Healthcare Federalism in an Age of Nation-to-Nation Interaction

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The lack of uniformity in healthcare allocation decision-making and healthcare provision in Canada contributes to substantive and procedural deficiencies in Canadian healthcare justice. Scholars have long lamented differential access to healthcare rates and health outcomes across Canada.[1] Public funding for many World Health Organization [WHO]-recognized essential medicines is inconsistent across the provinces even within the hospital and physician services sectors where medically necessary/required goods must be publicly-funded for provinces to receive federal funds under the *Canada Health Act* [*CHA*]: each province chooses what qualifies as medically necessary/required.[2] Barriers to care in these sectors appear in all provinces and public funding for essential medicines and other essential goods outside the sectors varies further.[3] The transparency and reviewability of healthcare allocation decisions is also inconsistent in Canada. Provinces provide different levels of access to the reasons for decisions and of details on

[1] See e.g., the essential medicines-focused Colleen M Flood, "Conclusion" in Colleen Flood, ed, *Just Medicare* (Toronto: U Toronto P, 2006) 449 [Flood, "Conclusion"]; William Lahey, "Medicare and the Law: Contours of an Evolving Relationship" in Jocelyn Downie, Timothy Caulfield & Colleen M Flood, eds, *Canadian Health Law and Policy*, 4th ed (Toronto: LexisNexis, 2011) 1 [Lahey, "Medicare"]; Annie Wand, Trudo Lemmens & Navindra Persaud, "Medication Access Via Hospital Admission" (2017) 63 Canadian Family Physician 344. While Lahey does not appear in the most recent volume of that textbook (Joanna Erdman, Vanessa Gruben & Erin Nelson, eds, *Canadian Health Law and Policy*, 5th ed (Toronto: LexisNexis, 2017)), his work remains accurate and relevant. See also related work on public health, like Amir Attaran & Kumanan Wilson, "A Legal and Epidemiological Justification for Federal Authority in Health Emergencies" (2007) 52(2) McGill LJ 381 and Amir Attaran & Elvina C Chow, "Why Canada is Very Dangerously Unprepared for Epidemic Diseases: A Legal and Constitutional Diagnosis" (2011) 5(2) JPPL 287. Attaran's COVID-19-based concerns below follow on this earlier text.

[2] *Ibid*. For the *Act*, see *Canada Health Act*, RSC, 1985, c C–6 [*CHA*]. For provincial and territorial implementation acts, see *Alberta Health Care Insurance Act*, RSA 2000, c A–20; *Hospital Insurance Act*, RSBC 1996, c 204; *The Health Services Insurance Act*, CCSM c H35; *Hospital Services Act*, RSNB 1973, c H–9; *Medical Care Insurance Act, 1999*, SNL 1999, c M–5.1; *Health Services and Insurance Act*, RSNS 1989, c 197; *Health Insurance Act*, RSO 1990, c H.6; *Health Services Act*, RSPEI 1988, c H–1.6; *Health Insurance Act*, CQLR c A–29; *Saskatchewan Medical Care Insurance Act*, RSS 1978, c S–29; *Health Care Insurance Plan Ac*t, RSY 2002, c 107, *Hospital Insurance and Health and Social Services Administration Act*, RSNWT 1988, c T–3, and *Hospital Insurance and Health and Social Services Administration Act*, RSNWT (Nu) 1988, c T–3.

[3] See e.g., note 1 sources. With respect to differential coverage outside the hospital and physician services sector in particular, it is notable how little has changed since Lahey, *ibid* at 7 raised this concern. For just one example of this phenomenon, consider differences in provincial emergency prescription drug plans. Karin Phillips, Library of Parliament, "Catastrophic Drug Coverage in Canada" (Ottawa: Library of Parliament, 2016) provides a useful summary that is dated in its particulars but whose general issues remain. The federal government has, of course, discussed a national 'Pharmacare' program in recent years. The scope of this potential program *still* remains unclear.

such decisions.[4] Provincial success rates for applications to review those decisions likewise vary.[5] Many Canadians thus do not receive sufficient shares of healthcare-related goods justice requires.

While some consider these results acceptable outcomes of just decision-making processes in each province, concerns about the relative accountability and justice of provincial systems occasioned numerous calls for an increased federal role in Canadian healthcare law and policy (henceforth "healthcare policy").[6] Moe recently, the lack of a coordinated response to the global COVID-19 pandemic underlined the fragmentation of Canadian healthcare policy and related deficiencies, inspiring renewed calls for federal action.[7] While COVID-19 also highlighted problems with centralized responses to public health emergencies, concerns about the lack of a coordinated response to COVID-19 and federal government's minimal role in the health-related aspects of pandemic management are notable.[8] Consider COVID-related unjust distributions of health outcomes and access to healthcare goods across the provinces or lack of uniform testing and

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[4] E.g., Flood, "Conclusion," *supra* note 1; Colleen M Flood & Michelle Zimmerman, "Judicious Choices" in Jocelyn Downie & Elaine Gibson, eds, *Health Law at the Supreme Court of Canada* (Toronto: Irwin Law 2007) 25. I provide my own analysis of these issues in Michael Da Silva, "Medicare and the Non-Insured Health Benefits and Interim Federal Health Programs" (2017) 10(2) McGill JL & Health 101 [Da Silva, "Medicare"]. My recent book, Michael Da Silva, *The Pluralist Right to Health Care: A Framework and Case Study* (Toronto: U Toronto P, 2021) [Da Silva, *Pluralist*] draws on some of the same material when detailing these issues. The book's conclusion about the importance of an increased federal role in healthcare is part of what led me to conceive the present project.

[5] *Ibid*.

[6] See e.g., sources in notes 1, 4. See also the COVID-19-specific claims in the next note and sources cited therein.

[7] This possibility was discussed in entries in Colleen M Flood et al., eds, *Vulnerable: The Law, Policy and Ethics of COVID-19* (U Ottawa P, 2020) [*Vulnerable*]. At minimum, Colleen M Flood et al., "Overview of COVID-19: Old and New Vulnerabilities" in *ibid*, 1 and Amir Attaran & Adam R Houston, "Pandemic Data Sharing: How the Canadian Constitution Has Turned into a Suicide Pact" in *ibid*, 91 highlight coordination issues. Michael Da Silva & Maxime St-Hilaire, "Towards a New Intergovernmental Agreement on Early Pandemic Management" (2021) 41(2) Nat'l J Const L 77 also highlight coordination issues and cite others seeking an increased federal role. My own first wave-era writing, Michael Da Silva, "COVID-19 and Health-Related Authority Allocation Puzzles" (2021)30(1) Cambridge Quarterly of Healthcare Ethics 25 [Da Silva, "COVID-19"], likewise canvasses calls and arguments for federal control of health-related policy. For *popular* calls for an increased federal role, see André Picard's early pandemic-era editorials in *The Globe and Mail* at https://www.theglobeandmail.com/authors/andre-picard/.

[8] Da Silva, "COVID-19," *ibid* also discusses issues with centralized rule. See also the cities-focused Daniel Weinstock, "Harm Reduction in Pandemic Times" *Max Bell School of Public Policy Briefings* (21 April 2020), <https://www.mcgill.ca/maxbellschool/article/articles-policy-challenges-during-pandemic/briefing-harm-reduction-pandemic-times>, parts of which inform his "A Harm Reduction Approach to the Ethical Management of the COVID-19 Pandemic" (2020) 3(2) Public Health Ethics 166. Both my own and Weinstock's works were written early in the pandemic. More recent scholarship suggests that the pandemic experience as a whole does not determinatively favour centralized or decentralized health policy. Volume 51(4) Publius from late 2021 is an illuminating special issue devoted to federalism and responses to the COVID-19 pandemic. See also Nico Steyler, ed, *Comparative Federalism and Covid-19: Combatting the Pandemic* (New York: Routledge, 2021). However, those outcomes likely supports the broader point made below: there are good moral reasons to favour various allocations of healthcare policymaking powers other than the provinces. The pandemic recently highlighted them.

data collection standards.[9] While COVID-19 raises distinct questions about federal actions during crises, many COVID era problems mirror longstanding issues in Canadian healthcare policy.[10] Whether and how a federal government can and should increase its role is important absent crises.

This work abstracts from particular circumstances motivating discrete calls for an increased federal role in Canadian healthcare policy to examine the broader arguments therefor in light of an often-overlooked challenge.[11] Any increased federal role will face familiar hurdles. Most notably, while the Supreme Court of Canada [SCC] recognizes health and healthcare as areas of "concurrent jurisdiction" under Canadian constitutional law,[12] earlier SCC jurisprudence states that the provinces possess "the general authority over health."[13] Notwithstanding unique federal programs for specific populations,[14] provinces play the primary role in Canadian healthcare allocation decision-making and provision.[15] The federal *CHA* sets criteria provinces must meet to receive federal funds for their healthcare systems, but provinces maintain broad discretion over healthcare policy under the *Act*, leading to the differences above.[16] This state of affairs is often 'justified' by appeals to the epistemic and democratic benefits of local control, the importance of self-determination, and/or subsidiarity (defined below).[17] Yet COVID-19 also highlights another

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[9] These issues are raised in the sources in note 7. Picard presented a particularly stark example of the data collection problems in "We have to test and trace more to end lockdowns safely." *The Globe and Mail* (22 May 2020), <https://www.theglobeandmail.com/canada/article-we-have-to-test-and-trace-more-to-end-lockdowns-safely/> and later noted that the lack of a coherent national vaccination approach and the radically different results across the provinces in "Where's the urgency in Canada's Vaccine Rollout?" *The Globe and Mail* (4 January 2021) <https://www.theglobeandmail.com/opinion/article-wheres-the-urgency-in-canadas-vaccine-rollout/>. These are not, of course, the only issues stemming from a lack of coordination or federal action. Consider also, e.g., provincial acts that are outside their jurisdiction or violated rights (e.g., provincial border closures) without federal comment.

[10] Discussions about how emergency powers impact our analyses are thus beyond the scope of inquiry. Those interested in Canadian emergency powers and their impact on COVID-19 may consult *Vulnerable*, *supra* note 7.

[11] This work thus focuses on the general question at the end of the last paragraph, not crises.

[12] *Carter v Canada (Attorney General)*, [2015] 1 SCR 331, 2015 SCC 5 at para 53 [*Carter*].

[13] *Schneider v The Queen*, [1982] 2 SCR 112 at 137 [*Schneider*]. Even *Carter*, *ibid* at paras 50-51 discusses a "protected core" of provincial authority over health shortly before its statement on concurrent jurisdiction.

[14] These programs are primarily for military members and veterans, federal prisoners, immigrants, and Indigenous Canadians. As outlined in Martha Jackman, "Constitutional Jurisdiction Over Health in Canada" (2000) 8 Health LJ 95 [Jackman, "Jurisdiction"], these programs are justified by powers exercised under the *Constitution Act, 1867* (UK), 30 & 31 Vict, c 3, reprinted in RSC 1985, Appendix II, no 5, ss 91(7), 91(24), s 91(25), 91(28) [*1867*], and the so-called 'spending power' taken to be implicit in the text of that document. Jackson also identifies some specific programs that continue to exist. For an analysis of two, see Da Silva, "Medicare," *supra* note 4.

[15] Jackman, "Jurisdiction," *ibid* rightly stresses *1867*, *ibid*, s 92(7), 92(13), 92(16) as the primary sources for this provincial authority. See also sources like Colleen M Flood & Sujit Choudhry, *Strengthening the Foundations* (Discussion Paper No 13) (Ottawa: Royal Commission on the Future of Health Care in Canada, 2002) or William Lahey, "The Legal Framework for Intergovernmental Health Care Governance" in Katherine Fierlbeck & William Lahey, eds, *Health Care Federalism in Canada* (Montreal/Kingston: McGill-Queen's UP, 2013) 71.

[16] Recall note 2.

[17] This is clear in several texts on Canadian law discussed above. Discussion of the Canadian understanding of 'subsidiarity' in Peter W Hogg, *Constitutional Law of Canada*, 5th ed (Toronto: Thomson Carswell, 2018) at 5.1(g)

set of important arguments that challenge the status quo of primary provincial control over health policy and may constrain federal attempts to increase their role. These arguments call for sub-state national control over healthcare policy (also defined below). Pandemic-related calls for greater authority over health policy for Indigenous and Québécois 'nations' due to concerns that provincial decisions did not adequately protect sub-state national groups or reflect their needs mirror longstanding calls for greater sub-state national control that cannot be easily dismissed.[18]

Calls for sub-state 'national' control over different policy areas are common in multinational states, including Canada.[19] Arguments therefor can be grounded in the principles that purport to ground provincial control. For instance, even geographically disperse nations may know more about their members than federal and provincial governments and be better positioned to respond to local issues.[20] Nations, including the Québécois, Acadians, and Indigenous sub-state groups, could also marshal international self-determination rights to argue for increased control.[21] If those arguments fail, recognition of Québec as a 'nation-within-a-nation' and the sovereignty of Indigenous nations should make the importance of *those* sub-state nations parametric in analyses of Canadian laws.[22] Yet allocating health-related authority to them could limit federal actions.

