

The Legal Structure of the Canadian Health Care System

LEARNING OUTCOMES

- Describe the two basic sources of legal obligations: legislation and the common law.
- Understand the areas of the health care system that are assigned to the provinces and to the federal governments by the Constitution.
- Understand the approach that the courts take when analyzing claims made under the *Canadian Charter of Rights and Freedoms*.
- Understand the role of the *Canada Health Act* in the Canadian health care system.
- Critically evaluate whether the provinces are following the *Canada Health Act*.

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I. Introduction

Canada's health care system is a universal, **single-tier health care system**. All Canadians are eligible for Medicare, and all health services designated as medically necessary are provided through the public health care system. Canada is unique in this regard, as most other countries allow for medically necessary services to be both privately purchased (via out-of-pocket payments or private health insurance) and obtained through the public health system. Canada's health care system is tax-funded and provides **first-dollar coverage** for insured services. This means that Canadians do not have to pay **co-payments** or **deductibles** when they receive insured health care services, but rather the government pays the entire amount. Both of these cost-sharing mechanisms, especially co-payments, are common in other health systems and can deter patients from receiving medically necessary care. One of the key benefits of Canada's system is that it provides access to insured health services on the basis of need rather than ability to pay, thereby

single-tier health care system: a health care system in which all medically necessary services are provided through the public health care system

first-dollar coverage: a situation whereby patients do not pay anything out-of-pocket for health services before being entitled to receive such services

co-payment: a fee or charge that a patient must pay when receiving a health care service

deductible: an amount that a patient must spend out-of-pocket before health insurance coverage kicks in

facilitating equitable access. In countries with a **two-tier health care system**, it is often the wealthy, who are generally less sick, that can access private care, while those with lower incomes are relegated to the public system.

Although there are positive aspects to the way that Canada has structured its health care system, there are also concerns. For example, in international rankings of health systems, Canada generally performs poorly, especially in terms of wait times. It is sometimes argued that a parallel private system would ease the burden on the public system, as some patients would pay for their care privately, thereby removing themselves from public wait lists.

TABLE 1.1 Commonwealth Fund ranking of health care systems

	AUS	CAN	FRA	GER	NETH	NZ	NOR	SWE	SWIZ	UK	US
OVERALL RANKING	2	9	10	8	3	4	4	6	6	1	11
Care Process	2	6	9	8	4	3	10	11	7	1	5
Access	4	10	9	2	1	7	5	6	8	3	11
Administrative Efficiency	1	6	11	6	9	2	4	5	8	3	10
Equity	7	9	10	6	2	8	5	3	4	1	11
Health Care Outcomes	1	9	5	8	6	7	3	2	4	10	11

Source: The Commonwealth Fund, “Health Care System Performance Rankings,” online: <<http://www.commonwealthfund.org/interactives-and-data/chart-cart/report/2017-mirror-mirror/health-care-system-performance-rankings>>.

Another criticism of Canada’s system is that while it provides equitable access to services that are publicly insured, many health services fall outside of public insurance plans. Medicare focuses on hospital and physician services, with the provinces covering other important health care services such as pharmaceuticals, dental care, home care, and long-term care through a patchwork of programs with varying criteria for eligibility. Under these public programs, patients are often required to bear part of the cost, which may deter them from seeking necessary care. Canada’s focus on hospital and physician services is unique—the health systems of other countries tend to cover a broader range of health services. The services insured in many other countries may do more to advance health at a lower cost than some of the hospital and physician services that Canadian provinces currently insure.

Although Canada is typically thought of as having a single health care system, there are actually ten provincial and three territorial health care systems, with each jurisdiction having its own laws to regulate public health insurance. This is because Canada’s **Constitution** divides responsibility for health care between the federal government and the provinces/territories,¹ with the latter having the authority to pass laws relating to health care facilities, health professionals, the rights of patients, and many other important matters. The federal government also has various health-related powers, including providing health services to Indigenous people living on reserve, regulating pharmaceuticals, and establishing criminal law prohibitions relating to public health. After briefly introducing the Canadian legal system in Part II, Part III of this chapter discusses how the Constitution divides up the responsibilities for regulating the health sector between the various levels of government. The other part of the Constitution, the *Canadian*

two-tier health care system: a health care system in which medically necessary services can be obtained either through the public health care system or privately

constitution: a document setting out the basic principles of a country that defines the powers and duties of the government and the rights of its citizens

Charter of Rights and Freedoms,² also plays a crucial role in shaping Canada's health care system. The rights contained in this document have been raised in various health sector cases, including those relating to abortion, medical assistance in dying, and what health services the government will fund. The approach Canadian courts take to analyzing Charter claims is also discussed in Part III of this chapter.

Along with the Constitution, the other key legal document responsible for shaping Canada's health care system is the *Canada Health Act*.³ Under this law, the federal government will help to fund medically necessary hospital and physician services, provided that a province's health care system meets certain criteria: public administration, comprehensiveness, universality, portability, and accessibility. Although these conditions merely represent a funding arrangement between the two levels of government, they have come to represent the expectations that Canadians have of the health care system, as evidenced by legal claims against the provinces for alleged breaches of the Act. Part IV of this chapter discusses the funding criteria set out in the CHA. It also offers a critique of the Act, including the vaguely defined principles, its under-inclusiveness, and the federal government's failure to hold the provinces accountable when they breach the legislation or, more generally, to take a greater leadership role in the delivery of health services.

II. Understanding the Canadian Legal System

There are two main sources of legal obligations: legislation and case law. The former are legal rules generally drafted by either the provincial or federal governments, while the latter are the decisions of judges. These two sources of legal obligations are interrelated, as judges may have to apply and interpret legislation in a given case. For example, if you are in a coma, then a substitute decision-maker will consent to treatment on your behalf and must act in your best interest. If a doctor thinks that your substitute decision-maker is not following the legislation and acting in your best interest, then a court may have to interpret what that phrase means in your particular situation. Similarly, case law may affect the development of legislation. For example, Ontario's health care consent law contains principles formed by the courts before they became part of legislation.

Bills, or proposed laws, are introduced into either the provincial legislature or the federal Parliament, which are made up of elected officials. These proposed laws are debated, amended, and voted on. Federal bills undergo the same process of debate, amendment, and voting in the Senate. If a bill receives the support of a majority of the members voting on it, it is given royal assent, at which time it becomes a law.

One particularly important law is the Constitution. It sets out the basic structure of Canada's government, divides responsibilities for particular subjects between the provinces and the federal government, and lists the fundamental rights to which Canadians are entitled. The Constitution is often called the "supreme law of the land" because all other laws must follow it or risk being struck down by the courts. For example, in a recent case, the Supreme Court of Canada struck down criminal law prohibitions on assisted suicide because they violated the rights to life and security of the person. In response, the federal government drafted new laws that legalized and regulated medical assistance in dying.

