

MAJOR TRENDS IN HEALTH LEGISLATION IN CANADA 2001-2005



PAN AMERICAN HEALTH ORGANIZATION
HEALTH SYSTEMS STRENGTHENING AREA (HSS)
HEALTH POLICIES AND SYSTEMS DEVELOPMENT UNIT (HP)

NOVEMBER 2006

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I. INTRODUCTION

The years from 2001 to 2005 in Canada were characterized by deep concerns about the future of the cherished national public health care system and the ability of the nation to respond to public health emergencies. Changes to health legislation reflected these concerns. The public health care system, Medicare, was studied and various reforms were initiated or proposed. A new national Public Health Agency was established in an attempt to improve Canada's response to public health crises. Despite these reforms, the future remains uncertain for Medicare and the new framework for public health has yet to be tested.

II. HEALTH CARE REFORM

Background

In the Canadian federation, the primary responsibility for health care lies with the provinces, as the provincial and territorial governments deliver health care services.¹ However, the federal government has played a large role in the development of Canada's publicly funded health care scheme, primarily as a result of its spending power.²

The province of Saskatchewan was the first province in Canada to enact health insurance legislation. In 1957, the federal *Hospital Insurance and Diagnostic Services Act* gave monetary contributions to provinces with public health insurance schemes. The purpose of the Act was to share the costs of implementing hospitalization and medical insurance plans. By 1961, all the provinces had a public health insurance scheme.³ The *Canada Health*

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¹ For example, provincial governments make decisions on the number of hospitals and other facilities, oversee the management of hospitals, negotiate fees with health professionals, and regulate the health professions. Odette Madore, "The Canada Health Act: Overview and Options" (Ottawa, Ont.: Parliamentary Information and Research Service, May 16, 2005) 3.

² *Ibid.* at 10-13.

³ Colleen M. Flood, "The Anatomy of Medicare" in Jocelyn Downie, Timothy Caulfield & Colleen Flood, eds., *Canadian Health Law and Policy*, 2nd ed. (Markham, Ont.: Butterworths Canada Ltd., 2002) 1 at 17-18

Act was enacted in 1984 and remains as the governing federal legislation for Canada's Medicare program today.⁴

The *Canada Health Act* sets out the criteria which the provinces and territories must meet in order to qualify for federal funding for publicly insured services. The five criteria are: non-profit public administration; portability of coverage across Canada; universal access to insured services; comprehensive coverage of insured services; and uniform accessibility to health services.⁵ The Act provides for deductions from federal contributions if a province imposes user fees or allows extra charges to patients for insured services.⁶

Medicare has often been described as a single payer system which suggests that all health care is publicly funded. In reality, the system might be better described as a series of "concentric circles."⁷ Core services are publicly funded. These services comprise "medically necessary" hospital and "medically required" physician services.⁸ In the next circle, there are services, like prescription drugs and home care, in which the level of public funding varies across the provinces. The outer circle consists of services which attract no public support. For these services, the patient either pays out of pocket or through private health insurance. The scope of unfunded services varies from province to province and may include items such as: dental care; vision care; long-term care; ambulance services; psychological services; chiropractic services; physiotherapy; and

(The Saskatchewan legislation was enacted in 1947).

⁴ R.S.C. 1984, c. C-6.

⁵ Health Canada, "Overview of the Canada Health Act (CHA)", online: Health Canada <http://www.hc-sc.gc.ca/hcs-sss/medi-assur/overview-apercu/index_e.html>.

⁶ Health Canada, "Federal Transfers and Deductions", online: Health Canada <http://www.hc-sc.gc.ca/hcs-sss/medi-assur/transfer/index_e.html>.

⁷ Carolyn Hughes Tuohy, "The costs of constraint and prospects for health care reform in Canada" (2002) 21:3 Health Affairs 32 at 36.

⁸ 'Medically necessary' and 'medically required' are not defined by the *Canada Health Act*. *Supra* note 3 at 22; Timothy Caulfield, "Wishful thinking: Defining Medically Necessary in Canada" (1996) 4 Health Law Journal 63; Glenn Griener, "Defining Medical Necessity: Challenges and Implications" (2002) 10:3 Health Law Review 6.

prescription drugs outside a hospital setting.⁹ At present, approximately 30% of health care spending in Canada is privately financed.¹⁰

The private sector delivers most health services. The majority of hospitals are private non-profit operations and most physicians are in private practice. Many ancillary services, such as laundries, meal preparation services, laboratories, and diagnostic clinics are private, for-profit businesses. All these entities are compensated for their services by the public insurance scheme.¹¹

The Future of Medicare

Since the mid-1990s, health care reform has been a major political and social issue in Canada. A number of surveys have indicated that Canadians regard health care as the top social issue.¹² In 2001, a majority of Canadians believed that the Medicare system was in crisis and in need of restructuring.¹³ The issues of greatest concern are the costs of the program and the quality of access to medical services.

The current crisis in the Medicare program can only be understood in the context of funding cuts which took place in the late 1980s and early 1990s. In that period, public spending on health sharply decreased.¹⁴ Governments were seeking to cut public

⁹ Canada, Health Canada, *Canada Health Act Annual Report 2004-2005* (Ottawa, Ont.: Health Canada, 2005).

¹⁰ Canadian Institute for Health Information, *Health Care in Canada 2005* (June 8, 2005) 17, online: CIHI <<http://secure.cihi.ca>>.

¹¹ Odette Madore & Marlisa Tiedemann, "Private Health Care Funding and Delivery under the Canada Health Act" (Ottawa: Parliamentary Information and Research Service, December, 2005)

¹² Timothy A. Caulfield & Barbara von Tigerstrom, "Preface" in Timothy A. Caulfield & Barbara von Tigerstrom, eds. *Health Care Reform & the Law in Canada*, (Edmonton, Alberta: The University of Alberta Press, 2002) 9.

¹³ *Supra* note 7 at 32.

¹⁴ Ivan Beck and Matthew Thomson argue that the sharp cuts in health care spending during this period were the result of a report by two economists who concluded that there was a health care spending crisis and recommended cutting the number of physicians and closing hospitals. In reality, there was no crisis, rising costs were associated with an aging population that governments were obliged to accommodate. The cuts in funding resulted in lengthy waiting lists which are currently jeopardizing the principle of universal and equal care. See Ivan Beck & Matthew Thomson, "The Health Care Philosophy that Nearly Destroyed Medicare in Canada in a Single Decade" (2006) 29:2 *Clinical and Investigative Medicine* 65.

spending, reduce deficits and achieve balanced budgets. Between 1984-1992 real per capita health spending in the public sector increased by 20%. In contrast, between 1992-2000 real per capital public health spending increased by 9%.¹⁵

Part of the anxiety about the cost to the public purse of Medicare is focused on whether the program can be sustained into the future, given the likelihood of increasing costs. At present, health care spending accounts for 9.6% of Canada's gross domestic product, which is on par with spending in other Western developed countries.¹⁶ However, a number of studies have concluded that the present level of public funding cannot be sustained.¹⁷ This conclusion is based on the reality of an aging population (as a result of the post-World War II baby boom) and the increased costs to the system of new technologies.¹⁸ An underlying issue is the belief that the health care delivery system is inefficient and that money is being wasted.

Along with cost, the other major issue is the quality of access to health care services. Waiting times for treatments, including elective surgeries and cancer treatments, have been a major issue in the recent past.¹⁹ Restructuring of the system in an effort to contain costs has resulted in hospital closures, bed shortages and emergency room overcrowding. There is a shortage of medical personnel, particularly in rural areas.²⁰

¹⁵ *Supra* note 7 at 33-34.

¹⁶ *Supra* note 10 at 18.

¹⁷ Brent J. Skinner, *Paying More, Getting Less 2005* (Vancouver, B.C.: The Fraser Institute, 2005), online: The Fraser Institute <<http://www.fraserinstitute.ca>>; Alberta, Premier's Advisory Council on Health for Alberta, *A Framework for Reform* (December, 2001) [Mazankowski Report]; Quebec, *Rapport Menard*, online: <<http://www.solidaritedesgenerations.qc.ca/presse/RapportMenard.pdf>>[Menard Report].

¹⁸ Canadian Medical Association, *In Search of Sustainability: Prospects for Canada's Health Care System* (Ottawa, Ont.: Canadian Medical Association, 2001) v, online: CMA Online <<http://www.cma.ca>>.

