

## **PART IV: COMPARATIVE AND INTERNATIONAL LAW PERSPECTIVES**

### **The Failing Federation: Why Canada Is Ineffective at COVID-19**

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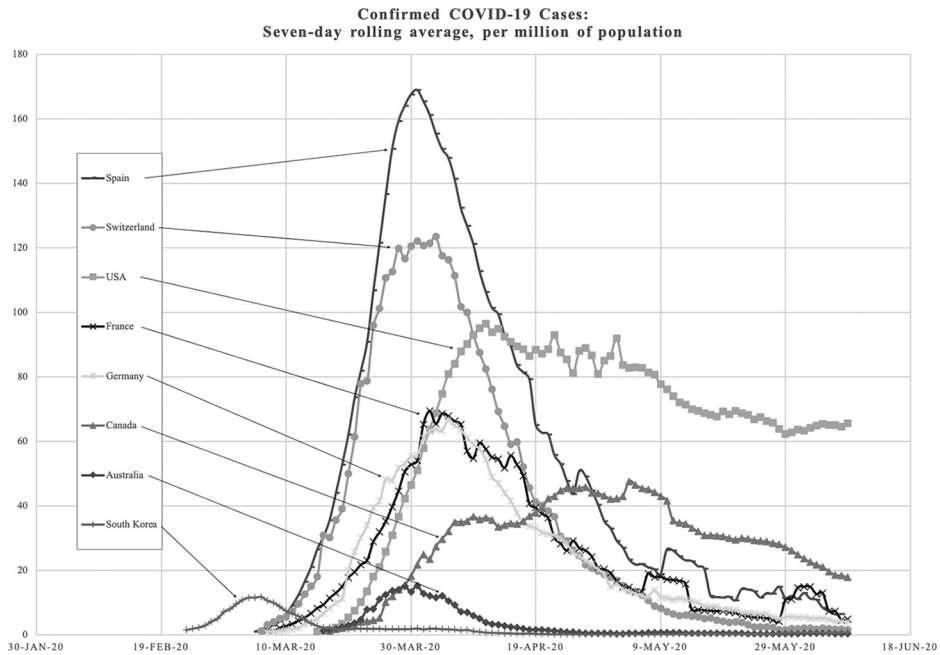
My goal in this article is to explain how Canada’s Constitution has come to help—or hinder—an effective response to COVID-19. The principal purpose is not to advocate for Canadian law reform, which is clearly necessary. Rather the aim is to explain how health law generally, and the legal and political contours of Canadian federalism more specifically, have acted as a brake on the country’s response to COVID-19, which, while better than that of the United States, is still so shockingly bad as to deserve no emulation. Both countries have failed at COVID-19 and are examples of how *not* to prepare for and respond to pandemic emergencies. Indeed, it is difficult to find countries, even much more severely affected ones, whose performance at tamping down the epidemic has been worse.

This article has three parts. Part I describes the constitutional underpinnings of health care and public health in Canada, as it relates to federalism and historical struggles between the federal government and the provinces. It will show that Canada has, at least on paper, a far stronger federal government than the United States, which could bring itself to bear on COVID-19 and future pandemics. But because there is an enormous difference between the paper “reality” and the true reality, Part II details how Canada’s federal response to COVID-19 has been staggeringly effete and incompetent, and is arguably the single greatest cause of lives lost in the pandemic. Part III discusses reforms that could be put into place. Because Canada is such a failure on COVID-19, three other federal countries that have performed better—Australia, Germany, and Switzerland—merit consideration as models.

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**Figure 1:**  
**Data from the European Centres for Disease Prevention and Control.**



This article argues that Canada's Constitution is not the problem that most Canadians think it is. Rather the problem is a self-neutering political disinclination of the federal government to act—and it has killed Canadians. Flipping the famous words of Justice Jackson in *Terminiello v. City of Chicago* on their head, it is not the doctrinaire logic of Canada's Constitution that is a danger, but the lack of practical wisdom in the present-day federal government which in pandemic times has transformed the Constitution into a suicide pact.<sup>1</sup>

### I. THE CONSTITUTIONAL POSITION

Canada's health system is often caricatured in American discourse, along lines that reflect America's own political schisms. To progressives, Canada is celebrated because it has publicly-funded healthcare accessible to all legal residents. To conservatives, Canada is reviled because publicly-funded healthcare smacks of socialism and occasionally results in long waiting lists for necessary medical services. Both these positions contain an element of truth and are endlessly debated,

1. *Terminiello v. City of Chicago*, 337 U.S. 1, 37 (1949) (Jackson, J., dissenting).

though a single fact refracts enough light to show which system is objectively better: Canadian life expectancy at birth exceeds American by over three years.

But the fact that Canada's health system is *better* is not the same as saying that Canada's health system is *good*, and that is because of Canada's oftentimes bitter constitutional schisms. Canada's founding constitutional document, the *Constitution Act, 1867*, as amended from time to time, contains in sections 91-95 the fundamental division of powers between the federal government and the ten provincial governments.<sup>2</sup> The lion's share of federal and provincial powers are assigned in sections 91 and 92, respectively, which set out catalogues of nominally "exclusive" powers that in practice often are not (the other level of government can usually intrude if it does so ancillary to one of its exclusive powers).