You will often hear terms that relate to legislation, including laws, statutes, regulations, and by-laws. While legislation and laws are more general terms, statutes, regulations, and by-laws refer to specific types of laws. Statutes originate as bills and set out basic rules. Most statutes have at least one set of related regulations that elaborate on the content of the statute. Unlike statutes, regulations do not have to go through Parliament and are not voted on and, as such, can be more easily changed. For example, all provinces have public health statutes that require doctors to report certain infectious diseases to public health authorities. The list of diseases that must be reported is generally contained in the regulations rather than the statute itself. This way, if a new health threat emerges, the regulation can be quickly and easily changed (generally by the provincial minister of health) to designate that disease as reportable.

The term “by-law” may refer to the legal rules of cities, towns, or other municipalities. Municipal by-laws relevant to health include rules about where tobacco can be consumed in public and new rules setting out the distance between cannabis retail stores and schools. The term by-law may also refer to the internal rules of corporations and other organizations. For example, hospitals and the provincial colleges of physicians and surgeons have their own by-laws.

Apart from legislation, the other main source of legal obligations is case law, which is sometimes called jurisprudence or the common law. In a common law system such as Canada, judges develop the law by referring to previous court decisions known as **precedents**. For example, the law of negligence and informed consent originated in the decisions of courts rather than in legislation. Although judges are bound by previous decisions from their own court and higher courts, they may decide that a particular precedent does not apply to the facts before them, which allows the common law to evolve to meet new and novel situations. In contrast to the rest of Canada, Quebec has a civil law system, which is based on a code that contains a comprehensive set of rules that judges follow in deciding court cases. This book focuses primarily on the common law, although many of the same principles apply to cases decided under civil law.

III. Constitutional Responsibility for Health

Canada’s Constitution has two main parts—the Charter and the **division of powers**. The former guarantees a variety of individual rights and prevents governments from infringing on those rights without adequate justification. Sections 91 and 92 of the Constitution assign particular areas of responsibility to either the federal or provincial governments. Because the Constitution is the supreme law of the land, a litigant can challenge a provincial or federal law on the basis that it violates a Charter right and/or it contravenes the division of powers.

A. *The Canadian Charter of Rights and Freedoms*

Historically, the provision of health care was very paternalistic and reflected the saying “doctor knows best.” However, there has been a dramatic shift toward the legal recognition of patient autonomy, which has been supported by a variety of Charter cases. For example, provincial laws allow patients to access their health records and limit how that information can be used or disclosed by health information custodians (such as health professionals and health facilities). Provincial mental health laws permit patients to be hospitalized involuntarily when, for example, a mental illness makes them a danger to themselves or others. However, this legislation also gives patients various procedural rights in this process that were historically unknown to patients with mental illnesses. Provinces also have laws addressing a patient’s right to consent to treatment and, if that patient is incapacitated, who will act as the substitute decision-maker and how that person must make treatment decisions.

The Charter sets out a variety of rights, some of which are political (e.g., the right to vote), some of which relate to criminal law (e.g., the right to be presumed innocent), and some of which address social values (e.g., the right to be free from discrimination). Charter claims are addressed throughout the remainder of this book, including cases relating to mental health, reproductive health, and challenges to the government’s health spending decisions. In all of these cases, the courts apply the same analytical framework.

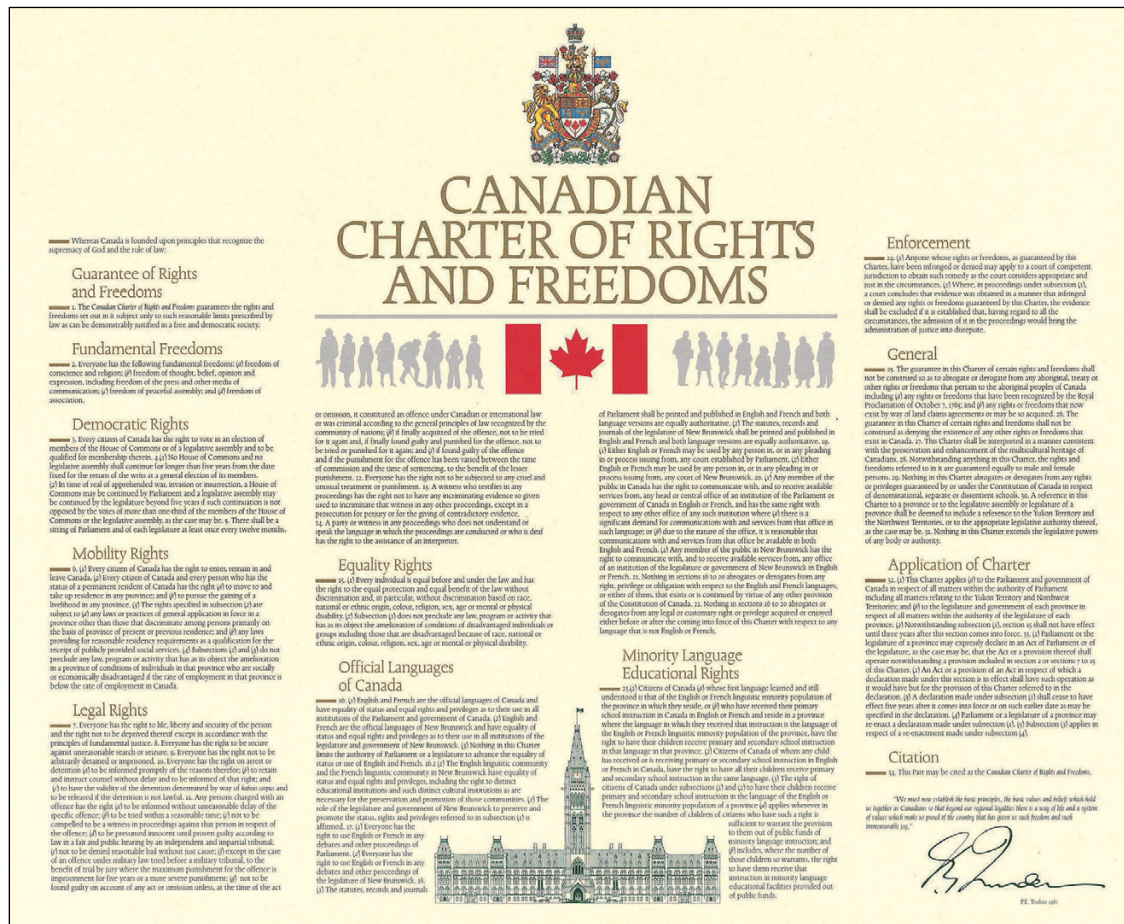
First, it is important to remember that the Charter binds only governmental actors. In other words, if an individual is fired from a private company after he develops a disability, he cannot claim that his employer violated his Charter right to be free from discrimination (although he could bring a claim against his employer based on human rights law). However, individuals can challenge governmental laws and policies to argue that they violate the Charter.

precedent: a rule established in a previous case that is either binding on or persuasive for a court deciding a similar case

division of powers: a list of provincial and federal areas of responsibility

In order to analyze a Charter claim, the courts employ a two-stage analysis. First, the claimant must prove that her rights were breached. If she succeeds, then the government has an opportunity to justify that rights violation. If the government succeeds, then its law or policy can remain in place. However, if the government cannot justify its law or policy, then the courts have the power to grant a variety of remedies. Most common among the cases discussed in this book is that a court can declare the offending parts of the law invalid. In some cases, the court will temporarily delay the implementation of its ruling to give the government time to make new laws or policies that comply with the Charter. This is called a **suspended declaration of invalidity**.