¹⁹ Canadian Institute for Health Information, *Waiting for Health Care in Canada: What We Know and What We Don't Know* (Ottawa, Ont.: Canadian Institute for Health Information, 2006); Pauline Comeau, "Wait-time benchmarks fall short" (2006) 174:3 CMAJ 299; Nadeem Esmail & Michael Walker, *Waiting Your Turn: Hospital Waiting Lists in Canada*, 15th ed. (Fraser Institute, 2005).

²⁰ For example, in a 2006 report, the Alberta Medical Association estimated that there was a shortage of 1000 physicians in Alberta, with similar shortages of other health professionals. The Association predicts that the shortages will increase in the next five years. Alberta Medical Association, *Access to Doctors. Access to Care*. (Alberta Medical Association, March, 2006).

Reports on the Future of Medicare

In response to the crisis over the future of publicly funded health care, a number of national and provincial studies of Medicare have been completed.²¹ The Federal Commission on the Future of Health Care in Canada [Romanow Report] released its final report in November 2002. The Commission recommended that federal funding of public health care be significantly increased, with the federal government providing 25% of the cost of insured services under the *Canada Health Act*. There were many other recommendations, including increased coverage for home care and prescription drugs, increased numbers of health care providers in rural areas, greater funding for diagnostic services; and creation of a national personal electronic health record system. The Commission found that increasing the scope of privately funded health care would simply shift the burden to individuals and there was no evidence that this would be more affordable or efficient.²²

In October 2002, the Senate Parliamentary Standing Committee on Social Affairs, Science, and Technology [Kirby Report] released the last of its six reports on the status of health care in Canada. Like the Romanow Report, the Senate Committee recommended expanded funding for home care, prescription drugs, and a national electronic health records system. The Report recommended the formulation of waiting time guarantees by the federal government to address the problem of waiting times. Significantly, the Report found that the current system of funding Medicare was not sustainable and recommended

²¹ Quebec, *Clair Commission: Emerging Solutions – Report and Recommendations* (Quebec: Government of Quebec, 2000); Quebec, *Rapport Menard*, online: <<http://www.solidaritedesgenerations.qc.ca/presse/RapportMenard.pdf>>[Menard Report]; Saskatchewan, *Fyke Commission – Caring for Medicare: Sustaining a Quality System* (Government of Saskatchewan, April 2001); Alberta, Premier's Advisory Council on Health for Alberta, *A Framework for Reform*, (December, 2001) [Mazankowski Report]; New Brunswick, *Health Renewal: A Discussion Paper* (2002); Newfoundland and Labrador, *Newfoundland and Labrador Strategic Health Plan* (September, 2002); Canada, Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada* (November 28, 2002) [Romanow Report]; Canada, Senate Standing Committee on Social Affairs, Science and Technology, *The Health of Canadians – Federal Role – Final Report* (October 2002) [Kirby Report].

²² Romanow Report, *ibid.* at Executive Summary, online: Health Canada, <http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/HCC_Executive_Summary.pdf>; Canada, News Release, "Romanow Report Proposes Sweeping Changes to Medicare" (28 November 2002), online: Health Canada <<http://www.hc-sc.gc.ca/english/care/romanow/hcc0403.html>>.

a national sales tax directed to health care or a national health insurance premium based on income.²³

At the provincial level, both the Manzankowski Report in Alberta and the Menard Commission in Quebec concluded that the current level of spending on health care was not sustainable into the future. The Mazankowski Report recommended rationing services to sustain the public system. The Report found that waiting times were too long and that there was a serious shortage of medical personnel.²⁴ The Report concluded that the services covered by Medicare could not be comprehensive and that the number of insured services should be reduced.²⁵ It recommended that other options for paying for services be explored, such as medical savings accounts.²⁶ The Menard Commission recommended increased private sector involvement to improve access to health care. Private sector involvement was one of the great innovations proposed by the report.²⁷

Private Law Challenges to Medicare

Two recent decisions of the Supreme Court of Canada have potentially impacted the future of Medicare. In *Auton (Guardian ad litem of) v. British Columbia (Attorney General)*²⁸, a constitutional challenge was brought on behalf of a group of autistic children in respect of the provincial government's failure to provide public funding for a beneficial educational program. The Supreme Court held that the program was not a core service and therefore, it had not been discriminatory to deny funding. This decision, along with the earlier decision in *Elridge v. British Columbia (Attorney General)*²⁹, has affected the

²³ Kirby Report, *supra* note 21, online: Parliament of Canada
<<http://www.parl.gc.ca/37/2/parlbus/commbus/senate/com-e/soci-e/rep-e/report02vol6highlights-e.htm#INTRODUCTION>>.

²⁴ Mazankowski Report, *supra* note 21 at 4.

²⁵ *Ibid.* at 6.

²⁶ *Ibid.* at 44.

²⁷ Rapport Menard, *supra* note 21. In contrast, the Clair Commission, which reported in 2001, concluded that public funding should remain the backbone of the system and suggested a "loss of autonomy" tax to pay for the health care needs of an aging population. See Howard Chodos, "Quebec Health Review (The Clair Commission)" (Ottawa, Parliamentary Information and Research Service, 2001) 5.

²⁸ [2004] 3 S.C.R. 657; 2004 SCC 78.

²⁹ [1997] 3 S.C.R. 624 (In this case, the Court found that the failure by a health facility to provide a deaf

continuing debate over what health services comprise ‘medically necessary’ or ‘medically required’ services under the *Canada Health Act*.³⁰ Many of the pressures on the health care system stem from the search for a definition of medical necessity.³¹

The most recent decision of the Supreme Court in *Chaoulli v. Quebec*³² has potentially removed the ability of provincial governments to prohibit private health insurance for publicly funded services. The case was brought by a patient who had waited one year for hip replacement surgery under Medicare and a physician who wished to open a private hospital offering a private alternative to publicly funded services. The Court struck down a Quebec law which prohibited Quebec residents from purchasing private health insurance for services covered under the provincial health care system. The majority of Justices found that the legislation was a violation of a patient’s right to security under s. 1 of the Quebec *Charter of Rights and Freedoms*. The decision concluded that there was insufficient evidence to show that allowing a parallel private health care would affect the integrity of the Medicare system.

It is widely believed that the decision has opened the door to the formation of a ‘two-tier’ health care service in Canada.³³ Some academic writers feel that the impact of the decision cannot be overstated.³⁴ The decision has received both praise and censure. The Premier of Alberta was supportive of the decision, going so far as to write a newspaper editorial detailing how the decision was an endorsement of Alberta’s plan to introduce a

woman with translation services was a violation of her s. 15 rights under the *Charter of Rights and Freedoms*).

³⁰ *Supra* note 4.

³¹ Griener, *supra* note 8 at 7.

³² [2005] SCC 35.

³³ See Barbara Sibbald & Pat Sullivan, “Medicare on Trial: Chaoulli and autism case” (2004) 171:2 CMAJ 122; “Private Medical Care Comes to Canada,” Editorial (2005) 173:3 CMAJ 225; Lawrie McFarlane, “Supreme Court Slaps For-Sale Sign on Medicare” (2005) 173:3 CMAJ 269; Colleen M. Flood & Terrence Sullivan, “Supreme Court Disagreement: The highest court affirms an empty right” (2005) 173:2 CMAJ 142.

³⁴ Colleen M. Flood, Mark Stabile & Sasha Kontic, “Finding Health Policy ‘Arbitrary’: the Evidence on Waiting, Dying, and Two-Tier Systems” in Colleen Flood, Kent Roach & Lorne Sossin, eds. *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto, Ont.: University of Toronto Press, 2005) 296 at 296.

parallel private health care system.³⁵ Two months after the decision, the majority of delegates to the national medical association convention voted in favour of the legalization of private health care for services that the public system was unable to provide in a timely manner.³⁶ Other commentators were also in favour of the decision.³⁷

A major criticism of the decision was the assertion that the Supreme Court had failed to properly consider evidence from other jurisdictions showing that parallel private systems do not necessarily decrease waiting times.³⁸ Other writers maintained that the decision was a regressive step which did not reflect Canadian values in favour of a universally accessible public health care system.³⁹ Another view regarded the decision as potentially applying only to Quebec and counseled a 'wait and see' attitude, pointing out that as the implementation of the decision had been postponed until June 2006, the actual impact of the decision might be minimal.⁴⁰

It is widely believed that there will be further constitutional challenges to the provision of health care in the future.⁴¹ The Supreme Court may be asked to decide

³⁵ Ralph Klein, "Time to Embrace Change in Health Care: Albertans Have a Right to More Choices in Obtaining the Health Care They Need," Editorial, *Edmonton Journal* (30 July 2005) A17.

