
The Enforcement of the Canada Health Act

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The commitment to comprehensive and universal health care, as reflected in the *Canada Health Act*, is often regarded as a defining characteristic of our country. Today, Medicare in Canada faces a number of challenges which pose a serious threat to its survival. The increasing financial pressure placed on health-care budgets has led to cost-cutting measures which may contravene the fundamental principles of Medicare, as spelled out by the Act.

Overlooked in the political debate about the future of Medicare has been the potential to achieve social justice through the existing statutory framework of the Act. The author examines whether the basic criteria laid down in the C.H.A. are capable of giving rise to legal liability and proposes a legal strategy for enforcing the terms of the Act. To this end, the feasibility of a legal claim against both federal and provincial governments is examined in turn. The author discusses the many hurdles that must be overcome in order for an individual to successfully bring a claim against the government.

The author concludes that the C.H.A. can function as both a political and a legal document. In terms of legally enforcing the C.H.A.'s criteria, liability is likely to be restricted to the federal government, since the Act is probably not enforceable against the provinces. A successful claim would have the effect of inducing greater vigilance with respect to meeting the criteria of the C.H.A. Ultimately, however, it is argued that regardless of whether an individual legal claim is successful, it is the political value of litigation that could make a challenge worthwhile. The result of such litigation would be to raise public awareness of the challenges facing Medicare and, thus, lead to political change. In this way, the C.H.A. can serve a dual purpose and prove to be an effective tool for ensuring the integrity of the Medicare system.

L'engagement d'offrir des soins médicaux complets et universels, tel que reflété dans la *Loi canadienne sur la santé*, est souvent perçu comme une caractéristique de notre pays. De nos jours, le programme canadien d'assurance-maladie fait face à de nombreux défis qui menacent sérieusement son existence. Les contraintes budgétaires touchant les programmes de santé ont mené à l'adoption de mesures de réduction de coûts qui pourraient contrevenir aux principes fondamentaux du programme d'assurance-maladie, tels qu'énoncés dans la loi.

Le débat politique sur l'avenir du programme d'assurance-maladie a longtemps ignoré la possibilité d'aboutir à une justice sociale par l'intermédiaire du cadre offert par la loi. L'auteur cherche à déterminer si les critères fondamentaux formulés dans la loi peuvent servir de base à une responsabilité légale et il propose une stratégie légale permettant d'appliquer les dispositions de la loi. À cette fin, il examine la faisabilité d'une revendication légale contre les gouvernements fédéral et provinciaux. L'auteur traite des nombreuses étapes qu'un individu devra franchir afin que sa revendication auprès du gouvernement soit fructueuse.

En définitive, la loi peut fonctionner comme un document à la fois politique et légal. En ce qui a trait à l'application légale des critères de la loi, l'auteur conclut que la responsabilité sera vraisemblablement restreinte au gouvernement fédéral, puisque la loi n'est probablement pas applicable à l'égard des provinces. Une revendication fructueuse entraînerait plus de vigilance en ce qui concerne le respect des critères prévus dans la loi. Nonobstant le succès d'une revendication légale individuelle, l'auteur estime que ce serait l'aspect politique du litige qui lui donnerait sa valeur. Le résultat d'un débat serait d'informer le public des défis auxquels fait face le programme d'assurance-maladie et, ainsi, mener à un changement politique. De cette façon, la loi peut servir deux buts à la fois et être un instrument efficace pour assurer l'intégrité du système d'assurance-maladie.

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Conclusion: The Politics of Medicare

Introduction

*Medicare is a remarkable achievement. Through a process of evolution, with minimum dislocation and disruption, a cost-effective universal health insurance plan has been made possible for virtually all residents of this vast country. Yet this achievement now appears endangered.*¹

Health and Welfare Canada

These words were written in the early 1980s, when Medicare was coming under threat from extra-billing by physicians and user fees imposed by provincial health plans. To many, the adoption of the *Canada Health Act*² was meant to solve these problems, guaranteeing Canadians access to comprehensive and universal health care. Today, unfortunately, Medicare faces new challenges. Provincial health budgets have come under increased financial pressure over the last decade, due to decreased federal transfer payments and the increasing supply of physicians. In response, many provincial governments are contemplating de-listing certain medical procedures from provincial health plans and adopting other measures to reduce costs.³ These cost-cutting measures and the prospect of declining federal financing for Medicare are generating a storm of political protest.

The C.H.A. has often been invoked by the various actors in the health-policy arena — health-care providers, hospitals, and various levels of government — as defining an ideal Canadian medical system. It is interesting to contrast this political role for the C.H.A. with the proposals put forth during the last round of constitutional reform for justiciable social and economic rights, including a right to health care,⁴ and with the attempt to interpret section 7 of the *Canadian Charter of Rights and Freedoms*⁵ as guaranteeing welfare rights (including a right to medical services).⁶ Overlooked, however, has been the potential to achieve social justice

¹ Health and Welfare Canada, *Preserving Universal Medicare* (Ottawa: Supply and Services Canada, 1982) at 16.

² R.S.C. 1985, c. C-6 [hereinafter C.H.A.].

³ Examples of such measures include: hospital closures; emergency ward closings; reductions in the number of hospital beds; reductions in the number of hours of elective surgery; reductions in the number of emergency operating rooms; and requiring patients to pay for non-medical costs associated with hospital stays.

⁴ See generally: J. Bakan & D. Schneiderman, eds., *Social Justice and the Constitution: Perspectives on a Social Union for Canada* (Ottawa: Carleton University Press, 1992); C. Scott, "Social Values Projected and Protected: A Brief Appraisal of the Federal and Ontario Government Proposals" in D. Brown, R. Young & D. Herperger, eds., *Constitutional Commentaries: An Assessment of the 1991 Federal Proposals* (Kingston: Queen's University Institute of Intergovernmental Relations, 1992) 81.

⁵ Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [hereinafter *Charter*].

⁶ See: M. Jackman, "The Protection of Welfare Rights Under the Charter" (1988) 20 *Ottawa L. Rev.* 257; I. Johnstone, "Section 7 of the Charter and Constitutionally Protected Welfare" (1988) 46 *U.T. Fac. L. Rev.* 1; R. Howse, "Another Rights Revolution? The *Charter* and the Reform of Social Regulation in Canada" in P. Grady, R. Howse & J. Maxwell, eds., *Redefining Social Security* (Kingston:

through the existing statutory framework: by recognizing the C.H.A. as not merely a political, but a legal instrument.

To date there has been little scholarship on the legal consequences under the C.H.A. of provincial cost-cutting measures and on avenues open to individuals — the intended beneficiaries of the C.H.A. — to protect their interests through the courts.⁷ Can the C.H.A.'s five criteria — universality, comprehensiveness, public administration, portability, and accessibility — engender legal liability? This paper explores this possibility. Part I provides a brief history of Medicare in Canada and a description of the provisions of the C.H.A. Part II provides two reasons for renewed legal interest in the C.H.A.: the current importance and awareness of decisions regarding resource allocation and the federal government's failure to enforce the C.H.A.'s terms. Part III examines the prospects for and efficacy of an enforcement claim against the federal government through a consideration of standing, the argument's merits, and the available remedies under federal administrative law. Part IV considers the possibility of obtaining a suitable remedy directly against provincial governments. The Conclusion assesses the merits of enforcing the C.H.A. through citizen-initiated litigation. It may be that taking up the proposed legal strategy would have a greater impact in the legislatures than it does in the courts.

I. Background

A. *A Brief History of Medicare in Canada*⁸

Medicare grew out of a set of federal proposals tabled at the Dominion-Provincial Conference on Reconstruction⁹ at the conclusion of the Second World War. Although the "Green Book Proposals" were never adopted, they signalled a radical, new approach in the provision of health care in Canada. Until then, medical treatment had been available, like any other consumer service, on the market

School of Policy Studies, Queen's University, 1995) 102 at 108-110; M. Jackman, "Poor Rights: Using the *Charter* to Support Social Welfare Claims" (1993) 19 *Queen's L.J.* 65 at 67-79.

⁷ Two exceptions are: Canadian Bar Association, *What's Law Got to Do With It? Health Care Reform in Canada* (Ottawa: Canadian Bar Association, 1994) at 77-79 [hereinafter C.B.A.]; S.L. Martin, *Women's Reproductive Health, the Canadian Charter of Rights and Freedoms, and the Canada Health Act* (Ottawa: Canadian Advisory Council on the Status of Women, 1989) at 18-22. On the other hand, some commentators have examined the question of whether the *Charter* may impose some restrictions on resource allocation in health care. The role of the *Charter* is beyond the scope of this paper. For a recent discussion, however, see R.Z. Shaul, *The Implications of sections 1, 15, and 24 of the Canadian Charter of Rights and Freedoms on Health Care Allocation Decisions* (LL.M. Thesis, University of Toronto, 1993) [unpublished].

⁸ The most comprehensive history of Canadian Medicare is provided by M.G. Taylor, *Health Insurance and Canadian Public Policy*, 2d ed. (Montreal: McGill-Queen's University Press, 1987).

⁹ See Dominion-Provincial Conference on Reconstruction: Dominion-Provincial Submissions and Plenary Conference Discussions (Ottawa, August 1945) at 31-33 [hereinafter Conference on Reconstruction].

and subject to the laws of supply and demand. As a result, the amount and quality of available care depended on a person's ability to pay. The federal proposals, *inter alia*, sought to replace this private market with a system of public health insurance, partially funded by federal grants, which would cover a wide range of services.¹⁰ These proposals were never adopted, however, because they were part of a complex package that included a redistribution of taxation power that was unacceptable to the provinces.¹¹ Nevertheless, as Taylor notes, they served to focus public attention on the economic barriers to health care.¹²

Despite the failure of the Conference on Reconstruction, in 1947 the Saskatchewan government ultimately implemented a provincial health-insurance plan funded without federal support.¹³ The plan was universal (covering all residents) and compulsory, in that it was funded through a special tax. Moreover, the plan "provided for an almost complete range of hospital services as benefits".¹⁴ Saskatchewan's plan served as a model for other provinces and played an instrumental role in prompting the federal government to introduce a national health-insurance program in 1957,¹⁵ the *Hospital Insurance and Diagnostic Services Act*.¹⁶ The Act authorized the federal government to provide financial support to provincial health-insurance schemes that covered both in-patient and out-patient hospital services.¹⁷ These payments were calculated according to a cost-sharing formula, whereby the provincial and federal governments each contributed fifty percent of the cost of hospital services.¹⁸ In exchange, the provinces had to covenant "to make insured services available to all residents of the province upon uniform terms and conditions",¹⁹ which is generally thought to be a guarantee of universal coverage. In section 1, the Act listed precisely which services were mandatory under the provincial plans.

¹⁰ The proposals also offered federal financial assistance to the provinces in the forms of (1) grants for the planning and administration of public health-insurance systems and (2) loans for the construction of hospitals (see Conference on Reconstruction, *ibid.* at 31, 36).

¹¹ The federal government proposed that provincial governments "forego the imposition of personal income taxes, corporation taxes, and succession duties, leaving to the Dominion government the full and exclusive access to these revenue sources". In exchange, the federal government proposed to "substantially expand its present payments to the provincial governments under an arrangement which would ensure stable revenues and provide for their growth in proportion to increases in population and per capita national production" (Conference on Reconstruction, *ibid.* at 48).

¹² See *ibid.* at 67.

¹³ See *Health Services Act*, S.S. 1944, c. 51. Although the Act was passed in 1944, the program did not come into effect until January 1, 1947.

¹⁴ Taylor, *supra* note 8 at 102.

¹⁵ See S.J. Kunitz, "Socialism and Social Insurance in the United States and Canada" in C.D. Naylor, ed., *Canadian Health Care and the State: A Century of Evolution* (Kingston and Montreal: McGill-Queen's University Press, 1992) 104 at 115.

¹⁶ S.C. 1957, c. 28 [hereinafter *Hospital Insurance Act*].

¹⁷ See *ibid.* at s. 3.

¹⁸ See *ibid.* at s. 4.

¹⁹ *Ibid.* at s. 5(2)(a).

The Act laid the basis for future federal-provincial co-operation on health insurance by allowing the federal government to use its superior taxation power to fund provincial programs. Its most significant shortcoming, however, was its failure to cover non-hospital services. The first province to go beyond the requirements of the federal Act was Saskatchewan. The Saskatchewan government had always intended to extend its original plan to cover all medical treatments. The new federal financial support, therefore, afforded it the opportunity to create a truly comprehensive provincial medical-insurance program. In 1959, it proposed its new plan, which came into force in 1962.²⁰

In an attempt to prevent the application of Saskatchewan's model of comprehensive medical insurance to the rest of Canada, the Canadian Medical Association ("C.M.A.") requested that the federal government study the problem of health insurance in 1960.²¹ Prime Minister Diefenbaker responded in 1961 by creating the Royal Commission on Health Services, chaired by Mr. Justice Emmett Hall, Chief Justice of Saskatchewan. The Commission reported back on June 19, 1964 and, to the dismay of the C.M.A., recommended the implementation of comprehensive, universal health insurance across Canada. In 1966, this recommendation was enacted as the *Medical Care Act*.²² Unlike the 1957 *Hospital Insurance Act*, which covered hospital-based treatment, the new legislation covered non-hospital care. Moreover, in contrast to the 1957 legislation, the *Medical Care Act* laid down specific eligibility criteria for provincial plans: operation on a non-profit basis by a public authority; reasonable access to persons across the province on uniform terms and conditions; coverage of no less than ninety-five percent of a province's residents; and portability of coverage between the provinces.²³ All of these criteria were eventually incorporated into the C.H.A. and are discussed below. Like the *Hospital Insurance Act*, the *Medical Care Act* provided for half of the expenditures under a provincial medical-insurance plan.²⁴

Not surprisingly, the equal cost-sharing formula contained in the 1957 and 1966 legislation became a large financial burden for the federal government. The federal government's primary concern was its inability to control the level of transfer payments, since it was under a legal obligation to match funds to expenditures made under provincial plans.²⁵ The incentives for the provinces to economize were not as strong as they would have been had they been wholly responsible for their

²⁰ See *Medical Care Insurance Act*, S.S. 1962, c. 1

²¹ See C.B.A., *supra* note 7 at 7.

²² S.C. 1966, c. 64.

²³ See *ibid.* at s. 4.

²⁴ See *ibid.* at s. 5.

²⁵ Monique Bégin also argues that the program was

biased in favour of building and physical expansion, which are always expensive ... A new hospital here, a clinic there, a new wing on an existing institution, a new maternity ward, new laboratories — it all made for excellent local politics and good economic sense, since a province would then receive large sums of money from Ottawa (M. Bégin, *Medicare: Canada's Right to Health* (Ottawa: Optimum, 1988) at 55).

health-care budgets. In the wake of annual cost increases of twenty and one-half percent in 1975 and twenty percent in 1976,²⁶ the federal government proposed a system of block funding to the provinces. After extensive negotiations, the provinces accepted this approach which was enacted by Parliament as the *Federal-Provincial Fiscal Arrangements and Established Programs Financing Act* in 1977.²⁷ The Act provided federal funding indexed to changes in the Gross National Product and population growth.²⁸

Toward the end of the 1970s, Canada witnessed an alarming rise in two sorts of direct charges to patients: extra-billing²⁹ and user charges.³⁰ Public outcry over those direct charges led to the appointment in 1979 of the Honourable Emmett Hall to the head of a special commission to review the state of Medicare and, in particular, whether the conditions of portability, reasonable access, universal coverage, and comprehensiveness were being met.³¹ In his 1980 report, Hall concluded that direct charges were undermining reasonable access to medical care.³² This assessment became integral to federal government policy³³ and was echoed by an all-party House of Commons task force.³⁴ An epic political battle ensued, pitting the federal government against the medical profession (represented by the C.M.A.) and the provinces. The provinces resented what they saw as an incursion into pro-

²⁶ See Taylor, *supra* note 8 at 421.

²⁷ S.C. 1977, c. 10 [hereinafter E.P.F. Act]. The E.P.F. Act actually covered three programs: post-secondary education; medical care; and hospital insurance.

²⁸ See *ibid.* at ss. 18-22.

