Cutting the Threads of Patchwork Policy: The Impact of Decentralization on Pandemic Containment in Nova Scotia and British Columbia

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A Thesis Submitted to
Saint Mary's University, Halifax, Nova Scotia
in Partial Fulfillment of the Requirements for
the Degree of Honours Political Science.

April, 2021, Halifax, Nova Scotia

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Date: April 22, 2021

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Abstract

This thesis explores the topic of Canadian federalism and decentralization in the context of the COVID-19 pandemic. Federalism has shaped Canadian healthcare and over time has led to discrepancies in health policy and administration in terms of the distribution of federal, provincial, and territorial powers, and the institutional design of healthcare that varies across jurisdictions. The emergence of the COVID-19 pandemic has thrust public health to the forefront of policy at all levels, placing tension on Canada's already fragmented healthcare system. These tensions are analyzed further through a comparative case study of the provinces of Nova Scotia and British Columbia to demonstrate how the historic federal, provincial, territorial divide has impacted provincial containment of COVID-19 during the first wave of the pandemic (January 2020 - September 2020). A brief history of Canadian federalism is given in section one, followed by an assessment of the strict public health measures that are necessary to effectively contain the virus in section two, and lastly section three contains a case study of the provinces of Nova Scotia and British Columbia to analyze how these provinces were able to effectively manage the spread of the virus in the first wave. As their shared success began to diminish in the second wave of the pandemic, this thesis argues that a bottom-up, pan-Canadian health strategy could foster continued collaboration between the federal, provincial, and territorial governments, through the establishment of documented best practices to encourage the implementation of the public health measures needed to contain the virus. For it is in times like these; when entire healthcare systems across the country are called to action, that our "patchwork" model of healthcare governance manifests its true weakness and highlights the need for change.

April 22, 2021

Acknowledgements

Writing this thesis amid the COVID-19 pandemic was one of the most rewarding yet challenging experiences of my four years at Saint Mary's. Adjusting to the constant change that has occurred during the pandemic would not have been possible without the support of the Political Science department in continuing the Honours program online, as well as the support of my family and close friends as I began my research in such unfamiliar times. I would like to express my immense gratitude to Dr. Don Naulls for your support and guidance both as my thesis supervisor and as a mentor throughout my time at Saint Mary's, your support and encouragement are invaluable. Thank you to Dr. Alexandra Dobrowolsky, for your dedication and enthusiasm in supporting both myself and Michael Trotter throughout the entire research process of our projects, and for making the 2020-2021 Honours program both memorable and engaging in an online mode of learning. Last but certainly not least I owe it to my partner, Lucas, and my mom, Janice, my dad, Michael, and my brother, Liam for your infinite love and support.

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Abbreviations

B.C. – British Columbia

CMOH/CMOHs – Chief Medical Officer(s) of Health

COVID-19 – Coronavirus Disease of 2019

F/P/T – Federal/Provincial/Territorial

H1N1 – Influenza A virus AKA Swine Flu

N.S. – Nova Scotia

SARS – Severe Acute Respiratory Syndrome

Introduction

Across the globe, Canada is highly regarded for having universal, "free," health care. However, when one truly homes in on health policy and healthcare governance across the country's 10 provinces, three territories, and over 600 Indigenous communities, it becomes clear that many Canadians face immense social and economic barriers in their attempts to access key health care treatment and services. Long wait times and backlog in emergency rooms and walk-in clinics; overcrowding in long-term care facilities; wait lists that exceed the one-year mark to find a family doctor; and the inability to have a prescription filled without an adequate income or health care benefits are just some of the barriers that Canadians face in the current healthcare system of governance. Overall, the healthcare system is fragmented and decentralized with health care provisions falling primarily under jurisdiction of the provinces and territories according to section 92 of the Constitution Act of 1867 (the Constitution), with more broadly defined responsibilities shared between federal/provincial/territorial (F/P/T) power in healthcare financing (Flood et al., 2017, p. 1).

