



BACKGROUND PAPER

THE *CANADA HEALTH ACT*: AN OVERVIEW

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The Canada Health Act: An Overview
(Background Paper)

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EXECUTIVE SUMMARY

The *Canada Health Act* (CHA) sets out criteria and conditions that provincial and territorial health insurance plans have to meet in order to receive the full cash contribution for which they are eligible under the Canada Health Transfer.

The CHA requires that “medically necessary” or “medically required” hospital, physician or surgical-dental services be insured by the provincial or territorial plan. As a result, some health services that many Canadians view as essential to maintaining good health – such as prescription drugs and many mental health services – are not required by the CHA to be insured by the provinces and territories.

Provinces and territories are free to insure other health care services in addition to the ones prescribed by the CHA. This means that the basket of publicly insured health services varies among Canada’s provinces and territories.

Over the years, improvements to the CHA have been proposed by health care stakeholders, academics and parliamentarians.

This Background Paper describes the CHA, summarizes provincial and territorial compliance issues, and reviews parliamentary action related to the CHA.

THE CANADA HEALTH ACT: AN OVERVIEW

1 INTRODUCTION

The *Canada Health Act* (CHA) states that

the primary objective of Canadian health care policy is to protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.¹

This legislation, along with the Canada Health Transfer (CHT)² that supports it, is the vehicle that allows the federal government to influence health care, which is primarily within provincial/territorial jurisdiction. The CHA requires that health care insurance plans meet certain criteria and conditions in order for the provincial and territorial governments that manage them to receive the full cash contribution provided for under the CHT.

Canadians sometimes hold misconceptions about what the CHA does and how it may affect them as they access health services. For example, the CHA does not require that all health services be covered under provincial and territorial health insurance plans. Instead, it requires that the provincial or territorial plans cover “medically required” or “medically necessary” hospital services, physician services and surgical-dental services.³ As a result, some services that are seen as an integral part of health care by many Canadians, such as home care services, psychological services and prescription drug coverage, fall outside the scope of services that the CHA requires provincial and territorial plans to insure.

To clarify the CHA’s role in health care, this Background Paper will summarize the following:

- the CHA’s historical context, including a description of the jurisdiction over health of the various levels of government;
- the CHA’s main provisions;
- past and present provincial/territorial compliance issues;
- legal challenges, including *Cambie Surgeries Corporation v. British Columbia (Attorney General)*⁴ (*Cambie Surgeries*), the decade-long court challenge to certain provisions of British Columbia’s *Medicare Protection Act* that is seen by many advocates as threatening the principles enshrined in the CHA;
- criticism of the CHA; and
- parliamentary action relating to the CHA.

2 CONTEXT AND KEY PROVISIONS

2.1 DIVISION OF POWERS AND HEALTH

Sections 91 and 92 of the *Constitution Act, 1867*⁵ assign exclusive legislative authority over certain matters to either Parliament or to provincial legislatures. While some health-related subjects are listed in these sections (hospitals, other than marine hospitals, for example, are a provincial matter), there is no specific reference to “health.” As a result, health-related subjects and measures can be characterized as being within the jurisdiction of either Parliament or provincial legislatures depending on the purpose and effect of a particular measure.

Generally, the provinces have jurisdiction over health care services, the practice of medicine, the training of health professionals and the regulation of the medical profession, hospital and health insurance, and occupational health. Power over these areas is granted by sections 92(7) (hospitals), 92(13) (property and civil rights) and 92(16) (matters of a merely local or private nature) of the *Constitution Act, 1867*.

Parliament has exercised its jurisdiction over health matters under its criminal law power (section 91(27)) and the federal spending power, which is inferred from its jurisdiction over public debt and property (section 91(1A)), and its general taxing power (section 91(3)).

The CHA is an example of the use of the federal spending power. In order to receive the full cash contribution to which provinces and territories are entitled under the CHT, provincial and territorial health insurance plans must meet certain criteria and conditions.