²⁹ The Department of National Health and Welfare has defined extra-billing as “the direct billing of an insured person for an insured health service provided by a medical practitioner in an amount in excess of the amount payable for the service under a provincial health care insurance plan” (Health and Welfare Canada, *supra* note 1 at note 1, p. 5).

³⁰ A user charge is defined as “any charge that is authorized under a provincial health care insurance plan for any insured health service and that is payable directly by an insured person” (Health and Welfare Canada, *ibid.* at note 2, p. 5). Monique Bégin, the federal minister responsible for the adoption of the C.H.A., has argued that the federal government itself contributed to the increase in user fees. Under the 1957 and 1966 legislation, Ottawa engaged in minute supervision of each province’s health-insurance scheme, reviewing and approving each expense. In 1977, with the adoption of the E.P.F. Act, the Federal government ceased its billing supervision. The impact on user fees was profound. Prior to 1977, the federal government deducted the amount of user fees charged by a province from the federal transfer payment. After 1977, this practice ceased. Bégin states: “[U]ser fees were no longer prohibited — since they were no longer penalized — therefore they were allowed” (Bégin, *supra* note 25 at 66).

³¹ See Taylor, *supra* note 8 at 429.

³² See E.M. Hall, *Canada’s National-Provincial Health Program for the 1980’s* (Ottawa: Department of Health & Welfare, 1980) at 27 (extra-billing), 42 (user charges).

³³ Medicare is threatened. The small direct charges of the past are now growing and spreading. Medicare as we knew it is gradually eroding. Through a cumulation of direct charges on the sick — each one possibly not a big increase in itself — the goal of complete insurance, fully prepaid, is being abandoned (Health and Welfare Canada, *supra* note 1 at 3).

³⁴ See Parliamentary Task Force on Federal-Provincial Relations, *Fiscal Federalism in Canada* (Ottawa: Department of Supply & Services, 1981).

vincial jurisdiction; the medical profession considered Hall's recommendations a direct assault on its freedom. Over these objections, however, Parliament adopted the C.H.A. in 1984.

B. The C.H.A.³⁵

Section 7 of the C.H.A. provides that provincial health-care insurance plans must satisfy five basic criteria — public administration, comprehensiveness, universality, portability, and accessibility — throughout the fiscal year to qualify for federal funding. Although these terms are defined in the C.H.A., their precise meanings are unclear and will become a matter for judicial interpretation.³⁶

The least controversial of the C.H.A.'s criteria is its requirement in section 8 that provincial health-insurance plans be “administered and operated on a non-profit basis” by a public authority who is accountable to the provincial government.

Section 9 defines a comprehensive health-insurance plan as one which covers “all insured health services” provided by hospitals, physicians, or dentists. Insured services are defined in section 2 as “hospital services, physician services, and surgical-dental services provided to insured persons”, who are defined as residents of the province. Hospital services, in turn, are defined as those which are “medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability”. Physician services which are “medically required services rendered by medical practitioners” are covered. Provinces must therefore insure all medically necessary services to qualify for funding under the

³⁵ The legality of the C.H.A. was upheld by the Alberta Court of Appeal in *Winterhaven Stables Ltd. v. Canada (A.G.)* (1988), 62 Alta. L. R. (2d) 266, 53 D.L.R. (4th) 413 (C.A.), as an exercise of the federal government's spending power. Under the power, Parliament may expend monies in areas of provincial jurisdiction, thereby achieving through economic pressure what it could not do directly. The power is not express but is inferred by reading together three of Parliament's enumerated powers under the *British North America Act (Constitution Act, 1867)* (U.K.), 30 & 31 Vict., c. 3 [hereinafter B.N.A. Act]: the powers to levy taxes (*ibid.* at s. 91(3)), to regulate public property (*ibid.* at s. 91(1A)), and to appropriate federal funds (*ibid.* at s. 106) (see P.W. Hogg, *Constitutional Law of Canada*, 3d ed. (Toronto: Carswell, 1992) at 150).

In the late 1980s, The Ontario Medical Association (“O.M.A.”) launched, and then dropped, a legal challenge against the constitutionality of the C.H.A. (see: M. Mason, “The *Canada Health Act* and the *Health Care Accessibility Act*: the legal challenge” (1989) 56:6 Ont. Med. Rev. 20; R.D. Fletcher, “Perspectives on Deferring the *Canada Health Act* Challenge” (1990) 57:5 Ont. Med. Rev. 25; R.D. Fletcher, “Council Debates OMA Position Statement Toward a Partnership for the 1990s” (1990) 57:6 Ont. Med. Rev. 9).

³⁶ By far the most detailed and helpful analysis of these provisions has been done by Martin, *supra* note 7 at 12-18.

C.H.A.³⁷ The meaning of “medical necessity”, left undefined in the Act, will be discussed later.

Universality, a hallmark of Medicare, is defined in section 10. The C.H.A. requires provincial plans to cover one hundred percent of provincial residents on uniform terms and conditions. Presumably, this excludes plans that categorize residents according to medically irrelevant criteria, such as income level.

Portability is defined in section 11 and requires plans to “not impose any minimum waiting period of residence in the province, or waiting period, in excess of three months before residents of the province” are entitled to be covered by the provincial plan. Moreover, plans must cover expenses for treatment received outside a province, both within Canada and abroad, up to the cost of the service within the province. An exception to the portability principle is allowed for “elective insured health services”, defined as “services other than services that are provided in an emergency” or when “medical care is required without delay”.

Section 12 defines accessibility, requiring that provincial plans “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.”³⁸ By relying on “reasonable access”, the C.H.A. has adopted a definition of accessibility which is “not one of free access or easy access”, but is relative and circumstantial.³⁹ The reference to “insured health services” incorporates “medical necessity” into the definition of accessibility, as it did for comprehensiveness. However, the two terms should not be confused. The latter refers to *what* is covered, whereas the former refers to *how* people may obtain those insured services.

In its background paper, Health and Welfare Canada identified two problems with the legislation that preceded the C.H.A.⁴⁰ First, the enforcement mechanism (established under the regulations) was considered too blunt because it required the federal government to withhold all cash contributions to a province if the program criteria were not met. Second, the criteria established for federal funding did not seem to be specific enough to exclude direct charges to patients, both in the forms of extra-billing and user fees. Given those charges’ impact on accessibility, this was a source of major concern for the federal government.

Both of these concerns are addressed in the new legislation. A detailed enforcement mechanism is spelled out in sections 14 to 17. If the Minister of Na-

³⁷ Since the French version of the Act uses the term “*médicalement nécessaires*” exclusively, it will be assumed that “medically necessary” and “medically required” are identical (see C.B.A., *supra* note 7 at note 89, p. 30).

³⁸ C.H.A., *supra* note 2 at s. 12(1)(a).

³⁹ Martin, *supra* note 7 at 16.

⁴⁰ See Health and Welfare Canada, *supra* note 1 at 30.

tional Health and Welfare believes that a province is in breach of the criteria described above, he or she must refer the matter to the Governor in Council.⁴¹ However, before this stage is reached, the Minister must attempt to consult the province involved to clarify the matter, report on his or her findings, and if requested, meet to discuss the matter.⁴² Under section 15, if the Governor in Council is of the opinion that the criteria are not being met, federal contributions *may* be withheld either, (1) in respect of each default by “an amount that the Governor in Council considers to be appropriate” or (2) in their entirety, depending on the circumstances.⁴³

As regards direct fees, sections 18 and 19 explicitly condition the receipt of federal contributions on the absence of extra-billing and user charges, respectively. Unlike the discretion granted under section 15, section 20 makes deductions for extra-billing and user fees mandatory. The amount is to be equal to the direct fees charged through extra-billing⁴⁴ and user charges.⁴⁵

II. Reasons for Renewed Legal Interest in the C.H.A.

A. Resource Allocation

The C.H.A. reflects Canada’s commitment to high-quality health care accessible to all. Indeed, access to health care based on need, not the ability to pay, is regarded by many to be a defining characteristic of our country and an important element of social citizenship. Noted health economist, Robert Evans, has suggested that equality before the health-care system is as important to Canadians as is equality before the law.⁴⁶

Unfortunately, the Canadian health-care system is coming under increasing financial pressures, making it more and more difficult to meet these goals. The growing national debt⁴⁷ has motivated successive federal governments to reduce

⁴¹ See C.H.A., *supra* note 2 at s. 14(1).

⁴² See *ibid.* at s. 14(2).

⁴³ Claude Forget has suggested that section 36 of the *Constitution Act, 1982* (*Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11), may prohibit a complete withholding of federal payments, if so doing would imperil “the delinquent province’s ability to provide its residents with public services of reasonable quality” (C.E. Forget, “The Harmonization of Social Policy” in M. Krasnick, ed., *Fiscal Federalism* (Toronto: University of Toronto Press, 1986) 97 at 111). Section 36 provides that Parliament, the provincial legislatures, and the federal and provincial governments “are committed to ... (c) providing essential public services of reasonable quality to all Canadians.”

⁴⁴ See C.H.A., *supra* note 2 at s. 20(1).

⁴⁵ See *ibid.* at s. 20(2).

⁴⁶ See R.G. Evans, “‘We’ll Take Care of It for You’: Health Care in the Canadian Community” (1988) 117:4 *Daedalus* 155 at 165.

⁴⁷ Between 1985 and 1991, the Net Federal Debt increased from 202.4 billion dollars to 385 billion dollars (see Statistics Canada, *Canada Year Book* (Altona: D.W. Friesen & Sons, 1994) at Table 9.8).

their health-care contributions to the provinces.⁴⁸ To some extent, this trend began in 1977, with the replacement of fifty-fifty cost-sharing with the block grants discussed above. In 1986, however, the funding formula was altered again,⁴⁹ and in 1991 federal transfer payments were frozen for two years.⁵⁰ The impact of the changes in the federal formula can be seen in the declining levels of relative federal contributions to provincial health-insurance plans. In 1977, provincial health plans expended 11.1 billion dollars, of which federal transfers accounted for 41.8 percent (4.6 billion dollars). By 1986, this figure had dropped to thirty-nine percent (twelve billion dollars of 30.9 billion dollars), and by 1993 (the latest year for which data has been published), to 31.8 percent (15.6 billion dollars of 49.1 billion dollars).⁵¹

The federal funding formula for health care is about to change again. Under the *Budget Implementation Act*,⁵² block grants made under the E.P.F. Act will be replaced with a new block grant, the Canada Health and Social Transfer ("C.H.S.T."). This block grant will cover not only health care, but federal transfer payments for social assistance, post-secondary education, and other social services. The Act retains the enforcement mechanism under the C.H.A., but provides that deductions be made from the C.H.S.T., not payments made pursuant to the E.P.F. Act.⁵³ It has been suggested that in the wake of the new funding arrangements "it is not hard to imagine how poverty — and thus the poor — will get lost in the shuffle in favour of health and education",⁵⁴ yet it is no harder to imagine how health-care budgets, which have become a political target, will be affected by the adoption of these new funding arrangements, because of a reduction in the total amount of federal transfer payments to the provinces.⁵⁵

Another source of financial pressure on the system is the growth in physician supply,⁵⁶ a common problem for most western industrialized nations. In 1992, Canada had nearly 60,000 active physicians, providing for an approximate ratio of one

⁴⁸ See J.K. Iglehart, "Canada's Health Care System Faces its Problems" 322 *New Eng. J. of Med.* 562 at 564.

⁴⁹ See *An Act to Amend the Federal-Provincial Fiscal Arrangements Act, 1977*, S.C. 1986, c. 34 [hereinafter *Act to Amend*]. Section 2 of that Act reduced the escalator for federal transfer payments laid down in the E.P.F. Act by two percentage points. Nevertheless, transfer payments were still a function of population growth and growth in gross national product.

⁵⁰ See *Government Expenditures Restraint Act*, S.C. 1991, c. 9.

⁵¹ See Health and Welfare Canada, *National Health Expenditures in Canada, 1975-1993* (Ottawa: Supply and Services Canada, 1994) at Table 3A.

⁵² S.C. 1995, c. 17 (assented to 22 June 1995).

⁵³ See *ibid.* at s. 38.

⁵⁴ C.M. Scott, "Covenant Constitutionalism and the Canada Assistance Plan" (1995) 6 *Const. Forum* 79 at 80.

⁵⁵ The *Budget Implementation Act* sets the total federal contribution to the provinces at 26.9 billion dollars for social assistance, health care, and post-secondary education (see *supra* note 52 at s. 48). At the time of writing, the funding arrangements for shared-cost programs remain in a state of flux. The federal funding formula might change again, reserving the C.H.S.T. for health transfers only.

⁵⁶ See Iglehart, *supra* note 48 at 567.

physician to 450 residents.⁵⁷ Since the mid-1970s, the growth in the supply of physicians has outpaced population growth by 2.3 percent per year, amounting to an increase in total physician supply of almost seventy percent.⁵⁸ The link between physician supply and health-care costs is referred to as “supplier-induced demand” and is relatively controversial.⁵⁹ The argument is that the physician-patient relationship is different from a normal consumer-supplier relationship because of asymmetries in information and the vulnerability of the patient. The imbalance in this relationship allows physicians who supply services, not the patients who receive them, to create the demand for their own services. Given that most Canadian doctors are remunerated on a fee-for-service basis, the result is a system which encourages high rates of utilization. The data seem to bear out this hypothesis: the growth rate of physician supply nearly matches increased *per capita* utilization of health-care services.⁶⁰

Provincial governments have adopted a number of responses to deal with these growing financial concerns. One set of responses seeks to *rationalize* the use of existing health-care services, in order that “all citizens ... receive all necessary services at an overall cost that most societies can shoulder.”⁶¹ Chandrakant Shah has provided a more precise definition:

Rationalization of health services may involve re-structuring, re-alignment, de-centralization and some institutional closures. These changes are undertaken to minimize duplication of services, provide appropriate levels and type of care, consolidate strengths, shift toward innovative structures and functional arrangements which may make more effective use of resources and contain costs.⁶²

For example, the “outcomes movement” in clinical medicine has encouraged provincial health ministries to ask physicians that they provide treatments that have demonstrated benefit for the patient.⁶³ As well, existing health-care resources can

⁵⁷ See R.G. Evans, “Canada: The Real Issues” (1992) 17 J. Health Pol., Pol. & L. 739 at 755.

⁵⁸ See T.R. Marmor, “Lessons from the Frozen North” (1993) 18 J. Health Pol., Pol. & L. 763 at 767.

⁵⁹ R.G. Evans, *Strained Mercy: The Economics of Canadian Health Care* (Toronto: Butterworths, 1984) at 83.

⁶⁰ See Marmor, *supra* note 58 at 767. In response, provincial governments have used their enormous bargaining power to negotiate tougher fee schedules with physicians (see R.B. Deber, “Canadian Medicare: Can it Work in the United States? Will it Survive in Canada?” (1993) 19 Am. J. of L. & Med. 75 at 90).

⁶¹ C.D. Naylor, “A Different View of Queues in Ontario” (1991) 10:3 Health Aff. 110 at 124.

⁶² C.P. Shah, *Public Health and Preventive Medicine in Canada*, 3d ed. (Toronto: University of Toronto Press, 1994) at 360.

⁶³ N.K. Choudhry, J.G. Wright & P.A. Singer, “Outcome Rates for Individual Surgeons: Concerns about Accuracy, Completeness, and Consequences of Disclosure” (1994) 115 Surgery 406. The outcomes movement arose in response to large variations in the rates of medical procedures among otherwise identical populations (see *e.g.* R.E. Hall & M.M. Cohen, “Variations in Hysterectomy Rates in Ontario: Does the Indication Matter?” (1994) 151 Can. Med. Assoc. J. 1713).

be better utilized through more efficient management. Thus, in a highly-publicized episode, long waiting lists for open-heart surgery in Ontario were alleviated by changing booking procedures by individual physicians through the establishment of a central patient registry for the entire province, which facilitated the use of unutilized physician resources.⁶⁴

Rationalizing attempts to contain costs in a way that ensures accessibility and comprehensiveness. However, as Naylor has written, this approach has limits: "In an ideal world, appropriate health services would be available without charge or delay. The reality, however, is that allocative decisions must be made."⁶⁵ In other words, *rationing* scarce health-care resources is unavoidable. Implicit rationing has been part of Canadian Medicare for some time. With health budgets tightly controlled, both physicians and administrators "will eliminate waste and accept the burden of making more difficult decisions about allocation of funds to individual units, particular services and, ultimately, individual patients".⁶⁶ Increasingly, however, the idea of explicit rationing is gaining currency in policy circles. This would generally entail the de-listing of certain medical procedures⁶⁷ but could include any explicit measures which would limit coverage for non-medical reasons.

