THE REGULATION OF PRIVATE HEALTH CARE UNDER THE *CANADA HEALTH ACT* AND THE CANADIAN *CHARTER*

Martha Jackman

INTRODUCTION

Like most aspects of the modern Canadian welfare state, the publicly funded health care system is under ever increasing strain. Canadians' near universal equation of health with access to medical services in the event of illness, the emphasis on the delivery of services by physicians and in-hospital settings, growing health insurance plan and hospital revenue shortfalls, and the pressure on governments to reduce spending, have contributed to the current situation.[1] These problems have in turn fuelled renewed debate over the merits of the national medicare system, with some commentators suggesting that the *Canada Health Act*[2] and the system as a whole need to be overhauled to allow for more private activity and greater competition in the delivery of services.[3]

Successive federal health ministers have, however, held firm in their defence of the existing single-payer model, and have threatened to cut federal transfers to provinces sanctioning practices perceived to be at odds with the *Canada Health Act* principles of accessibility and universality. Most recently, the federal government's determination to forestall any movement towards a two-tier health care system has prompted Health Minister Diane Marleau to threaten to penalize Alberta and British Columbia for permitting extra-billing and the operation of private health clinics in those provinces. In Marleau's words: "Canadians do not want cash-register medicine — with or without an express line."[4]

Against this background, the following comment will consider what legislative or constitutional limits now exist on governments' ability to regulate private, or for-profit, health care in Canada. To this end, the paper will first describe the evolution of the Canadian health care system from an essentially private to a largely public one over the past fifty years. Second, it will discuss the *Canada Health Act* and its impact on the provision of private health care services. Third, it will consider whether governments can restrict the provision of private health services if a right to health care is recognized under section 7 of the *Canadian Charter of Rights and Freedoms*.[5] On the basis of this review, the paper will conclude that, regardless of whether a *Charter* right to health is found, the major constraint on governments' ability to restrict private health care services is a political rather than a legal one.

THE EVOLUTION OF THE NATIONAL HEALTH INSURANCE SYSTEM

In his book on the Canadian health insurance system,[6] Malcolm Taylor describes the origins of the present system and the methods of paying physicians in the pre-medicare era:

> In private practice, prior to any form of prepayment, the medical practitioner billed his patients on a fee-for-service basis, taking into consideration the presumed "intrinsic" worth of the medical "act" and, in many cases, also the patient's ability to pay ... As the provincial medical associations became more involved with fee issues, their "tariff" committees developed standardized fee schedules as guidelines or "minimum sug-

gested fees" for an ever-increasing range of procedures.[7]

From the 1930s onwards, a growing number of commercial insurance companies introduced medical insurance policies, using these fee schedules as a basis for their indemnity rates. The private plans generally provided for reimbursement at less than the official tariff, and for a fixed deductible before the insurance took effect. During the same period, physicians came together in a number of provinces to introduce their own competing profession-controlled prepayment plans. Under these plans, in contrast to the commercial regimes, participating physicians accepted the plan's reimbursement as payment in full, so that subscribers effectively enjoyed 100 percent coverage.[8] As Taylor recounts, by the second world war, the Canadian medical establishment had fully approved the principles of health insurance. In 1943, the Canadian Medical Association formally endorsed the idea of a national health insurance plan, although it envisioned the role of government as limited to subsidizing the premiums of those who could not afford to make their own payments to the voluntary agencies.[9]

Thus, when the Royal Commission on Health Services, chaired by Justice Emmett Hall, was established in December 1960, the notion of health insurance as a means of facilitating individual access to health care was well established in Canadian thinking. As Taylor notes, by 1965 almost five million Canadians were insured to some degree under commercial insurance policies, and over 5.6 million were covered under physician-sponsored or approved plans.[10]

The *Report*[11] and Recommendations of the Hall Commission did not seriously question the insurance model as the appropriate vehicle for ensuring universal access to health care.[12] What was different in the Hall Commission recommendations was the proposal that administration of health insurance plans be taken over from the private sector by provincial governments, and that the plans be fully and universally subsidized by federal and provincial governments, rather than paid for through individual subscriptions.[13]

The Hall Commission recommendations for the creation of a government sponsored national health insurance plan, meeting conditions of comprehensiveness, universality, public administration and portability, were implemented in the national *Medical Care Act* which came into force in December 1966.[14] All of the provinces and territories adopted health insurance plans, meeting the conditions of the *Medical Care Act*, and thereby became eligible for federal financial contributions over the next six years. In order to do so, each of the provinces displaced pre-existing physician-sponsored or private insurance plans, although an effort was made in some provinces to integrate non-profit plans into the new system.[15]