The burden is on the plaintiff at the first stage of the analysis to prove that his rights have been violated. Many Charter rights have been raised in the context of health law, including freedom of expression (laws limiting tobacco advertising), freedom of religion (a law preventing a minor who was a Jehovah's Witness from refusing a blood transfusion), freedom from discrimination (government's decision not to fund sign language interpretation for patients who are hearing-impaired), and the right to life, liberty, and security of the person (laws limiting access to abortion), among other Charter rights. Whether a claimant's Charter rights have been violated is context-specific, and there are legal principles to aid the courts in interpreting different rights.



The Canadian Charter of Rights and Freedoms helps guide the courts in cases relating to health care rights and limitations.

suspended declaration of invalidity: when a court strikes down a law on the basis that it is unconstitutional but puts that declaration on hold in order to give the government time to pass new legislation

If the claimant successfully proves that his rights have been violated, then the government has the opportunity to justify that rights infringement. This is because Charter rights are not unlimited or absolute but must be balanced against other social values. According to section 1 of the Charter, rights are subject to “reasonable limits” that are “demonstrably justified in a free and democratic society.” In determining whether the government has justified a rights violation, the courts use a framework called the **Oakes test** (because it was developed by the Supreme Court of Canada in a criminal law case called *R v Oakes*⁴).

The *Oakes* test involves four stages, which are laid out in the text of the decision. First, the court will ask whether the government’s law had a “pressing and substantial objective.” In other words, the government must have a good reason for infringing on a Charter-protected right such as public safety, national security, or protecting a vulnerable group. Second, the government must show that its law is “rationally connected to the achievement of its objective.” This involves showing a link between what the law does and the objective it is supposed to achieve (e.g., it is reasonable to draw a connection between government laws limiting tobacco advertising and a reduction in smoking rates). In almost all cases, the government succeeds in satisfying the first two stages of the *Oakes* test.

Third, the government must show that its law or policy minimally impairs the plaintiff’s rights. This is the most important stage of the *Oakes* test, and almost all Charter cases turn on whether the government could have achieved its objective in a way that affected the plaintiff’s rights to a lesser degree. The final stage of the *Oakes* analysis is a balancing test, whereby the courts ask whether the benefits of the law (called salutary effects) outweigh the extent of the infringement on the plaintiff’s rights (called deleterious effects). The courts almost universally reach the same result at this final stage of the test as they did when examining minimal impairment in the third stage.

B. Division of Powers Relating to Health

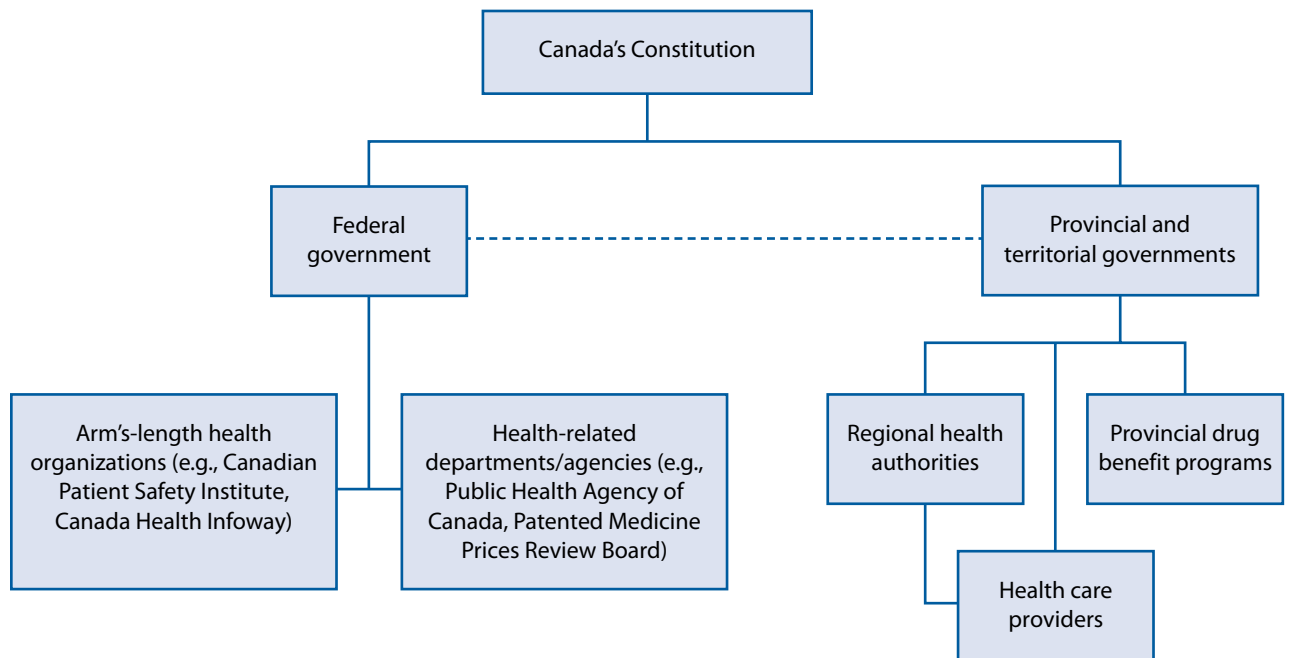
If a province or the federal government passes a law that is outside of its enumerated areas of responsibility, that law is said to be **ultra vires**, a Latin term meaning “beyond the powers.” A court can strike down a law on the basis that it is *ultra vires* the level of government that passed it. In deciding whether a law is *ultra vires*, a judge will determine the subject matter of the law, which is called its **pith and substance**, and then which enumerated federal or provincial power that subject falls within.

There is no power to regulate “health” listed in the Constitution, but several federal and provincial powers are relevant. This is, in part, because the division of powers was drafted in 1867, when the health care system was in its infancy and many medical treatments did more harm than good. At that time, ill people were often cared for at home, medical technologies and pharmaceuticals were largely unknown, and the few hospitals that did exist were not regulated by governments but were run by religious or charitable organizations. According to the Supreme Court of Canada, “health is not a matter which is subject to specific constitutional assignment but instead is an amorphous topic which can be addressed by valid federal or provincial legislation, depending on the circumstances of each case on the nature or scope of the health problem in question.”⁵

Oakes test: the analytical approach used by Canadian courts to determine if a rights infringement can be justified

ultra vires: Latin for “beyond the powers,” in reference to a law that falls outside the powers granted to a particular level of government

pith and substance: the subject matter of a law

FIGURE 1.1 Basic structure of Canada's health care system

1. Provincial Powers Related to Health

The powers granted to the provinces are set out in section 92 of the Constitution. One of the most important constitutional powers relating to the health care system is the exclusive jurisdiction granted to the provinces to regulate “the establishment, maintenance and management ... of hospitals.” The power to regulate hospitals extends to other health facilities such as diagnostic clinics, private hospitals, and long-term care homes. Provincial laws regulating health facilities address such diverse issues as funding, licensing, maintenance and inspection, governance structures, management procedures, treatment standards and practices, the rights of patients and health care workers, health facility staffing requirements, and the creation, retention, and confidentiality of health records.⁶

In addition to the power to regulate hospitals, the provinces also have authority over property and civil rights and local or private matters, both of which have been interpreted broadly. Jackman argues that “[t]aken together, these provisions give the provinces primary constitutional responsibility for health care and health care services in Canada.”⁷ These powers have enabled the provinces to enact a wide variety of laws relating to health, including mental health laws, consent and capacity laws, public health laws, and laws regulating health professionals.