³⁶ Trudo Lemmens & Tom Archibald, "The CMA's Chaoulli Motion and the Myth of Promoting Fair Access to Health Care" in Colleen Flood, Kent Roach & Lorne Sossin, eds. *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto, Ont.: University of Toronto Press, 2005) 323 at 323.

³⁷ For example Nadeem Esmail "A Big Leap in the Right Direction" *Fraser Forum* (July/August 2005) 3.

³⁸ *Supra* note 34 at 298.

³⁹ Andrew Petter, "Wealthcare: The politics of the *Charter* Revisited" in Colleen M. Flood, Kent Roach & Lorne Sossin, eds. *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto, Ont.: University of Toronto Press, 2005) 116 at 117; Allan C. Hutchinson, "'Condition Critical': The Constitution and Health Care" in Colleen M. Flood, Kent Roach & Lorne Sossin, eds. *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto, Ont.: University of Toronto Press, 2005) 101.

⁴⁰ Bernard M. Dickens, "The Chaoulli Judgment: Less than Meets the Eye – or More" in Colleen M. Flood, Kent Roach & Lorne Sossin, eds. *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto, Ont.: University of Toronto Press, 2005) 19.

⁴¹ David Baker & Faisal Bhabha, "Universality and Medical Necessity: Statutory and Charter Remedies to Individual Claims to Ontario Health Insurance Funding" (2004) 13:1 *Health Law Review* 25; Nola M. Ries, "Section 7 of the Charter: A Constitutional Right to Health Care? Don't Hold Your Breath" (2003)

whether the *Charter of Rights and Freedoms* may offer a guarantee of access to publicly funded health care.⁴²

Health Renewal vs. Privatization

A. Introduction

There have been two major areas of response to the crisis in Medicare. On the one hand, a trend toward increased privatization has continued, in part due to changes in health care delivery patterns as provinces have attempted to contain costs and improve efficiency. On the other hand, there have been a number of initiatives to renew the Medicare program in an effort to ensure a sustainable future. Trends which began in the 1990s have continued and include, for example, decentralizing health administration by moving to regional health authorities and transferring functions previously performed by doctors or nurses to other medical personnel. More recent innovations have included attempts to manage wait lists, primary care delivery reform and electronic health records.

B. Increasing Privatization

The increase in privatization of the public health care system has taken a number of forms. The provinces have moved to restrict the scope of services covered by Medicare. Financial constraints have resulted in the delivery of more health care services in the community and this has shifted the provision of some health care treatments to the private sector.

There has been a reported increase in the number of private clinics and surgical facilities operating in Canada.⁴³ A number of provinces have legislation allowing private

12:1 Health Law Review 29; Donna Greschner, "How Will the Charter of Rights and Freedoms and Evolving Jurisprudence Affect Health Care Costs - Discussion Paper 20" (Canada: Commission on the Future of Health Care in Canada, September 2002); Martha Jackman, "The Implications of Section 7 of the *Charter* for Health Care Spending in Canada - Discussion Paper No. 31" (Canada: Commission on the Future of Health Care in Canada, October 2002).

⁴² The right to health care has been recognized in international covenants. Tamara Friesen, "The Right to Health Care" (2001) 9 Health Law Journal 205; see also Lorne Sossin, "Towards a Two-Tier Constitution? The Poverty of Health Rights" in Colleen M. Flood, Kent Roach & Lorne Sossin, eds. *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto, Ont.: University of Toronto Press, 2005).

clinics to offer various medical services.⁴⁴ For example, in Ontario, some of the services currently available in independent health facilities are anesthesia, induced abortion, cosmetic and plastic surgery, nuclear medicine, gynecologic procedures, ophthalmologic procedures, radiology, ultrasounds, magnetic resonance imaging [MRI], and computerized axial tomography [CT] scans.⁴⁵

An area of current concern is the increase in the number of private MRI clinics.⁴⁶ These facilities have been criticized as they allow patients to circumvent waiting lists for MRIs under Medicare. It is commonplace to hear reports of patients having had an MRI done privately to avoid the lengthy wait time for the procedure under Medicare.⁴⁷ In 2005, the Federal Minister of Health wrote to four provinces to express concern about private MRI clinics and possible non-compliance with the Canada Health Act in terms of user charges and queue jumping.⁴⁸

⁴³ See Alexandra Shimo, "The rise of private care in Canada" *Macleans* (25 April 2006), online: Macleans <http://www.Macleans.ca/topstories/health/article.jsp?content=20060501_125881_125881>; Corina Crawley, "Health Care Privatization in 2003" (Canadian Union of Public Employees, May 2003); Loreen Pindera, "Increasing private delivery of public services" (2005) 172:2 CMAJ 167; Robert Steinbrook, "Private Health Care in Canada" (2006) 354:16 New England Journal of Medicine 1661; Wayne Kondro, "Copeman Clinics Come Under Scrutiny" (2006) 174:6 CMAJ 753; "For-profit clinic founder is CMA's new president-elect" (2006) 174:7 CMAJ 912; Dennis Bueckert, "Debate rages over private clinics" *The Gazette* (21 September 2004) A.12; Scott Stinson & James Cowan, "Privatized care keeps expanding" *National Post* (15 September 2004) A.1; Matt Borsellino, "Quebec: epicentre of medicare's demise" 40:31 Medical Post 10.

⁴⁴ Examples of provincial legislation permitting this type of facility are: Ontario, *Independent Health Facilities Act*, R.S.O. 1990, c. 13 as amended by *Savings and Restructuring Act*, 1996, S.O. 1996, c.1 (the amendment removed the requirement that a facility offer only insured services at Sch. F, s.19); Alberta, *Health Care Protection Act*, R.S.A. 2000, c. H-1; British Columbia, *Medical Practitioners Act*, R.S.B.C. 1996, c. 285; Saskatchewan, *Health Facilities Licensing Act*, S.S. 1996, c. H-0.02.

⁴⁵ Joan Gilmour, "Regulation of Free-Standing Health Facilities: An Entrée for Privatization and For-Profit Delivery in Health Care" *Precedent & Innovation: Health Law in the 21st Century* (2003) Special Edition, *Health Law Journal* 131 at 135.

⁴⁶ *Supra* note 1 at 17.

⁴⁷ Brian Laghi, "Pay for an MRI and jump the queue: Who will object?" *The Globe and Mail* (6 December 2002) A14-A15.

⁴⁸ Growth of these type of facilities is checked by the fact that most provinces have legislation which discourages physicians from practicing in both the public and private sectors and a majority of provinces also prohibit private health insurance for publicly covered services. *Supra* note 1 at 16. However, this

Another recent trend is partnerships with the private sector for hospital construction in which the government rents or leases privately built and managed facilities.⁴⁹ This represents a shift toward a for-profit system as the majority of hospitals in Canada are private, non-profit facilities.⁵⁰

Provinces have moved to restrict the scope of publically funded Medicare by de-listing previously insured services. This has created disparities in coverage across the country. For example, warts can only be removed under Medicare in Newfoundland, Prince Edward Island and Quebec. In other parts of the country, this is a procedure that must be paid for privately.⁵¹ However, it has been estimated that de-listing has not reduced health care spending by a significant amount.⁵²

Another phenomenon which has increased is what has been termed ‘passive privatization’. Many services which are arguably “medically necessary” hospital treatments and thus, within the *Canada Health Act*, are now delivered in the community or at home. Advances in technology have resulted in shorter hospital stays and fewer invasive medical procedures. These community and home treatments are often not covered by Medicare. The Romanow Commission recommended that the range of publicly insured services be expanded to cover these types of situations, for example, by offering publicly funded home care and prescription drugs.⁵³

Three provinces have recently announced plans for health care reform which appear to include the introduction of a parallel private health sector. Early in 2006, Alberta

situation may change in light of the *Chaoulli v. Quebec* decision of the Supreme Court of Canada discussed above.

⁴⁹ Lewis Auerbach, *Issues Raised by Public Private Partnerships in Ontario's Hospital Sector* (Canadian Union of Public Employees, December 2002)

⁵⁰ *Supra* note 1 at 13.

⁵¹ *Supra* note 1 at 14.

