotiations that may yield a new set of principles for Medicare. The

¹ R.S.C. 1985, c. C-6 [hereinafter *CHA*].

² Canada, *The Budget Plan 2000* (Ottawa: Department of Finance, 2000), online: Department of Finance <<http://www.fin.gc.ca/budget00/toce/2000/bud2000e.htm>> (date accessed: 5 July 2000).

second event was the passage of Bill 11.³ Bill 11 will permit the operation of private, for-profit clinics in Alberta. These clinics will be able to offer services covered by the provincial health insurance plan. But, in addition, they will be able to offer “enhanced” medical services on a fee-for-service basis, which may only differ from insured services in that they are of higher quality, or provided more quickly. In addition to generating massive public opposition within Alberta, Bill 11 has sparked a war of words between the Alberta and federal governments regarding Alberta’s compliance with the *CHA*.

These two events provide a useful occasion to reflect on the current state of Medicare. What is particularly striking is that the public debate spawned by each event has been dominated by financial considerations. There are three interrelated issues here. First, there is the question of the *level of funding* for Medicare. Are current levels of funding adequate? If not, what level of funding would be required to ensure that the system fulfills its objectives of providing comprehensive and accessible medical care to all Canadians? Second, there is also the question of the *source of funding*. Assuming that more monies are required, where are they to come from? If the sources of funding are to be strictly public, should these new monies come from the federal or the provincial governments? If non-public sources are an option, what kinds of sources should be considered? Should we encourage private investment, particularly with respect to large capital expenditures? Or should we re-open the question of whether patients should pay directly for the medical services that they receive? Third, there is the question of *distribution* or *allocation*. Once we have identified the level and sources of funding, according to what principles or criteria should we distribute medical goods and services?⁴

Financial issues have dominated the discourse of all political actors on all sides of the debate over the future of Medicare. And to be sure, funding is of fundamental importance, particularly if the federal

³ Bill 11, *Health Care Protection Act* 4th Sess., 24th Leg., Alberta, 2000 (assented to 10 May 2000) [hereinafter “Bill 11”].

⁴ Financial considerations are certainly central to the federal funding story. But financial considerations are also an important part of the debate over Bill 11. One of the principal concerns with Medicare is that waiting lists pose a risk to the health of individuals in need of rationed medical treatments. The Alberta government has argued that Bill 11 would alleviate this difficulty, because the availability of a privately financed option would allow those with the financial means to withdraw from the public queue, thereby freeing up resources for those remaining in the public system. As it turns out, the evidence from other jurisdictions is mixed on whether this would actually occur. See P. McDonald *et al.*, *Waiting Lists and Waiting Times for Health Care in Canada: More Management!! More Money?* (Ottawa: Health Canada, 1998) at 285-86.

government proposes to create national homecare and pharmacare systems. But my concern is that the fixation on funding has occurred at the expense of an examination of the place of supervisory institutions in the health care system. Supervisory institutions will be of central importance to the future of Medicare, no matter what scenario unfolds, because any future system will include some national standards. These standards, to be effective, must be interpreted, applied and enforced by institutions of some kind.

Institutions hold a particular interest for me, because I approach Medicare as a student of federalism. The basic question of federalism is who governs, or, more specifically, which set of institutions, federal or provincial, has jurisdiction to regulate a certain area of socio-economic activity. An analogous question—which institutions should govern Medicare—is central to the debate over the future of health care in this country. However, it is a question that has been largely ignored by politicians on all sides of the debate, the media, and even academic commentators. This omission is problematic and short-sighted, because institutions are central to the durability of Medicare. Simply put, without institutions to enforce them, national standards for Medicare are merely political platitudes. In this article, I focus on two specific institutional questions: the federal enforcement of the existing national standards of the *CHA*, and the pressing need for dispute-settlement machinery under the *Social Union Framework* signed by Ottawa and nine provinces in 1999.⁵

⁵ *A Framework to Improve the Social Union for Canadians—An Agreement between the Government of Canada and the Governments of the Provinces and Territories* (4 February 1999), online: Government of Canada <http://socialunion.gc.ca/news/020499_e.html> (date accessed: 21 June 2000) [hereinafter *SUF*]. Quebec declined to sign the final document. For the position of the government of Quebec, see Quebec, *Québec's Political and Constitutional Status: An Overview* (1999) at 33-36. In addition to a news release: see Secrétariat aux Affaires intergouvernementales canadiennes, News Release, "Joseph Facal rend publiques huit analyses d'experts sur l'Union sociale" (21 June 2000), online: Secrétariat aux Affaires intergouvernementales canadiennes <<http://www.cex.gouv.qc.ca/saic/c990609.html>> (date accessed: 25 May 2000), the following documents, all analyzing the *SUF*, were released by the government of Quebec in a single unpublished volume entitled *Entente-cadre sur l'Union Sociale* (1999), online: <<http://www.cex.gouv.qc.ca/saic/index-etudes.htm>> (date accessed: 21 June 2000): A. Noël, "Étude générale sur l'Entente"; A. Binette, "Étude sur le chapitre 1 de l'Entente-cadre (principes)"; J. Frémont, "Étude sur le chapitre 2 de l'Entente-cadre (mobilité)"; G. Otis, "Étude sur le chapitre 3 de l'Entente-cadre (imputabilité publique et transparence)"; A. Gagnon, "Étude sur le chapitre 4 de l'Entente-cadre (travailler en partenariat pour les Canadiens)"; and G. Tremblay, "Étude sur le chapitre 6 de l'Entente-cadre (prévention et règlement des différends)." For commentary on the *SUF*, see M. Young, "The Social Union Framework Agreement: Hollowing Out the State" (1999) 10 Const. Forum 120; B. Cameron, "A Framework for Conflict Management" (1999) 10 Const. Forum 129; and K. Banting *et al.*, "Four Views of the Social Union" (1999) 21:3 Pol'y Options 68.

II. FEDERAL ENFORCEMENT OF THE *CANADA HEALTH ACT*

A. *A Legal Primer on the Canada Health Act*

Let me begin with a legal primer on the *CHA*.⁶ The political rhetoric surrounding the *CHA* appears to suggest that it imposes legally binding obligations on provincial governments that receive federal monies for Medicare. Since jurisdiction over health care is thought to go to the provinces under the division of powers, the *CHA* has accordingly been portrayed by some as a massive incursion by the federal government into provincial jurisdiction.⁷ The legal situation, however, is sharply at odds with this picture. The *CHA* does not purport to legally bind provincial governments. Rather, it binds the federal government, by defining the conditions that must be met for federal payments to the provinces to be legal. The interesting feature of the *CHA* is that the legality of *federal* payments is conditioned upon *provincial* compliance with the conditions spelled out therein. The *CHA* also contains enforcement mechanisms that are triggered in cases of provincial non-compliance, which I discuss in detail below.

Why is the *CHA* framed in this way? There is a complicated constitutional story here. The starting point is a pair of decisions of the Supreme Court of Canada and the Privy Council in 1938 which held that jurisdiction over unemployment insurance rests with the provinces.⁸ Although rather specific in focus, the judgments also contain broader language that suggests that publicly operated insurance schemes which seek to safeguard persons against the risk of illness or poverty lie outside federal jurisdiction.⁹ As a consequence, the conventional wisdom is that

⁶ In this paragraph, I follow S. Choudhry, "The Enforcement of the *CHA*" (1996) 41 McGill L.J. 461 at 461-76 [hereinafter "Enforcement of the *CHA*"].

⁷ Former federal health minister Monique Bégin later recalled that during the drafting of the *CHA*, "[j]ust before the Committee meetings started, I had a meeting [on 20 January 1984] with the Quebec Minister of Health, Pierre-Marc Johnson ... [M]y provincial colleague began by declaring the project unconstitutional": see M. Bégin, *Medicare: Canada's Right to Health* (Ottawa: Optimum, 1988) at 163-65.

⁸ *Canada (A.G.) v. Ontario (A.G.)*, [1936] S.C.R. 427 (*Reference re The Employment and Social Insurance Act*) [hereinafter *UI Reference (SCC)*]; and *Canada (A.G.) v. Ontario (A.G.)*, [1937] A.C. 355 (P.C.) (*Reference re The Employment and Social Insurance Act* 1935) at 686 [hereinafter *UI Reference (PC)*].

⁹ Thus, in the *UI Reference (SCC)* *supra* note 8 at 451, Rinfret J., for the majority, stated that "[i]nsurance of all sorts, including insurance against unemployment and health insurances, 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.'" Later on,

direct federal regulation of social policy, including health insurance, is unconstitutional.¹⁰ It would be unconstitutional, for example, for the federal government to operate a national health insurance scheme.¹¹ However, these decisions also stated that it would be entirely constitutional for the federal government to spend monies in areas of provincial jurisdiction by making transfer payments to provinces, and by attaching conditions to those funds.¹² The rather obvious concern raised by these holdings is that conditional grants to the provinces allow the federal government to indirectly regulate social policy through the use of financial incentives, an end they are constitutionally precluded from achieving directly through legislative or “coercive” means. As well, as Andrew Petter has argued, this distinction finds little support in the text

in the same judgment, he stated that the federal act at issue was *ultra vires* because it was in relation to, *inter alia*, “insurance against unemployment, for aid to unemployed persons, or other forms of social insurance and security” [emphasis added], which were “subject-matters falling with the legislative authority of the provinces”: *ibid.* at 454. At the Privy Council, Lord Atkin in *UI Reference (PC)*, *supra* note 8 at 365 came to the same conclusion: “There can be no doubt that, prima facie, provisions as to insurance of this kind, especially where they affect the contract of employment, fall within the class of property and civil rights in the Province, and would be within the exclusive competence of the Provincial Legislature.”

¹⁰ See, for example, A. Petter, “Federalism and the Myth of the Federal Spending Power” (1989) 68 Can. Bar Rev. 448 at 452 (education, health “and other social services” all fall within provincial jurisdiction).

¹¹ P.W. Hogg, *Constitutional Law of Canada*, 4th ed. looseleaf (Toronto: Carswell, 1996) at 6.8(a).

¹² This possibility was spelled out in some detail in *UI Reference (SCC)* *supra* note 8 at 457, and *UI Reference (PC)* *supra* note 8 at 366. The constitutionality of the federal spending power was recently confirmed by the Supreme Court in the *Reference Re Canada Assistance Plan* [1991] 2 S.C.R. 525 [hereinafter *CAP Reference*], where it fell to the court to assess the constitutionality of a federal statute that reduced the level of federal contributions under the *Canada Assistance Plan*, R.S.C. 1985, c. C-1 [hereinafter *CAP*]. The attorney general of Manitoba argued that Parliament lacked jurisdiction to amend the *CAP*, because that statute intruded on provincial jurisdiction over social policy. The Court rejected this argument in *CAP Reference* *supra* at 567:

The written argument of the Attorney General of Manitoba was that the legislation “amounts to” regulation of a matter outside federal authority. I disagree. The Agreement under the *Plan* set up an open-ended cost-sharing scheme, which left it to British Columbia to decide which programmes it would establish and fund. The simple withholding of federal money which had previously been granted to fund a matter within provincial jurisdiction does not amount to the regulation of that matter. Still less is this so where, as in this case, the new legislation simply limits the growth of federal contributions. In oral argument, counsel said that the *Government Expenditures Restraint Act* “impacts upon [a] constitutional interest” outside the jurisdiction of Parliament. That is no doubt true, but it does not make the Act *ultra vires*. “Impact” with nothing more is clearly not enough to find that a statute encroaches upon the jurisdiction of the other level of government.