The Constitution is silent on "Health." The framers did not assign the subject to either level of government. This omission is a source of endless difficulty, for while health spending accounts for 11.6% of Canada's GDP, in the absence of express constitutional assignment health possesses an ambiguous constitutional identity and is highly exposed to larger federal-provincial confrontations. Principal among these is the centuries-old conflict over the status of Quebec, which in 1995 very nearly led to the partition of Canada in a secession referendum which failed by a margin of about 1%.<sup>3</sup> Generational change has dimmed the specter of Quebec secession greatly since then, but in its place has risen a contemporary separatist movement centered on Alberta and Saskatchewan, both heavily conservative-leaning, oil-producing provinces, whose discourse is reminiscent of the states' rights movement.

It therefore has fallen to successive federal and provincial governments to pronounce on where the jurisdictional contours of health lie, through a political process that evolves through both consensus and confrontation. The Supreme Court of Canada, while issuing some health decisions that shifted the landscape, has seldom been responsible for seismic change, and American constitutional lawyers would likely find it surprising how little Supreme Court jurisprudence there is on the Constitution and health (more on that later).

Section 92(7) of the *Constitution Act, 1867*, assigns the provinces exclusive jurisdiction for "the Establishment, Maintenance, and Management of Hospitals", save for "marine hospitals" which are federal.<sup>4</sup> The "hospital" power is the principal source of provincial jurisdiction over not just bricks-and-mortar hospitals, but also for healthcare writ large, including each province's publicly-funded health insurance scheme, the regulation of health professions (including non-insured ones, such as dentistry), clinical practice standards, and the custody and protection of healthcare records and data. The federal government has virtually no day-to-day direction or oversight in these areas. Consequently, the provincial

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2. Constitution Act, 1867, §§ 91-95, 30 & 31 Vict., c 3, (U.K.). The Act is also known as the *British North America Act, 1867*.

3. Stephen J. Toope, *Re Reference by Governor in Council Concerning Certain Questions Relating to Secession of Quebec from Canada*. 161 D.L.R. (4th) 385, 93 AM. J. INT'L L. 519, 520 (1999).

4. Constitution Act, 1867, § 92(7), 30 & 31 Vict., c 3 (U.K.).

healthcare mandate is *enormous*, and while Canadian political and electoral discourse rarely recognizes it, from a fiscal perspective nothing else competes. For example, currently in the most populous province, Ontario, out of a C\$154 billion operating budget, C\$62 billion is for the Ministry of Health and Long-Term Care.<sup>5</sup> No other ministry's budget is even half as large. The provincial governments are, with only some exaggeration, health insurers that build roads and operate schools on the side.

But come to public health—which the pandemic serves to remind is population-based and preventive, and not to be confused with healthcare that is patient-based and curative—the Constitution is murkier.

Public health ill fits the provincial “hospitals” jurisdiction. It is instead captured by section 92(14), which gives provinces exclusive jurisdiction over “Generally all Matters of a merely local or private Nature in the Province.” But that wording is less expansive than it might seem at first glance. Not all public health challenges possess dimensions of a “local or private Nature,” in the sense of being within provincial territorial jurisdiction. Some aspects of public health relevant to pandemic preparedness or response do have purely provincial dimensions, but many other aspects do not, because pandemics by definition are extra-provincial and international threats that transcend provincial territory, jurisdiction, and competence.

For pandemic public health, the Constitution equips the federal government far better than the provinces, at least in theory. Section 91(11) gives the federal government exclusive jurisdiction over “Quarantine and the Establishment and Maintenance of Marine Hospitals,” but strikingly the “quarantine” power has never been judicially interpreted by the Supreme Court, or possibly any lower court.

There is also an interesting, though as yet judicially untested, question of whether the word “quarantine” in the Constitution should be read as quarantine *stricto sensu* and frozen in time, or in a broader meaning which today corresponds to epidemic prevention and control. One can make a strong argument for the latter. When the Constitution was framed in 1867, the germ theory of disease was not yet accepted by the scientific establishment, and “quarantine” was practically synonymous with epidemic prevention and control because other interventions hardly existed.<sup>6</sup> Until the courts rule on what “quarantine” means, the answer is anyone's guess, but since Canada expressly rejects an ossified “originalist” school of constitutional interpretation in favor of a doctrine where the “Constitution is a living tree which, by way of progressive interpretation, accommodates and addresses the realities of modern life,” one would think the federal

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5. In Canada's parliamentary system, which is replicated in the provinces, the Cabinet presents Estimates to the legislature in every budget cycle, from which these numbers are taken.

6. Amir Attaran & Kumanan Wilson, *A Legal and Epidemiological Justification for Federal Authority in Public Health Emergencies*, 52 MCGILL L. J. 381 (2007).

“quarantine” power is broader than the naked text suggests.<sup>7</sup> Rather it is a federal power for prevention and control of epidemic emergencies such as pandemics, because they inherently transcend provincial territorial jurisdiction, with extra-provincial and international dimensions that are impossible to shoehorn into section 92(14).

Several other enumerated constitutional powers give the federal government collateral authority in public health, in cases having judicial consideration. Section 91(6) confers exclusive federal power over “Statistics,” in this context epidemiological statistics (which the provinces possess too, ancillary to their other powers). Section 91(27) gives exclusive power over “The Criminal Law,” but defined formulaically rather than by subject matter: any statute containing a prohibition, a penalty, and possessing a moral purpose against an “evil” is valid criminal law.<sup>8</sup> Several of the most potent federal health laws, such as the federal *Food and Drugs Act*, are criminal law.<sup>9</sup> But the power is not limitless, as the *Assisted Human Reproduction Act* was only partially upheld by the Supreme Court in a very split decision (a rarity in Canada) which struck down certain provisions on the basis that they were more accurately characterized as relating to provincially-run healthcare.<sup>10</sup> The exclusive power over patents in section 91(22) gives the federal government control over patented medicine prices, and famously so, because Canada has very much less expensive drugs than the United States.<sup>11</sup> The exclusive power over national telecommunication networks, expressly excluded from provincial jurisdiction by section 92(10)(a), is also of some relevance to electronic contact tracing for infection control.<sup>12</sup>