⁵² It has been suggested that cost-cutting is not the only reason for de-listing. De-listing may further the interests of certain physician groups and may support the ideological views of the government on certain issues. For example, a policy of no public funding for contraceptive advice. See *supra* note 3 at 22-23; *supra* note 7.

⁵³ Romanow Report, *supra* note 22.

announced it planned to introduce a new *Health Care Assurance Act* which would allow physicians to work in both the private and public sector, allow patients to pay for joint and cataract surgery at private clinics to avoid waiting times in the public system, and eliminate public coverage of prescription drugs and continuing care.⁵⁴ Shortly after the announcement, the Government decided not to proceed with the legislation. It appears that public opposition to the legislation was instrumental in the decision.⁵⁵

The Quebec government announced proposed “wait-time guarantees” for surgeries treating cancer, heart conditions, cataracts, and joint replacements. Under the guarantees, the Province would pay for cataract and joint replacement surgeries in private clinics if the wait list guarantees were not met.⁵⁶ British Columbia has recently announced plans for health care reform and has proposed that the *Canada Health Act* include a “sustainability” provision and has suggested that legislation be introduced to allow a greater use of private facilities within the public system.⁵⁷

There is the potential that legislative changes which would allow private, for-profit health care may have implications for Canada under international agreements and, in particular, the North American Free Trade Agreement [NAFTA]. An increase in private, for-profit health care may result in increased participation by American for-profit insurers and health care providers. The structure of the NAFTA agreement is such that, if in the

⁵⁴ Lisa Gregoire, “Alberta’s hybrid public-private Third Way” (2006) 174:8 CMAJ 1076; Alberta, Alberta Health and Wellness, “Getting on with better health care” (July 2005); Alberta, M.L.A. Task Force on Health Care Funding and Revenue Generation, “A Sustainable Health System for Alberta” (October 2002); Canadian Press, “Alberta to introduce private health legislation” (20 February 2006), online: CTV News <<http://www.ctv.ca>>; Katherine Harding, “Alberta reshapes medicare. Plan allows patients to pay for fast access, MDs to offer both public and private care” *The Globe and Mail* (1 March 2006) A1.

⁵⁵ Barbara Kermode-Scott, “Albertans Oppose Third Way” (2006) 42:15 Medical Post 6; Michelle Lang, “Health Minister buries remains of Third Way” *Calgary Herald* (12 May 2006) A.1; James Baxter, “Klein’s health plans slammed: Nothing much to gain from ‘third way’ proposals” *The Province* (27 April 2006) A.22; Dawn Walton & Bill Curry, “Alberta backs off private medicare blueprint” *The Globe and Mail* (21 April 2006) A1.

⁵⁶ Rheel Seguin, “Quebec opens door to private health care. Wait-time guarantee includes promise to cover private clinic bills if necessary” *The Globe and Mail* (17 February 2006) A1; CTV, “Quebec opens door to private health care” (17 February 2006), online: CTV News <<http://www.ctv.ca>>.

⁵⁷ Andrea Ventimiglia, “BC to reform health care” (2006) 174:8 CMAJ 1077

future, a government changed its mind and decided to prohibit a parallel for-profit health system, financial penalties under NAFTA might preclude such a decision.⁵⁸

C. Health Renewal

In 2003 and 2004, the federal, provincial and territorial governments took important steps to sustain the public Medicare system. In February 2003, the “Accord on Health Renewal” was signed with the purpose of improving wait times, access to home and community care, coverage for catastrophic drug costs, and access to quality care in all parts of the country. In September 2004, a second agreement, the “10-year Plan to Strengthen Health Care” was signed with the goal of ensuring that the principles of the Canada Health Act were upheld and that all Canadians had access to “medically necessary” services regardless of ability to pay.⁵⁹ Most important, both these agreements included significantly increased federal payments to the provinces for universal health care. The 2004 plan included an additional \$41.3 billion dollars over ten years and legislated cash transfers from the federal government to 2013-2014. This commitment by the federal government had the purpose of reinvesting in health care and ensuring stability of federal funding.⁶⁰ The Health Council of Canada was established in 2003 to monitor progress toward achieving the goals set out in the agreements.⁶¹

There have been provincial efforts to strengthen Medicare. For example, in 2003, British Columbia enacted amendments to the *Medicare Protection Act* prohibiting extra charges for medically necessary diagnostic care in an effort to address the problem of

⁵⁸ Tracey Epps & David Schneiderman, “Opening Medicare to Our Neighbours or Closing the Door on a Public System? International Trade Law Implications of *Chaoulli v. Quebec*” in Colleen M. Flood, Kent Roach & Lorne Sossin, eds. *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto, Ont.: University of Toronto Press, 2005) 369; Jon R. Johnson, “How Will International Trade Agreements Affect Canadian Health Care - Discussion Paper No. 22” (Canada: Commission on the Future of Health Care in Canada, September 2002).

⁵⁹ Health Council of Canada, Annual Report to Canadians 2005, “Health Care Renewal in Canada: Clearing the Road to Quality” (February 2006) 2.

⁶⁰ Canada, “Canada Health Act Annual Report 2004-2005” (Ottawa, Ont.: Health Canada, 2005), online: Health Canada <<http://www.hc-sc.gc.ca>>.

⁶¹ *Supra* note 59 at 9.

private, for-profit diagnostic clinics. Ontario enacted legislation espousing a commitment to Medicare and re-introduced a health care premium tax.⁶²

D. Health Care Delivery Innovation

1. Regional Health Authorities

There has been a continuation of the trend toward grouping hospital administration into regions. In the autumn of 2004, Ontario became the last province to move to regional health authorities with the creation of 14 Local Health Integration Networks. In contrast, Prince Edward Island returned to a central administrative structure under the Department of Health. Restructuring of regional health authorities has also occurred. For example, in 2003, Quebec passed a law to reorganize health administration in the 18 health regions with the aim of providing multi-disciplinary care.⁶³

2. Primary Care Delivery

Most provinces are beginning to move to interdisciplinary teams of health professionals to deliver primary health care. In the majority of instances, the primary care team consists of physicians and nurses, but some provinces include health professionals such as: nurse practitioners; pharmacists; social workers; and mental health workers. The Health Council of Canada reported in 2006 that progress toward implementation of primary health care groups had been slower than expected.⁶⁴

Another initiative has been the implementation of extended telephone access to health care. Nine provinces and territories now have some form of access to after-hours service. The type of service varies; some provinces have services which offer information and advice, while others provide a referral service to other providers. Only five jurisdictions inform the patient's primary health provider of the phone call.⁶⁵

⁶² British Columbia, Ministry of Health Services, News Release, "Amendments to strengthen legislation, protect patients" (17 November 2003); see also Ontario, *Commitment to the Future of Medicare Act, 2004*, S.O. 2004, c. 5; Jeremiah Hurley, "Healthcare at a premium" (2004) 170:13 CMAJ 1906.

⁶³ *Supra* note 10 at 7.

⁶⁴ *Supra* note 59 at 18.

⁶⁵ *Ibid.* at 19.

A few provinces and territories, particularly in the North, are implementing telehealth programs. This type of service may offer more than information and advice. For example, patients may be able to consult long distance with health providers and receive diagnosis and treatment. Health professionals may be able to consult with other health professionals. As well, families may be able to visit with patients receiving treatment away from home.⁶⁶

3. Wait List Management

The issue of waiting lists for publicly funded health care has been a key issue over the past five years. A recent article detailed how some Canadians are seeking private surgery abroad to avoid lengthy waiting times for surgery.⁶⁷ The Fraser Institute has estimated that waiting times in Canada are 90% longer in 2005 than they were in 1993.⁶⁸ A recent survey found that the richest provinces had the longest wait times to see a specialist on an urgent referral.⁶⁹

There are difficulties in assessing wait times for procedures because the waiting time may vary within jurisdictions and within facilities. For example, in Saskatchewan in June 2005, 14% of cataract patients waited three weeks or less for the surgery, while 12% waited for more than a year.⁷⁰

In 2005, national benchmarks for wait times in certain areas were announced.⁷¹ Prior to this announcement, many provinces were working to reduce wait times through initiatives such as the Western Canada Waiting List Project.⁷² Provinces are utilizing the

⁶⁶ *Ibid.* at 21.

⁶⁷ Laura Eggertson, "Wait-list weary Canadians seek treatment abroad" (2006) 174:9 CMAJ 1247.

⁶⁸ Nadeem Esmail & Michael Walker, *supra* note 19 at 5.