The Court recently confirmed the constitutionality of the federal spending power in *Eldridge v. British Columbia (A.G.)* [1997] 3 S.C.R. 624 at 647.

of the *Constitution Act, 1867*¹³ which allocates jurisdiction not on the basis of *policy instruments* but rather on the basis of *subject-matter*, a point relied on by the Supreme Court itself in the context of jurisdiction to implement international treaties and Crown immunity.¹⁴ Petter has also argued that in addition to resting on a weak doctrinal foundation, the federal spending power runs counter to important constitutional values, for example, because it allows national majorities to determine policy in areas of provincial jurisdiction, and because it weakens the lines of political accountability by divorcing jurisdiction over policy areas from control over policy outcomes.¹⁵ By and large, the courts have been unsympathetic to these criticisms, responding to them by drawing fairly questionable distinctions between legislative activity on the one hand, and spending on the other, and ignoring altogether the arguable tension between the spending power and important constitutional values.¹⁶ And as it turns out, conditional grants have been an extremely effective policy instrument. The end result is that the spending power has allowed the federal government to play a central role in the development of the post-war welfare state in Canada (now dubbed the Social Union), although it lacks jurisdiction over social policy.¹⁷

¹³ *Constitution Act, 1867*(U.K.), 30 & 31 Vict., c. 3, reprinted in R.S.C. 1985, App. II, No. 5.

¹⁴ Petter, *supra* note 10 at 456-57. The leading cases here are *Canada (A.G.) v. Ontario (A.G.)*, [1937] A.C. 326 (P.C.) (international treaties); and *Amax Potash Ltd. v. The Government of Saskatchewan*, [1977] 2 S.C.R. 576 (Crown immunity).

¹⁵ Petter, *supra* note 10 at 463-68.

¹⁶ *Porterv. Canada*, [1965] 1 Ex. C.R. 200; *Central Mortgage and Housing Corp. Co-op College Residences* (1975) 13 O.R. (2d) 384 (C.A.); *Winterhaven Stables Ltd. v. Canada (A.G.)*(1988), 62 Alta. L.R. (2d) 266 (C.A.), leave to appeal to S.C.C. denied (1989) 55 D.L.R. (4th) viii; and *YMHA Jewish Community Centre v. Brown*, [1989] 1 S.C.R. 1532.

¹⁷ My sense is that the constitutional compromise crafted by the Privy Council has generated a peculiar political dynamic that we see at play in the debate over Bill 11. On the one hand, Alberta argues, with some justification, that the federal role in health care is an incursion on provincial jurisdiction. On the other hand, the federal government argues, also with some justification, that that role has been explicitly sanctioned by the courts.

Constitutional scholars have generated an extensive critical literature on the federal spending power. See, for example, Petter, *supra* note 10; E.A. Driedger, "The Spending Power" (1981) 7 Queen's L.J. 124; K. Hanssen, "The Constitutionality of Conditional Grant Legislation" (1966-67) 2 Man. L.J. 191; J.E. Magnet, "The Constitutional Distribution of Taxation Powers in Canada" (1978) 10 Ottawa L. Rev. 473; G.V. La Forest, *The Allocation of Taxing Power under the Canadian Constitution*, 2nd ed. (Toronto: Canadian Tax Foundation, 1981); A. Lajoie, "The Federal Spending Power and Meech Lake" in K.E. Swinton & C.J. Rogerson, eds., *Competing Constitutional Visions: The Meech Lake Accord*(Toronto: Carswell, 1988) 175; B. Laskin, "Provincial Marketing Levies: Indirect Taxation and Federal Power" (1959-60) 13 U.T.L.J. 1; W.R. Lederman, "Some Forms and Limitations of Co-operative Federalism" (1967) 45 Can. Bar Rev. 409; J.E. Magnet, "The Constitutional Distribution of Taxation Powers in Canada" (1978) 10 Ottawa L. Rev. 473; F.R. Scott, "The Constitutional Background of Taxation Agreements" (1955) 2 McGill L.J. 1; D.V.

B. *The Enforcement of the CHA: The Ideal*

With this brief introduction in mind, let us turn to the dispute over Bill 11.¹⁸ Aside from the massive public opposition to Bill 11 within Alberta, one of the notable features of the dispute has been the active role of the federal government. On 16 November 1999, Alberta announced its intention to allow for-profit clinics to offer insured medical services; a short time thereafter, Allan Rock expressed concern in a letter to his provincial counterpart, Halvar Jonson, that such a

Smiley, *Conditional Grants and Canadian Federalism* (Toronto, Canadian Tax Foundation, 1963); and P.E. Trudeau, *Federalism and the French Canadians* (Toronto: Macmillan, 1968). That body of work has revolved around the question of whether the spending power allows the federal government to circumvent the division of powers. I am sympathetic to these arguments, but in my view, constitutional scholars have ignored a logically prior question—why social policy falls under exclusive provincial jurisdiction. Of course, this proposition is the assumption that underlies the critique of the generous approach to the federal spending power taken by the Privy Council and the modern Supreme Court. This question is one which I examine in a work in progress (tentatively entitled “Recasting Social Canada: A Reconsideration of Federal Jurisdiction over Social Policy.”) If the provinces cannot agree with the federal government on the shape of Medicare in the future, the courts may have to confront this question as well.

¹⁸ Premier Klein’s televised announcement of the release of a health care policy statement was made on 16 November 1999; see R. Klein, TV Address, “Improving Alberta’s publicly-funded health care system” (16 November 1999), online: Government of Alberta <<http://www.gov.ab.ca/premier/speech/healthaddress/index.cfm>> (date accessed: 21 June 2000). The following day, Alberta Health and Wellness released the policy statement as well as a document covering questions and answers regarding the statement: see Alberta Health and Wellness, News Release, “Policy Statement on Health Principles Released” (17 November 1999), online: Alberta Health and Wellness, <<http://www.health.gov.ab.ca/whatsnew/1999%20releases/nov17-99.htm>> (date accessed: 24 June 2000); Alberta Health and Wellness, News Release, “Policy Statement on the Delivery of Surgical Services” (17 November 1999), online: Alberta Health and Wellness, <http://www.health.gov.ab.ca/health_protection/questions.htm> (date accessed: 10 July 2000); and Alberta Health and Wellness, News Release, “Policy Statement on the Delivery of Surgical Services: Common Questions and Answers” (26 January 2000), online: Alberta Health and Wellness, <<http://www.health.gov.ab.ca/Policy/q&a.htm>> (date accessed: 10 July 2000). In response to the concerns of Albertans, in February 2000 the government released another publication that answered questions concerning the policy statement: see Alberta Health and Wellness, “We are Listening: Here’s What We’ve Heard; A Summary of Albertans’ Views on the Policy Statement on Surgical Services” (February 2000), online: Alberta Health and Wellness <http://www.health.gov.ab.ca/health_protection/index.html> (date accessed: 24 June 2000). After tabling *Bill 11* on March 2, 2000, the Alberta government outlined its provisions in a news release posted to its website: see Government of Alberta, News Release, “Legislation Introduced Prohibiting Private Hospitals and Two-Tier Health Care” (2 March 2000), online: Government of Alberta, <<http://www.gov.ab.ca/acn/200003/8843.html>> (date accessed: 21 June 2000). Alberta capped charges for enhanced medical goods and services purchased in hospitals and other health authority facilities on 8 March 2000: see Government of Alberta, News Release, “Charges for Enhanced Medical Goods and Services Capped” (8 March 2000), online: Government of Alberta, <<http://www.gov.ab.ca/acn/200003/8863.html>> (date accessed: 21 June 2000).

course of action might run afoul of the *CHA*.¹⁹ Federal expressions of concern turned into public criticism once the text of Bill 11 was tabled on 2 March 2000. A few days later, in a remarkable spectacle, Rock gave a public address at the University of Calgary's Faculty of Medicine, arguing that Bill 11 would do nothing to reduce costs, cut waiting lists, or to improve the quality of care.²⁰ Federal criticism of Bill 11 peaked in a letter Rock sent to Jonson on 7 April 2000. In that letter, Rock requested amendments to Bill 11, *inter alia*, prohibiting overnight stays in for-profit clinics and the sale of enhanced services in combination with the provision of insured services, and by so doing, implied that Bill 11 (before it was amended) might not comply with the *CHA*.²¹ However,

¹⁹ Health Canada, News Release, "Minister Rock Responds to Premier Klein's Policy Statement on the Delivery of Surgical Services" (26 November 1999), online: Health Canada <<http://www.hc-sc.gc.ca/english/archives/releases/26nov99e.htm>> (date accessed: 21 June 2000) [hereinafter "Minister Rock Responds"]. Jonson replied by assuring him that Alberta would comply with the *CHA* (see Alberta Health and Wellness, News Release, "Health Minister Responds to Federal Government" (10 December 1999), online: Alberta Health and Wellness <<http://www.health.gov.ab.ca/whatsnew/1999%20releases/dec10-99.htm>> (date accessed: 24 June 2000)) [hereinafter "Health Minister Responds"].

²⁰ A. Rock, "Canada's Health Care System" (University of Calgary, Faculty of Medicine, 10 March 2000), online: Health Canada <<http://www.hc-sc.gc.ca/english/archives/speeches/10mar2000mine.htm>> (date accessed: 24 June 2000). In response to Rock's speech, Jonson initially charged the federal health minister with misleading the public: see Alberta Health and Wellness, News Release, "Federal Health Minister Misleading Canadians" (10 March 2000), online: Alberta Health and Wellness <<http://www.health.gov.ab.ca/whatsnew/Releases%202000/mar10b-2000.htm>> (date accessed: 18 May 2000). Jonson subsequently sent a letter to Rock on March 14, 2000, in which he accused him of speaking on matters within provincial jurisdiction, and demanded that the Minister state whether Bill 11 complies with the *CHA*: Government of Alberta, Notice to the Editors, "Letter to Allan Rock from Halvar Jonson" (14 March 2000), online: Government of Alberta, <<http://www2.gov.ab.ca/healthfacts/PrinterFriendly.cfm?ID=143>> (date accessed: 24 June 2000). In a reply dated 16 March 2000, Rock denied intruding on provincial jurisdiction, pledged to continue speaking out on "health issues which are of such great importance to all Canadians," and repeated his intention to complete a review of Bill 11 before determining whether it violated the *CHA*: see Health Canada, News Release, "Letter to the Honourable Halvar Jonson, M.L.A." (16 March 2000), online: Health Canada <http://www.hc-sc.gc.ca/english/archives/letter_16mar2000.htm> (date accessed: 24 June 2000).

²¹ Health Canada, "Letter to the Honourable Halvar Jonson" (7 April 2000), online: Health Canada <http://www.hc-sc.gc.ca/english/archives/letter_07apr2000.htm> (date accessed: 24 June 2000). Amendments to Bill 11 introduced by the Alberta legislature on April 12, 2000 included, *inter alia*, a strengthening of the queue jumping prohibition, a requirement that "enhanced" medical goods and services be reasonably priced, and an obligation on health authorities to use existing hospital facilities efficiently: see Alberta Health and Wellness, News Release, "Government Introduces Amendments to Bill 11" (12 April 2000), online: Government of Alberta <<http://www.gov.ab.ca/acn/200004/9004.html>> (date accessed: 24 June 2000). The same day, Allan Rock reiterated, in a letter to Halvar Jonson, that the federal government's standpoint regarding private clinics being considered hospitals under the *CHA* had not changed since Diane Marleau's letter dated 6 January 1995: see Health Canada, News Release, "Letter to the Honourable Halvar Jonson" (12 April 2000), online: Health Canada <<http://www.hc-sc.gc.ca/english/archives>

on 11 May 2000, Rock effectively conceded, in a speech to the House of Commons, that Bill 11 on its face did not violate the *CHA*.²² I will return to the question of Bill 11's compliance with the *CHA* below.