The CHA was enacted in 1984, largely in response to the 1979–1980 national Health Services Review. Precursors to the CHA were the federal *Hospital Insurance and Diagnostic Services Act* (1957) and the *Medical Care Act* (1966). The former was a cost-sharing vehicle relating only to hospital and diagnostic services while the latter also included physician services provided outside hospitals.⁶

A key difference between the CHA and the earlier laws is that the CHA restricts physicians from charging patients fees in addition to what they bill the province or territory for an insured service. These fees are referred to in the CHA as extra-billing and user charges (see section 2.2 below).

2.2 DEFINITIONS, CRITERIA AND CONDITIONS, EXTRA-BILLING, AND USER CHARGES

There are a number of key terms in the CHA whose definitions are required to understand the scope of the Act. These are set out in Table 1 below.

Table 1 – Key Terms in the *Canada Health Act*

Term	Definition
Hospital services	“[S]ervices provided to in-patients or out-patients at a hospital, if the services are medically necessary for the purpose of maintaining health, preventing disease or diagnosing or treating an injury, illness or disability.” A number of specific services are listed in the <i>Canada Health Act</i> under this definition.
Insured health services	“[H]ospital services, physician services and surgical-dental services provided to insured persons,” specifically excluding health services that a person is entitled to, and eligible for, under any legislation or worker’s compensation.
Insured person	A person who is a resident of a province or territory other than a person who has not met the minimum residency/waiting period, a member of the Canadian Forces or “a person serving a term of imprisonment in a penitentiary as defined in Part I of the <i>Corrections and Conditional Release Act</i> .”
Physician services	“[A]ny medically required services rendered by medical practitioners.”
Surgical-dental services	“[M]edically or dentally required surgical-dental procedures performed by a dentist in a hospital, where a hospital is required for the proper performance of the procedures.”

Source: Table prepared by the author based on information obtained from Canada Health Act, R.S.C. 1985, c. C-6, s. 2.

The qualification that services be either “medically necessary” or “medically required” has been the subject of debate for many years. These terms are not defined in the CHA, which has left it open to the provinces and territories to interpret and determine what services are medically necessary or medically required.⁷ As a result, the list of insured services varies from one jurisdiction to another across Canada.

The CHA sets out five criteria and two conditions that must be met so that a province or territory can receive the full contribution for which it is eligible under the CHT.

Table 2 below summarizes the five criteria contained in the CHA.

Table 2 – The Five Criteria of the *Canada Health Act*

Criteria	Summary
Public administration	Requires that the provincial and territorial health care insurance plan be administered on a non-profit basis by a public authority responsible to the provincial government. The public administration criterion only applies to the administration of the plan; it does not mean that health care services cannot be delivered by private entities as long as insured persons are not charged for these services (section 8(1)(a) of the <i>Canada Health Act</i> [CHA]).
Comprehensiveness ^a	Requires that all “insured health services” (as defined in the CHA) be insured by the provincial or territorial health care insurance plan (section 9).
Universality	Requires that all “insured persons” (as defined in the CHA) in a province or territory be entitled to insured health services on uniform terms and conditions (section 10).
Portability	Restricts the maximum period of residency required to be eligible for insured services to three months (section 11(1)(a)) and sets out requirements relating to payments for insured health services provided to insured persons outside the province or territory (section 11(1)(b)(i)) or out of country (section 11(1)(b)(ii)).
Accessibility	Requires that a province or territory provide reasonable access to insured health services on uniform terms and conditions and without financial or other barriers (section 12(1)(a)).

Note: a. The comprehensiveness criterion requires that the provincial or territorial health insurance plan cover all insured health services. These include those provided by hospitals, medical practitioners and dentists, and if the provincial or territorial legislation permits, similar or additional services provided by other health care practitioners.

Sources: Table prepared by the author based on information obtained from [Canada Health Act](#), R.S.C. 1985, c. C-6; and Government of Canada, “The criteria: 1. Public Administration (section 8),” [Canada Health Act Annual Report 2017–2018](#).

In addition to meeting the five criteria, provincial and territorial governments must also fulfill two conditions set out in section 13 of the CHA to qualify for the CHT. The first condition requires that provincial and territorial governments provide the federal Minister of Health (federal minister) with information prescribed in the regulations. The second condition requires that provinces and territories acknowledge the CHT in public documents and advertising that relate to insured health services and extended health care services.