⁶⁹ Mark O. Baerlocher & Allan S. Detsky, "Do richer provinces have shorter wait times to see specialists?" (2006) 174:4 CMAJ 447.

⁷⁰ Canadian Institute for Health Information, *supra* note 19 at 31.

⁷¹ *Supra* note 59 at 47.

⁷² Gregory P. Marchildon, "Managerial versus financial reform and the future of public health care in Canada" (2006) 12:1 Eurohealth 23 at 25; Gregory P. Marchildon, "Private Insurance for Medicare: Policy

Wait Times Reduction Fund to invest in equipment, provide training to health care workers and increase the number of surgeries.⁷³

4. Electronic Health Records

The provision of all patients with an electronic health record [EHR] has been part of the effort to renew the public health system. Canada Health Infoway, a nonprofit corporation, was established in 2001 to foster investment in EHR initiatives across the country. The federal government has provided significant funding to the corporation.⁷⁴ As of spring 2006, the corporation had 146 active or completed projects, in areas such as registries, diagnostic imaging, public health surveillance, telehealth, drug and laboratory information systems.⁷⁵ As an example, the corporation is collaborating in Ontario on a project which will give emergency rooms access to the prescription drug history of senior citizens and patients with high drug costs. The corporation is also involved in a project in Alberta to digitize x-rays, CT and MRI scans across the province.⁷⁶ The goal is to have EHRs in place for 50% of the Canadian population by 2009.⁷⁷ All provinces have agreed on a common architecture and a common set of data and standards to ensure that all systems will be able to communicate with each other.⁷⁸

History and Trajectory in the Four Western Provinces" in Colleen Flood, Kent Roach & Lorne Sossins, eds. *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto, Ont.: University of Toronto Press, 2005) 429 at 448.

⁷³ *Supra* note 59 at 47.

⁷⁴ The corporation received funding of \$500 million in 2000 and an additional \$600 million in 2003. Anthony A. Morris, "The Electronic Health Record in Canada: The First Steps" (2005) 14:2 Health Law Review 14 at 17; see also Glenn Griener, "Electronic Health Records as a Threat to Privacy" (2005) 14:1 Health Law Review 14; Nola M. Ries & Geoff Moysa, "Legal Protections of Electronic Health Records: Issues of Consent and Security" (2005) 14:1 Health Law Review 18.

⁷⁵ "Infoway Program Update Summary" (2006) 4 EHRnews@Infoway 3.

⁷⁶ Don Detmer & Elaine Steen, *Learning from Abroad: Lessons and Questions on Personal Health Records for National Policy* (Washington, D.C.: American Medical Informatics Association, 2006) 18.

⁷⁷ Patricia Kosseim "The Advent of Electronic Health Records (EHRs) in the Current Legal and Policy Context" (Lecture presented to the Electronic Health Information and Privacy Conference, Ottawa, Ontario, November 30, 2005).

⁷⁸ *Supra* note 59 at 61.

A number of privacy concerns have arisen in connection with a national EHR system and many of these concerns have yet to be addressed. An intention to use EHR information in research has been articulated. However, it is not yet clear whether commercial researchers will have access and how consent will be obtained for research use.⁷⁹

5. Regulation of Health Professionals

Following an international trend, some provinces have recently enacted umbrella legislation covering self-governing health professions. In general, these laws set out core principles and establish rules supervising professional regulatory bodies.⁸⁰

Another significant trend is the redefinition of scopes of practice and the creation of enhanced roles for health professionals. This trend stems from the shortage of family physicians and nurses. The goal is to transfer some of the traditional responsibilities of these health professionals. The certification and regulation of 'nurse practitioners' has given nurse practitioners the authority to order tests and prescribe certain drugs.⁸¹ Another profession which has been given an enhanced role is pharmacists. A task force in Ontario has recently recommended the certification of 'registered pharmacy technicians' who would have the ability to dispense drugs. The technicians will allow pharmacists to take on an expanded role in providing health care.⁸² In Alberta, recently passed regulations will allow pharmacists to prescribe the widest range of drugs in Canada.⁸³

⁷⁹ *Supra* note 77.

⁸⁰ William Lahey & Robert Currie, "Regulatory and medico-legal barriers to interprofessional practice" (2005) Supp. 1 *Journal of Interprofessional Care* 197 at 200.

⁸¹ Karen Irving, "Regulating to Meet New Demands" (2005) 37:5 *Nursing BC* 4; Ann Graham Walker, "Nurse Practitioner Legislation Passed in Nova Scotia" (2002) 38:3 *Medical Post*; "Nurse Practitioner, Laws and Regulations" (2003) 59:8 *Alberta RN* 5; Ontario, Health Professions Regulatory Advisory Council, *Regulation of Health Professions in Ontario: New Directions* (Toronto: Health Professions Regulatory Advisory Council, April 2006) 89 [New Directions]. In some provinces, licensed practical nurses are also being given increased responsibilities. See Lynette Best & Bonnie McLeod "Preparing LPNs to work in the OR" (2006) 38:1 *Nursing BC* 11.

⁸² *New Directions, ibid.* at 178.

⁸³ Alberta, News Release, "New regulation to grant prescribing powers to pharmacists" (31 May 2006), online: Government of Alberta <<http://www.gov.ab.ca/home/index.cfm?page=1458>>.

Future Directions

A. Home Care

The need for home care has continued to increase in Canada due to a number of factors, including increasing mobility, increasing numbers of women in the workforce and changing patterns of health delivery.⁸⁴ Under the health renewal plans, the provinces and the federal government agreed to work toward providing a basic package of home care services across the country, in an effort to alleviate discrepancies in coverage. The provinces are due to report on progress by the end of 2006.⁸⁵ The federal government has made changes to the *Canada Labour Code* to provide protected compassionate leave for Canadians caring for seriously ill or dying relatives. This program began in January 2004 and provides for up to eight weeks of paid leave. Most provinces have enacted complementary changes to their labour laws to provide further protection.⁸⁶

B. Pharmaceuticals

The 2003 Health Care Accord included a promise to provide all Canadians with catastrophic prescription drug coverage. At present, a national pharmaceutical strategy is in the process of being formulated.⁸⁷

C. Inter-Professional Practice

The use of primary care groups and other health delivery changes has expanded the numbers of different health professionals who work in a team setting. This has created a need to foster inter-professional practice between health professionals. Currently, there are plans to provide inter-professional education at a number of universities.⁸⁸ It has been recommended that the provincial and territorial governments take steps to remove

⁸⁴ *Supra* note 59 at 35.

⁸⁵ *Ibid.* at 34.

⁸⁶ At the end of 2005, British Columbia, Alberta, and the Northwest Territories had not amended their legislation. The eligibility requirements in the compassionate leave program have been criticized for being too narrow. *Ibid.* at 37.

⁸⁷ *Ibid.* at 40.

⁸⁸ *Ibid.* at 27-28.

regulatory and legal barriers which impede inter-professional practice, including unnecessary restrictions on scope of practice and mobility.⁸⁹

III. OTHER HEALTH LEGISLATION AREAS

A. Regulation of natural health products and practitioners

There has been an increasing use of alternative medical therapies and natural health products in Canada. In 2000, the federal government established the Office of Natural Health Products and the Natural Health Products Directorate. In 2004, regulations came into force which are to be phased in over a period of six years. The regulations stipulate that all natural health products sold in Canada must be licensed, with a review of the product by Health Canada for safety and efficacy.⁹⁰ As well, there are regulations with respect to labeling, manufacture and reporting of adverse reactions. The regulations apply to vitamins and minerals, as well as herbal remedies.⁹¹ Recently, the Natural Health Products Directorate has been considering establishing a separate list for natural products that are considered high risk.⁹² The regulations affect approximately 42,000 products sold in Canada with a retail value of \$2.5 billion in 2005.⁹³

There has been increasing regulation of natural health practitioners. Ontario has recently introduced legislation to regulate traditional Chinese medicine, including acupuncture.⁹⁴ The proposed Act includes establishment of a self-regulating college. At present, British Columbia is the only other province to regulate traditional Chinese medicine including acupuncture.⁹⁵ Alberta and Quebec regulate acupuncture only.⁹⁶ A

⁸⁹ *Ibid.* at 32-33.

⁹⁰ New Directions, *supra* note 81 at 149-150.

⁹¹ Health Canada, "At a Glance: A Regulatory Framework for Natural Health Products", online: Health Canada <http://www.hc-sc.gc.ca/dhp-mps/prodnatur/about-apropos/glance-apercu_e.html>.