The arrival of the COVID-19 pandemic in Canada on January 25, 2020, with the first presumptive case identified in Toronto has amplified the barriers produced by this fragmented system, as the provinces direct their healthcare resources and infrastructure capabilities towards pandemic containment (The Canadian Press, 2020). COVID-19 is a highly communicable virus requiring strict measures of social distancing and droplet precautions to mitigate and contain its spread. Due to its high contractibility, efforts to contain the virus must occur *en masse* with actions taken by all levels of government and by society as a collective. Given the historic tension and division that is present between

the federal, provincial, and territorial governments and the fragmented history of the Canadian healthcare system, establishing a coordinated policy approach to the pandemic has been a great challenge for our federation. According to Paquet and Schertzer, the existing intergovernmental processes and norms of working together between the federal and provincial governments may pose barriers to achieving the level of collaboration needed to contain the virus (2020, p. 345). As a result, generating a response to the pandemic has been one of trial and error for the provinces as they attempt to navigate what policies are effective versus those that have no bearing. Pandemic response plans have therefore become a double-edged sword that pits the effectiveness of policy responses against the spread of the virus.

The aim of this project is to determine the role that a pan-Canadian health strategy could play in fostering better collaboration and best practices between the federal, provincial, and territorial governments to contain the pandemic by encouraging a more coherent approach to health administration and management. This research is significant now more than ever, as our fragmented healthcare system has been a point of concern in this country for a long time which has amplified the barriers and strain imposed by this system on health professionals and the public during the pandemic. This essay argues that a pan-Canadian health strategy is one method that could produce positive change in our healthcare system under cooperative federalism and serve to guide provincial/territorial policy approaches through the establishment of effective collaboration between governments so that the health of all Canadians is prioritized, and the virus is contained. Through a comparative analysis of the two Canadian provinces of Nova Scotia (N.S.) and British Columbia (B.C.), this project will explore how a national strategy on healthcare in

the time of the COVID-19 pandemic could serve as an effective approach to contain the virus, with a particular focus on the first wave (from January 2020 – September 2020). For it is in times like these; when entire healthcare systems across the country are called to action, that our "patchwork" model of healthcare governance manifests its true weakness and reveals limitations that are detrimental to the lives of Canadians.

Using the theoretical approach of historical institutionalism; a social science approach commonly used by comparative scholars to study how institutions are affected by historic timing and known for "[…] its attention to the ways in which institutions structure and shape behaviour and outcomes" (Steinmo, 2008, p. 118), this thesis will track the F/P/T distribution of powers in healthcare institutions overtime, to further understand how the historic tensions in healthcare governance have impacted the containment of COVID-19 across the country during the first wave. These tensions will be analyzed further through a comparative case study of the provinces of N.S. and B.C. to measure how the historic F/P/T divide impacted their provincial pandemic containment during the first wave, as well as how a pan-Canadian health policy framework could be implemented to overcome the challenges of containing this highly contractible virus. Based on democratic rule and institutions, federalism has shaped Canadian health care and over time has led to many discrepancies in health policy and administration not only in terms of the federal-provincial-territorial distribution of power, but also the institutional design of the healthcare system in individual provinces. According to Wilson and MacLennan: "Federalism is a form of government in which centralized rule is combined with regional government and no order of government is necessarily subordinate to the other" (2005, p. 5). However, this is not how federalism has

historically played out in Canada, as the provinces and territories hold most of the decision-making power in terms of healthcare management and administration which has had various pros and cons in fostering adequate access to health care treatment and services. The concept of "path dependence" explains this further as according to Broschek: "[…] path dependence provides that the institutional pillars of a federal order are often stably reproduced over time" (2012, p. 663). Canadian federalism has followed down a particularly problematic path; with provinces wielding most of the authority regarding health care fostering a lack of collaboration between provinces that becomes apparent when outbreaks or other national health emergencies occur. As a result, more cooperative federalism with a strengthened federal role and pan-Canadian targets is needed to achieve equity in the Canadian healthcare system. If we are to achieve containment of COVID-19 across Canada, then the provinces and territories must collaborate with one another to implement a national policy strategy and shared goals to eliminate the virus once and for all.