There are also taxation powers, and with those, the ability to spend. Here the federal government has a giant leg up on the provinces. Section 91(3) empowers the federal government to use “any Mode or System of Taxation,” while section 92(2) limits the provinces only to “Direct Taxation” (except for natural resources). In practice that means only the federal government can levy taxes on income and earnings, while the provinces must settle for paltry sales, property, or excise taxes and resource royalties. Without federal transfer payments—which are *entirely* discretionary, and to which the federal government can attach any rules or conditions it likes, down to conjuring up entirely new social programs—no province would be close to solvent.<sup>13</sup> Whatever the textual realities elsewhere in the Constitution, the unparalleled federal power to tax and spend is a giant carrot—or stick.

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7. *Edwards v. Canada (Att’y Gen.)*, [1930] AC 124, 136 (P.C.). The “living tree” doctrine remains good law. *See, e.g.*, *Reference re Same-Sex Marriage*, [2004] 3 S.C.R. 698, paras. 21-28 (Can.).

8. *Reference re Firearms Act*, [2000] 1 S.C.R. 783, para. 27 (Can.).

9. *Food and Drugs Act*, R.S.C. 1985, c F-27. *See also R. v. Wetmore*, [1983] 2 S.C.R. 284 (Can.).

10. *Reference re Assisted Hum. Reprod. Act*, [2010] 3 S.C.R. 457 (Can.).

11. *See Patent Act*, R.S.C. 1985, c P-4, §§ 79-103 (Can.).

12. *Alberta Gov. Telephones v. Canada (Canadian Radio-television and Telecomm. Comm’n)*, [1989] 2 S.C.R. 225 (Can.).

13. *Reference Re Canada Assistance Plan (B.C.)*, [1991] 2 S.C.R. 525, 567 (Can.).

Finally, there is the federal residual power that opens section 91, called the “Peace, Order, and Good Government” (“POGG”) power. This contrasts so interestingly with the American Constitution that it is worth a digression.

Since constitutions can ever speak with completeness, there always has to be a default level of government to receive the unassigned powers. In the United States that is achieved by the Tenth Amendment, which defaults to the states when a subject matter is unassigned federally and not prohibited to the states. The counterpart in Canada is the POGG power—except it does almost exactly the opposite. The doctrine of POGG defaults to the federal government, and allows it to trench upon (some would say usurp) the assigned, exclusive provincial powers in two situations: if the dominant purpose of a federal law is aimed either at an “emergency”, or is a matter of “national concern” in the peculiar sense that evidence establishes a provincial inability to deal with the matter because it possesses extra-provincial dimensions. Pandemics obviously could fit under either branch of the POGG power, and while that has not been squarely decided, there is POGG jurisprudence saying that “pestilence” counts, and upholding other types of federal health law under the power.<sup>14</sup>

If all you knew about Canada is the black-letter law you read here, then surely you would imagine that Ottawa is light-years ahead of Washington in federalizing pandemic preparedness and response. The enumerated powers of the *Constitution Act, 1867*, undeniably hand the federal government better cards than the provinces, even before considering the sheer might and discretion of the federal taxation and spending power, and the POGG power which inclines federally and opposite the Tenth Amendment. To top it off, there is the constitutional doctrine of federal paramountcy, which says that when valid federal and provincial statutes operate in conflict, the federal takes precedence and the provincial is inoperative.<sup>15</sup> Those constitutional features all suggest a strong central government and vassal provinces.

Except that’s wrong. Actually, Washington is far more powerful than Ottawa, because Ottawa is cowed before the provinces. Black-letter law has almost nothing to do with it. The next section will show how that is.

## II. THE POLITICAL REALITY, AND FAILURE ON COVID-19

To understand Canadian federalism, it often helps *not* to think like a jurist. Less is explained by law or jurisprudence than by historical and political fact.

Take the example of quarantine. It is a power no doubt exclusively reserved to the federal government under section 91(11). Yet when Parliament rewrote the federal *Quarantine Act* in 2005, in response to Canada’s 2003 epidemic of Severe

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14. *See Ontario (Att’y Gen.) v. Canada Temperance Fed’n*, [1946] AC 193 (P.C.); *R. v. Hauser*, [1979] 1 S.C.R. 984 (Can.).

15. *British Columbia (Att’y Gen.) v. Lafarge Canada Inc.*, [2007] 2 S.C.R. 86 (Can.).

Acute Respiratory Syndrome (“SARS”), it limited the federal government’s reach to quarantine of persons and conveyances in *international* movement, not in inter-provincial or intra-provincial movement.<sup>16</sup> In other words, quarantine to the outside world is statutorily authorized, but internally, the *cordon sanitaire* which has been the mainstay of epidemic control for centuries is simply impossible. In the final analysis the federal government achieves a stupid result: it enjoys the authority to quarantine travelers from Miami to Montreal, but not from Montreal to Moncton—not an idle worry when Montreal’s *per capita* death rate is one of the world’s highest, approaching New York City’s.<sup>17</sup>

Surprisingly, Parliament rejected this same limitation for animal quarantine. In that field, the federal government exercises quarantine powers throughout its sovereign territory under the *Health of Animals Act* and associated regulations.<sup>18</sup> It has done so for outbreaks on farms, most notably for “bird flu,” which also infects humans. It is no exaggeration to observe that, judging by the statute book, Parliament and the federal government are more solicitous of the health of Canadian poultry than that of Canadian people.