Another important area of provincial jurisdiction is the regulation of health insurance. According to the Supreme Court of Canada, “[i]nsurance of all sorts, including insurance against unemployment and health insurance, have always been recognized as being exclusively provincial matters under the head ‘Property and Civil Rights’ or under the head ‘Matters of a merely local or private nature in the Province.’”⁸ Provincial governments have enacted health insurance laws setting out the basic entitlements of Canadians to publicly funded health care services. For example, these laws detail the criteria for determining who qualifies as an insured person and what services are insured in that province. While the federal government helps to fund public health insurance through the *Canada Health Act* (CHA) as discussed below, it is the provinces that establish and administer these health insurance plans and regulate the delivery of insured health services.

2. Municipal Powers Related to Health

Although municipal government powers are not listed in the Constitution, the provinces delegate various important health-related responsibilities to municipalities. Depending on the province, municipalities or other local authorities may have extensive powers to regulate public health. For example, Ontario is divided into 36 local boards of health with broad responsibilities for health promotion and disease prevention. Toronto Public Health's website lists over 100 programs and initiatives spanning many topics, including Food Handler Certification, AIDS & Sexual Health InfoLine and eChat, helmet safety, Body Safe (infection prevention for piercing and tattooing), bed bugs, pedestrian safety, rabies prevention, Gastrobusters (to report food poisoning), child-care centre hygiene, and sun safety, among many others.⁹

One area of municipal responsibility that is the subject of ongoing debate and policy-making is the regulation of cannabis. While in some provinces cannabis is sold through government-run stores, other provinces permit cannabis sales through private government-licensed retailers. In those provinces, cannabis retailers receive a licence to operate from the province but must also have municipal permission. Various municipal by-laws relating to zoning govern where cannabis stores can be set up. For example, Calgary's City Council requires cannabis retail stores to be located a prescribed distance from one another and from shelters and schools.¹⁰ Provincial laws regulate what hours cannabis stores can be open and where cannabis can be consumed,¹¹ but municipalities can pass rules that are stricter than provincial laws. For example, while Alberta law allows cannabis to be consumed in public, subject to the same limits as tobacco (e.g., restrictions on smoking in specific places such as on school property), Calgary has tightened these rules, banning public consumption entirely, similar to how alcohol is regulated.¹²

3. Federal Powers Related to Health

The powers granted to the federal government are set out in section 91 of the Constitution. One of the most important federal powers related to health is its constitutional authority to regulate criminal law, which has been interpreted broadly. Canada's *Criminal Code*¹³ contains several offences relevant to health law, including those restricting abortion (which the Supreme Court of Canada has since declared to be of no force and effect) and recently modified restrictions on medical assistance in dying. Courts have also found that the criminal law power extends to regulating food safety, drugs, and medical devices, because they are related to protecting the "physical health and safety of the public."¹⁴ This phrase, which is quite broad, is often used by the courts to describe legislation that relates to the valid use of the federal government's criminal law power.

CASE STUDY

***RJR-MacDonald Inc v Canada (AG)*, [1995] 3 SCR 199**

This was a constitutional case relating to the federal *Tobacco Act*, which restricted the advertising and promotion of tobacco products and required health warnings on tobacco packages. These laws were challenged by tobacco companies on the basis that they did not fall within the federal government's criminal law power. A majority of the Supreme Court described the federal government's broad criminal law power over health-related matters: "The scope of the federal power to create criminal legislation with respect to health matters is broad, and is circumscribed only by the requirements that the legislation must contain a prohibition accompanied by a penal sanction and must be directed at a legitimate public health evil" (at

para 32). The purpose of the *Tobacco Act*, which was to reduce tobacco consumption and protect public health, was certainly directed at a public health evil and there were penal sanctions attached to certain breaches of the law. Because the law fell within the federal government's criminal law power, it was not *ultra vires*.

However, it should be noted that although the court did not strike down the law on the basis of the division of powers, they did find that the restrictions on advertising and packaging constituted an unjustified intrusion on freedom of speech (which extends to commercial speech such as advertising) and, as a result, the federal government had to redraft its law.

The federal government may also regulate public health matters under a catch-all provision in section 91 of the Constitution allowing it “to make laws for the peace, order and good government of Canada” relating to matters not assigned “exclusively to the legislatures of the provinces.” This is referred to as the **POGG clause**, and there is a great deal of case law interpreting its meaning. However, in short, the courts have interpreted the power as being validly exercised in times of emergency or in relation to matters of “national concern.”¹⁵ This power might be used, for example, in the case of a major disease outbreak transcending provincial boundaries that required the federal government to close borders or conduct disease surveillance on a national basis.¹⁶ However, public health is also an area of shared jurisdiction, with provincial public health laws addressing such matters as what diseases must be reported by health professionals to public health authorities, mandatory vaccination of schoolchildren, and the power to make orders to control the spread of disease.

Although the federal government can generally justify public health interventions as falling within the criminal law power, health-related laws that do not address a public health purpose may be at greater risk of being declared unconstitutional. Disputes have occasionally arisen between the federal and provincial governments respecting their jurisdiction over health-related matters.

CASE STUDY

Reference Re Assisted Human Reproduction Act, 2010 SCC 61

In 2004, after a series of reports and consultations, the federal government passed legislation that comprehensively regulated assisted human reproduction, including sperm and egg donation, surrogacy, and various other reproductive technologies. Specifically, the legislation did the following:

- Prohibited various activities (e.g., human cloning, the commercialization of human reproductive material, and the use of in vitro embryos without consent).
- Regulated various activities (e.g., performing assisted reproductive services in a facility without a license, and receiving reimbursement for egg or sperm donation unless permitted in the regulations).
- Created a system to manage information related to assisted human reproduction (e.g., a registry of data about individuals conceived through assisted reproductive technologies).
- Established the Assisted Human Reproduction Agency of Canada to study and regulate these matters.

