

Uncharted Territory: Policy Options for a Public Health Emergency in Canada

Amy Swiffen and Mona Kayal

Abstract

This paper analyzes the state of the law in Canada regarding preparedness and response in a national public health emergency. Although there has yet to be a national public health emergency in Canada, such events are anticipated to arise in the future. It is therefore important to assess Canada's legal preparedness for such an event and identify reforms to the legal structure that may be needed to facilitate response. This paper identifies the challenges that Canada's constitutional division of powers poses to public health emergency response and assesses two policy proposals for enhancing the power of the federal government to respond in a public health crisis. The implications of the proposals are explored through a case study of the use of quarantine during the SARS crisis in 2003. The paper concludes with a discussion of how the current approach to legal preparedness addresses difficulties posed by the constitutional division of powers, but it does not take into account the role of the jurisdictional division between the government and the judiciary.

Introduction

This paper analyzes the state of the law in Canada regarding preparedness and response in a national public health emergency. Although there has yet to be a national public health emergency in Canada, such events are anticipated to arise in the future and efforts are underway to reform Canada's legal infrastructure for such an eventuality. While it is important to assess Canada's legal

preparedness for such an event and identify reforms to the legal structure that may be needed to facilitate response, it is equally important to assess the broader implications of such reforms and the kind of legal power they unleash. The paper begins by identifying the challenges that Canada's constitutional division of powers poses to public health emergency response, as well as case law precedents that could inform judicial responses to the power of the government in an emergency. It then assesses two policy proposals for enhancing the power of the federal government to respond to public health emergencies. The implications of the proposals are explored through a case study of the use of quarantine during the SARS crisis in 2003. The paper then considers how the legal system and the courts are dealing with public health in non-emergency situations as a national security issue (political and collective matter) while taking into account s. 7 of the Charter (individual rights). It concludes with a discussion of how current policy proposals, while addressing the difficulties posed by the constitutional division of powers, fail to consider the significance of a jurisdictional division between the government and the judiciary.

Public Health Legal Preparedness

The field of healthcare pertains to medical interventions between health professionals and individual patients, while the field of public healthcare seeks to manage the health of a population. The two fields have different objects and objectives.

The object of healthcare is the body of the individual, whereas the object of public healthcare is the life of the population. In conventional healthcare, the objective is curing an infection in a person, whereas in the practice of public healthcare, the objective is “breaking the chain of transmission of infection in a community” (Attaran and Wilson 2007: 392). As a consequence of these differences, the practice of public healthcare is quite different from conventional healthcare. It entails the organized efforts of society, which implicates more stakeholders and requires greater organizational and policy considerations (Last 2001). The role of law is central in this regard in public healthcare, as it is the mechanism that allows for the coordinated action of different authorities in the case of an emergency. Law creates a structure within which various public health officials and state authorities can act together to protect the population’s health in a crisis.

The concept of public health legal preparedness has developed as an attempt to identify the specific legal reference points vital to intervention in a public health emergency (Moulton et al. 2003). There are multiple aspects that must be considered, including legislation and legal documents; policies for public institutions and organizations involved in land planning and transportation; enforcement tools for public health policies, such as administrative regulations, quarantine and other coercive powers; as well as intergovernmental agreements (Moulton et al. 2003). Responsibility for legal preparedness belongs to the government, which must establish institutional mechanisms to maintain the health of the population. This includes the capacity for response to emerging public health threats within a territory (Wilson 2004). Importantly, public health legal preparedness also implicates the courts, which must decide how much discretion to accord to government in the course of its response.