Sections 18 and 19 of the CHA provide that a provincial or territorial health care insurance plan must not permit extra-billing or user charges by health facilities or health care practitioners. Extra-billing is defined in section 2 of the CHA as “the billing for an insured health service rendered to an insured person by a medical practitioner or a dentist in an amount in addition to any amount paid or to be paid for that service by the health care insurance plan of a province.” “User charge” is defined in the CHA as

any charge for an insured health service that is authorized or permitted by a provincial or territorial health care insurance plan that is not payable, directly or indirectly, by a provincial or territorial health care insurance plan, but does not include any charge imposed by extra-billing.

Amounts charged to patients in the form of either extra-billing or user charges must be deducted from cash contribution made under the CHT (section 20). The information on extra-billing and user charges that needs to be provided by provinces and territories, and the timing and manner of filing that information, are set out in the *Extra-billing and User Charges Information Regulations*.⁸ Provinces and territories are sometimes only made aware of cases of extra-billing and user charges when individuals who have paid such charges make complaints about them.

2.3 COMPLIANCE AND ENFORCEMENT

If the federal minister is of the opinion that a province or territory's health care insurance plan does not meet one of the criteria, or that the province or territory is not meeting the conditions necessary for receiving the CHT, the minister may refer the matter to the Governor in Council (section 14 of the CHA). The Governor in Council's possible actions are outlined in section 15:

15(1) Where, on the referral of a matter under section 14, the Governor in Council is of the opinion that the health care insurance plan of a province does not or has ceased to satisfy any one of the criteria described in sections 8 to 12 or that a province has failed to comply with any condition set out in section 13, the Governor in Council may, by order,

(a) direct that any cash contribution to that province for a fiscal year be reduced, in respect of each default, by an amount that the Governor in Council considers to be appropriate, having regard to the gravity of the default; or

(b) where the Governor in Council considers it appropriate, direct that the whole of any cash contribution to that province for a fiscal year be withheld.

As mentioned above, section 20 of the CHA provides that an amount, as determined by the federal Minister, equal to the total amounts charged in extra-billing or user charges by a province must be deducted from the CHT cash contribution to that province.

The CHA requires the federal minister to submit an annual report to Parliament that includes information about provincial/territorial compliance with the criteria and conditions. Possible compliance issues are reviewed by the Compliance and Interpretation Unit of the Canada Health Act Division within Health Canada. The review process includes communicating with the province or territory involved, and, where necessary, asking the province or territory to investigate the issue. The federal minister is involved only if the Canada Health Act Division is unable to resolve the issue. All jurisdictions other than Quebec have also agreed to a dispute avoidance and resolution process.⁹ However, it does not appear that this formal process has ever been used.¹⁰

Over the last decade, CHA compliance issues have included the following:

- extra-billing and user charges at private clinics (British Columbia);
- magnetic resonance imaging (MRI) and computerized tomography (CT) services paid for out of pocket by Canadians;
- clinics that charge annual enrolment and membership fees;¹¹
- Quebec residents not being reimbursed for out-of-province health services at the rate of the province or territory in which the service was provided;
- patients paying for drugs administered in hospital outpatient clinics (medically necessary drugs administered in hospitals are insured services); and
- access to abortion services.

Table 3 lists the provinces that have had deductions or estimated reconciliations applied between 2005 and 2017, and the amounts deducted or subject to reconciliation.¹²

Table 3 – Deductions and Reconciliations Applied to Cash Contributions Under the Canada Health Transfer, 2005-2017 (\$)

Year	British Columbia	Quebec	Nova Scotia	Newfoundland and Labrador	Total
2005–2006	29,019	–	(8,121)	–	20,898
2006–2007	114,850	–	9,460	–	124,310
2007–2008	42,113	–	–	–	42,113
2008–2009	66,195	–	–	–	66,195
2009–2010	73,925	–	–	–	73,925
2010–2011	75,136	–	–	3,577	78,713
2011–2012	33,219	–	–	58,679	91,898
2012–2013	280,019	–	–	50,758	330,777
2013–2014	224,568	–	–	(10,765)	213,803
2014–2015	241,637	–	–	–	241,637
2015–2016	204,145	–	–	–	204,145
2016–2017	184,508	9,907,229 ^a	–	–	10,091,737
2017–2018	15,861,818	9,907,229 ^a	–	–	25,769,047

Note: a. This amount was based on extra-billing and user charges. Because the province addressed these charges, the amounts deducted were subsequently refunded.