I: Historic Tensions: Health Care and the Canadian Federation

Federalism: Background and Ideology

The Canadian federation is complex and uniquely defined by notable shifts between centralized and decentralized policy approaches and "new," federalisms that reflect the politics of the day and vary depending on the political party in power and the policy issue at hand (Bickerton, 2011, p. 205). Our political institutions reflect these shifts as they completely reshape the relations between the federal and provincial governments, the division of powers and responsibilities between them, and the ways in which they engage with one another (Simeon, 1980, p. 15). The concepts of centralized

and decentralized federalism refer to the concentration of constitutional powers that differ depending on the "kind" of federalism; with constitutional power held predominantly by the federal government under more centralized notions of federalism, whereas decentralized federalism entails that constitutional power is concentrated within provincial/territorial governments (Stevenson, 2006). Both are often associated with ideological positions on the political spectrum; with those on the left arguing for more centralization and those with more right-wing views arguing for decentralization (Stevenson, 2006). Therefore, government responses to the political, social, and economic challenges that face society at the time will vary based on the distribution of powers and the federal-provincial relations at play, all of which reflect the values of government leaders and may be framed as "new" federalisms. To make this process more complex, generating a response to such challenges requires federal-provincial agreement under the Constitution, which is often difficult to achieve depending on the issue area (Simeon, 1980, p. 16). In times of crisis, this division is amplified as the need for cooperation and collective decision-making increases when certain issues require an urgent response from all levels of government in a fast and effective manner, such as the COVID-19 pandemic.

The fragmented nature of Canadian federalism and intergovernmental relations demands constant re-evaluation and reconfiguring of government powers and relations, so much so, that when a particular issue arises, we must grapple with the federation before a response is generated. Richard Simeon refers to this as "the crisis of the Canadian federal system," in which a variance in political priorities and the social, political, and economic tensions of society; whether it be on the topic of the economy or

community organizing, are "mobilized, channelled and expressed through Canada's federal and provincial governments and their leaders" (1980, p. 15). As a result, intergovernmental relations are "simultaneously" the point at which the tensions and challenges facing Canadian society are emphasized and deliberated, and the apparatus by which to establish resolutions and develop plans to solve and overcome such tensions (Simeon, 1980, p. 15). The COVID-19 pandemic has been no different, as to effectively contain its spread we must confront what Simeon refers to as "the crisis of the Canadian federal system," meaning we must confront the current, pre-existing flaws in Canadian healthcare and reconfigure the structural mechanisms at play to effectively overcome this public health crisis.

Federal'isms': Collaboration Versus Cooperation

The "new" federalism that dominates the Canadian federation today is known as collaborative federalism. According to Cameron and Simeon, collaborative federalism prioritizes the establishment of broad national policies and co-determination, rather than the federally led, cooperative form of federalism that is often associated with the post-World War II period (2002, p. 49). Further, adherents of collaborative federalism often maintain an understanding of Canadian governance as a "partnership between two equal, autonomous, and interdependent orders of government that jointly decide on national policy" (Cameron & Simeon, 2002, p. 49). There are different approaches to how collaborative federalism is exhibited as some approaches are more open to provincial authority, such as Harper's "open federalism," in which the provinces were left to focus on their own jurisdictions while the PM maintained an "openness to take unilateral action towards national goals," while others are more closed off and support actions that are

unilateral in nature (Schertzer, 2016). However, Prime Minister Justin Trudeau's collaborative federalism is known for supporting both through his promotion of policies rooted in strong pan-Canadian goals and his consideration for regional and provincial interests (Schertzer, 2016).

Alternatively, cooperative federalism describes an approach in which governments work together "for the betterment of all 'the people,'" meaning the provinces are accountable to the federal government, instead of the citizens within their own regions (Breton, 1987, p. 274). This form of federalism is commonly associated with building the post World War II welfare-state and the policies and programs that emerged during this period. Some of the policies included were: "provincial social assistance, health care and post-secondary education regimes," all of which were partially funded through conditional federal transfer payments (Simmons & Graefe, 2013, p. 30). According to Simmons and Graefe, the prioritization of accountability to the citizens via public reporting of policy results, instead of to the federal government through fiscal reporting, marked the shift towards the collaborative federalism era (2013, p. 30). In the area of health care and other social policies, proponents of cooperative federalism perceive this approach as more adaptable and one that better reflects the social, political, and economic changes that occur in society. As a result, the federal government often takes a cooperative approach to crises when they arise to efficiently streamline government approaches and respond in an urgent manner. However, the extent to which the federal government should intervene is often up for debate, even with the emergence of the COVID-19 pandemic.

Health Care Federalism: What powers?