Structural Limits of Canadian Federalism

In Canada, legal preparedness in public health is complicated because it must be carried out in accordance with an established constitutional federalist framework. Federalism is a political system in which centralized regulation is applied alongside regional governance, with neither being subordinate to the other. This type of legal structure presents particular challenges to public healthcare because the area of health is not subject to specific constitutional assignment (Wilson 2006). As the Supreme Court of Canada (SCC) explains in *Schneider v The Queen* (1982):

“Health”... is an amorphous topic which can be addressed by valid federal or provincial legislation, depending on the circumstances of each case on the nature or scope of the health problem in question. (142; See also *Eldridge v. British Columbia* 1997: 646–47)

This means that the federal and provincial governments share responsibilities in the area of health and in the area of public health (Wilson and MacLennan 2005). Legal preparedness for a public health emergency must therefore consider not only lateral coordination among the multidisciplinary organizations and institutions that make up the health system, but also hierarchical coordination among provincial, federal and international authorities (Moulton et al. 2003: 674). The next section considers the health powers associated with each level of government in Canada to highlight the precise challenges these jurisdictional divisions might pose in a public health emergency.

Public health legislative jurisdictions in Canada

As the area of health is not explicitly named in the list of jurisdictions in ss. 91 and 92 of the Canadian *Constitution Act* (1867/1982) (also known as the *British North America Act*), the jurisdictions of the federal and provincial governments are justified in different ways. At the provincial level, legislative authority in the area of health is recognized in accordance with the powers of “The Establishment, Maintenance, and Management of Hospitals” [*Constitution Act*, 1867/1982, s. 92(7)], the “Property and Civil Rights in the Province” [*Constitution Act*, 1867/1982, s. 92(13)] and “All matters of a purely local or private nature in the Province” [*Constitution Act*, 1867/1982, s. 92(16)]. These sections have translated into provincial jurisdiction over the delivery of healthcare, including emergency response healthcare, in Canada. This means that the role of provincial authorities in a public health emergency is pivotal because they are best equipped to practically identify and respond to health-related issues.

The federal government has taken a more creative approach to its power in the area of health. Some of its jurisdiction is based on the power to quarantine in s. 91(11) of the *Constitution Act* (1867/1982). This is reflected in the *Quarantine Act* (2005), the purpose of which “is to protect public health by taking comprehensive measures to prevent the introduction and spread of communicable diseases” at Canada’s borders (s.4). It allows for the use of quarantine and case-specific isolation measures at national borders. The federal government also has some jurisdiction in the area of health based on its power in criminal matters outlined in s. 91(27) of the *Constitution Act*. The SCC affirmed the use of this federal power in the area of health in *MacDonald v Canada* (1995):

The scope of the federal power to create criminal legislation with respect to health matters is broad, and is circumscribed only by the requirements that the legislation must contain a prohibition accompanied by a penal sanction and must be directed at a legitimate public health evil (32).

Thus, regulating public health has been recognized as a legitimate criminal law purpose as long as the characteristic elements of a criminal law are present in legislation, i.e., that it applies a penal sanction to prohibited conduct and that some legitimate public purpose underlies the prohibition (Gammon 2006).

Another option for the federal government is to use its power to make laws “for the Peace, Order and good Government of Canada” (POGG), as stipulated in the preamble of s. 91 of the *Constitution Act* (1867/1982). This power is twofold: it allows the federal government to act on national issues and in an emergency situation. The doctrine of emergency combined with the national mandate may afford the federal government the power to encroach on provincial jurisdiction in an emergency. In *Re: Anti-Inflation Act* (1976), the SCC found that the doctrine of emergency applies in situations “imperilling the well-being of the people of Canada as a whole and requiring Parliament’s stern intervention in the interests of the country as a whole.” (425) Importantly, the government’s decision to declare an emergency cannot be based on the cause of the emergency but only on its anticipated or actual consequences. While the SCC did not rule on a public health emergency, it seems the doctrine of emergency outlined in *Re: Inflation Act* would apply in those cases (Rosenthal 1991).

