Applicability of the Charter in the Healthcare Context Through the Lens of Vaccination-or-Mask Policies

by

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Faculty of Law
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Abstract

Despite numerous Supreme Court of Canada decisions on Charter applicability, there has been limited discussion on how the Charter applies to entities operating in the healthcare sector. This paper uses vaccination-or-mask policies as a test case to illustrate the difficulties in applying the current law to determine if the Charter applies to various actors, including hospitals, regional health authorities, physicians’ offices and other for-profit healthcare companies, and the professional regulatory bodies. The analysis demonstrates that the current test remains confusing and unclear, does not significantly reduce the possibility of government shirking its Charter obligations, and may lead to a differential protection of rights across the provinces. A solution is proposed that requests the court to consider a more holistic approach to characterizing an entity as governmental or not. Also, it may be useful to recognize that healthcare as a public monopoly is a unique case for Charter applicability.
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1 Introduction

The Canadian healthcare system is a large point of pride for Canadians and is often thought to be woven into our national identity. Many countries have adopted universal healthcare over the past decade, but the Canadian solution has been unique as a single-payer, publicly-funded, first-dollar system. The *Charter of Rights and Freedoms* has been similarly tied to Canadian identity since its introduction in 1982 with the repatriation of the constitution.¹ Yet there has been little analysis as to the application of the Charter in the healthcare context. Most analyses tend to focus on specific cases or rights, rather than on the preliminary issue of the application of the Charter to the various entities operating within the healthcare system.²

The nature of the Canadian system raises interesting questions as to how Charter rights arise and are protected in the healthcare context and this analysis looks to explore the different ways in which the Charter will apply to issues arising from healthcare delivery. To help ground the analysis in a real-world scenario, this analysis will use vaccination-or-mask policies to guide some of the more fact-driven portions of the analysis. Part 2 provides background information on vaccination-or-mask policies. Part 3 provides a review of the existing legal framework for determining the applicability of the Charter, with a particular focus on Supreme Court of Canada decisions. This includes a discussion of two cases that occurred in the healthcare context specifically; the *Stoffman* decision from 1990, which found that hospitals were not part of government for the purposes of Charter application, and the subsequent *Eldridge* decision from 1997 which recognized that the Charter could apply to the specific activities of non-governmental actors when they are implementing a government policy, such as the delivery of a public healthcare program.³ Part 4 will attempt to apply the principles found in the Supreme Court of Canada case law reviewed in Part 2 to specific healthcare entities, including hospitals, regional health authorities, physicians’ offices, and professional regulatory bodies. Part 5 will

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examine the difficulties of applying the Eldridge test to specific healthcare policies, using vaccination-or-mask policies as a working example of the complex nature of healthcare-related policies. Part 6 summarizes the current challenges associated with applying the Charter to healthcare institutions and policies and offers a suggestion for a way to resolve some of them through a more coherent and principled framework for Charter application in healthcare.

2 Background on Vaccination-or-Mask Policies

Nosocomial influenza infections account for about 17% of influenza cases in Canada, and all-cause influenza is responsible for around 8000 deaths in Canada annually.⁴ Voluntary healthcare worker vaccination rates typically hover around 45% each year in Canadian health institutions, despite education campaigns to improve voluntary uptake.⁵ Since direct contact with patients is the most common method of transmission, there is a strong desire by government and healthcare institutions to improve the rate of healthcare worker influenza vaccination.

Increasing healthcare worker uptake of seasonal influenza vaccination has proved difficult. Initiatives to improve voluntary uptake include education campaigns on the benefits of vaccination for patient care, contests between wards and other incentives, introducing vaccine ambassadors, and incorporating mobile vaccination units on each ward.⁶ Most of these programs have focused on rewarding higher vaccination rates, but more punitive policies have been experimented with as well. The most common version has required employees to stay home during an outbreak if they have not been vaccinated; so-called time-off policies.⁷ Despite these efforts, voluntary programs seem to reach a ceiling uptake of around 60%, although they can be very successful in individual institutions or jurisdictions.⁸

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This intransigence has led officials to consider more coercive policies. While no Canadian jurisdiction has mandated the vaccination of healthcare workers outright, 16 American states have implemented laws requiring that healthcare workers in acute care facilities be vaccinated against influenza.\(^9\) Canadian efforts have instead focused on policies introduced as a condition-of-service for employees or as part of a collective bargaining agreement by either regional health authorities or by individual hospitals. The most recent form of such policies are known as vaccination-or-mask policies, which require healthcare workers to become vaccinated against the flu or wear a mask while on duty during the flu season. Early evaluations of institutions that have adopted such policies have found that mandatory policies are able to achieve vaccination rates over 95%, making them by far the most effective solution to date.\(^10\)

Mandating vaccination of healthcare workers raises the dilemma of balancing healthcare workers’ legal rights of bodily autonomy with the need for patients to receive healthcare services in a safe and non-jeopardizing environment. There are a number of decisions by arbitrators, tribunals and courts that give legal treatment to vaccination policies for healthcare workers.\(^11\) Most have been concerned with time-off policies.\(^12\) Only two — Health Employers Assn. of British Columbia v Health Sciences Assn (“HEABC”) and Sault Area Hospital v Ontario Nurses’ Association (“ONA”) — considered a vaccination-or-mask policy. Both were labour arbitration awards.

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\(^12\) These policies require that healthcare workers who experience flu-like symptoms stay at home, with pay. These policies have fallen out of favour because they do not appear to increase vaccination uptake or decrease nosocomial infection rates. Furthermore, there is a concern that asymptomatic individuals may still be capable of transmitting the virus thereby limiting the overall effectiveness of these policies.
The vaccination-or-mask policy is clearly constructed in order to provide employees with a semblance of choice so as not to attract the legal attention that might come with an outright vaccination mandate. For example in ONA, the arbitrator suggested that the masking option did not constitute a real choice and was merely a way to push people towards vaccination, although the discussion of this issue was not in the context of a Charter challenge. In HEABC, the only decision to consider the Charter issues raised by a vaccination-or-mask policy, the arbitrator hinted that the element of choice might have been enough to avoid Charter scrutiny. The academic literature has thus far been broad and general as to the application of the Charter to mandatory vaccination policies in general and has not considered the relatively new form of vaccination-or-mask policies.

For a Charter challenge to even get off the ground, it must be determined whether the Charter applies to the policy being challenged. This question is complicated by two factors. First, the structural complexity of the healthcare system means that vaccination-or-mask policies can be implemented by a number of different actors. The policy in HEABC was implemented by a regional health authority ("RHA") — a statutory body created to manage health services in different regions across a province — whereas the policy in ONA policy was implemented by an individual hospital administration. These different legal entities may have different sets of Charter obligations. Second, the Supreme Court of Canada’s guidance on when the Charter applies in the healthcare has been muddy. This is partly because of the nature of the Canadian healthcare system, but also because the court continues to struggle with the issue of when the Charter ought to apply to private bodies engaging in public activities. Recent lower court decisions on the applicability of the Charter to universities make it clear that when and on whom the Charter applies is far from a settled legal question. In the analysis that follows the review of the Supreme Court of Canada decisions, we will examine whether a vaccination-or-mask policy


14 See, for example, R Rodal et al., “Influenza vaccination for health care workers: towards a workable and effective standard” (2009) 17 Health Law Journal 297.

15 See, for example Pridgen v. University of Calgary, 2012 ABCA 139, 524 AR 251; BC Civil Liberties Association v. University of Victoria, 2016 BCCA 162.
will be subject to the Charter based on the entity that implements the policy, and alternatively whether the policy itself can be characterized as part of a public healthcare program.

3 Interpretation of s. 32 of the Charter

3.1 The Case Law Pre-\textit{Eldridge}

Found under the heading “Application of Charter”, s. 32(1) of the Charter states:

32. (1) This Charter applies

(a) to the Parliament and government of Canada in respect of all matters within the authority of Parliament including all matters relating to the Yukon Territory and Northwest Territories; and

(b) to the legislature and government of each province in respect of all matters within the authority of the legislature of each province.

The first consideration of the interpretation of s. 32 by the Supreme Court of Canada came in \textit{Dolphin Delivery}. The case involved a labour union’s challenge to a common law rule against picketing. The court held that the common law was indeed subject to the Charter, but at the same time a plain-language reading of s. 32 excluded the Charter’s application to private litigation that was completely divorced from any connection with government. Attempting to clarify it further, McIntyre J. explained that the Charter would apply to actions by the legislative, executive, and administrative branches of government, but not the judicial branch in the form of court orders. He hesitated to precisely define the degree of government intervention that would be necessary to trigger Charter applicability in litigation between two private actors, but suggested that it might apply to delegated legislation such as regulations, orders in council, municipal by-laws, and by-laws and regulations of other creatures of Parliament and the legislatures. Therefore,


17 Dolphin Delivery, at para. 34, 36.

Dolphin Delivery’s interpretation of s. 32 clarified that an element of government action is required to make a Charter challenge, and that strictly private activities were not subject to the Charter. In the cases that would follow, the court would grapple with the degree of government involvement that would sufficiently trigger s. 32 when the entity or institution is not clearly a part of the legislative or executive branches of government.

The Supreme Court revisited the s. 32 interpretation in McKinney v University of Guelph. Here the court considered the policies implemented by several Ontario universities that required the mandatory retirement of employees at age 65. LaForest J., writing for the majority, reiterated the Dolphin Delivery position that s. 32 signalled that the Charter was meant to keep the government in check over the rights of the individual, and not to be applied to strictly private activities. He also pointed out that undesirable private activities could be regulated by the government, but that the government itself needed to be constrained by the Charter, and so this was the clear intent of s. 32.

