Provincial flexibility under the Canada Health Act

When does change become a violation?

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In any modern federation there is a certain amount of overlap and cooperation between levels of government. In Canada, the federal government is directly or indirectly involved in many areas over which the provinces have constitutional jurisdiction. After important changes in the 1990s, the federal government's direct supervision of many of these cost-shared activities decreased. Most transfers to the provinces became unconditional, with a general expectation that monies would continue to go to the programs and activities built up in joint programs since the mid-20th century. However, the federal government continued to expect the provinces to live up to the conditions of the Canada Health Act (CHA), a piece of federal legislation designed to impose a general set of national standards (namely public administration, comprehensiveness, universality, portability and accessibility) in the field. Almost a quarter century after the legislation was enacted, health care could not be more prominent on provincial government agendas. Every province is facing escalating costs and public expectations about what the health care system should provide. Responding to those challenges and expectations requires the provinces to be innovative and experimental. But just how much flexibility do the provinces have under the CHA to bring in creative solutions?

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Federal Act dictates federal behaviour

It is worth recognizing that as a strict matter of law, the CHA governs the conduct of the federal government, not the provinces. The Act specifies the conditions under which the federal government can legally transfer resources to the provinces for spending on health care. Were the federal government to turn a blind eye to practices contrary to the standards of the Act, the provinces could operate as thought the Act did not exist. In short, if the provinces are not living up to the principles of the Act and the federal government continues to transfer resources to them, it is the federal government and not the province involved that is actually in violation of the Act. As a cardinal principle of constitutional jurisdiction, the federal government cannot dictate what the provinces do within the health care field. Federal legislation can only dictate what the federal government does with its money, and this includes assuring that certain expectations are met in the use of federal funds by the provinces.

Factors that determine the degree of flexibility

The real question becomes, then, how creative can provinces can be in interpreting the terms of the Act before the federal government is compelled to intervene? In this light, provincial flexibility under the CHA is influenced by three factors. First, interpretations of the general standards in the Act can differ between governments because the five principles of the CHA are not overly specific. Broad interpretations provide the provinces more flexibility, while narrower interpretations tend to limit provincial creativity in the delivery of health care programs. Enforcement, understood as the willingness and ability of the federal government to police the principles of the Act, is a second variable affecting provincial flexibility. Finally, flexibility could be influenced by other constitutional requirements. Provincial governments are obliged to conduct themselves in accordance with human rights statutes passed by their legislatures, and both levels of government are subject to the provisions of the Charter of Rights and Freedoms.

Interpretation

The governing principles of the CHA are stated in fairly open-ended language. For

example, the general language of the Act's commitment to public administration could be interpreted as either allowing or prohibiting for-profit clinics and hospitals to operate within a single public payer system. Neither does the comprehensiveness principle eliminate interprovincial variation in coverage for procedures and treatments, though the more significant variations, such as coverage for pharmaceuticals, are in areas that lie outside the CHA.

Who decides?

The Act provides little guidance about who should determine what the principles of the CHA actually mean. No branch of the federal health care bureaucracy is specifically charged with defining and interpreting those principles. And this isn't inherently wrong: in many ways the provinces, as providers and managers of complex health care systems, are the real experts on the limits and capacities of a universal public health system. But under the Act, provinces are the object of standards rather than the setters of standards.

The federal government lacks the fundamental capacity and perhaps the political will to specify detailed benchmarks that the provinces need to meet to fulfill the principles of the Act. The federal government has made moves to increase its information capacity, creating the independent Canadian Institute for Health Information (CIHI) to help it monitor data such as wait times, the availability of health human resources, and provincial use of special funds provided by the federal government to deal with specific priorities. Federal standards may have some appeal in the name of national unity and equal entitlements, but given the differences between provinces in financial and human resources, and in the distribution and demographics of their populations, these would be very difficult to define and impose.