The concern is that some of these restrictive measures could contravene the C.H.A. An initiative of the former N.D.P. government in Ontario is a case in point. Increasing numbers of elderly Canadians are spending their winters in the United States, sometimes requiring medical treatment while they are there. Until recently, the Ontario Hospital Insurance Plan ("O.H.I.P.") paid up to four hundred dollars per day for hospital coverage. Faced with shrinking hospital budgets at home, the provincial government decided to reduce hospital coverage to one hundred dollars per day.⁶⁸ It is estimated that this move would have produced a savings of twenty million dollars annually, which the government planned to apply to health-care delivery in Ontario.⁶⁹

The province's decision, however, may have been in breach of section 11 of the C.H.A., which requires that provincial health plans be portable. Section 11(1)(b) requires that a provincial plan cover the medical costs for insured services of insured persons who are "temporarily absent from the province". In section 11(1)(b)(ii), the Act states that this coverage extends to services which "are provided out of Canada". Payment must be "made on the basis of the amount that would have been paid by the province for similar services rendered in the province". On the face of it, setting a ceiling that is unrelated to the cost of the same

⁶⁴ See Naylor, *supra* note 61 at 116.

⁶⁵ *Ibid.* at 123-24.

⁶⁶ D. Naylor & A.L. Linton, "Allocation of Health Care Resources: A Challenge for the Medical Profession" (1986) 134 Can. Med. Assoc. J. 333 at 335.

⁶⁷ Perhaps the most famous example of explicit rationing has occurred in Oregon (see H.E. Emson, "Down the Oregon trail — The way for Canada?" (1991) 145 Can. Med. Assoc. J. 1441).

⁶⁸ See O. Reg. 489/94.

⁶⁹ See P. Todd, "When the Gray Panthers come calling" *Law Times* (22-28 August 1994) 4.

medical procedures in Ontario would seem to violate this provision. Of course, this hinges on the meaning of “temporarily absent”. Would a person who has dual residency and who spends six months in each country be temporarily absent? The scope of this term awaits definition by the courts.⁷⁰

B. The Failure of Public Enforcement by the Federal Government

According to section 15 of the C.H.A., the Governor in Council can withhold federal transfer payments to provinces that fail to comply with the Act’s terms. This decision, however, may only take place after a referral by the Minister of National Health and Welfare. The actual task of monitoring provincial compliance rests with the Health Insurance Directorate, which advises the Minister.⁷¹

A review of the Directorate’s monitoring procedure was conducted by the Office of the Auditor General of Canada in 1987.⁷² The report found that while provincial legislation was regularly being monitored for compliance with the terms of the C.H.A., the actual operation of provincial health plans was not, making the monitoring scheme woefully inadequate:

[T]he Department has no formal procedures to satisfy itself that health plans are being operated in accordance with provincial and territorial legislation, and thus that federal requirements are being met in practice. Its sources of information, in this regard are discussions and correspondence with the provinces, review of provincial publications and news reports. The Department does not obtain explicit assurance, written or otherwise, from provinces and territories that their health systems are operating within their legislative framework. Without such assurance, the Department cannot adequately assess the extent of compliance with the *Canada Health Act*.⁷³

Moreover, the Department did not document its monitoring procedures, nor did it periodically document its overall assessment of provincial compliance.⁷⁴ Furthermore, there was no documentation of departmental action taken in response to non-compliance.⁷⁵

⁷⁰ Before its repeal, this regulation was upheld on an application for judicial review in *Collett v. Ontario (A.G.)* (1995), 124 D.L.R. (4th) 426, O.J. No. 776 (Gen. Div.) [hereinafter *Collett* cited to D.L.R.].

⁷¹ See Health Canada, *Canada Health Act Annual Report 1992-93* (Ottawa: Supply & Services Canada, 1993) at 13 [hereinafter *Annual Report 1992-93*].

⁷² See Office of the Auditor General, *Report of the Auditor General of Canada to the House of Commons* (Ottawa: Auditor General’s Office, 1987) at paras. 12.90-12.111 [hereinafter *Report*, 1987].

⁷³ *Ibid.* at paras. 12.98-12.99.

⁷⁴ See *ibid.* at para. 12.100.

⁷⁵ See *ibid.* at para. 12.103.

These inadequacies were compounded by the ineffectiveness of parliamentary supervision. Under the C.H.A., the Minister must make an annual report to Parliament, "including all relevant information on the extent to which provincial health care insurance plans have satisfied the criteria" of the Act.⁷⁶ This report does not, however, contain any assessments of provincial compliance conducted by the Department. Rather, it simply relates information provided by the provinces. The report stated that it found "no evidence to indicate that the Department assesses the completeness of the information that it receives".⁷⁷ The report concluded:

By not assessing and reporting to Parliament on the extent of provincial compliance, the Minister is not discharging fully his responsibilities under the *Canada Health Act*. As a result, it is difficult for Parliament to determine whether billions of dollars in annual transfer payments are being made in accordance with the conditions it set in authorizing the transfers.⁷⁸

Two recommendations were made: (1) to monitor the actual operation of provincial health-care systems for compliance with the criteria of the C.H.A., and (2) to include this information in the annual report provided to Parliament.⁷⁹ In 1990, the Auditor General reported that neither of these recommendations had been adopted.⁸⁰

Two factors suggest that private enforcement of the C.H.A. — citizens acting through the courts — would operate more effectively than the current regime of public enforcement. The first is the availability of accurate information. Given the meagre information obtained by the Department on provincial compliance, it is unsurprising that federal payments have never been withheld under section 15(1).⁸¹ Individuals who use provincial health plans, on the other hand, possess the very information needed to assess compliance with the C.H.A. For example, the de-listing of a medical procedure, which might be in violation of the principle of comprehensiveness, would come to the attention of patients who desired that procedure. Although federal supervision would be more effective if the Department obtained information on specific policies adopted by provincial plans, this information would still be inadequate, because the actual impact of particular policies on accessibility and comprehensiveness might only be understood when they operate in practice. Given the size and complexity of the health-care system, it may be

⁷⁶ C.H.A., *supra* note 2 at s. 23.

⁷⁷ *Report*, 1987, *supra* note 72 at para. 12.107.

⁷⁸ *Ibid.* at para. 12.108.

⁷⁹ See *ibid.* at paras. 12.110-12.111.

⁸⁰ See Office of the Auditor General, *Report of the Auditor General of Canada to the House of Commons* (Ottawa: Auditor General's Office, 1990) at paras. 4.175-4.177. Indeed, the 1992-93 C.H.A. report contains the following cryptic phrase: "[D]uring the year under review, a number of issues related to possible non-compliance were identified and subsequently resolved, while some cases are currently under review" (*Annual Report 1992-93*, *supra* note 71 at 13).

⁸¹ However, the mandatory enforcement mechanism for extra-billing and user fees has been used with considerable success.

beyond the ability of the federal government to obtain all the necessary information.

The second factor favouring private enforcement is the political climate surrounding the C.H.A. Notwithstanding their willingness to accept federal transfer payments, provinces are fiercely opposed to federal activity in the realm of health care. The federal government is unlikely to risk political confrontation by acting under section 15(1) even if it were to have sufficient information about non-compliance.⁸² Put another way, enforcement of the C.H.A. is currently conditioned not by the needs of the health-care system's clients, but by the political needs of the federal government. It is, therefore, in the interest of affected individuals to launch legal challenges in order to effect changes from provincial governments that will provide them with better medical care. Thus, it may be left to individuals, acting as "private attorneys-general", to enforce the terms of the C.H.A. through the courts.

III. Enforcing the C.H.A. Against the Federal Government

A. Introduction

The C.H.A. is commonly described as imposing obligations on provincial governments who wish to receive federal monies for Medicare. Although this may represent a current political reality, the legal situation is the opposite. Federal statutes in areas of provincial jurisdiction (such as health insurance) cannot, by themselves, impose legal obligations on provincial governments. As a matter of law, the C.H.A. imposes obligations on the federal government. It defines the conditions that must be met by the provinces for federal payments to be legal.⁸³ If a provincial plan falls short of these conditions, the federal government is obliged to take certain enforcement measures, which, in the extreme, can include withholding all contributions to the offending province.⁸⁴ In this way, decisions made by provincial governments affect the legality of federal funding.

As discussed above, the federal government may lack either the information or the political will to enforce the C.H.A. In those cases, the legality of federal contributions can be challenged by an individual citizen through judicial review. In order to succeed, however, a plaintiff would have to clear a number of hurdles. First, without standing, judicial review could not advance, since a court cannot proceed on its own motion to examine the legality of executive action. It will be argued that

⁸² The present dispute between the federal government and Alberta over the operation of private clinics in that province is a vivid but isolated counter-example (see: E. Greenspon, "Ottawa tallies clinics' fees" *The [Toronto] Globe and Mail* (16 October 1995) A5; A. Coyne, "Health Minister's strong stance calls premiers' bluff" *The [Toronto] Globe and Mail* (16 October 1995) A14).

⁸³ See C.H.A., *supra* note 2 at s. 7.

⁸⁴ See *ibid.* at ss. 14, 15.

an aggrieved citizen, however, could probably obtain public-interest standing to launch judicial review of federal payments. Second, the plaintiff would have to establish that cabinet's failure to exercise its discretion to withhold payments under section 15(1) was *ultra vires* the C.H.A. This would require the courts to examine the reasonableness of cabinet's actions, which, in turn, would require an assessment of the factual background against which cabinet decided or failed to decide not to withhold payments. An applicant would, therefore, have to demonstrate non-compliance of the provincial plan with the C.H.A.'s criteria, overcoming the attendant evidentiary difficulties.

B. Standing

1. The Law on Public-Interest Standing

Would an individual have standing to bring a legal challenge to federal transfer payments for health care? A similar set of circumstances faced the Supreme Court in *Canada (Minister of Finance) v. Finlay*.⁸⁵ The applicant, Finlay, was a welfare recipient under Manitoba's social-assistance scheme. Due to an earlier overpayment, the province deducted a percentage of his allowance over a period of time. The province operated its welfare program with substantial financial support from the federal government, under the *Canada Assistance Plan*.⁸⁶ That spending statute authorizes the federal government to encourage provinces, through conditional grants, to develop welfare and social-assistance programs. Its conditions are statutorily imposed. Finlay contended that the federal payments were illegal, since the provincial plan, *inter alia*, breached section 6(2)(a) of the C.A.P., which sets as a condition that a province agree to "provide financial aid or assistance to ... any person in the province who is a person in need ... in an amount or manner that takes into account the basic requirements of that person".⁸⁷

The Court had to decide whether Finlay had the requisite standing to bring an action against the federal government. Le Dain J., speaking for a unanimous Court,

⁸⁵ [1986] 2 S.C.R. 607, 33 D.L.R. (4th) 321 [hereinafter *Finlay (no. 2)* cited to S.C.R.].

⁸⁶ R.S.C. 1985, c. C-1 [hereinafter C.A.P.].

⁸⁷ The C.A.P. will be repealed by the *Budget Implementation Act* (see *supra* note 52 at s. 32), which alters the terms of federal assistance for social assistance in a number of respects. Instead of shared-cost funding, federal transfer payments for social assistance will now become a part of the C.H.S.T. Furthermore, the terms of that federal assistance will change. The C.A.P. requires that: provinces who wish to receive federal funding ensure that their plans provide financial assistance to persons in need; the level of financial assistance takes into account each individual's budgetary requirements; persons have recourse to procedures whereby they may challenge the denial of financial assistance; and persons not be forced to work in exchange for receiving social assistance. These conditions will no longer be attached to federal transfer payments.

Nevertheless, the caselaw on the C.A.P., both in relation to obtaining standing and the merits of an action, is still relevant. This body of law illustrates how federal-provincial shared-cost programs have legal implications which could prove useful to individuals seeking to protect their entitlements through the courts.

held that he did.⁸⁸ The decision proceeded in two parts. First, the Court held that Finlay did not have standing as a matter of right (private standing). Although the purpose of the C.A.P. was to benefit individuals in need, there was no “nexus” or “causative relationship”⁸⁹ between the alleged provincial non-compliance and the alleged illegality of the federal payments, because it was not clear that Manitoba would amend its plan to comply with the federal conditions if an illegality were found.⁹⁰ The Court held, however, that it had discretion to grant public-interest standing to Finlay to bring an administrative law action. Le Dain J. extended the Court’s previous caselaw, which had only granted public-interest standing for constitutional challenges.⁹¹ This promoted the policy underlying the conferral of public-interest standing — to avoid immunizing legislation or the exercise of administrative authority from judicial review by denying standing to anyone other than the Attorney-General. *Finlay (no. 2)*, therefore, serves the public interest in ensuring that governments only act within their granted legal authority, a basic tenet of the rule of law.

The decision establishes a four-part test for standing. First, the issue must be justiciable; it must involve a question of law. The federal government argued that provincial compliance with the conditions laid down by the C.A.P. were inappropriate for judicial resolution and should be left to government review and inter-governmental negotiations. The Court held, however, that the issue of statutory authority to make payments was justiciable. The courts should not “decline to determine it on the ground that because of its policy context or implications it is better left for review and determination by the legislative or executive branches of government”.⁹² Second, the issue must be “serious”. This term is unclear and suggests that the courts would consider the merits of the decision. In *Finlay (no. 2)*, the Court decided that the allegation was “far from frivolous”.⁹³ Third, and also unclear, is the requirement that the applicant have a “genuine interest” in the issue: “[A] person in need within the contemplation of the [Canada Assistance] Plan who complains of having been prejudiced by the alleged provincial non-compliance ... is a person with a genuine interest”.⁹⁴ Finally, there must be “no other reasonable

⁸⁸ See *Finlay (no. 2)*, *supra* note 85 at 634.

⁸⁹ *Ibid.* at 622.

⁹⁰ This part of the decision has been criticized by J.M. Evans, “Developments in Administrative Law: The 1986-87 Term” (1988) 10 *Supreme Court L.R.* 1 at 17-18.

⁹¹ See T.A. Cromwell, “From Trilogy to Quartet: *Minister of Finance of Canada v. Finlay*” (1987) 7 *Windsor Y.B. Access Just.* 103 at 110. The trilogy refers to: *Thorson v. Canada (A.G.)* (1974), [1975] 1 S.C.R. 138, 43 D.L.R. (3d) 1 [hereinafter *Thorson*]; *Nova Scotia (Board of Censors) v. McNeil*, [1976] 2 S.C.R. 265, 55 D.L.R. (3d) 632; *Canada (Minister of Justice) v. Borowski*, [1981] 2 S.C.R. 575, 130 D.L.R. (3d) 588 [hereinafter *Borowski*]. *Borowski* itself was not a constitutional question in the strict sense, in that it involved a conflict between the abortion provision of the *Criminal Code*, R.S.C. 1985, c. C-46, and the *Canadian Bill of Rights*, S.C. 1960, c. 44, reprinted in R.S.C. 1985, App. III.

⁹² *Finlay (no. 2)*, *supra* note 85 at 632.

⁹³ *Ibid.* at 633.

⁹⁴ *Ibid.*

and effective manner in which the issue may be brought before a court”.⁹⁵ This means that there is no one with a more direct interest to bring a challenge, and that the Attorney-General, in all reasonable probability, would not have exercised his or her discretion to grant public-interest standing.⁹⁶ This requirement was met as well.

The decision in *Finlay (no. 2)* is notable not only for extending public-interest standing to judicial review of administrative action, but also for articulating the functional concerns underlying the rules of public-interest standing generally. The Court addressed these directly and related them to the various elements of the test. It is important to outline these concerns, because they provide a useful guide to whether public-interest standing will be granted in other situations.