The Canada Health Act is a primary federal mechanism for facilitating healthcare governance in Canada. According to Tomblin Murphy: "Governance is the process whereby societies or organizations (including governments) interact to achieve and be accountable for common goals while operating in a complex world" (2013, p. 118-19). The Canada Health Act lays bare the terms and conditions that all provincial and territorial healthcare plans must follow to be granted access to federal funding. Such terms and conditions include: "portability, universality, accessibility, comprehensiveness, and public administration" (Martin et al., 2018, p. 1720). Additionally, the Canada Health Act is responsible for provincial Medicare programs that fund health care treatment and services across the country. But there is more to Canadian health care than these funding mechanisms, as healthcare management involves various key stakeholders who interact with one another both directly and indirectly for these systems to function (Tomblin Murphy, 2013, p. 119). Notably, Canadian healthcare governance is shared between federal and provincial jurisdictions, although the federal government is known to pass off some of its powers. Simply stated, healthcare governance is not clear cut as many tend to assume.

The F/P/T divisions of power on health care are laid out in the Constitution Act of 1867. However, the language used on health care provisions is extremely broad and overlapping and as a result, the courts have been tasked with interpreting it to determine who governs health care delivery and financing (Flood et al., 2017, p. 1). According to Flood and colleagues, the only direct mention of health care in the Act of 1867 is found in section 92 which states that the provinces have jurisdiction over the "establishment, maintenance, and management of hospitals, asylums, charities and eleemosynary

institutions" as well as "[…] property and civil rights" (2017, p. 1). By contrast, health care funding is broadly divided between provincial and federal governments although many associate the federal government with possessing most of the financial power and responsibility in this area. However, the federal Parliament can use its power to govern health care through other streams such as, criminal law, its duties in relation to First Nations, power over patents, and its "power to regulate in pursuit of "peace, order and good government"" (Flood et al., 2017, p. 2-3). The federal government has made progress in exercising its powers in certain aspects of health care, such as establishing the conditions for national Medicare; regulating approval of pharmaceuticals and medical equipment and technology; and regulating the advertising and sale of tobacco (Flood et al., 2017, p. 3). Regardless of the notable gains the federal government has made in health care, they continue to demonstrate an apparent hesitancy to use their power and take an executive approach around health policy especially during the COVID-19 pandemic.

In addition to the challenges posed by the federal-provincial division of powers on pandemic containment, the varying responsibilities and legislative powers allotted to Canada's Chief Medical Officers of Health (CMOHs) have greatly impacted provincial policy responses, as these powers differ between the provinces. Across the country, CMOHs possess different internal responsibilities; where they have varying roles as confidential advisors to the Premier and they may or may not be granted a management role, as well as varying external roles as a public health communicator and advocate (Fafard et al., 2018, p. 586). The legislative authorities allotted to provincial/territorial CMOHs has a significant impact on pandemic containment as it fosters inconsistencies in

the degree of health-based decision making that can occur within each jurisdiction and the level of influence that CMOHs have over health care decisions across Canada, as well as their capacity to intervene or take precedence over the premier in cases where decisions may be highly politicized. A legislative analysis done in 2018 by Fafard and colleagues examines this issue extensively through a comparative study of CMOH roles in various provinces and territories across Canada assessing factors such as "[…] the presence and degree of advisory, communication, and management roles […]" (p. 586). The difference in the allocation of these roles and the legislative authority of CMOHs in the provinces and territories across the country further reinforces Canada's system of patchwork healthcare policy and management.

In terms of how this complex distribution of federal-provincial powers has fared during the COVID-19 pandemic, not much has changed aside from a slightly amplified role of the federal government as a guide to foster increased cooperation and instil a semi-emergency-based response. However, the provinces have been primarily responsible for facilitating the pandemic response in their jurisdictions with very little agreement on the most basic of public health measures such as social distancing, mask wearing, gathering limits, contact tracing, lockdown, inter-provincial travel and much more. Notably, there has been no uniformity in physical distancing or quarantine regulations amongst provinces, nor any agreement between provinces around screening and testing those who may have the virus (Attaran & Houston, 2020, p. 96). According to Migone (2020), the Canadian health policy response to the pandemic consists of a blended approach of allocating different roles and responsibilities across jurisdictions in which the Provinces hold Constitutional prominence; the federal government runs

