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Jurisdictional, organizational and regulatory framework for health care delivery in Canada

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I. Jurisdictional issues

I.1 Canadian provinces have constitutional jurisdiction in the regulation of health care and health care professions and over labour and civil rights law within the scope of that jurisdiction.

I.2 The role of the federal (national) government in health care, labour law and civil rights is limited to areas within its constitutional jurisdiction, such as the regulation of some business like banks and airlines, as well as the management of the armed forces, RCMP and indigenous treaties and lands.

I.3 Occasionally the provinces and federal governments have overlapping constitutional jurisdictions that arguably permit both to act in almost identical ways. For example, the constitution authorizes only the federal government to impose quarantines, but similar restrictions have been imposed by provincial governments under states of emergency declared under provincial legislation.[1]

I.4 Some issues involve distinct federal and constitutional jurisdictions that require different responses from national and provincial governments. For example, exemptions to the criminal law to permit euthanasia and assisted suicide are exclusively within federal jurisdiction. However, provinces have the authority to regulate the practices within the parameters set by the criminal law.

I.5 The national government can use its criminal law power to prohibit procedures that might be asked of physicians or other health care workers. It has forbidden female genital mutilation,[2] and is now planning to prohibit some forms of "conversion therapy."[3] Subject to constitutional challenges, criminal legislation would override contrary provincial law.

I.6 On the other hand, the federal government has provided a legal vehicle for the coordinated national exercise of provincial jurisdiction in health care through the Medical Council of Canada (MCC), the creation of a federal statute.[4] The Council sets national standards for medical practice. To practise medicine in Canada, one must be qualified by the MCC and enrolled as a Licentiate in the Canadian Medical Register. This is constitutionally possible only because provincial governments passed complementary legislation to make the scheme effective and continue to cooperate in it.[5,6] MCC certification is necessary, but only

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provincial medical regulators can grant licences to practice.

I.7 Finally, as a practical matter, the federal government can use the power of the purse to influence provincial health care policy. Under the *Canada Health Act*, the national government can set minimum standards in health care delivery that provinces must meet in order to be eligible for federal financial support.[7]

II. Organization of health care professions

II.1 Medicine, nursing, midwifery and pharmacy are among the better-known self-regulated health professions. Each profession is publicly represented by incorporated provincial and national generalist associations, respectively exemplified by the Ontario Medical Association and Canadian Medical Association. Specialists have formed analogous provincial and national associations, like the Alberta College of Family Physicians and the College of Family Physicians of Canada. Medical, nursing, midwifery and pharmacy students have also formed associations.[8]

II.2 Provincial associations support professional development and practice. They act as unions representing their members to the public and in negotiations with provincial governments about fees, working conditions and health policy.[9] National associations also support professional development and practice, represent their professions in developing law and health policy and facilitate communication and cooperation among their provincial counterparts.

II.3 Professional associations have no power to regulate their members, and membership is voluntary. However, they have considerable impact on policy and practice because they develop technical and ethical standards for professional practice, including codes of ethics. The Royal College of Physicians and Surgeons and the College of Family Physicians are especially prominent in the accreditation of medical specialists and family practitioners respectively, and associations are deeply involved in the accreditation of other professional schools and educational programmes.[10]

III. Regulation of health care professions

III.1 General

III.1.1 Canadian health care regulators are established by legislation in each province. Medical, nursing, midwifery and pharmacy regulators are typical, but there can be many others — a total of 20 in British Columbia, for example.[11] They are typically identified as provincial "colleges" of physicians, nurses, etc., membership in which is mandatory.[12] They are legally required and empowered to maintain ethical, legal, and competency standards, provide professional guidance, investigate complaints against regulated professionals and impose remedial or disciplinary measures on those who fail or refuse to conform to the standards.[13]

III.1.2 Regulators may directly enforce ethical and practice standards developed by professional health care associations by formally recognizing or adopting standards or codes of ethics, verbatim or in modified form, or by making their accreditation a condition of licensure. They

may indirectly support association standards by recommending them as reliable resources. However, regulators can ignore or override those developed by professional associations in favour of standards they develop independently or those proposed by influential lobbyists.