In essence, the Hall Commission and the *Medical Care Act* entrenched a national public health care system based upon a private insurance model. All Canadians became policy holders in a nationalized health insurance plan, with premiums paid through the tax system instead of directly, and with a general assumption that services would continue to be provided by individual physicians who would simply be reimbursed by the provinces instead of by profession-controlled or commercial insurers. Physicians also expected that they would continue to be reimbursed on a fee-for-service basis, at tariffs set largely by them, thereby preserving a significant degree of professional and economic independence from governments — now occupying the dual role of regulator and insurer.

THE *CANADA HEALTH ACT* AND ITS IMPACT ON THE PROVISION OF PRIVATE HEALTH CARE SERVICES

In principle, the *Medical Care Act* and the *Hospital Insurance and Diagnostic Services Act*,[16] its companion legislation in relation to hospital services, had established a system of free and universal health care throughout Canada by the early seventies. By the early 1980s, however, extra-billing by physicians and the imposition of user fees by hospitals had become widespread. These practices were viewed by the federal government and by the public alike as threatening the basic principle that all Canadians should have access to the health care system, irrespective of individual ability to pay. In 1984, the federal government responded by enacting the *Canada Health Act*, which added the criteria of "accessibility"[17] to pre-existing federal requirements that provincial health insurance plans be comprehensive,[18] universal,[19] portable,[20] and publicly administered,[21] in order to be eligible for federal cash contributions.[22]

The accessibility criterion under section 12 of the *Act* was designed to eliminate extra-billing by physicians and the imposition of hospital user charges. Provinces which allowed such practices were, by virtue of section 18 (with respect to extra-billing)[23] and section 19 (with respect to user charges),[24] disentitled to receipt of the full federal cash contribution towards provincial health insurance costs pursuant to the *Established Programs Financing Act*.[25]

What the *Canada Health Act* prohibits, therefore, is not the provision of private health care services *per se*. Rather the provinces are prevented, under threat of losing federal funds, from permitting health care providers to bill patients directly for amounts over and above what they receive for such services under provincial health insurance plans. Similarly, hospitals may not be allowed to impose outpatient fees, or other user charges, directly on patients for use of insured hospital services.

In short, the *Canada Health Act* does not regulate health care providers directly, but simply dictates the terms upon which federal cash transfers to the provinces will occur. As such, the legislation does not prevent private, or for-profit, institutional providers from delivering, and being reimbursed for, provincially insured health services, so long as extra-billing of patients is not involved. Nor does the *Act* prevent the provinces from allowing private health care providers, whether individual or institutional, to operate outside the state subsidized health care system.

That is, health care providers may opt out of provincial health insurance plans altogether, and bill patients directly for the full cost of services provided, without any penalty being imposed on the province under section 18 of the *Act*. In these cases patients must also be ineligible for reimbursement under provincial health insurance plans, in order to avoid the ban on extra-billing under section 18. Finally, the *Canada Health Act* does not preclude private insurers from supplementing provincial health insurance plans, by insuring supplementary or non-insured services at an additional cost to the subscriber.

THE *CHARTER* AS A BARRIER TO GOVERNMENT LIMITS ON PRIVATE HEALTH SERVICES

As discussed above, the provision of private, or for-profit, services is permissible under the current legislative framework so long as it does not amount to extra-billing. The question which remains is whether the *Charter* places any limits on governments' ability to impose further restrictions, or even to prohibit altogether, the provision of private health care in Canada.

Aside from the statutory conditions of accessibility and universality set out under the *Canada Health Act*, a credible claim can be made that section 7 of the *Charter* guarantees a constitutional right to health care. In practical terms, a right to life and to security of the person is meaningless without access to health care, both in a preventive sense, and in the event of acute illness. The Law Reform Commission of Canada recognized this in suggesting, in its Working Paper on *Medical Treatment and Criminal Law*, that "the right to security of the person means not only protection of one's physical integrity but the provision of necessaries for its support."[26]

With the advent of medicare, Canadian citizens and Canadian governments alike have come increasingly to perceive free and universal health care as a basic right of citizenship.[27] As Justice Wilson stated in her decision in *Stoffman v. Vancouver General Hospital*: "...government has recognized for some time that access to basic health care is something no sophisticated society can legitimately deny to any of its members."[28] An interpretation of the section 7 right to "life, liberty and security of the person" that includes a right to health care reflects the broader social context in which the *Charter* was adopted — the background against which the Supreme Court has argued the *Charter* must be understood.[29] This reading of section 7 is also consistent with, and to some extent dictated by,[30] Canada's extensive international human rights commitments in the area of social and economic rights, including in the area of health.[31]