⁹² New Directions, *supra* note 81 at 150.

⁹³ Earle R. Nestmann, Melody Harwood & Stephanie Martyres, "An innovative model for regulating supplement products: Natural Health Products in Canada" (2006) 221 *Toxicology* 50 at 58.

⁹⁴ Ontario, Bill 50, *Traditional Chinese Medicine Act* (2005), 2nd Sess., 38th Parl., 2005.

⁹⁵ British Columbia, *Traditional Chinese Medicine Practitioners and Acupuncturists Regulation*, B.C. Reg. 385/2000.

recent task force in Ontario has recommended that homeopaths be regulated and that the regulation of naturopaths be updated. The task force also recommended that the two professions be regulated together.⁹⁷

B. Assisted Human Reproduction

The *Assisted Human Reproduction Act* came into force on April 22, 2004. The Act sets out principles to be applied in the regulation of assisted human reproduction. The priority is the well-being and health of children born through these methods. The Act also protects the well-being of women, as women are directly affected by the technologies. There must be free and informed consent for the use of assisted human reproductive technologies.⁹⁸ The Act prohibits human cloning, the use of embryos for purposes other than creating a human being or providing instruction, and the commercialization of surrogacy. It also prohibits the purchase or sale of reproductive material.⁹⁹

C. Health Privacy Legislation

The rapidly changing face of health care delivery has focused attention on the privacy of health information. Provincial laws covering the privacy of public sector information were enacted in many provinces during the 1990s.¹⁰⁰ The federal privacy legislation, The *Personal Information Protection and Electronic Documents Act* [PIPEDA] has applied to personal health information since 2002, unless a province has enacted

⁹⁶ Alberta, *Acupuncture Regulation*, Alta. Reg. 42/88; Quebec, *An Act respecting Acupuncture*, R.S.Q., A-5.1.

⁹⁷ New Directions, *supra* note 81 at 147.

⁹⁸ Monique Hébert, Nancy Miller Chenier & Sonya Norris, "Bill C-13: Assisted Human Reproduction Act" (Ottawa: Parliamentary Information and Research Service, April 16, 2003) 3.

⁹⁹ Health Canada, "An Overview of Key Provisions of the Assisted Human Reproduction Act Coming into Force on April 22, 2004", online: Health Canada <http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2004/2004_ahr-pa_e.html>; Timothy Caulfield, "Bill C-13 The Assisted Human Reproduction Act: Examining the Arguments against a Regulatory Approach" (2002) 11:1 Health Law Review 20; Timothy Caulfield, "The Regulation of Embryonic Stem Cell Research: A Few Observations on the International Scene" *Precedent & Innovation: Health Law in the 21st Century* (2003) Special Edition Health Law Journal 87.

¹⁰⁰ For example, British Columbia, *Freedom of Information and Protection of Privacy Act*, R.S.B.C. 1996, c. 165; Nova Scotia, *Freedom of Information and Protection of Privacy Act*, R.S.N.S. 1993, c. 5; Ontario, *Freedom of Information and Protection of Privacy Act*, R.S.O. 1990, c. F-31.

substantially similar legislation.¹⁰¹ A number of provinces have enacted their own personal health information privacy acts. The latest legislation is in Ontario where *The Personal Health Information Protection Act, 2004* has recently come into force.¹⁰² Other provinces with this type of legislation include Manitoba, Saskatchewan, and Alberta.¹⁰³ The scope of the legislation varies by province. However, as an example, the Saskatchewan legislation sets out the duties of “trustees” of health information and the protected health information includes paper and electronic records. Although personal health information is protected, the information is available to the government for purposes of monitoring and evaluation.¹⁰⁴

D. Millennium Development Goals

There is no legislation which implements the Millennium Goals. However, Canada is working with other developed countries to assist in the implementation of the goals through international aid efforts. In April 2005, *Canada's International Policy Statement: A Role of Pride and Influence in the World* was issued with revised development priorities which support Canada's contribution to the achievement of the Millennium Goals. Canada has committed to providing more than \$5 billion in international assistance per year by 2010. In 2004-2005, international assistance was 21% higher than in the previous fiscal year. Canada is assisting in achieving all the goals. For example, with respect to universal primary education, Canada's has helped 6 million more children in Africa attend school. With respect to gender equality, Canada has contributed to an adult literacy program in Senegal where 75% of the students are women. In the area of child mortality, Canada is one of five major contributors to a worldwide immunization program. At present, Canada is the lead donor to the WHO “3 by 5” initiative to promote access to anti-retroviral drugs for 3 million HIV/AIDS patients. The above are just a few examples of how Canada has been working to achieve the Millennium Goals.¹⁰⁵

¹⁰¹ S.C. 2000, c. 5.

¹⁰² S.O. 2004, c. 3, Schedule. A.

¹⁰³ Alberta, *Health Information Act*, R.S.A. 2000, c. H-5; Manitoba, *Personal Health Information Act*, C.C.S.M. c. P-33.5; Saskatchewan, *The Health Information Protection Act*, S.S. 1999, c.H-0.021, as amended; Alberta, Office of the Information and Privacy Commissioner, *Health Information: A Personal Matter*, online: Office of the Information and Privacy Commissioner <<http://www.oipc.ab.ca>>.

¹⁰⁴ Saskatchewan, “The Health Information Protection Act (HIPA)”, online: Saskatchewan Health <www.health.gov.sk.ca/ph_br_health_leg_hipamain.html>.

¹⁰⁵ See Canadian International Development Agency, online: <<http://www.acdi->

IV. PUBLIC HEALTH IN CANADA

A. SARS

In the past five years, Canada has faced significant challenges in the area of public health. The outbreak of severe acute respiratory syndrome [SARS] in 2003 and contamination of the drinking water supply in a number of communities has focused attention Canada's public health system. The overall conclusion following these events was that Canada's public health system was sadly inadequate and in need of major restructuring.¹⁰⁶ The result has been major legislative initiatives at both the federal and provincial levels to deal with public health issues.

The outbreak of SARS, which was confined mainly to Toronto, saw hundreds of Canadians ill, more than 25,000 residents of Ontario placed in quarantine, paralysis of a major part of the Ontario health system and the deaths of 44 Canadians.¹⁰⁷ In 2000, the contamination of drinking water supplies in Walkerton, Ontario left seven Canadians dead and caused illness in 2,300 Canadians.¹⁰⁸ Following these events, numerous recommendations were made, including increased funding for public health, provincial legislation to ensure safe drinking water, and the establishment of a new federal public health agency.¹⁰⁹

The Public Health Agency of Canada was established by Order in Council on September 24, 2004 and a Chief Public Health Officer was appointed.¹¹⁰ The Public Health

cida.gc.ca/CIDAWEB/acdicida.nsf/En/JUD-13173118-GPM>.

¹⁰⁶ Ontario, The SARS Commission, *Second Interim Report: SARS and Public Health Legislation* (April 5, 2005) 8 (Commissioner: The Honourable Mr. Justice Archie Campbell) [SARS and Public Health].

¹⁰⁷ Canada, Health Canada, National Advisory Committee on SARS and Public Health, *Learning from SARS - A Renewal of Public Health in Canada* (Ottawa, Ont.: Health Canada, October, 2003) (Chairman: Dr. David Naylor) 11 [*Learning from SARS*].

¹⁰⁸ Doris Yan, "Public Health in Canada: Considerations on the history of neglect" (2004) 2:1 *History of Medicine* 34 at 34.

¹⁰⁹ *Learning from SARS*, *supra* note 106; Canada, Parliament of Canada, Senate Standing Committee on Social Affairs, Science and Technology, *Reforming Health Protection and Promotion in Canada: Time to Act*, 14th Report (November 2003); SARS and Public Health, *supra* note 105.

¹¹⁰ The previous agency responsible for public health was the Population and Public Health Branch of Health Canada. Marlisa Tiedemann, "Bill C-5: Public Health Agency of Canada Act" (Ottawa:

Agency of Canada Act is currently before Parliament.¹¹¹ The response to the SARS outbreak demonstrated a need to greatly improve communication and cooperation with the provinces during health emergencies. As the responsibility for public health lies mainly with provincial governments, there can be difficulties in coordinating a uniform response to a public health emergency and in effectively sharing information.¹¹² The role of the new agency will be to foster communication with the provinces, provide leadership in surveillance and research in public health, and initiate community action programs.¹¹³ The Public Health Agency will also oversee the fulfillment of Canada's international obligations in the public health field.¹¹⁴ Some of the challenges facing the new agency are privacy issues and working cooperatively with the provincial and territorial governments.¹¹⁵ There has been a recognition that spending on public health has been too low in the recent past. In 2002-2003, spending on public health represented between 1.8 and 2.5% of total spending on health care.¹¹⁶

The SARS outbreak led to the updating of the Quarantine Act. The new Act focuses on air travel, allowing the government to divert aircraft if necessary, and updates the list of communicable diseases. It also provides for the issuance of emergency orders prohibiting entry into Canada.¹¹⁷ The Act is designed to enhance existing provincial

Parliamentary Information and Research Service, April 26, 2006) 1.