The impression created by the energetic and aggressive federal stance toward Bill 11 is that bureaucrats in the Canada Health Act Division of Health Canada are actively monitoring the provincial health care systems, and constantly assessing them for compliance with the national standards spelled out in the *CHA*. Moreover, Allan Rock's very personal, and very public, involvement in the issue suggests that the federal government is willing to take the provinces to task for non-compliance with the *CHA* and to bear the political consequences of doing so. In fact, the available evidence points in exactly the opposite direction. There is a yawning gap between the rhetoric surrounding Bill 11 and the reality of the federal government's enforcement of the *CHA*. The truth is that the federal government is largely unaware of the degree of provincial compliance with the *CHA*, and, in suspected cases of provincial non-compliance, has followed the traditional norms of intergovernmental relations in Canada, shrouding its interactions with provincial governments in secrecy.

To provide a framework for critical analysis, let us consider what the *CHA* contemplates in terms of the enforcement of the conditions laid out therein. It is fairly clear that the *CHA* envisages a scheme approximating the image created by the rhetoric surrounding Bill 11, whereby the federal government monitors provincial compliance with the terms of the *CHA*, and, in cases of non-compliance, moves to ensure provincial compliance. This conclusion follows from the terms of the *CHA* itself. The *CHA* spells out a public enforcement machinery, centred on the federal government, or more accurately, two enforcement tracks, for two different sets of conditions. For the conditions of universality, comprehensiveness, accessibility, non-profit public administration, and portability, the *CHA* provides that provinces "must" satisfy these criteria in order to qualify for federal transfers.²³ However, the *CHA* provides that for breaches of these conditions, the federal cabinet "may" withhold funds from the offending province, after

/letter_12apr2000.htm> (date accessed: 24 June 2000).

²² In lieu of further action against Alberta, Rock simply promised to "monitor closely what may happen on the ground in private for profit facilities permitted under Bill 11 to ensure that queue jumping and other accessibility issues do not arise": *House of Commons Debates* (11 May 2000) at 6670 (A. Rock) [hereinafter *Federal Concessions*]. See also Health Canada, News Release, "Health Minister responds to Bill 11" (11 May 2000), online: Health Canada <http://www.hc-sc.gc.ca/english/archives/releases/2000/2000_46e.htm> (date accessed: 24 June 2000).

²³ *CHA*, *supra* note 1, s. 7.

mandatory consultation with the province.²⁴ The cabinet need not withhold these funds; its power to do so is discretionary. By contrast, for the *CHA*'s bans on extra-billing and user charges, the *CHA* provides for mandatory deductions, in an amount equal to the amount of those charges.²⁵ Another feature of the *CHA*'s enforcement machinery which is frequently overlooked is the requirement that the minister of health submit an annual report to Parliament respecting the administration and operation of the *CHA* that documents the extent of provincial compliance with national standards. The direct role of Parliament in monitoring compliance with the *CHA* illustrates the special importance of Medicare.²⁶

What would the ideal system of federal enforcement look like? Surprisingly, aside from the provisions I mentioned above, the *CHA* hardly speaks to this crucial issue. However, if we proceed from first principles, a very general picture emerges. An effective enforcement scheme would require that an institution be vested with responsibility for assessing provincial compliance with the standards laid down by the *CHA*. This institution could be a government department (like the Canada Health Act Division of Health Canada), or an arms-length agency; to date, the federal government has opted for the former approach. What would this institution do? A large part of its work would be devoted to gathering information about provincial health insurance plans. It could gather information in one of two ways. First, it could receive reports from provincial governments that document, in detail, their compliance with the *CHA*. Second, it could gather information through a complaints procedure, whereby aggrieved individuals, or public interest organizations, could bring alleged breaches of the *CHA* to

²⁴ *Ibid.*, ss. 15, 14.

²⁵ *Ibid.*, s. 20. In addition, s. 22(1)(c) of the *CHA* authorizes the federal cabinet to promulgate regulations that would require, as an additional condition for federal funding, that provinces provide "such information ... as the Minister may reasonably require for the purposes of the Act": s. 13(a). Only one regulation has been acted pursuant to this provision. That regulation authorizes the Minister to require that provinces provide information with respect to the type and amount of extra-billing: see *Extra-billing and User Charges Information Regulation* S.O.R./86-259.

²⁶ The conclusion that the *CHA* contemplates enforcement follows not only from its express terms, but also from the very logic of national standards themselves. As Sopinka J. observed in *Canada (Minister of Finance) v. Finlay (no. 3)*, [1993] 1 S.C.R. 1080 at 1125-26 [hereinafter *Finlay (no. 3)*], the national standards laid down by the now-inoperative *CAP* must have had some minimum content in order for the federal government to be able "to limit its contributions to schemes that were of the general nature it wished to support." If national standards are to be meaningful, and if the federal government is to be able to limit its contributions to provinces that operate health insurance plans that further its policy objectives, an institution (presumably the federal government) should ensure compliance with those standards.

the attention of federal authorities, which could then launch an investigation.

What kind of information would this institution gather? For some standards, all that would be required would be an examination of the relevant provincial statutes and regulations. Universality and portability fall into this category. However, other standards raise complex questions of fact that would require the federal enforcement agency to gather information regarding the actual operation of provincial health plans. Consider accessibility. For provincial plans to satisfy this criterion, they must “provide for insured health services on uniform terms and conditions and on a basis that does not impede or preclude, either directly or indirectly whether by charges made to insured persons or otherwise, reasonable access to those services by insured persons.”²⁷ The definition of accessibility clearly contemplates both financial and non-financial barriers to access. Some financial barriers, such as extra-billing and user fees, are specifically prohibited by the *CHA*. Non-financial barriers would probably include the lack of resources to meet the demand for medical services, manifested in the form of waiting lists, as well as geographic disparities in the availability of medical treatments. Presumably, relevant information would include patient to bed ratios, physician to patient ratios, specialist to patient ratios, and the length of waiting lists, among a host of other data.²⁸ Finally, the federal enforcement agency would need to be staffed with experts who could interpret this data. Moreover, either provinces would be obliged to provide this sort of information to the federal enforcement

²⁷ *CHA*, *supra* note 1, s. 12(1)(a).

²⁸ Comprehensiveness, which requires that provincial health plans insure all “medically necessary” services (*CHA*, *supra* note 1, s. 9, read in combination with s. 2), poses different problems, and may accordingly require a different process for interpretation and specification. To be sure, there are important issues of fact to be resolved. Thus, the assessment of medical necessity would require, at the very least, an analysis of the effectiveness of certain medical interventions, an empirical question. However, the definition of “medical necessity” has also bedeviled health services researchers, health lawyers and bioethicists, because it has an inescapable normative component: see, for example, E.J. Emanuel, *The Ends of Human Life: Medical Ethics in a Liberal Polity* (Cambridge, Mass.: Harvard University Press, 1991) at 139-44; T.A. Caulfield, “Wishful Thinking: Defining ‘Medically Necessary’ in Canada” (1996) 4 *Health L.J.* 63. It may be that the specification of the list of insured services should be defined through a process that proceeds from shared premises as to the goals of health care delivery. On the other hand, some have argued that a list-based approach would be insufficiently flexible to take into account new treatments: National Forum on Health, *Canada Health Action: Building On the Legacy - Final Report* vol 2., (1997) online: National Forum on Health <www.nfh.hc-sc.gc.ca/publicat/finvol2/balance/pubpri4.htm> (date accessed: 24 June 2000). For the purposes of this paper, I would like to bracket this difficult issue, although in my analysis of Bill 11, I assume that the definition of medical necessity could be the subject of adjudication.

agency, or the agency would require both the resources and the legal authority to gather this data itself.

C. The Enforcement of the Canada Health Act: The Reality

The reality on the ground differs markedly from this sketchy and idealized picture. In order to get a sense of the nature and extent of federal enforcement, I have relied on four sources of evidence: the track-record of the *CHA*'s enforcement machinery, as contained in the annual reports submitted by the minister of health to Parliament; reports of the auditor general on the administration of the *CHA*; records of proceedings of the House of Commons in Hansard; and media reports regarding alleged violations of the *CHA*.

Let me begin with two facts. The first is that, despite the explicit bans on user charges and extra-billing—which are remarkably specific in a statute otherwise marked by its use of open-ended language—provinces continue to violate these conditions of federal funding (see Appendix, Table 1, below). Since these conditions are subject to the mandatory enforcement mechanism, the federal government is legally obliged to make deductions in federal transfer payments, and it appears that the federal government complies with the *CHA*. The latest year for which information is available is the 1998-99 financial year (1 April 1998 to 31 March 1999), during which the federal government withheld \$703,950 from Newfoundland, Nova Scotia, and Manitoba.²⁹ This figure is comparable to the mandatory deduction in 1997-98, \$772,000. By contrast, in 1995-96 and 1996-97, the mandatory deductions were much higher, totaling \$2,666,000 and \$2,022,000 respectively. The difference can be accounted for in part by large penalties imposed on Alberta (\$2,319,000 in 1995-96, \$1,266,000 in 1996-97) due to the operation of the Gimbel Eye Clinic, which I discuss below. Overall, the federal government has withheld a gross total of \$252,920,950 from provincial governments that permitted extra-billing and user charges. Of these monies, though, 96.8 per cent (\$244,732,000) were returned to provincial governments pursuant to section 20(5) of the *CHA*, which provides that if, in the opinion of the minister, extra-billing and user charges had been eliminated in a province by 1 April 1987, the total amount deducted in respect of extra-billing or user charges before

²⁹ Health Canada, *Canada Health Act Annual Report 1998-99* (Ottawa: Supply & Services Canada, 2000) at 9.

that date would be refunded. Of the remaining funds (\$8,188,950), 43.7 per cent (\$3,585,000) were withheld from Alberta.

In stark contrast, the discretionary enforcement mechanism, which attaches itself to the important conditions of universality, comprehensiveness and accessibility, has never been used. Juxtaposed against the active use of the mandatory deductions scheme, a casual observer could reasonably conclude that the federal government is actively monitoring provincial compliance with the terms of the *CHA*, and has come to the conclusion that provincial plans meet those national standards. Alternatively, one could conclude that instances of non-compliance have been resolved without the need for financial penalties. Indeed, Health Canada consistently makes these sorts of claims in the annual *CHA* Reports.³⁰

However, the reports of the auditor general tell a radically different story. The auditor general has examined the enforcement of the *CHA* on three occasions, in 1987, 1990, and 1999. I focus on the last report, because it is by far the most detailed, and because it repeats many of the concerns advanced in the first two. The auditor general indicated in 1999 that there had been numerous instances of non-compliance in the last five years. Six cases were resolved without the use of financial penalties; the report did not provide any details. However, the auditor general noted that there were other cases of non-compliance that had not been resolved. A number of provinces (which the auditor general did not name) contravened the portability condition, which requires that medical services received outside of a province (including outside of the country) by insured persons temporarily absent from that province be reimbursed at the same rate as inside the province. The portability condition was apparently violated by five provinces with respect to treatment received outside of Canada; in addition, one province violated the condition with respect to treatment received in other provinces. The auditor general also stated, without providing any detail, that “[o]ther examples of suspected non-compliance with the comprehensiveness and accessibility criteria have been the subject of considerable discussion between the federal government and the provinces and territories.”³¹ These disputes remained unresolved.