[Hogg, *CLC*]; Andreas Føllesdal & Victor Muñiz Fraticelli, "The Principle of Subsidiarity as a Constitutional Principle in the EU and Canada" (2015) 10(2) Ethics Forum 89; and Hoi Kong "Subsidiarity, Republicanism, and the Division of Powers in Canada" (2015) 45 RDUS 13 is also illuminating. For good overviews of the arguments for local control over public policy domains like healthcare, see Daniel Weinstock, "Cities and Federalism" in James E Fleming & Jacob T Levy, eds, *NOMOS LV: Federalism and Subsidiarity* (New York: NYU Press, 2014) 259; Ran Hirschl, *City, State: Constitutionalism and the Megacity* (OUP, 2020). The former volume and NW Barber, *The Principles of Constitutionalism* (Oxford: Oxford UP, 2018) c 7 assess the merits of these arguments.

[18] Recall note 8, noting its caveats. Note also that some of these calls pertain to public health, rather than care alone. In making this claim, I am, of course, aware of the complex intergovernmental complexities early in the pandemic.

[19] Québécois examples are legion. Citations are below. On Indigenous nations' calls for sub-state powers, see e.g., Felix Hoehn, *Reconciling Sovereignties* (Saskatoon: Native Law Centre, University of Saskatchewan, 2012); Ghislain Otis & Martin Papillon, eds *Federalism and Aboriginal Governance* (Laval: Les Presses de Université Laval, 2013). As Augie Fleras & Jean Leonard Elliott, *The 'Nation Within'* (Toronto: Oxford UP, 1992) c 1 notes, not all Indigenous 'peoples' qualify or desire to qualify as 'nations.' The desire of *some* to be nations is clear, justifying some consideration of Indigenous cases in a work on nations. However, the Indigenous case likely differs in important ways that suggest it is not best considered under nationalist rubrics. The analysis below underlines this.

[20] I discuss diaspora nations further in "Nations as Justified Sub-State Authorities" [Da Silva, "Nations"], which is forthcoming in Nations and Nationalism. Actual cases of Indigenous programs further highlight this possibility. See e.g., Josée G Lavoie et al., "Missing Pathways to Self-Governance" (2015) 6(1) Int'l Indigenous Policy J 1.

[21] This issue is complicated, but an international law-based argument is at least possible. Christian Walter et al., *Self-Determination and Secession in International Law* (Oxford: Oxford UP, 2014) is a good overview of relevant laws. Acadians share the sociological indicia of nationhood absent formal recognition; Michel Seymour, "Quebec and Canada at the Crossroads" (2000) 6(2) Nations and Nationalism 277 at 239 [Seymour, "Quebec"].

[22] Québécois recognition took place in *House of Commons Debates*, 39-1, 87 (27 November 2006) [*House*]. As I write, Québec is trying to secure constitutional recognition of their 'nation,' the implications of which are unclear. Indigenous recognition appears in many places, including Department of Justice Canada, *Principles: Respecting the Government of Canada's Relationship with Indigenous Peoples* (Ottawa: Her Majesty the Queen in Right of Canada, 2018). The implication of this recognition also remain hard to parse. *Cf.* Seymour, "Quebec," *ibid*; Alain-G

This work accordingly addresses whether 'sub-state nationalism' presents a genuine challenge to an increased federal role in Canadian healthcare and whether any options for an increased federal role better avoid potential sub-state nationalism-related issues. Starting from the assumption that there are some compelling reasons for federal actions to standardize aspects of the Canadian healthcare system, I examine the extent to which sub-constitutional recognition of sub-state nations constrains the federal government's ability to take an increased role in healthcare.[23] My analysis of the underlying issues focuses on Canada, but my arguments are largely conceptual and should at least partly generalize.[24] At minimum, the following is data for studies of how federal governments and/or sub-state nations can set social policy. Given real sub-state national desires for healthcare powers,[25] this provides a good case study in multinational state governance.

My analysis proceeds in four substantive parts. Part I outlines conditions for a successful argument for an increased federal role in healthcare. Part II presents three cases for allocating government powers to sub-state nations and outlines whether/how they challenge increased federal roles in healthcare. Part III introduces options for increased federal roles in healthcare in Canada and tests whether they can fulfill the conditions in Part I while at least blunting the impact of the challenges in Part II. Part IV offers observations on the findings in Part III. A conclusion follows.

My analysis demonstrates that no option for an increased federal role is likely to remedy even many issues with the Canadian healthcare system in a manner that is constitutional, effective,

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Gagnon & James Tully, *Multinational Democracies* (Cambridge: Cambridge UP, 2001); Michael Keating, *Plurinational Democracy* (Oxford: Oxford UP, 2001); Stephen Tierney, "Reframing Sovereignty? Sub-State National Societies and Contemporary Challenges to the Nation-State" (2005) 54 ICLQ 161; etc.

[23] I do not want to overstate the desirability of federal action. But there are compelling arguments above/below.

[24] I also do not want to overstate the extent to which my results generalize. I will not spend much time presenting comparative data and the following can be read as an exercise in non-ideal theory. That said, there is some reason to think things will generalizes. Versions of many interventions below could be adopted elsewhere. Even those with specific features that do not appear in other states (and thus may not fully generalize) are representative of the kinds of approaches that may be adopted in other states. The ways in which options below fail to resolve the tension then suggests that all real-world policy options necessitate key trade-offs. Measuring the relevant trade-offs offers a tool for rights-promoting policy selection. For instance, my finding that a nonbinding national healthcare strategy may best resolve the underlying tension stems from practical and theoretical concerns about the benefits of more coercive measures, like federal legislation that 'overrides' state law. This more broadly suggests that federal governments may benefit from using less coercive means to pressure other actors into helping realize the right to healthcare. I discuss other potential general implications of my findings below as they offer important considerations for general discussions of the relevant issues. The following has insights that do not rely on if my empirical findings and theoretical claims about the relationships between values generalizes. But there is reason to think they may. My account is empirically-sensitive as it responds to reasons in empirical literatures. But it is not primarily empirical.

[25] E.g., Nicola McEwan, "State Welfare Nationalism" (2002) 12(1) Regional and Federal Studies 66; Daniel Béland & André Lecours, "Sub-State Nationalism and the Welfare State" (2006) 12(1) Nations and Nationalism 77 [Béland & Lecours, "Sub"]; Daniel Béland & André Lecours, *Nationalism and Social Policy* (Oxford: Oxford UP, 2008).

and consistent with all plausible implications of sub-state nationalism. Several options could be effective, constitutional, and consistent with many implications. But nearly all present tensions between policy goals that require adopting a less demanding conception of sub-state nationalism or choosing whether to prioritize the rationales for federal action or sub-state national authority.

These findings contribute to distinct literatures. Simply identifying the tensions should further understandings of healthcare policy and sub-state nationalism. While I identify the tensions in the context of a Canadian case study, the problems posed are largely conceptual and demand scrutiny elsewhere.[26] Regardless of whether the tensions generalize, my explanation of how the adoption of a national healthcare strategy avoids the brunt of the tensions in Canada constitutes a concrete case for adopting a strategy and contributes to healthcare policy. Yet the imperfect reconciliation of competing demands even in this 'best' case suggests a still more interesting conclusion: theoretically ordering our preferences will not satisfactorily reconcile competing values in real-world contexts, so theoretical principles should be assessed in actual institutional contexts. Reconciling competing values is not a clean affair but requires difficult, empirically-sensitive normative work and trade-offs between values within institutional frameworks with their own rules and values. At least in critical areas like healthcare policy, one must do this work or risk serious harms. The following demonstrates how one can perform such analyses and offers examples of how to weigh values in a real-world context. I am more interested in demonstrating the importance of reconciling values, the impossibility of cleanly doing so in key scenarios, and exploring how to do so than in defending a national healthcare strategy as the best imperfect choice. If one reads this piece as more programmatic than argumentative, it should still have implications for debates in healthcare policy, federalism, nationalism, and non-ideal legal theory.

I. Success Conditions for Arguments for an Increased Federal Role in Canadian Healthcare Policy

A federal intervention in healthcare must meet acceptability conditions for a federation like Canada if it is to be even a potential candidate for adoption that would warrant testing its relationship to sub-state nationalism. Exploring the case for an increased federal role identifies helpful acceptability criteria. In short, before a potential federal intervention can raise questions about its consistency with sub-state nationalism, it should show promise of remedying identified deficiencies in the healthcare system; be formally constitutional; and respect constitutional values/ends, striking an appropriate balance of and understanding connections between them.

[26] Recall note 24, including its caveats.

Attending to arguments for federal control over healthcare policy and basic facts of Canadian law make this clear. While scholars debate whether a stronger federal role would improve the Canadian healthcare system,[27] the best case for an increased federal role does not even primarily rest on empirical predictions about how an increased federal role would change care.[28] It instead rests on the federal government's responsibility to ensure adequate healthcare in Canada. On this view, the federal government's moral and legal responsibility to fill gaps in Canadian realization of the healthcare justice is overdetermined. Filling the gaps is the kind of thing federal governments must do. The question is *how* they should do so. Further criteria limit the possibilities.

Defending an increased federal role is beyond my scope of inquiry, but basic considerations suffice to ground a strong prima facie for federal control. They also identify additional acceptability criteria for an increased federal role. Most notably, perhaps, they suggest that an acceptable increased federal role should further ends purportedly justifying federal action. For example, even if one accepts empirical critiques about the Canadian federal government's capacity to produce better access to healthcare, health outcomes, etc., provincial governments have produced suboptimal results.[29] Canada is not the only country where leaving power over healthcare policy in provincial hands produced distributive justice issues, not only with respect to healthcare goods, but also to related social goods, including the goods of political involvement.[30] A federal government is a good candidate for remedying such justice-related concerns. Federal governments arguably have moral duties to remedy these issues absent provincial action.[31] A plausible

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[27] Debates have continued for decades. Recall e.g., classic critiques of the different calls for increased federal roles in Commission on the Future of Health Care in Canada (Roy J Romanow, Commissioner), *Building on Values; The Future of Health Care in Canada* (Ottawa: Commission on the Future of Health Care in Canada, 2002) and the Standing Senate Committee on Social Affairs, Science and Technology (Michael Kirby, Chair), *The Health of Canada* (Ottawa: Standing Senate Committee on Social Affairs, Science and Technology, 2003) and more recent critiques of the call for an increased federal role in Health Canada Advisory Panel on Healthcare Innovation (David Naylor, Chair, *Unleashing Innovation* (Ottawa: Health Canada, 2015). Divergent views on the appropriate role of the federal government in Canadian healthcare and possible effects of an increased role often appear in the same volume; e.g., Erdman, Gruben & Nelson, *supra* note 1; Fierlbeck & Lahey, *supra* note 15. As discussed above, recent events like the COVID-19 pandemic have renewed interest in different authority allocations.

[28] Sources above/below provide mixed empirical results. The point here is that an increased federal role is plausibly necessary even if it is not the all-things-considered best prescription for Canada on a given metric for improvement. Recall also note 24.

[29] Recall notes 1, 3-4, and surrounding. Further details appear below.

[30] I again do not want to overstate the issues with federalism. The claim here is that there are problematic cases of devolution. See e.g., Jamila Michener, *Fragmented Democracy* (Cambridge: Cambridge UP, 2018) on the U.S.A. Works that provide evidence of this claim in Europe speak to social policy more broadly; e.g., Bea Cantillon, Patricia Popelier & Ninke Mussche, eds, *Social Federalism* (Cambridge/Antwerp/Portland: Intersentia, 2011).

[31] This point is often made with respect to federal powers generally. For a healthcare-specific version, see Douglas MacKay & Marion Danis, "Federalism and Responsibility for Health Care" (2016) 30(1) Public Affairs Quarterly 1.

understanding of the aforementioned principle of subsidiarity whereby local control is justified *only to the extent that it meets minimal standards* further supports an increased federal role in healthcare where provinces fail to meet such standards.[32] Canada's statutory duties under the *CHA*, international obligations, and fiduciary obligations to Indigenous Canadians then place it under legal obligations to ensure adequate, equitable access to care.[33] This factual matrix suggests that the case for increased federal action is overdetermined. The task then becomes specifying what the federal government can and should do given existing constitutional, politics, and moral constraints.

The requirement that any acceptable federal intervention remedy deficiencies in the healthcare system (and, by extension, healthcare justice) is tied to the motivation for seeking an increased federal role in the first place and presents clear conditions on candidate federal interventions. Deviating from existing legal and political arrangements, particularly where those arrangements are consistent with established constitutional practice, is unwise absent good reasons. Yet if arrangements produce results that violate basic norms of justice that claim to justify them, those failures can justify deviations from established practice. They also help identify candidate federal interventions for remedying those failures. For instance, given above issues with the Canadian healthcare system, any candidate federal intervention in Canadian healthcare policy should increase access to essential healthcare goods, absolute health outcomes, equity in healthcare access and health outcomes, or the administrative justice of the system (by e.g., improving the system's transparency or opportunities for review of healthcare-related government decisions).[34]

Basic facts of Canadian law establish still further acceptability criteria. Even interventions that can remedy the healthcare system's existing faults cannot be adopted if they undermine federalism, which not only provides the structure of Canadian legal and political governance but is also a basic constitutional value in Canada.[35] Any federal interventions in healthcare must accordingly conform to the constitutional text, respect Canadian constitutional values (including federalism itself), and not greatly diminish recognized moral and legal benefits of federalism.

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[32] Barber, *supra* note 11, c 7. I do not find that principle compelling. But it is viewed as important in international, regional, and domestic law and in political philosophy. Recall also note 17 and sources therein.