The first concern is the proper constitutional relationship between the courts and other branches of government. Although courts adjudicate upon a wide range of matters, it is more appropriate to allow the other branches to make decisions of socio-economic policy, for which they ultimately can be held accountable to the electorate. The test in *Finlay (no. 2)* meets this concern by requiring that a justiciable question exist. Since the “policy context”⁹⁷ of an executive decision will not factor into the question of justiciability, the logic of *Finlay (no. 2)* might apply to other federal-provincial programs operating under similar legal frameworks, such as the C.H.A. Furthermore, the Court once again rejected the adoption of the “political questions doctrine” from U.S. constitutional law.⁹⁸ Thus, a court should not be deterred from intervening merely because a legal dispute mirrors a dispute which is occurring simultaneously in the political realm. However, the Court did state that “[t]here will no doubt be cases in which the question of provincial compliance with the conditions of federal cost-sharing will raise issues that are not appropriate for judicial determination.”⁹⁹ It did not, however, say what those circumstances would be.

The second concern is the need to conserve scarce judicial resources by screening out claims from busybodies — individuals or groups whose apparent purpose is to harass governments. This concern is met by ensuring that a serious issue is raised, and that the applicant has a genuine interest in the issue. The final concern is that, in deciding these questions, the courts benefit from hearing from those who are most directly affected. Granting public-interest standing has the po-

⁹⁵ *Ibid.*

⁹⁶ As Le Dain J. explains, no prior request to the Attorney-General need be made. That the Attorney-General would not intervene in favour of *Finlay* was evident from his position in the proceedings (see *Finlay (no. 2)*, *ibid.* at 634).

⁹⁷ *Ibid.* at 632.

⁹⁸ The Court also rejected the political-questions doctrine for the purposes of *Charter* adjudication in *Operation Dismantle v. R.*, [1985] 1 S.C.R. 441 at 472, 18 D.L.R. (4th) 481. For a discussion of that doctrine, see generally L.H. Tribe, *American Constitutional Law*, 2d ed. (Minneapolis: Foundation Press, 1988) at 96-107.

⁹⁹ *Finlay (no. 2)*, *supra* note 85 at 632.

tential to displace others who have a more direct interest in the complaint.¹⁰⁰ This concern is reflected in the requirement that there be no other reasonable and effective manner in which the issue could be brought before a court.

2. Applying *Finlay (no. 2)*

The potential to adapt *Finlay (no. 2)* to an action against the Department of National Health and Welfare for payments made under the C.H.A. is promising.¹⁰¹ Like the C.A.P., the C.H.A. is enacted under Parliament's spending power, which provides payments to provinces who must conform to a set of federal conditions. To illustrate how an argument for public-interest standing might be made, reliance will be placed on the facts of *Hughes v. Canada (A.G.)*.¹⁰²

The plaintiff alleged that Prince Edward Island ("P.E.I.") failed to meet the conditions of comprehensiveness, universality, and accessibility, as required by sections 9, 10, and 12(1), respectively, of the C.H.A. by demanding that an individual have a social-insurance number to receive coverage. She sought a number of remedies, including a declaration that the federal payments to P.E.I. were illegal and an injunction prohibiting payments to the province until it changed its policy.

The federal government brought a motion to strike, arguing that the plaintiff's claim disclosed no reasonable cause of action. This argument was rejected by Reed J., who held, by analogy with *Finlay (no. 2)*, that a justiciable issue existed, although she did not state why.¹⁰³ However, it may be inferred that the court seemed willing to determine whether P.E.I. had met the conditions laid out in the C.H.A., despite the political controversy surrounding the Act. The decision shows that although the criteria of the C.H.A. raise difficult questions of justiciability, the courts are willing to review them to ensure the legality of federal government funding.

The issue in *Hughes* was whether a justiciable issue existed. The court was not asked to decide whether the plaintiff had standing and, therefore, did not consider the other parts of Le Dain J.'s test. It is likely, however, that these criteria would have been met as well. In *Finlay (no. 2)*, the Supreme Court considered "provincial non-compliance with the conditions and undertakings to which the federal cost-sharing payments are made subject by the [Canada Assistance] Plan and ... statutory authority for such payments"¹⁰⁴ to be a serious issue. The same reasoning applies to the C.H.A. The requirement of genuine interest is also met: a patient denied medical coverage would certainly have a genuine interest at stake as a person

¹⁰⁰ Thus, in a recent case, the Canadian Council of Churches was denied public-interest standing to challenge certain provisions of the refugee hearing process, out of a fear that claimants themselves would not be heard (see *Canadian Council of Churches v. Canada*, [1992] 1 S.C.R. 236, 88 D.L.R. (4th) 193 [hereinafter *Canadian Council of Churches*]).

¹⁰¹ See Martin, *supra* note 7 at 22.

¹⁰² (1994), 80 F.T.R. 300, F.C.J. No. 964 (Q.L.) (T.D.) [hereinafter *Hughes* cited to F.T.R.].

¹⁰³ See *ibid.* at 304.

¹⁰⁴ *Finlay (no. 2)*, *supra* note 85 at 633.

within the contemplation of the plan.¹⁰⁵ Furthermore, granting public-interest standing would not thwart the policy behind these two parts of the test; Mrs. Hughes, or for that matter any person covered by public health insurance, is not a busybody. Given the cost of private medical insurance, not receiving coverage poses a potentially insurmountable barrier to access, especially for those with insufficient financial means. Finally, there was no other reasonable and effective manner to bring the issue before the courts. The Government of Canada attempted to strike Mrs. Hughes's claim; it is, therefore, difficult to imagine the Attorney-General exercising discretion to grant public-interest standing. Furthermore, there appears to be nobody more directly affected by the provincial policy, although others may have been equally affected.¹⁰⁶

The focus of this paper is on the ability of individuals to enforce the C.H.A. through the courts. However, it is likely that public-interest groups, for example those representing women (the Women's Legal Education and Action Fund) or the disabled (the Canadian Disability Rights Council), would wish to launch legal challenges as well. The test in *Finlay (no. 2)* could make it difficult for these groups to obtain standing. The "genuine interest" requirement is designed to screen out busybodies whose only desire is to harass governments. Courts might view these public-interest groups as professional busybodies and deny them standing. However, groups who advocate on behalf of persons who themselves have a genuine interest in the issue are not motivated by malice. Rather, they are using the courts to ensure that governments are responsive to the concerns of their constituents.

The final branch of the test in *Finlay (no. 2)* could also pose problems for public-interest groups. *Canadian Council of Churches* suggests that the courts may be unwilling to grant groups standing, for fear of not hearing from those most affected. This line of reasoning should not apply to challenges based on the C.H.A. for two reasons. First, while the bar to standing for groups seems more appropriate where governments have acted unfairly toward isolated individuals who choose not to challenge those acts, excluding groups makes little sense when what is being challenged is a government policy which affects many persons. This bias represents a residuum of private-law theory which ignores the public interest served by judicial review. Indeed, it is wrong to think of public-interest groups as displacing those directly affected, because these groups may represent those who cannot afford to bring legal challenges themselves. Second, the complex nature of litigation suggests that groups, not individuals, are best situated to bring such claims under the C.H.A. Individual claimants may have neither the time nor the resources to marshal medical studies and expert testimony in preparation for trials about the

¹⁰⁵ In *Hughes*, however, it was the plaintiff's daughter who was affected by the provincial policy. Nevertheless, since the plaintiff was required to pay the bills for her daughter's treatment, it could be argued that she did have a genuine interest in that she was a person within the contemplation of the C.H.A.

¹⁰⁶ This issue was not a bar in *Thorson*, *supra* note 91.

provision of health-care services and the efficacy of certain medical treatments. Since the burden of proof rests with claimants, these difficult problems of proof would make litigation difficult for all but the most sophisticated plaintiffs.¹⁰⁷

C. *Merits*

1. Statutory Interpretation

a. *Lessons from Finlay (no. 3)*

In *Canada (Minister of Finance) v. Finlay (no. 3)*,¹⁰⁸ a majority of the Supreme Court (per Sopinka J., Lamer C.J., Gonthier, Iacobucci, and Major JJ. concurring) found that Manitoba's welfare deductions did not violate the C.A.P. The provincial program provided an allowance for "basic necessities", which included food, clothing, shelter, utilities, fuel, personal needs, a housekeeper during illness, funerals, and the care of children in special circumstances. This list corresponded closely to the "basic requirements" of section 6(2)(a) of the C.A.P. and set out in section 2(a) of the C.A.P.¹⁰⁹ By definition, an overpayment provided Finlay with more than his "basic requirements". The deduction, therefore, allowed "for the

¹⁰⁷ The restrictive approach taken by the Supreme Court in *Canadian Council of Churches, supra* note 100, with respect to the requirement that there be no other reasonable and effective manner to bring the issue to court was subsequently followed in *Hy and Zel's Inc. v. Ontario (A.G.)*, [1993] 3 S.C.R. 675, 107 D.L.R. (4th) 634 [hereinafter *Hy and Zel's* cited to S.C.R.]. In that case, the Court denied public-interest standing to retailers, who had brought a civil action to challenge the constitutionality of provincial legislation which required them to close their stores on certain specified days, because they had failed to demonstrate that there was no other reasonable and effective manner to bring the issue to court.

The basis of the Court's conclusion on this point is unclear but may be that the provisions at issue did "not discourage challenge" (*Hy and Zel's, ibid.* at 693). On this interpretation, *Hy and Zel's* seems to preclude the possibility of public-interest standing whenever there is someone who is directly affected by the impugned decision or legislative provisions. If so, the Court may have narrowed the circumstances in which public-interest standing will be granted to groups because it did not discuss the *reasonableness* of relying on individual litigants to bring the issue to court; rather, the Court may have been satisfied by the *mere possibility* that there was an individual litigant who could raise the matter in court. For commentary, see P. Bowal, "Speaking up for Others: *Locus Standi* and Representative Bodies" (1994) 35 C. de D. 905 at 933-35.

¹⁰⁸ [1993] 1 S.C.R. 1080, 101 D.L.R. (4th) 567 [hereinafter *Finlay (no. 3)* cited to S.C.R.]. For commentary, see M.E. Young, "Starving in the Shadow of Law: A Comment on *Finlay v. Canada (Minister of Finance)*" (1994) 5 Const. Forum 31.

¹⁰⁹ 2. In this Act,

"assistance" means aid in any form to or in respect of persons in need for the purpose of providing or providing for all or any of the following:

(a) food, shelter, clothing, fuel, utilities, household supplies, and personal requirements (hereinafter referred to as "basic requirements") (C.A.P., *supra* note 86 at s. 2).

gradual recovery of an amount that should not have been paid out in the first place".¹¹⁰

The majority believed that the C.A.P. should not dictate the exact terms of provincial legislation. Rather, its purpose was to encourage provinces to develop social-assistance programs that met broadly-stated national objectives. This follows from the preamble of the C.A.P.: "[T]he Parliament of Canada ... is desirous of encouraging further development and extension of assistance and welfare services programs throughout Canada by sharing more fully with the provinces in the cost thereof."¹¹¹ Thus, there ought to be some flexibility in the interpretation of the Act. Since the preamble to the C.H.A. contains nearly identical language,¹¹² it may be that the courts will give its terms a flexible interpretation generous to the provinces. This would be consistent with the spirit of co-operative federalism that underlies these financial arrangements. Indeed, the majority urged that in interpreting the terms of the C.A.P., regard should be had for regional differences: "Moreover, some flexibility in the standard imposed upon the provinces is to be expected having regard for the context of C.A.P. It is, after all, a spending statute designed to encourage provinces to develop programs consistent with national objectives."¹¹³

However, the Court clearly stated that the Statute *did* set a national minimum standard. It was argued that section 6(2)(a) of the C.A.P. allowed the provinces to provide assistance as they saw fit, because it only required an amount that "takes into account the basic requirements of that person". Sopinka J. firmly rejected this position:

In my view, s. 6(2)(a) requires assistance to be provided in an amount that is compatible, or consistent, with an individual's basic requirements. It thus requires something more than mere "consideration" of an individual's basic requirements. If that were all that were required, a province could provide almost any amount of assistance, including an amount far less than that which would be compatible with basic requirements, as long as it had turned its mind to such requirements. Such an interpretation would not even permit the federal government to limit its contributions to schemes that were of the *general* - nature it wished to support. I cannot accept this as Parliament's intention.¹¹⁴

The Court was unanimous on this point. McLachlin J., in her dissent (L'Heureux-Dubé and Cory JJ. concurring, and La Forest J. concurring on this point), stated: "[Section] 6(2)(a) sets out the minimum standards to which the provinces *must* agree if they are to obtain a contribution from the federal govern-

¹¹⁰ *Finlay (no. 3)*, *supra* note 108 at 1127.

¹¹¹ C.A.P., *supra* note 86 at "Preamble", cited *ibid.* at 1123.

¹¹² "[T]he Parliament of Canada wishes to encourage the development of health services throughout Canada by assisting the provinces in meeting the costs thereof" (C.H.A., *supra* note 2 at "Preamble").

¹¹³ *Finlay (no. 3)*, *supra* note 108 at 1126.

¹¹⁴ *Ibid.* at 1125-26.

ment.”¹¹⁵ The Supreme Court decision demonstrates a willingness to examine open-textured terms like “basic requirements” in order to ensure that federal purposes are not frustrated by non-compliant provinces. But, however encouraging, *Finlay (no. 3)* is a rather weak basis upon which to stake future litigation. The Court’s interpretation of the C.A.P. displays no concern for the adequacy of provincial programs. Rather, its desire was to police the operation of programs which it viewed as instruments of fiscal federalism.

However, to consider the C.A.P. and the C.H.A. as merely federal-provincial financial schemes would be a serious mistake. To understand why, we need turn no further than the preamble to the C.A.P. itself. The majority in *Finlay (no. 3)* emphasized the C.A.P. preamble’s reference to federal-provincial co-operation. However, the preamble also states that the purpose of the C.A.P. is “the provision of adequate assistance to and in respect of persons in need and the prevention and removal of the causes of poverty and dependence on public assistance ...”.¹¹⁶ This part of the preamble points to a very different interpretation of the C.A.P. It suggests that the Act is far more than a matter of fiscal convenience between two governments. Parliament’s purpose in enacting the C.A.P. was to establish a system of basic socio-economic rights for all Canadians. There is no reason to regard the C.H.A., particularly given the historical development of Medicare, any differently. Consider the following provisions in the preamble to the C.H.A.:

Canadians, through their system of insured health services, have made outstanding progress in treating sickness and alleviating the consequences of disease and disability *among all income groups*

...

[C]ontinued access to quality health care *without financial or other barriers* will be critical to maintaining and improving the health and well-being of Canadians ...¹¹⁷

The seeds of this approach can be found in the dissent, which decided in *Finlay*’s favour. In construing the terms of the C.A.P., McLachlin J. relied on the adequacy principle, developed by courts in the United States. According to this principle, when faced with a statute establishing a scheme of social benefits, a court “should adopt an interpretation which best assures adequacy of assistance”:¹¹⁸

The Court does not believe Congress chose by enactment of the Work-Study Program to draw the cycle of poverty tighter, but rather was attempting to

¹¹⁵ *Ibid.* at 1107.

¹¹⁶ C.A.P., *supra* note 86 at “Preamble”.

¹¹⁷ C.H.A., *supra* note 2 at “Preamble” [emphasis added]. The Act also provides:

It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services *without financial or other barriers* (C.H.A., *ibid.* at s. 3) [emphasis added].

¹¹⁸ *Finlay (no. 3)*, *supra* note 108 at 1113.

break its bonds upon untrained poor. The Court will not allow the defendants to defeat this beneficent purpose by their own interpretation of the law, especially when the interpretation, however faithful it may be to the letter of the law, totally defeats the spirit of the law, and services only a sterile administrative purpose.¹¹⁹

But, applying the *Bates dictum* to the interpretation of the C.H.A. would impute an intent to Parliament without explaining why it would legislate for that purpose. The adequacy principle points to a deeper rationale for why Parliament may have intended that the C.A.P. and the C.H.A. lay the foundation for social schemes that are generous to the intended beneficiaries.

