POGG as a Basis for Federal Jurisdiction over Public Health Surveillance

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Introduction

In the aftermath of Severe Acute Respiratory Syndrome (SARS) and with concern growing about avian flu, mad cow, and other emerging diseases, public health surveillance has become a matter of importance to Canadians. Such surveillance is a key component of the fight against these diseases; it involves the systematic collection, analysis, interpretation, and dissemination of data about health-related events for use in public health responses. Indeed, new technologies enable "data mining" at an unprecedented scale, both in the amount and type of information that can be collected, and in the extent to which that information can be used to identify public health concerns. All this has made the concept of "anonymous" information less and less realistic.

Laws are needed to govern the collection, use, and disclosure of personal health information. The question at issue is whether or not the federal government has the jurisdiction to legislate in this area. This article will argue that it does. After first providing an overview of the history of public health regulation in Canada, the article will identify different constitutional bases for federal jurisdiction. It will focus in particular on the national concern branch of the "Peace, Order, and Good Government" (POGG) power to justify federal involvement in the field of public health surveillance.

Public Health – An Overview

Defining Public Health

The concept of "public health" has not been explicitly defined in any Canadian legislation or case law. A 2003 report published by Health Canada's National Advisory Committee on SARS and Public Health (the Naylor Report) defines public health as "the science and art of promoting health, preventing disease, prolonging life and improving quality of life through the organized efforts of society."[1] The report emphasizes two elements: "the prevention of disease, and the health needs of the population as a whole."[2] This description of public health has also been adopted by the Canadian Public Health Association.[3] Similarly, the federal *Department of Health Act* describes the Minister's public health mandate as one of "the promotion and preservation of the physical, mental and social well-being of the people of Canada . . . the protection of the people of Canada against risks to health and the spreading of diseases . . . [and] the investigation and research into public health, including the monitoring of diseases."[4]

On this basis, public health is perhaps best described as the practice of developing measures to prevent illness and promote the general health of the entire population. This is to be contrasted with "health care," which is more curative in approach and focuses on treating the particular ailments of an individual. Public health can cover a wide range of efforts to keep Canadians healthy as well as efforts to relieve pressure on health care systems. These include

such measures as immunization, infection control, emergency preparedness and response, disease detection, surveillance, laboratory testing, and regulations to support these and other public health activities.[5] Depending on the circumstances, these activities could fall within either federal or provincial jurisdiction, or in some cases both. Jurisdiction, of course, is determined in accordance with the federal division of powers set out in the *Constitution Act, 1867*.[6] Under the Constitution, public health matters of a local nature, including city drinking water safety, school health checks, private workplace safety, and immunization fall within provincial jurisdiction. In turn, provinces frequently delegate these powers to municipalities.

Constitutional Support for a Federal Role

Traditional provincial jurisdiction over health-related matters

A key reason why public health has been so difficult to define, particularly from a constitutional standpoint, is that it did not exist as a concrete concept at the time of Confederation. The attempt to find constitutional support for federal jurisdiction over public health surveillance is further complicated by the fact that courts have traditionally assigned jurisdiction over many health-related matters to the provinces. One example is the Supreme Court decision in *Schneider v. The Queen*, where the appellant argued that British Columbia's *Heroin Treatment Act*[7] (which provided for compulsory treatment and detention of heroin users) was *ultra vires* the provincial legislature. In dismissing the appeal, Justice Dickson stated for the majority: "the view that the general jurisdiction over health matters is provincial (allowing for a limited federal jurisdiction either ancillary to the express heads of power in s. 91 or the emergency power under peace, order and good government) has prevailed and is now not seriously questioned."[8]

The basis for provincial jurisdiction over health matters is tied largely to the power of the provinces pursuant to the *Constitution Act, 1867* to legislate in relation to "The Establishment, Maintenance and Management of Hospitals," as well as to "Generally all Matters of a merely local or private Nature in the Province."[9] There is evidence indicating that in 1867 health was viewed primarily as a matter of private or local interest, with most people depending primarily on their families, neighbours, charities or religious institutions for care in times of illness.[10] Few institutionalized health services were delivered by the state, and the administration of public health was at a primitive stage. This was clearly recognized by The Royal Commission on Dominion-Provincial Relations in 1938:

> In 1867 the administration of public health was still in a very primitive stage, the assumption being that health was a private matter and state assistance to improve or protect the health of the citizen was highly exceptional and tolerable only in emergencies such as epidemics, or for purposes of ensuring elementary sanitation in urban communities. Such public health activities as the state did undertake were almost wholly a function of local and municipal governments. It is not strange, therefore, that the British North America Act does not expressly allocate jurisdiction in public health, except that marine hospitals and quarantine (presumably ship quarantine) were assigned to the Dominion, while the province was given jurisdiction over other hospitals, asylums, charities and eleemosynary institutions.[11]

Over time, health matters have come to adopt an increasingly public role in Canada. Correspondingly, the courts have come to hold that provinces possess jurisdiction to legislate over such public health-related matters as sanitation and prevention of the spread of communicable diseases.[12] Provinces have exercised this jurisdiction to engage in such activities as health surveillance, outbreak investigation, quarantine, isolation and mandatory health treatment.[13] Each province has its own public health legislation regulating these activities.

Recognition of federal jurisdiction over health

Despite this traditional provincial jurisdiction over health-related matters, courts have also recognized a federal role in those aspects of public health that are national in scope. The Supreme Court has on different occasions held that the federal government can legislate on public health matters in its own right, even in fields

in which provinces have already legislated. In *Schneider*, for example, Justice Laskin referred to a legitimate field of public health regulation under the POGG power, "directed to protection of the national welfare."[14]

Also in *Schneider*, Justice Estey argued in favour of federal legislation in relation to health problems having a national rather than local dimension.[15] He pointed out that health "is an amorphous topic which can be addressed by valid federal or provincial legislation, depending on the circumstances of each case and on the nature or scope of the health problem in question."[16] Justice LaForest in *RJR-MacDonald Inc. v. Canada (Attorney General)* later added that the "amorphous" nature of health as a constitutional matter means "that Parliament and the provincial legislatures may both validly legislate in this area."[17]

Hence, even if the provinces have, to date, been the primary actors in such fields as public health surveillance and infectious disease control, the federal government retains jurisdiction to legislate in these fields. However, provinces are still likely to view the creation of any public health system as a form of encroachment on their traditional jurisdiction. It is essential, therefore, that such a system be grounded "on an incontrovertible constitutional foundation."[18]

There are a number of possible bases for federal authority over public health, including federal constitutional authority over criminal law, quarantine, spending, inter-provincial trade, and peace, order and good government.[19] Of these, the POGG power is probably the most helpful. Over a series of cases, courts have interpreted the POGG provision as having emergency, gap, and national concern branches.[20] The emergency branch has been interpreted to apply to temporary legislative measures enacted to address an emergency situation. The gap branch has been interpreted to apply to matters not contemplated at the time of Confederation, or inadvertently omitted from the *Constitution Act*, *1867*. It is the third branch, national concern, that is likely to lend the most support to a federal power in public health surveillance. This branch is described in more detail in the next section.

POGG – National Concern

Concern to the Nation

The national concern branch of the POGG power was analyzed by the Supreme Court in *R. v. Crown Zellerbach Canada Ltd*. In that case, the respondent argued that section 4(1) of the *Ocean Dumping Control Act*,[21] which applied to the dumping of waste in waters within a province, was *ultra vires* Parliament. In allowing the appeal, the Court held that section 4(1) is constitutionally valid as enacted in relation to a matter falling within the national concern doctrine of the POGG power.

The Court went on to elaborate that the national concern branch itself has two sub-elements. The first of these is that the power applies only to matters that are of concern to the nation, in other words, to matters that have attained such significant national dimensions as to warrant the granting of federal jurisdiction.[22] As acknowledged in *Crown Zellerbach*, this aspect of the national concern doctrine was first formulated by the Privy Council in *Attorney-General of Ontario et al. v. Canada Temperance Federation et al*.[23] That case examined the validity of the *Canada Temperance Act*,[24] which provided an option for municipalities to opt-in to a scheme for prohibition. The Court held that the true test was whether the matter was one of national concern and therefore supported by the POGG power:

> [T]he true test [in invoking POGG] must be found in the real subject-matter of the legislation: if it is such that it goes beyond local or provincial concern or interests and must from its inherent nature be the concern of the Dominion as a whole . . . then it will fall within the competence of the Dominion Parliament as a matter affecting the peace, order and good government of Canada, though it may in another aspect touch upon matters specially reserved to the Provincial Legislatures. War *and pestilence*, no doubt, are instances" [emphasis added].[25]

As can be seen, it was specifically suggested in *Canada Temperance Federation* that federal legislation in response to such public health matters as an epidemic of "pestilence" would

fall within the purview of the POGG national concern doctrine.[26] The case went so far as to state that federal legislation based on national concern in respect of pestilence or disease need not be limited to an emergency measure, but could also extend to a preventative measure:

> To legislate for prevention appears to be on the same basis as legislation for cure. *A pestilence has been given as an example of a subject so affecting, or which might so affect, the whole Dominion that it would justify legislation by the Parliament of Canada as a matter concerning the order and good government of the Dominion. It would seem to follow that if the Parliament could legislate when there was an actual epidemic it could do so to prevent one occurring and also to prevent it happening again*" [emphasis added].[27]

Canada Temperance Federation was also cited by the Supreme Court in *Schneider* to support its assertion that "federal legislation in relation to 'health' can be supported where the dimension of the problem is national rather than local in nature."[28]

Increasing national dimension of public health

According to *Crown Zellerbach*, matters falling within the national concern branch may be new, but they may also be "matters which, although originally matters of a local or private nature in a province, have since, in the absence of national emergency, become matters of national concern."[29] On this basis, it can be argued that in comparison to 1867, today's society is far more national or global than provincial, a change that is significant in the context of health risk, particularly the risk of infectious disease.

The increasing permeability of international borders and the changing nature of transportation methods have altered the potential impact of what were once considered merely local health problems. Globally, there were 715 million international tourist arrivals registered at international borders in 2002.[30] The volume, speed, and reach of contemporary travel did not exist in 1867; today, Canadians live within twenty-four hours of virtually any location on Earth. This time frame is shorter than the incubation period for many communicable diseases, which increases the likelihood of the transmission of infectious diseases via human migration. As the recent SARS crisis has illustrated, a local disease affecting China's Guangdong province may be very quickly carried by travellers from there to Hong Kong, and then to Vietnam, Singapore and on to Canada.[31]

The Naylor Report also points out that certain emerging infectious diseases are a new phenomenon of the late twentieth and twenty-first centuries. Over thirty previously unknown viral and bacterial diseases have emerged in recent decades including Ebola virus, Legionnaire's disease, HIV/AIDS, hepatitis C, variant Creutzfeldt-Jakob disease, avian flu, and West Nile virus.[32] These are diseases of international significance. There are also other new infectious disease trends threatening Canadians. Environmental changes such as global warming, deforestation, and water pollution have increased the incidence of Lyme disease, for example.[33] The new health risks posed by disease re-emergence, environmental change, and such factors as globalization and bioterrorism, have arguably altered the scope and response time expected of any health surveillance program.[34]

Various parliamentary and government bodies have begun to acknowledge the importance of an increased federal role in some areas of public health. Between 1999 and 2001, for example, the Standing Senate Committee on Social Affairs, Science and Technology studied the state of the Canadian health care system and the federal role in that system. In its subsequent multi-volume report (the Kirby Report), the Committee declared that the federal government has an important role to play in the fields of health protection, disease prevention, and health and wellness promotion. It also recommended that some of the objectives of the federal government in this area should be to:

(a) "strengthen our national capacity to identify and reduce risk factors which can cause injury, illness and disease, and to reduce the economic burden of disease in Canada"; and

(b) "encourage population health strategies by studying and discussing the health out-

> comes of the full range of determinants of health, encompassing social, environmental, cultural and economic factors."[35]

International and inter-provincial aspects of public health

Another factor making certain areas of public health a matter of national concern is Canada's recent assumption of international reporting commitments, cannot be met which unless the federal government has national jurisdiction over personal health information. The World Health Organization (WHO) has established International Health Regulations (IHRs)[36] laying out expectations for member states regarding surveillance, reporting, and outbreak management to help stem the spread of infectious diseases. IHRs emphasize the collection of national data regardless of internal boundaries and the establishment of a single contact point for data collection. Both factors support the case for federal jurisdiction.