Source: Table prepared by the author based on data obtained from Health Canada, “Deductions and Reconciliations to CHST [Canada Health and Social Transfer]/CHT [Canada Health Transfer] Cash Contributions in Accordance with the Canada Health Act (in dollars) – 1992–1993 to 2017–2018,” [Canada Health Act Annual Report 2017–2018](#).

The amounts deducted from Quebec's CHT were based on extra-billing and user charges. Because the province addressed these charges, the amounts were subsequently refunded. The amounts deducted from British Columbia relate to extra-billing and user charges at the Cambie Surgeries clinic. These amounts will be eligible for reimbursement if the province carries out an action plan to eliminate extra-billing and user charges.¹³

In August 2018, the federal minister advised the provinces and territories of three CHA-related initiatives: a Diagnostic Services Policy, a Reimbursement Policy and revised reporting requirements.¹⁴

The Diagnostic Services Policy confirms that medically necessary diagnostic services such as MRIs and CT scans are insured services. This policy responds to jurisdictions that have allowed residents to obtain faster access to diagnostic services by paying for them out of pocket. Where provinces or territories have permitted payment for these services, an amount equivalent to those charges will be deducted from the CHT. This policy will come into effect on 1 April 2020. Starting in December 2022, provinces and territories will be required to report any patient charges.

The new Reimbursement Policy relates to patient charges that have resulted in deductions from the CHT. Where provinces or territories eliminate patient charges that have resulted in CHT deductions and have met specified conditions, deductions may be reimbursed.

Reporting requirements will now include publication in the CHA annual report of provincial and territorial extra-billing and user charges reports.¹⁵

3 **SELECTED ISSUES OF CONCERN**

3.1 **ABORTION**

In New Brunswick, abortions performed outside hospitals (i.e., in a private clinic) are excluded from the list of insured health services. This situation was first raised as an issue of concern in the *Canada Health Act Annual Report 2014–2015*¹⁶ in relation to the comprehensiveness and accessibility criteria. Paying for travel costs and having to take time off work to travel to a hospital for abortion services disproportionately affects women with low incomes.

Up until a few years ago, CHA annual reports had also referred to concerns that Prince Edward Island did not provide access to abortion services on the island. That province also did not insure abortion services performed outside hospitals. Abortion services are now available in Prince Edward Island through the Women's Wellness Program & Sexual Health Services. The *Canada Health Act Annual Report 2016–2017*¹⁷ indicated that P.E.I. is now complying with the CHA. Media reports have also suggested that Ontario may be in violation of the CHA with respect to private facilities that perform surgical abortions where patients are paying a fee in addition to the fee for the procedure that is billed to the province.¹⁸

3.2 PRIVATE CLINICS

The term “private clinic” can refer to facilities that provide health services to patients outside the provincial and territorial health insurance systems, meaning that patients pay physicians directly for services instead of physicians billing the province or territory. Some provinces reimburse patients of these physicians, referred to as non-participating physicians, for amounts equivalent to what the physicians could bill their province. The term “private clinic” can also refer to facilities that provide health services that are billed to the province or territory but that also charge patients directly in the form of a facility fee.

Some commentators over the years have expressed concerns that the existence of private clinics is contrary to the spirit and intent of the CHA, as individuals with the means to pay for health services can access them more quickly than individuals who cannot afford to do so. In 1994, federal/provincial/territorial meetings took place in relation to private clinics that provided “medically necessary services funded partially by the public system and partially by patients.” The Federal Policy on Private Clinics released in 1995 following these meetings stipulates that if provincial or territorial health insurance plans pay physicians’ fees for services in this type of clinic, they must also pay the fees that clinics charge to patients or the federal transfer will be reduced.¹⁹

While provincial and territorial health insurance plans must meet the criteria and conditions set out in the CHA, and must not permit extra-billing or user charges, there is no requirement in the CHA that a province or territory prohibit medically necessary services from being provided outside the provincial or territorial health insurance system. However, to varying degrees, provincial and territorial health insurance plans include provisions that are seen as discouraging medically necessary services from being provided outside the provincial and territorial health insurance systems. It is this type of provision that is currently being challenged in the courts in British Columbia in *Cambie Surgeries*, which is discussed in section 4 of this paper.