agencies such as the Public Health Agency of Canada (PHAC) and uses the Public Safety Canada ministry to manage the global and national sides of the pandemic, as well as their notable fiscal responsibility to the provinces; while local authorities are the major contributors to local containment (p. 393-94). However, the Trudeau government has failed to implement a national mandate on COVID-19 testing, contract tracing, nor isolation, and guidance from PHAC has been inadequate in terms of clarity and authority (Freeman & Freeman, 2020). As Canadian lives are at stake, we must not allow these discrepancies in health management to be the difference between life and death. A streamlined pandemic response, increased pandemic preparedness and effective collaboration across the provinces and territories must be integrated into our system as an essential part or it will only continue to fail (Freeman & Freeman, 2020).

II: A Pan-Canadian Health Framework to Turn the Tides of The First Wave

"Stay the Blazes Home": The Impact of Economic Versus Health-Based Policy

On March 11, 2020, Prime Minister Justin Trudeau announced Canada's "whole-of-government approach," to respond to the COVID-19 pandemic. However, this approach is primarily concerned with the allocation of monetary support and resource distribution to individual provinces and does not effectively ensure that provinces coordinate their pandemic responses between jurisdictions. This whole-of-government approach includes the establishment of more than $1 billion towards a COVID-19 Response Fund, facilitating measures to directly respond to the outbreak, and new investments to limit national spread of the virus and prepare for its potential impacts on "people, the economy, and small businesses" (Prime Minister of Canada Justin Trudeau, 2020a). Unfortunately, this whole-of-government approach does not necessarily translate

to the provinces and territories, except through funding and resources which may or may not be directed towards health-focused efforts. As a result, this approach is no more than detached guidance as the funding and distribution of resources does not guarantee a reduction in positive COVID-19 cases. Rather, it is the implementation of strict public health measures that enforce social distancing and increase droplet precautions, along with strategic and effective resource allocation that are imperative to reducing case counts. Therefore, Trudeau's whole-of-government approach only achieves a fraction of this task by allocating money and resources to the provinces and providing the broad advice of Dr. Tam, the Chief Public Health Officer of Canada, for her recommendations on the public health measures that provinces *should* implement such as "[…] detecting cases, contact tracing, social distancing and self-isolating" (Perreaux et al., 2020). However, as there has been no legislated strategy or act by the federal government to facilitate coordinated, long-term, nationwide containment, the provinces ultimately decide on the public health measures that are implemented, regardless of whether or not they align with federal recommendations.

In their continued efforts to implement strategic health policy approaches to contain the pandemic, many provinces have allowed the looming threat of a suppressed economy to prevail over the act to increase public health restrictions and measures to protect the lives of their citizens. In March 2020, Dr. Tam herself stated that "Concerted action across Canada is needed," however, this statement is barred by the fact that the provinces and territories themselves determine what measures will be implemented and how, as well as how public spaces, businesses, and places of work will be expected to adjust to these measures (Perreaux et al., 2020). As a result, this contradictory guidance

by the federal government has set the stage for a plethora of patchwork policies on COVID-19. For example, the initial gathering recommendation made by Dr. Tam and federal Health Minister Patty Hadju in March 2020 was that at a minimum, events of up to or more than 50 people should be cancelled (Perreaux et al., 2020). Provincial responses to this recommendation varied drastically and were not necessarily beneficial in terms of limiting the spread of the virus in their respective jurisdictions. For example, Québec's initial gathering limits were set at 250 people, while the city of Ottawa took a strict approach by limiting gathering recommendations to just five people (Perreaux et al., 2020). As the initial spread of the virus across Canada was quite strong in city centres like Montréal and Ottawa, it is shocking to see such a difference in the gathering recommendations for these areas. Although the health systems across jurisdictions vary in capacity, funding, structure and etcetera, the virus does not cater to the unique structure or layout of healthcare systems across Canada and therefore, provinces experiencing similar rates of spread and case counts of the virus should have similar public health measures in place if long-term containment is to be reached.