III.1.3 Most colleges are governed by a board or council, function through committees, and are managed by a registrar and support staff. Boards/councils are usually comprised of members of the profession elected by their peers and public members appointed by the government. Board/council meetings are likely to be held three or four times annually. It appears that the actual exercise of a board/council's intended powers of governance depends upon the size of the college and profession, the scope of college activities, and the degree to which college operations are dominated by the registrar, college bureaucrats and key committee members.[14]

III.1.4 Regulatory authorities have jurisdiction only within their own provinces, but they can federally incorporate national organizations for the purpose of harmonizing their standards and pursuing policy goals. Examples include the National Association of Pharmacy Regulatory Authorities (NAPRA), the Canadian Council of Registered Nurse Regulators (CCRNR), the Federation of Medical Regulatory Authorities of Canada (FMRAC) and the Canadian Midwifery Regulators Council (CMRC). These organizations have no regulatory power, but their ability to influence public policy is considerable.

III.1.5 Regulators are subject to the *Canadian Charter of Rights and Freedoms* because they are government actors that provide the means for state control of professional practice. Their directives and guidance have the force of law, even if not enacted as regulations under their foundational statutes. Nonetheless, the leading Canadian case supports professional regulators who compel health care workers to facilitate morally contested procedures, even if doing so violates their deeply-held religious convictions.[15]

III.2 Regulation of health care ethics

III.2.1 When the Canadian Medical Association was considering its policy against euthanasia and assisted suicide prior to the Carter decision, CMA official Dr. Jeff Blackmer claimed that the Association could refuse to change the policy even if the procedures were legalized. "We could say ethics trumps the law," he said.[16]

III.2.2 However, state regulation of health care delivery and the health care professions in Canada means that the law not only trumps ethics, but the state can define the ethics of health care professions. This power is demonstrated most clearly in Quebec, where professional codes of ethics are provincial statutes. It was exemplified in Alberta when the Government amended a College of Physicians and Surgeons standard of practice by Order in Council.[17] In Ontario, the College of Physicians and Surgeons describes itself as "the embodiment in statute of the ethics of the profession."[18]

IV. State delivery of health care

IV.1 Medicare, Canada's state-run health insurance system, enjoys broad public support because it guarantees and pays for universal access to medically required services.[19] As a result, objecting physicians and health care providers face an entrenched attitude of entitlement.

Since "we all pay for this medical system to receive services," said CPSO President Dr. Preston Zuliani, "if a citizen or taxpayer goes to access those services and they are blocked from receiving legitimate services by a physician, we don't feel that's acceptable."[20]

IV.2 The state health care system is also often seen as key element in Canadian national identity, especially for the purpose of distinguishing between Canadian and American societies — a distinction also central to Canadian identity.[21] The difference between Canadian and American responses to the Covid-19 pandemic continues to reinforce this view.[22]

V. Summary

V.1 Provincial governments are responsible for defining, funding, managing and ensuring access to medically required services, the regulation of health care professions, and the protection of freedom of conscience and other fundamental freedoms of both patients and health care professionals and institutions.

V.2 The federal government has a much higher public profile, but its actual responsibilities and powers in health care and civil rights are constitutionally limited. Technically, the *Canada Health Act* could be used to pressure provincial governments to adopt protection of conscience laws and policies. However, the central purpose of the *Act* is to ensure patient access to adequate health care, so to apply it in this way would be perceived as contrary to the purpose of the law and, probably, as an 'un-Canadian' attack on patient rights.

V.3 National and provincial professional associations have no regulatory powers but can significantly influence the development of professional ethical norms and standards of practice. They may also advocate effectively for — or against — the fundamental rights and freedoms of their members.

Notes

1. Sean Fleming, "Quarantine and the constitution: Are Newfoundland and Labrador's public health measures legal?" *CBC* (17 May 2020), online: <https://www.cbc.ca/news/canada/newfoundland-labrador/quarantine-and-the-constitution-1.5571151>.

2. *Criminal Code*, RSC 1985, c C46, s268.

3. Department of Justice, News Release, "Federal Government introduces legislation to criminalize conversion therapy-related conduct in Canada" (9 March 2020), online: <https://www.canada.ca/en/department-justice/news/2020/03/federal-government-introduces-legislation-to-criminalize-conversion-therapy-related-conduct-in-canada.html>.