In 1995, the World Health Assembly instructed the WHO Secretariat to begin the process of revising the IHRs. Following the SARS outbreak of 2003 and the 2004 epidemic of avian flu, this revision process was accelerated. In May 2005, the World Health Assembly finally approved a new set of IHRs to "prevent, protect against, control and provide a public health response to the international spread of disease."[37] These regulations provide member states with even broader obligations to build national capacity for routine preventive measures as well as to detect and respond to public health emergencies of international concern.[38] For example, the revised IHRs call for state parties to "utilize existing national structures and resources to meet their core capacity requirements under these Regulations, including with regard to…their surveillance, reporting, notification, verification, response, and collaboration activities."[39] The new regulations are to come into force 15 June 2007.

In this context, it is important to note that it is the federal government which has responsibility over treaty making. Moreover, the Supreme Court has held that where an international treaty stipulates that a policy matter straddles the divide between provincial and federal jurisdiction, the case for federal jurisdiction is stronger.[40] One prominent Canadian scholar of health law, Professor Dale Gibson, has suggested that the following two public health matters would fall "unquestionably" within the POGG (national concern) power:

> (a) "taking measures to prevent the spread of disease from one province to another"; and
>
> (b) "negotiation, implementation and enforcement within Canada of international treaties concerning health-related matters."[41]

Gibson authored an influential 1976 article in which he described the national concern branch of POGG,[42] and argued that the "national dimensions"[43] branch matters cover "beyond the ability of the provincial legislatures to deal with."[44] He also argued that where the matter at issue "requires the co-operative action of two or more legislatures, the 'national dimension' concerns only the risk of non-co-operation, and justifies only federal legislation addressed to that risk."[45] In fact, Gibson's approach to the national dimension branch of POGG was adopted by the majority of the Supreme Court in *Crown Zellerbach*, which remains the most comprehensive court review of the POGG power to date.

Single, Distinctive and Indivisible

The second sub-element of the national concern branch pursuant to *Crown Zellerbach* is that the matter at issue must have a "singleness, distinctiveness and indivisibility that clearly distinguishes it from matters of provincial concern."[46] According to the Court, in making this determination it is relevant to consider what the effect on extra-provincial interests of a provincial failure to deal effectively with the control or regulation of the "intra-provincial aspects of the matter" would be; this has come to be known as the provincial inability test.[47]

Impacts on other provinces

To satisfy the provincial inability test, it

must be shown that significant deleterious effects would result from the inability of the provinces to address a matter. This might occur in areas where the impact of policy both within and outside a province is linked, where a province cannot effectively regulate a policy area on its own, or where the failure of one province to regulate would affect the health of residents of another province.[48] All that is required is that the "provincial failure to deal effectively with the intra-provincial aspects of the matter *could* have an adverse effect on extra-provincial interests" [emphasis added].[49] Theoretically at least, federal jurisdiction in this context could even extend to a disease outbreak confined entirely to one province.

There is a strong argument to be made that infectious disease surveillance satisfies these requirements. As was noted in the Naylor Report, "if any province fails to contain an outbreak [of disease] efficiently, the results for all of Canada are devastating on multiple levels."[50] Even Ontario's SARS Commission in its Interim Report lamented the lack of federal-provincial cooperation in public health protection. The report states outright that, "[o]ne of the biggest problems during the Ontario SARS crisis was the inability of the federal and provincial governments to get their acts together."[51] The SARS Commission goes on to argue that "the evidence from SARS makes one thing crystal clear: the greatest benefit from new public health arrangements can be a new federal presence in support of provincial delivery of public health."[52] It also warns that, "[i]f a greater spirit of federal-provincial co-operation is not forthcoming in respect of public health protection, Ontario and the rest of Canada will be at greater risk from infectious disease and will look like fools in the international community."[53]

According to the Interim Report, "[p]roblems with the collection, analysis and sharing of data beset the effort to combat SARS." This "prevented the timely transmission from the Ontario Public Health Branch of vital SARS information needed by Ottawa to fulfill its national and international obligations."[54] This point is significant because federal-provincial or inter-provincial collective action problems are important indicia of provincial inability.[55] Hence, the failure of the federal and provincial governments to agree on an effective system of national surveillance supports an argument for federal jurisdiction over this field.