One possible rationale is found in liberal political theory, which serves as the basis of many elements of the modern welfare state. A central claim of liberalism is the importance of persons being able to pursue their own conception of the good life, which is closely tied to the idea of fair equality of opportunity. Many liberals believe that, from a moral point of view, events beyond one's control, which often change the range of opportunity that an individual may have to pursue one's conception of the good life, are arbitrary. These may be social contingencies, such as disparities in income and education due to socio-economic class, or natural contingencies, such as inherited talents and abilities. It then becomes a matter of social justice to mitigate the results of this lottery in order to ensure a "level playing field" for all persons, guaranteeing fair equality of opportunity for all.¹²⁰

This version of liberalism requires schemes of social redistribution, including progressive income tax, inheritance tax, subsidized access to education, and welfare programs, because individuals' opportunities are often limited by their poverty and lack of education. But one's range of opportunities is also influenced by one's health, which is, itself, dependent on social and/or natural contingencies. Norman Daniels has made this argument: "Impairment of normal functioning through disease and disability restricts an individual's opportunity relative to that portion of the normal range his skills and talents would have made available to him were he healthy."¹²¹ Indeed, poor health in the absence of Medicare would exacerbate the existing inequalities which limit fair equality of opportunity. Those who are ill would necessarily devote more resources to their medical needs than healthy individuals, and the rich would be able to meet these needs more easily than the poor. The resulting inequity in the range of opportunities open to these persons would mean that the relatively disadvantaged members of our society would be even

¹¹⁹ *Brown v. Bates*, 363 F. Supp. 897 at 902-903 (N.D. Ohio, 1973) [hereinafter *Bates*], quoted *ibid.* at 1114, McLachlin J.

¹²⁰ E.J. Emmanuel, *The Ends of Human Life: Medical Ethics in a Liberal Polity* (Cambridge, Mass.: Harvard University Press, 1991) at 121. For the seminal statement on fair equality of opportunity, see J. Rawls, *A Theory of Justice* (Cambridge, Mass.: Harvard University Press, 1971) at 73-74, 83-89.

¹²¹ N. Daniels, *Just Health Care* (New York: Cambridge University Press, 1985) at 33-34.

more limited than they already are in pursuing their own conceptions of the good life.

This reading of the C.H.A. is supported by statements made to the House of Commons by Monique Bégin when introducing the Act to Parliament.¹²² In criticizing premiums as a means of financing Medicare, she argued that they were deficient: “[T]hey hit people in a very unfair way. They hit poor people in exactly the same way as those with lots of money.”¹²³ Later, she reinforced this view by suggesting that Medicare should be funded through a progressive tax system, ensuring that “people would pay according to their means.”¹²⁴ These statements express the view that everyone should have equal access to health services, regardless of differences in socio-economic status. But the concern with income disparities, albeit implicitly, represents a commitment by Parliament to fair equality of opportunity regardless of social and/or natural contingencies.

From a liberal reading of the C.H.A., it is clear that the point of Medicare is to ensure that sick persons are restored to a state of health in which they may enjoy the same range of opportunity as do healthy persons. For the purposes of statutory interpretation, it requires that we imagine shared-cost programs, like the C.A.P. and the C.H.A., as laying the foundation for a national social citizenship. This view is supported by the fact that provincial plans must be universal and portable. As we shall see, this theory of the C.H.A. becomes most important in assessing the meaning of medical necessity.¹²⁵

¹²² These statements are a guide to interpreting the Act (see generally *R. v. Sullivan*, [1991] 1 S.C.R. 489 at 502-503, 63 C.C.C. (3d) 97).

¹²³ *House of Commons Debates* (16 January 1984) at 427.

¹²⁴ *Ibid.* at 428.

¹²⁵ Alternatively, it could be argued that it is unnecessary to debate the intent of Parliament in enacting the C.A.P. and the C.H.A. Coupled with the possibility of obtaining standing under *Finlay* (no. 2) to enforce these rights in the courts, it is no exaggeration to regard the C.A.P. and the C.H.A. as providing for “quasi-constitutional” rights, which should be interpreted purposively without any reference to Parliamentary intent. Bruce Porter has made this point regarding the C.A.P.:

Some people may think of C.A.P. merely as a fiscal agreement or social policy legislation. For poor people, however, C.A.P. has meant more than national standards or social policy. C.A.P. entrenches fundamental human rights, that is rights of citizens which are binding on our governments. If these rights are violated, we are able to go to court to seek a remedy (Charter Committee on Poverty Issues, “Bill C-76 and the Human Rights of Poor People in Canada” (Presentation to the Standing Committee on Finance of the Parliament of Canada, 16 May 1995) at 3 [unpublished]).

It is also possible to make a communitarian argument for Medicare. For example, a communitarian might argue that: Medicare promotes mutual dependence and, therefore, leads to the development of relationships of trust between individuals, thereby, promoting the development of the “relational aspects” of our identity; Medicare promotes deliberative democracy, because it requires collective decisions to be made about the allocation of scarce social resources; and Medicare “offers a unique opportunity to restore a sense of national community and to re-establish a principle of mutual sacrifice for the common good” (Note, “Universal Access to Health Care” (1995) 108 *Harv. L. Rev.*

b. Assessing Compliance

Because the C.A.P. establishes a statutory list of basic requirements in section 2(a), the Court's task in *Finlay (no. 3)* was relatively straightforward. There are provisions in the C.H.A. which are equally specific and would therefore create few difficulties of interpretation.¹²⁶ Difficulty arises, however, in trying to interpret the requirements of accessibility at section 12 and comprehensiveness at section 9; these provisions are most likely to be invoked to challenge provincial decisions to ration health care. There are two sorts of concerns here, both coming under the rubric of justiciability.¹²⁷ The first is judicial legitimacy. Under the doctrine of the separation of powers in a parliamentary democracy, the legislature enacts laws, which the executive implements, and the judiciary interprets. Asking courts to analyze the content of medicare programs necessarily involves asking them to make decisions about the allocation of resources. It is conventionally argued that it is better for the executive and legislative branches to make these decisions, because they are ultimately accountable to the electorate; hence the political enforcement mechanism of section 15(1). These criticisms, however, work best against the constitutionalization of social rights, which puts courts above elected legislatures. In contrast, the statutory regime of the C.H.A. does not present the same concern; in fact, on the traditional understanding of the doctrine of the separation of powers, courts are under a constitutional *duty* to give meaning to the terms of the C.H.A.

The second justiciability concern is institutional competence. The idea is that the courts are poorly equipped to adjudicate on these matters. The accessibility and comprehensiveness provisions in the C.H.A. force the courts to wade into issues of policy, a role to which they may be ill-suited. Health policy, on this argument, should be left to the expertise of health administrators, while courts should confine their activity to what they are good at, such as policing procedures. For example, Lon Fuller defined adjudication on policy matters as "polycentric":

1323 at 1328-29). See also: Emmanuel, *supra* note 120 at c. 4; D. Harris, *Justifying State Welfare: The New Right versus the Old Left* (Oxford: Basil Blackwell, 1987) at 55-57.

¹²⁶ For example, the C.H.A. provides: "[T]he health care insurance plan of a province must be administered and operated on a non-profit basis by a public authority" (*supra* note 2 at s. 8(1)(a)). Similarly, section 10 states that universality requires that a provincial plan entitle "one hundred percent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions". The portability provisions are equally precise:

[T]he health care insurance plan of a province

(a) must not impose any minimum period of residence in the province, or waiting period, in excess of three months before residents of the province are eligible for or entitled to insured health services (C.H.A., *ibid.* at s. 11(1)(a)).

¹²⁷ See C. Scott & P. Macklem, "Constitutional Ropes of Sand or Justiciable Guarantees? Social Rights in a New South African Constitution" (1992) 141 U. Pa. L. Rev. 1 at 17-26.

We may visualize this kind of situation by thinking of a spider web. A pull on one strand will distribute tensions after a complicated pattern throughout the web as a whole. Doubling the original pull will, in all likelihood, not simply double each of the resulting tensions but will rather create a different complicated pattern of tensions.¹²⁸

According to Fuller, while strictly legal questions are bipolar and lend themselves to all-or-nothing answers, policy questions are a matter of degree and raise interlocking concerns that go beyond the specific disputes at hand.

Fuller may have underestimated the ability of courts to grapple with complex policy matters as the jurisprudence under the *Charter* demonstrates.¹²⁹ The issue is better put as one of judicial experience:

“Justiciability” is a deceptive term because its legalistic tone can convey the impression that what is or is not justiciable inheres in the judicial function and is written in stone. In fact, the reverse is true: not only is justiciability variable from context to context, but its content varies over time. Justiciability is a contingent and fluid notion dependent on various assumptions concerning the role of the judiciary in a given place at a given time as well as on its *changing character and evolving capability*.¹³⁰

Indeed, adjudication may have some advantages for the resolution of policy questions. For example, the adversarial process gives parties incentives to provide detailed information. Moreover, if large numbers of parties are joined, a wide range of information will be provided, leading to a better-informed decision.¹³¹

i. Accessibility

The meaning of accessibility was debated in the decision of the Manitoba Court of Appeal in *Lexogest v. Manitoba (A.G.)*.¹³² The applicant, Lexogest Inc., owned and operated a free-standing abortion clinic in Winnipeg. The College of Physicians and Surgeons of Manitoba had approved the clinic as a non-hospital surgical facility where therapeutic abortions could be performed. Pursuant to the *Health Insurance Services Insurance Act*,¹³³ however, the provincial government

¹²⁸ L.L. Fuller, “The Forms and Limits of Adjudication” (1978) 92 Harv. L. Rev. 353 at 395.

¹²⁹ See e.g.: *R. v. Morgentaler*, [1988] 1 S.C.R. 30, 44 D.L.R. (4th) 385 [hereinafter *Morgentaler* cited to S.C.R.] and the discussion of this case, below; *Tétreault-Gadoury v. Canada (E.I.C.)*, [1991] 2 S.C.R. 22, 81 D.L.R. (4th) 358, in which the Court addressed a socio-economic policy question. In that case denial of unemployment benefits to those over 65 years old violated section 15 of the *Charter* and could not be saved under section 1, because there were less restrictive means of achieving the legislative policy that persons over 65 years old should not receive a “double” return of both pension and unemployment benefits.

¹³⁰ Scott & Macklem, *supra* note 127 at 17 [emphasis added].

¹³¹ See A. Chayes, “The Role of the Judge in Public Law Litigation” (1976) 89 Harv. L. Rev. 1281.

¹³² (1993), 85 Man. R. (2d) 8, 101 D.L.R. (4th) 523 (C.A.) [hereinafter *Lexogest* cited to Man. R.].

¹³³ R.S.M. 1987, c. H35.

adopted a regulation which removed insurance coverage for therapeutic abortions performed outside a hospital. The applicant argued, *inter alia*, that the regulation did not comply with the intent of the C.H.A. Although the case is not directly on point because the claim was brought against the provincial government, one could imagine an action launched against the federal government to withhold funding from Manitoba for non-compliance with the C.H.A.

A majority of the court (Helper, Philip, and Huband J.J.A.) did not consider the C.H.A. and held that the regulation was *ultra vires* the parent provincial statute. Scott C.J.M. (Lyon J.A. concurring), however, in his dissent, did analyze the compatibility of the regulation with the C.H.A.¹³⁴ The issue was whether section 12's condition of accessibility had been breached. The applicant argued that restricting coverage for therapeutic abortions to hospitals breached the requirement of "reasonable access". Scott C.J.M.'s simple reply was that "[r]easonable accessibility does not prohibit access to care being restricted in certain circumstances to a hospital setting,"¹³⁵ but he did not attempt to elaborate those circumstances. Did the regulation significantly impede access to abortions, or were hospital services adequate to meet demand? Since the clinic was located in Winnipeg, access was perhaps minimally affected (although there was no evidence on this point). But, what if the clinic had served a rural area where no hospitals performed abortions? What if no hospitals in the province performed abortions, as is the case in P.E.I.? What if hospitals in Winnipeg performed abortions but were so understaffed that women had to wait an unacceptable length of time?

The situation in *Lexogest* is further complicated by considering the province's reasons for excluding the service. Manitoba's aim was purely political: to restrict access to abortion in the wake of the *Morgentaler* decision. But suppose its motivation had been economic? Husband J.A. would have been willing to uphold the regulation if it had been "designed to control costs by specifying where the service is to take place".¹³⁶ On the facts, confining abortions to hospitals increased costs, because free-standing clinics operated more efficiently; but if they had not, would the principle of reasonable access have been violated?¹³⁷

¹³⁴ Scott C.J.M.'s opinions are clearly *obiter dicta*, since he was of the opinion that the C.H.A. did not impose binding legal obligations on the provincial government. This point will be returned to below.

¹³⁵ *Lexogest*, *supra* note 132 at 23.

¹³⁶ *Ibid.* at 31.

¹³⁷ It has been argued that allowing private and public health-care systems to provide the same services might violate the principle of reasonable accessibility, because it would lead to a two-tier system, one for the poor and one for the rich, who could avoid waiting-lists and obtain access to higher quality specialists. This has become an important issue in Alberta, where a system of private clinics is in operation. The province pays for the medical treatment, but the patient must pay a substantial facility fee (see C.B.A., *supra* note 7 at 90-91).

However, the C.B.A. report states that prohibiting private health-care services may be a violation of section 7 of the *Charter* (*ibid.* at 93-95). Although the Supreme Court has held that economic rights (e.g. contractual freedom) do not fall within the ambit of section 7 (see *Irwin Toy Ltd. v. Que-*

In *Lexogest*, Scott C.J.M. may have been deterred by justiciability concerns. He may have wished to defer to the political choices made by the provincial government regarding the provision of abortion services; moreover, he may have doubted his ability to assess the complex evidence which would have been required to establish a breach of section 12 of the C.H.A. A court is, however, capable of making such an assessment. The *Morgentaler* decision is a good illustration.

In *Morgentaler*, the Supreme Court struck down the *Criminal Code*'s provision on abortion¹³⁸ on the ground that it infringed a woman's right, under section 7 of the *Charter*, not to be deprived of life, liberty, and security of the person except in accordance with the principles of fundamental justice. In coming to its decision, the Court examined a vast amount of data on Canadian abortion services. For example, in Ontario, there was evidence of an average delay of eight weeks between first contact with a physician and the performance of a therapeutic abortion.¹³⁹ Moreover, because hospitals had allocated limited funds for abortions, there was some suggestion that women had to apply to several hospitals to obtain an abortion, which could create a delay;¹⁴⁰ 38.2 percent of hospitals imposed quotas on abortions on the basis of place of residence.¹⁴¹ The Court relied heavily on the results of a federal report commissioned to examine the operation of procedures for obtaining therapeutic abortions across Canada. The report found that the requirement that there be three physicians on a therapeutic abortion committee, not including the physician performing the abortion, resulted in 24.6 percent of hospitals being too small to form committees.¹⁴² Furthermore, abortions could only be performed in hospitals accredited by the Canadian Council on Hospital Accreditation and approved by provincial ministers of health, according to criteria which varied from province to province.¹⁴³ On this measure, fifty-eight and one-half percent of hospitals were ineligible. Furthermore, eligible hospitals were under no obligation to actually establish committees, and only forty-eight and one-half percent had

bec (A.G.), [1989] 1 S.C.R. 927, 58 D.L.R. (4th) 577) that decision left open the question of "whether those economic rights fundamental to human life or survival" (*ibid.* at 1003) could be protected by section 7. Conceivably, a *Charter* claim might be made by a patient if medically necessary services were not being adequately provided by the public-health plan, but an individual could obtain those services from a private provider. The crucial question, however, is whether such a restriction is "in accordance with fundamental justice" (*Charter*, *supra* note 5 at s. 7) or a reasonable limit "demonstrably justified in a free and democratic society" (*ibid.* at s. 1). Does Medicare minimally impair the life and security interests protected by section 7?

On the ability of institutional providers and individual providers of health care to challenge the constitutionality of public health care, see M. Jackman, "The Regulation of Private Health Care under the *Canada Health Act* and the *Canadian Charter*" (1995) 6 *Const. Forum* 54.

¹³⁸ R.S.C. 1970, c. C-34 at s. 251.

¹³⁹ See *Morgentaler*, *supra* note 129 at 100.

¹⁴⁰ See *ibid.*

¹⁴¹ See *ibid.* at 99.