[33] Details appear below. Note, e.g., that international law requires that states have national healthcare strategies with benchmarks and indicators for success to meet their right to health obligations; U.N. Committee on Economic, Social and Cultural Rights, *General Comment 14*, 22d Sess, UN Doc E/C.12/2000/4, (2000); Michael Da Silva, "The International Right to Health Care" (2018) 39(3) Michigan J Int'l L 343 [Da Silva, "International"].

[34] Again, recall notes 1, 3-4.

[35] *Reference Re Secession of Quebec*, [1998] 2 SCR 217 at para 32 [*Secession Reference*].

The constitutional text presents clear limitations. It does not permit interventions that would allow the federal government to "cover the field" of healthcare regulation.[36] Healthcare must remain an area of concurrent jurisdiction.[37] Some believe that the provinces should retain "primary" control over healthcare, but that is less clear.[38] At minimum, provincial legislatures must maintain control over "hospitals" and "property and civil rights."[39] This reflects a deeper limit sourced in the structure of the Canadian constitution: the "architecture" of the Constitution of Canada requires that each level of government have exclusive authority over the areas in which they are granted power in the text of sections 91 and 92 of the *Constitution Act, 1867*.[40] Canada must remain dualist such that federal and provincial governments each has exclusive powers.[41]

Consistency with constitutional principles requires that interventions respect "democracy, constitutionalism and the rule of law, and respect for minority rights."[42] These relate to the basic moral and legal values of federalism, which include the ability to balance the moral goods of unity and diversity,[43] maximizing the values of democracy, citizenship, and liberty,[44] and administrative efficiency.[45] Federalism's normative commitments are, of course, highly contested, but each specification of federalism that ties to normative ideals appears to seek compromises between competing moral values and synthesis of their basic insights.[46] The SCC views all the values as

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[36] On covering the field, see Peter W Hogg, "Paramountcy and Tobacco" (2006) 34 SCLR (2d) 335 at 336-337.
[37] *Carter*, *supra* note 12.
[38] *Ibid* may pre-empt *Schneider*, *supra* note 13. But recall the point about *Carter* in note 13.
[39] See note 14.
[40] *Quebec v Canada*, 2015 SCC 14, [2015] 1 SCR 693 maintains this feature of *1867*, *supra* note 14. While Reference re *Greenhouse Gas Pollution Pricing Act*, 2021 SCC 11 may weaken it, unique competences remain necessary. For a stronger statement on this issue, see Asher Honickman, "Watertight Compartments" (2017) 55(1) Alberta LR 225
[41] *Ibid*. On dualism more broadly (and its relationship to monism), see e.g., Francesco Palermo & Karl Kössler, *Comparative Federalism* (Oxford/Portland: Hart, 2017) at 39.
[42] *Secession Reference*, *supra* note 35 at para 49.
[43] Nicholas Aroney & John Kincaid, "Comparative Observations and Conclusions" in Nicholas Aroney & John Kincaid, eds, *Courts in Federal Countries* (Toronto: U Toronto P, 2017) 482 at 536; Eugénie Brouillet, "The Federal Principle and the 2005 Balance of Powers" (2006) 34 SCLR (2d) 307 at 310; Michael Burgess, "Federalism and Federation" (2018), <http://50shadesoffederalism.com/theory/federalism-federation-putting-record-straight/>.
[44] Daniel Weinstock, "Towards a Normative Theory of Federalism" (2001) 53(167) International Social Science Journal 75.
[45] Jenna Bednar, *The Robust Federation* (Cambridge: Cambridge UP, 2009).
[46] For an introduction to relevant issues, see Andreas Føllesdal, "Federalism" (2003/2018 *The Stanford Encyclopedia of Philosophy*, online: <https://plato.stanford.edu/entries/federalism/>. I take a less theoretically-loaded view of what federalism requires, but the Canadian constitutional principle has theoretical content and clearly seeks to balance *some* values. For instance, *Secession Reference*, *supra* note 35 at para 66 claims that federalism "enables different provinces to pursue policies responsive to the particular concerns and interests of people in that province. At the same time, Canada as a whole is also a democratic community in which citizens construct and achieve goals on a national scale through a federal government acting within the limits of its jurisdiction."

mutually self-defining, such that e.g., "[t]he function of federalism is to enable citizens to participate concurrently in different collectivities and to pursue goals at both a provincial and a federal level."[47] Federal interventions must not only respect constitutional values and fulfill the goods federalism is meant to promote. They must also strike a reasonable balance between these aims to fulfill (at least the Canadian constitutional version of) the principle of federalism in the first place.[48]

These considerations permit some federal interventions into healthcare and limit the possibilities thereof. Potentially competing arguments for greater 'sub-state national' involvement in healthcare policy offer other potential limitations. I will outline them before analyzing the extent to which they challenge any increased federal role(s) in healthcare policy. The meaning of 'sub-state nation' is contested, but one can examine sub-state nationalism's implications for the present issue without a general account of sub-state nations. On one approach, sub-state nations are conceptually impossible: to be a nation is to have sovereignty, which is indivisible.[49] To be a sovereign is to have absolute, undivided decision-making authority within a jurisdiction. No other entity has a legitimate claim to independently make or substitute in its own decisions. While a sovereign may devolve decision-making powers to another party, the sovereign always maintains ultimate authority and can thus revoke the powers at any time. Insofar as possessing sovereignty is a condition for 'nationhood,' truly 'sub-state' nations are impossible: purported 'nations' that lack sovereignty fail to meet a central condition of 'nationhood.'[50] On another approach, sub-state nations are a sociological fact: purported nations justifiably do not always actually possess their own states or even strong political rights within it.[51] I am interested in accounts that could challenge an increased federal role in healthcare policy, so I do not attend to approaches that make sub-state nationalism normatively inert. I instead focus on the normative cases for sub-state

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[47] *Secession Reference*, *ibid*.
[48] See note 46. Following on note 24, conceptual issues in notes 43-46 apply broadly. See sources therein. Empirical challenges also appear elsewhere; e.g., Palermo & Kössler, *supra* note 41; Aroney & Kincaid, *supra* note 43.
[49] The conception of federalism discussed here is broadly inspired by Jean Bodin, *On Sovereignty* (Cambridge: Cambridge UP, 1576/1992) and continues to have an impact on discussions of the very possibility of federalism.
[50] Equating 'nations' and 'states' has not been common for some time. EJ Hobsbawm, *Nations and Nationalism Since 1780*, 2d ed (Cambridge: Cambridge UP, 1990/1992) famously critiqued a 'nation = state' equation. The concept of sovereignty itself has a contested history. Peter Russell, *Sovereignty: The Biography of An Idea* (Toronto: U Toronto P, 2021) is a nice overview of this concept. Russell himself ultimately suggests that the meaning of the term is negotiated in political debates. The basic idea here nonetheless retains supporters.
[51] Several speakers in *House*, *supra* note 22 took themselves to only be recognizing a sociological fact. David Miller, "Nationality in Divided Societies" in Gagnon & Tully, *supra* note 22, 299 and Keating, *supra* note 22 are just two works that recognize the sociological fact and analyze its normative implications.

national control over discrete policy areas, examine which powers they would entail for the plausible candidate sub-state nations in Canada, and determine whether specific types of potential federal inventions in healthcare policy would unjustifiably infringe on those powers.

II. Motivating the Case(s) for Increased Sub-State National, Rather Than Federal, Control

There are, I submit, three plausible normative cases for sub-state national control over discrete policy areas.[52] I examine each here to outline plausible logical space. First, the 'remedial' case states that sub-state nations should have powers that they can exercise free from regular state government interference to remedy past wrongs against the nation or its members.[53] This case grounds special treatment in recognized moral wrongs and reflects several sub-state nations' actual claims.[54] A nation's status as 'nation' may not ground special treatment here. This case likely justifies powers for other historically wronged groups,[55] thereby requiring an explanation of why nations can be selected for special treatment if other wronged groups do not or cannot receive those powers. A successful version should also maintain plausible connections between national control and uncontroversial moral principles. While some may argue that this case fails to account for when past wrongs cease to require remedies, that concern does not apply as often in the healthcare context: many historical injustices have demonstrable ongoing negative health outcomes.[56]

The bigger issue with this remedial case is that may not have uniform implications. The number of powers required to remedy the wrong should be indexed to the extent of the wrong. In the Canadian healthcare case, this would entail some healthcare powers for Indigenous Canadians. Colonialism negatively impacted Indigenous health and Indigenous health-related knowledge.[57] Colonial wrongs appear to continue to impact Indigenous health.[58] The Canadian healthcare

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[52] I defend this schema and my preferred approach in Da Silva, "Nations," *supra* note 20. I also apply the schema in my "Individual and 'National' Healthcare Rights: Analysing the Potential Conflicts" 35(8) Bioethics 734.

[53] E.g., Allen Buchanan, "What's So Special About Nations?" (1997) 26(Sup1) Can J Phil 283 [Buchanan, "Special"] states that all 'special treatment' of nations is essentially remedial and so not fundamentally concerned with features of nations but with historical injustices faced by national groups.

[54] *Ibid*. See also the vast literature on 'remedial secession.' The role of remedial justice in the Indigenous case is complex, but some remedial claims are made. For helpful introductions to Indigenous nations as sub-state nations and some discussion of the remedial components thereof, see the sources in note 19.

[55] Indeed, Buchanan, "Special," *ibid* grants this much.

[56] Truth and Reconciliation Commission of Canada, *Honouring the Truth, Reconciling for the Future* (Winnipeg: Truth and Reconciliation Commission of Canada, 2015) [TRCC].

[57] *Ibid*. See also e.g., Constance MacIntosh, "Indigenous Peoples and Health Law and Policy" in Downie, Caulfield & Flood, *supra* note 1, 575.

[58] E.g., the Residential School System's inter-generational impacts were accepted as facts in Government of Canada, "Indian Residential Schools Resolution Health Support Program" (2018), <https://www.canada.ca/en/indigenous-services-canada/services/first-nations-inuit-health/health-care-services/indian-residential-schools-health-supports/indian-residential-schools-resolution-health-support-program.html>. I will not weigh into any controversies

system continues to treat Indigenous peoples unjustly, providing them with less access to care and programs that produce gross inequities in Indigenous and non-Indigenous health outcomes.[59] Many worry about Canada's ability to protect Indigenous health-related knowledge.[60] Remedying the related cluster of wrongs requires provision of better healthcare services to Indigenous Canadians. It may require Indigenous control over (at least) healthcare allocation decisions to acknowledge that alternative forms of healthcare governance in Canada were unjust towards Indigenous Canadians and did not provide them with the basic health goods that should plausibly be correlative with state power over healthcare allocation. It may also be necessary to recognize how past programs failed to account for Indigenous perspectives on health and well-being.

Remedial requirements for increased Québécois and Acadian healthcare powers are much less clear. Both groups have been wronged by Canadian governments, but the sources and extent of the wrongs and their relationship to healthcare are less clear. Indexing the powers granted to the wrong committed is thus difficult and may not secure strong healthcare-related powers. Some nations may not get any powers. This could have non-ideal, possibly worrisome implications. The Québécois seek increased powers as part of their status as a nation-within-a-nation,[61] so failure to secure powers for them in that paradigmatic case of recognition could prove problematic.[62]

That said, the remedial approach for sub-state national control over discrete policy areas at least provides a way of testing federal involvement in healthcare policy in particular from a sub-state nationalism perspective. To put it simply, any such federal involvement in healthcare should neither exacerbate recognized historical wrongs against sub-state nations nor infringe on powers necessary to remedy past wrongs. It should thus be consistent with some Indigenous self-governance over healthcare and leave room for acts necessary for remedying historical wrongs against the Québécois and Acadians, though the scope of this latter requirement is contestable.

Second, the 'general self-determination' case for sub-state national control over discrete policy areas states that nations should have powers to allow individual members to pursue their

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about intergenerational issues here and take this as given for the sake of argument. The ongoing impact on many of these wrongs avoids concerns about the non-identity problem that might otherwise face historical injustice cases.

[59] Indeed, the United Nations recognized this fact; Committee on Economic, Social and Cultural Rights, *Review of the 4th and 5th Periodic Reports: Concluding Observations of the Committee on Economic, Social and Cultural Rights: Canada*, 36th Sess, UN Doc E/C.12/CAN/CO/4.

[60] E.g., Julian A Robbins & Jonathan Dewar, "Traditional Indigenous Approaches to Healing and the Modern Welfare of Traditional Knowledge, Spirituality and Lands" (2011) 2(4) International Indigenous Policy Journal 2.

[61] See e.g., Québec-related examples in works in note 22; Seymour, "Quebec," *supra* note 21; Michel Seymour, "On Redefining the Nation" (1999) 82(3) The Monist 411 [Seymour, "Redefining"].

[62] The examples in *ibid* do, however, also demonstrate that Québec possesses related powers.

individual rights in tandem. Individuals have rights to pursue their conceptions of the good.[63] These can be understood as constituting an individual right to self-determine. Individuals are also free to associate and to do so to pursue their conception.[64] These could justify rights to self-determine *through* a group. Being able to make decisions for the group unfettered by state involvement may then be necessary to exercise that right.[65] If so, this case grounds special treatment for nations in less controversial liberal moral principles (e.g., individual self-determination, free association) and fits arguments that national groups make for special treatment within states. It can be uniformly applied across all nations: whatever is needed for national self-determination in a context, it should be uniform across all relevant cases. On this account, self-determination rights each possess a basic structure and formal content regardless of the specific acts necessary for groups to exercise their formal self-determination rights in particular contexts.