While the language in the Dolphin Delivery opinion had seemed to focus on the need to find government actions or activities in order to mount a Charter challenge, the majority decision in McKinney took the approach of determining whether universities, as institutional entities, were government actors. The court rejected a number of characteristics of universities that might have suggested they were government entities. The court ruled that a public body or a creature of statute would not automatically be considered a government actor for the purposes of determining Charter applicability. They might simply be non-governmental entities that happened to be created by government and, akin to corporations, their statutory origin merely facilitated private individuals to do things of their own choosing. An important consideration for the court was whether the day-to-day operations of the universities were under the “effective control” of the government, either directly or through an ability to determine the members of the universities’ boards or governing councils. In contrast to colleges, which are discussed below, the court found that the university boards were relatively autonomous actors. The degree of discretion that universities had to negotiate contracts or enter into collective bargaining

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20 McKinney, at pp. 265-266.
agreements – and to include in them mandatory retirement provisions – was itself viewed by the court as a degree of autonomy and independence from government compulsion or influence, statutory or otherwise.

The court considered other arguments as to whether universities were government actors. For example, even though the parties had accepted that the universities served a public purpose, this alone was not enough to characterize a university as a government body. LaForest J. agreed that carrying out a public purpose might mean that some of its decisions would be subject to judicial review, but it did not require that the entire institution be subject to the Charter. Even the fact that historically universities were developed as part of a public system of post-secondary education and that their survival depends on government funding was not considered enough to favour their characterization as a government actor. Furthermore, in a concurring opinion, Sopinka J. emphasized that the core functions of universities were non-governmental in nature, and this seemed determinative in characterizing the institution as a whole as a non-government entity.\(^{21}\) He did, however, more explicitly state that some activities by universities were governmental in nature, hinting at a possible role for Charter application in a different context. Therefore, even though the court acknowledged that universities were part of a public education system, their non-government status was demonstrated through the university’s ability to control its own affairs and the fact that it enjoyed independence from government influence in important internal matters. Other connections to government were likewise less important, including the fact that government bodies largely coordinated and regulated the universities’ activities through operating and capital grants, special funds, control over tuition fees and approval of new programs.\(^{22}\) The university’s autonomous board of governors seemed sufficient to shield university-implemented policies from Charter attacks.

In a companion case, decided at the same time as *McKinney*, the court considered the government status of colleges with respect to s. 32.\(^{23}\) In *Douglas College*, the court contrasted the structural makeup of the board of directors for colleges to that of universities. In a brief

\(^{21}\) *McKinney*, supra note 19 at p. 444. Unfortunately, Sopinka J. does not elaborate on the point.

\(^{22}\) *McKinney*, supra note 19 at p. 273.

\(^{23}\) *Douglas/Kwantlen Faculty Assn v Douglas College*, [1990] 3 SCR 570 [*Douglas College*].
analysis, LaForest J. found that community colleges did not have the same degree of autonomy and freedom from government control as universities and so were subject to the Charter. The determinative fact was that the executive branch had full control over the appointment and removal of board members. For the court, that was enough to show that the college was simply part of the apparatus of government. One argument made in the Douglas College case was that even if the entities in question were generally part of government for the purposes of s. 32, the Charter should not apply to the private or commercial arrangements they engage in. In an important ruling that has had a significant impact on the legal framework that has developed under s. 32, the court rejected this argument and held that when an entity is determined to be part of the fabric of government, the Charter will apply to all of its activities, including those that might in other circumstances be thought of as “private”.24

Alongside the decisions in McKinney and Douglas College, the Supreme Court of Canada released the decision in Stoffman where it found that the Vancouver General Hospital was not bound by the Charter.25 As in McKinney, the court was asked to consider whether the mandatory retirement policy of the hospital would be subject to Charter scrutiny. In his analysis, LaForest J. considered the relevant provisions of the Vancouver General Hospital Act that statutorily incorporated the hospital. He acknowledged that the statute required the hospital to have government representation on its board of directors, that the Minister of Health held a supervisory function over its bylaws, that its board of directors was predominantly appointed by the minister, and that the hospital itself was incorporated solely to carry out a public program. Despite recognizing that these aspects of the hospital’s structure and function suggested a more public character, the court held that the hospital was not a government entity for the purposes of the Charter. Applying the same “effective control test” as in McKinney, the court found that the board of directors could make a wide range of autonomous decisions free from direct government involvement, such as the granting and revocation of admitting privileges for doctors. This satisfied the court that the hospital was autonomous enough to be considered a private entity. Therefore, like those of universities, the mandatory retirement policy of the Vancouver General Hospital would be protected from the Charter. It is worth noting that in contrast to

25 Stoffman v. Vancouver General Hospital, [1990] 3 SCR 483 [Stoffman].
McKinney, where the decision was a joint decision that applied to a number of Ontario universities, the Stoffman decision only considered the governmental status of the Vancouver General Hospital.

Two dissenting opinions in Stoffman would have found the Vancouver General Hospital to be a government entity for the purposes of s. 32. Wilson J. set out a set of questions that would help to characterize entities in the future: (1) Does the legislative, executive or administrative branch of government exercise general control over the entity in question?, (2) Does the entity perform a traditional government function or a function which in more modern times is recognized as a responsibility of the state?, and (3) Is the entity one that acts pursuant to statutory authority specifically granted to it to enable it to further an objective that government seeks to promote in the broader public interest? In her opinion on the first question, the government exerted influence over the hospital through its governing structure, its policy-setting, and its funding. The statute set out the function and powers of the hospital and the hospital’s bylaws — which set out the composition of the board — required ministerial approval before they could be passed. Section 32 of the regulations under the Hospital Act gave the Minister of Health and the Lieutenant Governor broad powers to impose their will on the hospital’s board. She also noted that the hospital enjoyed some government-like powers, such as protection from expropriation. With respect to the second and third questions, Wilson J. noted that s. 92(7) of the Constitution Act, 1867 gives the provinces exclusive jurisdiction over the establishment and maintenance of hospitals, leading her to conclude that it was a traditional government function and likewise that providing healthcare was an important function in the public interest. In sum, she would have characterized the Vancouver General Hospital as a government entity subject to the Charter and the mandatory retirement policy as unjustifiably infringing the equality right under the Charter.

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26 L’Heureux-Dubé J. concurred with her in this part of the analysis.
27 The section provides as follows: 32. The minister may require that the bylaws or rules of a hospital or society or corporation having among its objects the provision of hospital facilities or the operation of a hospital be revised in a manner satisfactory to him in order to meet changing conditions and policies, and to provide for greater uniformity and efficiency in all matters concerning the administration and operation of hospitals., B.C. Reg. 289/73.
3.2 Structural, Financial, and Functional Attributes of Entities

Before reviewing the Eldridge case, which would expand the Charter’s reach, it is useful at this point to consider the different factors that might be relevant to the court in determining whether an entity that is part of the legislative or executive branch of government. Three such factors may be identified from the cases discussed thus far: structural, financial and functional. Structural factors relate to the governance structure of the institutions implementing the challenged policy. The effective control test (that comes from Stoffman and McKinney) focuses primarily on structural factors, such as the degree of autonomy of the board, the selection process for its members, and the degree of influence that government itself has on the board’s decision-making. These factors were the focus of the court’s analysis in both McKinney and Stoffman, and were determinative in deciding whether the institutions at issue were sufficiently autonomous and free from effective government control. In both cases the court discussed how an institution as a whole would be characterized as a government actor where the government had statutory authority to exercise substantial control over the day-to-day operations and policy-making of the institution. Therefore, even if the entity appears to be independent of the legislative or executive branches, it will be considered a government actor if it is nonetheless sufficiently under the control of either of those arms of government. The court would ask questions such as the following: Is there a law that directs how the institution will operate? Does the government appoint the majority of the institution’s board of directors? Does the institution have any history or guarantees of independent action from government?

Financial factors relate to the degree to which the survival of the entities in question depends on government funding. In McKinney and Stoffman, the court acknowledged that both universities and hospitals depended on government funding of their programs, but held that this was not determinative of the degree of control the government had over the institution.

The third factor is the institution’s functional responsibilities. This refers to the dominant activities of the entity or its raison d’être. This factor was given little consideration in the analyses in Stoffman and McKinney. The court did not seem to place a great deal of weight on the fact that universities were part of a larger goal of delivering public education and that

hospitals, too, were part of a larger scheme of a public healthcare program. The court did, however, consider the delivery of public education as important in its finding that colleges were governmental actors. Insofar as the court considered other types of activities that the institutions engaged in, it mainly focused on administrative and other minor activities that stemmed from the power and autonomy of their boards. The fact that universities and hospitals had the authority to implement employment-related policies (such as mandatory retirement policies) suggested that there was a set of activities separate from the direct delivery of public education or public healthcare for those institutions, which in turn reinforced their autonomy. Indeed, the opinion in *Eldridge* seems to acknowledge as much.\(^{29}\) Whatever the explanation, the broader functional attributes of the institutions in question did not seem to factor heavily into the final characterization of whether they were a public or private entity or an entity under effective government control.

Grouping the court’s considerations according to the structural, financial, and functional attributes of the entities in question helps to illustrate the court’s emphasis on structural attributes prior to *Eldridge*. It also highlights that in these early cases that articulated the effective control test, the decision of whether the Charter would apply was made at the institutional level, with all the activities of the institution being subject to the Charter if the entity was found to be under the effective control of government. *Eldridge* would expand the basis for application of the Charter; first by placing a slightly greater emphasis on the challenged institution’s functional attributes, and second — and more importantly — by allowing the Charter to apply to individual policies of private actors rather than to the institution as a whole.

### 3.3 The *Eldridge* Decision

As previously mentioned, the initial language in the *Dolphin Delivery* decision seemed to suggest that the Charter would apply to government activities themselves. With the *McKinney*, *Douglas College* and *Stoffman* decisions, however, the emphasis switched to the structural characteristics of the entities, with little or no analysis being paid to the functional attributes of these institutions. *Eldridge* is the only other Supreme Court of Canada case to examine the Charter’s applicability in the healthcare context since *Stoffman*. To be clear, *Eldridge* does not

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\(^{29}\) *Eldridge*, at para. 47.
place a greater emphasis on functional attributes in characterizing institutions and does not depart from the relying primarily on structural factors when characterizing entities as governmental or not. Instead, it takes a decisive step in requiring the courts to look more closely at the impugned activity, policy, or decision to decide whether it itself is governmental in nature. The policy being challenged in Eldridge was a hospital’s decision not to pay for sign language interpretation services for those requiring them in connection with their receipt of medically necessary services within the hospital. In order to understand the decision, it is necessary to outline the statutory framework that governed how hospital services were funded in BC at the time the Charter challenge was made.