¹⁴² See *ibid.* at 66.

¹⁴³ See *ibid.*

chosen to do so.¹⁴⁴ Also, eighteen percent of committees were dormant; they existed on paper but did not approve abortions.¹⁴⁵

From this mass of empirical evidence, the Court was able to conclude that there was an “absence or serious lack of therapeutic abortion facilities in many parts of the country”.¹⁴⁶ It was able to arrive at this conclusion even though there was no one “right” way to organize abortion services, because the provision of health care is a polycentric, not a bipolar, matter. Although the decision in *Morgentaler* is based on the *Charter*, not the C.H.A., it demonstrates how a court can assess a complex and rich body of evidence to arrive at an assessment of whether provincial governments are meeting their commitment to provide reasonably accessible services to the public. The question is not one of competence, but of judicial will.

ii. Comprehensiveness

No cases have yet grappled with the definition of comprehensiveness, which incorporates a requirement of medical necessity. This is bound to occur in the near future, since provincial governments are moving toward setting priorities in their allocation of scarce resources. Several different criteria for rationing have been suggested, including the patient’s quality of life and life expectancy post-treatment.¹⁴⁷ Deciding which criteria to use, and how to apply them, is not an exact science. In the end, it involves difficult trade-offs and requires that choices be made among a number of medical procedures, all of which patients would like to have included in a public-insurance plan. Put simply, how is a court to compare a hip replacement with open-heart surgery? Which treatments are medically necessary, which are not, and under what circumstances?

The C.H.A. is silent on the definition of medical necessity. The C.B.A. has stated that this was a deliberate choice by the federal government. The goal was to leave “it up to each province and territory to establish its own definition”.¹⁴⁸ But no province has defined medical necessity either.¹⁴⁹ This lacuna, coupled with the complexity of the question, makes it tempting to leave the matter to provincial governments and not have the courts assess whether medically necessary services are being provided. The message from *Finlay (no. 3)*, however, is that there must be some *minimum* content to provincial plans for federal schemes to be effective; refusing to address the question of medical necessity would effectively read comprehensiveness out of the C.H.A. Furthermore, since the C.H.A. does not ex-

¹⁴⁴ See *ibid.* at 97.

¹⁴⁵ See *ibid.*

¹⁴⁶ *Ibid.* at 95, Beetz J.

¹⁴⁷ See J.F. Kilner, *Who Lives? Who Dies?: Ethical Criteria in Patient Selection* (New Haven, Conn.: Yale University Press, 1990).

¹⁴⁸ C.B.A., *supra* note 7 at 31.

¹⁴⁹ See *ibid.* at 37-39.

pressly delegate to provincial governments the task of defining medical necessity, its meaning remains a matter of statutory interpretation. Finally, failing to give meaning to the requirement of comprehensiveness would defeat the whole point of Medicare, which is to guarantee fair equality of opportunity. What has not been suggested in Canada to date, however, is that we look to this purpose in trying to define what medical necessity means.

Health-care needs are a matter of social justice, because they limit the range of individuals' opportunities to pursue their conceptions of the good life. The idea is that but for one's disease or disability, one would be able to enjoy a wider range of opportunities. Framing the impact of ill health in this way makes the relevant comparison between a diseased or disabled state of health and a normal state of health, which persons are entitled to enjoy, a matter of justice. The object of Medicare is to ensure that individuals are returned to that normal state.¹⁵⁰

Leaving aside controversies over the definition of disease and illness, medical ethicist Ezekiel Emmanuel has written that it is possible to come up with a definition of "normal human functioning" which can serve as the basis for defining medical necessity:

Biomedical science offers a fairly clear way of identifying the range of natural human functions that constitute a healthy organism and the range of deviations labelled diseases. Furthermore, this conception of medical need is not just a theoretical definition, but also one that guides current medical practices.¹⁵¹

With this formulation of medical necessity, there is an intimate connection between the purpose behind the C.H.A. and the sort of empirical evidence and expert testimony with which courts are familiar. Although not ideal, the most sensible solution would be to rely on expert evidence, on a case-by-case basis, to determine whether a procedure is medically necessary.¹⁵² Testimony would come not only from physicians, but also from health-service researchers. On this theory of medical necessity, Emmanuel suggests that insured services would include:

(1) preventive services — programs for public health, vaccination, food and drug protection, nutrition education, and education for healthy life-styles; (2) personal medical and rehabilitative services — services that cure diseases and restore normal functioning, such as antibiotics and appendectomies; (3) chronic medical services — services, such as dialysis, aimed at those diseases that cannot be cured but only ameliorated; and (4) nursing and social services — services for those whose ailments cannot be cured or ameliorated, including

¹⁵⁰ This argument was first made by Daniels, *supra* note 121.

¹⁵¹ Emmanuel, *supra* note 120 at 109.

¹⁵² Proposals made by the R.A.N.D. Corporation for defining medical necessity in the United States rely heavily on expert consensus (see D.C. Hadorn & R.H. Brook, "The Health Care Resource Allocation Debate: Defining Our Terms" (1991) 266 J. Am. Med. Assoc. 3328 at 3330).

Seeing-Eye dogs, Braille education, wheelchairs, and specially designed vans for the paralyzed.¹⁵³

There is some precedent for this approach in the medical context. The Ontario *Regulated Health Professions Act*¹⁵⁴ makes it an offence to perform a “controlled act” (defined by the Statute) “in the course of providing health care services to an individual unless ... the person is a member authorized by a health profession Act to perform the controlled act”.¹⁵⁵ For physicians, the relevant statute is the *Medicine Act*.¹⁵⁶ Section 4 authorizes physicians to perform controlled acts “[i]n the course of engaging ... in the practice of medicine” that are defined in section 3 as “the assessment of the physical or mental condition of an individual and the diagnosis, treatment, and prevention of any disease, disorder, or dysfunction”. What constitutes the practice of medicine, which is at the core of this legislative regime, is left largely undefined; but, the definition has been given specific content through the testimony of members of the medical profession.

The decision in *Morgentaler* also demonstrates that a court, equipped with the testimony of experts, can make sophisticated judgments about the advisability of certain procedures. Beetz J. held that the *Criminal Code*'s abortion provisions requiring abortions to be performed in hospitals did not conform with the principles of fundamental justice, because they were unnecessary in relation to Parliament's objective, which was to ensure maternal safety.¹⁵⁷ Indeed, evidence suggested that there was no medical justification for such a requirement. On the contrary, the evidence indicated that first-trimester abortions could be safely performed in specialized clinics outside of hospitals, and that complications could be handled — perhaps even better handled — by such clinics.¹⁵⁸ Beetz J. also looked at both the high percentage of abortions (76.9 percent) performed on an out-patient basis and evidence that performing the procedure in clinics did not raise the rate of complications.¹⁵⁹

The real concern with this theory of medical necessity is not its lack of justifiability, but its “voraciousness”: “[It] mandates that people receive most of what modern medicine has to offer as a guarantee of fair equality of opportunity.”¹⁶⁰ Health-care coverage fashioned on this criterion could threaten other schemes of social provision provided through the government, such as welfare and public education, by consuming an ever-increasing share of society's resources. This line of criticism suggests that a new theory — not fair equality of opportunity — should underpin the C.H.A. and ground the interpretation of “medical necessity”. If this is

¹⁵³ Emmanuel, *supra* note 120 at 122.

¹⁵⁴ S.O. 1991, c. 18.

¹⁵⁵ *Ibid.* at s. 27(1)(a).

¹⁵⁶ S.O. 1991, c. 30.

¹⁵⁷ See *Morgentaler*, *supra* note 129 at 114-15.

¹⁵⁸ See *ibid.* at 115.

¹⁵⁹ See *ibid.* at 116.

¹⁶⁰ Emmanuel, *supra* note 120 at 110, 123.

the case, however, the solution is not for courts to change their interpretation of the C.H.A., but for Parliament to amend it. The basic theory underlying the Act demands a generous approach to determining Medicare's coverage. Abandoning this theory would fundamentally change the very nature of the C.H.A. Such a change should be made by Parliament with the attendant political consequences. Additionally, by not proceeding by this route, the courts would allow provincial governments to achieve a *de facto* amendment to a federal statute by changing their definitions of medical necessity, even though the C.H.A. does not make an express delegation.

2. Reviewing Cabinet Discretion

In *Hughes*, the statement of claim asked for an injunction to restrain the Minister of National Health and Welfare from making payments under the C.H.A., presumably by analogy with *Finlay (no. 3)*. It must be pointed out, however, that *Finlay (no. 3)* is not directly on point, because of an important difference between the C.H.A. and the C.A.P. Section 7 of the latter provides:

Contributions or advances on account thereof shall be paid, upon the certificate of the Minister, out of the Consolidated Revenue Fund at such times and in such manner as may be prescribed, *but all such payments are subject to the conditions specified in this Part and in the regulations and to the observance of the agreements and undertakings contained in an agreement.*¹⁶¹

Thus, transfer payments are conditional. Had *Finlay* successfully shown that the province failed to meet a condition of the C.A.P., the federal payments would have been illegal, and relief would have been granted accordingly. The C.H.A. contains a similar provision, in section 7:

In order that a province may qualify for a full cash contribution ... for a fiscal year, the health care insurance plan of the province *must, throughout the fiscal year, satisfy the criteria described in sections 8 to 12 respecting the following matters ...*¹⁶²

Since provincial plans "must" meet the conditions described in sections 8 to 12 (public administration, comprehensiveness, universality, portability, accessibility), section 7 of the C.H.A., on its face, looks like section 7 of the C.A.P.¹⁶³ The problem with this interpretation, however, is that it effectively reads out sections 14 to 17 of the C.H.A.; no corresponding provisions exist in the C.A.P. These provisions establish an elaborate mechanism of consultation and investigation, culminating in a decision by the federal cabinet whether to withhold funding under section 15(1):

¹⁶¹ C.A.P., *supra* note 86 at s. 7 [emphasis added].

¹⁶² C.H.A., *supra* note 2 at s. 7 [emphasis added].

¹⁶³ The bans against extra-billing, at section 18, and user charges, at section 19, are not listed in section 7 as "program criteria". This is because they are subject to their own enforcement mechanism, requiring mandatory deductions from federal transfer payments (C.H.A., *ibid.* at s. 20).

Where ... *the Governor in Council is of the opinion* that the health care insurance plan of a province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12 ... the Governor in Council *may*, by order,

(a) direct that any cash contribution or amount payable to that province for a fiscal year may be reduced, in respect of each default, by an amount that the Governor in Council considers to be appropriate, having regard to the gravity of the default; or

(b) where the Governor in Council considers it appropriate, direct that the whole of any cash contribution or amount payable to that province for a fiscal year be withheld.¹⁶⁴

The subjective wording of section 15(1) indicates that cabinet has a discretion to withhold federal payments.¹⁶⁵ An action would arise if cabinet were to refuse to exercise its discretion. If the plaintiff is to succeed, this refusal must be challenged.

Although there is a consensus that unfettered statutory discretion does not exist,¹⁶⁶ there is some debate over the standard by which it should be reviewed. On the one hand, there is the “patently unreasonable” test, formulated by Lord Greene M.R. in *Associated Provincial Picture Houses Ltd. v. Wednesbury Co.*¹⁶⁷ “It is true to say that if a decision on a competent matter is so unreasonable that no reasonable authority could ever have come to it, then the courts can interfere ... but to prove a cause of that kind would require something overwhelming.”¹⁶⁸ This standard incorporates a high degree of deference toward administrative decision-makers. *Wednesbury* has not been adopted by the Supreme Court but has been applied by some provincial courts of appeal.¹⁶⁹ Its deferential approach would make it attractive to a court seeking to avoid questioning a decision of cabinet. This argument is based on the doctrine of the separation of powers. It is more appropriate that the executive, which is accountable to the democratically-elected legislature and, through it, to the public, make decisions of an economic and social nature than an unelected and unaccountable judiciary. The problem with this argument, however, is that it places inordinate reliance on venues of political accountability, which may function very poorly in practice.¹⁷⁰

¹⁶⁴ *Ibid.* at s. 15(1) [emphasis added].

¹⁶⁵ This is unlike the duty to withhold payments for extra-billing and user charges imposed by sections 20(1) and 20(2), respectively, where the lack of any discretion makes the matter of enforcement straightforward.

¹⁶⁶ See J.M. Evans *et al.*, *Administrative Law: Cases, Text and Materials*, 4th ed. (Toronto: Emond Montgomery, 1995) at 1023.

¹⁶⁷ [1948] 1 K.B. 223, [1947] 2 All E.R. 680 (C.A.) [hereinafter *Wednesbury* cited to K.B.].

¹⁶⁸ *Ibid.* at 230.

¹⁶⁹ See: *Sundance Beach (Summer Village) v. W.A.W. Holdings Ltd.* (1980), 2 A.R. 451, [1981] 1 W.W.R. 581 (C.A.); *MacMillan Bloedel Ltd. v. British Columbia (Minister of Forests)*, [1984] 3 W.W.R. 270, 51 B.C.L.R. 105 (C.A.); *McDonald v. North Norfolk (Rural Municipality)* (1992), 83 Man. R. (2d) 44, 98 D.L.R. (4th) 436 (C.A.).

¹⁷⁰ For an analysis of the British situation, see I. Harden & N. Lewis, *The Noble Lie: the British Constitution and the Rule of Law* (London: Hutchinson, 1988).

Set against *Wednesbury* is the idea that a discretion must be exercised to promote the purposes of the act which confers it. The leading case on this approach is the House of Lords' decision in *Padfield v. Minister of Agriculture*.¹⁷¹ The Minister declined to exercise his statutory discretion to refer a complaint about a milk-pricing scheme to a committee of investigation. The House of Lords, however, issued a writ of *mandamus* directing him to do so, because the purpose of the Statute was to convene a hearing for aggrieved parties. Lord Reid said:

Parliament must have conferred the discretion with the intention that it should be used to promote the policy and object of the Act ... if the Minister, by reasons of his having misconstrued the Act or for any other reason, so uses his discretion as to thwart or run counter to the policy and objects of the Act, then our law would be very defective if persons aggrieved were not entitled to the protection of the court.¹⁷²

The purposive approach to reviewing statutory discretion was recently adopted by the Supreme Court in *Shell Canada Products Ltd. v. Vancouver (City of)*.¹⁷³ The Vancouver City Council passed resolutions directing the City of Vancouver to refuse doing business with Shell Canada, because of Shell's involvement in South Africa. Shell Canada applied to have the resolutions quashed, because they were *ultra vires* the enabling statute.¹⁷⁴ A majority of the Court held that the resolutions did not promote the purpose of the Statute, because they did not "provide for the good rule and government of the city",¹⁷⁵ but were, rather, "based on matters external to the interests of the citizens of the municipality".¹⁷⁶

These cases show that statutory discretion may be subject to a stricter standard of review than patent unreasonableness. It may be argued, however, that the Canadian courts show extreme deference to the exercise of statutory discretion by cabinet, out of a concern for constitutional propriety.¹⁷⁷ The Court in *Collett* took this view, when it stated in *obiter* that the C.H.A. "intended that the Governor in Coun-

¹⁷¹ [1968] A.C. 997, 1 All E.R. 694 (H.L.) [hereinafter *Padfield* cited to A.C.].

¹⁷² *Ibid.* at 1030. See also *Roncarelli v. Duplessis*, [1959] S.C.R. 121, 16 D.L.R. (2d) 689.

¹⁷³ [1994] 1 S.C.R. 231, 110 D.L.R. (4th) 1 [hereinafter *Shell* cited to S.C.R.].

¹⁷⁴ *Vancouver Charter*, S.B.C. 1953, c. 55.

¹⁷⁵ *Ibid.* at s. 189.

¹⁷⁶ *Shell*, *supra* note 173 at 279, Sopinka J.

