Forum of Federations

Reflections on COVID and Federalism in Canada: A Scoping Exercise

André Juneau

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Over much of the last year, the coronavirus pandemic has totally dominated life in Canada including, more than ever, the work of governments at all levels. This provides an unusual opportunity to observe the federation in action. On the other hand, in addition to the constant evolution of the situation, the lack of access to government and other actors during the crisis necessarily limits the information available to observers and researchers.

Prepared at the request of the Forum of Federations, this scoping paper explores in broad terms four dimensions of the interaction of the pandemic with Canadian federalism.

- What are the public health roles and responsibilities of the various orders of government?

- Does the current crisis affect roles and responsibilities? In some cases, the effect of a major crisis appears to be centralizing. Is the current arrangement effective?

- Does the current distribution of roles reflect anything governments have learned, or should have learned, from previous public health crises?

- Are the considerations above modified by adopting a multilevel view, namely including international organizations, regional and local governments and First Nations governments?

In conclusion, what further research could be conducted?

The further question to consider is how this work might contribute not just to a better understanding of Canadian federalism, but how its operations might be improved as result. If that were an important goal, then the involvement of practitioners in a scoping exercise would be essential.

Public Health Roles and Responsibilities: the federal government has a greater role than usual

It is commonly asserted that health care is a provincial responsibility under the Canadian Constitution. This is true but does not provide the full picture. The pandemic illustrates this once again. Public health, which is clearly connected to and is arguably a central component of, health care, is in fact a shared jurisdiction and is broadly recognized as such by provincial and territorial governments. To summarize: the federal government has the relationship with the World Health Organization (I once represented Canada on the Executive Board of the World Health Organization). This alone involves a range of different functions and activities. Canada has been an active participant in international disease surveillance collaboration since the mid to late nineties. It also has observer status at the Council of Europe and there are scientific relationships with staff of the Council, for example, on regulatory issues related to blood. It is not practical for provincial and territorial governments to match or duplicate Canada's technical capacity, hence the Canadian Public Health Agency's national microbiology laboratory in Winnipeg. The federal government alone can use the criminal power to regulate dangerous behavior. It is the federal criminal law power that is the constitutional basis of federal food and drug legislation for instance.

The Public Health Agency was created in 2004 response to the Severe Acute Respiratory Syndrome (SARS) episode. It was made up of parts of Health Canada, particularly in this case the public health functions that came under the Health Protection Branch's Laboratory for Disease Control, and portions of the health promotion branch. I had left Health Canada when this happened but I had doubts about appearing to weaken Health Canada's role which is so often challenged, particularly outside but also within Ottawa. This was made worse in my opinion by locating the agency in Winnipeg. This has since been remedied by moving most of the Public Health Agency to Ottawa. Having said that, in the current pandemic, a case can be made that a separate agency was able to move faster than a branch of a department. It would take some careful field work to find out how the coordination between Health Canada and the agency worked. The latter's networks in Canada and around the world seem to work well other than the unfortunate demise of its international intelligence gathering role. In federalism terms, as I note in this paper, while there are good intergovernmental epidemiological networks, it remains to be

seen how challenging it has been to connect the agency to overall intergovernmental affairs (IGA) relationships which has clearly also been required.

Finally, the federal government's purchasing capacity for vaccines and other relevant supplies is much greater than that of provincial territorial governments, as Minister Anand, the federal minister responsible for procurement, has repeatedly pointed out. Also, as brutally illustrated by this pandemic, only the federal government "controls" the border. In normal times this includes the medical admissibility of immigrants and quarantine which is specifically attributed to the federal government in s.91.11 of the Constitution.

This being said, even though the federal government has the jurisdiction noted above, the question is whether the interests of the provinces were adequately taken into account early enough in Canada's response to the crisis. Border control and quarantine for instance are rather esoteric issues at the provincial level. I am reminded how frequently I, as a senior federal immigration official, had to explain to provincial immigration officials what issues federal immigration were required to handle, with or (mostly) without provincial cooperation.

I have always believed that these federal responsibilities in the health sector need to be underlined to remind Canadians that the federal government makes a significant contribution to their health, and in fact therefore to the sustainability of Medicare - Canada's publically funded health care system.

It is apparent from this brief survey that intergovernmental cooperation is essential to successful public health strategies.

The provinces are very active in public health and several of the provincial chief public health officers have become familiar media faces. They provide province-specific public guidance and direction. Their functional authority over health institutions such as hospitals and clinics and health professionals such as doctors and nurses varies across the country and may not be adequate, at least in times of crisis.