3.3 PORTABILITY

As mentioned in Table 2 of this paper, the CHA contains a portability requirement that relates to health care services obtained outside the province or territory of residence or outside the country. The portability criterion outlined in section 11(1)(b) of the CHA requires, among other matters, that the health insurance plan of a province

provide for the payment of amounts for the cost of insured health services provided to insured persons while temporarily absent from the province on the basis that

(i) where the insured health services are provided in Canada, payment for health services is at the rate that is approved by the health care insurance plan of the province in which the services are provided, unless the provinces concerned agree to apportion the cost between them in a different manner, or

(ii) where the insured health services are provided out of Canada, payment is made on the basis of the amount that would have been paid by the province for similar services rendered in the province, with due regard, in the case of hospital services, to the size of the hospital, standards of service and other relevant factors.

On 1 January 2020, most of Ontario's provisions relating to coverage for out-of-country health care services will be revoked.²⁰ As a result, out-of-country coverage for Ontario residents will be available in very limited circumstances only.

At the time that Ontario's changes to out-of-country health insurance were proposed, the then-federal minister, the Honourable Ginette Petitpas Taylor, reportedly advised Ontario's health minister that Ontario would be the first Canadian province or territory that does not provide any coverage for out-of-country emergency health services, and that Ontario's plan would be inconsistent with the CHA.²¹

The *Canada Health Act Annual Report 2017–2018* noted that with respect to the portability criterion and out-of-country coverage, “insured services [for insured persons] are to be paid at the home province's rate.”²²

That report also noted that

[f]or all jurisdictions, except Prince Edward Island and the three territories, the per diem rates for out-of-country hospital services appear lower than home province or territory rates, which is contrary to the requirement of the portability criterion of the CHA.

4 COURT CHALLENGES: *CHAULLI V. QUEBEC (ATTORNEY GENERAL) AND CAMBIE SURGERIES CORPORATION V. BRITISH COLUMBIA (ATTORNEY GENERAL)*

In the early 2000s, a Quebec doctor (Jacques Chaoulli) and patient (George Zeliotis) challenged Quebec's provisions that prohibited residents of the province from obtaining private health insurance for services that were covered by the provincial health insurance plan.²³ Such insurance would be used to pay for a service obtained from a physician who works outside the provincial health insurance plan, enabling individuals to obtain health care services faster than in the provincially insured system.

The plaintiffs in *Chaoulli v. Quebec (Attorney General)* argued that the prohibition on private insurance was contrary to sections of the *Canadian Charter of Rights and Freedoms*²⁴ and the *Quebec Charter of Human Rights and Freedoms* (Quebec Charter).²⁵ Ultimately, the Supreme Court of Canada determined that the prohibition was contrary to the Quebec Charter.²⁶ Since the decision was not based on the *Canadian Charter of Rights and Freedoms*, the decision had no application outside Quebec.

A similar case has been before the courts in British Columbia for the past decade. In *Cambie Surgeries*, the plaintiffs are challenging provisions in British Columbia's *Medicare Protection Act*²⁷ that

- prohibit the purchase of private insurance for services that are insured under the provincial plan;
- restrict medical practitioners from what is referred to as dual practice (meaning that they can practise both within the provincially insured system and outside it); and
- prohibit a non-participating practitioner from charging patients amounts greater than those that would be reimbursed by the provincial health insurance plan.

The plaintiffs argued that these sections are contrary to section 7 (life, liberty and security of the person) and section 15 (equality rights) of the *Canadian Charter of Rights and Freedoms*. The section 7 argument focuses on wait times in British Columbia, alleging that “the BC Government cannot both fail to provide timely medically necessary services to the population, and also prohibit patients from protecting their health by obtaining those services outside of the public system.”²⁸ With respect to section 15, the plaintiffs reasoned that the sections being challenged

impose an unequal burden in a manner linked to protected grounds of discrimination, specifically age, disability, and type of disability. That is because the *Act* prohibits access to private treatment for many BC residents, but exempts others from this harmful restriction – such as those injured at work.²⁹