¹⁷⁷ Thus, Dickson J. made this clear in *Thorne's Hardware Ltd. v. R.*, [1983] 1 S.C.R. 106, 143 D.L.R. (3d) 577 [hereinafter *Thorne's Hardware* cited to S.C.R.]:

[D]ecisions made by the Governor in Council in matters of public convenience and general policy are final and not reviewable in legal proceedings. Although, as I have indicated, the possibility of striking down an Order in Council on jurisdictional or other compelling grounds remains open, it would take an egregious case to warrant such action (*Thorne's Hardware*, *ibid.* at 111).

cil have a great deal of discretion in relation to its options should a health insurance plan cease to satisfy the federal criteria".¹⁷⁸

However, two other decisions suggest this attitude may be changing, at least in the context of health care. In *British Columbia Civil Liberties Assoc. v. British Columbia (A.G.)*,¹⁷⁹ the B.C. Cabinet enacted a regulation which declared that abortions were not "medically required" and, therefore, not insured unless: (1) there was a significant threat to the woman's life, and (2) the abortion was performed in a hospital. The regulation's broad scope effectively eliminated coverage for abortions under the provincial health-insurance scheme. The court found that the Cabinet had exceeded its jurisdiction. Although it could have de-insured abortions entirely, it did not have the power to declare abortions as not "medically required".¹⁸⁰ Although *B.C. Civil Liberties* is a case on jurisdiction (error of law), not discretion, it is very hard, if not impossible, to prevent questions of jurisdiction from becoming evaluations of the merits of a decision.¹⁸¹

In *Morgentaler v. Prince Edward Island (Minister of Health and Social Services)*¹⁸², the court struck down a similar regulation de-insuring abortions unless: (1) they were performed in a hospital, and (2) they were deemed necessary by a provincial agency or its medical advisory committee. The regulation was made by the agency and approved by the provincial Cabinet. Unlike *B.C. Civil Liberties*, the question before the court was one of discretion, not error of law. Applying *Padfield* (and citing academic criticism of *Thorne's Hardware*),¹⁸³ the court held that the regulation did not further any of the purposes of the parent legislation.¹⁸⁴

¹⁷⁸ *Collett*, *supra* note 70 at 430. The issue in *Collett* was whether the limitation of hospital coverage for treatment outside of Canada by O.H.I.P. was *ultra vires* section 45(1)(h) of the Ontario *Health Insurance Act*, R.S.O. 1990, c. H.6, which authorized the provincial cabinet to prescribe amounts payable by O.H.I.P. for insured services except in a manner which "would disqualify the Province of Ontario under the [C.H.A.], for the contribution by the Government of Canada because the [Ontario Health Insurance] Plan would no longer satisfy the criteria under that Act". The court held that the application was premature because the consultation process set out by section 14 of the C.H.A. had not yet been followed.

¹⁷⁹ (1988), 24 B.C.L.R. (2d) 189, 4 W.W.R. 100 (Sup. Ct.) [hereinafter *B.C. Civil Liberties* cited to B.C.L.R.]. For a criticism of the decision, see D.G. Cowper, "Case Comment: B.C. Civil Liberties Association versus Attorney General for British Columbia" (1989) 47 *Advocate* 621.

¹⁸⁰ *Ibid.* at 193. The parent legislation was the *Medical Service Act*, R.S.B.C. 1979, c. 255.

¹⁸¹ See P. Cane, *An Introduction to Administrative Law*, 2d ed. (Clarendon Press: Oxford, 1992) at 113. This is unsurprising, since jurisdictional error is a "notoriously elastic concept" (J.M. Evans, "The Principles of Fundamental Justice: The Constitution and the Common Law" (1991) 29 *Osgoode Hall L.J.* 51 at 65).

¹⁸² (1995), 122 D.L.R. (4th) 728, P.E.I.J. No. 20 (Sup. Ct.) (Q.L.) [hereinafter *Morgentaler v. P.E.I.* cited to D.L.R.].

¹⁸³ *Ibid.* at 748.

¹⁸⁴ See *Health Services Payment Act*, R.S.P.E.I. 1988, c. H-2. These purposes were sustaining or advancing the role of hospitals, controlling the medical profession, ensuring the health of patients, and controlling costs (see *Morgentaler v. P.E.I.*, *ibid.* at 750-51). A crucial element of the decision was

Following *B.C. Civil Liberties* and *Morgentaler v. P.E.I.*, the federal cabinet must exercise its discretion under section 15(1) in accordance with the purposes of the Act. One purpose can be found in section 3 of the C.H.A., which articulates the overall aims of Canadian health policy: “It is hereby declared that the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.” This section must be read together with section 4:

The purpose of this Act is to establish criteria and conditions that must be met before full payment may be made under the ... [*Federal-Provincial Fiscal Arrangements and Federal Post-secondary Education and Health Contributions Act*] ... in respect of insured health services and extended health care services provided under provincial law.¹⁸⁵

Taken together, sections 3 and 4 indicate that if cabinet were faced with a grievous breach of the C.H.A. criteria (laid out in sections 8 to 12), it would be *ultra vires* not to exercise its discretion under section 15(1) to withhold federal payments. Failure to do so would undermine the explicitly stated goal of section 4, which is to ensure that federal support is only provided to provincial health-insurance plans that meet the requirements of public administration, comprehensiveness, universality, portability, and accessibility. Furthermore, in the absence of any obvious purpose for a decision by cabinet not to withhold transfer payments, it may be open to a court, in extreme circumstances, “to ponder the context and background realities surrounding”¹⁸⁶ the breach of the C.H.A.’s criteria and, thus, rule the decision *ultra vires*. These realities might include the desire of cabinet to avoid a confrontation with the provinces, who are likely to point to declining federal contributions for health care, or to avoid drawing attention to the inadequate monitoring mechanisms in place at the Health Insurance Directorate.

D. Remedies

What remedies would be available to the applicant in *Hughes*? Remedies in administrative law are granted at the discretion of the court. Two different directions suggest themselves: (1) a declaration that the Governor in Council’s failure to exercise its discretion under section 15(1) was *ultra vires* or (2) an order of *mandamus* directing the Governor in Council to withhold federal payments by exercising its discretion under section 15(1).¹⁸⁷

that the provincial agency had already determined that abortions were “basic health services” for the Province. The court held that this determination was inconsistent with the regulation (*ibid.* at 754).

¹⁸⁵ C.H.A., *supra* note 2 at s. 4.

¹⁸⁶ *Morgentaler v. P.E.I.*, *supra* note 182 at 751.

¹⁸⁷ An injunction stopping federal payments until a province had complied with the terms of the C.H.A., however, would not be an appropriate remedy, as it is based on an incorrect reading of section 7. This idea is discussed above.

Mandamus would be the more effective of the two. However, it is an established rule that this remedy (and other forms of mandatory relief) may not issue against the Crown, which would, of course, include the Governor in Council. A legal fiction employed extensively by the courts to circumvent that rule — that is, allowing mandatory relief against a servant of the Crown — would not apply, because the discretion is exercised directly by the Governor in Council. The position is not entirely clear, however, because of the power of judicial review conferred on the Federal Court of Canada under the *Federal Court Act*.¹⁸⁸ The court has jurisdiction to review the actions of “any federal board, commission or other tribunal” which exercises powers “conferred by or under an Act of Parliament”.¹⁸⁹ It has been held by some courts that this definition includes the Governor in Council.¹⁹⁰ Since the court has the power to issue a writ of *mandamus* against any body within its supervisory jurisdiction, this power would seem to extend to the Governor in Council.

However, even if a writ of *mandamus* were available, it is unlikely that a court would grant it. First, this writ is usually only granted to compel the exercise of a legal duty. Although it is available to correct a mistaken exercise of discretion,¹⁹¹ if a discretion is not binary (that is, it does not leave only two choices), a court will probably not grant *mandamus*. Since section 15(1) of the C.H.A. gives the Governor in Council considerable freedom to choose what an “appropriate” amount to withhold would be, a court may be reluctant to determine this amount. A similar choice was made by the Federal Court of Appeal in the *Native Women’s Association of Canada v. Canada (A.G.)*.¹⁹² The court found that the funding of certain aboriginal organizations to the exclusion of the N.W.A.C. violated sections 2(b) and 28 of the *Charter*. However, the court declined to issue a prohibition (a form of mandatory relief) on funding of those other groups until the N.W.A.C. was provided with equal funding:

[T]he evidence does not permit a judicial conclusion that funding of N.W.A.C. equal to that provided to each of the designated aboriginal organizations is what is necessary to accord aboriginal women the equal measure of freedom of expression guaranteed them by s. 28 of the Charter. It may be inadequate or it may be excessive. The appropriate quantum of funding would seem to me very much a matter to be determined by the executive ...¹⁹³

¹⁸⁸ R.S.C. 1985, c. F-7, as am. by S.C. 1990, c. 8.

¹⁸⁹ *Ibid.* at s. 2(1).

¹⁹⁰ See e.g. *National Anti-Poverty Organization v. Canada (A.G.)*, [1989] 1 F.C. 208, 21 F.T.R. 33, rev’d (without comment on this point) [1989] 3 F.C. 684, 60 D.L.R. (4th) 712 (C.A.).

¹⁹¹ See P.P. Craig, *Administrative Law*, 3d ed. (London: Sweet & Maxwell, 1989) at 528. A famous example of the use of *mandamus* to direct the exercise of a discretion is *Padfield*.

¹⁹² [1992] 3 F.C. 192, 95 D.L.R. (4th) 106 (C.A.), rev’d (on other grounds) [1994] 3 S.C.R. 627, 119 D.L.R. (4th) 224 [hereinafter *N.W.A.C.* cited to F.C.].

¹⁹³ *Ibid.* at 219.

Moreover, when a problem is systemic, the court may decline to issue mandatory relief, as *Finlay (no. 3)* demonstrates. In the Federal Court (Trial Division), after finding for Finlay on the merits, the court issued an injunction against the Minister of Finance prohibiting payments under C.A.P. until Manitoba brought its program into compliance.¹⁹⁴ The Federal Court of Appeal, although upholding the decision on the merits, allowed an appeal from the injunction, because it would have adversely affected too many programs.¹⁹⁵

On the surface, a declaration would seem to be a much weaker remedy than *mandamus*, because it does not compel any sort of behaviour. Kent Roach has written, however, that the Canadian courts have shown a preference for declarations because they

do not require courts to supervise compliance by means of their contempt powers and this allows declarations to be more open-ended and less specific than injunctions. This in turn, allows governments some flexibility in deciding exactly what steps they should take to implement the court's declaration and this can contribute to an appropriate institutional division of labour between the court and the government.¹⁹⁶

In the context of the C.H.A., declarations help courts to avoid playing health administrator, leaving the federal government to determine the exact amount to withhold from an offending provincial government. Declarations are also useful because they may clarify the law, thereby helping to prevent future violations.¹⁹⁷

The disadvantage of a declaration, however, is that it ends a court's involvement in a case; a court will be unaware of what steps are taken to respond to the declaration. This shortcoming, however, may be offset by the involvement of the Auditor General of Canada. Under the *Auditor General Act*,¹⁹⁸ the Auditor General shall report to Parliament on matters that he or she considers to be important, including cases where "money has been expended other than for purposes for which it was appropriated by Parliament".¹⁹⁹ It would seem that a declaration that a province was not complying with the conditions of the C.H.A., and that cabinet had failed to exercise its discretion appropriately by failing to stop federal payments, would certainly fall within the ambit of section 6(2)(c). This information would appear in the Auditor General's report to Parliament and would, thus, become available to the public. The resulting political embarrassment would exert pressure on the federal government to act in accordance with the court's decision.

IV. Enforcing the C.H.A. Against Provincial Governments

¹⁹⁴ (1989), 25 F.T.R. 45, 57 D.L.R. (4th) 211.

¹⁹⁵ See [1990] 2 F.C. 790, 71 D.L.R. (4th) 422 (C.A.).

¹⁹⁶ K. Roach, *Constitutional Remedies in Canada* (Aurora: Canada Law Book, 1994) at para. 12.30.

¹⁹⁷ See *ibid.* at para. 12.290.

¹⁹⁸ R.S.C. 1985, c. A-17.

¹⁹⁹ *Ibid.* at s. 6(2)(c).

A. Introduction

It is apparent that the above remedies are very indirect because they are targeted at the federal government and not at the offending provincial health-care scheme. The federal government would then have to use its financial leverage to encourage provincial compliance. If judicial review is sought to alleviate specific problems facing patients, however, the judicial remedies discussed above have inadequacies.

One obvious alternative would be to enforce the criteria of the C.H.A. directly against a province. In a handful of cases, such attempts have proven unsuccessful.²⁰⁰ In order to succeed, an applicant would have to overcome three substantial hurdles. First, the applicant must show that a province undertook to comply with the terms of the C.H.A. It will be argued that the lack of written agreements between the provinces and the federal government on Medicare (in contrast to the regime under the C.A.P.) raises significant problems in meeting this requirement. Second, an applicant must demonstrate that this undertaking or “agreement” was legally enforceable (that is, not merely a political document with unintended legal consequences). The caselaw on inter-governmental agreements to date, however, probably points to the opposite conclusion. Finally, a claimant must obtain third-party standing to challenge this agreement; however, this issue is unresolved under the existing caselaw.

Only after overcoming these three hurdles could a claimant proceed to examine the compliance of a provincial plan with the criteria of the C.H.A. This point was dealt with in detail, above,²⁰¹ along with the issue of remedies. The following discussion will therefore focus on the three barriers outlined above. As will become apparent, the feasibility of such a claim is purely speculative and, in the end, would most likely be unsuccessful.

B. Identifying an Undertaking

Nothing defines the era of co-operative federalism like the inter-governmental agreement. Negotiated and signed by federal and provincial governments, these documents range from the general to the very detailed. The incentive to enter these agreements is evident: they help to formalize and regularize relations between levels of government. Should a dispute arise, the terms of the agreement can be referred to and conduct assessed against them. An example of the use of inter-governmental agreements in the field of shared-cost social programs is the C.A.P. Section 4 authorizes the Minister of National Health and Welfare to enter into

²⁰⁰ The C.H.A. was raised in argument in three cases: *Lexogest*, *supra* note 132; *B.C. Civil Liberties*, *supra* note 179; *Morgentaler v. P.E.I.*, *supra* note 182.

²⁰¹ See Part III, above.

agreements with provincial governments to pay a federal contribution toward their social-assistance and welfare programs.²⁰²

A crucial distinguishing feature between the C.A.P. and the C.H.A. is the absence of agreements between the federal government and the provinces. In fact, inter-governmental agreements have not been used in health care since the 1957 *Hospital Insurance Act*.²⁰³ The 1966 *Medical Care Act*, which extended Medicare to cover non-hospital based medical care, did not utilize agreements. The C.H.A. adopted this approach. Claude Forget has argued that this was a deliberate decision on the part of the federal government, because Québec had indicated that it would no longer enter into such agreements.²⁰⁴

In the absence of an express agreement, a court would, therefore, have to imply an undertaking. Professor Martin has drawn a useful private-law analogy, whereby courts have implied the existence of unilateral contracts.²⁰⁵ Thus, the terms of the C.H.A. would be an offer to the provinces, which they accept by taking monies from the federal government. Provincial breach of those terms would lead to either political or legal liability.²⁰⁶

The difficulty with this approach, however, is that the federal and provincial governments could have entered into agreements had they so wished. This practice is well established in other areas, such as the environment.²⁰⁷ Unilateral contracts, on the other hand, can be viewed as equitable devices, which are implied by a court where no written contract could be reasonably negotiated. For a court to imply such an agreement would import principles from contract law into inter-governmental relations without a full appreciation of the different policy interests at stake. In fact, by doing so, courts may dissuade governments from co-operating, since they may have deliberately chosen to cooperate informally in a particular area, perhaps in an effort to pre-empt the possibility of judicial involvement.

²⁰² A partial text of the agreement between British Columbia and the federal government under C.A.P. can be found in *Reference Re Canada Assistance Plan*, [1991] 2 S.C.R. 525 at 537-38, 83 D.L.R. (4th) 297 [hereinafter *C.A.P. Reference* cited to S.C.R.].

²⁰³ Subject to this Act, the Minister may, with the approval of the Governor in Council, enter into an agreement with any province to provide for the payment by Canada to the province of contributions in respect of the cost of insured services incurred by the province pursuant to provincial law (*Hospital Insurance Act*, *supra* note 16 at s. 3(1)).

²⁰⁴ See Forget, *supra* note 43 at 134.