Every province and territory would benefit from more effective public health policy. This is especially true for provinces with populations smaller than those of even medium-sized cities around the world (e.g., Prince Edward Island, Newfoundland, and Saskatchewan), which may not be able to generate large enough sample sizes to produce meaningful research or identify significant health trends on their own. The relatively small population of Canada, and the preference this creates for a national approach to disease surveillance, was highlighted in a 2002 Health Canada Report,[56] which urged the creation of a single national database of personal health information on the basis that:

(a) it would allow for sensitivity to patterns that may emerge from the analysis of a large number of cases, but which may not be as evident when analysing a smaller number of cases within a province or territory;

(b) it is important in disease prevention to be able to "make comparisons between different regions of the country regarding ways [a disease] is transmitted between people, the types or symptoms of the disease and the effectiveness of different prevention or control programs";

(c) it would be a "cost-effective means of ensuring that all provinces and territories, and national agencies, have access to these services";

(d) differences exist across provinces in how they keep statistics, how they define health terms, and how they count cases, making it difficult to "aggregate provincial and territorial statistics into a national picture."[57]

Other benefits of a federally-run surveillance system

In contrast to the efforts of ten individual provinces, the larger scale of a national surveillance network may be more efficient and cost-effective. It would facilitate the sharing of

expertise and the accumulation of experience within a single network.[58] This in turn would make it more competitive in attracting the type of scientists needed for a world-class health protection system. It would also provide a focal point for Canada to manage health issues at its borders and to interact with the global community.[59] For example, the Naylor Report cites the example of observers who feel that Canadian officials failed to communicate adequately with officials in Hong Kong, Singapore and China during the SARS crisis, thus missing the opportunity to learn from foreign public health officials with relevant experience. This problem could have been more easily addressed had there been a national surveillance body to coordinate these efforts.

The increasing mobility of Canada's population also means that national record sharing is needed to ensure consistency of care. In this vein, the Naylor Report recommended a national surveillance system and argued that, "surveillance … should not only detect emerging health risks, but include systems that allow public health officials to monitor and evaluate progress in health protection and disease prevention."[60] Furthermore, the report of the Commission on the Future of Health Care in Canada recommended both public health programs that deal with epidemics and a national immunization strategy.[61]

Infectious vs. Chronic Diseases

At this point it is worthwhile to consider an important secondary question arising in the context of debate over the existence of federal jurisdiction over health surveillance particularly under the POGG "national concern" branch: is federal jurisdiction restricted to infectious disease, or can it also extend to chronic diseases such as cancer, diabetes, and heart disease? A look at the history of public health regulation in Canada seems to suggest that the original mission of public health was to protect against infectious disease. For example, one of the earliest pieces of public health legislation was an Act passed in 1833 in Upper Canada calling for the establishment of boards of health "to guard against the introduction of malignant, contagious and infectious diseases in this province."[62]

Distinction between infectious and chronic disease breaking down

There are important distinctions between infectious and chronic disease which explain why jurisdiction should extend only to the former in any federal public health system. For example, the threat from infectious disease is direct and immediate: "an outbreak of infectious disease, if not controlled, can bring a province and eventually the country to its knees within days or weeks, a threat not posed by chronic or lifestyle diseases."[63] Moreover, "infectious disease prevention requires an immediate overall response because it moves rapidly on the ground and spreads quickly from one municipality to another and from province to province and country to country, thus engaging an international interest."[64]

Nevertheless, many of the traditional distinctions between infectious and chronic disease are beginning to blur. This is due in part to the changing nature of our understanding of chronic disease. More and more chronic diseases are now understood to be caused by infections, or at least to have infection co-factors.[65] Furthermore, the ability to fight chronic disease is closely linked to the ability of a population to withstand the onslaught of infectious disease. Consider the fact that the very people already suffering from a chronic disease tend to be the ones at highest risk of contracting an infectious disease. This was aptly demonstrated during the SARS crisis, when most SARS victims were people already suffering from diabetes and other chronic diseases.[66]