This case may not, however, non-arbitrarily pick out nations as proper bases for special treatment. People use other groups to exercise individual self-determination rights, including groups liberal states cannot traditionally treat differently.[66] Moreover, this account also raises the concern that there is no individual right to self-determination, but a species of such rights.[67] Resolving claims may require more detail on what *this* health-related self-determination right can and should look like. The general self-determination case, in other words, provides a way of testing whether federal interventions in the healthcare sector infringe upon deserved sub-state nationalist powers but does so in a way that is not particularly action-guiding for the present inquiry. One must articulate the structure and formal content of the self-determination right in the healthcare sector and then determine whether the federal intervention makes exercising that right impossible.

Consider the following. Exercising political self-determination through 'readymade' groups like the Québécois, Acadians, and Indigenous groups is reasonable. The groups historically secured individual goods for their members and start-up costs for otherwise exercising political self-determination are high.[68] States choosing such groups for special treatment need not be

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[63] John Rawls, *A Theory of Justice* (Cambridge: Harvard UP, 1971).
[64] *Ibid* at e.g., 272-273. The treatment of Rawls here is admittedly somewhat simplified. This work is not on Rawls.
[65] E.g., Seymour, "Quebec," *supra* note 21; Seymour, "Redefining," *supra* note 61; Anna Moltchanova, "Nationhood and Political Culture" (2007) 38(2) Journal of Social Philosophy 255.
[66] Buchanan, "Special," *supra* note 53 on religious groups. See also Harry Brighouse, "Against Nationalism" (1997) 26(Sup1) Can J Phil 365.
[67] Allen Buchanan, "Self Determination, Secession, and the Rule of Law" in Robert McKim & Jeff McMahan, eds, *The Morality of Nationalism* (Oxford: Oxford UP, 1997) 301 at 306.
[68] I discuss this further in Da Silva, "Nations," *supra* note 20. In that article, I also specify when and how I believe that nations can avoid the critique holding that they cannot be non-arbitrarily selected as sub-state authorities.

arbitrary even if they would not be the ideal vessels for self-determination in ideal theory: the national groups are 'special' because they have been chosen as sites for exercising self-determination and, unlike religious groups, do not claim authority that is inconsistent with higher state authority as a general matter or deny that other sites of collective agency are equally valuable.[69] All one must do is figure out what the right of self-determination in healthcare entails and apply it to the existing political nations. Yet specifying what, if anything, a right in the healthcare setting should entail is difficult. Groups requiring some self-determination rights does not mean that they must have unfettered discretion in all areas to be nations. Saying otherwise denies the possibility of sub-state nations; it requires that nations possess full state sovereignty. Absent a better account of the relevant healthcare-specific right, then, this approach cannot specify what bases for self-determination can or must limit the exercise of federal powers in healthcare.

Finally, the (related) 'specific context for self-determination' case for sub-state national control over discrete policy areas states that nations should have some powers to provide individuals with a context in which they can even exercise their individual self-determination rights. There are instances where one cannot realize one's self-determination rights on one's own. Individuals plausibly have rights to do what is necessary to establish the group as a viable entity: a right to self-determine ought to entail a right to a forum for exercising that right.[70] There are cases where group identities are formed through the exercise of authority.[71] In such cases, the claim that self-determination rights can require providing some authority to the group to provide a context for choice has much to favour it. For instance, national groups are commonly based around characteristics that are created through political nation-building processes.[72] For example, giving the Québécois power over language policy to protect their ability to foster a common language that is core to their political identity is a plausible implication of grounding sub-state nationalism in self-determination rights. Certain cultural protection powers may also be justified on this view.

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[69] *Ibid*.
[70] This is clear as early as Rawls, *supra* note 63.
[71] E.g., the sources in note 25 also demonstrate how social policy powers promote nation-building.
[72] André Lecours, "Political Institutions, Elites, and Territorial Identity Formation in Belgium" (2001) 3(1) National Identities 51. This phenomenon, at least, generalizes. See Hobsbawm, *supra* note 50. While building the French language and ethnicity through political actions intended to form commonalities for the then-new 'French' political group may be problematic today, nation-building today need not be so-totalizing, especially in the sub-state context at issue here in which other identities matter too. I also discuss this in Da Silva, "Nations," *supra* note 20.

This case requires elaboration, but the basic idea is reasonably compelling.[73] Unfortunately, it is unclear whether it can justify providing *healthcare*-related powers to nations. Whether any group need unfettered power over healthcare allocation or other healthcare powers to exist as a viable political entity is contestable. If nations are constituted by their values and solidarity is a characteristic value,[74] this may require providing healthcare policy-making powers to nations. The empirical record on healthcare as a means of building national identity could favour such power-sharing.[75] Yet narrower understandings of 'constitution' that identify nations with their fundamental sociological characteristics (language, ethnicity, shared history, etc.) may be more plausible.[76] They could leave the federal government free from charges that any of its interventions violate the principles of sub-state nationalism. The Québécois, Acadians, and Indigenous groups could require some social powers to serve as sites for self-determination. But they may not require healthcare-related powers that could potentially limit federal interventions.

III. Options for an Increased Federal Role and their Relations to Sub-State Nations

With these approaches to sub-state nationalism and their potential limitations on federal inventions into healthcare in mind, I can now assess potential federal interventions. I address six here, briefly outlining each and then discussing their relative merits and challenges with a particular focus on issues related to sub-state nationalist claims.[77] My options go beyond the boundaries of present political feasibility to take a comprehensive look at constitutionally available options for an increased federal role. This examination of logical space with even a slight air of reality is a feature of my account, not a bug. Comprehensiveness is necessary to vindicate my

[73] Again, see Da Silva, *ibid* for a longer discussion of this approach.
[74] Seymour (the author of Seymour, "Quebec," *supra* note 21 and Seymour, "Redefining," *supra* note 61, among other classic works on nationalism (often focusing on the Québec case)) makes this claim. So do political actors in Québec and Scotland; McEwan, *supra* note 25; Béland & Lecours, "Sub," *supra* note 25 at 80; Alisa Henderson & Nicola McEwan, "Do Shared Values Underpin National Identity?" (2005) 7(2) National Identities 173.
[75] Sources in *ibid* provide details.
[76] Da Silva, "Nations," *supra* note 20 again contains more details. Policies that lead to all group members failing to receive care or do not cover goods primarily or exclusively required by a group could, eventually, lead to elimination of all group members. But those wrongs can be avoided without giving the group power over healthcare.
[77] I do not address options that would *decrease* the existing federal role even if they could standardize the system, like creation of an arm's length agency to decide on how to operate equalization payments (Daniel Béland & André Lecours, "The Institutional Politics of Territorial Redistribution" (2013) 46(1) Canadian Journal of Political Science 93 [Béland & Lecours, "Institutional"]. Analyzing their implications for the current topic requires its own work. I also do not assume that any tool can remedy all issues with the Canadian system. I am aware of Ezra Rosser, "Self-Determination, the Trust Doctrine, and Congressional Appropriations" in Otis & Papillon, *supra* note 19, 189's claim that the tool selected does not matter if Indigenous health services are still going to be under-funded.

conclusion that no available option avoids difficult value trade-offs in real-world contexts. It also helps establish the potentially wide scope of future research projects on this oft-overlooked issue.

1. Enforcing Existing Law

a. Outline

The federal government enforcing its own laws is, perhaps, an easier route to its improving Canadian healthcare justice. At least two variants of this option merit consideration: enforcement of the *CHA* and resolving issues with existing federal healthcare programs. First, simple enforcement of the *CHA* should improve Canadian healthcare outcomes. *CHA* transfers are contingent on provinces providing "hospital services … [that] are medically necessary" and "medically required services rendered by medical practitioners" ("physician services") to "one hundred per cent of insured persons."[78] Generally, private practitioners provide healthcare in every province and are reimbursed for the provision of insured services.[79] Provinces technically must ensure that practitioners do not subject patients to additional fees for insured services to receive federal funding under the *CHA*.[80] Provincial governments must bar extra billing and user fees. The federal government must withhold payment transfers to provinces that fail to ensure free point-of-service provision of insured services and has withheld them due to extra billing in some provinces.[81] The federal government can also withhold transfers to provinces that do not meet other transfer criteria.[82] They do not exercise this power.[83] Doing so would, of course, be politically difficult (to be it rather mildly). The statute provides ample room not to take such controversial actions. The definitions of the "public administration;" "comprehensiveness;" "universality;" "portability;" and "accessibility" criteria leave ample room for provincial discretion, limiting the instances in which withholding can be uncontroversially enforced.[84] For example, universality only requires that "the health care insurance plan of a province must entitle one hundred per cent of the insured persons of the province to the insured health services provided for by the plan on uniform terms and conditions,"[85] leaving the content of those terms and conditions unspecified.

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[78] *CHA*, *supra* note 2, ss 5, 7-12.
[79] Lahey, "Medicare," *supra* note 1 at 28.
[80] *CHA*, *supra* note 2, s 18.
[81] Flood & Choudhry, *supra* note 15 at 17.
[82] *CHA*, *supra* note 2, ss 15-17.
[83] On these powers, see Lahey, "Medicare," *supra* note 1 at 28; Flood & Choudhry, *supra* note 15 at 17. At best, exercise of these powers is rare.
[84] *CHA*, *supra* note 2. For the criteria, see s 7. For specifications, see ss 8-12.
[85] *Ibid*, s 10.

Yet withholding funds for failure to meet plausible readings of the criteria remains possible under the *CHA*, providing a tool for an increased federal role in healthcare that could improve the system.

Concerns about provincial discretion in defining criteria notwithstanding, then, the federal government could enforce its withholding powers under the *CHA* in a manner that ensures greater continuity of coverage between the provinces with respect to essential healthcare goods that any acceptable definition of medical necessity/requirement should cover. Where provinces fail to secure de minimus access to goods necessary for a dignified existence in the hospital and physician services, the federal government has compelling arguments for withholding funds. The political costs of such action may be high, and the federal government must ensure that it only targets failures that fail to conform to any plausible definitions of the criteria. But legal discretion to withhold funds remains. While judiciary is unlikely to require the federal government to enforce the *CHA*, the federal government could choose to enforce it to standardize care across Canada.

Second, the federal government could improve the Canadian healthcare system by improving its own healthcare-related programs. The most promising version of this variant requires it to ensure that federal Indigenous healthcare programs, like the Non-Insured Health Benefits Program [NIHBP], meet the substantive and procedural demands of healthcare justice. Canada's constitution grants the federal government authority over and responsibility for "Indians, and Lands reserved for the Indians." [86] The federal government thus funds healthcare services on First Nations reserves and provides on-reserve services in some remote regions.[87] The First Nations and Inuit Health Branch of Health Canada further supplements *CHA*-implementation regimes through the NIHBP by providing healthcare services that are provincial insurance programs (e.g., prescription drugs, dental benefits) do not insure to (at least) First Nations and Inuit persons.[88] Indigenous groups claim rights to federal healthcare provision through the NIHBP and on-reserve healthcare service programs, pointing to federal obligations under treaty and fiduciary law.[89] The federal government grants that it has some duties to fund healthcare on-reserve, though it also claims that federal service provision through the NIHBP in particular is discretionary.[90] Case law has not yet settled this dispute. More broadly, "whether Canada has legal discretion to

[86] See note 14.
[87] For a helpful (if somewhat dated) list of programs, see The Jordan's Principle Working Group, Assembly of First Nations, *Without Denial, Delay, or Disruption* (Ottawa: Assembly of First Nations, 2015) at 62.
[88] See Da Silva, "Medicare," *supra* note 4; MacIntosh, *supra* note 56 at 605.
[89] MacIntosh, *ibid* at 608 [also cited in Da Silva, *ibid*].
[90] MacIntosh, *ibid*.

not address the health care needs of Indigenous peoples" is a live question.[91] But the NIHBP exists regardless of its technical legal pedigree. It fills some gaps in healthcare coverage, though access to goods to which persons are entitled under it is often undermined by myriad barriers and decisions in the program are difficult to review, undermining the program's procedural fairness.[92]

The federal government could, in short, play an increased role in the Canadian healthcare system by taking a more 'hands-on' approach to the NIHBP, removing barriers and subjecting its own decisions to review. Like *CHA* enforcement, this would technically be leveraging an existing role towards new healthcare justice-compliant ends but would require more federal action, thereby plausibly qualifying as 'new.' Similar arguments can most likely apply to other federal programs.

b. Benefits

This option should contribute to remedying some Canadian health justice deficiencies without raising significant questions about the legal bases for an increased federal role that could be raised with respect to several options below. A robust version of the *CHA* enforcement strategy could require provision of some essential medicines, remedying issues with access to those goods in the physician and hospital services sectors. That robust approach is the most legally contentious version of this variant. Yet if enforcing the *CHA* alone cannot add essential medicines to the list of goods each province must cover, *CHA* enforcement should require universal access to the essential medicines each province covers on paper. Withholding funds when the five criteria are unmet is not legally suspect, even if it is politically difficult. Provisions of reasons for federal decisions to withhold funds could, additionally, increase the Canadian healthcare system's transparency by necessitating clear public rationales for all funding-related decisions. Proposed NIHBP-based recommendations would remedy access and transparency issues without raising questions about the federal government's abilities to act. While opinions diverge as to whether the federal government must take relevant actions, few would argue that they lack authority to do so.