The Supreme Court of Canada issued a complex decision in which the court was deeply divided. Three justices found that the legislation fell wholly within the federal government’s

criminal law power. While they acknowledged that it would have some impact on provincial matters, these justices characterized the law as a series of prohibitions with subsidiary provisions related to their administration. Three other justices disagreed and found that the legislation fell with provincial jurisdiction over hospitals, property and civil rights, and matters of a local nature, characterizing the law as regulating a particular health service. The seventh member of the court to hear the case, who wrote his own opinion, felt that parts of the act fell within federal powers while others fell within provincial powers.

The result of the litigation was that the parts of the legislation relating to the administration of assisted reproductive services, such as requiring facilities to have licences and maintaining a registry of information about individuals conceived through assisted human reproduction, were invalid. This left the prohibitions and controlled activities intact. This has left Canada with an incomplete regulatory scheme for assisted reproductive services and very limited enforcement of the remaining laws, as the provinces have not stepped in to regulate in this area.

POGG (peace, order, and good government) clause: the federal government’s power to regulate in relation to emergencies or areas of national concern

Other federal constitutional powers relate to specific areas of the health care system. For example, the federal power to regulate patents affects whether Canadians can access safe and reasonably-priced pharmaceuticals. Patents are the exclusive right to sell an invention, such as a pharmaceutical or a medical device, for a specific period (generally 20 years). Although patents reward technological innovation and encourage companies to research and develop new drugs and devices, they can also drive up costs because no other company can manufacture and sell these products during the 20-year period of patent protection.

The federal government also has the power to regulate “militia, military and naval service, and defence” and, as such, is responsible for providing health services to individuals enlisted in the military. Another power listed in the Constitution is “Indians, and Lands reserved for the Indians,” which gives the federal government responsibility for providing health services to individuals living on reserves. As discussed in Chapter 14, this is the subject of much controversy, given the poor health status of Indigenous people and the squabbling between the federal and provincial governments as to who has an obligation to provide and pay for certain health services delivered to Indigenous people. Finally, the federal government has authority over “naturalization and aliens,” which includes the health services to which immigrants and refugees in Canada are entitled.

Given the spread of people and goods across national borders, there are also important global dimensions to the field of health law. The federal government has signed several international agreements, which are generally not binding but can affect domestic law, such as the *Framework Convention on Tobacco Control* and the *Convention on the Rights of Persons with Disabilities*. Another area of international law that influences human health is trade law. For example, when countries attempt to pass laws that restrict tobacco use, tobacco companies have argued that these laws restrict trade.

In addition to laws that directly address health-related issues, it is important to note that many other municipal, provincial, and federal laws that fall outside of the purview of health law also affect human health. For example, environmental laws may protect the spread of certain diseases, agricultural laws can contribute to antimicrobial resistance, and municipal zoning laws can affect the distribution of greenspace, thereby contributing to obesity. Given the significant impact of socio-economic factors on health, housing laws, education laws, or those laws governing access to social programs can have a profound effect on mortality and morbidity.

IV. The Canada Health Act

A. The Spending Power

The most important federal legislation relating to the health care system is the CHA. This law sets out the underlying principles upon which the system is based, reflecting the philosophy that health care should be accessed on the basis of need rather than one’s ability to pay. The provision of insurance for physician and hospital services falls within provincial jurisdiction over insurance, hospitals, civil rights, and matters of a local nature. Indeed, Canada’s national Medicare program began as a provincial program in Saskatchewan. However, the federal government can use what is referred to as the “spending power” to indirectly regulate areas it cannot directly regulate due to the constitutional division of powers. Section 91 of the Constitution gives the federal government the power to pass laws relating to “public debt and property” and “taxation,” and the courts have said this includes the authority to grant money to the provinces in areas of provincial responsibility and to attach conditions to those funds.¹⁷ The CHA is a set of conditions that the provinces must fulfill to receive federal funding.

According to the Supreme Court of Canada, the federal government has played “a leading role in the provision of free, universal medical care” by “employing its inherent spending power to set national standards for provincial medicare programs.”¹⁸ Canadian courts have upheld the constitutionality of conditional federal funding programs in several cases.¹⁹

B. Funding Conditions

Universal public health insurance began in Saskatchewan in the 1940s, and the federal government was instrumental in expanding this program to the rest of Canada. It did so through two pieces of legislation that were later amalgamated into the CHA. According to this law, if the provinces provide health insurance for hospital and physician services that meets certain criteria, they are entitled to annual funding from the federal government. These conditions include public administration, comprehensiveness, universality, portability, and accessibility.

To satisfy the public administration criterion, a province's health care insurance plan must be administered and operated on a non-profit basis by a public authority. However, the legislation does not require health care services themselves to be publicly delivered. For example, hospitals in Ontario are corporations not directly run by government (although they are subject to significant government oversight and regulation and are funded almost entirely with public dollars). Similarly, doctors are not employees of the government (even those who receive all of their income from the public health insurance plan).

The second criterion in the CHA is comprehensiveness. This is a confusing requirement that is poorly defined in the legislation. According to the Act, "the health care insurance plan of a province must insure all insured health services provided by hospitals, medical practitioners or dentists."²⁰ The legislation unhelpfully defines "insured health services" to mean "hospital services, physician services and surgical-dental services provided to insured persons."²¹ In other words, insured services are whatever a province determines should be designated as insured services, and a province meets the comprehensiveness criteria merely by providing to its citizens those services it has decided should be insured.

As will be discussed below, it is questionable whether a health care system focused primarily on hospital and physician services can be designated as "comprehensive" in light of the increasing role played by health professionals other than doctors, the importance of pharmaceuticals, the deinstitutionalization of patients from hospitals, and the growing demand for health services required by Canada's aging population, such as long-term care and home care. However, the federal government has elected to take a hands-off approach to the definition of comprehensiveness, preferring to allow the provinces to determine what services ought to be insured for their citizens.

The third criterion, universality, is satisfied if the health care insurance plan of a province entitles "one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions."²² The first part of this definition is circular—a health plan is universal if it covers everyone that the province decides to cover by designating them as insured persons. However, the second part of the definition is more helpful, as it clarifies that everyone within a province is entitled to the same health care coverage. Equitable access to health care services is central to Canadian Medicare.

The fourth condition is that a province's health care insurance plan must be portable. Portability relates to a citizen's ability to move within Canada without losing health care coverage and to receive health care services while travelling within Canada or abroad. With regard to the former, a province's health insurance plan must not impose any minimum period of residence or waiting period longer than three months before residents are eligible for health insurance. Second, provinces must provide for the payment of health services during any minimum period of residence or waiting period imposed by the health insurance plan of another province for a resident who has moved. When read together, the effect of these two requirements is that when



Doctors in Saskatchewan protesting the introduction of universal public health insurance.

someone moves to another province, the new province cannot make the individual wait longer than three months before he qualifies for health insurance and, during that time, the original province will cover the cost of any health services performed in the new province.

The second part of the portability criterion relates to travel. If someone requires health services in a province other than the one in which she is a resident, the home province must pay for health services “at the rate that is approved by the health care insurance plan of the province in which the services are provided,”²³ unless the provinces agree to apportion costs differently. In other words, if a Saskatchewan resident is injured while skiing in Alberta, the Saskatchewan health insurance plan will pay the Alberta hospital’s own rate for treating the Saskatchewan resident.