If the argument that section 7 of the *Charter* guarantees a right to health is accepted, however, it is unlikely to entail more than an individual right to

basic and medically necessary care. In other words, the right, if it is found to exist, is likely to extend only to the actual person whose life, liberty or security of the person is threatened by a deprivation of care, and not to the individual or institution seeking to provide the care which is sought. Furthermore, and particularly in light of the accessibility and comprehensiveness of the current public system, it is unlikely that a right to health care would be read so expansively as to entitle an individual to demand unlimited freedom of access to services or to choice of providers, free from any restrictions. In other words, it is unlikely that section 7 could be successfully invoked to challenge existing provisions of the *Canada Health Act*, or to challenge further restrictions on access to private health care services, on the grounds that such restrictions amount to a deprivation of the right to health care.

Supreme Court jurisprudence also suggests that *Charter* rights of institutional providers of private health care services will be limited. In its decision in *Irwin Toy Ltd. v. Québec (A.G.)*, the Supreme Court held that section 7 of the *Charter* protects only the rights of human beings, and not of corporate and other artificial entities.[32] Based on a reading of the legislative history of section 7, the Court also rejected the claim that property-related rights, or economic rights of a corporate/commercial nature, are entitled to constitutional protection.[33] It is therefore unlikely that institutional providers of private health care service will enjoy independent constitutional protection. Thus it can be imagined that government restrictions or outright prohibitions of for-profit activities by institutional providers of private health care services would be constitutionally unobjectionable.

In the case of individual providers of private health services, potential *Charter* claims also appear weak. In *Wilson v. Medical Services Commission*,[34] the appellants challenged the validity of the British Columbia *Medical Services Act Regulations*,[35] which enabled the province to restrict the type and geographic locations of doctors' practices covered by the provincial health insurance plan, through the allocation of practitioner billing numbers. In its decision, the British Columbia Court of Appeal invalidated the B.C. regulations on the grounds that "denying doctors the opportunity to pursue their profession falls within the rubric of 'liberty' as that word is used in section 7."[36] In response to the suggestion that the appellant's claim involved a purely economic interest, the Court of Appeal maintained: "[d]enial of the right to participate under the plan is not the denial of a purely economic right, but in reality is a denial of the right of the appellants to practise their chosen profession within British Columbia."[37]

The soundness of the Court of Appeal's conclusion in the *Wilson* case was put into doubt by Justice Lamer's concurring judgment in *Reference Re ss. 193 and 195.1(1)(c) of the Criminal Code*.[38] In his decision, Justice Lamer argued that while the non-economic or non-pecuniary aspects of work are important to the individual, the rights under section 7 do not extend to the right to exercise one's chosen profession.[39] On the basis this reasoning, in contrast to the Court of Appeal's approach in *Wilson*, restrictions imposed by governments on the ability of individual health care providers, whether physicians or otherwise, to provide private health care services would not be subject to section 7 review.

Even if claims on behalf of individual or institutional providers of private health care services were to succeed under section 7, it would remain open to the government to attempt to justify any deprivation of these rights under section 1 of the *Charter*. In *McKinney v. University of Guelph*,[40] Justice LaForest suggested that the courts should apply the *Oakes*[41] test with a greater degree of circumspection in areas outside the field of criminal law, where legislative decisions are based on "a mix of conjecture, fragmentary knowledge, general experience and knowledge of the needs, aspirations and resources of society, and other components."[42] Citing his decision in *R. v. Edwards Books and Art Ltd.*,[43] Justice LaForest also proposed that where, in attempting to protect the rights of one group the legislature imposes burdens on the rights of another, it "must be given reasonable room to manoeuvre to meet these conflicting pressures."[44]

In order to justify restrictions on the section 7 rights, if any, of individual and institutional providers of private health care services, it would therefore be open to the government to argue that maintenance of a single-payer system is necessary in order to safeguard the integrity of the existing Canadian health care system. This argument was made at length in debates preceding the adoption of the *Canada Health Act*,[45] and support for it can also be found in more recent discussions on this issue, which reject the privatization of health care as a threat to the preservation of a high quality and universally accessible

health care system for all Canadians, irrespective of individual ability to pay.[46] As Justice LaForest's reasoning in the *McKinney* case suggests, given the complexities and the difficult balancing of competing public and private interests involved in this area, it is likely that the courts will grant governments considerable latitude in reviewing their health policy choices under section 1.