The federal government can thus remedy some deficiencies with the healthcare system without raising questions about its authority to act in both versions of this option. At least the Indigenous healthcare-related version of the second variant also helps Canada meet some claimed constitutional obligations. A successful argument for this option would thus not only avoid the charge that the option is constitutionally illegitimate but gain support for one reading of

[91] *Ibid* at 576.
[92] Da Silva, "Medicare," *supra* note 4.

constitutional texts. All proposals, including an increased federal role in enforcing the NIHBP, must be consistent with the Aboriginal and treaty rights recognized in section 35 of the *Constitution Act, 1982*.[93] They may require greater access to care in the NIHBP for at least some Indigenous Canadians and could require implementing new/expanded programs in consultation with Indigenous groups.[94] Consultation is clearly required for acts that impact Aboriginal land rights under Canadian constitutional law.[95] An expanded NIHBP could include more consultation.

c. Implications for Sub-State Nations

Unfortunately, the commitments to the status quo with respect to allocation of powers undergirding this option may limit the extent to which it can be consistent with an increased role for sub-state nations in healthcare allocation decisions and delivery in Canada. Existing powers could be used to improve healthcare for Indigenous Canadians, but face challenges from remedial and self-determination-based understandings of sub-state nationalism. A commitment to maintaining existing powers would keep any that constitute continuing historical wrongs in place and forestall full self-governance. Shifting healthcare delivery powers would also prove exceedingly difficult on this option. Even public coverage of Indigenous traditional medicines outside the NIHBP under the *CHA* may be practically impossible under current law. While better healthcare provision for Indigenous Canadians would help remedy one historical wrong, ossifying power could exacerbate others. They could also limit self-determination rights of all Canadian nations on stronger understandings of self-determination or the context necessary for providing it.

Enforcing existing law need not be committed to the ossification of existing powers but abandoning the commitment to maintaining existing powers undermines a benefit of this approach by suggesting one cannot select this option without raising difficult issues about how to enforce it. Sub-state nationalist challenges are then likely to arise. Simple enforcement of the existing *CHA* may be inconsistent with even minimal consultation requirements posited by plausible articulations of sub-state nationalism's healthcare implications. The federal government not only does not need to consult with other entities to enforce the law, but arguably should not do so. The

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[93] *Rights of the Aboriginal Peoples of Canada*, ss 35(1), Part II of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

[94] After all, one treaty includes a right to a medicine chest; *Treaty 6, Between Her Majesty the Queen and the Plain and Wood Cree Indians and Other Tribes of Indians at Fort Carlton, Fort Pitt and Battle River with Adhesions*, 1876, 1889, quoted in MacIntosh, *supra* note 56 at 589.

[95] *Haida Nation v British Columbia (Minister of Forests)*, [2004] 3 SCR 511, 2004 SCC 73; *Rio Tinto Alcan Inc v Carrier Sekani Tribal Council*, [2010] 2 SCR 650, 2010 SCC 43; *Mikisew Cree First Nation v Canada (Governor General in Council)*, [2018] 2 SCR 765, 2018 SCC 40; etc.

government has a duty to enforce the law and cannot do so only when other groups suggest doing so. While a more robust version of the NIHBP still allows consultation, this is partly because its rules are less clearly established in law. If and when the federal government recognizes it is duty-bound to offer the NIHBP, it may attempt to formalize the program's rules in a statute. But such a statute must allow for continuing consultation or be the product of consultation for the formalized program to be consistent with even less- demanding versions of sub-state nationalist arguments.

d. Other Issues

Unilateral federal action (even within the confines of existing federal powers) is, in turn, likely to engender significant political controversy while consultation with the provinces may create the kinds of political stalemates that would undermine this option's benefits. Persistent federal decisions not to withhold funds are understandable: past instances of unilateral federal action created significant political controversies and undermined support for the federal governments who took them. Even making decisions about the transfer formula is politically fraught.[96] Unilateral change is particularly controversial. The *Charlottetown Accord* thus called for an agreement to bar unilateral change of intergovernmental agreements.[97] While this constitutional amendment did not pass and unilateral amendment remains possible, political costs of unilateral action remain high. This provides further reason to question whether the *CHA*-based variant of this option can be implemented without costs that undermine its long-term viability.

Legitimate consultation may further undermine this option's effectiveness. Once we give up on the possibility of unilateral action by enforcing existing laws, risks of political stalemate become acute. Calls for increased consultation as part of a new understanding of how the federal government and provinces can interact to resolve issues are decades old.[98] While consultation between the federal government and Indigenous groups on how to improve the NIHBP may not require the provincial input that explains some past delays, risks of protracted discussions remain.

2. Amending Existing Law

a. Outline

The federal government could amend existing laws to help standardize and improve healthcare in Canada. It could, for instance, amend the *CHA* to more concretely specify what

[96] Béland & Lecours, "Institutional," *supra* note 77 at 104.
[97] Coordinating Committee, Consensus Report of the Constitution: Final Text, Doc CP22-45/1992E (Charlottetown: 27-28 August 1992), s 26 [Charlottetown Accord].
[98] E.g., Premiers of Canada, Calgary Declaration (Calgary: 14 September 1997) [Calgary Declaration].

provinces must do to receive transfers. For example, more precise definitions of 'medically necessary,' 'medically required,' and the transfer criteria terms and more detailed explanations of the implications of the relevant terms could standardize healthcare by limiting provincial discretion and tying federal transfers to more concrete considerations.[99] Additionally, amending the *Act* to make more withholding mandatory could limit concerns above by making withholding non-discretionary and so non-political, though the amendment itself would likely be politically costly.

More controversially, the federal government could, theoretically, amend the federal *Bill of Rights* to include substantive healthcare entitlements for all Canadians.[100] The *Bill of Rights*, the classic federal legislation that was among the first Canadian human rights laws, remains formally valid, if largely superseded.[101] It could be 'revived' and amended to include social rights.[102] The federal government would then be bound to provide those goods to the extent consistent with their jurisdiction. This could require them to take steps to standardize healthcare across the country by guaranteeing funding for some healthcare goods. Even if the *Bill* itself could not give the federal government power to provide healthcare goods to most Canadians (as a federal act cannot give the federal government power), it could be a tool in arguments for standardization or *CHA* reform.

b. Benefits

This option could establish uniform statutory entitlements to healthcare goods that the federal government would be bound to use its constitutional powers to fulfill equally for all Canadians, standardizing at least a de minimus level of entitlements for all Canadians and creating legal mechanisms Canadians could use to challenge the federal government when it fails to exercise its powers to standardize care. More precise definitions in the *CHA* or (much more radically) entitlements under the *Bill of Rights* would also increase the Canadian healthcare system's transparency by providing clear(er) standards for healthcare allocation decision-making and/or statements of the healthcare entitlements persons should have, thereby specifying considerations decisionmakers at least should be considering in their judgments. This could create better data for legal challenges to the healthcare system, bolstering another potential reform tool.

c. Implications for Sub-State Nations

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[99] But recall Flood & Zimmerman, *supra* note 4, who note that more precise definitions may be good policy but past attempts to improve standards by creating principles for identifying 'necessity' largely faltered.

[100] *Canadian Bill of Rights*, SC 1960, c 44 [*Bill*].

[101] *Ibid.*

[102] For a call for a Bill of Rights-like 'social charter,' see Noël Kinsella, "Can Canada Afford a Charter of Social and Economic Rights? Toward a Canadian Social Charter" (2008) 71 Sask LR 7 at 19-20.

However, this option too should likely only be exercised in consultation with sub-state nations that may not produce results that maintain the benefits of federal action without raising problems identified above. This option also appears to assume that existing power relations should continue, raising worries about its ability to coexist with sub-state nationalism's self-governance or self-determination-based implications. It is, further, unlikely to remedy subpar healthcare delivery for Indigenous Canadians, who often have problems with different origins, need to seek goods in other programs (like the NIHBP), and may struggle to ground claims under the *Bill of Rights* in particular. This option accordingly appears even more problematic than the last one.

d. Other Issues

This also faces the political bind above: the federal government can either act alone under this option and face political backlash or consult and face a possible political stalemate. Attempts to resolve stalemates by passing federal laws that do not accord with provincial desires could undermine program effectiveness. Provinces have opted out of programs when the federal government made other decisions on its own.[103] That risk is arguably even greater with this option.

The option also raises at least three unique issues. First, it raises constitutional concerns. The *CHA*-based variant relies heavily on use of the spending power, which remains constitutionally controversial[104] and particularly worrisome for secessionist sub-state nations.[105] While the *CHA* is often-recognized as a valid use of the spending power,[106] one may question the power's scope. The *Bill of Rights*-based variant also raises concerns that the *Bill* was superseded by the *Charter of Rights and Freedoms* and is thus no longer valid or that the *Bill* is quasi-constitutional and should not be unilaterally altered.[107] Second, neither variant binds provincial

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[103] E.g., Québec took its own path following the failure of the Social Union Framework Agreement discussed below; Alain Noël France St-Hilaire & Sarah Fortin, "Learning from the SUFA Experience" in Sarah Fortin et al., *Forging the Canadian Social Union* (Montreal: Institute for Research on Public Policy, 2003) 1 at 19. It previously 'went alone' on pensions; Gerard W Boychuk & Keith G Banting, "The Canada Paradox" in Daniel Béland & Brian Gran, eds, *Public and Private Social Policy:*(London: Palgrave Macmillan, 2008) 92.

[104] For strong arguments against the constitutionality of the spending power, see Andrée Lajoie, "The Federal Spending Power and Fiscal Imbalance in Canada" in Sujit Choudhry, Jean-François Gaudreault-DesBiens & Lorne Sossin, eds, *Dilemmas of Solidarity* (Toronto: U Toronto P, 2006) 145; Andrew Petter, "The Myth of the Federal Spending Power Revisited" (2008) 34 Queen's LJ 163 (2008); Alain Noël, "How Do You Limit a Power That Does Not Exist" (2008) 34 Queen's LJ 391. The constitutional status of the power was a topic of debate surrounding the Meech Lake and Charlottetown Reports respectively; Meeting of the First Ministers on the Constitution, the 1987 Constitutional Accord (Ottawa: 3 June 1987) [Meech Lake Accord]; Charlottetown Accord, *supra* note 92.

[105] Restricted use of the power was a key demand of the Parti Québécois from the late 1980s to at least the early 2000s; André Lecours, "Ethnic and Civic Nationalism" (2000) 4(2) Space and Polity 153 at 163.

[106] See the sources in note 14 and *Carter*, *supra* note 12.

[107] For discussion of the relationship between the *Bill*, *supra* note 100 and the *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11, see

governments, undermining this option's potential effectiveness. The *Bill of Rights* only binds the federal government and thus cannot require that provincial governments do anything, limiting its standardization prospects. The *CHA* imposes conditions on the provincial governments that want funding, but overly-onerous conditions may lead provinces to withdraw from the system and create new programs, undermining proposed moves towards standardization and potentially leaving some provinces less able to provide essential goods than they do now. Finally, even provincially-accepted amendments may not produce desired results. Past attempts to define 'medically necessary' and 'medical requirement' faltered.[108] Decisions remained opaque and did not remedy the Canadian healthcare system's substantive deficiencies.[109] Legal health rights recognition can also lead to misplaced allocation decisions, undermining health justice.[110] So, even this option's best variants may not fulfill basic effectiveness criteria for an increased federal role.

3. Using Part III of the *Constitution Act, 1982*

a. Outline

Some constitutional legitimacy issues above could be remedied by invoking another, often-overlooked provision of the Constitution that could bolster arguments for an increased federal role in healthcare. Part III of the *Constitution Act, 1982* contains a single provision.[111] Some scholars argue that it could create justiciable rights to the provision of some social goods.[112] It reads:

> **36.** (1) Without altering the legislative authority of Parliament or of the provincial legislatures, or the rights of any of them with respect to the exercise of their legislative authority, Parliament and the legislatures, together with the government of Canada and the provincial governments, are committed to

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Hogg, *CLC*, *supra* note 17, ch 35. For discussion of quasi-constitutionality that touches on the *Bill of Rights*, see Vanessa MacDonnell, "A Theory of Quasi-Constitutional Legislation" (2016) 53(2) Osgoode Hall LJ 508.

[108] See Flood & Zimmerman, *supra* note 4. I first flagged this point in note 99.

[109] *Ibid*.

[110] Florian F Hoffman & Fernando RNM Bentes, "Accountability for Social and Economic Rights in Brazil" in Varun Gauri & Daniel M Brinks, eds, *Courting Social Justice* (NY: Cambridge UP, 2008/2010) 100; Alicia Ely Yamin, Oscar Parra-Vera & Camilla Gianella, "Colombia" in Alicia Ely Yamin & Siri Gloppen, eds, *Litigating Health Rights* (Cambridge: Harvard International Human Rights Clinic, 2011) 103; Alicia Ely Yamin, "The Right to Health in Latin America: The Challenges of Constructing Fair Limits" (2019) 40(3) U Penn J Int'l l 695; etc.

[111] *Equalization and Regional Disparities*, s 36, Part III of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*ERD*].