The Attorney General of British Columbia (AGBC) defended the provisions in part because allowing duplicate private health insurance would “creat[e] an unequal, two-tier health care system in which those with the means to pay ... will have better access to care than those who are forced to rely on the public system.” The AGBC further argued that allowing duplicate private health insurance would likely worsen existing wait times for surgeries in the provincially insured system.³⁰

While the *Cambie Surgeries* action is not directly challenging the CHA, the Attorney General of Canada has intervened in support of the constitutionality of the provisions of the *Medicare Protection Act*, as they “reflect the principles of the CHA.”³¹ As the Attorney General of Canada stated in its final written argument,

striking the *Medicare Protection Act* extra-billing provisions would put British Columbia offside in respect of the *Canada Health Act* extra-billing and user charge provisions, which would have financial implications on British Columbia’s CHT payments. The ripple effect of allowing extra-billing and user charges, in combination with allowing private insurance to cover those costs, also has the potential to engage the accessibility and universality provisions of the *Canada Health Act*.³²

Closing arguments in the trial were heard in November 2019.³³

5 CRITICISM OF THE CANADA HEALTH ACT

The CHA has faced criticism over the years on a number of fronts. Some observers have highlighted the lack of a patient focus within the CHA.³⁴ It is also alleged by some critics that enforcement of the CHA’s provisions is lacking,³⁵ although policies introduced in 2018 by the then-federal minister suggest that the federal government may place a greater emphasis on ensuring compliance. The fact that the CHA requires only that provincial/territorial plans insure hospital, physician and surgical-dental services has also been raised as an issue.³⁶ While the focus of health care in the past may have been on acute care services provided in hospitals or by physicians, many of today’s health care services that are necessary for maintaining good health, such as many mental health services,³⁷ dental care and prescription drugs, are paid for out of pocket.³⁸ Of course, the CHA’s silence on these health care services does not prevent a province or territory from including them in its basket of insured services.³⁹

One proposal for reform is that the CHA require provinces and territories to have “a fair and transparent, and evidence-based process” for determining what health services will be insured.⁴⁰ At the same time, some commentators have suggested that the public administration criterion be amended in order that provinces and territories determine requirements for their plans.⁴¹ As mentioned in section 2.2 of this paper, the lack of definitions for “medically necessary” and “medically required” has also been the subject of debate over the years,⁴² although there does not appear to be consensus about whether any future CHA amendments should define the terms.

6 PARLIAMENTARY ACTION

6.1 PARLIAMENTARY COMMITTEES

In 2018, as part of its study on a national pharmacare program, the House of Commons Standing Committee on Health recommended that the CHA be amended to include prescription drugs dispensed outside hospitals in the definition of “insured health service.”⁴³

6.2 PRIVATE MEMBERS’ BILLS

In May 2019, K. Kellie Leitch, MP, introduced Bill C-450, An Act to amend the Canada Health Act.⁴⁴ That private member’s bill would have added an “accountability” criterion to the CHA. Among other things, the bill would have required provincial and territorial laws to include measures ensuring the delivery of insured health services in a timely manner and, where there was no “reasonable access to care under the plan,” allowed a person to receive insured services outside the plan. The bill died on the *Order Paper* before it was read a second time.

Another private member’s bill sought to amend the CHA to include Applied Behavioural Analysis (ABA) and Intensive Behavioural Intervention (IBI) for individuals with Autism Spectrum Disorder as medically necessary/required services. The bill was first introduced during the 1st Session of the 38th Parliament by Peter Stoffer, MP,⁴⁵ and it was reintroduced in subsequent Parliaments by Mr. Stoffer and then later by Glenn Thibeault, MP.⁴⁶ A similar bill was also introduced during the 39th Parliament by Shawn Murphy, MP; that bill would also have required the federal minister to convene a conference to develop a national strategy for the treatment of autism.⁴⁷

6.3 FEDERAL MINISTER OF HEALTH’S MANDATE LETTER

The mandate letter sent to the federal minister at the beginning of the 43rd Parliament asks the minister to consider making amendments to the CHA to address the following priorities:

- ensuring access to a family doctor or primary health care team;
- setting national standards for access to mental health services;
- improving access to home care and palliative care; and
- implementing national universal pharmacare.⁴⁸

If these amendments are introduced, it may also be an opportunity for the federal government to address some of the other CHA-related concerns that have been raised over the years.