First, like Wilson J. in the Stoffman decision, LaForest J. noted that at the federal level, the Canadian constitution gave provinces jurisdiction over hospitals and healthcare delivery. He also recognized the Canada Health Act as an important piece of federal legislation that helped to set out certain guiding principles for healthcare delivery. At the provincial level, the BC Medical and Health Care Services Act set up the Medical Services Commission that would determine the services that would be insured under the public program and that hospitals would be required to cover. Under s. 10 of the BC Hospital Insurance Act, hospitals were to be funded through lump sum payments that they were free to allocate as they saw fit among this list of services. After considering all the relevant federal and provincial legislation, the court found that none of these statutes explicitly prohibited the provision of sign language services. Instead they conferred a broad discretion to the Medical Services Commission and to individual hospitals to determine which services would be provided. Since the legislation itself was not strictly in violation of the Charter, the court turned its attention to the questions of whether the Charter would apply to either the Medical Services Commission or the Vancouver General Hospital. Thus the focus of the Charter challenge was on whether the decisions of either of those entities were subject to the Charter.

LaForest J. reviewed the McKinney/Douglas College/Stoffman line of cases discussed above and reiterated the finding that the Charter was restricted to government entities or those under

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31 R.S.B.C. 1996, c. 204.
effective government control. He also made clear that *Stoffman* was correctly decided and that hospitals — or at least hospitals in British Columbia — were autonomous from government.\textsuperscript{32} However, he expressed concern over the ability for government to create private institutions that could receive delegated powers from the government and have these activities shielded from a Charter examination:

In these circumstances, while it is a private actor that actually implements the program, it is government that retains responsibility for it. The rationale for this principle is readily apparent. Just as governments are not permitted to escape Charter scrutiny by entering into commercial contracts or other “private” arrangements, they should not be allowed to evade their constitutional responsibilities by delegating the implementation of their policies and programs to private entities. In these circumstances, while it is a private actor that actually implements the program, it is government that retains responsibility for it. The rationale for this principle is readily apparent. Just as governments are not permitted to escape Charter scrutiny by entering into commercial contracts or other “private” arrangements, they should not be allowed to evade their constitutional responsibilities by delegating the implementation of their policies and programs to private entities.\textsuperscript{33}

This passage highlights the interests the court was balancing in its attempt to refine the test for Charter application. On the one hand, *Dolphin Delivery* established that the language and historical context for s. 32 precluded the application of the Charter to private entities. On the other, the lack of a clear bright line between private and public activities meant there was a need to ensure that the government was not able to infringe Charter rights by simply delegating certain tasks to the private sector. Therefore, the court expanded the Charter’s reach to those activities of private actors that are in furtherance of a government program or policy. That meant that even though hospitals were still properly characterized as non-government entities for the purposes of the Charter, individual decisions may still be subjected to the Charter.

\textsuperscript{32} *Eldridge*, supra note 28 at para. 45, 46.

\textsuperscript{33} *Eldridge*, supra note 28 at para. 42.
The difficulty is that determining what constitutes a government program or activity by a private entity “do[es] not readily admit of any a priori elucidation.”\textsuperscript{34} In an attempt to provide some guidance, LaForest J. was clear that “the mere fact that an entity performs what may loosely be termed a “public function”, or the fact that a particular activity may be described as “public” in nature, will not be sufficient to bring it within the purview of “government” for the purposes of s. 32 of the Charter.”\textsuperscript{35} It must be carrying out a “specific” government policy or program and there must be a precisely-defined connection between the private actor’s policy and a government policy or program.

The question that needed to be answered in \textit{Eldridge} was whether healthcare was a government program and thus subject to the Charter, even if delivered by private institutions. The court explicitly rejected the idea that the introduction of publicly-funded healthcare was simply a change in funding models. Before 1958,\textsuperscript{36} hospitals were indeed private institutions much like any other corporation in a free marketplace. With the introduction of universal healthcare, hospitals continued to operate as before but began collecting payments for their services directly from the government. However, as the provinces began to implement public healthcare programs in their region, culminating with the enactment of \textit{Canada Health Act} and the creation of a national healthcare program,\textsuperscript{37} hospitals continued to be independently run. They exist now in an environment where government decides the cost of services, pays for those services, prohibits hospitals from charging patients privately, and mandates that hospitals provide their services to all eligible Canadians indiscriminately.\textsuperscript{38} Many provinces prohibit hospitals and physicians from collecting under the public insurance program if they also bill for private services and so private

\begin{itemize}
\item \textsuperscript{34} \textit{Eldridge}, supra note 28 at para. 42.
\item \textsuperscript{35} \textit{Eldridge}, supra note 28 at para. 43.
\item \textsuperscript{36} The passing of the \textit{Hospital Insurance and Diagnostic Services Act} in 1957 marked the beginning for cost sharing for hospital services between the provincial and federal governments.
\item \textsuperscript{37} R.S.C. 1985, c. C-6.
\item \textsuperscript{38} See \textit{Eldridge} para. 49, stating ‘As the definition of “hospital” in s. 1 makes clear, moreover, hospitals are required to furnish the general hospital services specified in the Act. While no single hospital makes all of these services available, the net effect of the Act is to entitle every qualified person to receive, and to require hospitals to supply, a complete range of medically required hospital services. Indeed, if the legislation did not assure this, it would run afoul of the \textit{Canada Health Act}. It is also apparent that while hospitals are funded on a “lump sum” and not a “fee-for-service” basis, they are not entirely free to spend this money as they choose.’
\end{itemize}
healthcare services are all but extinct in Canada. LaForest J. explicitly noted that the shift from a private to publicly-funded healthcare system in Canada was not merely an insurance scheme, but the instantiation a full government policy. “The interlocking federal-provincial medicare system I have described entitles all Canadians to essential medical services without charge. Although this system has retained some of the trappings of the private insurance model from which it derived, it has come to resemble more closely a government service than an insurance scheme.”

Therefore, after examining the regulatory framework as a whole, the court found that healthcare delivery was a specific government policy that attracted Charter scrutiny.

Having found that healthcare delivery was a government program, and that interpretation services were a necessary component of receiving healthcare, the court was led to the conclusion that the hospital’s decision not to fund interpretation services was part of the government’s program and so subject to the Charter. The court found the lack of funding to be unjustifiably discriminatory under s. 15 and ordered that the services be funded under the provincial health plan. To further the point, the decision not to fund sign language interpretation services was contrasted to other funding decisions that the court found hospitals did have the autonomy to determine without being encumbered by the Charter, such as the decision not to pay for transportation services or provide free parking. These were not sufficiently connected to the government’s policy objectives for a public healthcare program. A similar point was made regarding the mandatory retirement policy in Stoffman, which was characterized as an administrative and human resources matter more aligned with the day-to-day operations of the hospital rather than with the furtherance of a government policy. In the court’s view, then, the Eldridge reasoning was consistent with the decision in Stoffman.

Finally, the decision included a brief discussion on how the Medical Services Commission as an administrative body was undoubtedly subject to the Charter. The Commission had the statutory power to determine whether a service would be a reimbursable benefit (in lieu of a

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39 Efforts to introduce a greater degree of private care will likely require an act of government and political will — and likely a great deal of deregulation. Even the decision in Chaoulli v. Quebec (AG), [2005] 1 S.C.R. 791 where the Supreme Court of Canada recognized the right of an individual to obtain private medical insurance under the Quebec Charter has thus far not opened up the right to private healthcare in Canada generally.

40 Eldridge, supra note 28 at para. 50.

41 Note that in Eldridge, the statute explicitly stated that transportation services were not a reimbursable service.
comprehensive schedule of benefits in the legislation) and it was tasked with ensuring BC residents received medically necessary services free of charge. The Commission was therefore characterized as a government actor and its failure to enumerate sign language interpretation services as a medically necessary service was likewise in violation of s. 15 of the Charter and not saved by s. 1.\textsuperscript{42}

### 3.4 Decisions in Other Contexts

The concurrent cases of McKinney, Douglas College, and Stoffman and the Eldridge case are the only two times the Supreme Court of Canada has considered the application of the Charter in the healthcare context. It is necessary to review the principles of Charter application in a few other contexts insofar as they may be generalizable to other healthcare entities.

In Godbout v. Longueuil (City),\textsuperscript{43} the respondent was required, as a condition of obtaining permanent employment with the city, to sign a declaration that she would remain a resident of Longueuil. If she moved out of the city for any reason, she could be dismissed without notice. Six members of the court dealt with the case on the basis of the Quebec Charter. However, the other three members decided on the basis of the Canadian Charter and considered the application of the Charter to municipalities. The decision was released within weeks of the Eldridge decision and was also written by LaForest J.

The 3-member panel held that municipalities were government actors for the purpose of s. 32. Factors that were considered included the fact that municipal councils were democratically elected and accountable to the constituents, their general taxing power, and their ability to make and enforce bylaws. The ability to make and enforce bylaws was also compared to the powers delegated to statutorily appointed arbitrators who, the court had previously decided, were subject to the Charter.\textsuperscript{44} Moreover, throughout the opinion, there was a continued concern that since

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\textsuperscript{42} It is worth pointing out that the court could have come to the same result without expanding the Charter’s reach. The finding that the Medical Services Commission was a governmental body meant that all of its decisions were subject to the Charter. Expanding the reach of the Charter to public activities of private actors really only applied to the decision of the hospital in this case. The expanded test does seem to have been accepted by commentators and the courts as authoritative, but it is interesting that there is room to argue that these comments were merely \textit{obiter}.

\textsuperscript{43} [1997] 3 S.C.R. 844 \textit{[Godbout]}.

\textsuperscript{44} \textit{Slaight Communications Inc. v. Davidson}, [1989] 1 S.C.R. 1038.
\end{footnotesize}
municipalities were carrying out tasks that the provinces would otherwise have to carry out themselves, shielding them from the Charter might allow the provincial governments to circumvent their obligations by delegating powers and responsibilities to the municipalities.