[112] E.g., Kinsella, *supra* note 102; David R Boyd, "No Taps, No Toilets: First Nations and the Constitutional Right to Water in Canada" (2011) 57(1) McGill LJ 81 at 118-122; Martha Jackman, "Law as a Tool for Addressing Social Determinants of Health" in Nola M Ries, Tracey Bailey & Timothy Caulfield, eds, *Public Health Law & Policy in Canada*, 3d ed, (Toronto: LexisNexis, 2013) 91 at 107-109; Karen Busby, "'Providing Essential Services of Reasonable Quality to All Canadians'" (2015) 20(2) Rev Const Stud 191. Subsequent editions of Ries, Bailey, & Caulfield are excellent, but do not undermine the value of the earlier edition. As Kinsella notes at 11n14, former Premier of Newfoundland Clyde Wells viewed the provision as the basis for a 'Social Charter' in Canada.

> (*a*) promoting equal opportunities for the well-being of Canadians;
> (*b*) furthering economic development to reduce disparity in opportunities; and
> (*c*) providing essential public services of reasonable quality to all Canadians.
> (2) Parliament and the government of Canada are committed to the principle of making equalization payments to ensure that provincial governments have sufficient revenues to provide reasonably comparable levels of public services at reasonably comparable levels of taxation.[113]

At least two arguments suggest that this provision requires that all levels of government ensure access to healthcare in Canada. They could more specifically provide the federal government with a (potentially enforceable) *duty* to take an increased role in healthcare. First, subsection 36(1)(c) may require the provision of 'essential public services of reasonable quality,' which may entail a requirement to provide a better healthcare system.[114] Some of the limited scholarly discussion on the provision's content suggests that the federal government must ensure universal access to quality public services regardless of one's province of residency.[115] There is evidence that the provision was meant to justify and require federal spending for these social goods.[116] Perhaps the judiciary must require the federal government to remedy deficiencies in the Canadian healthcare system to meet its constitutional obligations. Further support for better healthcare services for at least Indigenous Canadians who face health disparities could then be grounded in subsections (a) and (b), which suggest that the quality must be up to the level necessary to provide equal opportunities for all. The commitments in section 36 supporting a mechanism for ensuring equality across the provinces, rather than quality within them, does not undermine the fact that this passage suggests that governments should ensure that quality services are provided under constitutional law.[117] Second, one could argue that subsections 36(1) and (2) should be read in tandem such that transfers must be conditional on the provision of quality care.[118] This could, in turn, require stronger federal transfer criteria or enforcement of existing withholding powers.

b. Benefits

Section 36 could justify increased federal roles in the healthcare sector and require that the judiciary compel the federal government act within its powers to standardize and improve

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[113] *ERD*, *supra* note 111, s 36.
[114] This tack is similar to the one taken by the authors in note 112.
[115] Aymen Nader, "Providing Essential Services" (1996) 19(2) Dal LJ 306 at 359-360. 365-366 discusses healthcare.
[116] See generally *ibid*.
[117] This line of argument is at least implicit in several passages in the works in note 112.
[118] This is a plausible reading of the brief argument in Jackman, "Jurisdiction," *supra* note 14 at 108-109.

healthcare decision-making and delivery. Its use could also support the previous options by helping eliminate some issues in the last two sections while opening the possibility of leveraging the provision to take further action to standardize care. Subject to other constitutional and political constraints, section 36 could justify various federal actions, allowing policy/lawmakers to test options until section 36's demands are met and existing healthcare deficiencies are remedied.

c. Implications for Sub-State Nations

Yet the flexibility of section 36 use makes it difficult to analyze its merits or implications – or even whether it can exist as a tool for federal acts independent of other options. Commentary on this provision is limited, so its contours remain opaque.[119] It risks becoming a legal black box or, even at best, a mere adjunct to other options that inherits their weaknesses with their benefits.

An independent section 36 also faces sub-state nationalist challenges. For instance, questions remain about whether binding sub-state nations who were not party to the constitutional text constitutes a wrong. Yet reading section 36 as *requiring* federal action may undermine the federal government's ability to act in accordance with the demands of sub-state nationalism while reading it as merely *justifying* such action raises still other issues identified above. If the federal government is required to act to standardize care, these requirements must be fulfilled even if they conflict with the desires of other entities with whom the federal government would like to consult, making consultation an exercise in futility. One cannot read a consultation requirement into section 36 to avoid this possibility: discussion at post 1982-constitutional conventions took for granted that section 36 did not require that the federal government consult with any province before introducing transfer-related legislation.[120] Building in consultation requirements for non-provincial nations is thus likely a non-starter. The *Charlottetown Accord* suggested consultation before transfer payment legislation[121] and would have demanded Indigenous consultation in certain areas,[122] so something like section 36 could be consistent with consultation. Yet *requiring* consultation under the provision likely necessitates a constitutional amendment while making

[119] See Busby, *supra* note 112 at 192n1 for some of the few cases and articles on the provision. The list there is non-exhaustive (as it misses e.g., Kinsella, *supra* note 102) but the basic point it represents is correct. As Busby rightly notes, Nader, *supra* note 115 remains the most extensive discussion of the provision. I further note that it is one of the few discussions outside of textbooks that does not discuss the provision for functional ends, though much of the text focuses how the provision instantiates a commitment to the federal spending power.
[120] Charlottetown Accord, *supra* note 97, s 5.
[121] *Ibid*, s 5.
[122] *Ibid*.

consultation optional raises the possibility that the federal government must take steps to fulfill section 36 absent consultation where optional consultation would hinder fulfilling its obligations.

The federal government also cannot cede authority to other groups on this understanding if there is any possibility that the exercise of that authority will fail to conform to section 36 requirements, further undermining possible sub-state nationalist projects. Self-governance and self-determination by sub-state nations will thus need to remain subject to any existing federal authority. Otherwise, the federal government will risk failing to meet its constitutional obligations.

d. Other Issues

Section 36's aforementioned opacity raises broader issues. To begin, existing commentary and appellate case law questions whether it creates justiciable government obligations.[123] Arguments for justiciability often rest on controversial uses of comparative and international law.[124] Plain language- and constitutional drafting history-based defenses of the use of section 36 provide stronger claims for justiciability,[125] which could ground some federal actions in social services sectors, including healthcare. Declaratory relief may have some positive impact on the realization of social goods if coercive relief is unavailable.[126] Yet the entitlements' contours remain unclear. Further, 'reasonable quality' admits multiple interpretations. Even those who believe that the provision could create some substantive healthcare protections worry that it would only protect programs that existed in 1982.[127] Finally, discussion of equal opportunities alone may not ground procedural guarantees. Section 36, then, could require problematic federal action or justify inertia.

4. Entering a Social Union

a. Outline

The federal government could also standardize healthcare in Canada as part of a new social union with the provinces, territories, and, perhaps, other nations. In 1999, the federal government and every province and territory except Québec famously concluded the Social Union Framework Agreement [SUFA].[128] The agreement explicitly committed all government parties to promoting

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[123] Hogg, *CLC*, *supra* note 17 at 6.6. As Hogg and Busby, *supra* note 112 at 199-200 note, the Nova Scotia Court of Appeal in *Cape Breton v Nova Scotia*, 2009 NSCA 44 stated that non-governmental entities cannot make section 36 claims even if it is justiciable. But Busby argues (at 200-202) that no principle of law would so-limit claimants.
[124] Boyd, *supra* note 112 at 121; Busby, *ibid* at 197-198, 202-206. Busby, like Nader, *supra* note 115 at 360-363, also controversially appeals to international law to spell out the content of the provision at 206-209.
[125] Nader, *ibid* at 311-312, 349-355; Boyd, *ibid* at 120-122; Busby, *ibid* at 203-204.
[126] Nader, *ibid* at 366.
[127] Kinsella, *supra* note 102 at 11-13.
[128] "A Framework to Improve the Social Union for Canadians" in Fortin, *supra* note 98, 235 [SUFA].

"equality of opportunity for all Canadians" in manners consistent with their constitutional powers.[129] It included several commitments whose fulfillment may have remedied Canadian healthcare justice issues. All commitments were supposed to be fulfilled in manner constituent with Aboriginal rights, including treaty rights,[130] potentially avoiding that limit on nations.

The original SUFA bound parties to "[e]nsure access for all Canadians, wherever they live or move in Canada, to essential social programs and services of reasonably comparable quality[,] … [r]espect the principles of medicare [sic] … [namely the *CHA*'s] comprehensiveness, universality, portability, public administration and accessibility" and to provide opportunities for citizen input into policy design.[131] Fulfilling these commitments would have also realized aspects of the international right to health.[132] Fulfilling SUFA's transparency and measurement of program effectiveness commitments would have realized procedural and systemic parts of the right.[133] Its ban on residency requirements "unless they can be demonstrated to be reasonable and consistent with the principles of" the agreement could have ensured that no one faces barriers to care based on when they arrived in the province.[134] Implementation of SUFA commitments to joint planning of social policies and consultation on same would have led to a federal role in development of provincial policies.[135] While SUFA also barred unilateral action by the federal government, another provision barred the creation of new federal social programs without the agreement of a majority of provinces,[136] and still another said that conditional transfers must respect provincial priorities,[137] these binds on federal authority largely reflected existing political reality and came with increased federal involvement in healthcare most provinces agreed to respect in SUFA.

SUFA-like agreements remain possible and could secure federal powers again. SUFA was once understood as expanding on provisions in section 36.[138] Some commentators believed it had the best chance of fulfilling the aims of positive rights proponents absent constitutional

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[129] SUFA, *ibid* at 235.
[130] *Ibid* at 236.
[131] *Ibid* at 235
[132] Da Silva, "International," *supra* note 33 highlights relevant provisions.
[133] SUFA, *supra* note 128 at 236-238.
[134] *Ibid* at 236.
[135] *Ibid* at 238.
[136] *Ibid* at 239.
[137] *Ibid* at 237-238.
[138] Kinsella, *supra* note 102 at 13.

amendment.[139] A similar agreement could again occur in the future absent constitutional amendment. Politics aside, nothing is stopping the federal government from entering a new union.

b. Benefits

Social union agreements are understood to be constitutionally valid products of negotiations between federal and provincial governments, avoiding concerns about formal inconsistency with constitutional law or ignorance of sub-negotiation consultation requirements. New agreements could be drafted in ways that guarantee remedies of existing deficiencies in Canadian healthcare justice. Agreements to publicly fund all essential medicines or make all reasons for healthcare allocation decisions public are just two possibilities. Agreements can also be drafted in ways that maintain the rights of sub-state nations. Sub-state nations could even be parties to a social union agreement and bargain for their interests. Past agreement demonstrated that federal and provincial governments, at least, can agree about the importance of remedying at least some substantive and procedural deficiencies with Canadian social policy in general. They also demonstrated a concern with ensuring any remedies respected the rights of at least some sub-state nations: all commitments were supposed to be fulfilled in manner constituent with Aboriginal rights, including treaty rights.[140] It is conceptually possible that a broader negotiation period could maintain this balance between interests. Instituting the negotiation process would be the first step in this increased federal role, but good faith within the negotiations and action in conformity with the product would constitute increased federal roles that are likely to be less politically suspect and could be effective. Having sub-state nations at the negotiation table could, in turn, ensure that effectiveness is reached with sub-state national concerns in mind.

c. Implications for Sub-State Nations

There are, however, questions about whether any social union that can be reached in Canada will respect sub-state nations and whether even negotiations for a social union that included nations could adequately incorporate sub-state national views. The historical SUFA did not deliver sufficient standardization or sufficient sub-state policy-making powers. It did not achieve a practically valuable balance between standardization of social policy across Canada and the existence of unique sub-state national powers in social policy. SUFA neither included most sub-state nations as parties nor gained support from Québec, the only candidate sub-state nation

[139] E.g., *ibid* at 19.
[140] SUFA, *supra* note 128 at 236.

involved in the negotiation process.[141] This alone provides reason to question whether the historical document incorporated and protected the interests of sub-state nations. The provision that would have allowed Québec and Canada to reach unique special agreements for social policy raised still further concerns. SUFA held that "[f]or any new Canada-wide social initiatives, arrangements made with one province/territory will be made available to all provinces/territories in a manner consistent with their diverse circumstances."[142] While the text of the agreement allowed some deviations from agreed upon standards and actually stated that each provincial and territorial government would "determine the detailed program design and mix best suited to its own needs and circumstances to meet the agreed objectives,"[143] this concession arguably undermined the path towards standardization that the historical SUFA was supposed to offer.

A new SUFA is unlikely to fare better than the historical one. Federal and provincial governments could theoretically reach a new agreement that avoids concerns in the last paragraph. A new agreement could include sub-state nations. Yet historical failures to reach agreements with Québec provide reason to question whether an agreement meet that province's demands for self-determination, let alone one that does so while ensuring proper Canada-wide standards, is possible.