NOTES

1. [Canada Health Act](#) [CHA], R.S.C. 1985, c. C-6, s. 3.
2. Government of Canada, [Canada Health Transfer](#).
3. The Supreme Court of Canada clearly articulates this point in [Auton \(Guardian ad litem of\) v. British Columbia \(Attorney General\)](#), 2004 SCC 78, para. 43:

The legislative scheme in the case at bar, namely the CHA and the [*Medicare Protection Act*], does not have as its purpose the meeting of all medical needs. As discussed, its only promise is to provide full funding for core services, defined as physician-delivered services. Beyond this, the provinces may, within their discretion, offer specified non-core services. It is, by its very terms, a partial health plan.
4. *Cambie Surgeries Corporation v. British Columbia (Attorney General)*, Vancouver Registry, Docket No. S-090663. At the time of writing, the case had not yet been decided.
5. [Constitution Act, 1867](#), 30 & 31 Victoria, c. 3 (U.K.), ss. 91 and 92.
6. For more information on the history of the CHA, see Marilyn E. Dunlop, "[Health Policy](#)," *The Canadian Encyclopedia*, 4 March 2015; André Picard, [The Path to Health Care Reform: Policy and Politics](#), The 2012 CIBC Scholar-in-Residence Lecture, Conference Board of Canada, Ottawa, 2013; and Government of Canada, [Canada's Health Care System](#).
7. See, for example, J. C. Herbert Emery and Ronald Kneebone, "[The Challenge of Defining Medicare Coverage in Canada](#)," *SPP Research Papers*, Vol. 6, No. 32, University of Calgary, School of Public Policy, October 2013; Canadian Health Services Research Foundation, [Medically Necessary: What is it, and who decides?](#), Commission on the Future of Health Care in Canada, Issue/Survey Paper, July 2002; and Timothy A. Caulfield, "Wishful Thinking: Defining 'Medically Necessary' in Canada," *Health Law Journal*, Vol. 4, 1996, pp. 63–85.
8. [Extra-billing and User Charges Information Regulations](#), SOR/86-259.
9. Government of Canada, [Canada Health Act Annual Report 2017–2018](#), Appendix C.
10. House of Commons, Standing Committee on Health [HESA], [Evidence](#), 1st Session, 42nd Parliament, 21 March 2016, 1650 (Abby Hoffman, Assistant Deputy Minister, Strategic Policy, Department of Health).
11. For a review of this issue and the CHA, see Gerard W. Boychuk, "[Grey Zones: Emerging Issues at the Boundaries of the Canada Health Act](#)," *C.D. Howe Institute Commentary*, No. 348, 26 April 2012.
12. Reconciliations occur within this framework when the estimated charges for extra-billing and user charges exceed the actual charges.
13. Government of Canada, [Canada Health Act Annual Report 2017–2018](#).
14. Government of Canada, "[Backgrounder: New Canada Health Act Initiatives \(August 2018\)](#)."
15. Government of Canada, [Canada Health Act Annual Report 2017–2018](#).
16. Government of Canada, [Canada Health Act Annual Report 2014–2015](#).
17. Government of Canada, [Canada Health Act Annual Report 2016–2017](#).
18. Carly Weeks, "[Ontario, New Brunswick violating Canada Health Act by forcing patients to pay for abortions: National Abortion Federation](#)," *Globe and Mail*, 16 July 2019.
19. Government of Canada, [Canada Health Act Annual Report 2017–2018](#).
20. Ontario Ministry of Health and Long-Term Care, "[OHIP Out of Country Services](#)," *Ontario Health Insurance Plan*.
21. The Canadian Press, "[Feds criticize Ontario for eliminating out-of-country health insurance](#)," *CBC News*, 24 July 2019.
22. Government of Canada, [Canada Health Act Annual Report 2017–2018](#).
23. [Chaoulli v. Quebec \(Attorney General\)](#), 2005 SCC 35.
24. [Canadian Charter of Rights and Freedoms](#), Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11.
25. [Charter of Human Rights and Freedoms](#), C.Q.L.R., c. C-12, s. 52.