Federal emergency law

There are two laws that have been created based on the federal government’s authority to govern in national emergencies. First, the *Emergency Management Act* (2007) provides a legislative framework for assisting provincial authorities if they request help in an emergency. It establishes the role and responsibilities of the Federal Minister of Public Safety in the coordination of emergency management activities of federal institutions in cooperation with the provinces (ss. 3 and 4). However, it does not allow for unilateral intervention on the part of the federal authorities; it provides a structure only for voluntary collaboration between the different levels of government. In this sense, the *Emergency Management Act* enshrines a cooperative approach to public health without imposing a jurisdictional hierarchy.

The second law, the *Emergencies Act* (1985), goes much further. It bestows authority on the federal government to declare a national emergency and respond without provincial cooperation under certain circumstances. A national emergency is defined in the act as “an urgent and critical situation of a temporary nature that ... cannot be effectively dealt with under any other law of Canada” (s. 3). Four types of emergency are defined under s. 5: war emergencies, international emergencies, public order emergencies and public welfare emergencies. A public health emergency would fall into the category of “public welfare emergency”:

“public welfare emergency” means an emergency that is caused by a real or imminent

(a) fire, flood, drought, storm, earthquake or other natural phenomenon,

(b) disease in human beings, animals or plants, or

(c) accident or pollution

and that results or may result in a danger to life or property, social disruption or a breakdown in the flow of essential goods, services or resources, so serious as to be a national emergency (*Emergencies Act* 1985, s. 5).

Consistent with the constitutional division of powers, the *Emergencies Act* also stipulates that to qualify as a national emergency a situation must “exceed the capacity or the authority ... [of the province]... to deal with” [s. 14(2)]. As it stands, therefore, this legislation would only apply after a public health emergency has exceeded the capacity of a single province to control.

An unsatisfactory state of law for public health emergencies

Part of assessing the effectiveness of emergency legislation involves identifying weaknesses in authorities’ response capacities. In the Canadian context, the interjurisdictional constitutional framework makes the effectiveness of The *Emergencies Act* questionable in a public health emergency. While it affords extraordinary power to the Executive branch of the government, it can only be invoked if an emergency extends beyond the control of a single province (Wilson and MacLennan 2005). In the context of a public health crisis, this is a problematic limitation. Natural disasters and accidents are by their nature confined to a geographic area, but an epidemic of a communicable disease is based not in a geographic location so much as the life of a population, which is a constantly moving target. From a public health perspective, the best response to the outbreak of a communicable disease is stopping the spread as soon as possible. However, under the current legislative framework, federal authorities could intervene only after the disease has spread beyond the borders of a single province. Thus, in a public health emergency, if a province is unable to deal with an outbreak or does not declare the situation to counterparts at the federal level, the situation will be come worse and be harder to contain (Wilson and Lazar 2005).

The SARS outbreak in Toronto in 2003 is illustrative in this regard. After it was over, the Commission to Investigate the Introduction and Spread of SARS issued a damning report that highlighted the “damaging combination of problems” evident in the response to the outbreak caused by “poor cooperation with the federal government,” including a “lack of any federal-provincial machinery of agreements and protocols to ensure cooperation” and a general “lack of

cooperative, collaborative spirit” (Campbell 2004: 68). This alarm had actually been sounded before SARS. In 1999 and 2002, the Auditor-General of Canada had issued reports stating that national public health surveillance and response systems were inadequate and that more coordination between levels of government was needed (Auditor-General of Canada 1999, 2002). The SARS crisis simply threw into stark relief the challenge that the jurisdictional division of powers presents in a public health crisis.

Policy Solutions: Federal Leadership?

The federal government attempted to develop a more comprehensive public health strategy after the SARS crisis, which involved the creation of the Public Health Agency of Canada (Wilson and MacLennan 2005: 5). The Agency was conceived as a centralized body responsible for coordinating interaction on public health issues between Canada and international organizations. Its creation brought Canada into compliance with the World Health Organization’s (WHO) *International Health Regulations* (2005) (Hodge 2010), which requires each signatory state to assess public health threats that occur within its borders and notify the WHO within 24 hours if the situation is an emergency of international concern. The WHO must be notified by way of a “focal point,” which in Canada’s case is the Public Health Agency of Canada [WHO 2005, s. 6(1)].