Why this self-sabotaging failure? There is a deep-seated sense in Canadian culture, more atmospheric than a black-letter legal reality, that any subject matter capable of possessing local and private dimensions ought to lie within section 92 (14) and provincial jurisdiction. This perception of what is constitutionally right and proper frequently dominates even where the Constitution says otherwise. It is explained by the omnipresent Canadian aversion to inflaming the provinces, and at the worst, waking the nodding bear of secession. As a result—and this is a generalization holding some relevance across virtually all of the Constitution—there is a systemic under-occupation of federal jurisdictions by federal legislation.

Which comes to the central thesis of this paper: *The single greatest source of Canada’s public health failure is the federal government’s timid reluctance, with rare exceptions, to assert its full constitutional authority.*

Nowhere is this truer than in the compilation and dissemination of health statistics, specifically epidemiological data: the who, what, when, where, how of infection and its control.

Timely, complete epidemiological data are a necessary, but not sufficient, requirement to abrogate and reverse the course of SARS-CoV-2 transmission (the virus of COVID-19). Without high quality data, public health experts effectively are reduced to combating an unseen enemy and are in no position to detect and isolate small outbreaks before they become conflagrations. To employ a military

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16. Quarantine Act, S.C. 2005, c 20; see also Amir Attaran & Elvina Chow, *Why Canada is Very Dangerously Unprepared for Epidemic Diseases: A Legal and Constitutional Diagnosis*, 5 J. PARL. & POL. L. 287 (2011).

17. As this was written on June 3, 2020, Montreal has 168 deaths per 100,000, and New York City 250 deaths per 100,000, based on data updated daily by the local health departments of those cities and adjusted for population (author’s calculation).

18. Health of Animals Act, S.C. 1990, c 21, §§ 25, 27, and 66; see also Health of Animals Regulations, C.R.C., c. 296, §91.4.

analogy, the daily epidemiological report is a SITREP upon which daily tactical decisions must be based to execute the strategy of driving and maintaining viral transmission below an effective reproductive number ( $R_t$ ) of 1.0, which epidemiologically is the metric of a shrinking epidemic and therefore success. Make the SITREP late or incomplete, and the kinetic response of public health systems is hobbled, even if those systems otherwise have appropriate command and control, standard operating procedures, and matériel to respond. Timely, complete epidemiological data are *indispensable*.

And in Canada, at a federal level, they are absent. The provinces collect most epidemiological data. When a person tests positive for COVID-19, how they became infected, their demographics, whether they were hospitalized, lived or died—all that is information at the coal face of provincial (or urban) public health departments and hospitals. It has to be transmitted to the federal government somehow, not just for situational awareness, but also for planning, and importantly, for epidemiological modelling (forecasting) of the tempo of the epidemic.

The federal government could invoke its section 91(6) “statistics” power to require provinces to share this information, but does not. Currently there is no federal statutory mandate obliging the provinces to provide such data, and all information sharing is purely *voluntary* under a federal-provincial Memorandum of Understanding, which has never been confirmed or signed by all the provinces, and which is so feebly worded as to be self-parodying:

This MOU is an expression of intent by the parties to explore, review and undertake the measures set out in this MOU with a view to making appropriate administrative, policy and legislative changes considered advisable by each party to give effect to the intentions expressed in this MOU.<sup>19</sup>

Naturally, this low-calorie bafflegab, and other voluntary arrangements like it, produces nothing but failure. At this writing in June 2020, the Public Health Agency of Canada (“PHAC”) possesses detailed data on only about 40% of the positive COVID-19 cases arising in Canada. That percentage rises and falls, but it has never come close to timeliness and completeness. Nor can it ever do so because, even assuming total cooperation from the provinces, the main method that Canada’s public health departments use to communicate case information is *the fax machine*. Montreal alone has hired two dozen clerks since COVID-19 began, just to type in information from faxed case reports! Immediately after the SARS epidemic, the federal and provincial governments began planning in 2004 to implement an electronic data system to replace the faxes, but it has never been fully implemented.

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19. PAN-CANADIAN PUB. HEALTH NETWORK, FEDERAL/PROVINCIAL/TERRITORIAL MEMORANDUM OF UNDERSTANDING (MOU) ON THE SHARING OF INFORMATION DURING A PUBLIC HEALTH EMERGENCY, § 2 (2007), [perma.cc/6WQP-BDTR](https://perma.cc/6WQP-BDTR).



Without complete disease intelligence, the federal government's epidemiological forecasting is non-existent. Five months into the pandemic, PHAC has yet to publish a single, methodologically sound epidemiological model, much less daily reckonings of effective reproductive number ( $R_t$ ). Some academic teams do this, but they are even more starved of data than PHAC is, which reduces the probative value and reliability of their models through no fault of their own.

Parliament has created statutory authority for the federal government to compel data from the provinces if it wishes. Sections 8 and 13 of the *Statistics Act* permit the Chief Statistician of Canada to issue a mandatory request for epidemiological data to any "person having the custody or charge of any documents or records that are maintained in any department [including in a province] or in any municipal office, corporation, business or organization." Procedurally, there is a 30-day waiting period before the request is effective, but there are no substantive limitations on the statistical information that can be requested. With this tool alone, the Chief Statistician could collect *existing* epidemiological data from the provinces.