³⁰ The 1997-98 report states, in this vein: “[D]uring the year under review, a number of issues related to possible non-compliance were identified and resolved, while others are currently under review”: Health Canada, *Canada Health Act Annual Report 1997-98* (Ottawa: Supply & Services Canada, 1998) at 8.

³¹ Office of the Auditor General, *Report of the Auditor General of Canada to the House of Commons* (Ottawa: Auditor General’s Office, 1999) at para. 29.49 [hereinafter *Report*, 1999].

The most charitable interpretation of the auditor general's findings to this point of the report is that the federal government has been aware of the extent of provincial non-compliance, has been able to resolve some but not all disputes through negotiation, and has been reluctant to use the powerful financial levers available to it to secure better compliance. However, the report then went on to state that the federal government was largely unaware of the true extent of provincial non-compliance, because it lacked the required information. The root of the problem was the federal government's approach to information gathering. Rather than taking an active approach to gathering relevant information from the provinces—which, as I argued above, follows from the logic of the *CHA*—the report stated that Health Canada “has taken a passive stance.”³² The provinces voluntarily submit annual reports, which are reproduced or summarized in the annual *CHA* reports. But as a perusal of the annual *CHA* reports reveals, the provincial reports are rather general in nature, and lack the specific data that would be necessary to assess compliance with criteria like accessibility and comprehensiveness. It appears that regulations that would have required more extensive provincial reporting were drafted in 1984, when the *CHA* was adopted, but faced stiff provincial opposition and were therefore never promulgated.³³ Other sources of information are restricted to “regional staff reports, correspondence and complaints from the public, newspaper clippings and other media reports.”³⁴ The report did note that the federal government monitored changes to provincial laws and regulations, but, as I argued above, some of the funding criteria require information about the actual operation of health care systems.

Worryingly, these are not new criticisms. In his first report on the enforcement of the *CHA* in 1987, the auditor general stated that the actual operation of provincial plans was not being monitored by Health Canada. It recommended that steps be taken to do so.³⁵ In his 1990 report, the auditor general noted that this recommendation had not been adopted.³⁶ The auditor general made a similar recommendation in his 1999 report. In response, Health Canada agreed to assess the

³² *Ibid.* at para. 29.51.

³³ *Ibid.* at para. 29.52.

³⁴ *Ibid.* at para. 29.53.

³⁵ Office of the Auditor General, *Report of the Auditor General of Canada to the House of Commons* (Ottawa: Auditor General's Office, 1987) at para. 12.109.

³⁶ Office of the Auditor General, *Report of the Auditor General of Canada to the House of Commons* (Ottawa: Auditor General's Office, 1990) at para. 4.176.

adequacy of its current information-gathering system and to determine how it can be improved.³⁷ Allan Rock recently announced that the federal government would allocate an additional \$4 million to the existing budget of \$1.5 million annually to monitor and assess provincial compliance.³⁸ These monies will go toward increased staff and to developing better methods of tracking information. The details of these arrangements, however, have yet to be announced.

The general lack of federal enforcement of the *CHA* is also evident from media reports and Hansard, although this source of information is far from comprehensive. Between 17 April 1984 (when the *CHA* came into force) and May 2000, there were numerous alleged violations of the *CHA*. Of these, several involved alleged violations of the prohibitions on user fees and extra-billing (see Appendix, Table 2, below). In most cases, the federal government *did* respond to the alleged violation through discussions with the relevant provincial government, and/or the imposition of a cash penalty. The most prominent example here is the dispute surrounding the Gimbel Eye Clinic in Calgary. The eye clinic is a privately-owned facility which specializes in laser surgery. From 1989 onward, the provincial health insurance plan covered the cost of these laser treatments. However, the clinics charged patients a “facility fee,” which was not covered by the provincial health insurance plan. In a letter to provincial and territorial ministers of health (dated 6 January 1995), then minister of health, Diane Marleau, took the position that the Gimbel clinic was a “hospital” for the purposes of the *CHA*, and that the facility fee therefore amounted to a kind of user charge for medically necessary services covered by the provincial health insurance plan, which is clearly prohibited under the Act.³⁹ The letter imposed a deadline of 15 October 1995 for provincial compliance. Alberta did not meet this deadline, and as a result, the federal government imposed a penalty of \$420,000 per month in November 1995. Soon thereafter, the federal government imposed penalties on Manitoba, Newfoundland and Nova Scotia. Alberta later complied, in July 1996.

However, the aggressive and public stance of the federal government with respect to the Gimbel Eye Clinic stands in stark contrast to the relatively timid federal response to a Quebec proposal in December, 1990 that patients visiting emergency rooms be charged a \$5

³⁷ *Report, 1999 supra* note 31 at para. 29.58.

³⁸ *House of Commons Debate* (11 May 2000) at 6670 (A. Rock).

³⁹ Letter from D. Marleau to provincial and territorial Ministers of Health (6 January 1995) [on file with author].

user fee. In response to questions in the House of Commons at that time, then Minister of Health Perrin Beatty “indicated that he believes that what he is doing can be done within the confines of the Canada Health Act.”⁴⁰ However, he did not provide any details. The federal government made no further public statements on the matter. The provincial proposal was eventually withdrawn. It is not clear whether the proposal was withdrawn in response to federal pressure; at the very least, the federal government made no announcement to this effect in the House of Commons.

With respect to the funding conditions subject to the discretionary enforcement mechanism (see Appendix, Table 3, below), however, the facts tell a different story. As I have mentioned, federal funds have never been withheld under this mechanism. However, since the *CHA* came into force, there have been several alleged violations of these funding criteria. Most of these appear to have generated no federal response in public. They are certainly not mentioned in any of the *CHA* reports. Indeed, this is even so for alleged violations of the portability condition, which is not subject to the difficulties of interpretation that bedevil comprehensiveness and accessibility. To be fair, the auditor general’s report does suggest that Health Canada is aware of the various breaches of the portability criterion; however, if this is true, the fact remains that these violations are ongoing. There have been complaints against several provinces regarding the rates of reimbursement for out-of-country treatment that are lower than provided for treatment within the province. In two provinces (British Columbia and Ontario), the question ended up before the courts; Canada declined to intervene in one case, *Collett v. Ontario (A.G.)*⁴¹ and in the other, *Brown v. British Columbia (A.G.)*⁴² conceded that the provincial health plan appeared to contravene the *CHA*, but asked the court to dismiss the action so that the matter could be resolved through intergovernmental negotiation. In addition, Quebec does not provide reimbursement for treatment received in provinces other than Ontario.⁴³ The federal government has taken no public position here as well.

⁴⁰ *House of Commons Debate* (20 March 1991) at 18728 (P. Beatty).

⁴¹ (1995), 124 D.L.R. (4th) 426 (Ont. Gen. Div.) [hereinafter *Collett*].

⁴² [1998] 5 W.W.R. 312 (B.C.S.C.).

⁴³ L. Surtees, “Patients to Recover Out-of-Province Costs Under New Agreement” *The Globe and Mail* (31 March 1988) A13; “Quebec Won’t Join Interprovincial Medicare Deal: Deputy Minister” *The [Montreal] Gazette* (8 December 1988) A5; and A. Riga, “Deal Covering Medical Costs in the Works With Ontario” *The [Montreal] Gazette* (15 February 1994) A6.

A large number of complaints have turned on waiting lists, and whether the threat they pose to health contravene the accessibility criterion. The issue has been raised in the House of Commons on several occasions.⁴⁴ In not one case did the federal government promise publicly to look into the matter. These complaints related to important services. On three occasions, for example, Members of Parliament alleged that women lacked access to abortion services, widely recognized by health professionals as being a crucial component of women's reproductive health. Other complaints related to waiting times for breast cancer treatment, hip replacements, and cataract surgery. Similarly, there have been a handful of complaints regarding alleged violations of the comprehensiveness and universality criteria. Likewise, these generated no federal response in public.

What has been the response of political actors, the media, and academic commentators to the lack of federal enforcement? To a large extent, this issue has been ignored. By comparison, other issues in health policy, especially declining federal support for health care, have received an enormous amount of attention. The portions of the auditor general's report in 1987 that dealt with the *CHA* prompted one question in the House of Commons;⁴⁵ the same portions of the 1990 report did not prompt a single question. However, the 1999 report did prompt three questions, although the report was not made into an issue by members of the opposition.⁴⁶ The media coverage has been equally scant.⁴⁷

⁴⁴ *House of Commons Debates* (11 May 1994) at 4208 (D. Harris); *House of Commons Debates* (10 June 1994) at 5160 (G. Hill); *House of Commons Debates* (4 April 1995) at 11484-85 (G. Hill); and *House of Commons Debates* (18 October 1995) at 15525 (D. Grey). For further references, see Appendix, Table 3, below.

⁴⁵ Ms. Sheila Copps (Hamilton East, Lib.) asked Hon. Jake Epp (Minister of National Health and Welfare) about the auditor general's conclusion, at s. 12.146 of his report, that the minister was negligent in not responding to specific requests from Members of Parliament to report on instances in which provinces violated the *CHA* by charging user fees. Epp responded that there are no provinces currently reporting extra-billing, and that the Ministry had made annual reports in compliance with the *CHA*: see *House of Commons Debates* (28 October 1987) at 10484-85.

⁴⁶ On 30 November 1999, Ms. Judy Wasylycia-Leis (Winnipeg North Centre, NDP) confronted the Hon. Allan Rock regarding the auditor general's conclusion that "the government has no idea whether or not the provinces are complying with the Canada Health Act." Rock responded that "the auditor general has made some very helpful suggestions, all of which we accept and many of which we are already implementing to ensure that the best information possible is given to parliament annually from the Minister of Health with respect to the status of the Canada Health Act throughout the country": see *House of Commons Debates* (30 November 1999) at 1950. On 1 December 1999, Miss. Deborah Grey (Edmonton North, Ref.) repeated the criticism leveled by the auditor general that "the federal government has no idea whether its health care spending ever makes it to the waiting lines or the emergency rooms." Rock responded once again that the recommendations were "useful" and were already being implemented: see *House of Commons*

Moreover, of the published articles on the *CHA* in the legal and medical literature, only two refer to the report of the auditor general, or the issue of non-enforcement generally.⁴⁸

In my view, the federal government's non-enforcement of the *CHA*, along with the failure of political actors and the academic community to highlight the federal government's abdication of its responsibilities, is a national embarrassment. In this connection, it is worth highlighting a remarkable statement in the auditor general's 1999 report: "Parliament cannot readily determine the extent to which each province and territory has satisfied the five criteria [*i.e.* universality, comprehensiveness, accessibility, portability and non-profit public administration] and the two conditions [*i.e.*, the bans on extra-billing and user fees] of the Act."⁴⁹ This criticism was offered in connection with the content of the Annual *CHA* reports presented to Parliament by the minister of health. The auditor general's concern (expressed also in 1987 and 1990) was that the reports are fundamentally flawed because they fail to indicate the degree of provincial compliance. This view, however, put together with the auditor general's finding that Health Canada really has no idea of the degree of provincial compliance with the *CHA*, suggests that the *CHA* is potentially being violated with impunity and

Debates (1 December 1999) at 1991. On 27 March 2000, Ms. Alexa McDonough (Halifax, NDP) reported that "[a]ccording to the auditor general, even before the federal government cash transfers for health, the government has never taken action to protect the five principles of medicare. Let me quote: 'Health Canada does not have the information it needs to monitor compliance with the act. The only departmental evaluation undertaken was limited, and it was five years before its results were reported to parliament.'" The Right Hon. Jean Chretien replied that in a recent meeting with Ralph Klein, he insisted that Alberta "would have to respect the five conditions of medicare.": *House of Commons Debates* (27 March 2000) at 5254-55.