If an individual is travelling outside of Canada, the portability principle requires her home province to pay for health services in “the amount that would have been paid by the province for similar services rendered in the province.”²⁴ For example, if that same Saskatchewan resident was injured while skiing in Colorado, the province would pay Saskatchewan hospital rates, even though the rates in Colorado are almost certain to be significantly higher. The shortfall would be either be paid through travel health insurance, if the individual had purchased such coverage, or out-of-pocket.²⁵

It should be noted that the CHA permits a province to limit the ability of residents to access non-emergency services outside of Canada without running afoul of the portability requirement. The provinces have set up extensive out-of-country regimes for residents to receive approval for non-emergency and non-experimental services outside of Canada, often because of wait times. For example, as discussed in greater detail in Chapter 13, Ontario allows its residents to receive treatment outside of Canada when waiting for care within Ontario would result in “death or medically significant irreversible tissue damage.”²⁶

The final CHA criterion is accessibility, which has several components. A province’s health care insurance plan must provide for insured health services “on uniform terms and conditions and on a basis that does not impede or preclude . . . reasonable access to those services by insured persons.”²⁷ Although all individuals within a province have the same eligibility for health care services, there may be significant variation in access to care within a province or a city. For example, access to health care services in remote locations can vary tremendously from the care provided in major cities. Even within a municipal area there may be significant variation between the care provided in a small hospital on the outskirts of the city versus that provided at a large teaching hospital affiliated with a university in the city’s centre. There is no guidance in the CHA itself or in other policy documents promulgated by the federal government as to when this variation becomes unacceptable or how best to address it, given Canada’s many sparsely populated regions.

The other components of accessibility relate to reimbursement for health services. First, the health care insurance plan “must provide for payment for insured health services in accordance with a tariff or system of payment authorized by the law of the province.” Second, the health care insurance plan “must provide for reasonable compensation for all insured health services rendered by medical practitioners or dentists.” Third, the health care insurance plan “must provide for the payment of amounts to hospitals, including hospitals owned or operated by Canada, in respect of the cost of insured health services.”²⁸ In sum, provinces must set out a payment system that includes reasonable compensation for health services provided by health professionals and reimbursement of the cost of hospital services.

“Reasonable compensation” is satisfied if a province has a process to determine how doctors’ fees will be set. The process that provinces employ to determine what services are insured and the fees that physicians will be paid for them has attracted criticism.²⁹ Canadian doctors have traditionally been paid on a **fee-for-service** basis, which arguably incentivizes the provision of

fee-for-service payment: a method of reimbursing doctors whereby they receive a set fee for each health service that is provided



Individuals protesting a case that would permit greater privatization in Canada's health system.

unnecessary services and such practices as doctors discussing only one health concern with their patients per visit. Given that these fees are paid by taxpayers, one might reasonably assume that the process by which they are set is transparent and involves public consultation, and that the services attracting public funding are those that are most cost-effective. However, in Canada, the list of insured services and the fee schedule detailing the rates at which those services are reimbursed is a matter of closed-door negotiation between provincial governments and provincial medical associations (the interest groups responsible for advocating on behalf of doctors). This approach stands in contrast to several other countries in which the government employs a transparent and evidence-based process for determining what health services to publicly fund.

In sum, although the five criteria of the CHA are important principles that have helped shape Canadian Medicare, the manner in which they are fulfilled is left largely to provincial discretion. The federal government has done little to define these criteria, either in the Act itself or through other guidelines, and has shown little leadership in evaluating provincial health insurance plans or holding the provinces accountable for the outcomes achieved by their health insurance plans.

C. Prohibition on Extra-Billing and User Charges

In addition to the five funding criteria, the CHA also sets out specific prohibitions on **extra-billing and user charges**, which are defined in section 2. According to this legislation, provinces will not receive their full annual funding if they permit either activity. Extra-billing is defined as “billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province.” Extra-billing would occur, for example, if a patient

extra-billing and user charges: when patients pay for insured health services, either through fees beyond those billed to the public insurance plan or other charges permitted by provincial health insurance plans

went to see his family doctor and that doctor billed the provincial health insurance plan for the visit, but also charged the patient an additional fee. Extra-billing used to be very common when Medicare was first implemented.³⁰ A user charge is defined as “any charge for an insured health service that is authorized or permitted by a provincial health care insurance plan” that is not payable by that plan, other than extra-billing. An example of a user charge could be legislation permitting a hospital to charge each patient a “facility fee” for using the hospital.

The efficacy of extra-billing and user charges have been debated.³¹ On the one hand, many countries require their citizens to pay for part of the cost of their health services out-of-pocket (apart from their contribution through paying taxes), either in the form of co-payments or deductibles. There is a belief that people will use the health care system more responsibly if they are made to bear some of the cost. On the other hand, these costs may deter patients from seeking necessary care. This may ultimately lead to higher health care costs when patients who avoided seeking care end up in the emergency room. This type of policy also has significant equity implications, as co-payments are likely to disproportionately affect those with lower incomes, who also tend to be sicker.

D. Legal Rights Under the CHA

Given that Medicare is often perceived as Canada’s most treasured social program and one that is integral to Canadian identity, there is sometimes a perception that Canadians have a legal entitlement to health care services. However, neither the CHA nor the Constitution provides such a right. The courts have frequently stated that the CHA’s legal status is merely that of a funding arrangement between the provinces and the federal government. Therefore, any breaches of the Act do not give legal rights to individual citizens but are a matter of intergovernmental negotiation.

CASE STUDY

Collett v Ontario (Attorney General) (1995), 124 DLR (4th) 426 (Ont Gen Div)

The plaintiffs in this case spent part of each year outside of Canada. The government had recently reduced the daily limits for emergency in-patient hospital services provided to Ontario residents while temporarily outside of Canada. Because of this change, if the plaintiffs required emergency care while abroad, they would have to pay significantly more for those services out-of-pocket. They argued that this change violated the CHA’s portability criterion. The court declined to opine on whether this regulatory change violated the CHA, stating that it was not a matter for individuals to enforce. Instead, if there was a breach of the CHA, the federal government could consult with the offending province and, if appropriate, address the problem in its annual transfer of funds to that province.