The Agency took several initiatives following the SARS crisis to develop institutional capacity and an integrated national public health surveillance system; however, its initiatives have so far been based on non-controversial subjects that are well in line with the jurisdictions of each level of government (Ries and Caulfield 2005). Consensual collaboration is obviously the preferred approach, and the role of provincial authorities in a public health emergency is crucial. However, there is still no legal framework to coordinate these activities in an emergency. There is no law that governs them and no jurisdictional hierarchy exists. The two levels of government continue to work independently, with the federal government relying on the provinces’ voluntary cooperation, and there is no guarantee that provincial authorities would cooperate with federal leadership (McDougall 2009).

A lower threshold for a public welfare emergency

Two policy solutions have been suggested to address the lack of jurisdictional hierarchy in a public health emergency in Canada. Both centre on enhancing the power of the federal government vis-à-vis the provinces. One possibility is for Parliament to change the *Emergencies Act* (1985) to make it easier for the federal government to declare a public welfare emergency (Wilson and Lazar 2005). A provision could be added to the act that would authorize the executive branch to invoke it if there

is reason to believe that a public welfare emergency *risks* becoming a national emergency, even if it is restricted to one province and the province does not consent to the intervention. Recall, under the current framework, federal authorities can intervene only if an emergency exceeds the capacity of a province to deal with it. While the current jurisdictional framework enshrined in the *Emergencies Act* (1985) is considered appropriate for the first three types of emergency, a lower threshold is arguably appropriate for a public welfare emergency. The reason is that public welfare emergencies are not associated with violence and there is a presumed consensus that public welfare is a common good. In contrast, war emergencies, international emergencies and public order emergencies involve violence or the threat of violence, and certain groups (opposition parties, human rights activists, minorities, etc.) may oppose the declaration of an emergency in such cases (Wilson and Lazar 2005). It is always possible that the provinces would oppose this type of legislative reform as an intrusion into their jurisdiction, which would have negative consequences in an emergency. To mitigate this possibility, any new provisions could be limited by a legal test to ensure that the encroachment on provincial jurisdiction is constitutionally justified (Wilson 2006).

Federal authority via the power the quarantine

Another way to address the challenges facing public health emergency legal preparedness in Canada is to interpret the federal government’s constitutional power to quarantine [s. 91(11)] more broadly. This power is the foundation of the *Quarantine Act* (2005) mentioned above, which currently authorizes the federal government to use isolation or quarantine measures at Canada’s borders. However, since the *Constitution Act* was adopted, other techniques to control epidemics have developed, such as vaccination and prophylactic pharmaceuticals, and it could be argued that these should be included in the federal power [most experts agree quarantine is out of date and ineffective at controlling a communicable disease (Schabas 2007)]. The original authors of the provision likely intended not simply to authorize literal quarantine but to authorize a broader power aimed at preventing and controlling epidemics in general:

A better reading of subsection 91(11) is that, circa 1867, the only technology available to stem epidemics of great concern was quarantine *sensu stricto*, and so by that accident of history, the word “quarantine” received privileged mention in the constitution (Attaran and Wilson 2007: 400–01).

Section 91(1) interpreted along these lines would authorize *intra vires* federal laws that are genuinely aimed at controlling

the spread of a contagious disease (Attaran and Wilson 2007). This argument is consistent with the “living tree” doctrine in Canadian constitutional law, encapsulated in the phrase: “The *British North America Act* planted in Canada a living tree capable of growth and expansion within its natural limits” (Edwards v. Canada 1930, AC 124). According to this narrative, the Constitution should be interpreted in an open and progressive manner.