⁴⁷ Former federal health minister and Liberal MP Diane Marleau, without explicitly referring to the auditor general's report, contended in a 13 March 2000 interview that the federal government has the power to stop Alberta's Bill 11 and alleged violations of the *CHA* but never passed regulations to support the Act: see D. Bueckert, "Ottawa Can Stop Alberta: Ex-minister" *The Toronto Star* (13 March 2000) A6. Diane Marleau again derided government inaction regarding Bill 11 and other alleged *CHA* violations in a subsequent interview dated 6 April 2000: see M. MacKinnon, "Ex-minister Blasts PM on Medicare: Marleau Assails Her Own Party's Inaction" *The Globe and Mail* (6 April 2000) A1. Subsequently, federal Health Minister Allan Rock wrote in A. Rock, Letter to the Editor, *The Globe and Mail* (17 April 2000) A12:

In his report of Nov. 29, the Auditor-General of Canada recommended that Health Canada strengthen its ability to enforce the provisions of the *Canada Health Act* and improve on its ability to report on matters relating to the act. On May 11, I announced Health Canada's intention to devote new resources in order to respond directly to the Auditor-General's recommendations.

⁴⁸ "Enforcement of the *CHA*," *supra* note 6; and 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 26.

⁴⁹ *Report, 1999 supra* note 31 at para. 29.57.

that this fact is being kept from Parliament. Although politely worded, the overall message contained in the auditor general's report is damning.

Why the lacklustre federal performance? There would appear to be two reasons why the federal government has failed to aggressively enforce the national conditions spelled out in the *CHA*. The first is a lack of institutional capacity. Information gathering of the kind that is required to gauge provincial compliance with the conditions of accessibility and comprehensiveness, in particular, requires a serious commitment of human and capital resources. As I mentioned earlier, an expert staff, including persons with training in health services research, is a must.

However, it would be a mistake to reduce the federal government's neglect of the *CHA* to a lack of resources. The more fundamental problem is a lack of political will. The auditor general's report made an oblique yet revealing reference to this problem, when it stated that the enforcement of the *CHA* had been tempered by national unity concerns.⁵⁰ What the report was referring to was a long history of tense federal-provincial relations surrounding the federal spending power. Particular exercises of the federal spending power have long been regarded as federal impositions by provincial governments (although only one province, Quebec, has ever challenged the constitutionality of federal government expenditures in areas of provincial jurisdiction).⁵¹ The dynamic of fiscal federalism has also been profoundly affected by the dramatic decline in federal transfer payments, a point I discuss below with respect to the *SUF*. But I can state the basic point here: the legitimacy of the federal enforcement of national standards has been diminished along with its financial involvement.⁵² The failure to exercise its discretionary enforcement power accordingly reflects a loss of legitimacy and political capital on the part of the federal government.

To be fair, though, Bill 11 may mark a dramatic turning point in the federal government's stance toward the *CHA*. The federal government has responded energetically from the start. As well, insofar as the federal government has passed judgment on the compatibility of

⁵⁰ *Ibid.* at para. 29.50.

⁵¹ For a history of Quebec's stance on the federal spending power, see Secr teriat aux Affaires intergouvernementales canadiennes, "Qu bec's Historical Position on the Federal Spending Power 1944-1998" (July 1998), online: Secr teriat aux Affaires intergouvernementales canadiennes <<http://www.cex.gouv.qc.ca/saic/english.htm>> (date accessed: 24 June 2000). See also Quebec, *Report of the Royal Commission of Inquiry on Constitutional Problems* vol. 2 (Quebec: Royal Commission of Inquiry on Constitutional Problems, 1956) (Chair: T. Tremblay).

⁵² For references, see *infra* note 66.

Bill 11 with the *CHA*, and has made that judgment public, the federal government's actions are radical and new.⁵³ But again, it is important to note that the Canadian Union of Public Employees (CUPE) had released its own legal opinion on the compatibility of Bill 11 with the *CHA*.⁵⁴ Had the federal government not made its view public, it would have certainly lost face. On balance, it is fair to say that the experience surrounding Bill 11 is exceptional, not representative. The federal government has a long way to go.

D. *The Future*

What is the relevance of the federal government's non-enforcement of the *CHA* for the future? My sense is that national standards are here to stay, and may in fact become more, not less, important, in the years to come. As I have argued before, Canadians take Medicare to be constitutive of social citizenship, and are unlikely to accept a scenario in which that component of Canadian identity is abolished entirely. If the federal government creates national homecare and pharmacare programs, for example, federal financial support will probably come with conditions attached. If federal financial support for existing programs is increased, the standards in the *CHA* will remain, and, indeed, might be supplemented by standards regarding waiting-lists, as Allan Rock has suggested.⁵⁵ If federal financial support remains at current levels or declines, the standards in the *CHA* may be replaced by joint federal-provincial standards, as is provided by the CHST, or even inter-provincial standards, as was contemplated by Tom Courchene's ACCESS proposals.⁵⁶ If private financing becomes a more prominent feature of the system, standards to ensure reasonable access will be absolutely critical. And any scenario which involves national standards by necessity has an institutional component.

⁵³ *Federal Concession* *supra* note 22.

⁵⁴ J.J. Arvay & T.M. Rankin, "Canada Health Act and Alberta Bill 11" Legal Opinion, 8 (March 2000) [unpublished, on file with the author] [hereinafter "CUPE Opinion"].

⁵⁵ A. McIlroy, "Rock Plans Urgent Drive to Overhaul Health Care; Patient Waiting Lists, National Home Care Top His Agenda" *The Globe and Mail* (27 January 2000) A1.

⁵⁶ *Federal-Provincial Fiscal Arrangements Act* R.S.C. 1985, c. F-8, ss. 13(3), as am. by *Budget Implementation Act* S.C. 1995, c. 17, s. 48 [hereinafter *Federal-Provincial Fiscal Arrangements Act*] and T.J. Courchene, "ACCESS: A Convention on the Canadian Economic and Social Systems" (Ontario: Ontario Ministry of Intergovernmental Affairs, 1996).

A second point is the importance of accountability.⁵⁷ Accountability for performance is an idea that historically has been identified with the private sector, but which, in the 1990s, attracted support in public policy circles. As Colleen Flood has argued, enhanced accountability is a crucial component of any strategy to maintain public confidence in Medicare, which is the key to ensuring the survival of the public system. Accountability, at the very least, includes informing citizens of provincial compliance with benchmarks for performance. Typically, these benchmarks have been framed in terms of indicators that measure the quality of care. The Canadian innovation is to frame performance benchmarks in terms of distributive justice, which, as I have argued elsewhere, is the best way to understand the national standards of comprehensiveness and accessibility.⁵⁸ Examined through the lens of accountability, the federal enforcement of the *CHA* is sorely lacking. The *CHA* reports contain little or no detail regarding provincial non-compliance. The secrecy surrounding federal-provincial discussions reflects the norms of executive federalism, which has long been criticized for shielding public policy decisions from public scrutiny. By comparison, the auditor general's 1999 report at least gives a vague indication of both the number and nature of instances of provincial non-compliance. The system of federal enforcement is in sore need of reform in order to enhance the accountability of Medicare to Canadians. Can we trust the federal government to enforce national standards for health care? Until now, the public enforcement machinery has centred on the federal government. However, it is fair to say that the federal government has failed to live up to its responsibilities. It may be time to consider other options. One option is the establishment of Medicare Commission that would have a mandate to monitor provincial compliance with national standards. The Commission would be independent and non-partisan, and would be insulated from the political pressures that influence the federal cabinet at present. Information gathering would be active, not passive, and would include a requirement that provinces provide detailed information regarding the actual operation of health care systems. In this connection, the establishment of the Canadian Institute for Health Information (CIHI) is a positive development, because it may be able to assist both levels of government in generating the kind of hard

⁵⁷ C.M. Flood, "Accountability, Flexibility and Integration" (2000) 21:4 Pol'y Options 17 at 17-19.

⁵⁸ "Enforcement of the *CHA*," *supra* note 6.

data that is required.⁵⁹ This supervisory body would report directly to Parliament, and would be headed by a medicare commissioner. The commissioner would be assisted by an expert staff of health economists and health service researchers. What is missing from this proposal, of course, is any reference to an individual complaints process, as well as a dispute settlement mechanism. I will now address these issues, in the context of the *SUF*.

III. THE SOCIAL UNION

A. *Moving Away From Federal Unilateralism*

My proposal for a medicare commissioner is similar to existing arrangements inasmuch as it is centred on the federal government. However, the constitutional and financial context surrounding the *CHA* suggests that this sort of regulatory framework for evaluating provincial compliance may be inappropriate. Constitutionally, the understanding of the division of powers upon which the *CHA* is premised assumes a degree of de facto concurrent jurisdiction (provincial regulatory power, federal financing power) over large areas of social policy. Both the federal and provincial governments have a legitimate role to play in health policy, albeit through radically different policy instruments. An enforcement regime entirely within the hands of the federal government sits uncomfortably with joint federal-provincial responsibility for Medicare. This is all the more true given the policy instrument employed by the federal government, conditional grants. Conditional grants give rise, in political terms, to quasi-contractual relationships, because provinces agree to comply with national standards in exchange for federal funding. Given the reciprocal exchange of promises of performance, vesting authority with one party to authoritatively determine compliance lacks a certain degree of legitimacy in the political culture of Canadian federalism.

In addition, the financial circumstances surrounding the federal role in Medicare suggest that unilateral enforcement is not a realistic

⁵⁹ The Canadian Institute for Health Information, a national, non-profit organization, was launched in 1994, following its approval by federal, provincial and territorial ministers of health in September 1992. Its mandate is “to improve the health of Canadians and the health system by providing quality and timely health information.” See Canadian Institute for Health Information, “What We Do,” online: Canadian Institute for Health Information <<http://www.cihi.ca/wedo/do.htm>> (date accessed: 24 June 2000).

option at present. Given that the federal government's standing to serve as standard-setter derives from its fiscal involvement, it is material that that involvement has declined over the last twenty years.⁶⁰ The story of declining federal funding began in 1977, with the shift away from 50/50 cost-sharing to a block grant (the Established Programs Financing or EPF Grant) consisting of a mixture of cash and tax points, with the cash component tied to an escalator based on growth in per capita Gross National Product (GNP). In 1982, the escalator was applied to the entire EPF entitlement, not just the cash component, making the EPF cash transfer strictly residual. The escalator was then eliminated in stages, first in 1986 (when it was reduced to GNP less 2 per cent), then in 1990 (when the EPF per capita transfer was frozen). Finally, the EPF was eliminated in 1995, and replaced by a block grant for health, social assistance, and post-secondary education, known as the Canada Health and Social Transfer (CHST).

The CHST has generated an enormous amount of controversy, in part because the provinces claim that it radically reduced the level of federal transfers.⁶¹ And to be sure, the value of the cash component of federal transfers declined dramatically, from \$18.5 billion in 1995-96, the last year before the CHST came into force (representing combined cash contributions under the EPF and the Canada Assistance Plan) to a low of \$12.5 billion in 1998-99, a decline of \$6.0 billion overall. The provinces have emphasized this figure.⁶² However, the CHST consists of a mixture of cash transfers and tax points, and over time, the value of those tax points has increased significantly. For example, between 1995-96 and 1998-99, the value of the tax points increased from \$11.4 billion

⁶⁰ This summary is taken from Finance Canada, "A Brief History of Federal Transfers" (2000), online: Finance Canada <<http://www.fin.gc.ca/FEDPROVE/hise.html>> (date accessed: 22 June 2000).