It would important to consider the role of regional and local public health officials who have enjoyed various degrees of autonomy. Their relationship with local and regional elected officials, at least at the time of SARS, was not free of tensions.

Another set of relationships that may need attention is the connection between public health bureaucracies at all levels and officials of federal, provincial and territorial health departments who manage intergovernmental relations. The two worlds may have their own distinct approaches to intergovernmental relations, some at the scientific and professional level, others at the policy, program and political level. The lack of connection in the past was sometimes a source of slow decision-making. For example, when federal and provincial public health officials needed ministerial decisions on

vaccine campaigns in the 1990s, they were hampered by their lack of familiarity with the decision-making process and politics of intergovernmental relations.

If the past is a guide, the pandemic will have a limited impact on Canadian federalism

This issue can be studied in principle and in practice and at the macro and micro level. A series of papers for the 2010 conference of the International Association of Centers for Federal Studies examined whether the 2008-09 financial and economic crisis affected the balance of power in federal countries and resulted in more centralization. The general consensus was that it had not, with the exception of South Africa and Spain. It is too soon to tell what the outcome will be of this crisis in Canada but one can hope that the intense collaboration now in place will be reflected in future behavior. A working hypothesis is that this will be true for the current political and bureaucratic leadership. Could this extend beyond that, at least in obvious areas such as bulk purchasing? If so, there may be a positive impact on important features of a Canadian pharmacare program.

It is not the purpose of this scoping paper to describe current intergovernmental relations, but the weekly conference of First Ministers is worth noting because it represents a significant departure from the usual practice of holding such meetings rarely and irregularly.

A different question is whether, either in its fundamental architecture or in practice, the Canadian federal arrangement stands in the way of successfully managing the pandemic. In a recent unpublished paper, Patrick Fafard (Fafard 2020) reviews the various arguments often advanced by public health actors that we need significant centralization to be successful, and refutes this view. I agree with him and I would add the following observations. The Quebec public health community would not welcome more centralization partly because they know that their political masters would not. Having said that, I have long suspected that many Quebec public health experts have privately lamented situations when politics make it difficult to share information with other provinces and with the federal government. This problem may have been avoided in the current crisis.

A substantive consideration that critics ignore is that, both from a policy point of view and practically, public health needs to be much better integrated with health care. It remains to be confirmed but I strongly suspect that none of the provincial chief public health officers (their titles vary) have much authority over hospitals, clinics and health practitioners. In the current pandemic, I suspect this is significantly mitigated by the very visible involvement of provincial ministers of health, some more than others. Centralization would therefore bring the federal government even closer to a jealously guarded provincial jurisdiction. In addition, the federal government has close to no

knowledge of health care delivery. Both of these points are illustrated by the Prime Minister's musings on a federal role in residential care for seniors. The latter point does not detract from the national tragedy in these institutions and the pandemic should perhaps result in some appropriate collaboration.

There are other aspects of Canadian federalism Fafard does not include because of the explicit and valid focus of his paper. In my experience, as noted above, the federal-provincial-territorial public health community has not been typically close to health policy counterparts who "operate" the IGA machinery (subject to contemporary confirmation). Its loyalty tends to be, from a bureaucratic point of view, just like other highly specialized scientific professionals, towards its own community. The result was that straightforward issues were dealt with smoothly. But when a political intervention was required at the intergovernmental level, it could take a while, within health departments, for the right connections to be made. Even something as simple as arranging for an item to be placed on the agenda of a ministerial conference could become a drawn out process.

One area in particular has generated public and governmental anxiety and interest: the tragic situation in long-term care homes. Some believe that the federal government has a significant role to play. As solutions are examined, the first step should probably be an interprovincial comparison of new approaches. My own view is that the federal government is not likely to be able to contribute much policy advice but it can contribute money and research. Carolyn Tuohy has suggested an original federal-provincial, scheme based on the Canada Pension Plan-Québec Pension Plan model.

Are we learning anything? Yes and No

There are various sources of learning: from the past, from other jurisdictions and from other federations. Methodologically we can learn from the comparative study of other sectors. Two come to mind: education (Wallner 2018), and the environment (Fafard and Harrison 2000).
Learning is hard however. Why is that? This is a very interesting question for students of federalism everywhere. It is suggested that in the United States, state governments are laboratories for the testing of policies and programs (Derthick 2001). How are findings then disseminated? This might be as good a place as any to suggest that currently American federalism offers lessons in what not to do.