One versus the Many: Striking a Balance between Individual Rights and Public Health

Both of the policy proposals above address the impediment to public health emergency response caused by the constitutional jurisdictions of the federal and provincial levels of government, but neither addresses the fact that interventions in public health necessarily come into tension with individual rights. The right to privacy can be infringed when a surveillance report containing personal information is required; physical integrity can be violated in the case of mandatory vaccination, testing or treatment; and the right to personal autonomy may be restricted in the case of quarantine or isolation measures. This tension between collective well-being and individual rights poses a quite different question of jurisdiction than that between the levels of government. The question that neither proposal above addresses is what kind of jurisdictional structure is appropriate between the government and the judiciary in a public health emergency.

An analogy between public health law and the state’s power in criminal matters is helpful in exploring this question. Both areas of law use similar measures to protect society, which are identifying, removing and/or isolating a threat through restrictions on individual freedoms (Claborn and McCarthy 2011). In criminal law, preventive detention is the confinement of a person who has not been found guilty of a crime, and incarceration is a term associated with confinement as punishment for committing a crime. The practice of isolation in public health is similar to incarceration in that it separates a person who has a communicable disease from the healthy population, while quarantine is similar to preventative detention in that it restricts the movement of individuals who have been exposed to a communicable disease but are not symptomatic (Claborn and McCarthy 2011). In a sense, therefore, public health emergencies could indeed be said to involve violence, specifically legal violence in the form of the public power that identifies and removes individuals who are a threat to the collective. This is contra the assumption mentioned above that a public welfare emergency is not associated with violence, and it begs the question of what kind of jurisdictional division should apply between the courts and the government in a public health emergency. In other words, should the judiciary have a role in the determination of what constitutes a public

health emergency? This issue is explored in the next section through the presentation of a case study of the use of quarantine during the SARS crisis.

Case study: SARS

During the SARS crisis, governments in affected countries used quarantine in an attempt to stop the spread of the disease. A survey in Toronto, Shanghai and Hong Kong reveals different balances were struck between individual rights and the power to quarantine in each case. In Hong Kong and Shanghai, jurisdictions that historically have not had the strongest records when it comes to protecting individual rights, the quarantine approach was used more sparingly than in Canada. Of Toronto’s population of 3 million, almost 30,000 were quarantined. In Hong Kong, out of 7 million people, only 1,282 were quarantined. In Shanghai, out of a population of 18 million, some 4,090 individuals were quarantined during the crisis (Jacobs 2007). Contrary to what might be expected, therefore, individual rights were more marginalized in Canada, a jurisdiction where these rights are ostensibly taken more seriously (Gostin et al. 2003). Given the willingness of the Ontario Government to use quarantine and the parallel between the criminal law and public health powers discussed above, it is evident that the issue of jurisdiction between the judiciary and the government is important to consider in a public health emergency.

In the criminal law, there is a jurisdictional division between legal interpretation and the enactment of legal violence. A judge ponders the balance of interests in a criminal case to determine criminality and decide whether to impose preventive detention or incarceration. However, there is no evidence that health authorities followed the same procedure during the SARS crisis in Toronto. Rather, individuals subject to quarantine were simply informed by telephone of the conditions they were under (Jacobs 2007). There was no judicial oversight in the determination of what constitutes a legitimate threat to public health or whether the restrictions on individual rights were justified. Thus, in addition to a jurisdictional tension between the federal and provincial governments, there is a need to consider the relationship between the judiciary and the government. This is not addressed by the policy proposals mentioned above. The next section explores this issue further by identifying relevant precedents that could apply to a public health emergency, including jurisprudence on national security and non-emergency public health imperatives.

Public health and the Canadian Charter

Jurisprudence in public health is a rare commodity and the Canadian legal corpus says little about the application of the *Charter of Rights and Freedoms* in the event of an emergency

(Ries and Caulfield 2005). However, the few cases that exist reflect a clear tendency for the judiciary to defer to the government's determination of the need to limit individual rights in the name of collective health. Case law in non-emergency public health reflects judicial deference in the determination of what constitutes a legitimate public health purpose.