⁶¹ The figures in the following two paragraphs are taken from Canada, *Backgrounder on Federal Support for Health in Canada* (Ottawa: Finance Canada, 2000) at 5, online: Finance Canada <www.fin.gc.ca/activity/pubs/Health_e.pdf> (date accessed: 6 July 2000) [hereinafter *Federal Support*].

⁶² The provinces have accordingly called for cash transfers to be restored immediately to the levels where they stood in 1994-95 (\$18.7 billion dollars). According to the provinces, this would require an increase of \$4.2 billion, which suggests that they are relying on the 2000-01 cash base of \$14.5 billion. See Provincial and Territorial Ministers of Health, "Understanding Canada's Health Care Costs: Interim Report" (June 2000), online: Ontario Ministry of Health and Long-Term Care <http://www.gov.on.ca/health/english/pub/ministry/ptcd/ptcd_doc_e.pdf> (date accessed: 10 July 2000) at 19 [hereinafter *Provincial and Territorial Ministers of Health*]. In addition, the provinces have called for the adoption of "an appropriate escalator to ensure that funding for health through the CHST keeps pace with the economic trends, social factors, and changing health technology": see *ibid.* at 1. At present, CHST levels are set by s. 14 of the *Federal-Provincial Fiscal Arrangements Act* *supra* note 56.

to \$14.2 billion.⁶³ The net reduction over this period was therefore \$3.2 billion (from \$29.9 to \$26.7 billion), not the \$6.2 billion reduction in cash transfers pointed to by the provinces. Moreover, in the 1999 and 2000 budgets, the federal government did increase cash transfers to the provinces by \$11.5 and \$2.5 billion over five years, respectively, apparently bringing total cash transfers to \$15.5 billion annually by 2000-01. Moreover, the value of the tax points is expected to increase to \$17.2 billion in 2003-04, and as a consequence, the CHST is expected to stand at \$29.4 billion in 1999-2000, \$30.8 billion in 2000-01, \$31.3 billion in 2001-02, \$32.0 in 2002-03, and \$32.7 billion in 2003-04, compared to \$29.9 billion in 1995-96, the last year before the CHST came into force (none of these figures have been adjusted for inflation). However, it is important to note that of the new \$14 billion in cash transfers, only \$8 billion will be added to the cash base of the CHST, and will be ongoing, which raises serious questions regarding the future stability of federal cash contributions. Nevertheless, let us proceed on the assumption that those one-time supplements constitute part of the CHST.

An additional complication is that it is now difficult to gauge the actual level of federal financial support for health care because the CHST is a block grant for health, post-secondary education and social assistance, which provinces are free to spend as they choose. The federal government has addressed this problem by allocating a portion of the CHST to health expenditures, according to a complex formula described in Appendix, Table 4, below. Since the provinces have not proposed a formula of their own,⁶⁴ I will rely on it here. When these calculations are performed, federal support for health care stood at \$15.7 billion in 1995-96, declined to a low of \$14.4 billion in 1997-98, and since then has increased, to \$15 billion in 1998-99 and \$17.5 billion in 1999-2000. It is projected to increase to \$18.5 billion in 2000-01, \$19 billion in 2001-02, \$19.5 billion in 2002-03 and \$19.9 billion in 2003-04.

⁶³ The provinces continue to question the legitimacy of counting CHST tax points as a form of federal transfer payment, *inter alia*, because the tax transfer does not appear in the federal government's Public Accounts, because it does not appear as an expenditure in federal budgets, because increases in federal personal and corporate income taxes have offset the tax room vacated by the federal government in 1977, and because the tax room was originally transferred by the federal government to the provinces in 1942: see *Provincial and Territorial Ministers of Health* supra note 62 at 10-13. However, the same report acknowledges that the provinces agreed to the adoption of the EPF arrangement in 1977, which included tax points as part of the federal contribution: *ibid.* at 5. Moreover, the provinces "were not unhappy with the block fund concept (*including the tax transfer component*)": *ibid.* at 6 [emphasis added].

⁶⁴ The closest the provinces come to addressing the issue is in a recent report where they refuse to count federal tax transfers: *ibid.*

The final piece of the puzzle is the relative contribution of the federal government to provincial health care expenditures. The slight decline in total federal funding has occurred against the background of increasing health care expenditures by the provinces. According to the Canadian Institutes for Health Information, provincial government health expenditures increased from \$48.9 billion in 1995-96, to \$49.1 billion in 1996-97, to \$50 billion in 1997-98, and are estimated to have increased to \$52.8 billion in 1998-99 and \$55.6 billion in 1999-2000. As a percentage of provincial expenditures, then, the federal contribution has declined and then recovered over this period, from 32.1 per cent in 1995-96, to a low of 28.4 per cent in 1998-99, and then increased to 31.5 per cent in 1999-2000. However, federal cash contributions have dropped far more steeply, from 16.3 per cent in 1995-96 to a low of 10.1 per cent in 1998-99, and climbed back to 13.3 per cent in 1999-2000. It is these declining relative levels of federal cash transfers that have led to a loss of moral authority and financial leverage on the part of the federal government with respect to the enforcement of the national standards in the *CHA*.

B. *The Social Union Framework Agreement*

Prior to the current round of discussions on health care, a number of these concerns had already been raised by the provinces, and led to a set of federal-provincial negotiations that culminated in the *SUF*. Although the negotiations were prompted by the decline in federal financial support, it is important to recognize that other considerations were at play as well. The provinces were still bitter over the manner in which the CHST was introduced, accusing the federal government of having acted unilaterally, without prior notice or consultation. Moreover, the provinces had relied detrimentally on past promises of federal financial support, because they had been induced to create provincial programs, and, notwithstanding declining federal monies, were obliged as a condition of receiving federal funds both to continue those programs and to meet national standards. Additionally, recent initiatives, such as the Millennium Scholarship Fund, suggested that the federal government would expend new monies on direct federal initiatives instead of restoring federal transfer payments. The provinces called for a variety of measures, including provincial consent to the introduction of new shared cost programs, stable and adequate funding with a long-term commitment from the federal government, the right to

opt-out with compensation, à la Meech and Charlottetown,⁶⁵ and even the devolution of revenue-raising authority to reduce vertical fiscal imbalance. Lurking in the background were national unity concerns, such as the need to demonstrate the viability of non-constitutional options to renew the federation, and a desire to reassert social policy as an important component of Canadian identity in the face of economic globalization.⁶⁶

⁶⁵ Proposed constitutional amendments contained in the Meech Lake Accord and the Charlottetown Accord would have dramatically altered the legal framework surrounding the exercise of the federal spending power: Canada, *Constitutional Accord 1987* (Ottawa: Queen's Printer, 1987) at cl. 7.; and Canada, *Charlottetown Accord: Draft Legal Text* (Ottawa: Queen's Printer, 1992) at s. 16. These amendments would have allowed a province to opt-out from shared cost programs established after the coming into force of the amendment in areas of exclusive provincial jurisdiction, and to receive "reasonable compensation" if that province carried on "a program or initiative" that was "compatible with national objectives." These amendments were criticized by some for not going far enough in disciplining the exercise of the federal spending power, because they only applied to new and not existing shared cost programs, for example, those relating to health, welfare and education, because they applied to transfers to provinces, for example, the CHST, but not transfers to individuals, and because they required that provinces operate programs that were compatible with national objectives. In addition, Quebec sovereignists argued that the adoption of the amendment would have amounted to a victory for the federal government, because it formally recognized the existence of the federal spending power. Conversely, some argued that the amendments attached too many restrictions on the exercise of the federal spending power, because they would have made it extremely difficult for the federal government to introduce new national programs with minimum national standards, thereby eliminating shared cost programs as instruments of national unity, and because the threat of provincial non-participation would have forced the federal government to propose much looser and more general national standards. For a collection of these views, see K. Banting, "Political Meaning and Social Reform" in K.E. Swinton & C.J. Rogerson, eds., *Competing Constitutional Visions: the Meech Lake Accord* (Toronto: Carswell, 1988) 163; R.W. Boadway, J.M. Mintz and D.D. Purvis, "Economic Policy Implications of the Meech Lake Accord" in Swinton & Rogerson, *supra*, 225 at 229-32; Canada, *Report of the Special Joint Committee on the 1987 Constitutional Accord* (Ottawa: Supply and Services Canada, 1987) ch. 7; D. Coyne, "The Meech Lake Accord and the Spending Power Proposals: Fundamentally Flawed" in M.D. Behiels, ed., *The Meech Lake Primer: Conflicting Views of the 1987 Constitutional Accord* (Ottawa: University of Ottawa Press, 1989) 245; P. Fortin, "The Meech Lake Accord and The Federal Spending Power: A Good Maximun Solution" in Swinton & Rogerson, *supra*, 213; and P.W. Hogg, "Analysis of the New Spending Power (Section 106A)" in Swinton & Rogerson, *supra*, 155.

⁶⁶ See generally, R. Boadway, "Delivering the Social Union: Some Thoughts on the Federal Role" (1998) 19:9 Pol'y Options 37; T.J. Courchene, "In Praise of Provincial Ascendancy" (1998) 19:9 Pol'y Options 30; D. Cunningham, "Ontario's Approach to Improving Canada's Social Union" (1998) 19:9 Pol'y Options 14; J. Facal, "Pourquoi le Québec a adhéré au consensus des provinces sur l'union sociale" (1998) 19:9 Pol'y Options 12; D. Hancock, "Designing a New Social Framework for Canadians" (1998) 19:9 Pol'y Options 17; M. Jérôme-Forget, "Canada's Social Union: Staking Out the Future of Federalism" (1998) 19:9 Pol'y Options 3; H. Lazar, "The Social Union: Taking the Time to Do It Right" (1998) 19:9 Pol'y Options 43; A. McLellan, "Modernizing Canada's Social Union: A New Partnership Among Governments and Citizens" (1998) 19:9 Pol'y Options 6; K. Ng and D.R. Sloan, "Reforming Canada's Social Union: The Territorial Perspective" (1998) 19:9 Pol'y Options 23; A. Noël, "Les trois unions sociales" (1998) 19:9 Pol'y Options 26; R. Romanow,

The *SUF* addressed some of these concerns. Our specific focus here is Article 6, entitled “Dispute Avoidance and Resolution.” Coming into the negotiations, the provinces and social policy commentators had consistently called for the need to institutionalize federal-provincial relations in the social policy arena.⁶⁷ Unilateral federal enforcement of the *CHA*, in particular, was a source of provincial irritation. The provinces accordingly called for the establishment of dispute resolution machinery that was impartial. In the end, *SUF* did not establish the sort of machinery that the provinces sought. Rather, aside from some scattered specifics, Article 6 establishes a general framework for the creation of dispute settlement machinery in the future. Important details remain underspecified.

What does Article 6 actually say? Signatories committed themselves to “working collaboratively to avoid and resolve intergovernmental disputes.” In terms of substantive policy areas, dispute resolution would be applicable, *inter alia*, to the *CHA* (although Article 6 also states that existing legislative provisions will be respected). Article 6 appears to contemplate three types of processes: dispute avoidance, negotiations, and mediation. Dispute avoidance will be encouraged “through information-sharing, joint planning, collaboration, advance notice and early consultation, and flexibility in implementation.” Negotiations will be premised on joint fact-finding, which may be conducted by a third party, and which will be made public if one party so requests. In addition, negotiations may be accompanied by mediation; again, mediation reports will be made public if one party so requests. Mechanisms for dispute resolution must respect a list of general principles; they have to be “simple, timely, efficient, effective and transparent,” allow for the possibility of non-adversarial solutions, be appropriate for the specific sectors in which the disputes arise, and provide for the expert assistance of third parties.