More challenging is the problem of getting the provinces to collect *new* data, and in a fashion that is uniform to enable apples-to-apples comparisons. Section 15 of the *Public Health Agency of Canada Act* permits the Governor in Council (i.e., the Cabinet) to make regulations respecting "the collection, analysis, interpretation, publication and distribution of information relating to public health," subject to companion provisions in the *Department of Health Act*, and in turn the *Statistics Act*. Within days Cabinet could issue a regulation requiring provinces to share designated epidemiological data, and to do so in a prescribed, secure electronic form, which "Big Data" experts like Statistics Canada could build. Section 15 also helpfully empowers the Cabinet to craft bespoke protections for confidential or personal health information for the epidemic context, deviating to the extent necessary from the usual rules in the *Privacy Act* and the *Personal Information Protection and Electronic Documents Act*.<sup>20</sup>

In short, if the federal government wished to acquire more complete data from the provinces, it has the constitutional and statutory authority to do so, but to date it lacks the political will to invoke that authority, however necessary for effective tactical and strategic planning. In the dilemma of not unsettling the cozy nostrums of federation, or arresting an epidemic that kills Canadians, the current government has chosen politics over human life.

This tendency also probably explains the federal government's bizarre refusal to invoke its POGG emergency power. It has neither done so through an order under the umbrella statute of the *Emergencies Act*,<sup>21</sup> nor through bespoke

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20. See *Privacy Act*, R.S.C. 1985, c. P-21, § 8(2); *Personal Information Protection and Electronic Documents Act*, S.C. 2000, c. 5, §§ 7(3)(c.1)(iii), 7(3)(e).

21. See *Emergencies Act*, R.S.C. 1985, c 22 (4th Supp.) (Can.).

emergency legislation for COVID-19. As such, the legal position of the federal government remains that there is *not* an emergency.

Canada has used emergency powers for much less. The last time was in the 1970s, when Pierre Trudeau, the father of the current Prime Minister, Justin Trudeau, legislated temporary wage, price, and profit controls to combat the ostensible emergency of high inflation. The Supreme Court upheld the move, and on the very deferential standard that government need show only a “rational basis” for apprehending a temporary emergency.<sup>22</sup> This was so even though the word “emergency” was nowhere found in the *Anti-Inflation Act*. Surely if wage, price, and profit controls for double-digit inflation are constitutionally sustainable under the federal POGG emergency power, then a statute aimed at COVID-19—the deadliest peacetime catastrophe to face Canada in a century—also would be.

Justin Trudeau’s decision not to use emergency powers—quite unlike his father—to impose certain minimum, national standards, necessary for uniformity of approach, is the single greatest misstep Canada has made since COVID-19 emerged. His failure has led to reinventing the wheel in all ten provinces. For example, in early April 2020, no two provinces gave the same public medical advice to suspected COVID-19 patients, because each concocted its own case definition and screening tool for virus testing, which makes no medical sense.<sup>23</sup> It would have been better to bind each province to the PHAC’s national case definition, so as to promote a single, national standard of care, and so that the resulting epidemiological data from the provinces would not be tainted by apples-and-oranges inconsistency.

Likewise, each province has been left to devise its own testing system for COVID-19, without any attempt by the federal government to standardize the process or, as already noted, unify the testing data in one place. There is no federal guidance, much less a legal requirement, amounting to a national testing strategy. Yet testing, virtually all agree, is essential for a safe reopening of the country.

Once again, the failure to use federal emergency powers is dictated by politics, over the imperatives of disease control or the available constitutional jurisdiction. Currently, about 95% of Canada’s COVID-19 deaths arise from just two provinces—in order, Quebec and Ontario—which are the anchors of the ruling Liberal Party’s electoral support. Both provinces are, to put it none too politely, giant failures. Both pleaded with the federal government to deploy hundreds of Canadian Forces soldiers to take over the operation of seniors’ care homes where the majority of deaths occurred, after the staff proved unable—or in Quebec’s case, ran away and abandoned their patients. In short, both Ontario and Quebec received federal help, right down to military support. But when it

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22. Re: *Anti-Inflation Act*, [1976] 2 S.C.R. 373, 375 (Can.).

23. Brienne Olibris & Amir Attaran, *Lack of Coordination and Medical Disinformation in Canadian Self-Assessment Tools for COVID-19* (Apr. 18, 2020) (unpublished study) (on file with medRxiv), [perma.cc/8LTS-ZWUY](https://perma.cc/8LTS-ZWUY).

comes to the use of federal emergency powers, their electoral significance to the Liberal Party makes them untouchable.

Where the federal government has tried to lead, but without using its legal powers, it has achieved generally failing results. This is apparent in Canada's ongoing failure to come to grips with two other needs: contact tracing, and the supply of personal protective equipment.

There is unanimity among epidemiologists that when reopening Canada there will be new outbreaks of infection, and that the *only* way to nip incipient outbreaks in the bud before they become uncontrollably large is with an aggressive, agile program of tracing all the contacts of infected individuals, so as to isolate and test them very quickly before the infection spreads further. Every country that has fought off COVID-19 successfully has done so with contact tracing, mainly using a rapid reaction force of human contact tracers, but in some cases also using electronic tools (cell phones and Bluetooth technology) to map the intersecting lines of persons moving about in public places—in other words, both human and signals intelligence.

In April 2020, the federal government anticipated that Canada would need to recruit a regiment or division's worth of contact tracers, substantially in excess of what public health departments could provide. PHAC put out an urgent bulletin, saying "We need you!" and asking Canadians to volunteer for a national contact tracer corps.<sup>24</sup> More than 50,000 Canadians signed up. But as of June, it appeared that *not a single one* of these volunteers had been called on, because the federal recruiting effort was disconnected from any provincial request. There is no escaping that the federal government's recruitment drive was a sham—and a shame.