Chronic disease a matter of increasing national concern [since 1867]

In the past 100 years, chronic disease has taken on an increased significance relative to infectious disease as a matter of national concern to Canadians. In the early 1900s, infectious disease was the leading cause of death in Canada; today, it account for only 5 percent of all deaths in Canada and many of those are of people (particularly the elderly) already afflicted with chronic disease.[67] Not only has chronic disease become the leading cause of death and disability in Canada, it also accounts for the largest

proportion of the economic burden of illness.[68] As the picture of health changes dramatically, governments should respond accordingly.

A number of government reports have also recommended increased federal involvement in public health regulation to counter chronic disease. For example, the Kirby Report recommends the establishment of a National Chronic Disease Prevention Strategy that would incorporate public education efforts, mass media programs, and so on.[69] The Naylor Report also recommended a national public health strategy addressing infectious disease, but also the "causes of chronic diseases and injuries."[70] In this regard, it is interesting to note that the U.S. Center for Disease Control and Prevention already has jurisdiction over chronic disease prevention and control.[71]

POGG – Gap and Emergency

Gap

In addition to the national concern branch, the POGG power also has gap and emergency branches that can also be analysed in the context of public health. The gap branch applies to matters not contemplated at Confederation, or to matters inadvertently omitted from the *Constitution Act, 1867*. Indeed, the success of any gap analysis will likely depend on how the public health surveillance issue is framed.

For example, an argument could be made that concerns such as the disease trends referred to earlier or the volume and extent of international travel today, as well as the corresponding need for an intricate and wide-ranging health information network, stem from phenomena not contemplated at Confederation. However, if the matter were framed as one concerning the collection, control and use of personal health information, then it would likely not be novel enough to qualify under the gap branch.

Emergency

The last branch of POGG is the emergency power. The emergency power has been referred to in the past to grant Parliament the jurisdiction to regulate inflation (on the grounds that it posed an economic threat to Canada).[72] This applies to powers exercised to address a national emergency. There are cases holding that epidemics or pestilence would likely constitute such an emergency.[73] However, the emergency power is temporary, applying only for the duration of the emergency.[74] It cannot, therefore, constitute the basis of either preventative or permanent federal legislation in the field of public health. It was for these reasons that the Naylor Report concluded that, "the emergency branch of the POGG power could not serve as the constitutional basis of mandatory reporting for a national surveillance system."[75]

Quarantine

Another federal power worth analyzing in greater detail is the quarantine power pursuant to section 91(11) of the *Constitution Act, 1867*. The scope of this power is unclear, for example, as to whether its application is only to ship's quarantine, to quarantine at entry into and exit from Canada, or to something broader.[76] An argument can be made that the power should be interpreted broadly today to reflect the changing norms of domestic and international travel referred to earlier.

There is also some suggestion that the federal quarantine power can be derived not only from the section 91(11) quarantine provision of the *Constitution Act, 1867*, but also from the POGG power itself. For example, in *Labatt Breweries v. Attorney General of Canada*, the Supreme Court commented that "Parliament can make laws in relation to health for the peace, order and good government of Canada: quarantine laws come to mind as one example."[77] On this basis, perhaps the quarantine power in conjunction with POGG can assist in compelling the collection of information not only at Canada's borders, but within Canada as well, pursuant to national surveillance legislation and policy.

Conclusion

Public health is an area of concurrent federal and provincial jurisdiction. Federal jurisdiction can be derived from different parts of

the Constitution, the most useful being the national concern branch of the POGG power. Public health matters are also becoming increasingly more national in scope in light of the changing scale and character of international travel, emerging disease trends, and ongoing treaty commitments. Federal control is further justified by existing challenges with respect to the coordination of data-sharing between provinces, and the increased efficiency afforded by centralized federal control.