The court had previously recognized that the Charter could be applicable to municipal bylaws.\textsuperscript{45} Unfortunately, the opinion did not mention the \textit{Eldridge} decision, which might have suggested the Charter’s reach would be constrained to only those government-like activities. Instead, LaForest J. merely stated that because municipalities derived all their authority from the statute, all of their activities would be subject to the Charter. He also expressed concern about the inconsistency in Charter applicability that would arise if the Charter did not apply to this employment policy but would have applied if the city had chosen to impose the residency condition through a bylaw.\textsuperscript{46} The result was that municipalities would be subject to the Charter and all their activities would be subject to Charter scrutiny.

This idea that statutory creatures might or might not be subject to the Charter on that basis was revisited, albeit briefly, in \textit{Blencoe v. British Columbia (Human Rights Commission)}.\textsuperscript{47} In that case the court considered whether the Human Rights Commission was a government actor for the purposes of s. 32. Being autonomous or independent from government, the court said, was not enough to exclude the Commission from Charter scrutiny.\textsuperscript{48} Nevertheless, the majority seemed to suggest that the Commission as a whole was subject to the Charter based on the types of government-like actions the Commission could carry out, especially their statutory powers of compulsion.\textsuperscript{49} And whereas \textit{Dolphin Delivery} held that the judiciary was not subject to the Charter, the court disagreed in \textit{Blencoe} that the tribunal ought to be able to avoid Charter scrutiny because it carried out judicial functions. Furthermore, the court noted that the tribunal was carrying out a government purpose. Like \textit{Godbout}, there was little attention paid as to why the Charter would apply to the tribunal rather than simply those activities that were in


\textsuperscript{46} \textit{Godbout}, supra note 43 at para. 56.

\textsuperscript{47} [2000] 2 S.C.R. 307 [\textit{Blencoe}].

\textsuperscript{48} \textit{Blencoe}, at para. 34ff.

\textsuperscript{49} \textit{Blencoe}, at para. 40.
furtherance of the government purpose. The court found the Commission was a government entity under s. 32.

*Greater Vancouver Transportation Authority v. Canadian Federation of Students — British Columbia Component* provides further insight as to the types of statutorily incorporated entities that attract Charter scrutiny. In this case, the court found that two transit authorities (BC Transit and TransLink) were subject to the Charter. The transit authorities had policies against certain types of ads which the respondents wished to challenge as infringing their freedom of expression. BC Transit was a statutory body designated by its legislation as an “agent of the government”, with a board of directors whose members are all appointed by the Lieutenant Governor in Council. Moreover, the Lieutenant Governor in Council was able to manage BC Transit’s affairs and day-to-day operations by means of regulations. BC Transit was therefore not autonomous from the provincial government, and so was clearly subject to the Charter.

TransLink operated under the authority of the Greater Vancouver Regional District (GVRD). The GVRD was itself defined as a “local government” by the *Local Government Act*, and its board consisted of municipal directors and electoral area directors. The *Local Government Act* also provided that the GVRD was an “independent, responsible and accountable order of government”, that could order any service for its region and could make bylaws that were enforceable by fine or imprisonment. The GVRD was not simply defined as government by statute, but also had powers granted by the legislature consistent with that classification. Given that the GVRD had considerable control over the day-to-day operations of TransLink, including the power to appoint the vast majority of the members of TransLink’s board of directors, the transit authority itself was found to be wholly subject to Charter. It could not be viewed as operating independently or autonomously in a manner similar to either universities or hospitals and had no independent agenda other than that provided in its constituent Act. The court also pointed out it had no history of being an entity independent of government, suggesting that an institution’s pedigree may be a relevant factor in its characterization under s. 32(1) of the Charter.

[2009] 2 SCR 295 [GVT].

British Columbia Transit Act, R.S.B.C. 1996, c. 38, ss. 2(5) and 4(1).
One final set of cases bears mentioning – one where the court has recognized the Charter’s application to professional regulatory bodies without performing a full s. 32 analysis. In both *Black v. Law Society of Alberta*52 and *Rocket v. Royal College of Dental Surgeons of Ontario*53 the court considered whether the disciplinary decisions of these bodies infringed Charter rights. It is unclear from these rulings whether the Charter applies to these bodies as a whole, or simply to those government-like functions involving the exercise of coercive power that they are entrusted to perform. A more complete discussion of how the Charter might apply to the health professional regulatory bodies is provided in the next section.

### 3.5 Summary

In *Eldridge*, LaForest summed up the current interpretation of s. 32 as it stands today:

[T]he Charter may be found to apply to an entity on one of two bases. First, it may be determined that the entity is itself “government” for the purposes of s. 32. This involves an inquiry into whether the entity whose actions have given rise to the alleged Charter breach can, either by its very nature or in virtue of the degree of governmental control exercised over it, properly be characterized as “government” within the meaning of s. 32(1). In such cases, all of the activities of the entity will be subject to the Charter, regardless of whether the activity in which it is engaged could, if performed by a non-governmental actor, correctly be described as “private”. Second, an entity may be found to attract Charter scrutiny with respect to a particular activity that can be ascribed to government. This demands an investigation not into the nature of the entity whose activity is impugned but rather into the nature of the activity itself. In such cases, in other words, one must scrutinize the quality of the act at issue, rather than the quality of the actor. If the act is truly “governmental” in nature -- for example, the implementation of a specific statutory scheme or a government program -- the

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52 [1989] 1 S.C.R. 591 [*Black*].

53 [1990] 2 S.C.R. 232 [*Rocket*].
entity performing it will be subject to review under the Charter only in respect of that act, and not its other, private activities.\textsuperscript{54}

The review of the case law demonstrates an overarching tension between the court’s desire to restrict the Charter to the actions of government (which stems from a plain meaning interpretation of s. 32) and its desire to prevent governments from circumventing their Charter obligations by delegating authority or contracting out to a private actor. The court often emphasizes the structural characteristics of an entity, such as whether the government has control over board appointments and the degree of autonomy of the board as a whole. Financial characteristics such as the degree to which the entity relies on public funds for running its programs may also factor into the analysis, but less so. The later cases raise the importance of the entity’s functional attributes, such as a municipality’s ability to make bylaws or a tribunal’s powers of compulsion. Therefore, while the fact that an entity is statutorily created (e.g., a private corporation, university, hospital, or municipality) is not enough to characterize an entity as governmental, the regulatory power of a municipality or the power of compulsion of a tribunal appears to elevate not just those specific activities to governmental status, but the entire entity, with the result that all of the activities of that body are subject to the Charter.

Oftentimes the case law is not clear as to when the court is applying the \textit{Stoffman/McKinney} effective control test to find that the whole entity is a government entity subject to the Charter, or if they are simply finding a certain activity by the body to be government policy under \textit{Eldridge}. It is particularly difficult to reconcile the finding in \textit{Eldridge} — that the delivery of a public healthcare program is a government policy that is subject to the Charter — with the finding in \textit{Stoffman} that hospitals are not government actors because it is unclear what sort of activities hospitals might engage in that are not merely ancillary or supportive of the ultimate task of delivering health services under the public program. This is true for other independent entities whose dominant purpose is to carry out a government program, such as the administrative bodies in \textit{Eldridge} (i.e., the Medical Services Commission), \textit{Blencoe} (i.e. the human rights tribunal), \textit{Godbout} (i.e., a municipality), or \textit{Black/Rocket} (i.e. professional regulatory bodies). Each of these entities are statutorily incorporated with the sole purpose of carrying out a government

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\textsuperscript{54} \textit{Eldridge}, supra note 28 at para. 44.
\end{footnotesize}
policy or regulate a specific area that government would have otherwise had to do itself. Because the reasons in the cases do not provide a thorough treatment of why the Charter applies to these bodies, it is unclear if they are being characterized as government on the basis of the effective control test, the nature of their dominant function, or some other criteria.

It is interesting to note that LaForest J. stated that the rationale for characterizing an entity as government might be based on “its very nature or in virtue of the degree of governmental control exercised over it”. If an enquiry into the “nature” of an institution is separate from a determination of whether it is under the effective control of the government, this may clarify some of the findings in the above cases where it is not clear which test the court is applying to conclude that the Charter is applicable. An enquiry into the nature of an institution may also be an opportunity to give greater weight to an entity’s functional attributes in its characterization and improve the clarity of the court’s decisions. The decision Godbout, for example, is clearer if the nature of municipalities is examined separately. Municipalities are likely government entities for the purposes of the Charter because of the collective nature of what they do and the cultural and political understandings that they are a third level of government. It also provides greater clarity for those decisions that looked at entities, such as human rights tribunal in Blencoe or the transit authorities in GVTA, that are independent of government in their decision-making but were established to actually regulate and administer government policy in an area. What complicates this issue is that these entities perform many functions — some are rule-making bodies, some involve coercive power, and others just make decisions and implement policy. It may be difficult to characterize institutions based on their nature or dominant function without some clearer direction from the court.

Finally, for healthcare delivery in particular, Eldridge made clear that it was a government program and that decisions and policies connected to the provision of medically necessary services were vulnerable to Charter attacks. The next section will attempt to apply the principles that emerge from the Supreme Court of Canada rulings to various entities operating in the healthcare context. Even for those entities that are ultimately described as non-government actors, this part of the Eldridge decision will mean that a substantial range of their activities will nevertheless be subject to Charter scrutiny.
4 Applicability of the Charter to Various Types of Healthcare Institutions

4.1 Difficulties Arising from the s. 32 Analysis

Applying the current state of the law to the healthcare context raises a number of difficulties. First, the law is highly contextual and fact-specific, making it difficult for an institution to know whether it will be subject to the Charter, or which specific activities will attract Charter attention. The analysis that follows will attempt to draw some parallels and similarities from other entities, but the facts of a case that ultimately raise the question of whether a particular entity is governmental may shift the balance in either direction. It should also be acknowledged that in some cases, such as the 3-panel decision on the status of municipalities in Godbout, Supreme Court of Canada decisions may not be the final word until a larger majority of the court adopts that position.