E. Criticisms of the CHA

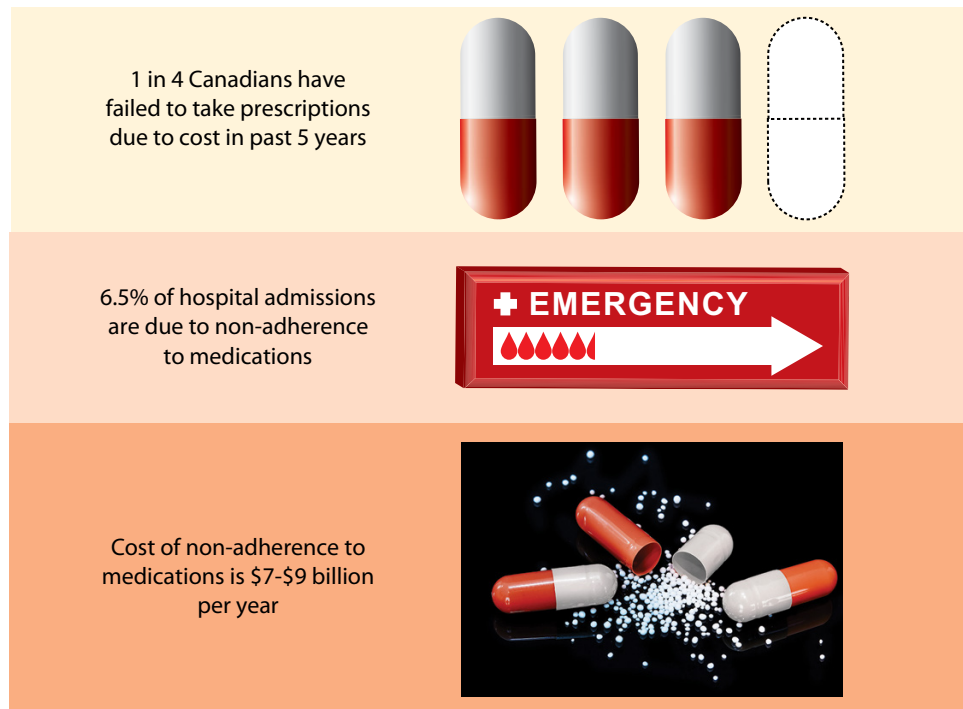
1. Under-Inclusiveness

One of the primary criticisms of the CHA relates to its focus on hospital and physician services. When Medicare was first conceived, pharmaceuticals and medical devices were much less prevalent, and medicine had a long way to come in terms of prolonging the lives of individuals with chronic illnesses, who now require access to services such as long-term care. Changes outside of the health care system have also affected demand for health services. For example, while women were historically available to care for ill family members, their entry into the workforce in large numbers has created a greater demand for services such as home care. Although Canada is perceived to have a “public” health care system, the reality is that 30 percent of health spending is private (including out-of-pocket payments and private insurance),³² due to the many services currently outside of Medicare.

Partly due to the CHAs focus on hospital and physician services, provincial health insurance plans also revolve around these services. Provincial governments have a patchwork of public programs to fund and deliver services outside of the CHA, such as pharmaceuticals, dental care, long-term care, and home care. These programs vary significantly from province to province and there are various restrictions on eligibility based, for example, on age or income. Some programs also require out-of-pocket payments. For example, it is common for provincial drug programs to require individuals to either pay a portion of their drug costs (sometimes based on income) or to spend a certain amount on prescriptions before public coverage kicks in.

There is an emerging body of compelling evidence to suggest that universal public insurance should be expanded to a variety of other health services. In many cases, these services offer much better value-for-money than continuing to add to the list of insured hospital and physician services. For example, Canada is the only developed country with a universal health care system that does not include coverage for drugs outside of hospital. According to Morgan et al, Canada could save billions per year through universal public coverage of pharmaceuticals, primarily by achieving better prices through bulk purchasing.³³ In addition to the cost savings associated with such a program, there would also be a reduction in morbidity and mortality, given that many Canadians do not take prescribed medications due to financial factors.³⁴ Universal pharmacare may be on the horizon at least in some provinces, with Ontario recently committing to this program for individuals under the age of 25. The federal government is also currently studying its feasibility.³⁵

FIGURE 1.2 Affordable access to medicine



Source: Monika Dutt, "Affordable Access to Medicines: A Prescription for Canada" (2014) Canadian Doctors for Medicare, Canadian Centre for Policy Alternatives Policy Briefing Series, online: Canadian Centre for Policy Alternatives <https://www.policyalternatives.ca/sites/default/files/uploads/publications/National%20Office/2014/12/Affordable_Access_to_Medicines.pdf>.

2. Enforcement

Another criticism of the CHA relates to the lack of federal enforcement when its conditions are breached. If a province fails to satisfy one or more of the five funding criteria, the CHA sets out a process by which the federal government can consult with the offending province and collect information, and the province can undertake to remedy the deficiency. If the province fails to do so, the federal government can reduce the annual cash contribution, having regard to the gravity of the deficiency.

The CHA takes a stricter approach to provincial breaches relating to extra-billing and user charges. If a province permits these activities, “there shall be deducted from the cash contribution to the province for a fiscal year an amount that the Minister ... determines to have been charged” through extra-billing or user charges.³⁶ In other words, if a province allows extra-billing or user charges, then the minister must deduct money from the annual transfer payment on a dollar-for-dollar basis. Despite the use of the word “shall,” which indicates that the minister does not have discretion to ignore a deficiency, the federal government has historically ignored breaches of the CHA.³⁷

There is a concern with various ongoing practices that undermine the CHA and equitable access to health care services. For example, there has been a growth in the number of private diagnostic clinics that charge patients to jump the queue for services such as MRIs, which is arguably prohibited under provincial laws. There are also various clinics appearing across Canada that charge patients an annual fee. In exchange for this fee, these clinics provide various health care services that fall outside of the list of insured services, such as full-body diagnostic PET scans and around-the-clock telephone consultations. Because these services are not insured under provincial health insurance plans, clinics are permitted to charge for them. However, there is a concern these clinics are intermingling these uninsured services with insured services, thereby granting preferential access to medically necessary health care for those who can afford the annual fee.

CASE STUDY

British Columbia Nurses’ Union v Attorney General of British Columbia, 2008 BCSC 321

The BC Nurses’ Union became concerned with medical clinics that appeared to be charging patients for insured services. Under the relevant legislation, the Medical Services Commission (which is responsible for administering BC’s health insurance plan) is not permitted to pay doctors for procedures performed within the public system if they impose user charges or extra-billing in relation to those procedures. The union argued that the commission was failing to follow this law by paying doctors for procedures that were ineligible for reimbursement because of extra-billing or user charges. Although the union did not receive an order to compel the commission to enforce its governing legislation, this case brought sufficient public attention to the issue that action was taken against the private clinic. The litigation between the private clinic and the government is ongoing.

V. Summary

Canada’s health care system is at a critical juncture. Although the CHA provided needed access to health care services at the time of its implementation, it is starting to show its age. It is questionable whether the CHA still adequately addresses the health needs of Canadians, given the law’s focus on hospital and physician services. Instead of continuing to expand the list of insured services provided by doctors and in hospitals, it is arguably time to rethink the CHA and to develop a process that looks at all health services (regardless of where they are provided and by

whom) and decide, in a transparent and evidence-based manner, which are the most cost-effective and thus should attract public funding. Health care costs already consume nearly 40 percent of provincial budgets,³⁸ so it is essential that Canadians receive good value for this significant financial investment.