Nor has the federal government been helpful with electronic contact tracing, which relies on the federal power over cellular telecommunications networks. In the second half of April 2020, the federal Industry Minister stated that the department was "still [in] early stages" of its work, although the pandemic was quite well advanced, and that the federal government would "deploy all the tools that we need" for electronic contact tracing.<sup>25</sup> Two months later, there was still no federal tool. Nor was there, apparently, federal assistance to provinces that built and deployed electronic contact tracing apps themselves, as Alberta did. The effectiveness of provincial apps would be severely limited anyway, since the provinces lack constitutional authority to compel cell phone companies to "push" an app to users' phones and to implement adequate privacy rules—both rate-limiting factors for public adoption and the ability of electronic contact tracing to perform at high levels of coverage.

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24. Adam Miller, *Canada Has an Army of Volunteers Ready to Help Fight COVID-19—So Why Aren't We Using Them?*, CBC NEWS (June 6, 2020, 4:00 AM), [perma.cc/7PDE-63VX](https://perma.cc/7PDE-63VX).

25. Catharine Tunney, *Ottawa Pursuing Technological Approaches to COVID-19 Contact Tracing*, CBC NEWS (Apr. 17, 2020, 6:31 PM), [perma.cc/SL92-2J4K](https://perma.cc/SL92-2J4K).

Another need is for the armor that protects health care workers. Early in the pandemic, and still at this writing, Canada and the provinces have had tremendous difficulty securing adequate surgical masks, N95 respirators, medical gowns, and other commodities collectively known as personal protective equipment (“PPE”). It is a surprising failure, since after Canada’s 2003 outbreak of SARS—the world’s worst outside of Asia—numerous reports, studies, and even a judicial commission of inquiry concluded that Canada required an emergency PPE stockpile.<sup>26</sup> Building stockpiles became a project of both federal and provincial governments.

Yet when COVID-19 hit, those PPE stockpiles were nearly empty, due entirely to gross negligence. Both federal and provincial governments failed to rotate and refresh their stocks of PPE, which expired, were discarded, and were never replaced. Stock rotation is not hard: the clerks earning minimum wage at the grocery store successfully rotate the bread and milk, with greater skill than federal and provincial governments exhibited for commodities of strategic, life-saving importance. In the years before COVID-19, Ontario destroyed and never replaced about 55 million N95 respirators, and Canada another 2 million. Parliamentary testimony after the fact revealed that the provincial and federal stockpiles were not coordinated at all, and the federal government had no idea how large the stockpiles actually were.<sup>27</sup>

It gets worse. The sudden global shortage of PPE, exacerbated by President Trump’s order blocking N95 respirator exports to Canada, set off a buying frenzy, which the federal government tried and failed to manage. Although it pledged to coordinate procurement for the provinces, at this writing it only secured delivery of less than 10% of the quantities of N95 respirators it set out to acquire, and most of those were discovered to be substandard and not of medical quality. The failure of federal coordination led the provinces to a Hobbesian free-for-all in which they separately chartered private aircraft and *competed* against one another to import PPE from China, but some of these aircraft deadheaded back empty—predictably so, since foreign policy is not a strength (or within the jurisdiction) of the provinces.<sup>28</sup>

All of these problems have been noticed in Parliamentary hearings—many experts testified, including the author (twice)—but Parliament is rarely as aggressive as Congress, and oversight has been mostly ineffective. Parliament has been in an induced coma because of agreements between the Trudeau government and

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26. THE HON. MR. JUSTICE ARCHIE CAMPBELL, *THE SARS COMM’N TO INVESTIGATE THE INTRODUCTION AND SPREAD OF SARS IN ONTARIO, FINAL REPORT* (2007), [perma.cc/23ZF-JQPC](https://perma.cc/23ZF-JQPC); see also NAT’L ADVISORY COMM. ON SARS AND PUB. HEALTH, *LEARNING FROM SARS: RENEWAL OF PUBLIC HEALTH IN CANADA* (2003), [perma.cc/5ECS-BSHC](https://perma.cc/5ECS-BSHC).

27. See *Briefing on the Canadian Response to the Outbreak of the Coronavirus: Hearing Before the Canadian House of Commons Standing Committee on Health*, 43d Parl., 1st Sess., No. 15 (2020) (testimony of Ms. Sally Thornton, Vice-President, Health Security Infrastructure Branch, Public Health Agency of Canada).

28. Andy Blatchford, *Melee for Chinese PPE Will Produce More Empty Planes*, POLITICO (Apr. 22, 2020, 6:43 PM), [perma.cc/4PH6-EXHF](https://perma.cc/4PH6-EXHF).

opposition parties since March 2020 to limit sittings, with the House of Commons meeting only occasionally with a tiny complement of its Members (about 10%), and more recently as a somewhat larger but still very incomplete number convening by videoconference. Without full democratic accountability, the opportunities to debate and solve these failures have been lamentably much too limited.

To wrap up this section: the federal government has been essentially jejune about anything to do with COVID-19. But I would argue that its aversion to involvement, while disappointing and at times negligent, ought not be surprising. Apart from the atmospheric sense of Canadian federalism and not meddling with the provinces and “their” business, when it comes to pandemics, the federal government has never been a willing player. The three “mandate letters” that Prime Minister Trudeau issued to his health ministers since coming to office do not even passingly mention pandemic preparation, much less prioritize it, demonstrating that in the years before COVID-19 there was no intent on the part of Mr. Trudeau or the Liberal Party to assume responsibility. Indeed, the only role the federal government has embraced is that of an insurer, pumping nonstop life-support payments of about \$40 billion monthly into the Canadian macroeconomy. That ultimately is a reed-slender, failing model for governance, not just because it is fiscally unsustainable, but because no real insurer is able to survive by assuming liabilities without mitigating risks. Yet that is plainly federal Canada’s approach.