Second, part of the motivation behind Eldridge was the court’s desire to reduce the opportunities for governments to circumvent its Charter obligations by delegating authority or contracting out duties to private entities. While Eldridge does expand the reach of the Charter to certain activities carried out by private actors, it also introduces greater uncertainty in the law as to how to properly characterize activities. The decision not to fund sign language interpretation services was seen as part of the larger government program involving the delivery of healthcare. As Part 5 will discuss, some activities, such as vaccination-or-mask policies, are not as readily characterized.

Third, because of the fact that healthcare falls under provincial jurisdiction, combined with the importance of the specific terms of the incorporating statute in characterizing whether a given institution is governmental or not, there is a potential for a large degree of disparity in Charter-protected rights across the country. The implementation of a policy by a hospital in one province may, for example, be characterized differently from the same policy implemented by a hospital

55 To be clear, the concern is less that government will create independent institutions in order to deliberately avoid their Charter obligations and more that the independent decisions to use private entities to implement government policies may also result in a dilution of the Charter’s effectiveness and an unevenness in Charter application.
in another province. Indeed, Part 6 will discuss how this phenomenon may be unique to Charter application in the healthcare context.

The analysis that follows will attempt to highlight these difficulties when Charter application is being determined for a variety of healthcare players attempting to implement a vaccination-or-mask policy as an example.

4.2 Provincial Governments

From the outset, it is worthwhile noting that the provincial legislatures could themselves enact a requirement for healthcare workers to be vaccinated when working with their patients. A number of U.S. states have done exactly that. For example, the New York State Health Commissioner promulgated regulations that, as a precondition of employment and annually thereafter, would require healthcare workers who have direct contact with patients or who may expose patients to disease to receive the influenza vaccine. Any regulation of this kind would certainly be captured under the Charter.

4.3 Hospitals

The Stoffman decision, with its reaffirmation in Eldridge, found that BC hospitals are private entities with only their activities and decisions related to healthcare delivery being subject to the Charter. But by the time Eldridge made it to the Supreme Court of Canada, BC had restructured its healthcare system such that hospitals were no longer governed by individual boards and were instead brought under the management of the regional health authorities. It is unlikely that the Stoffman decision would apply to hospitals in the modern BC context and instead their activities will likely be attributed to the regional health authorities. However, the ruling in Stoffman is still relevant in some provinces. For example, the establishment of regional health authorities in

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57 In Eldridge, the court was willing to read the discretionary law that gave the Medical Services Commission the authority to determine the list of medically necessary services to be consistent with the Charter. The Charter will therefore apply to a provincial law, but the courts will make a reasonable attempt to interpret it in a manner that avoids violating the Charter. The enquiry will then turn to the entity that has been granted the power to make those discretionary decisions under the law.

58 The characterization of regional health authorities for the purposes of Charter application is discussed in Section 4.4.
Ontario in 2005 did not result in the abolition of individual hospital boards. Most hospitals in Ontario are statutorily incorporated, not-for-profit bodies and are autonomously governed similar to how the Vancouver General Hospital was prior to 1996. The government’s perpetual effort to maximize efficiency through restructuring contributes to the complexity of applying the case law across jurisdictions and time periods (even relatively short time periods). As it stands though, a reasonable interpretation of Stoffman and Eldridge cases would be that hospitals with independent boards remain private actors and only those decisions directly related to the delivery of the public healthcare program will be subject to the Charter.

However, the application of the Eldridge test to other activities that are not connected to the delivery of healthcare may likewise result in those being subject to the Charter. For example, Ontario hospitals are given the mandate to create bylaws to govern the academic requirements, credentialing review process, and appointment of privileges for health professionals. These bylaws are mandated by Regulation 965 of the Public Hospital Act, which states that both the assessment of new appointments and their credentials must be delineated in individual hospitals’ bylaws. This means that accreditation requirements and licensing privileges for healthcare professionals lies largely in the hands of individual hospitals. Compared to municipalities and professional regulatory bodies, the exercise of this rule-making power is not a major activity for hospitals and so is unlikely to change the court’s position that hospitals are private actors. It is likely, though, that those rule-making powers and disciplinary-related decisions will be subject to the Charter. If true, it would further narrow the range of activities that hospitals perform that would be free from Charter scrutiny.

The Eldridge test remains useful for certain exceptional cases that remain part of the healthcare system. While most Ontario hospitals are statutorily incorporated, not-for-profit institutions like the Vancouver General Hospital, Shouldice Hospital is one of seven grandfathered private hospitals in Ontario that continue to operate purely as private institutions. If statutorily incorporated hospitals are considered private actors for the purposes of s. 32, then a fortiori

59 Hospital Management, RRO 1990, O/Reg 965.

Shouldice Hospital would be equally free from Charter scrutiny, even though it receives government funding for select surgical procedures it performs. Therefore, healthcare workers facing a vaccination-or-mask policy imposed by Shouldice’s management may be prevented from challenging the policy on the basis of the Charter while their colleagues in not-for-profit hospitals would likely have less problems overcoming that hurdle. On the other hand, the *Eldridge* finding that a public healthcare program is the expression of government will and policy suggests that even this privately-funded, for-profit institution may find its decisions susceptible to Charter attacks. In that case, if vaccination-or-mask policies fall under the public healthcare program, then even Shouldice employees may be able to challenge the policy using the Charter. If Ontario’s public hospitals fall under the *Stoffman* characterization, the *Eldridge* test provides consistency as to whether the Charter applies across both public and private hospitals.

The Shouldice example also serves as a test case for another problem that is introduced by the *Eldridge* doctrine. Policy positions of governments change faster than the law. In an era of increasing healthcare expenditures, there may be a growing acceptance among the public and politicians for reintroduction of a private tier of healthcare delivery in Canada. The *Chaoulli* decision is a step in that direction and other challenges based on a Charter right to private healthcare are currently before the courts. So long as healthcare delivery operates almost exclusively as a public monopoly, the *Eldridge* decision holds up. Just as a restructuring of the healthcare system could change how hospitals are characterized, a shift in how healthcare is delivered may call into question whether healthcare remains an expression of public policy or if it instead has been diminished to a mere public insurance program. These realities and others suggest that a more robust test to detect Charter applicability may be needed to increase the legal certainty.

### 4.4 Regional Health Authorities

The question of whether the Charter would apply to regional health authorities in the context of vaccination-or-mask policies was raised in *Health Employers Assn. of British Columbia v.*

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Health Sciences Assn, but the arbitrator did not come to a conclusion on whether the health authorities were government actors. Regional health authorities (RHAs) are creatures of provincial statute, funded wholly through the provincial government, whose primary purpose is to plan, integrate, and fund healthcare services in a specific geographical region. Each has its own board of directors and executive team that oversees the management and administration of health services in its jurisdiction. Their purpose is to ensure that healthcare dollars and policies are utilized optimally at the regional level.

The structure of RHAs in British Columbia and Ontario (where they are known as Local Health Integration Networks, or “LHINs”) is representative of their structure in other provinces. In both provinces, the boards are appointed by the respective health ministers and assigned an operating budget to plan and deliver healthcare services within their geographical regions that includes the types of services that will be offered in the region, the type, size and location of facilities in the region, and the human resources requirements. They may also develop policies, set priorities, and submit budgets to the minister to allocate resources in the region, administer and allocate grants made by the government for the provision of services, enter into agreements with public and private bodies for the delivery of those services, and develop standards and performance goals for the region.

Health authorities in British Columbia are statutorily incorporated by the Health Authorities Act and may be directed by the minister to provide specific health services to a region, or make certain public health decisions. Individual hospitals do not have separate boards, but are managed by the RHA’s executive team. The RHAs are therefore typically responsible for ensuring that certain quality standards are met, such as hospital accreditation or health professional licensing requirements. BC also coordinates a large number of specialty services through the Provincial Health Services Authority, which has the same governance structure as the regional health authorities but is responsible for certain services for the entire province.

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63 Health Authorities Act, RSBC 1996, c. 180. For other provinces, see for example Regional Health Authorities Act, RSNB 2011, c 217; Regional Health Authorities Act, CCSM c R34; Health Authorities Act, SNS 2000, c 6; Regional Health Authorities Act, RSA 2000, c R-10.
These include cancer care services (through the BC Cancer Agency) as well as provincial-level public health services (through the BC Centre for Disease Control).

In Ontario, however, the health authorities do not have authority over hospitals, who continue to have individually elected boards. The LHINs typically oversee provincially-run long-term care and nursing homes and family health teams (which deliver primary care services to the community through a team of healthcare professionals). However, specialty services do not have a dedicated LHIN as they do in BC. Cancer services fall under the purview of Cancer Care Ontario and public health services are the responsibility of Public Health Ontario, and each has an independent board appointed by the Lieutenant Governor in Council that reports directly to the Minister of Health.

On the face of it, a combined application of Stoffman and Eldridge would seem to tip the balance in favour of RHAs being categorized as government actors as compared to hospitals. While the RHAs do have independent boards, appointments may be made either directly by the provincial government or require its approval. The statutory authority that the RHAs exercise is largely administrative to implement the province’s public healthcare system and their operating budgets are set and funded by the executive branch. In many ways, these structural characteristics are similar to those of community colleges, and generalizing from Douglas College would lead to the conclusion that the RHAs will likely be seen as government actors for the purposes of the Charter.

The RHAs might be compared to the types of entities found to be government actors in other cases, focusing on the dominant functions that those entities perform to make the analogy. The RHAs in some provinces may include the setting of standards, policies, or bylaws to help regulate other actors in the health system, but this rule-making power likely makes up a small fraction of its activities. There seems to be no indication that they exercise coercive powers like tribunals or professional regulatory bodies. Instead, their activities seem related to making operational decisions and implementing government policies. In this sense, the dominant functions of RHAs seem most akin to the Medical Services Commission in Eldridge and the Greater Vancouver Regional District in GVTA.