As our understanding of the character of public health changes, so too should our interpretation of the Constitution evolve. Federal jurisdiction need not be restricted to infectious disease as the definitional line distinguishing it from chronic disease continues to blur. It must be stressed, however, that jurisdiction is limited to public health with a national scope, and will not include local and provincial public health matters. In the aftermath of SARS, public health surveillance will be essential to addressing future public health threats of national concern. The time is ripe for the federal government to draw upon its jurisdictional authority and regulate this practice.

Notes

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1 Canada, National Advisory Committee on SARS and Public Health, *Learning from SARS: Renewal of Public Health in Canada* (Ottawa: Health Canada, 2003) (Chair: Dr. David Naylor) at 46 [Naylor Report].

2 *Ibid.*

3 Canadian Public Health Association, *Public Health Goals for Canada* (Ottawa: Public Health Agency of Canada, 2004) at 1.

4 *Department of Health Act*, S.C. 1996, c. 8, s. 4(2)(a.1-c).

5 Public Health Agency of Canada, *2005-2006 Report on Plans and Priorities* (Ottawa: 2005), online: <http://www.phac-aspc.gc.ca/rpp-2005-06/> (last updated: 24 March 2005).

6 (U.K.), 30 & 31 Vict., c. 3, reprinted in R.S.C. 1985, App.II, No.5 (CanLII) [*Constitution Act, 1867*].

7 R.S.B.C. 1979, c. 166.

8 *Schneider v. The Queen*, [1982] 2 S.C.R. 112 at 138 (CanLII) [*Schneider*].

9 *Constitution Act*, *1867,* ss. 92(7) and (16).

10 Martha Jackman, "Constitutional Jurisdiction Over Health in Canada" (2000) 96 Health Law Journal 8 at 96.

11 Canada, Royal Commission on Dominion-Provincial Relations, *Report of the Royal Commission on Dominion-Provincial Relations* (Ottawa: J.O. Patenaude, Printer to the King, 1940) (Co-chairs: N.W. Rowell, J. Sirois).

12 Naylor Report, *supra* note 1 at 166.

13 *Ibid*.

14 *Schneider*, *supra* note 8 at 115.

15 *Ibid*. at 142.

16 *Ibid*. at 143.

17 [1995] 3 S.C.R. 199 at para. 32 (CanLII).

18 Nola M. Ries & Tim Caulfield, "Legal Foundations for a National Public Health Agency in Canada" (2005) 96 Canadian Journal of Public Health 4 at 282.

19 See respectively ss. 91(27) (Criminal Law), 91(11) (Quarantine and the Establishment and Maintenance of Marine Hospitals), 91(General) (powers of the Parliament), 91(2) (Trade and Commerce), and 91(Preamble) of the *Constitution Act, 1867.*

20 See e.g. *R. v. Crown Zellerbach Canada Ltd.*, [1988] 1 S.C.R. 401 [*Crown Zellerbach*].

21 S.C. 1974-75-76, c. 55.

22 *Crown Zillerbach*, *supra* note 20 at 422.

23 *Ibid*. at 423.

24 R.S., c. 152, s.1.

25 *Attorney-General of Ontario et al. v. Canada Temperance Federation et al*, [1946] 2 D.L.R. 1 at 5 [*Canada Temperance Federation*].

26 A pestilence has been defined as "a contagious or infectious epidemic disease that is virulent and devastating." See the *Merriam-Webster Dictionary*, 2005, *s.v.* "pestilence" online edition: <www.m-w.com>.

27 *Canada Temperance Federation, supra* note 25 at 7.

28 *Schneider*, *supra* note 8 at 142.

29 *Crown Zellerbach*, *supra* note 20 at para. 33.

30 Naylor Report, *supra* note 1 at 2.

31 *Ibid.* at 15.

32 *Ibid.*

33 Canada, Standing Senate Committee on Social Affairs, Science and Technology, *The Health of*

Canadians – The Federal Role, Volume 2: *Current Trends and Future Challenges* (Ottawa: 2002) (Chair: Michael Kirby) at 47 [Kirby Report, Volume 2].

34 Naylor Report, *supra* note 1 at 92.

35 Canada, Standing Senate Committee on Social Affairs, Science and Technology, *The Health of Canadians - the Federal Role*, Volume 4: *Issues and Options* (Ottawa: 2001) (Chair: Michael Kirby) at 23.