In 1995, in *Canadian AIDS Society v. Ontario* (1995), the Court of Ontario ruled on whether the Red Cross was obliged to inform donors who gave contaminated blood and declare them to provincial authorities under the *Health Protection and Promotion Act* (1990). The Canadian AIDS Society argued that the obligation was a violation of s. 7 of the *Charter*, which guarantees the "right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice" (The *Constitution Act* 1982). Although the court found no effective violation of s. 7, it specified that even if there has been a violation, it would have been "in accordance with the principles of fundamental justice" given the state's responsibility to protect public health (*Canadian AIDS Society v. Ontario* 1995, par. 133). An Ontario court applied the same logic in 2002 in *Toronto (City, Medical Officer of Health) v. Deakin* (2002). In this case, a patient suffering from tuberculosis was detained for treatment. He had at times been held prisoner so that he would not escape. He argued that this was a violation of his right to liberty protected by s. 7 and tried to convince a court to order his release. However, the judge ruled in favour of the City of Toronto, stating that what was done to the patient "was carried out for the protection of public health and the prevention of the spread of tuberculosis, a disease that [a medical specialist] described as extremely contagious" (par. 26). This line of reasoning highlights a fundamental difference between the area of public health and criminal matters. In the criminal law model, the individual is the legal subject. In contrast, in a public health, the population is the legal subject to which the individual is a means to an end.

In an emergency, this precedent could be problematic. For example, an analysis of various emergency triage protocols recently found that the algorithms designed to allocate medical resources during an outbreak excluded patients with physical or mental disabilities (Hensel and Wolf 2011). In some cases, a particular disability was excluded because it negatively affected the likelihood that the medical intervention would succeed. In others, individuals with certain disabilities were excluded because they would need a longer period of time to recover, were anticipated to have a poor quality of life post-treatment or otherwise had a limited long-term prognosis. These exclusions were all based on criteria of "medical effectiveness," which are seen as neutral because "unlike subjective interpretations regarding quality of life,"

they involve an empirical evaluation of a patient's individual health condition (Hensel and Wolf 2011: 723). However, if medical effectiveness is determined on the basis of pre-existing conditions, the outcome will necessarily be systematic exclusion of the disabled from care during an emergency. This might be appropriate from a public health perspective but it problematic from a moral, social justice or rights-based perspective.

Conclusion

An evaluation of federal emergency legislation in Canada reveals a jurisdictional structure that is ill-equipped to deal with a public health emergency. Given the structural limitations of the Canadian federal system, governmental response to a public health emergency could cause conflict between provincial and federal authorities. This jurisdictional structure begs the question of how the law can help protect the collective against threats to public health, and at the same time protect the individual against the powers the state takes upon itself to protect against those threats. The two policy proposals considered above both represent strategies for giving the federal government more power to act in a public health emergency. This would address the lack of a jurisdictional hierarchy in the area of health. It was suggested, however, that while attention has been paid to the difficulties the constitutional division of powers poses in a public health emergency, little attention has been paid to the question of what jurisdictional divisions should organize the enactment of public health powers. It appears that the public power that would be unleashed in an emergency under such reforms would be very robust and subject to little or no judicial oversight. In a public health emergency, the task of legal interpretation would belong exclusively to the executive branch of the government. A parallel between public health law and the criminal law illustrates some of the implications of this lack of jurisdictional division. A question that must urgently be addressed in public health legal preparedness is whether and how to impose juridical jurisdiction given the demands for quick decisions and action when a public health emergency occurs.

About the author

Amy Swiffen is an associate professor of sociology at Concordia University, Montreal, Canada. Her research is focused on the relationship between law and society.

Mona Kayal has taught Political Science at the Canadian Forces College and is a jurist specialising in Health law (B.C.L, L.L.B, McGill University). She can be contacted by e-mail at mona.kayal@gmail.com.

Correspondence may be directed to: Amy Swiffen, PhD; e-mail: amy.swiffen@concordia.ca

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