There is, more broadly, ample reason to question whether negotiation processes for a new SUFA-like arrangement can properly incorporate sub-state national views and interests. Problems with nation-to-nation negotiations in Canada are well-documented. Some appear above. The ways in which negotiations often presuppose state-wide values or take place in the context of significant power imbalances are just two exemplary issues with negotiation-based approaches to resolving state and sub-state national disagreements.[144] They also help explain why negotiations between states and sub-state nations on central legal and policy matters often fail. Moving outside healthcare settings, recall also issues with negotiations that did not even address important Indigenous rights claims, which were called for in the *Meech Lake Accord* and the *Charlottetown Accord* and still sought by some sub-state political actors.[145] Negotiations to plan future negotiations and the *Accords* themselves unravelled. Concerns about different Canadian

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[141] St-Hilaire & Fortin, *supra* note 103 at 8.
[142] SUFA, *supra* note 128 at 238.
[143] *Ibid* at 239.
[144] Michael Coyle, "Establishing Indigenous Governance" in Otis & Papillon, *supra* note 19, 141. Another article in the same volume, from a lead negotiator on the Nisga'a Treaty, affirms the issues raised by Coyle; Jim Aldridge, "The Nisga'a Treaty" in Otis & Papillon, *ibid*, 159.
[145] See note 112 for relevant texts.

governments' lack of respect for sub-state nationality and power imbalances partially explain these failures; they also explain why governmental reports once called for negotiation for Indigenous nations to resolve outstanding issues,[146] but no longer do so.[147] Negotiations are a problematic tool for nation-to-nation interaction. Self-determination rights are often implicitly denied at the outset. Rights thereto are often omitted from outputs. So, new agreements may inadequately incorporate or protect sub-state nationalist viewpoints or interests.

d. Other Issues

If all relevant parties were able to reach a new SUFA-like arrangement, parties still may not fulfill its terms. Those who remember SUFA most likely remember that it did not increase transparency or intergovernmental cooperation – or even create the kind of public support that would pressure government to increase them (since most Canadians were unaware of it).[148] By 2003, just 4 years after the agreement was reached, it could be described as "an agreement that ended up having relatively little significance"[149] Its impact on healthcare was negligible at best.[150] Social union agreements are also easy to replace: a new government opts out and they end. Any new social union may not even get buy-in from every potential party, as Québec showed last time.

The federal government seeking social union agreements in a piecemeal fashion will not resolve the problem of new governments easily opting out. It then raises a further concern: 'side deals,' like the 2004 post-SUFA 'Health Accord,' are highly politically contentious, even when constitutional,[151] and so likely to exacerbate tensions. Buy-in from some provinces can increase tensions with others, undermining any attempts at desirable standardization. Moreover, while SUFA was widely viewed as constitutionally legitimate, even effective SUFA-like agreement could prove inconsistent with (at least Canadian) federalism: to wit, any cooperation agreement that does not maintain distinct spheres of federal and provincial action will raise questions about whether the parties agreed to deviate from the constitutional text in a legally contestable fashion.[152]

5. A National Healthcare Strategy

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[146] E.g., Royal Commission on Aboriginal Peoples, *Report of the Royal Commission on Aboriginal Peoples*, vol 1 (Ottawa: Canada Communication Group, 1996) ch 16.
[147] E.g., TRCC, *supra* note 56.
[148] St-Hilaire & Fortin, *supra* note 103 at 3-4.
[149] *Ibid* at 4.
[150] Antonia Maoini, *Discussion Paper No 34* (Ottawa: Commission on the Future of Health Care in Canada, 2002) at 7-9.
[151] E.g., Sujit Choudhry, Jean-François Gaudreault-DesBiens & Lorne Sossin, "Introduction" in Choudhry, Gaudreault-DesBiens & Sossin, *supra* note 104, 3 at 10.
[152] As Bednar, *supra* 45 rightly notes, an agreement to deviate is still a deviation.

a. Outline

The federal government could also adopt a national healthcare strategy to help improve health outcomes in Canada. This strategy could take many forms but would likely be institutionalized as a non-legislative document or through a mix of federal legislation binding the federal government and federal draft legislation that could be adopted by others. The federal government can easily adopt a policy that does not bind the provinces to do anything but calls on them to do so. It can likely also adopt draft healthcare legislation that becomes valid when adopted by provinces under section 94 of the *Constitution Act, 1867*.[153] Non-specialists often over gloss that provision. Section 94 allows the federal government to make laws for (common law) property and civil rights, but the laws are only valid if and when provinces opt in.[154] On the standard understanding, provinces that do not opt into the system are compensated for what they would have received under the provision.[155] While section 94 is rarely discussed, a plausible interpretation suggests that it could combine with section 36 to justify a federal healthcare power.[156] At minimum, it seems to allow federal draft legislation to which provinces could opt in.

A national healthcare strategy would offer a potential path for the federal government to promote standardization of healthcare policy in Canada, regardless of whether it is instantiated through a non-binding federal policy document or draft legislation passed under section 94. Such a strategy could clearly specify goods that should be covered under public health insurance programs or the procedural and structural guarantees Canadian programs should ensure.

b. Benefits

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[153] *1867*, *supra* note 14, s 94.

[154] Marc-Antoine Adam says it should apply to all provinces; "Fiscal Federalism and the Future of Canada" in John R Allan et al., eds, *Canada: The State of the Federation 2006/07* (Kingston: McGill-Queen's UP 2008) 295; "Federalism and the Spending Power" (2008) Policy Options 30, IRPP <http://irpp.org/wp-content/uploads/assets/po/equalization-and-the-federal-spending-power/adam.pdf>. It is written more narrowly:

> Notwithstanding anything in this Act, the Parliament of Canada may make Provision for the Uniformity of all or any of the Laws relative to Property and Civil Rights in Ontario, Nova Scotia, and New Brunswick, and of the Procedure of all or any of the Courts in those Three Provinces, and from and after the passing of any Act in that Behalf the Power of the Parliament of Canada to make Laws in relation to any Matter comprised in any such Act shall, notwithstanding anything in this Act, be unrestricted; but any Act of the Parliament of Canada making Provision for such Uniformity shall not have effect in any Province unless and until it is adopted and enacted as Law by the Legislature thereof.

[155] See both works in *ibid*. Note, however, that Meech Lake Accord, *supra* note 104, s 106A and Charlottetown Accord, *supra* note 97, s 25 would have required compensation for those who do not participate in "shared cost programs." One could read these as implying that no compensation is needed absent adoption thereof.

[156] See note 154.

This option is likely constitutional. It maintains exclusive spheres of jurisdiction for federal and provincial governments. The proposal may also be required for Canada to fulfill its international right to health commitments,[157] suggesting that it may have extraterritorial benefits. Buy-in for strategy-promoted programs would remedy deficiencies in Canadian healthcare justice. Even the specified goals in weaker variants of the option could remedy deficiencies by placing pressure on some provinces to conform to the strategy, though the pressure (and thus remedies) are admittedly unlikely to be uniform. This option thus offers a federalism-compliant possibility of more standardized healthcare policy and improved healthcare decision-making and delivery.

c. Implications for Sub-State Nations

A national health strategy could be developed in consultation with sub-state nations and allow differentiation for particular locations and populations consistent with at least aspects of remedial and self-determination-based accounts of sub-state nationalism and their implications for social policy. Both the opt-out system and non-binding strategy are consistent with (and could even help foster) Québécois self-determination with the opt-out system even compensating Québec for any goods provided to other entities, thereby providing funds that could help realize Québec's province-specific aims. Moreover, in both cases, the existence of the national strategy could (again) create at least political pressure for (some) provinces to conform to the strategy, offsetting some risks of non-standard or subpar provincial decision-making and delivery discussed above.

A national healthcare strategy could also include mechanisms for (in the section 94 case) or political pressure for moves towards (in the non-binding guidance case) remedying some injustices against Indigenous Canadians, if not Acadians or the Québécois. A strategy could, for instance, include increased Indigenous access to healthcare goods, public funding for Indigenous medicines and health knowledge protection, and increased Indigenous health outcomes as key foci.

While this option *might*, in turn, assist Québécois self-determination to some degree, neither variant realizes aspects of Indigenous or Acadian self-determination. National healthcare strategies are in tension with Indigenous self-governance. Such strategies seemingly presuppose state governance as a prior good and do not provide easy mechanisms for self-governance within them. The section 94-based variant of this option also does not provide Indigenous Canadians or Acadians with options as to whether to opt into the national program, let alone compensation for not opting in that could further self-determination. Such a variant could foster sub-state

[157] Da Silva, "International," *supra* note 33.

nationalism where sub-state nations co-extend with provinces. But, as noted above, the best cases for sub-state national powers in the healthcare context apply to Indigenous Canadians. An option that gives them less power than other sub-state nations is, accordingly, at best far from ideal.

There may be a further concern about whether this option can be consistent with any sub-state national role in healthcare that should follow from the specific context for self-determination case for sub-state nationalism. The most plausible account of why that case entails that sub-state nations should have some social policy powers states that control over social policy is necessary for there to be a sub-state nation. I suspect that the best case for applying this in the healthcare setting is that healthcare policy is fundamentally value-laden, and one needs to be able to make healthcare decisions in conformity with national values to exercise one's right to self-determine through a nation. This combination of claims led Québec and Scotland to claim that their differential (in both cases, then-more left-leaning) politics grounded entitlements to social policy powers.[158] The claim was that full control over healthcare policy is necessary to foster these solidaristic national values. While that case is contentious – nations need not share political orientations and full control over policy is likely unnecessary to foster solidarity in any case – the concern that national healthcare policies forestall the creation of unique national values remains. Any national healthcare policy must allow value-based deviations to avoid the concern.

d. Other Issues

There is reason to question whether this option will bring about its desired ends, but at least the second version shows promise in the right political circumstances. The first version, use of section 94, is clearly constitutional but relies on substantial provincial opt-in (or political pressure to conform to healthcare justice when provinces opt-out) to ensure that existing deficiencies in Canadian health justice are remedied. There is little reason to think that provinces will opt in now or that circumstances will arise that create the kind of political pressure that would lead opt-out provinces to remedy deficiencies. Andrew Petter accordingly critiques reliance on section 94 to increase the federal role in social policy generally.[159] He then notes that a section 94-based approach to policies could lead to power asymmetries with the federal government having more power in some provinces (viz., where section 94 reigns) than others.[160] This may violate the spirit,

[158] Béland & Lecours, "Sub," *supra* note 25 at 80. See also Da Silva, "Nations," *supra* note 20.
[159] Petter, *supra* note 104 at 170-172.
[160] *Ibid*.

if not the letter, of federalism. The second version, a non-binding national healthcare strategy, relies even more on political pressure to bring about certain ends. Whether the federal strategy can create the right kind of pressure is contestable. SUFA-like concerns linger. Yet the option's non-binding nature at least avoids Petter's further concern about power asymmetries. Given the right circumstances where political pressure can be assumed, a non-binding national healthcare strategy may be advisable given its benefits and the relatively minimal number of potential drawbacks.

6. Constitutional Amendment

a. Outline

Finally, constitutional amendments could provide the federal government with increased roles in healthcare or paths towards standardization with a strong federal role. One amendment could create explicit healthcare powers for the federal government.[161] Another could entrench the spending power and specify ways that it can be used for standardizing healthcare in Canada.[162] A flexible amending power could effectively move healthcare powers to the federal government.[163] Constitutional rights to healthcare goods for 'everyone' or Indigenous Canadians alone could also be recognized.[164] Such rights could apply to both levels of government, standardizing care for all. Provision of a "reasonable standard of living" as a constitutional "economic union" policy objective or creation of a Social and Economic Union could provide a federal role in standardizing healthcare by explicitly constitutionalizing the viability of a social union.[165] The *Charlottetown Accord* included a non-justiciable provision that would have led to the creation of a "Social and Economic Union."[166] One objective would have (non-justiciably) quasi-constitutionalized the *CHA*: its social union policy objectives included "providing throughout Canada a health care system that is comprehensive, universal, portable, publicly administered and accessible."[167] Other nations recognize non-justiciable healthcare guarantees short of rights to healthcare.[168] Canada

[161] For the relevant provisions allowing and specifying conditions for amendment of the constitution, see *Procedure for Amending the Constitution of Canada*, Part V of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11 [*Procedure*].
[162] *Ibid*.
[163] Petter, *supra* note 104 at 172-173.
[164] The rules would again be those in *Procedure*, *supra* note 161.
[165] Charlottetown Accord, *supra* note 97.
[166] *Ibid*.
[167] *Ibid.*
[168] For a comprehensive list, see Evan Rosevear, Ran Hirschl & Courtney Jung, "Justiciable and Aspirational Economic and Social Rights in National Constitutions" in Katharine G Young, ed, *The Future of Economic and Social Rights* (Cambridge: Cambridge UP, 2019) 37.

could too. While the federal government cannot make constitutional amendments on its own, valid constitutional amendments could give it powers to standardize care or require that it take steps necessary to standardize care (to the extent its pre-existing constitutional powers allow). I cannot address all possible amendments here. Common benefits and weaknesses permit a joint analysis.

b. Benefits

Given the level of buy-in necessary to pass a constitutional amendment in Canada, adopted constitutional amendments will come with a level of legitimacy that will make it difficult to pass healthcare policy inconsistent with constitutionally-entrenched health-related aims. Constitutional commitments to certain health justice goals could also serve an important expressive role. Acknowledging a constitutional health justice value of some kind would reflect many Canadians' self-understanding and make health justice an interpretive tool for all constitutional analysis.[169]

c. Implications for Sub-State Nations

Unfortunately, some potential health outcome/justice-promoting amendments fit uneasily with national self-determination, let alone self-governance, and constitutional negotiations raise the same issues as SUFA-like agreements. Further, Acadians may not be invited to future constitutional conventions and constitutional amendment procedures that do not include all sub-state nations likely fail to respect sub-state nationalism. Where any amendments likely require the equality of the provinces, there is also reason to wonder whether they can allow proper sub-state nationalism. Past constitutional negotiations stressed the equality of the provinces.[170] The *Calgary Declaration* limits the possibility of the Québécois nation having powers that do not belong to other provinces: "If any future constitutional amendment confers powers on one province, these powers must be available to all provinces."[171] Scholars question whether sub-state nationalism can be consistent with provincial equality.[172] If one avoids that concern,[173] Québec still may not be able to possess powers qua nation under a possible amendment where that would violate provincial equality. Amendments that give the *federal* government additional powers remain possible. But the possibility of creating such powers in ways that allow the flexibility necessary for the powers