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64 Local Health System Integration Act, 2006, SO 2006, c 4.
The Medical Services Commission had the discretionary power to decide which services were medically necessary for the purposes of public coverage. The commission was a 9-member panel composed of representatives of the government, the British Columbia Medical Association, and health consumers. Though the governmental status of the Commission was not contested by either party, its powers and purposes, if not its composition, were similar to those of RHAs. The RHAs have a similar discretionary power to provide and pay for services in their regions. Ultimately, the Eldridge decision did not provide a thorough discussion as to whether the Charter applied to the Medical Services Commission. Instead, it seemed to treat the decision of the Commission as an activity that was part of the public healthcare program that was subject to the Charter. Given the nature of the Commission, it seems that the whole of its activities were the exercise of delegated powers from the province, and so likely subject to the Charter. The same reasoning would apply to RHAs given the nature of these bodies and the scope of their activities.

The GVRD had a degree of autonomy in that it had an elected board and had the authority to order and manage transit services in its region. The Supreme Court of Canada also stressed that it had been defined as a government entity by statute, and it had the authority to make and enforce bylaws, consistent with that definition. Whereas the activities of RHAs managing healthcare services in their region are analogous to the activities of the GVRD, they are not defined as local governments by the statute. Moreover, the bylaws they create simply determine the credentials required of healthcare professionals in order to work in those regions, and are not enforceable by fine or imprisonment as is the case for GVRD. While the lack of these latter features might make RHAs less governmental than the GVRD, there is still much in common that would suggest they are more akin to the GVRD than a non-governmental entity.

Again, the exact makeup an provincial framework surrounding RHAs will ultimately determine their governmental status, but the findings in Douglas College, Eldridge, and GVTA would likely support their characterization as government actors.

4.4.1 A Note on Strategizing Policies Between RHAs and Hospitals

Even before considering the characterization of other healthcare entities, it is clear that governments could choose to be strategic in their implementation of vaccination-or-mask policies by choosing to have individual hospitals adopt the policies rather than putting them into
law or implementing them through RHAs. A policy created and enforced by the RHAs could result in a broader application — encompassing nursing homes, hospitals, and other publicly-run health facilities — but the governmental nature of RHAs would subject all of their policies and mandates to Charter scrutiny. On the other hand, policies implemented at the individual hospital level have a chance of being shielded from a Charter challenge, depending on whether or not the policy itself is ultimately characterized as the implementation of a government program. Also, if hospitals are truly autonomous from government, then the government runs the risk of hospitals not implementing the policy at all. However, the ability of governments to set performance goals (such as decreasing the number of nosocomial infections) means that they may be persuasive in getting hospitals to adopt certain policies. Implemented at the hospital level, the policies have a chance of escaping Charter scrutiny. Given that hospitals in BC and Ontario may end up being characterized differently by the courts, this could lead to different results as to whether the Charter applies to policies adopted by the same type of institution in different provinces. The resulting inconsistency is but one example of how governments might try to sidestep Charter scrutiny even within the existing tests for s. 32, and could also result in an imbalanced application of the Charter among the provinces.

4.5 Physicians’ Offices and Other For-Profit Healthcare Delivery Organizations

A separate examination of physicians’ offices and other for-profit healthcare corporations is warranted for a number of reasons. While the Eldridge decision made clear that the Canadian healthcare system was the expression of government policy, it is not entirely clear which services will fall under this categorization. The staple of the Canadian healthcare system is public, first dollar coverage for medically necessary hospital, physician, and surgical dental services for all

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65 As noted above in note 55, deliberate strategizing by the government is not likely to occur, but there may be situations that come very close to the line. In HEABC, supra note 13, the arbitrator noted that the decision to implement a vaccination-or-mask policy by the BC RHAs was in part due to the strong recommendations coming from the Chief Medical Officer and the BC Ministry of Health. Though neither of these actors might have had “effective control” over the day-to-day operations of the RHAs, it is not unreasonable that these members of the executive branch may nevertheless exercise a strong influence over the decisions that the RHAs made. As mentioned, the arbitrator refrained from deciding whether the RHAs in that case were public or private entities for the purposes of Charter application. Even if deliberate strategizing is unlikely to occur, a robust legal test ought to remove any incentive to do so.

66 See Eldridge, supra note 28 at para. 65.
Canadians as defined under the *Canada Health Act*. Consistent with *Eldridge*, therefore, the majority of healthcare-related activities that occur in physicians’ offices will likely fall under the purview of the Charter. Subject to the qualifications discussed above (i.e., that hospitals continue to be characterized as non-government actors post-*Eldridge*), physicians’ offices and hospitals will likely have similar Charter obligations. Nevertheless, there are some important differences that are worth considering under the s. 32 analysis.

Community physicians’ offices are not just mini-hospitals and the court’s favouring of structural characteristics will likely lead them to be characterized as private entities. The main difference from hospitals is that they are in fact for-profit corporations, rather than not-for-profit statutory creatures. The board usually consists of the physician herself, and the corporation will employ various support staff, pay rent, and negotiate insurance contracts. Clinics operating with multiple physicians may be independently operated corporations with an expense sharing agreement (for receptionists, nurses, etc.), be co-owned, or be owned by a third-party whereby the physician assigns a portion of her billing to the owner. Just as in hospitals, all the services provided are insured and paid through the public plan, but the clinics are structurally autonomous and free of any level of government decision-making. In other words, it seems that an even stronger case can be made that physician corporations are private entities under s. 32 than hospitals. If so, the *Eldridge* decision will merely capture those activities in connection with the delivery of healthcare services under the Charter while excluding those operational and day-to-day decisions that accompany running the business. Furthermore, and in contrast to hospitals, physicians’ offices are structured and operate similarly across the provinces and so, in this regard, the ultimate characterization of physicians’ offices will likely be uniform across the country.

If the above analysis is correct, it could inform how other for-profit healthcare corporations ought to be characterized in the context of a public healthcare system. While it is clear that hospital and physician services are properly captured under the umbrella of public healthcare as involving the implementation of a government policy, other healthcare-related services are less easily categorized. For example, every province includes coverage for prescription drugs for seniors over 65 years. Is the coverage of prescription drugs for this population an extension of the government policy to provide a public healthcare system, or is it simply a change in funding model for this population and this specific service? The answer is not quite clear.
There are important implementation differences between the coverage of hospital and physician services and senior pharmacare programs in the provinces. The Canada Health Act specifically lists medically necessary hospital, physician and surgical dental services, but many note that the original architects of the public health system in Canada envisioned a more expansive program — one that included pharmacare.\textsuperscript{67} Whether pharmacare will ever make it into the Canada Health Act remains to be seen, but for now the costs of prescription drugs are not included as part of the basket of insured health services. And while copays, deductibles, and user fees have all been found to infringe on the Canada Health Act’s requirement for “accessibility”, copays and deductibles are common cost-curbing measures for senior pharmacare programs across the provinces. Patients are free to carry extra insurance. All this lends greater weight to the argument that in the pharmacare context, as it stands today, the provincial programs seem more like public insurance programs rather than a full blown expression of government policy. On the other hand, the extension of the same type of coverage to other disadvantaged populations — as part of the basket of services for those with disabilities or who are unemployed — increases the public policy nature of the program. This includes the federal government’s participation in providing pharmacare services to First Nations and refugee populations. Viewing the pharmacare program offering through this wider lens gives the program a more public policy character. Therefore, while pharmacies are no doubt private actors like physicians’ practices, it is difficult to judge whether the provision of pharmacare services would fall under the Charter under the Eldridge definition of a public program.

4.6 Professional Regulatory Bodies

Professional regulatory bodies are also important healthcare entities whose status under the Charter require careful consideration. The provinces have set up a number of self-regulating professions in the healthcare context, each with their own regulatory body and set of bylaws governing their activities. Broadly speaking, the professional regulatory colleges are charged with protecting the public and ensuring patient safety in the course of their interactions with practicing members of the college. This requires them to impose obligations and standards of practice that may infringe on certain rights and freedoms in the interests of ensuring patient

safety. The regulatory colleges may impose positive obligations as a matter of minimum competencies, or may recognize the failure to live to a certain level of competency as an act of professional misconduct.

Professional regulatory bodies are in a difficult position with respect to potential Charter violations. They are mandated to protect the public by ensuring that their members meet certain competency standards. This duty requires them to impose certain requirements on health professionals that may in turn infringe on the rights of health professionals. Policies that require members to prescribe or dispense birth control, for example, could raise the possibility of limiting a healthcare professional’s freedom of religion. The current debate on physician-assisted death is likewise problematic for physicians who refuse to provide such services on religious grounds. The regulatory colleges have typically balanced a patients’ needs for accessible and timely health services with the rights of healthcare workers by adopting conscientious objection policies. These “conscience clauses” impose an obligation on a healthcare professional to refer their patient to a provider who will be able to provide the requested treatment, although in some circumstances the healthcare professional may be obligated to provide the service to ensure that the patient’s access is not unduly limited. The colleges could similarly require their healthcare members to vaccinate-or-mask in the interests of protecting patient health. The policies that the regulatory colleges adopt for the purposes of protecting access and quality of patient healthcare services, often by imposing on the rights of their members, make the colleges easy targets for Charter challenges.

As noted above, the Supreme Court of Canada has not engaged in a comprehensive analysis of how s. 32 applies to professional regulatory colleges, but the Charter has been applied without question in at least two cases that reached the Supreme Court of Canada. In both cases the court considered the Charter implications of regulatory and disciplinary decisions made by the colleges. As with municipalities or tribunals, the applicability of the Charter to professional

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regulatory bodies clearly extends to their rule-making powers: their ability to pass bylaws, their ability to impose penalties and other disciplinary measures, and the quasi-judicial nature of their proceedings. If the colleges were to adopt a vaccination-or-mask policy as a standard of care for their members, failure to comply could result in disciplinary proceedings that would be subject to the Charter.

A more difficult question is whether the nature of a professional regulatory body as a whole rises to the level of a government actor, such that all of its activities will be subject to the Charter. Focusing on their structural attributes, the professional bodies have independent boards elected by their members and are able to set bylaws and rules to regulate member conduct. However, the dominant functions they perform are jobs that the provincial legislatures might have otherwise had to do themselves. If the court insists on applying the effective control test to determine Charter applicability, it may be that these professional bodies are not as a whole subject to the Charter. Only those decisions related to government will be covered. In that case, whether a mandatory vaccination-or-mask policy implemented by these bodies would be captured under the definition of a public program will depend on how the policy is characterized (which is discussed in detail in Part 5). If, however, the court considers the dominant functions of these bodies and their overall nature in determining their ultimate characterization as government entities or not, then it is likely that the professional bodies will be seen as government and have all their decisions subject to the Charter.