36 See generally *International Health Regulations* (1969), World Health Organization, online: <http://www.who.int/csr/ihr/en/> (last visited: 24 October 2005).

37 World Health Assembly, *Revision of the International Health Regulations*, WHA 58.3, 23 May 2005 [Revised IHRs], Article 2 (purpose and scope).

38 See e.g. *ibid*. Articles 4.1 (responsible authorities) and 10.1 (verification).

39 *Ibid*. Annex 1.

40 See generally *Ordon Estate v. Grail*, [1998] 3 S.C.R. 437; *Schneider*, *supra* note 8.

41 Dale Gibson, "The Canada Health Act and the Constitution" (1996) 4 Health Law Journal 1 at 20 [Gibson].

42 Dale Gibson, "Measuring National Dimensions" (1976) 7 Manitoba Law Journal 15.

43 The phrases "national dimensions," "national scope," and "national concern" have been used synonymously in the case law with respect to this branch of POGG.

44 Gibson, *supra* note 41 at 33.

45 *Ibid*.

46 *Crown Zellerbach*, *supra* note 20 at para. 33.

47 *Ibid*. at para. 35. As the Court explained: "It is because of the interrelatedness of the intra-provincial and extra-provincial aspects of the matter that it requires a single or uniform legislative treatment."

48 Kumanan Wilson et al., "Understanding the Impact of Intergovernmental Relations on Public Health: Lessons from Reform Initiatives in the Blood System and Health Surveillance" (2004) 30 Canadian Public Policy, at 191.

49 *Crown Zellerbach*, *supra* note 20 at para. 35.

50 Naylor Report, *supra* note 1 at 105.

51 Ontario, The SARS Commission, *SARS and Public Health in Ontario* (Toronto: 2004) (Commissioner: Hon. Mr. Justice Archie Campbell) at 163 [Interim Report].

52 *Ibid*.

53 *Ibid*.

54 *Ibid*. at 7.

55 See e.g. *Crown Zellerbach*, *supra* note 20 at para. 34.

56 Population and Public Health Branch Surveillance Coordination Committee, *Case Studies: Examples of Health Canada's Use of Personal Information for Health Surveillance and Research Activities* (Ottawa: Health Canada, 2002).

57 *Ibid.* at 35-48.

58 Federal/Provincial/Territorial Advisory Committee on Health Infostructure, *National Surveillance Networks for Chronic Disease in Canada: Charting a Path Forward* (Ottawa: 2001) at 10.

59 Canada, The Standing Senate Committee on Social Affairs, Science and Technology, *Reforming Health Protection and Promotion in Canada: Time to Act* (Ottawa: 2003) (Chair: Michael Kirby) at 19.

60 Naylor Report, *supra* note 1 at 92.

61 Canada, Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada* (Ottawa: 2002) (Commissioner: Roy Romanow) at 115.

62 Ontario, Association of Local Public Health Agencies, *Orientation and Reference Manual* (Toronto: 2004) at 1.

63 Interim Report, *supra* note 51 at 20.

64 *Ibid*.

65 Peptic ulcer disease, for instance, was recently found to be integrally linked to infection by the *Helicobacter pylori* bacteria. See *Naylor Report, supra* note 1 at 115-16.

66 Interim Report, *supra* note 51 at 199.

67 Kirby Report, Volume 2, *supra* note 33 at 45.

68 *Ibid*. at 46.

69 *Ibid*.

70 Naylor Report, *supra* note 1 at 81.

71 U.S., National Center for Chronic Disease Prevention and Health Promotion, *Mission Statement*, online: <http://www.cdc.gov/nccdphp/> (last updated: 6 October 2005).

72 *Reference re Anti-Inflation Act*, [1976] 2 S.C.R. 373 at 460 (CanLII) [*Anti-Inflation*].

73 See e.g. *Toronto Electric Commissioners v. Snider*, [1925] 2 D.L.R. 5 at 15-16; *Canada Temperance Federation et al.*, *supra* note 25.

74 See *Anti-Inflation, supra* note 72 at 460.

75 Naylor Report, *supra* note 1 at 168.

76 *Ibid*. at 169.

77 [1980] 1 S.C.R. 914 at 17.