[169] Da Silva, *Pluralist*, *supra* note 4 further analyzes the pros and cons of a constitutional values approach.
[170] See two different notes in Calgary Declaration, *supra* note 98, s 2 and Meech Lake Accord, *supra* note 104.
[171] Calgary Declaration, *ibid*, s 6,
[172] See generally the works of Michel Seymour, including those cited above.
[173] *Ibid*.

to co-exist with sub-state nationalism and the possibility of Québec buying into an amendment process, legitimizing the output from a sub-state national perspective, would then be minimized.

d. Other Issues

Constitutional amendment is more broadly unlikely and healthcare reform is not the most pressing topic for any amendment process that may occur. An entrenched constitutional federal spending power is likely advisable, but unlikely to get support. Provinces are unlikely to agree to provide more power to the federal government over healthcare or recognize healthcare-related rights that threaten to upset government purses. Gaining necessary support from Québec will be especially difficult. Such support is, moreover, likely to require concessions that may undermine use of the spending power to standardize care in the first place. One expects that Québec would require the ability to set the terms of funding to sign on to any amendment. At minimum, history suggests it will likely require 'side deals' on funding. Those deals face the issues outlined in the previous sub-section: even if they could be resolved as a matter of Canadian constitutional law, political or economic power asymmetries between sub-state units often destabilize federations.[174]

Even if other amendments were possible, they are likely inadvisable. For instance, recognizing rights to health or healthcare can create many issues. Comparative data suggests that justiciable health rights are often tools for middle-class resource grabs and create, rather than remedy, healthcare injustice.[175] It also suggests that non-justiciable rights, like the aforementioned social union policy, can be used to fashion justiciable rights out of existing constitutional rights, creating the potential for similar kinds of injustice.[176] There is reason to question whether judges in any country are well-suited to make the determinations necessary to remedy healthcare justices. Yet health rights will surely rely on such judicial competence if they are going to be effective tools.

IV. Observations: The Need for Trade-offs and Relative Value of a National Healthcare Strategy

The preceding analysis of options for an increased federal role in healthcare in Canada and their fit with plausible accounts of sub-state nationalism suggests several considerations. I will now address the most notable ones from the most general to the narrowest, thereby first articulating

[174] Patricia Popelier & Bea Cantillon, "Bipolar Federalism and the Social Welfare State" (2013) 43(4) Publius 626.
[175] See e.g., the sources in note 110. I draw on these in more detailed discussions in Da Silva, *Pluralist*, *supra* note 4.
[176] *Ibid*. See also Shylashri Shankar & Oratap Bhanu Mehta, "Courts and Socioeconomic Rights in India" in Gauri & Brinks, *supra* note 110, 146; Ottar Maested, Lise Rakner & Octavio L Motta Ferraz, "Assessing the Impact of Health Rights Litigation" in Yamin & Gloppen, *supra* note 110, 273. India may have slightly better results.

observations with implications for multinational democracies in general and ending with a concrete policy recommendation for the Canadian case study at the centre of my analysis.

First, the preceding suggests that no option for an increased federal role in Canadian healthcare policy fits easily with more demanding accounts of sub-state nationalism. While some options may remedy some past injustices and permit 'some involvement' by sub-state nations in healthcare decision-making and delivery, including consultation, no option easily fits with sub-state national self-governance and/or full sub-state national control over healthcare policy. This at least suggests (without proving) that an increased federal role in healthcare policy may be functionally, if not formally, inconsistent with versions of the self-determination and the specific context for self-determination cases for sub-state nationalism. At minimum, there is a tension between an increased federal role and some variants of those accounts of sub-state nationalism.

This could lead us to question whether the federal government is best placed to remedy the issues, adopt a less demanding account of sub-state nationalism's implications, or accept the potential tension and choose which good (standardization or sub-state powers) we value more. The potential tension alone does not speak to which response is preferable. Rather, it highlights an issue that may lead us to re-evaluate our normative concepts or policy preferences. We need to determine whether our best accounts of healthcare justice and sub-state nationalism can cohere. We may use evidence of coherence as support for our accounts being the best. Yet we cannot assume that our best accounts will cohere. We may need to decide which one we value more.

That outcome establishes burdens for those who seek to promote more federal action. If one prefers standardization, one likely faces the further task of establishing that the federal government is substantially more likely to achieve it than other actors. An explicit commitment to a policy preference should commit one to the actions necessary to realize it. Prioritizing federal pursuit of healthcare justice over sub-state national control is best justified where it can be shown that it will better fulfill the prior aim of standardization and improvement of care. At best, this creates a further burden of justification of federal programs than many would expect. The preceding analysis thereby sheds light on the relationship between the relevant phenomena. Similar normative considerations apply in other multinational states and those states will have similar policy-making options, which makes it likely that the tensions will appear elsewhere. This at least demands scrutiny of whether and how they apply elsewhere and how other countries can resolve them. It is likely that other countries will also need to trade off different normative commitments.

Second, the preceding suggests that the standardization and improvement rationales for increased federal roles only justify increased federal roles in healthcare in particular political circumstances and any negotiation requirements of sub-state nationalism may undermine those aims. This observation too likely generalizes beyond the Canadian case, though Canada raises unique issues. Several options are beneficial partly due to the flexibility that they afford the federal government to act to remedy deficiencies with the Canadian healthcare system. But this flexibility is often politically contentious, could present constitutional law issues in the Indigenous case, and raises concerns about proper respect for sub-state nations on some understandings of sub-state nationalism. At minimum, requiring the federal government to consult with sub-state nations is necessary to resolve these issues. But some forms of consultation are likely to undermine flexibility and undermine the federal options' effectiveness and thus rationale. This tension is likely to arise in other states since consultation is desirable in federal arrangements even where it is not constitutionally required. But existing Canadian laws make the issue particularly acute in Canada.

The underlying concern is greater still in negotiation contexts. This suggests that only a weaker consultation requirement in which the federal government can continue to act flexibly in the face of negative appraisals of their proposed actions in the consultation process can be consistent with successful adoption of several options for an increased federal role. But such a requirement is far less than many real sub-state nations desire. Canadian constitutional consultation requirements for Indigenous Canadians in Aboriginal rights cases are critiqued for failing to reflect the true status of sub-state nations and moral implications of that status.[177] Here too the preceding analysis presents a challenge that requires further evaluation of one's preferences and concepts. One can adopt a weaker consultation requirement or an account of sub-state nationalism that does not entail consultation or negotiation to address this issue. Or one can again choose whether one values standardization or sub-state nationalism(s) more. Some choice always remains necessary.

Third and relatedly, the preceding analyses suggest that many potential options for an increased federal role are unable to improve healthcare justice in Canada in particular in a manner that is consistent with both Canadian constitutional law *and* plausible accounts of sub-state nationalism. The tension between federal control and sub-state national control and the tension between effective federal policy and sub-state national involvement in policy creation are not the only tensions identified above. There is, it seems, another tension between the sufficiency criteria

[177] E.g., sources in note 19.

for an increased federal role that is consistent with sub-state nationalism. The analyses above suggest that no option is likely to perfectly fulfill the more demanding versions of all the criteria.

Among the options above, the social union agreement and non-binding national healthcare strategies appear to face the fewest challenges from sub-state nationalism and constitutional law. Yet there is scant evidence that a new social union agreement can be reached in Canada or that any such output will improve Canadian healthcare justice. A national healthcare strategy can be more easily implemented, but a poorly designed strategy is also unlikely to improve health justice.

One may worry that fulfilling all these criteria is accordingly impossible in the real world, but that is likely too strong. The above instead demonstrates that the circumstances in which a constitutionally sound increased federal role can avoid all legitimate charges from sub-state nationalists and still affect necessary change are limited. This is, perhaps, to be expected: policy-making is hard. My analysis confirms that this common-sense banality. Happily, it also provides a better understanding of the limits of an increased federal role and suggests one should look out for political circumstances in which the federal government can take one of the options above in a way that will actually improve the Canadian healthcare system. It also suggests that one may need to make choices about one's policy preferences. Historically, English Canadians tend to prefer standardization; French Canadians do not.[178] Now one can see why the relevant choice may be necessary in our non-ideal circumstances, seek to minimize its necessity, and commit to the adoption of healthcare policies that do not create as much tension between the relevant norms.

Indeed, fourth, the preceding analysis provides Canada in particular with reasons to adopt a national healthcare strategy. Adopting such a strategy is likely wise in any case.[179] As noted above, it is needed for Canada to meet its international obligations.[180] It is also likely to an effective tool for guiding policy-making towards discrete, publicly available ends. The above provides further reason to adopt it now even if it will not fix all issues with the Canadian healthcare system.

My evaluation of the options suggests that a national healthcare strategy best balances the (now seemingly competing) demands of an acceptable increased federal role in healthcare policy and sub-state nationalism. That option is far from a panacea, but it is likely to create necessary political pressure even in current circumstances, particularly where international law already

[178] E.g., Will Kymlicka, *Finding Our Way* (Oxford: Oxford UP, 1998) at 161-162.
[179] I highlight independent benefits in Da Silva, *Pluralist*, *supra* note 4.
[180] See note 157 and surrounding.

requires such a strategy and soft pressure from the international community can bolster the national strategy's soft pressure to improve care.[181] Where a strategy is developed in consultation with provinces and sub-state nations, it should be viewed at least partly as a product of those entities and so create further pressure on those entities to act under their respective authorities to achieve its aims and so better realize healthcare justice in Canada. Adoption of a national healthcare strategy may be a far less ambitious endeavour than other proposals for an increased federal role in healthcare. But where there is already reason to recognize it and it is the option for an increased federal role in Canada that best balances competing demands, adopting it appears wise. Those who wish to adopt other options must take substantive stands on various issues to resolve the tensions above. Adopting this option can be done now without such potentially controversial commitments.

The preceding thus identifies several tensions that law and policy-makers will face if they try to adopt federal options for improving healthcare justice and seek to respect sub-state national interests in healthcare policy but is not normatively inert. Theoretically, it provides reason to question our understanding of our normative concepts or policy preferences. Practically, it provides reasons to adopt a national healthcare strategy committed to remedying deficiencies in the Canadian healthcare system in consultation with the provinces and sub-state nations. This policy fix should be adopted now absent resolution of other issues. Yet the fact that this best practical option remains imperfect then reinforces the need to make value trade-offs when resolving tensions in the non-ideal institutional context of healthcare policy. The preceding further demonstrated the need to make these trade-offs and one method of doing so.

Conclusion

Tensions between effective federal action in healthcare policy and plausible accounts of sub-state nationalism clearly operate in Canada. They are likely to operate in any multinational democracy. Many can be resolved by choosing to prioritize federal pursuit of healthcare justice over sub-state national control, by adopting different understandings of sub-state nationalism or its implications, or other tacks. But one must make a choice in any case. Preferences must ultimately be ordered. The federal government of Canada in particular can likely remedy several persistent issues with the Canadian healthcare system, but many of its options for doing so are likely to less effective if they need to conform to some of the demands of plausible accounts of sub-state nationalism and its implications for healthcare. Canada, like any other state, must do the

[181] *Ibid.*

hard work of deciding which values to trade off when making decisions about which healthcare laws and policies it is going to allow and adopt in the state. Stakeholders must pay close attention to the trade-offs as shocks to traditional governance, including the COVID-19 context from which I abstracted above, force reassessments of basic health-related authority allocation questions.[182]

If one rejects a basic commitment to the status quo– and I grant that one could take the forgoing as suggesting that the status quo is the best all non-ideal options available –further analysis of provincial options for resolving deficiencies in Canadian healthcare justice remains necessary. We should seek an explanation of how they will better remedy issues while respecting sub-state nationalism before determinatively stating that we should leave primary healthcare policy concerns to the provinces. Indeed, some plausible aforementioned readings of section 36 and the constitution's Indigenous rights provisions suggest that the federal government cannot stay idle while above issues remain, regardless of how provinces are attempting or plan to remedy them.[183] Those broadly committed to the status quo and provincial primacy should be interested in meeting Canada's international obligations and in consulting clear standards to help guide their own policies. Exploring options for establishing those goods should interest those across the political spectrum. Those generally committed to the status quo too may thus consider promoting a national healthcare strategy as the least disruption means of furthering those ends. Those committed to even greater sub-state national control will, in turn, need to wrestle with the various challenges outlined above and may find that national frameworks still permit useful variance.

While I favour a national healthcare strategy, then, I take no *strong* stance on which option for increased federal action is best here. The primary finding from the preceding is the need to identify the need to make trade-offs in the non-ideal circumstances of real-world healthcare policy (and, indeed, social policy more generally). Adopting an 'anything goes' approach in the face of persistent tension and complication is highly problematic in areas so central to stakeholders' basic well-being. One must decide which values to trade off in the real world where even perfectly aligned ideal value scaling is impossible in reasonably adopted institutional contexts. If nothing else, I hope that I have demonstrated how one can do so in Canada and similar multinational states.

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[182] On a return to 'first principles,' see Mireille Paquet & Robert Schertzer, "COVID-19 as a Complex Intergovernmental Problem" (2020) 53(2) Canadian Journal of Political Science 343.

[183] There may also be moral reasons that make the federal government responsible for acting to improve healthcare in federal states even where provincial actors make some efforts; MacKay & Danis, *supra* note 31.