²⁰⁵ See Martin, *supra* note 7 at 18. A classic example of a unilateral contract is *Carlill v. Carbolic Smoke Ball Co.*, [1893] 1 Q.B. 256, 67 L.T. 837 (C.A.).

²⁰⁶ This distinction will be discussed in Part IV.C., below.

²⁰⁷ See: S.A. Kennett, *Managing Interjurisdictional Waters in Canada: A Constitutional Analysis* (Calgary: Canadian Institute of Resources Law, 1991) at 63-89; S.A. Kennett, "Hard Law, Soft Law and Diplomacy: The Emerging Paradigm for Intergovernmental Cooperation in Environmental Assessment" (1993) 31 Alta. L. Rev. 644; J.O. Saunders, *Interjurisdictional Issues in Canadian Water Management* (Calgary: Canadian Institute of Resources Law, 1988) at c. 5.

C. *Legal Status of Inter-governmental Agreements*

Even if a court were to imply an agreement between the provincial and federal governments concerning the terms of transfer payments, its legal status would be unclear at best.²⁰⁸ It has been suggested that inter-governmental agreements could be characterized as contracts, treaties, or hybrids “encompassing aspects of both”.²⁰⁹ However, the better view is that these agreements are purely political in nature and do not carry legal force. The leading case on this point is the *C.A.P. Reference*.²¹⁰ Pursuant to section 4 of the C.A.P., the federal government entered into agreements with each of the provinces in 1967. Section 5 stated that the federal government would pay fifty percent of the cost of provincial plans. Section 8(1) provided that “every agreement shall continue in force so long as the provincial law remains in operation,” subject to section 8(2), which allowed termination by consent or with one year’s notice by either party. In 1990, the federal government decided to limit its payments to Ontario, Alberta, and British Columbia.²¹¹ British Columbia questioned the power of the federal government to unilaterally amend the agreement.

The Supreme Court upheld the legality of the limit on C.A.P. There are three possible ways to interpret the decision, and each of them has different implications for the enforceability of inter-governmental agreements. First, a narrow reading would hold that the agreement did not specify the levels of payment, leaving this matter to federal legislation. Thus, the agreement was not breached, and the question of legal enforceability was not decided.²¹² A second, and slightly broader, reading of the decision would be that the agreement was binding but could be discharged by conflicting legislation. The Court made it clear that “the government could not bind Parliament from exercising its power to legislate amendments to the Plan. To assert the contrary would be to negate the sovereignty of Parliament.”²¹³

²⁰⁸ Unlike constitutionalized inter-governmental agreements, such as the *British Columbia Terms of Union*, R.S.C. 1985, Appendix II, which do have legal force.

²⁰⁹ D. Culat, “Coveting thy Neighbour’s Beer: Intergovernmental Agreements Dispute Settlement and Interprovincial Trade Barriers” (1992) 33 C. de D. 617 at 620.

²¹⁰ *Supra* note 202. For criticism, see S. Rutwind, “A Cap on CAP” (1991) 3 Const. Forum 38.

²¹¹ See *Government Expenditures Restraint Act*, *supra* note 50 at s. 2.

²¹² See K. Swinton, “Law, Politics, and the Enforcement of the Internal Trade Agreement” in M.J. Trebilcock & D. Schwanen, eds., *Getting There: An Assessment of the Agreement on Internal Trade* (Ottawa: Hignell, 1995) 196 at 199-200.

²¹³ *C.A.P. Reference*, *supra* note 201 at 548. See also *Re Lofstrom* (1971), 22 D.L.R. (3d) 120 (Sask. C.A.) [hereinafter *Re Lofstrom*]. The applicant sought a writ of *certiorari* to quash a decision of the Saskatchewan Welfare Board, on the grounds, *inter alia*, that it contravened the C.A.P. The Saskatchewan Court of Appeal stated that the C.A.P.

in no way restricts the legislative competence of a provincial legislature ... The fact that the provincial legislation and Regulations contravene the term of the agreement [entered into under the C.A.P.] would not render such legislation and Regulations invalid if it is otherwise within the legislative competence of the Province (*Re Lofstrom*, *ibid.* at 122).

Until Parliament or a provincial legislature did enact conflicting legislation, governments would be bound to comply with the terms of the agreement and could be held accountable by a court. The third, and broadest view, however, seems to be that the agreements only created political, not legal, obligations:

[I]t must be remembered that this is not an ordinary contract but an agreement between governments ... In lieu of relying on mutually binding reciprocal undertakings which promote the observance of ordinary contractual obligations, these parties were *content to rely on the perceived political price to be paid for non-performance*.²¹⁴

Even in the absence of formal, written agreements, similar arguments have been put before the courts regarding the enforceability of the C.H.A. In two decisions that pre-date the *C.A.P. Reference*, the courts applied the third view of the legal status of inter-governmental agreements with reference to the C.H.A. In *B.C. Civil Liberties*, it was argued that the provincial regulation limiting access to abortion was in breach of the accessibility requirement of the C.H.A. McEachern C.J.S.C. dismissed this point. In his view, that the provincial regulation may have disqualified British Columbia from federal transfer payments had no bearing on the question of law before the court: "It is for the Cabinet to assess the risk of losing federal funding and take such other political steps and political responsibility as it may be advised."²¹⁵

Scott C.J.M., dissenting in *Lexogest*, took a similar view. There, the applicants had argued that the provincial regulation conflicted with the C.H.A., and was, therefore, rendered inoperative by the doctrine of paramountcy. His Lordship rejected this argument: "[A]ny conflict between the two statutes (not going to the constitutional vires of the provincial regulation in question) is not justiciable in any event ... The consequences of non-compliance ... are set out in the federal Act itself, and are of a political nature."²¹⁶ The comments in *B.C. Civil Liberties* and *Lexogest* were *obiter dicta* but were, nevertheless, followed by the court in *Morgentaler v. P.E.I.* In that case, the impugned policy was challenged, *inter alia*, on the ground that it was inconsistent with the C.H.A. The court quickly dismissed this point, stating that it was for the government, and not the court, to weigh "the

Re Lofstrom was approved by the Supreme Court in *Finlay (no. 2)*:

A declaration that the federal cost-sharing payments are illegal would necessarily involve a finding that the province had failed to comply with the conditions and undertakings imposed by the Plan, but this would not affect the validity of the provincial legislative provisions about which complaint is made ... (*Finlay (no. 2)*, *supra* note 85 at 623).

²¹⁴ *C.A.P. Reference*, *supra* note 202 at 553-54, Sopinka J. [emphasis added].

²¹⁵ *B.C. Civil Liberties*, *supra* note 179 at 193.

²¹⁶ *Lexogest*, *supra* note 132 at 23 [emphasis added].

risk of losing federal funding and to exercise political considerations as it may be advised".²¹⁷

Morgentaler v. P.E.I. probably represents an accurate view of the existing law. Inter-governmental agreements, in general, and the C.H.A., in particular, do not impose enforceable legal obligations on provinces. Indeed, proposed constitutional amendments which formed part of the *Charlottetown Accord* would have conferred legal status on inter-governmental agreements,²¹⁸ an unnecessary measure had these agreements already been legally enforceable.²¹⁹

However, the legal position of inter-governmental agreements remains somewhat unclear. To some extent, the broad reading of the *C.A.P. Reference* is drawn from a classical version of Canadian federalism, with federal and provincial governments operating in discrete and exclusive areas of jurisdiction. However, as the caselaw on inter-governmental delegation of authority indicates, the courts have shown some flexibility in facilitating the arrangements of co-operative federalism.²²⁰ The interpretation of the *C.A.P. Reference* that is most consistent with co-operative federalism would allow for agreements to be binding on governments in the absence of conflicting legislation. Given Sopinka J.'s statement in the *C.A.P. Reference*,²²¹ however, this is probably an unlikely prospect.

D. Third Parties

Even if these agreements were legally binding, it is unclear if a third party could enforce them in the courts. *Reference Re Anti-Inflation Act*²²² established that an inter-governmental agreement required implementing legislation in order to become part of the law of a province. An issue in the case²²³ concerned an agreement between Ontario and the federal government purporting to apply the terms of the federal *Anti-Inflation Act*²²⁴ to the provincial public sector. Although the Supreme Court held that the government had the authority to enter into the agreement, Laskin C.J. stated that this alone "would not make the agreement part of the law of

²¹⁷ *Morgentaler v. P.E.I.*, *supra* note 182 at 740. Although it was decided after the *C.A.P. Reference*, *Morgentaler v. P.E.I.* did not refer to that decision.

²¹⁸ See *Draft Legal Text* (9 October 1992) (Ottawa: Supply & Services Canada, 1992) at s. 17. This section proposed inserting a new section 126A into the B.N.A. Act (see *supra* note 35).

²¹⁹ See generally, L. Friedlander, "Constitutionalizing Intergovernmental Agreements" (1994) 4 N.J.C.L. 153.

²²⁰ Compare: *Coughlin v. Ontario (A.G.)*, [1968] S.C.R. 569, 68 D.L.R. (2d) 384 (allowing anticipatory incorporation by reference of provincial legislation by federal legislation); *Nova Scotia (A.G.) v. Canada (A.G.)*, [1951] S.C.R. 31, [1950] 4 D.L.R. 369 (*Nova Scotia Reference*) (holding it unconstitutional for a provincial legislature to delegate legislative authority to Parliament).

²²¹ See quote accompanying note 214, above.

²²² [1976] 2 S.C.R. 373, 68 D.L.R. (3d) 452 [hereinafter *Anti-Inflation Reference* cited to S.C.R.].

²²³ The major issue was whether the Statute could be brought within Parliament's power to legislate for the peace, order, and good government of Canada (see B.N.A. Act, *supra* note 35 at s. 91).

²²⁴ S.C. 1974-75-76, c. 75.

Ontario".²²⁵ In short, without implementing legislation, there is no cause of action for an individual. Strictly speaking, however, the case did not consider the standing of a third party to sue on an agreement which was otherwise legally enforceable, and so, the question remains undecided.

Relying on contractual principles, one could argue that third parties are not privy to inter-governmental agreements and should, therefore, not be able to sue on them. That view of third parties, however, should be reconsidered in light of *Finlay (no. 2)*. In addition to defining the law on public-interest standing, *Finlay (no. 2)* is also notable for allowing a private person (albeit acting in the public interest) to legally challenge certain aspects of inter-governmental relations. Prior to that decision, it was thought that inter-governmental relations were solely relations between governments. *Finlay (no. 2)* changed this equation and also highlighted the weak mechanisms of political accountability, which govern the conduct of federal-provincial relations. Donald Smiley, most famously, underscored this fact by coining the phrase "executive federalism".²²⁶ If *Finlay (no. 2)* helped to promote accountability and transparency in inter-governmental relations through judicial scrutiny, the same concern would support the argument for an extension of the decision to third-party actions on inter-governmental agreements. The privity objection makes little sense, because the policy concerns in contract law are very different. In contract, privity serves to protect the control over agreements by the parties who entered into them. In the political realm, however, where the parties themselves need to be held accountable, the rationale for privity disappears.

Nigel Bankes has suggested a strategy whereby federal criteria could be legally enforced by individuals against provincial governments without the need for extending the caselaw. Federal spending statutes, such as the C.H.A., could require that provinces adopt implementing legislation identical to the terms of the C.H.A., or that they clearly state that the legislation is intended to adopt the federal criteria and should be interpreted in a manner consistent with those criteria. This would allow for the possibility of judicial review of provincial governments along the lines described above in relation to the federal government. Individuals would have to obtain standing and then establish that the provincial plan did not comply with one of the C.H.A.'s criteria. The advantage of this approach is that successful claimants would have access to a host of public-law remedies against a provincial government which would enhance the effectiveness of a court challenge. To encourage provinces to adopt such legislation, federal payments could be conditional

²²⁵ *Anti-Inflation Reference*, *supra* note 222 at 433. Legislation by prerogative has been unknown to the Common law since *The Case of Proclamations* (1611), 12 Co. Rep. 74. Thus, international treaties must be implemented by federal or provincial legislation to become part of the law of Canada (see *Canada (A.G.) v. Ontario (A.G.)*, [1937] A.C. 326, 1 D.L.R. 673 (P.C.) (*Labour Conventions*)).

²²⁶ D.V. Smiley, *Canada in Question: Federalism in the Eighties*, 3d ed. (Toronto: McGraw-Hill Ryerson, 1980) at 91.

upon the adoption of provincial legislation. As Bankes states, “[t]his would dramatically improve the prospects for success in the provincial superior courts.”²²⁷

Unfortunately, the prospects for this sort of initiative are very poor at present. We are currently witnessing a retreat from federal involvement in welfare and health care. The *Budget Implementation Act* is only the latest episode in this story. Some indication of the direction of federal policy in this area can be gleaned from the fact that the Act will repeal the C.A.P., thereby ending the regime of inter-governmental agreements which governed transfer payments. As discussed above, they will be replaced by a system of block grants with almost no conditions attached for social assistance. Coupled with the attitude of the federal government would be the hostility of the provinces to the imposition of new conditions so long after the adoption of the C.H.A., especially at a time when federal funding for health care is declining.

E. Conclusions

Ultimately, the lack of a legal remedy against an offending provincial government may not really matter. Since the issue in the judicial review of federal payments under the C.H.A. would be the compliance of a provincial government with federal criteria, a declaratory judgment against the federal government would be politically damaging for the offending provincial government. The publicity coupled with the political popularity of Medicare would make it politically costly for a provincial government not to respond in some way.

Conclusion: The Politics of Medicare

This article began by stating that the C.H.A. had largely been viewed as a political document, and relatively little had been written on the legal enforceability of its criteria. The criteria of the C.H.A. are capable of giving rise to legal liability. The scope of liability, however, would most likely be limited to the federal government, since the C.H.A. is probably not directly enforceable against the provinces. Moreover, the courts' preference for declaratory relief would limit the effectiveness of an action for judicial review.

At the end of the day, it may be the political value of litigation which makes legal challenges based on the C.H.A. worthwhile. The political impact would operate on two levels. At the level of individual claims, a decision finding a provincial program in breach of the C.H.A. would exert significant pressure on both levels of government to respond. A legal determination of rights and responsibilities would play an important role in the political process.

²²⁷ N. Bankes, “Co-operative Federalism: Third Parties and Intergovernmental Agreements and Arrangements in Canada and Australia” (1991) 29 *Alta. L. Rev.* 792 at 806.

Litigation on the C.H.A., however, could do more than achieve justice in specific disputes; it has the potential to remind governments and citizens alike of the importance of Medicare. Widely publicized litigation against the government would serve to highlight the value that Canadians place on access to quality health care and would feed into the larger political discourse. If successful, claims under the C.H.A. might result in governments being more vigilant in meeting the Act's criteria. Even if unsuccessful, claims framed in terms of the language of the C.H.A. would have the potential to raise public awareness of the challenges facing Medicare and could, therefore, lead to political change.²²⁸

It is readily apparent that the enforcement of the C.H.A. is not merely a legal, but also a political, question. It would be a mistake, however, to conclude that this fact would dissuade the courts from adjudicating on the matter. As the *Patriation Reference*²²⁹ showed, the courts are sensitive to the defining characteristics of our country. Since the C.H.A. is part of Canada's definition of social citizenship, the courts will likely take cases like *Hughes* very seriously indeed.

²²⁸ The legislative response to the Supreme Court's decision in *Thibaudeau v. R.*, [1995] 2 S.C.R. 627, 124 D.L.R. (4th) 449, is a good illustration of the political impact of public-law litigation. In that decision, the Court rejected a constitutional challenge to provisions of the *Income Tax Act*, S.C. 1970-71-72, c. 63, which tax child support payments in the hands of the custodial parent, while allowing the parent who has paid such amounts to deduct them from income. It had been argued that these provisions violated section 15(1) of the *Charter* and could not be justified under section 1; the Court found no violation of section 15(1). Although the decision upheld the legislation, the federal government has recently announced that it will amend the *Income Tax Act* in order to tax child-support payments in the hands of parents who made those payments, not in the hands of custodial parents. No doubt, this legislative initiative was prompted in large part by the litigation launched by Ms. Thibaudeau.

²²⁹ *Reference Re Amendment of the Constitution of Canada*, [1981] 1 S.C.R. 753, 125 D.L.R. (3d) 1.