It is difficult to get a handle on what specific procedures would be consistent with Article 6. Indeed, there are many institutional

“Reinforcing ‘The Ties That Bind’” (1998) 19:9 Pol’y Options 9; C. Thériault, “New Brunswick’s Perspective on the Social Union” (1998) 19:9 Pol’y Options 20; and F. Vaillancourt, “Alter the Federal-Provincial Powers Mix to Improve Social Policy” (1998) 19:9 Pol’y Options 50.

⁶⁷ Canadian Intergovernmental Conference Secretariat, News Release, “Framework Agreement on Canada’s Social Union” (6 August 1998), online: Canadian Intergovernmental Conference Secretariat <http://www.scics.gc.ca/cinfo98/85007010_e.html> (date accessed: 25 May 2000); J. Richards, “The ‘Unholy Alliance’ Versus ‘Securing Our Future Together’” (1998) 19:9 Pol’y Options 40 at 41; K.G. Banting, “Social Citizenship and the Social Union in Canada” (1998) 19:9 Pol’y Options 33 at 36; L. Johnson, *Behind the “Social Union”* (Toronto: Ontario Legislative Library, 1999), online: Ontario Legislative Library <<http://www.ontla.on.ca/library/b29tx.htm>> (date accessed: 24 June 2000); and D. Schwanen, *More Than the Sum of Our Parts: Improving Mechanisms of Canada’s Social Union* (Toronto: C.D. Howe Institute, 1999) at 27-28.

questions surrounding the design of dispute resolution that remain unresolved. With respect to the modes of dispute resolution that are referred to—negotiations and mediation—Article 6 does not address important issues. For example, Article 6 does not stipulate that either negotiations or mediation be obligatory. Without such an obligation, negotiations or mediation may not even be commenced (witness the Bill 11 dispute). As well, the role of the mediator is not addressed. As Guy Tremblay has written in his analysis of Article 6, in the labour relations context, mediators can often propose solutions to parties, which may incorporate the interpretation and application of the relevant legal materials to the facts at hand.⁶⁸ If a mediator were charged with producing this sort of report, and if such a report were made public, it might carry a normative force that compensated for its lack of legal enforceability.

But the central problem is the failure of Article 6 to refer to dispute settlement mechanisms other than negotiation and mediation. The obvious omission is adjudication. The gap is all the more glaring because compliance with the terms of the *CHA* is justiciable.⁶⁹ An individual could launch a court case in which the issue would be the compliance of a provincial health insurance scheme with the national standards spelled out in the *CHA*. Similar litigation occurred with respect to the now-defunct *Canada Assistance Plan*.⁷⁰ Indeed, had the federal government sought to challenge Bill 11, it could have proceeded by way of a reference to the Supreme Court of Canada. Alternatively, public interest organizations in Alberta could still launch a court case either in the Alberta superior courts or the federal court, although there are important hurdles to overcome with respect to standing and the review of cabinet discretion.⁷¹ It is important that adjudication be available, because negotiations and mediation may fail. Indeed, the possibility of adjudication may create the incentives for a negotiated or mediated solution.

What institutions should be vested with adjudicative responsibility? The options are courts, specialist panels, or some

⁶⁸ Tremblay, *supra* note 5. Tremblay refers to a consensus document agreed to by all the provinces in Victoria on 29 January 1999, which would have made mediation obligatory, and in the event of an impasse, would have required the report to be made public.

⁶⁹ In fact, the funding criteria in the *CHA* have been interpreted in a handful of cases: *Lexogest Inc. v. Manitoba (A.G.)* (1993), 101 D.L.R. (4th) 523 (Man. C.A.); and *Collett*, *supra* note 41.

⁷⁰ *Canada (Minister of Finance) v. Finlay*, [1986] 2 S.C.R. 607 and *Finlay (no. 3)*, *supra* note 26.

⁷¹ I discuss these at length in “Enforcement of the *CHA*,” *supra* note 6.

combination of the two. My preference is for the latter option. Both courts and specialist panels possess institutional advantages over the other that should be harnessed by any dispute settlement system. Specialist panels would possess the requisite expertise to engage in the sort of fact-finding that the criteria of accessibility and comprehensiveness demand. As I mentioned earlier, a variety of data, ranging from information regarding cost-effectiveness, to waiting lists and physician to patient ratios, will play into the interpretation of these criteria. An additional advantage of specialist panels is the ability to appoint non-lawyers with expertise in health policy, and with intimate knowledge of the health care system. Finally, specialist panels can be constituted from a list mutually agreeable to the federal and provincial governments, an option constitutionally precluded for courts.

In this scheme, courts would serve a supervisory function, largely confined to ensuring that the panel system conforms to norms of procedural propriety. But courts would also be important in securing access to dispute resolution for citizens. Although I have emphasized the importance of bilateral mechanisms in light of joint federal-provincial responsibility for health care, these should not operate to the exclusion of citizen interests. Medicare is a central part of the Canadian understanding of social citizenship, and, ultimately, is concerned less with financial relationships between governments than with providing high quality medical care to Canadians in the service of fair equality of opportunity. The constitutionally secured independence of courts would ensure that dispute settlement machinery would not fall prey to the political dynamic of executive federalism.

Thus, I contemplate a two-track process whereby either governments, federal or provincial, or citizens could invoke the dispute settlement machinery established under the *SUF*. A similar arrangement currently exists under the *Agreement on Internal Trade*⁷² although it would be inappropriate to simply apply that model here.⁷³ Under the *AIT*, citizens may launch complaints against provincial or federal laws or practices in one of two ways. A government may act on behalf of a citizen with whom it has a substantial and direct connection, or if a government refuses to act on behalf of a citizen, a citizen may act on her own. Under the latter process, the intergovernmental body created by

⁷² Canada, *Agreement on Internal Trade* (Ottawa: Industry Canada, 1994) [hereinafter *AIT*].

⁷³ For a discussion of the dispute settlement mechanisms under the *AIT*, see R.J. Howse, "Between Anarchy and the Rule of Law: Dispute Settlement and Related Implementation Issues in the Agreement on Internal Trade" in M.J. Trebilcock & D. Schwanen, eds., *Getting There: An Assessment of the Agreement on Internal Trade* (Toronto: C.D. Howe Institute, 1995) 170.

the *AIT*, the Internal Trade Secretariat, exercises a gatekeeping function to screen out frivolous complaints. The principal difference between the economic union and social union contexts is that provincial and individual interests are not aligned in the latter, whereas they are in the former. Challenges to provincial measures under the *AIT* are typically brought by non-resident economic entities (citizens or corporations)—outsiders—that are legally resident in another province, and on whose behalf the home province may have good economic and political reasons for acting. An outsider, for example, may be a large corporate entity that employs individuals and consumes services in the home province. With respect to the *CHA*, by contrast, aside from barriers to interprovincial mobility, challenges to provincial measures will typically be brought by *insiders* against their provinces of residence. Other provinces would have no incentive to take up claims on their behalf, and indeed, in order to protect themselves from claims brought by other provinces, might act collusively to impede citizen complaints. Accordingly, citizens should not be required, in the first instance, to convince governments to bring claims on their behalf.

C. *Does Bill 11 violate the CHA? The Need for Dispute Settlement Machinery*

The *SUF* was referred to by both the federal and Alberta governments early on in the Bill 11 dispute. Rock invoked the *SUF* in his initial letter to Jonson of 26 November 1999, as a justification for raising questions regarding Bill 11.⁷⁴ Jonson confirmed that Alberta was a signatory to the *SUF* in his letter to Rock of 10 December 1999, with respect to the *SUF*'s provisions on accountability.⁷⁵ However, neither party has referred to the need for dispute settlement machinery or Article 6.

This is extremely disappointing, since dispute settlement machinery would have been particularly useful in the Bill 11 dispute. For legal scholars, one of the most interesting features of the Bill 11 dispute is that behind the political rhetoric lies a real legal disagreement. This disagreement was framed around dueling legal opinions commissioned by CUPE and the Alberta government on the compliance of Bill 11 with

⁷⁴ “Minister Rock Responds,” *supra* note 19.

⁷⁵ “Health Minister Responds,” *supra* note 19.

the *CHA*, that arrived at opposing answers to this question.⁷⁶ At its core, this disagreement turns on competing interpretations of both Bill 11 and the program criteria in the *CHA*. The existence of this sort of legal disagreement, of course, suggests both the potential and the need for institutions to resolve it.

So what is the legal dispute? Although far from a model of clear legislative drafting, Bill 11 clearly contemplates that two different categories of surgical services will be available in Alberta. The first consists of surgical services covered by the provincial health insurance scheme. The Act refers to these as “insured surgical services,” which it defines as services that are “provided by a physician, or by a dentist in the field or oral surgery, in circumstances under which a benefit is payable under the *Alberta Health Care Insurance Act*.”⁷⁷ Where can insured surgical services be received? Section 2(1) of Bill 11 provides that surgical services, not just insured surgical services, can only be received in a public hospital or “an approved surgical facility,” the language used by Bill 11 to refer to for-profit clinics. An approved surgical facility is either a facility “designated” to provide insured surgical services, or a surgical facility accredited to provide uninsured surgical services.⁷⁸ By implication, it appears that *insured* surgical services can be received at a public hospital or a designated surgical facility. However, there are two restrictions on the kinds of insured surgical services that can be provided at designated surgical facilities. No such facility may provide a “major surgical service,” to be defined in by-laws enacted pursuant to the *Medical Profession Act*.⁷⁹ It follows that insured surgical services that are also major surgical services cannot be provided at designated surgical facilities, although what a major surgical service constitutes remains unclear. In addition, only public hospitals may admit patients for medically supervised stays exceeding twelve hours,⁸⁰ which suggests that insured surgical services requiring supervised stays of more than twelve hours cannot be provided by

⁷⁶ “CUPE Opinion,” *supra* note 54; and J.C. Levy, “*Canada Health Act and Alberta Bill 11*” Legal Opinion, 27 March 2000 [unpublished, on file with the author]. Halvar Jonson relied on this opinion in a news release dated 5 April 2000, in which he reasserted his claim that Bill 11 did not in any way violate the *CHA*: see Government of Alberta, News Release, “Bill 11 Consistent with *Canada Health Act*” (5 April 2000), online: Government of Alberta <<http://www.gov.ab.ca/acn/200004/8976.html>> (date accessed: 22 June 2000).

⁷⁷ Bill 11, *supra* note 3, s. 29(i).

⁷⁸ *Ibid.*, s. 29(b), read in combination with s. 16.

⁷⁹ *Ibid.*, s. 2(2).