4. Formerly the Dominion Medical Council, the formation of which was authorized by the *Dominion Medical Act* of 1902, as amended in 1912 (now the *Canada Medical Act*).

5. "Dominion Medical Act: An English Review of its Purpose and Provisions (British Medical Journal)", *The Gazette* (12 July, 1902).

6. “The Roddick Act” (1912) 1:2680 Br Med J 1090, online: <.https://www.jstor.org/stable/25297153>.

7. “Canada Health Act”(24 February 2020), Government of Canada (website), online: <https://www.canada.ca/en/health-canada/services/health-care-system/canada-health-care-system-medicare/canada-health-act.html>.

8. Such as the Canadian Nursing Students’ Association (http://cnsa.ca/links/), the Canadian Association of Pharmacy Students and Interns (https://capsi.ca/), the Canadian Federation of Medical Students (https://www.cfms.org/), and the Student Midwives Association of Canada (http://www.smacaceps.com/).

9. “Working for Change” (2017) , Doctors of BC (website), online: <https://www.doctorsofbc.ca/working-change>

10. They participate in the Canadian Council for Accreditation of Pharmacy Programs, Canadian Association of Schools of Nursing, Committee on Accreditation of Canadian Medical Schools, Canadian Association for Midwifery Education.

11. Canada, Steering Committee on Modernization of Health Professional Regulation, *Recommendations to modernize the provincial health profession regulatory framework*, (Victoria: Ministry of Health, 2020) [*BC Committee*] at 4, online: <https://www2.gov.bc.ca/assets/gov/health/practitioner-pro/professional-regulation/recommendations-to-modernize-regulatory-framework.pdf>

12. Note that the term “college” is sometimes used by voluntary professional associations that have no regulatory power (like the College of Family Physicians).

13. Molly Dingwall et al, eds, Ethical, Legal and Organizational Aspects of Medicine, in Toronto Notes 2014 (Toronto: University of Toronto) 2014 online: <https://medicinainternaucv.files.wordpress.com/2013/02/ethics-toronto-notes-2014.pdf>.

14. Sean Murphy, “Tunnel vision at the College of Physicians”, *National Post* (13 April 2015), online: <https://nationalpost.com/opinion/sean-murphy-tunnel-vision-at-the-college-of-physicians>.

15. *The Christian Medical and Dental Society of Canada v. College of Physicians and Surgeons of Ontario*, 2018 ONSC 579, online: <https://www.canlii.org/en/on/onscdc/doc/2018/2018onsc579/2018onsc579.html>.

16. Sharon Kirkey, “Canadian doctors want freedom to choose whether to help terminal patients die: CMA to revisit issue of doctor-assisted death after delegates pass motion supporting physician's right to 'follow their conscience'”, *canada.com* (19 August 2014), online: < https://o.canada.com/news/national/canadian-doctors-want-freedom-to-choose-whether-to-help-t

erminal-patients-die>

17. *Order respecting Medical Assistance in Dying Standards of Practice*, OIC 142/216, (10 June, 2016), online: <https://www.qp.alberta.ca/documents/orders/Orders_in_Council/2016/616/2016_142.pdf>.

18. College of Physicians and Surgeons of Ontario, *The Practice Guide: Medical Professionalism and College Policies*, Toronto: CPSO, 2007 at 3, online: <https://www.cpso.on.ca/admin/CPSO/media/Documents/physician/polices-and-guidance/practice-guide/practice-guide.pdf#page=3>

19. “Canada’s Health Care System (Medicare)” (2016) Government of Canada (website), online: <http://hc-sc.gc.ca/hcs-sss/medi-assur/index-eng.php>.

20. Stuart Laidlaw,“Does faith have a place in medicine?" *Toronto Star* (18 September 2008), online: <http://www.thestar.com/living/article/500852>.

21. Carolyn Hughes Tuohy, “What’s Canadian About Medicare? A Comparative Perspective on Health Policy” (2018) 13:1 Healthc Policy 11–22 at 12, online: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6044263/pdf/policy-13-011.pdf>.

22. David Frum, “Canada Got Better. The United States Got Trump.” *The Atlantic* (24 July 2020), online: <https://www.theatlantic.com/ideas/archive/2020/07/i-moved-canada-during-pandemic/614569/>.