CONCLUSION

In conclusion, although it can be argued that section 7 of the *Charter* includes a right to health care, it is unlikely that the courts would interpret such a right as extending constitutional protection to those seeking to provide services unhindered by government regulation. It would therefore be open to the provinces, pursuant to their jurisdiction in relation to health under sub-sections 92(7), (13) and (16) of the *Constitution Act, 1867*,[47] to restrict or to entirely prohibit the provision of private health care services.[48]

It would be difficult for the federal government to support similar, direct, legislative restrictions on providers of private health care services under the federal peace, order and good government power.[49] However, pursuant to its spending power, the federal government could attempt to achieve this result by modifying the terms of the *Canada Health Act*.[50] In the same way as it now requires that provincial health insurance plans be comprehensive, universal, portable, publicly administered and accessible, the federal government could insist that the provinces prohibit private health services as a condition for receiving federal financial support towards provincial health insurance plans.

As described in the first part of the paper, the creation of a national, state sponsored, health insurance regime in the late 1960s illustrates the federal and provincial governments' ability to regulate, even to the point of eliminating, private health services. As in the case of the *Canada Health Act*, adopted two decades later, the primary obstacle facing governments in their regulation of private health services remains a political, and not a legal, one. Those who believe that maintaining the current single-payer system is fiscally irresponsible, poor health policy, or contrary to the health interests of Canadians, will therefore have to look beyond the *Charter* for support for greater privatization of the Canadian health care system.❑

Martha Jackman
Associate Professor, Faculty of Law, University of Ottawa. An earlier version of this paper was prepared for the Canadian Bar Association Health Care Task Force in April, 1994. The author wishes to thank Ruth Sullivan for helpful comments.

Endnotes

1. See for example Canadian Bar Association Task Force on Health Care, *What's Law Got To Do With It? Health Care Reform in Canada* (Ottawa: Canadian Bar Association, 1994); Royal Commission on New Reproductive Technologies, *Proceed With Care: Final Report of the Royal Commission on New Reproductive Technologies*, Volume 1 (Ottawa: Ministry of Government Services Canada, 1993) at 75-84; P.M. Leslie, "Financing Health Care and Post-Secondary Education" in S. Torjman, ed., *Fiscal Federalism for the 21st Century* (Ottawa: The Caledon Institute of Social Policy, 1993) 27; Canada, House of Commons, Standing Committee on Health and Welfare, Social Affairs, Seniors and the Status of Women, *The Health Care System in Canada and its Funding: No Easy Solutions* (Ottawa: Queen's Printer, June 1991) (Chair: B. Porter); National Council of Welfare, *Funding Health and Higher Education: Danger Looming* (Ottawa: Supply and Services Canada, 1991); National Council of Welfare, *Health, Health Care and Medicare* (Ottawa: Supply and Services Canada, 1990).

2. R.S.C. 1985, c. C-6.

3. See for example R. Sutherland & J. Fulton, *Spending Smarter and Spending Less: Policy and Partnerships for Health Care in Canada* (Ottawa: Canadian Hospital Association Press, 1994) at 319-24; and the essays collected in A. Blomqvist & D.M. Brown, eds, *Limits to Care: Reforming Canada's Health Care System in an Age of Restraint* (Vancouver: C.D. Howe Institute, 1994).

4. M. Kennedy, "Minister fines B.C. to stop extra-billing" *The Ottawa Citizen* (27 April, 1994) A1, A12; see also S. Feschuk, "Marleau renews threat to Alberta" *Globe and Mail* (29 November, 1994) A1, A12.

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

6. M.G. Taylor, *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System and their Outcomes*, 2d ed. (Montreal/Kingston: McGill-Queen's University Press, 1987). See also C.D. Naylor, *Private Practice: Canadian Medicine and the Politics of Health Insurance 1911-1966* (Montreal/Kingston: McGill-Queen's University Press, 1986); D. Guest, *The Emergence of Social Security in Canada*, 2d ed. rev'd (Vancouver: University of British Columbia Press, 1985); A. Crichton & D. Hsu, *Canada's Health Care System: Its Funding and Organization* (Ottawa: Canadian Hospital Association Press, 1990) at 27-48.