26. Three of the seven judges also found that the prohibition was contrary to the *Canadian Charter of Rights and Freedoms*.
27. [Medicare Protection Act](#), R.S.B.C. 1996, c. 286.
28. "[Plaintiffs' Final Argument](#)," *Cambie Surgeries Corporation v. British Columbia (Attorney General)*, para. 2656.
29. *Ibid.*, para. 2968.
30. "[Defendant's \[Attorney General of B.C.\] Closing Submissions](#)," *Cambie Surgeries Corporation v. British Columbia (Attorney General)*, paras. 7 and 8.
31. Government of Canada, *Canada Health Act Annual Report 2017–2018*.
32. "[Final Written Argument of the Attorney General of Canada](#)," *Cambie Surgeries Corporation v. British Columbia (Attorney General)*, para. 255.
33. For more information on the case, see, for example, Kelly Grant, "[Universal health care on trial: What you need to know about a historic Charter challenge in B.C.](#)," *Globe and Mail*, 14 November 2019. For commentary on the issues at play in *Cambie Surgeries Corporation v. British Columbia (Attorney General)*, see Marie-Claude Prémont and Cory Verbauwhede, "Canadian legislatures and the regulation of the private health-care industry," *University of Toronto Law Journal*, Vol. 68, No. 2, Spring 2018, pp. 231–258.
34. See, for example, Claude Castonguay, "[Is our healthcare system's future tied to the Canada Health Act? Part 1](#)," *Health Innovation Forum*.
35. See, for example, Colleen M. Flood and Bryan Thomas, "[Modernizing the Canada Health Act](#)," *Dalhousie Law Journal*, Vol. 39, No. 2, 2016, pp. 399–400 (2016 CanLIIDocs 4119).
36. See, for example, Stephen Skyvington, *This May Hurt a Bit: Reinventing Canada's Health Care System*, Dundurn Press, Toronto, 2019, p. 41; and Flood and Thomas (2016), p. 407.
37. See, for example, Erika Dyck, "[Bitter pills: the impact of medicare on mental health](#)," *Health Economics, Policy and Law*, Vol. 13, 2018, pp. 263–279; and Canadian Mental Health Association, "[Mental Health in the Balance: Ending the Health Care Disparity in Canada](#)," September 2018.
38. In some cases, private health insurance (included either as a work benefit or obtained separately) covers some or all costs of those health services.
39. See, for example, Greg Marchildon and Bill Tholl, "Addressing Ten Unhelpful Myths about the *Canada Health Act* and Why It Matters," *Health Law in Canada*, Vol. 37, Nos. 2–3, February 2017, pp. 32–44.
40. Colleen M. Flood, Bryan Thomas and David Rodriguez, "The Rise and Fall of Canadian Medicare & the Role of Law," Chapter 2 in *Canadian Health Law and Policy*, eds. Joanna Erdman, Vanessa Gruben and Erin Nelson, 5th ed., LexisNexis Canada, 2017, p. 69.
41. Jason Clemens and Nadeem Esmail, [First, Do No Harm: How the Canada Health Act Obstructs Reform and Innovation](#), Turning Point 2014 Series, Macdonald-Laurier Institute, Ottawa, June 2012.
42. See, for example, Emery and Kneebone (2013); Canadian Health Services Research Foundation (2002); and Caulfield (1996).
43. House of Commons, HESA, [Pharmacare Now: Prescription Medicine Coverage for all Canadians](#), Fourteenth Report, 1st Session, 42nd Parliament, April 2018, p. 85.
44. [Bill C-450, An Act to amend the Canada Health Act](#), 1st Session, 42nd Parliament.
45. [Bill C-459, An Act to amend the Canada Health Act \(Autism Spectrum Disorder\)](#), 1st Session, 38th Parliament.
46. [Bill C-360, An Act to amend the Canada Health Act \(Autism Spectrum Disorder\)](#), 2nd Session, 40th Parliament.
47. [Bill C-304, An Act to provide for the development of a national strategy for the treatment of autism and to amend the Canada Health Act](#), 1st Session, 39th Parliament.
48. Justin Trudeau, Prime Minister of Canada, [Minister of Health Mandate Letter](#), 13 December 2019.