### III. WHAT OTHERS CAN TEACH CANADA ABOUT REFORM

Because this article is so harsh on Canada’s failure, it would be churlish not to discuss reforms. Other federations have done far better at stanching the number of ill or dead from COVID-19, while burdened with similar federal/provincial complications. It is from these leaders that Canada needs to learn.

But will it? It has to be admitted that Canada has demonstrated a closed mind before. After the 2003 SARS epidemic, there were government reports and a judicial commission of inquiry running to several volumes, followed by reports by the Auditor General of Canada, all excoriating Canada’s state of pandemic preparedness and the dysfunctions of its federation.<sup>29</sup> Since the vast majority of recommendations in these exercises were ignored, it would be frankly naïve to think that Canada is predisposed to making the reforms that the inevitable COVID-19 *post mortem* (literally) will spotlight.

If I were to speculate beyond COVID-19, the chances of Canada choosing to become more adept at pandemic preparation and response are virtually nil.

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29. See Tunney, *supra* note 25; see also OFF. OF THE AUDITOR GEN. OF CAN., MAY 2008 REPORT OF THE AUDITOR GENERAL OF CANADA TO THE HOUSE OF COMMONS, CHAPTER 5: SURVEILLANCE OF INFECTIOUS DISEASES—PUBLIC HEALTH AGENCY OF CANADA (2008), <https://perma.cc/7KB8-A3XC>.

The only way that Canada might feel obliged is if it were forced by foreign countries into a biosafety treaty of some kind, one that goes beyond the WHO's *International Health Regulations*.<sup>30</sup> Something similar happened for climate change: while Canada is one of the worst countries in the world for *per capita* greenhouse gas emissions, the pressure and embarrassment of failing to meet international benchmarks eventually drove the federal government to legislate a national carbon price, despite furious opposition from most provinces. (That legislation is heading this fall to the Supreme Court in three separate constitutional appeals by the provinces. Full disclosure: I am counsel in those cases.)

If readers in other countries are worried that Canada is structurally incapable of fighting pandemics (and they should be) and poses a global danger because of the serious mistakes it made in SARS and now COVID-19, my advice is simple: first drag Canada into a post-COVID-19 biosafety treaty, and then force it to implement its provisions. It is *only* because of foreign pressure to align with international law that Canada—or for that matter, China—might feel impelled toward necessary reforms.

What should the reforms look like? The answer to this question is found in the best practices of other constitutional federations, which have outperformed Canada on COVID-19. That would be deserving of a long study when the pandemic finally is well and truly over, but for present purposes three examples come to mind: Australia, Germany, and Switzerland.

Australia's performance seen in Figure 1 at the front of this article is one of the best in the world. It has succeeded in controlling COVID-19 without the draconian measures seen in some Asian countries, but rather in a society that is culturally similar to Canada's. At this writing, it has only about 100 recorded COVID-19 deaths, or *one-eightieth* of Canada's 8000+ dead. Both are geographically large, thinly-populated federations, with public healthcare. While it is tempting to ascribe the difference to Australia being an island and Canada bordering the United States, this does not hold up under scientific scrutiny. In mid-March, when Canada closed the U.S. border to non-essential travel, it and Australia were tied for case prevalence at just over 1 per 1,000,000. The vast divergence happened *later*, mostly because Prime Minister Trudeau dithered on forcing returning travelers into isolation for about ten days longer than Australia—an eternity when dealing with rapid exponential growth—and subsequently failed in federal leadership.<sup>31</sup>

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30. World Health Organization [WHO], *World Health Assembly Res. 58.3, Revision of the International Health Regulations*, at 7, WHO Doc. WHA58/2005/REC/1 (May 23, 2005), <https://perma.cc/SSJ5-PGT2>.

31. See Joel Negin, Shitji Kapur & Nancy Baxter, *Canada and Australia: A Tale of Two COVID-19 Responses*, GLOBE & MAIL (Apr. 18, 2020), [perma.cc/3BPF-F84T](https://perma.cc/3BPF-F84T); Editorial, *Two Weeks Too Late, Ottawa Finally Orders Overseas Travelers to Self-Isolate*, GLOBE & MAIL (Mar. 25, 2020), [perma.cc/6CG4-2L8L](https://perma.cc/6CG4-2L8L).

Australia avoided these critical failures. On the same day it started a national lockdown (March 13, 2020) its Prime Minister and state Premiers signed a partnership agreement on healthcare funding and disease control, based around the federal government's *Australian Health Sector Emergency Response Plan for Novel Coronavirus* which had been prepared in February.<sup>32</sup> In other words, Australia developed a plan just before the onslaught, and Australia's states and federal government had a mature meeting of minds to perform it—which they later did, brilliantly. To sweeten the partnership, the federal government offered the states additional funding for COVID-19. This is what leadership looks like.