7. Taylor, *Health Insurance and Canadian Public Policy*, *ibid.* at 436.

8. Taylor, *ibid.* at 435-436; Naylor, *Private Practice*, *supra* note 6 at 143-152.

9. Taylor, *ibid.* at 334-35.

10. *Ibid.* at 336-37.

11. Canada, *Report of the Royal Commission on Health Services* (Ottawa: Queen's Printer, 1964) (Chair: E.M. Hall).

12. As Taylor recounts, the Canadian Labour Congress was the only group to squarely address the insurance issue. It its brief to the Hall Commission the CLC argued that while the prepayment plans had been useful, they were simply a convenient technique for the budgeting of health care costs. The CLC insisted that the real issue was Canada's health care system, which should be thought of as a public service, and not simply as an insurance mechanism; Taylor, *Health Insurance and Canadian Public Policy*, *supra* note 6 at 358.

13. *Ibid.* at 342-47.

14. S.C. 1966-67, c. 64.

15. Taylor, *Health Insurance and Canadian Public Policy*, *supra* note 6 at 374-376.

16. S.C. 1957, c. H-8.

17. Under section 12 of the *Act*, "accessibility" means reasonable access to services on uniform terms and conditions, unimpeded by direct or indirect charges or otherwise.

18. Under section 9 "comprehensiveness" means coverage of all insured health services provided by hospitals, medical practitioners, dentists, and where permitted, by other health care practitioners.

19. Under section 10 "universality" means universal entitlement to services on uniform terms and conditions.

20. Under section 11 "portability" means a maximum provincial waiting period of three months, and coverage during such waiting periods and during temporary absences from a province.

21. Under section 8, "public administration" means by a public non-profit authority designated by and responsible to the province, and subject to audit. Subsection (2) authorizes the provinces to designate a non-governmental agency to receive amounts payable under the provincial health insurance plan, or to carry out any responsibilities in connection with the receipt or payment of accounts rendered for insured services.

22. For a general discussion of the *Act*, see Health and Welfare Canada, *Canada Health Act Annual Report 1992-1993* (Ottawa: Minister of Supply and Services, 1993); Taylor, *Health Insurance and Canadian Public Policy*, *supra* note 6 at 415-62; S.L. Martin, *Women's Reproductive Health, the Canadian Charter of Rights and Freedoms, and the Canada Health Act* (Ottawa: Canadian Advisory Council on the Status of Women, 1989) at 14-34; Guest, *The Emergence of Social Security in Canada*, *supra* note 6 at 227-29.

23. Section 18 of the *Act* provides: "In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, no payments may be permitted by the province for that fiscal year under the health care insurance plan of the province in respect of insured health services that have been subject to extra-billing by medical practitioners or dentists."

24. Section 19 of the *Act* provides: "(1) In order that a province may qualify for a full cash contribution referred to in section 5 for a fiscal year, user charges must not be permitted by the province for that fiscal year under the health care insurance plan of the province. Sub-section (2) makes an exception for user charges for patients in institutional chronic care.

25. *Fiscal Arrangements and Federal Post-Secondary Education and Health Contributions Act* (*Established Programs Financing Act*), R.S.C. 1985, c. F-8. Section 20 of the *Canada Health Act* provides for a deduction from the federal cash transfer to a province of an amount equal to the amount charged to patients in the province through extra-billing or through hospital user fees.

26. Law Reform Commission of Canada, *Medical Treatment and Criminal Law* (Ottawa: Supply and Services Canada, 1980) at 6.

27. The evolution of Canadians' attitudes towards the health care system are described in Naylor, *Private Practice, Public Payment*, *supra* note 6; Taylor, *Health Insurance and Canadian Public Policy*, *supra* note 6; and Guest, *The Emergence of Social Security in Canada*, *supra* note 6; and see also M. Bégin, *Medicare, Canada's Right to Health* (Montreal: Optimum Publishing, 1988).

28. [1990] 3 R.S.C. 483 at 544.

29. For an extended discussion of the claim that section 7 of the *Charter* guarantees social welfare rights, including the right to health care, see M. Jackman, "The Protection of Welfare Rights Under the *Charter*" (1988) 20 *Ottawa L.Rev.* 257; see also I. Johnstone, "Section 7 of the Charter and Constitutionally Protected Welfare" (1988) 4 *J.L. & Social Pol'y* 33.

30. The Supreme Court of Canada has held that the *Charter* should be read in a manner consistent with Canada's international human rights obligations; see

for example *Slaight Communications v. Davidson* [1989] 1 S.C.R. 1038 at 1056-1057.