5 Characterization of the Scrutinized Activity or Policy

5.1 Introduction

The variety of healthcare entities provides a number of possible places for healthcare policies to be adopted. As has been shown, for those entities that are ultimately found to be government actors, all their activities and decisions will be subject to the Charter. For the private actors, the Eldridge decision expanded the reach of the Charter to those entities to the extent that they are implementing a government objective or policy. The Supreme Court of Canada found that the decision not to fund sign language interpretation services in connection with the receipt of medically necessary services was a decision to which the Charter applied and went on to find that it was discriminatory under s. 15. Interpretation service were an important component of the implementation of the government’s objective of a public healthcare system. It is therefore
necessary to examine the nature and purpose of the impugned policy or action, but without more
direction from the court the task is not a straightforward one. The difficulties of delimiting the
parameters of a public healthcare system, which have been discussed above in the context of the
provincial pharmacare programs, demonstrate just how difficult it can be to determine whether
an activity falls under the domain of a government program. A given policy may be
characterized as having a number of different objectives — some governmental, others not —
and the current law offers no guidance as to how to select between competing options.
Vaccination-or-mask policies will be used to illustrate the complexities that can arise from trying
to characterize the nature of a policy arising in the healthcare context.

5.2 Three Possible Characterizations of Vaccination-or-Mask Policies

There are three ways to characterize the vaccination-or-mask policies: as a measure to improve
public health, as a measure to improve inpatient health, or as an administrative tool for the
hospital. Each will be considered in turn. The public health objective is perhaps the most
straightforward. There continue to be a large number of influenza-related deaths in Canada and
so preventing and minimizing influenza outbreaks is a pressing public health concern. Increasing
the number of people vaccinated reduces the spread of infection, and through herd immunity, can
work multiplicatively. This is especially important for people who cannot get vaccinated for a
variety of medical reasons. These vulnerable populations – most of whom are elderly or
immunocompromised and make up a large proportion of hospital inpatients – depend on being
surrounded by people who are vaccinated in order to minimize their risk of contracting influenza.
A targeted policy that could improve the overall vaccination rate in an under-vaccinated group
would help decrease the spread of influenza in society.

Vaccination-or-mask policies may also be targeted at improving individual patient health.
Hospitals concentrate their attention on the treatment and care of their inpatient population and
have an interest in preventing and controlling outbreaks of any kind. The biological mechanism
is the same as in the public health context — higher vaccination rates lead to fewer and smaller
outbreaks — but the primary focus is shifted from the general public to protecting the inpatient
population. There may also be ethical arguments made that patients ought to be able to receive
healthcare services in an environment that does not unduly or unnecessarily put them at risk of contracting a separate disease like influenza.

Finally, vaccination-or-mask policies may be seen as matter of employment policy and the day-to-day administration of an institution. Higher employee vaccination rates can mean fewer sick days, decreased inpatient stays, and the fulfillment of certain performance metrics that hospitals may be required to meet as a condition of funding. These metrics can include employee performance measures, patient wellness measures, cost containment metrics, outbreak surveillance indicators, and more. Healthcare institutions may also see it as a legal liability and a duty of care to their patients to reduce the possibility of those patients contracting a nosocomial infection. These reasons might support the use of a vaccination-or-mask policy as an internal administrative tool as part of the day-to-day operations of a hospital or for-profit healthcare institution.

Each of these characterizations has different implications for Charter applicability. As Eldridge makes clear, if a private actor’s activity involves implementing a government program, then it can be scrutinized under the Charter. How the court ultimately categorizes the policy can mean the difference between full Charter treatment and none at all, and each of the three characterizations laid out above may lead to a different outcome. While the jurisprudence has provided at least some guidance on how to go about characterizing institutions using the effective control test, there is no discussion in Eldridge or the cases that follow on how to go about characterizing individual activities of private entities. I can foresee two viable approaches. One approach that might be particularly effective in this context would be to examine the scientific rationale for such policies, and the likelihood of achieving the desired objective under each characterization. We might then choose the characterization that aligns best with the realistic expectations of the policy. This is favourable for two reasons. The first is that the healthcare community has stressed the need for evidence-based policy decisions, which typically amounts to policy grounded in scientific evidence. It seems reasonable to select a characterization of the policy that best lives up to that aspiration. More important, from a legal perspective, is the recognition that downfield in the Charter analysis, the court will ask whether the limit on a Charter is proportional and justifiable under a s. 1 analysis. Therefore, a reasonable
approach would be to select the characterization that is best supported by the evidence in order to maximize the likelihood that will be found justifiable in the s. 1 analysis.\(^70\)

Another approach would be to consider the character of the implementing institution itself and its ability to enforce the policy. It may be that a policy implemented under a collective bargaining agreement and challenged through a labour arbitrator is more likely to be regarded as an administrative and labour policy. A hospital or physician’s office (or other for-profit healthcare entity) typically operates in its own self-interest and it seems unlikely the court would view such policies as purely for public health reasons. How and by whom a policy is enforced will provide an indication as to the nature of the policy. We will consider both of these approaches in the case of vaccination-or-mask policies.

### 5.3 Scientific Evidence

The public health characterization is hampered in a number of ways. One surprising problem is that the actual burden of influenza-related deaths is deliberately overestimated.\(^71\) Distinguishing between true influenza and influenza-like illness (ILI) cannot be done clinically, but laboratory confirmation is not done or required. Therefore, estimates of the disease are based on mathematical models that measure ILI, which can capture anything from a head cold, pneumonia, respiratory synctitial virus, and a host of other respiratory-related illnesses, including influenza strains that are not covered by the vaccine. This makes it unclear just how large a problem influenza is. To top it off, only a fraction of true, vaccine-preventable influenza results in nosocomial transmissions.\(^72\) Figure 1 schematically depicts the disease burden of influenza-related illnesses.

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\(^70\) It is worth noting that the court does not typically consider scientific evidence at the application stage of a Charter analysis. The trend has been to push the examination of this type of evidence to the final stage of the s. 1 analysis to determine whether the specific implementation of a government decision is rationally justified and proportional. The proposal here is not to supplant that analysis or move it to the beginning of the Charter analysis. Rather, I am proposing that without a clear test from the court for characterizing an impugned activity, using the scientific evidence may be one way to tackle this problem. It does have the effect of duplicating some of that later analysis and makes the Charter analysis more complicated up front, which in turn reduces how easily individuals can determine whether the Charter will apply to their specific case.


\(^72\) See Taylor et al., supra note 4.
Another difficulty is that the influenza vaccine does not confer the broad, population level infection control that we have come to expect from other vaccines. Paradoxically, the vaccine’s effectiveness is best among those who are least impacted by the flu, namely the healthy adult population between 18 and 65 years. This demographic is the least likely to contract the flu, and if they do, they usually recover within 2 weeks. Yet it is this group for whom the vaccine is most effective and even then effectiveness peaks at around 55%. This limited effectiveness is due to a number of factors, including the virus’s high mutability and the fact that the vaccine’s effects last for only six months. Contrast this to other vaccines, like that for measles/mumps/rubella (MMR), which typically has a 99% effectiveness rate and confers immunity for life. All this amounts to a poor public health intervention, because it means that even if vaccination rates are high, immunity rates will not reach the levels needed to observe herd immunity (typically around 90-95%). The best protection comes from oneself being vaccinated, and even then personal immunity rates will be low, will vary year to year, and will require annual vaccinations. Using vaccination-or-mask policies to achieve public health objectives seems weakly effective at best.

The vaccine’s dismal effectiveness also challenges the characterization of the policy as a patient health and safety policy. To be clear, there have been at least four, randomized control trials suggesting that inpatients do indeed get sick less during their hospital stays in facilities with higher employee vaccination rates. When this and other evidence was presented by experts in both the HEABC and ONA decisions, there was a clear split on whether the evidence was to be trusted and whether it indeed reflected a potentially realizable real-world effect. In other words, the weak ability for the influenza vaccine in specific to confer herd immunity on a population undermines the characterization of vaccination-or-mask policies for either public health or patient safety reasons.

The characterization as a labour tool seems best supported by the scientific evidence. The vaccine is most effective in conferring immunity in healthy adults, which most healthcare workers will fall under. That immunity benefits the vaccinated more than it does the people they come into contact with. That is, it is better at preventing personal illness rather than creating herd immunity, meaning it is more likely to decrease employee sick days than it is to prevent an inpatient from contracting influenza.

5.4 Implementing Institution and Enforcement

The scientific evidence is not the only factor contributing to the policy’s characterization as a labour policy. The characterization of a policy may also be influenced by how the policy is implemented and its enforceability. Implementation and enforcement at the hospital level seems to favour a more labour-type characterization. most policies tend to target all staff within the hospital, rather than simply those who have direct patient contact, where the vaccine or the mask would be most effective. Figure 2 illustrates how a vaccination-or-mask policy may be implemented to cover the different groups of persons that interact with the hospital, with varying degrees of ability to enforce the policy depending on the nature of the groups.

The complex relationships between physicians and hospitals makes enforcement tricky, and indeed, it may be that the hospitals have little ability to control physician behaviour. The only concrete action the hospitals may have available to them is to revoke admitting privileges, but this presents its own set of risks and complexities. The result may be that characterization of the policy will depend on the actor challenging the policy. The lack of enforcement may favour a more patient-health based characterization in the case of physicians or visitors — where the
hospital does not have adequate means of monitoring and enforcement — and a more labour-based characterization for employees. To complicate it further, some physicians are indeed hospital employees who may be subject to more effective enforcement policies. The result is that monitoring and enforcement — and hence the characterization of the policies — can vary widely depending on the relationship of the complainant with the implementing institution. Differing characterizations based on who brings the Charter challenge would bring a problematic lack of consistency to the issue of Charter application.

On the other hand, implementation and enforcement by the professional regulatory bodies may suggest a more patient-safety based characterization. Policies implemented in this fashion would not apply to non-regulated employees, such as receptionists or porters, but might nevertheless be effective in reducing inpatient contraction of influenza. This is buttressed by the regulatory body’s mandate to protect the public and the scope of its authority.