But well after Australia's governments formalized their cooperation, nothing similar could be seen in Canada. There is still no national response plan, and no partnership agreement with the provinces. Viewed in this light, while COVID-19 may have been the infectious *agent* that cost 8,000 Canadian lives, the actual *cause* of those deaths is the immoral failure of Prime Minister Justin Trudeau and the governing Liberal Party to lead as Australia did. *If Canada learns only a single lesson from COVID-19, it ought to be more "Australian" in the approach to federalism when an epidemic emerges.*

Germany also worked hard to align the federal government with the *Länder*, but did so more slowly and less effectively than Australia. Between March 16 and March 22—too late, given the rapid growth of their epidemic around those dates in Figure 1—the federal government and *Länder* agreed on non-binding but still widely adopted guidelines for social distancing and closure of public spaces, and the key elements of these guidelines were later given legal force by both levels of government.<sup>33</sup> Because Germany's approach lacked the foresight of Australia's and was more reactive than proactive, it could not prevent an explosion of cases. Nonetheless, it exemplifies a functioning, minimum form of "cooperative federalism" in which the federal and *Länder* governments independently exercised their respective powers around common purposes agreed upon in the guidelines.

If I had been asked hypothetically in 2019 about how Canada would react in a pandemic, I would have guessed that it would be slow off the mark and govern through non-binding guidelines such as Germany—and I would have been wrong. Even the weak tea of Germany's cooperative federalism is more than Canada is able to serve up. Indeed, one has to question the continued use of the term "cooperative federalism" in Canada's constitutional discourse and Supreme Court health jurisprudence, because COVID-19 proves that it is a misnomer. Because the federal and provincial governments did not even *attempt* to cooperate on non-binding guidelines for closures and social distancing, this is better called "uncooperative federalism."

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32. DEP'T OF HEALTH (AUSTL.), AUSTRALIAN HEALTH SECTOR EMERGENCY RESPONSE PLAN FOR NOVEL CORONAVIRUS (COVID-19) (2020), [perma.cc/35E2-24TG](https://perma.cc/35E2-24TG); COUNCIL OF AUSTL. GOV'TS, NATIONAL PARTNERSHIP ON COVID-19 RESPONSE (2020), [perma.cc/SH9Q-YD3P](https://perma.cc/SH9Q-YD3P).

33. See Johannes Saurer, *COVID-19 and Cooperative Administrative Federalism in Germany*, REG. REV. (May 13, 2020), [perma.cc/S8DR-SLHV](https://perma.cc/S8DR-SLHV).

Switzerland is remarkable because it did the very thing that Canada unwisely refused to do: declare a federal pandemic emergency. As in Germany, the Swiss federal government acted too late, after an explosive epidemic. But once it acted, it assumed a war footing without hesitation, and enacted an ordinance that side-stepped the cantons by federalizing all the key elements of the response: not just closures and social distancing, but also measures that eluded Canada so badly, such as the allocation of PPE, and the provision of epidemiological data.<sup>34</sup> The same ordinance that dealt with matters of a national character, such as border closures or export controls, also delved into the most local of issues, such as child-care and acquiring contact tracing details from public businesses. As the epidemic evolved, the ordinance was amended to keep pace, sometimes every few days. The extraordinary precision and agility of Switzerland's central orchestration served its confederation extremely well: it wrestled one of the most explosive and prevalent outbreaks in Europe—at the peak, much worse than Germany's or Canada's—to near-total control in about two months.

What these countries teach is that there are several ways for a constitutional federation to succeed in a pandemic (what later waves will bring is anyone's guess). Australia did so by extraordinarily early foresight and planning, which situated its federal government as the natural leader to the states, a position later cemented by all the states signing a formal partnership agreement with the lure of additional federal funding. Its proactiveness got out ahead of logarithmic growth, and it was rewarded by having a very small epidemic and swift return to near normalcy. Germany took a similar approach, in that its federal government coalesced with the *Länder*, albeit without the formal step of a partnership agreement, and only did so after missing the boat of an early response, which brought it heavy losses but eventual success. Switzerland on the other hand did not coalesce until it faced such a catastrophically large, ferocious, and lethal epidemic that the Federal Council chose to set aside cooperation with the cantons in favor of a martial-like emergency ordinance that seized command of every significant lever against the pandemic—and this too succeeded.

And Canada? None of the above.

#### CONCLUSION

Pandemics are a special case in the human condition. The brilliant historian of epidemics, Professor Frank Snowden, is known for popularizing the metaphor that they are a “mirror” for society and the relationships it contains among humans, the natural environment, and our own mortality. Something similar can be said about countries, which succeed or fail when placed *in extremis* by pandemics, and not strictly because of formal codifications of law, but because the

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34. Le Conseil federal Suisse [Federal Council of Switzerland], Ordinance 2 sur les mesures destinées à lutter contre le coronavirus (COVID-19) du 13 mars 2020, RS 818.101.24, [perma.cc/ET9A-7U9H](https://perma.cc/ET9A-7U9H). An unofficial English translation is found at [perma.cc/8GWF-QXF2](https://perma.cc/8GWF-QXF2).



same human frailties reflected in Snowden's mirror have a counterpart in institutional frailties.

Canada's dreadful performance, and it appears to this author that of the United States as well, are the result of institutions overcome by the stress test of COVID-19. In the United States, this takes the form of the President and executive branch exhibiting bizarre behavior and undermining public health institutions by diverting them from their appointed tasks into fruitless dead ends such as promoting chloroquine or injected disinfectants as treatment. In Canada, the misrule is more subtle, and takes the form of Cabinet and Parliament incapacitating their powers in a fashion not contemplated by constitutional law, leading to dysfunction in the public health institutions that the SARS epidemic 17 years ago warned us were necessary.

One could, perhaps, label America's failure *malfeasance*, and Canada's bungling *misfeasance*, but either way the effect is baleful: federal institutions have sidelined themselves as positive agents, precisely when they are most needed. Both countries have a very necessary *post mortem* ahead.

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