Non-negotiables

The portions of the CHA that are the least open to interpretation are the bans on user fees and extra billing by health care providers. Such fees are relatively easy to detect and the federal government has very little discretion in deciding whether the Act was violated or not. Perhaps not coincidentally, the enforcement of bans on user charges and extra billing is nondiscretionary. The federal government is obliged to deduct money from provincial transfers on a dollar-for-dollar basis, matching in penalties every dollar collected in user fees or extra billing in the province. This is the single largest category of penalties that have been applied in the history of the CHA. There is very little room for the provinces to experiment with user fees and extra billing, as failing to punish these infractions puts the federal government in direct violation of its own laws.

Enforcement

The federal government is ultimately responsible for the enforcement of the standards specified in the CHA. The ban on extra billing and user charges is easily the least flexible standard in the Act. Other violations are only really violations if the federal government says they are, and it has the discretion to impose penalties or not.

Before discretionary penalties can be applied, Health Canada has an obligation to consult with the province(s) in question on the perceived violation and potentially negotiate a compromise before resorting to withholding transfers.

Unpenalized violations

A brief look at allegations raised by Members of Parliament and media coverage of individual complaints (see Sujit Choudry, "Bill 11, The Canada Health Act and the Social Union: The Need for Institutions," Osgoode Hall Law Journal 2000;38:1)

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suggests that there are routine violations of the CHA principles that go unpunished, notably to the accessibility principle (long travel distances for treatment, availability of abortion services, wait lists and queue jumping), the portability principle (limits on coverage outside Canada and on reimbursement for services received in another province) and the comprehensiveness principle (removal of services from provincial plans, lack of coverage for fertility treatments and intensive therapies for autism). The federal Auditor General, for one, has noted the federal government's reluctance to strictly enforce standards or even collect the necessary information to judge the degree of provincial noncompliance. There is no reliable way to record routine violations of the CHA. A violation only really occurs when the federal government determines that a principle has been violated.

The result is considerable flexibility for the provinces under the CHA, because the enforcement mechanism is used at the federal government's discretion and the federal government has a political disincentive to aggressively enforce the standards of the Act.

Overriding constitutional requirements

Considerable legal effort has been spent examining how public interest litigation might be used to oblige the federal government to more fully enforce the standards of the CHA. The federal government does indeed have statutory obligations and the courts could potentially intervene to require the federal government to apply penalties for provincial violations of the CHA. If successful, such litigation would limit provincial flexibility, as CHA enforcement would no longer be a matter of federal discretion. Going directly after the provinces to force them to adhere to the standards of the CHA through litigation is less likely to be successful, as Canadian courts have demonstrated considerable reluctance to patrol the legalities of intergovernmental agreements and practices. Finally, the CHA, like all federal legislation, is subject to the standards of the Charter of Rights and Freedoms. If the principles in the CHA were challenged as unduly restricting provincial freedom to innovate in the delivery of health care services, a court could find the restrictions on individual liberty enacted by the CHA unconstitutional. This possibility has been most fully realized to date in the *Chaoulli* decision that the Québec ban on private insurance for medically necessary services was in violation of the Québec Charter. But it is only a small leap from there to a similar challenge under the federal Charter against the CHA's requirement of public administration.

A generous interpretation of the Charter rights to security of the person might challenge the constitutionality of the CHA's principles and open up considerably more room for provincial variation. On the other hand, the Charter's right to equality could be invoked to reinforce the accessibility and comprehensiveness principles of the CHA and effectively limit provincial flexibility in deciding the range of services offered by the public health system and the access different populations have to those services.

Recourse to the courts on any basis could also have unforeseen consequences. Decisions like *Chaoulli* that appear to open up the system to greater privatization might alienate governments and public opinion. Canada has consistently high public support for universal health care. If judicial decisions seem to threaten the basis for publicly provided health care, they just might provide the federal government with the apparently missing political will to more aggressively enforce CHA standards. ■