5.5 Summary

There is a clear need for further guidance on how to characterize a policy or activity under the Eldridge test to see if it constitutes an expression of government policy. The example of vaccination-or-mask policies shows how a single policy can be characterized differently depending on how the objective of the policy is framed, the quality of the scientific evidence supporting that objective, the nature of the implementing institution and its perceived role in society, and the degree to which the policy may be enforced. The question of how a policy ought to be characterized may even be influenced by the nature of the challenge made against it.74 It also highlights that while the Eldridge test may have extended the application of the Charter to

74 For example, policies and decisions from administrative bodies are vulnerable to attacks on the grounds that they are made ultra vires the body’s authority. A recent decision from the British Columbia examined the authority for the College of Pharmacists to introduce a bylaw prohibiting pharmacies from awarding loyalty points or offering other incentives in connection with health-related services (see Sobeys West Inc. v. College of Pharmacists of British Columbia, 2014 BCSC 1414). The College argued that the policy was needed to improve patient safety and ensure that the profession did not incentivize the use of pharmacy services, such as filling un-needed prescriptions to gain free rewards. Sobeys West argued that the policy was more anti-competitive in nature, meant to protect the interests of independent pharmacy owners at the expense of chain grocers. The BC Superior Court agreed with the characterization that the policy was more commercial in nature, and so ultra vires the College’s authority. The BC Court of Appeal sided with the patient safety characterization, and upheld the College’s bylaw (see Sobeys West Inc. v. College of Pharmacists of British Columbia, 2016 BCCA 41).
private actor activities, it did not increase the certainty in the law. The following section proposes one solution that may reconcile some of these difficulties while adhering to the core principles of Charter applicability the Supreme Court of Canada has articulated throughout the years.

6 Modifying the Stoffman/Eldridge Test

The example of vaccination-or-mask policies illustrates three problems that arise from trying to apply the Stoffman-Eldridge rules. The first is an inherent lack of clarity and certainty in how the test will be applied in future cases and the likely outcome it will yield for different institutions. The lack of more coherent, predictable and consistent rules will likely lead to more costly litigation and greater confusion among complainants and institutions.

It also highlights the fact that the court has only marginally succeeded in reducing the number of avenues available to the government to shirk its Charter obligations — a concern it consistently raised in the cases reviewed above. Table 1 shows the likely outcomes in terms of how a vaccination-or-mask policy might ultimately be viewed in a Charter analysis depending on whether an RHA or hospital implements the policy, and which characterization the court ultimately accepts. While the Eldridge decision does decrease this possibility for strategic behaviour, it remains a viable option to be exploited.

Table 1: Comparison of Charter applicability to vaccination-or-mask policies implemented by RHAs and hospitals.

<table>
<thead>
<tr>
<th>Subject to the Charter?</th>
<th>Implementing entity</th>
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<tr>
<td></td>
<td>RHA (government actor)</td>
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<td>Characterization of vaccination-or-mask policy</td>
<td>Administrative objectives</td>
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<td></td>
<td>Patient Health</td>
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<td>Public Health</td>
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A third problem that was raised previously is that the differing structural and regulatory makeup of the regional health authorities, hospitals, and other healthcare entities across the provinces may result in an unequal protection of Charter rights depending on the province in which the challenge is brought. This phenomenon may be unique to the healthcare context. I can think of no other national public program where the state holds a de facto monopoly and yet the program
is implemented differently across the provinces. So long as Canada continues to operate a single tier, public-only healthcare program, it may be useful to regard it as sui generis for the purposes of Charter litigation. The complex and restrictive regulatory framework that surrounds the delivery of healthcare means that institutions, in particular hospitals and physicians’ offices where services are fully insured, are likely to be perceived by the public as government actors. The public might be forgiven for expecting their Charter rights to be protected when they come in contact with these institutions, regardless of the province they operate in, their historical roots, their structural makeup, or their statutory powers. Insofar as Stoffman and Eldridge are compatible, the result is that all but a small fraction of activities performed by hospitals are related to the delivery of healthcare. Given that hospitals exist exclusively to carry out a public program where the regulatory scheme creates a public monopoly, it seems reasonable to conclude that any degree of autonomy that hospitals or physicians’ offices exercise is merely ancillary to that primary function of carrying out a government program. This includes all the day-to-day administrative duties, such as labour and employment-related decisions.

A workable solution that would address some of the problems raised here would see the courts placing a greater emphasis on the financial and functional characteristics of an institution when deciding whether it is a government actor for the purposes of s. 32. That is, rather relying so heavily on the structural characteristics of an entity and whether or not it is under the effective control of the government or whether it has autonomy in its day-to-day decision-making, the court ought to place greater weight on the nature of the institution as a whole. Framed another way, the court could begin to place a greater emphasis on the financial and functional characteristics of the institution when determining whether it is under the effective control of government. In particular, it seems reasonable to give more consideration to the entity’s dominant function. Insofar as the entity is carrying out government activities (such exercising rule-making, coercive, or disciplinary powers) or predominantly responsible for delivering a public service (such as healthcare in a public monopoly or public transit services), it seems that these entities ought to be characterized as government actors notwithstanding any degree of autonomy they might otherwise have.

I believe this approach is defensible for a variety of reasons. First, the original language in Dolphin Delivery suggested that the court was going to apply the Charter to government activities, and only in the later cases of Stoffman and McKinney did the enquiry turn to an
examination of whether the Charter applied to the individual institutions. The decisions themselves do not provide adequate reasoning for why the focused shifted this way, and it seems like Eldridge attempted to steer part of the analysis back to focusing on governmental activities. Furthermore, the court does not make a convincing argument as to why control over the day-to-day operations is more important than other structural characteristics. For example, it seems that the ability of the legislature to repeal a statute incorporating a hospital or other entity ought to factor more prominently in the court’s analysis.

Second, the summary of the test for s. 32 by LaForest J. as cited above suggests that the court may look at the nature of the institution or whether the government has effective control over it. An examination as to the nature of an institution is analogous to my plea of giving greater prominence to financial, functional and structural characteristics that go beyond the effective control test. Indeed, the court may already be doing this implicitly. The review of the case law in Part 2 illustrates that the court is not rigidly applying the effective control test to characterize an entity, and then moving to the Eldridge analysis to examine the governmental nature of certain activities by private actors. In many cases, the question of Charter application seems almost trivial, with little or no reasoning provided why the Charter might apply in a certain context. It may be that in some cases, such as municipalities or human rights tribunals, the courts are simply considering that the nature of these institutions are obviously governmental, and so find it unnecessary to provide a thorough analysis under s. 32. If so, an acknowledgement by the court that this is indeed the case would help provide some clarity to the issues.

Finally, expanding the types of characteristics that the court considers when determining whether an entity is a government actor provides a more dynamic test that can respond more easily to changing policies and regulatory frameworks. It is already difficult to determine whether hospitals continue private actors in BC after having been restructured under the authority of the RHAs. Therefore, a more contextual, fact-sensitive test is not likely to impede the generalizability that might come from a more monolithic characterization of entities. Furthermore, by advocating for a more holistic approach to characterizing institutions, I continue to support the Eldridge decision to apply the Charter to government activities carried out by private actors. This provides the court with the greatest deal of flexibility while still retaining a significant degree of certainty in the law.
Expanding the categories of characteristics the court considers when characterizing an institution leads to different results in the case of a public monopoly like healthcare than the current test. In my opinion, entities that function primarily to deliver a public program — especially if they do so in a public monopoly — ought to result in characterizing those entities as government actors with all their decisions subject to the Charter. This would likely bring all the different types of entities discussed in Part 4 under the umbrella of the Charter. In particular, hospitals and physicians’ offices would be considered government entities with all of their activities subject to the Charter. It would align with how these entities’ activities are exclusively publicly-funded and highly regulated. I also suspect it aligns with how Canadians view these actors agents of government in society.

Perhaps the more striking result is that the physicians’ offices are government actors. When considering whether an actor is a private or public actor outside of the Charter context, a for-profit institution leans heavily in the direction of being viewed as a private actor. It seems strange, then, that a private actor would be characterized as a government entity for the purposes of the Charter, rather than simply characterizing it as a private actor carrying out a public program. I think this speaks to the uniqueness of the Canadian healthcare sector. Physicians have a unique relationship with their provincial governments. Their practices are highly regulated. They bargain collectively without being a formal union. They have their malpractice insurance premiums paid by taxpayers directly. They operate in a public monopoly but are not accountable to voters. This heavily intertwined relationship between physicians and the government means that government has less than an arm’s length relationship with them, which to me justifies their characterization as public entities for the purposes of the Charter. If a national pharmacare program that mirrors medicare is ever implemented, I might be inclined to extend the analogy to pharmacies and other for-profit institutions. Again, it is the nature of the Canadian healthcare system that makes Charter application in this area complex and which may lead to otherwise unexpected results.

7 Conclusion

If the delivery of healthcare is a public program, per Eldridge, then activities taking place in that domain, whether in direct or indirect realization of the government’s objective, ought to be subject to the Charter. Healthcare may be sui generis as the only national government program
that is independently implemented by the individual provinces within a regulatory regime that gives the government a *de facto* monopoly over the service. The patchwork of regulatory environments can make it difficult to predict when the Charter might apply to different institutions involved in delivering care, including RHAs, hospitals, physicians’ offices, professional regulatory bodies and other healthcare providers. Moreover, this may lead to a differential protection of rights across the provinces. This makes the exercise of determining whether the Charter will apply in the healthcare area highly contextual and dependant on factors such as the nature of the complainant, the nature of the implementing institution, and the regulatory environment around the domain of the activity. Recognizing the issues raised in this paper may assist the court in developing a more coherent and consistent doctrine for Charter application in the healthcare context.
Figure 2: Two schematics showing the relationship of various categories of individuals purported to be covered by a hospital vaccination-or-mask policy status and level of patient contact.

*indirect patient contact: an individual with no direct patient contact but does contact objects that a patient ultimately interacts with directly