⁸⁰ *Ibid.*, s. 29(m), read with s. 1.

designated surgical facilities. With respect to insured surgical services, Bill 11 prohibits queue jumping, i.e. the giving or accepting of money or valuable consideration in order to give any person priority for the receipt of an insured surgical service.⁸¹ Moreover, Bill 11 also prohibits designated surgical facilities from imposing user charges.⁸²

Bill 11 also refers to a second category of surgical services, which fall within the ambit of a broader category termed “enhanced medical goods or services.” These are defined as “medical goods or services that exceed what would normally be used in a particular case in accordance with generally accepted medical practice.”⁸³ The list of enhanced medical goods and services will be defined by the provincial cabinet through regulation.⁸⁴ It appears that enhanced medical goods or services can be provided by public hospitals and surgical facilities designated to provide insured surgical services;⁸⁵ it is not clear whether surgical facilities that have been accredited to provide uninsured surgical services can provide enhanced medical goods and services as well. Bill 11 accords enhanced medical goods and services and insured surgical services differential treatment in two respects. First, Bill 11 contemplates user charges for enhanced medical goods and services, subject to a disclosure requirement,⁸⁶ whereas user charges for insured surgical services are clearly forbidden.⁸⁷ Second, it appears that the prohibition on queue jumping in section 3 might be inapplicable to enhanced medical goods or services, because payments for those services would be payments not “for the purpose of giving any person priority for the receipt of an insured surgical service” but for the purpose of by-passing the public system altogether.⁸⁸ Taken together, the legality of user charges and the

⁸¹ *Ibid.*, s. 3.

⁸² *Ibid.*, s. 4(b).

⁸³ *Ibid.*, s. 29(f).

⁸⁴ *Ibid.*, s. 25(1)(g). Note that this provision does not require the provincial cabinet to exercise its regulation making power in accordance with the *CHA*.

⁸⁵ *Ibid.*, s. 5(1).

⁸⁶ *Ibid.*, ss. 5(1), 5(2).

⁸⁷ However, s. 5(1.1), *ibid.*, caps the rate for enhanced medical goods or services as “cost plus a reasonable allowance for administration.” This language was introduced into Bill 11 to limit the price for uninsured services. However, given that the cost of enhanced goods and services will in part be a function of factors of production that are supplied by markets that are not covered by public health insurance, this may prove to be an illusory limit on prices.

⁸⁸ However, s. 3, *ibid.*, does prohibit persons from paying or accepting payment “for enhanced medical goods or services ... for the purpose of giving any person priority for the receipt of an insured service,” which arguably does extend the prohibition against queue jumping to enhanced

potential legality of queue jumping mean that enhanced medical services and goods will be allocated on the basis of ability to pay.

Given that market forces will determine the distribution of enhanced medical services and goods, what services and goods fall into that category is of critical importance. Indeed, the central disagreement between the Alberta and CUPE opinions is the relationship between enhanced medical goods or services and insured surgical services. To be fair, Bill 11 is silent on this crucial point, but commentators have been willing to offer interpretations. The CUPE opinion suggests enhanced medical goods or services could differ from insured services or goods in one of two ways. First, they may be goods or services that are of higher quality than insured goods or services, but which address the same underlying medical condition. For example, whereas the health insurance plan may provide a basic hearing aid or pacemaker that meets the test of medical necessity, individuals may be able to purchase a hearing aid or pacemaker of higher quality. Second, enhanced medical services may be identical to insured services in every respect except that they are provided more quickly than medical necessity requires. The concern expressed by the CUPE opinion is that the ability of individuals to obtain more quickly the same services available from the public insurance scheme would eviscerate the ban on queue jumping. The Alberta opinion, by contrast, offers a more benign interpretation of enhanced medical goods and services, by suggesting those services can only be provided when bundled with insured surgical services. The textual basis for this interpretation of Bill 11 is a provision that stipulates that persons who receive insured surgical services shall not pay for enhanced medical goods or services unless certain disclosure requirements have been met.⁸⁹ The implication drawn by the Alberta opinion is that enhanced medical goods and services merely supplement, but do not substitute for, insured surgical services.

Which view is correct? To begin, the Alberta opinion is flawed, because there are other provisions in Bill 11 which clearly suggest that the relationship between enhanced and insured services and goods is not one just of supplementation, but also of substitution. In this regard, subsection 5(5)(a) is quite explicit, because it refers to a situation where a patient is provided with an enhanced medical good or service *because* the normal medical good or service is not available; presumably, if it were available, it would be unnecessary to receive the enhanced good or service. It would appear, then, that enhanced goods or services may

medical goods and services.

⁸⁹ *Ibid.*, s. 5(1).

either supplement or substitute for insured goods or services. Does this mean that the CUPE opinion is correct? In the end, a great deal will turn on the implementation of Bill 11 through regulations. But it does seem that Bill 11 is open to implementation in the manner envisaged by CUPE.

If Bill 11 were implemented in this way, would the resulting scheme contravene the *CHA*? The key national standard is comprehensiveness, which requires that provincial health plans provide all “medically necessary” or “medically required” hospital and physician services. Although it is not entirely clear on this point, the CUPE opinion argues that Bill 11 breaches the comprehensiveness criteria because it provides that provincial health insurance plan will only cover those medical goods that are “minimally” medically necessary, rather than those which are medically necessary. There are a number of difficulties with this argument. First and foremost, Bill 11 does not define what medical goods and services can or will be covered by the provincial health insurance plan. Rather, Bill 11 only defines the content of enhanced medical goods and services that may be offered outside the provincial insurance system.

The CUPE opinion, however, offers a more complex argument that links up Bill 11 with the provincial health insurance plan. Recall that Bill 11 defines enhanced goods and services as those “that exceed what would normally be used in a particular case in accordance with generally accepted medical practice,” a phrase that is clearly a benchmark of medical necessity. Indeed, Bill 11 states at one point that enhanced medical goods or services are *not* “medically required.”⁹⁰ The CUPE opinion (1) reads back this definition of medical necessity into the *Alberta Health Care Insurance Act*⁹¹ which defines insured services as those services provided by physicians that are “medically required,”⁹² and (2) argues that this definition is merely one of “minimal” medical necessity, which falls short of the comprehensiveness standard in the *Canada Health Act*. Let us assume that point (1) is correct. What about point (2)? CUPE’s argument is that the standard of medical necessity laid down by Bill 11 falls short of the standard of medical necessity laid down by the *CHA*. However, the *CHA* is famously ambiguous on this point. Although medical necessity is the central concept in the *CHA*, the Act does not define this crucial term. I have argued elsewhere that in the

⁹⁰ *Ibid.*, s. 5(2)(b)(iii).

⁹¹ R.S.A. 1980, c. A-24.

⁹² *Ibid.* at s. 1(n).

face of this ambiguity, “medical necessity” should be interpreted in a generous manner, to encompass any and all services which restore individuals to a state of normal functioning.⁹³ However, the definition of “medical necessity” adopted in Bill 11 is another plausible interpretation, particularly because it relies on medical judgment, not cost-effectiveness, as the framework of reference. If that is right, then Bill 11 may not contravene the comprehensiveness requirement. At the very least, the point is unsettled.⁹⁴ And when interpretive disagreements of this sort arise, so does the need for institutions to resolve them.⁹⁵

The better objection to Bill 11 is that the resulting scheme would contravene not the letter, but the spirit of the *CHA*. As the CUPE opinion puts it, “patients with identical medical conditions would receive different standards of care or different waiting times for care, depending entirely on their ability to pay.”⁹⁶ The genesis of public health insurance schemes in Canada, of course, was a rejection of unregulated markets as the appropriate mechanism for the allocation of medical goods and services. Two-tier medicine sits uncomfortably with the moral premises of Medicare. This is not the first time that events on the ground have pointed to a gap between the ambitions of and the legal framework surrounding Medicare. Indeed, the introduction of explicit bans on user fees and extra-billing in 1984 was a response to the concern that existing program criteria, such as accessibility, were inadequate means for pursuing that end.

As well, although Bill 11 may not violate the *CHA*, it might set in place a process that will create a state of affairs in Alberta that *will* contravene the Act. The standard criticism against the creation of a

⁹³ “Enforcement of the *CHA*,” *supra* note 6 at 485-86.

⁹⁴ In this vein, Charles *et al.* have observed that “the concept of medical necessity has taken on diverse, implicit, and subtextual meanings over time to accommodate the different policy interests of specific groups”: Charles *et al.*, “Medical Necessity in Canadian Health Policy: Four Meanings and ... a Funeral?” (1997) 75 *Milbank Q.* 365 at 367. Included in this list of meanings is “what physicians and hospitals do,” which is roughly equivalent to the standard laid down by Bill 11. For an argument that medical necessity should be re-oriented away from comprehensiveness toward reasonable access, and that attempts to define a concise and operational definition of medical necessity are futile, see J. Hurley *et al.*, *Defying Definition: Medical Necessity and Health Policy Making*, Centre for Health Economics and Policy Analysis, Working Paper 96-16.

⁹⁵ But even if the definition of “medical necessity” in Bill 11 does contravene the comprehensiveness requirement, it does not follow that Alberta’s health care system has violated the *CHA*. What counts in the end is the list of covered services and goods on the provincial health insurance scheme. Bill 11 does not purport to amend this list. If, for example, the list of insured goods and services exceeds the minimum set by the provincial legislation, and the federal legislation sets a higher standard that Alberta meets, the *CHA* would have been complied with.

⁹⁶ “CUPE Opinion,” *supra* note 54 at 29.

privately funded health care system that exists alongside and in parallel to a publicly funded system is that it will siphon off resources from the public system. A private system, it is argued, will attract the best physicians, which will increase waiting lists for specialist treatments, rather than decreasing them. As well, the availability of a private option will facilitate the exit of the wealthy from the public system, and will eliminate both their incentive to ensure that that system functions effectively, and their desire to contribute financially to that system. In the end, all of these developments would impede accessibility. Defenders of Medicare routinely present these factual propositions as articles of faith, whereas in fact, they are empirical propositions that must be tested against the evidence. Thus, Bill 11 creates the need for effective monitoring machinery that can determine whether threats to accessibility actually materialize.

D. *Is the Social Union Framework Dead?*

My suggestion that dispute settlement machinery be established under the *SUF* suggests that the *SUF* possesses some normative force, and for that reason, that governments will seek to implement it. But does it? I am afraid here that the limited evidence available suggests that the *SUF* has not had the domesticating or civilizing influence on intergovernmental relations with respect to social policy that its framers envisaged.

Consider two recent examples. The first was the federal government's homelessness initiative, announced last December. This initiative involves rather significant federal government expenditure in an area of provincial jurisdiction-housing. It appears that most of these monies will consist of grants to local governments and non-profit entities. The relevant point is that under the *SUF*, the federal government was obliged to give at least three months' notice to provincial governments and to offer to consult with them. It appears that this term of the *SUF* was not complied with. Indeed, my understanding is that provincial ministers with responsibility for social policy were meeting in Ottawa on the very day of the federal announcement, and heard about the federal initiative from the media.

The second example, of course, is the controversy surrounding Bill 11 in Alberta itself. The active role of the federal government masks the fact that the *SUF* has played little or no role in the dispute. Under the *SUF*, Alberta was obliged to give the federal government advance notice prior to the announcement of Bill 11, and to offer consultations.

Neither of these requirements was met. Moreover, as I have discussed, neither party invoked Article 6 and suggested the creation of dispute settlement machinery to determine the compliance of Bill 11 with the *CHA*.

IV. CONCLUSION

The reform of Canadian Medicare will be one of the dominant policy issues of the next decade. Canadians are in search of practical solutions that simultaneously satisfy the constraints of costs and justice, and which respond to the changing realities of medical practice. My argument in this paper has been that the role of supervisory institutions is an additional topic that should not be ignored. The crafting of supervisory institutions—whether in the form of a Medicare Commission, and/or dispute settlement machinery under the *SUF*—must be responsive both to political realities and to the constitutional framework surrounding Medicare. But above all, since Medicare is constitutive of the Canadian understanding of social citizenship, these institutions must ensure that Medicare is accountable to Canadians.