Rethinking the CHA would require federal leadership, which would be a significant change from its hands-off approach to defining the requirements of the CHA and holding the provinces to account when they fail to measure up. Federal leadership in health care can be challenging, given its decreasing contribution to the cost of hospital and physician services—a source of past conflict with the provinces. However, working with the provinces is required, given how the Constitution divides responsibility for health between the various levels of government. The federal heads of power relevant to health include criminal law, POGG, patents, Indigenous people, and spending. The provinces have the power to regulate hospitals, property and civil rights, and local matters, which have been interpreted to include health insurance and most of the health care delivery system. The other part of the Constitution, the Charter, also plays a significant role in shaping the Canadian health system, having been the basis of important cases on medical assistance in dying, abortion, tobacco control, and which health services attract public funding.

QUESTIONS AND ISSUES FOR DISCUSSION

1. Should there be a greater role for the federal government in the health sector? What are some of the benefits of having the provinces deliver health services to their populations? What would be the benefits of a national approach to the organization and delivery of health services?
2. How would you define comprehensiveness under the CHA? What health services do you think should be publicly funded and how should governments decide?
3. What are the problems with paying doctors on a fee-for-service basis? What other payment models exist and what are their advantages and disadvantages?
4. Do you think that Canadian provinces should allow duplicate private health insurance and the private delivery of health care services? Why or why not?

NOTES AND REFERENCES

1. *Constitution Act, 1867* (UK), 30 & 31 Vict, c 3, reprinted in RSC 1985, Appendix II, No 5.
2. Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [Charter].
3. RSC 1985, c C-6 [CHA].
4. [1986] 1 SCR 103 [*Oakes*].
5. *Schneider v The Queen*, [1982] 2 SCR 112 at 142.
6. Martha Jackman, “Constitutional Jurisdiction Over Health in Canada” (2000) 8 Health LJ 95 at 111.
7. *Ibid* at 110.
8. *Reference Re Employment and Social Insurance Act*, [1936] SCR 427 at 451.
9. Toronto, “Health Programs & Advice: Featured Programs & Initiatives,” online: <<https://www.toronto.ca/community-people/health-wellness-care/health-programs-advice/>>.
10. There must be a 300-metre separation between cannabis stores and 150 metres between cannabis stores and shelters or schools. Calgary, “Cannabis Store Business Guide,” online: <<http://www.calgary.ca/PDA/pd/Pages/Business-licenses/Cannabis-Store.aspx>>.
11. *Gaming and Liquor Control Act*, RSA 2000, c G-1.
12. Calgary, “Public Consumption of Cannabis,” online: <<http://www.calgary.ca/CSPS/ABS/Pages/Bylaws-by-topic/public-consumption-of-cannabis.aspx>>.
13. RSC 1985, c C-46.
14. *R v Wetmore*, [1983] 2 SCR 284.
15. Jackman, *supra* note 6 at 102-5.
16. In *Reference Re Anti-Inflation Act*, [1976] 2 SCR 373 at 436, Justice Ritchie found that the emergency branch of POGG could be invoked in the case of an “urgent and critical situation adversely affecting all Canadians and being of such proportions as to transcend the authority vested in the Legislatures of the Provinces and thus presenting an emergency which can only be effectively dealt with by Parliament.”

17. For a discussion of the spending power and some of its critiques, see e.g. Hamish Telford, “The Federal Spending Power in Canada: Nation-Building or Nation-Destroying” (2003) 33:1 *Publius* 23; Andrew Petter, “Federalism and the Myth of the Federal Spending Power” (1989) 68 *Can Bar Rev* 448; David Cameron & Richard Simeon, “Intergovernmental Relations in Canada: The Emergence of Collaborative Federalism” (2002) 32:2 *J Federalism* 49.
18. *Eldridge v British Columbia (Attorney General)*, [1997] 3 SCR 624 at para 25.
19. *Reference Re Canada Assistance Plan*, [1991] 2 SCR 525. *Winterhaven Stables Ltd v Canada (Attorney General)* (1988), 53 DLR (4th) 413 (Alta CA) was another challenge to a number of federal spending statutes, including the CHA. In this case, the Alberta Court of Appeal agreed that the federal use of financial incentives placed substantial pressure on the provinces to participate in the program, but the court found that this was a legitimate use of power.
20. CHA, s 9. It is important to note that dental services are only insured if they are provided in hospital and there is very limited public coverage for basic preventive dental services provided by dentists.
21. CHA, s 2.
22. CHA, s 10.
23. CHA, s 11(1)(b)(i).
24. CHA, s 11.
25. Large hospital bills incurred by Canadians while abroad have sometimes attracted the attention of the media. See e.g. Jennifer Huculak, “Canadian Mom Faces Nearly \$1-Million Medical Bill After Unexpected Birth in US,” *The Globe and Mail* (19 November 2014), online: <<https://www.theglobeandmail.com/news/national/canadian-mom-faces-nearly-1-million-medical-bill-after-unexpected-birth-in-us/article21646844/>>.
26. *General Regulations*, RRO 1990, Reg 552, s 28.4.
27. CHA, s 12(1)(a).
28. CHA, ss 12(1)(b)-(d).
29. See e.g. Colleen M Flood & Bryan Thomas, “Modernizing the *Canada Health Act*” (2016) 39 *Dal LJ* 397.
30. Carolyn J Tuohy, “Medicine and the State in Canada: The Extra-Billing Issue in Perspective” (1988) 21:2 *Can J Political Science* 267.
31. There is a vast body of literature on this topic, but see e.g. Michael E Chernew et al, “Impact of Decreasing Copayments on Medication Adherence Within a Disease Management Environment” (2006) 27:1 *Health Affairs* 103; Adam Wagstaff et al, “Equity in the Finance of Health Care: Some Further International Comparisons” (1999) 18:3 *J Health Economics* 263; Astrid Kiil & Kurt Houllberg, “How Does Copayment for Health Care Services Affect Demand, Health and Redistribution? A Systematic Review of the Empirical Evidence from 1990 to 2011” (2014) 15:8 *European J Health Economics* 813.
32. Canadian Institute for Health Information, *National Health Expenditure Trends, 1975 to 2017* (Ottawa: CIHI, 2017) at 11, online: <<https://www.cihi.ca/sites/default/files/document/nhex2017-trends-report-en.pdf>>.
33. Steven J Morgan et al, “Estimated Effects of Adding Universal Public Coverage of an Essential Medicines List to Existing Public Drug Plans” (2017) 189:8 *CMAJ* E295.
34. See e.g. Robyn Tamblyn, Rejean Laprise & James Hanley, “Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons” (2001) 285:4 *JAMA* 421.
35. Naomi Powell, “Affordable Pharmacare the Goal of Study Launched in Federal Budget,” *Financial Post* (27 February 2018), online: <<http://business.financialpost.com/news/economy/federal-budget-affordable-pharmacare-the-goal-of-study-launched-in-federal-budget>>.
36. CHA, ss 19-20. Note that if the province eliminates the extra-billing or user charge, the minister then transfers the funds that were withheld to the province.
37. Sujit Choudhry, “Bill 11, the *Canada Health Act* and the Social Union: The Need for Institutions” (2000) 38:1 *Osgoode Hall LJ* 39.
38. Canadian Institute for Health Information, *supra* note 32 at 22.