¹¹¹ *Ibid.* at Legislative History.

¹¹² Jean-Francois Luc, Jane Speakman & Elaine Gibson, "Post-SARs Public Health Law Developments in Canada (Severe Respiratory Acute Syndrome)" (2005) 33:4 *Journal of Law, Medicine & Ethics* S106 [Post-SARs Public Health Law]. Although the major responsibility for public health lies with the provinces, there are numerous pieces of federal legislation which relate to public health. See for example: *Department of Health Act*, S.C. 1998, c. 8; *Pest Control Products Act*, R.S.C. 1985, c. P-9; *Food and Drugs Act*, R.S.C. 1985, c. F-27; *Hazardous Products Act*, R.S.C. 1985, c. H-3; *Canadian Environmental Protection Act*, 1999, S.C. 1999, c. 33; *Health of Animals Act*, S.C. 1990, c. 21; *Tobacco Act*, S.C. 1997, c. 13; *Canadian Food Inspection Agency Act*, S.C. 1997, c. 6.

¹¹³ Post-SARs Public Health Law, *ibid.*

¹¹⁴ Canada, Public Health Agency of Canada, News Release, "International Health Regulations" (3 November 2004), online: Public Health Agency <http://www.phac-aspc.gc.ca/media/nr-rp/2004/2004_ihr_e.html>.

¹¹⁵ Nola M. Ries & Timothy Caulfield, "Legal Foundations for a National Public Health Agency in Canada" (2005) 96:4 *Canadian Journal of Public Health* 281.

¹¹⁶ *Supra* note 107 at 35.

¹¹⁷ *Quarantine Act*, S.C. 2005, c. 20; Nola M. Ries, "Legal Foundations of Public Health in Canada" in

health legislation and to help Canada fulfill its obligations under the revised International Health Regulations. The Act is expected to come into force in the fall of 2006 after regulations have been approved.¹¹⁸

It has been suggested that the quarantine power may have been overused in Toronto during the SARS outbreak, given that Beijing quarantined roughly the same number of people with ten times the cases of SARS.¹¹⁹ It remains to be seen how the quarantine provisions under the new Act will be used. Another issue with the use of quarantine is protection of the livelihoods of workers who are in quarantine or caring for sick relatives. At the time of the SARS outbreak, Ontario enacted the *SARS Assistance and Recovery Act* which provided job protection and unpaid leave for workers affected by SARS.¹²⁰ It has been recommended that provincial legislation covering health emergencies include this type of protection.¹²¹

Following the SARS outbreak, Ontario passed amendments to its public health legislation to strengthen the independence of the Chief Medical Officer of Health in the province. In addition, an improved public health information system has been established and a committee on infectious diseases has been formed.¹²²

B. Drinking Water Contamination

The E-coli contamination of drinking water in Walkerton, Ontario in 2000¹²³, the contamination of drinking water in North Battleford, Saskatchewan with *Cryptosporidium* in 2001, and continuing problems with drinking water in Aboriginal

Tracey M. Bailey, Timothy Caulfield & Nola M. Ries, eds. *Public Health Law and Policy* (Markham, Ont.: Lexis Nexis Canada, Inc. 2005) 7 at 12-13.

¹¹⁸ Canada, Public Health Agency of Canada, "Update - Bill C-12" (16 May 2005), online: Public Health Agency of Canada <http://www.phac-aspc.gc.ca/media/nr-rp/2004/2004_54_e.html>.

¹¹⁹ Nola M. Ries, "Public Health Law and Ethics: Lessons from SARS and Quarantine" (2004) 13:1 Health Law Review 3 at 5.

¹²⁰ S.O. 2003 c. 1.

¹²¹ SARS and Public Health, *supra* note 105 at 7.

¹²² Post-SARs Public Health Law, *supra* note 111.

¹²³ See Ontario, *Report of the Walkerton Inquiry Part 1 and Part 2* (Ontario: Queen's Printer, 2002) (Commissioner: The Honourable Dennis R. O'Connor).

communities has led to a number of legislative initiatives to ensure drinking water quality. At present, there is no federal legislation dealing with drinking water quality, although there are a number of federal statutes aimed at preventing pollution of raw water sources.¹²⁴ Thus, the new legislation has been enacted at the provincial level.

In Ontario, the *Safe Drinking Water Act, 2002* established standards to ensure a safe drinking water supply in the province. The Act created the post of Chief Drinking Water Inspector, prescribed regulatory standards, imposed a requirement to report all adverse water test results, created licensing requirements for municipal drinking water systems and testing laboratories, and provided for broad inspection and enforcement powers. The Act also established severe penalties for offences, including fines of up to \$7 million for individuals convicted of offences that result in drinking water hazards.¹²⁵ The *Municipalities Act, 2001* gave municipalities authority over water issues within their sphere of jurisdiction, such as sewage, drainage, and flood control.¹²⁶ In June 2004, the draft *Drinking Water Source Contamination Act* was released which provides for the establishment of source protection boards and committees.¹²⁷ With respect to funding, Ontario enacted the *Sustainable Water and Sewage Services Act, 2002*. However, this Act has not yet been proclaimed in force.¹²⁸

In other regions of the country, British Columbia enacted an amended *Drinking Water Protection Act*. The amended Act and regulations came into force on May 16, 2003. The Act has increased the requirements for certification of operators and suppliers and for monitoring and reporting of hazards.¹²⁹

The quality of water in Aboriginal communities has been of increasing concern over the past few years. Outbreaks of disease due to water-borne bacteria and poor drinking water quality continue to occur. Responsibility for drinking water quality in

¹²⁴ Richard D. Lindgren, "Tapwater on Trial: Overview of Ontario's Drinking Water Regime" (Prepared for the Third Annual Conference on Water and Wastewater in Ontario, May 5-6, 2005) 5.

¹²⁵ S.O. 2002, c. 32; *ibid.* at 7-8.

¹²⁶ S.O. 2001, c. 25.

¹²⁷ *Supra* note 123 at 13-14.

¹²⁸ S.O. 2002, c. 29.

¹²⁹ British Columbia, Ministry of Health Services, News Release, "Tougher Rules Safeguard Province's Drinking Water" (30 May 2003).

these communities is shared between the federal government and the First Nations communities.¹³⁰ As of February 2006, drinking water was a potential health risk in two-thirds of Aboriginal communities and seventy-six First Nations communities were under boil-water advisories.¹³¹ The problems are due to obsolete or absent infrastructure, poorly trained operators, lack of appropriate testing and inspection, repeated bacterial contamination, and inadequate distribution systems.¹³² There is no legislation requiring the monitoring of drinking water safety in these communities.¹³³ The 2003 federal budget committed \$600 million over five years to upgrade and monitor Aboriginal community drinking water structures.¹³⁴ However, concerns were raised in 2005 that the additional funds had made little difference in correcting the problems.¹³⁵

C. Impact of the International Health Regulations

The new International Health Regulations which were approved in May 2005 have mandated increased reporting and surveillance requirements for Canada. The new Public Health Agency will play a key role in Canada's compliance with the Regulations. The Agency will be the centre of public health surveillance, disease prevention and identification of public health threats. It is planned that the Agency will work closely with other agencies, such as the World Health Organization, the European Centre for Disease Prevention and Control and the U.S. Centers for Disease Control and Prevention.¹³⁶

It has been suggested that federations, such as Canada, will have difficulty in complying with the Regulations. Much of the responsibility for public health in Canada

¹³⁰ Health Canada, "Drinking Water Quality", online: Health Canada <http://www.hc-sc.gc.ca/fnih-spni/promotion/water-eau/index_e.html>.

¹³¹ Canadian Broadcasting Corporation, CBC News Online, "Indepth: Aboriginal Waters: A Slow Boil" (20 February 2006), online: CBC News <<http://www.cbc.ca>>.