One hears that in Canada newly appointed provincial and territorial Ministers of Health want to know how their province compares to others. Officials have access to both formal and informal sources to answer their questions. Do their answers affect policy? One obstacle is that conditions vary across provinces and imported solutions rarely fit.

The research to find out what - if anything - has been learned from the past would be hard to conduct in the current context (although media are increasingly digging into the recent and not so recent past). As starting points one would look to the report prepared for the federal government by the National Advisory Committee and SARS and Public Health (Naylor 2003), as well as provincial SARS reports and to the 2008 Annual Report of the federal Auditor General (Auditor General of Canada 2008). It is also important to remember what Canada's chief public health officer has said: (at an April 9 2020 press briefing): this is a novel virus and past experience has limitations.

Public Health is as multilevel as any sector, perhaps more

For several years now, students of federalism have often suggested that in many situations it is better to talk about multilevel governance. It can "be defined as a situation in which power and authority are shared, sometimes in relationships established by constitutional law or treaty, sometimes in more informal working arrangements." (Bakvis, Baier and Brown 2009). Among others, Martin Papillon has written a good review of this point (Papillon and Juneau 2015).

For Canadian public health, there is the World Health Organization (and possibly other international bodies), the federal government, provincial governments and their regional and local public health agencies, territorial governments working with First Nations governments. There is the separate case of the B.C. First Nations Health Authority and the Quebec-Cree and Nunavik arrangements, and then local governments, many of which have their own medical officers of health. Listing all of these levels does not do justice to the many formal and informal links across all of them, personal and professional, in addition to the federal-provincial-territorial machinery mentioned above.

In this context, the role of local and regional public health authorities needs to be studied. They are not necessarily branches of the provincial level and they do not map easily over the structure of local and regional government. They often have significant decision-making capacity. This is illustrated in Ontario by the variations in results across the regions (e.g. Kingston and Windsor-Essex). If only to improve the understanding federal authorities have of constraints faced by provincial governments, this work would be desirable.

What consequences can be drawn from this governance reality? On the downside, one would expect less coordination, or greater coordination challenges, a risk of miscommunications, and more importantly in public health, gaps in coverage that negate the efforts of careful jurisdictions (e.g., the case of regionally spotty vaccines). These issues are probably mitigated in part by the many personal and professional relationships across this field. Could one talk about "federalism of professionals"?

On the upside the connection to international organizations significantly improves the timely knowledge of national authorities who will hopefully transmit it within the country.

We need much more research

Prior to the COVID-19 crisis, there appears to have been very little work on pandemics and federalism, other than that led by Harvey Lazar at the Institute of Intergovernmental Relations undertaken around 15 years ago, and some recent research by Patrick Fafard (Fafard 2020). Since I first drafted this piece however, there has been an explosion of work on this subject. A good source is the website of the Peter MacKell Chair in Federalism in the School of Law at McGill University. It would be interesting to review that work based on this paper's framework. There is very little scholarly work generally on public health and federalism, as is evident from reading Canadian books on health and federalism or chapters on health in books on Canadian federalism. The literature on comparative federalism is equally thin on the subject.

I would, however, note here the very useful paper by Wilson et al. on The New International Health Regulations and the Federalism Dilemma (Wilson, McDougall and Upshur 2006).

We need to understand how federalism and pandemics interact both in principle and in practice. A model for the latter from a machinery point of view could be Donna Wood's work on the labor market sector (which includes a comparison between Canada and the E.U.) (Wood 2018).

We need to study the extent to which the lessons of the past have been useful again at various levels.

Before undertaking much of the work, it makes sense, using perhaps the IJFS framework, to analyse the extent to which the Canadian literature on the environment and education provide methodological guidance.

A neglected feature of thinking about pandemics and federalism could the financial and economic impact of the crisis. This is not per se a public health issue (aside for the federal funding of provincial requirements) but it is clearly a consequence of the crisis which deserves attention from a federalism perspective.

The book co-edited by Lazar et al., Paradigm Freeze: Why it is so Hard to Reform Health-Care Policy in Canada (Lazar, Lavis, Forest and Church 2013) provides a detailed practical model for comparative analysis that could guide further work on the pandemic and federalism

Further work would also study the response of other federations, namely the U.S., Germany, Australia. The Australian Prime Minister has created a “national cabinet” which some have described as the Council of Australian Governments by another name. Comparative work could look at starting points in each country, namely what was the prior state of public health collaboration? Then the question would be: what arrangements were added to existing ones, if any? Thirdly, there would be questions related to the balance of power during and after the management of the pandemic. The problem of causation in assessing successes and failures would be significant because, as usual, the federal arrangement in each country is only one factor among others.

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