31. Paragraph 1 of Article 25 of the *Universal Declaration of Human Rights* (U.N.G.A. Res. 217 (III), 3 U.N. GAOR, Supp. (No. 13) 71, U.N. Doc. A/810 (1984)), endorsed by the members of the United Nations General Assembly including Canada in 1948, provides that "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including ... medical care ..." Article 12(1) of the *International Covenant on Economic, Social and Cultural Rights* (Annex to G.A. Res. 2200A, 21 U.N. GAOR, Supp. (No. 16) 49, U.N. Doc. A/6316, (1966)), ratified by Canada in 1976 after lengthy discussions with the provinces, recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". Article 12(2)(d) of the *Covenant* sets out States Parties' obligations to take all steps necessary for "The creation of conditions which would assure to all medical service and medical attention in the event of sickness." See generally Jackman, "The Protection of Welfare Rights Under the *Charter*", *supra* note 29 at 283-290; C. Scott, "The Interdependence and Permeability of Human Rights Norms: Towards a Partial Fusion of the International Covenants on Human Rights" (1989) 27 *Osgoode Hall L.J.* 769.

32. [1989] 1 S.C.R. 927 at 1004.

33. *Ibid.* at 1003-04.

34. (1988), 53 D.L.R. (4th) 171 (B.C.C.A.).

35. C.R.B.C. 1985, Reg. 144/68, adopted pursuant to the *Medical Services Act Amendment Act, 1985*, S.B.C. 1985, c. 39.

36. *Supra* note 34 at 189.

37. *Ibid.* at 187.

38. (1990), 109 N.R. 81 (S.C.C.).

39. *Ibid.* at 131, 143.

40. [1990] 3 S.C.R. 229.

41. *R. v. Oakes*, [1986] 1 S.C.R. 103.

42. *Supra* note 40 at 304-05.

43. [1986] 2 S.C.R. 713.

44. *Ibid.* at 795.

45. See for example E.M. Hall, *Canada's National Provincial Health Program for the 1980's* (Ottawa: Health and Welfare Canada, 1980) discussed in Taylor, *Health Insurance and Canadian Public Policy*, *supra* note 6 at 430; Bégin, *Medicare, Canada's Right to Health*, *supra* note 27; National Council of Welfare, *Medicare: the Public Good and Private Practice* (Ottawa: Supply and Services Canada, 1982); R.G. Evans, *Strained Mercy: The Economics of Canadian Health Care* (Toronto: Butterworths, 1984).

46. See for example Bégin, *Medicare, Canada's Right to Health*, *ibid.*; Royal Commission on New Reproductive Technologies, *Proceed With Care*, *supra* note 1 at 70-106; Canadian Hospital Association, *An Open Future: A Shared Vision* (Ottawa: Canadian Hospital Association Press, 1993); Standing Committee on Health, *The Health Care System in Canada and its Funding*, *supra* note 1 at 31-32; National Council of Welfare, *Health, Health Care and Medicare*, *supra* note 1.

47. (U.K.), 30 & 31 Vict., c. 3.

48. For a discussion of the federal-provincial division of powers in the field of health see generally M. Jackman, "The Constitution and the Regulation of New Reproductive Technologies" in *Overview of Legal Issues in New Reproductive Technologies*, Volume 3 of the Research Studies of the Royal Commission on Reproductive Technologies (Ottawa: Supply and Services Canada, 1993) at 3-18; A. Lajoie & P.A. Molinari, "Partage constitutionnel de compétences en matière de santé au Canada" (1978) 56 *Can. Bar Rev.* 579; R. T. McKall, "Constitutional Jurisdiction Over Public Health" (1975) 6 *Man. L.J.* 317.

49. For a discussion of the peace, order and good government power as a source of federal jurisdiction in the field of health, see Jackman, "The Constitution and the Regulation of New Reproductive Technologies", *ibid.* at 4-7; M. McConnel & L. Clark, "Abortion Law in Canada: A Matter of National Concern" (1991) 14 *Dalhousie L.J.* 81; J. Leclair, "La Théorie des dimensions nationales: une boîte à phantasmes: *Canada (Procureur Général) c. R.J.R.-MacDonald Inc*" (1993) 72 *Can. Bar Rev.* 524.

50. The argument that the *Canada Health Act* could not be supported under the federal spending power was rejected by the Alberta Court of Appeal in *Winterhaven Stables Ltd. v. Attorney General of Canada* (1988), 53 D.L.R. (4th) 413; leave to appeal refused [1989] 1 S.C.R.