¹³² *Supra* note 123 at 16.

¹³³ *Supra* note 130.

¹³⁴ *Supra* note 123 at 17.

¹³⁵ *Supra* note 130.

¹³⁶ Canada, Public Health Agency of Canada, News Release, "International Health Regulations" (3 November 2004), online: Public Health Agency of Canada <http://www.phac-aspc.gc.ca/media/nr-rp/2004/2004_ihr_e.html>.

lies with the provinces. It is possible that the Public Health Agency of Canada may have difficulty in obtaining information on health emergencies in a timely manner. For example, a province might be reluctant to share information which might result in a travel advisory, given the economic impact of such an advisory. During the SARS outbreak, obtaining data from the affected provinces was a major issue and limited the ability of the federal government to inform the World Health Organization as to the status of the crisis.¹³⁷

D. Public Health and Health Privacy

One of the important issues in the area of public health is health privacy. The provincial health privacy legislation in Canada varies in the extent to which information may be shared either with the federal government or other provinces. In five provinces, there are express provisions allowing the sharing of personal health information with other provinces, territories or the federal government to prevent the spread of infectious diseases.¹³⁸ In the other provinces and territories, legislation includes broad powers which may be utilized in the public interest. These powers might be used as a basis for releasing personal health information to other provinces or the federal government.¹³⁹ It has been recommended that the provinces, territories and the federal government develop clear and harmonized rules for the transfer of personal health information across the country and to the World Health Organization in order to improve surveillance and the ability to react to public health emergencies.¹⁴⁰

E. Tobacco and Public Health

Canada has committed protecting public health through a variety of initiatives to reduce the incidence of cigarette smoking. In 1999, the federal government and the provinces and territories agreed on a revised National Tobacco Control Strategy. The Strategy focuses on four areas: preventing young people from starting to smoke; helping

¹³⁷ Kumanan Wilson, Ross Upshur, & Christopher McDougall, "The New International Health Regulations and the Federalism Dilemma" (2006) 3:1 PloS Medicine e1.

¹³⁸ Bartha Marie Knoppers, *et al.*, "The Reporting and Management of Personal Information and Personal Health Information to Control and Combat Infectious Disease: An Analysis of the Canadian Statutory and Regulatory Framework" (Ottawa, Ont.: Health Canada, March 2004) 44.

¹³⁹ *Ibid.* at 45.

¹⁴⁰ *Ibid.* at 47.

smokers quit cigarettes; educating the public about the health dangers of tobacco use; and ensuring a smoke-free environment for nonsmokers.¹⁴¹

In the past few years, a number of provinces have introduced or strengthened existing legislation with regard to smoking. In Saskatchewan, the *Tobacco Control Act* was amended in June 2004 to provide that all enclosed public places are smoke-free by January 1, 2005. In New Brunswick, the *Smoke Free Places Act* came into force in October 2004. This Act prohibits smoking in indoor workplaces, school grounds, restaurants, retail stores, and other venues. In Alberta, the *Prevention of Youth Tobacco Use Amendment Act* was proclaimed in 2004. The Act prohibits possession or use of tobacco in a public place by young people under 18.¹⁴² In Ontario, the *Smoke Free Ontario Act* prohibits smoking in workplaces and enclosed public places.¹⁴³

Canada is a signatory to the international *Framework Convention on Tobacco Control* which came into force on February 27, 2005.¹⁴⁴ In the international arena, Canada provides funding for tobacco control efforts, mainly through support of the work of the World Health Organization.¹⁴⁵

F. HIV/AIDS

The incidence of HIV/AIDS in Canada is serious, although the disease has not taken hold in Canada to the same extent as in other countries. It is estimated that the number of cases of HIV/AIDS has increased in Canada by 12% since 1999.¹⁴⁶ A “Federal Initiative to

¹⁴¹ Health Canada, Tobacco Control Liaison Committee, *The National Strategy: Moving Forward. The 2005 Progress Report on Tobacco Control* (Ottawa, Ont.: Health Canada, 2005) 17-19.

¹⁴² R.S.A. 2000, c. P-22.

¹⁴³ S. O. 2005, c. 18; Ontario, Ministry of Health and Long-Term Care, News Release, “New Smoke-Free Ontario Act Will Protect Ontarians’ Health” (8 June 2005).

¹⁴⁴ Health Canada, “Framework Convention Tobacco Control”, online: Health Canada <<http://www.hc-sc.gc.ca>>.

¹⁴⁵ Health Canada, “Federal Tobacco Control Strategy - International Component”, online: Health Canada <<http://www.hc-sc.gc.ca>>.

¹⁴⁶ Canada, *Strengthened Leadership: Taking Action. Canada’s Report on HIV/AIDS 2005* (Ottawa, Ont.: Minister of Public Works and Government Services Canada, 2005) 3. See also Canada, *The Federal Initiative to Address HIV/AIDS in Canada*” (Ottawa, Ont.: Minister of Public Works and Government Services

Address HIV/AIDS in Canada” has been developed and, in May 2004, the federal government committed to increase ongoing funding from \$42.2 million annually to \$84.4 million annually by 2009.¹⁴⁷ A key part of the initiative is increased collaboration with organizations at the local level.¹⁴⁸

Canada continues to assist with international efforts to eradicate HIV/AIDS. The Canadian HIV/AIDS Network is currently developing model legislation in the areas of drug policies and women’s rights. The legislation on drug policy will focus on harm reduction, while remaining respectful of the rights of drug users. The model legislation on women’s rights will provide a framework for respecting the rights of women in the context of HIV/AIDS. The model legislation will be a resource for developing countries.¹⁴⁹

G. Health Inequality

1. Aboriginal Health

The overall health of Aboriginal peoples is worse than other Canadians. Aboriginal peoples have higher rates of suicide, obesity, smoking, and infant mortality. They also have a shorter life expectancy. In an effort to address this situation, the non-binding “Blueprint for Aboriginal Health” was entered into in November 2005 by the federal, provincial, territorial governments and national Aboriginal organizations. The plan calls for significant reductions in the rates of suicide among youth, infant mortality, obesity and diabetes. An investment of \$1.3 billion over five years is planned to stabilize and improve health services to Aboriginal peoples. The Blueprint calls for the establishment of the Aboriginal Health Reporting Framework which will report on progress toward specific health outcomes.¹⁵⁰

Canada, 2004).

¹⁴⁷ Public Health Agency of Canada, “Federal Initiative to Address HIV/AIDS in Canada”, online: Public Health Agency of Canada <<http://www.phac-aspc.gc.ca>>.

¹⁴⁸ *Supra* note 145 at 10.

¹⁴⁹ *Supra* note 145 at 14.

¹⁵⁰ *Supra* note 59 at 94.

2. Poverty

It has been recognized that health inequalities are caused by poverty. Lower-income neighborhoods have almost double the rates of infant mortality compared with higher income areas. In addition, residents of lower income areas report higher levels of smoking and lower levels of physical activity. The gap between rich and poor is widening in Canadian cities.¹⁵¹

This reality has led to increasing attention being given to social climates as a predictor of health.¹⁵² An emerging field which is receiving increasing attention is injury prevention and legislation which assists that goal.¹⁵³

V. CONCLUSION

Over the past five years, significant changes have taken place in the landscape of health care delivery in Canada. Patterns of health care delivery have changed with the expansion of inter-professional practice, electronic health records, and use of new technologies. Undoubtedly, rapid changes will continue to occur in health care delivery and these changes will play a large role in shaping the future of public health care in Canada. The future nature of Medicare remains in doubt and it is possible that Canada will move to a public-private hybrid system, similar to systems currently in place in countries like the United Kingdom and New Zealand.

The crisis in the health care system was accompanied by major public health crises which revealed weaknesses in Canada's public health system. This led to the creation of the Public Health Agency of Canada. It is hoped that Canada will now be able to respond effectively to any future public health crisis.

¹⁵¹ *Supra* note 59 at 89.

¹⁵² Solange van Kemenade, *Social Capital as a Health Determinant* (Ottawa, Ont.: Health Canada, July 2002)

¹⁵³ See Louis Hugo Francescutti, Tracey M. Bailey & Trevor L. Strome, "Injuries: Public Health's Neglected Epidemic" in Tracey M. Bailey, Timothy Caulfield & Nola M. Ries, eds. *Public Health Law and Policy in Canada* (Markham, Ont.: Lexis Nexis Canada Inc., 2005) 219.