To coordinate effective public health approaches across Canada's Indigenous communities as well as provincial and territorial jurisdictions, more action is needed that goes beyond passive calls by the provinces for the federal government to increase fiscal support whenever they see a spike in positive cases. This is especially prominent as when there is an overarching lack of public health measures in place in certain provinces to begin with, these requests for funding are part and parcel of the distribution of powers between the federal/provincial/territorial governments as they attempt to follow the traditional patterns of health care federalism in which the federal government takes a

stand-by approach and distributes funding to the provinces/territories. Around the end of the first wave, the Prime Minister began to call on the Premiers to "identify their specific needs," as the federal government continues to provide fiscal support and resources to the provinces claiming that his government: "[…] will do whatever it takes for as long as it takes […]" to protect Canadians (Prime Minister of Canada Justin Trudeau, 2020b). By publicly calling on the provinces, the PM showed the reluctancy of the federal government to execute its legislative power or to implement a national strategy further highlighting the responsibility of the provinces to contain this health emergency in their respective jurisdictions. This approach is very similar to what the provinces were accustomed to before the pandemic around healthcare, in which the federal government rarely exercised its Constitutional powers beyond the fiscal power of distributing the Canada Health Transfer.

The same issues that were already present from this approach have prevailed with a vengeance during the pandemic in which the provinces receive lump sums of money from the federal government for "health care" without setting targets for what the funding is for, giving the provinces the power to allocate the funding wherever they see fit. This issue stems from how federal funding for health and education is often distributed across Canada through block transfers in which the federal government cannot allocate funds to specific functions as provincial spending priorities vary across jurisdictions (Wlezien & Soroka, 2011, p. 36). However, in the time of a pandemic, the federal government can set out broad policy targets through federal legislation to enforce necessary public health measures, such as social distancing, gathering limits, mask wearing, and self-isolation after international or interprovincial travel. Implementing legislation on any one of these

targets could also help to regulate the allocation of federal assistance and reinforce best practices for containing the virus. For instance, according to Coyne (2020), this could be done by making federal assistance "[…] contingent on provinces meeting broader standards of policy stringency […]" in which a failure to meet such standards would result in assistance being withheld (para. 16). Such measures would therefore incentivize the implementation of necessary public health restrictions to yield better case results and ensure that provinces are not exploiting federal assistance.

The complex scientific makeup of the COVID-19 virus such as its ability to present an absence of symptoms in people who have been infected, also known as "asymptomatic carriers," has heightened the spread and contractibility of this virus; a sign that it is here to stay and will require on-going management. However, the sudden on-set and spread of the virus has led policymakers to make trade offs between health versus economic-based policy approaches. Throughout the pandemic, provinces have alternated between the implementation of short-term public health restrictions and lock down measures to keep public spaces and the economy open, yielding a brief decrease in case counts; or imposing strict public health restrictions and lockdown measures in the long-term to spark a significant reduction in cases, while making an immediate, hard impact on the economy (Coyne, 2020). The former approach has allowed the virus to persist in many regions as politicians opt to implement COVID-19 restrictions in the short-term to protect their economies, keeping the virus ever-present in the long-term. In the beginning of the pandemic, the absence and/or shortfalls of public health restrictions in some provinces may have been due to a lack of knowledge on how the virus is transferred as according to former Premier of Nova Scotia, Stephen McNeil:

> If you go back to the beginning it was stated that asymptomatic people were not supposed to be able to pass on the virus, public health was telling all of us that and people began to create public policy with that assumption. We now know that was wrong and, in some cases, it was a deadly assumption […]. (Air Quotes Media, 2021, 18:13-18:30)

Once it was determined that the virus could be spread by individuals who do not present with symptoms, public health measures such as strict social distancing regulations, increased gathering limits, and rapid COVID-19 tests were scaled up and pushed by public health officials as essential policy mechanisms required to limit community spread, as with a relative incubation period of up to two weeks the stakes for contracting the virus are high.

Despite the scientific evidence to prove that given its ability to spread via asymptomatic carriers, social distancing is imperative to combatting COVID-19, many provinces have continued to prioritize loose public health restrictions to keep businesses and workplaces open. This was especially evident across Canada during the end of the first wave, when provinces began to see a rise in cases around the month of October 2020, after COVID restrictions were significantly reduced (Hunter, 2021). Scientific data trends show that social distancing and limiting personal contacts yields less community spread and a decrease in case counts. Therefore, the provinces and territories must take it upon themselves to enforce social distancing and ensure that their citizens limit their contacts and reduce community spread by closing non-essential public spaces and services. In my current time of writing this, over a year after the pandemic arrived in Canada, a third wave is beginning to surge across the country with a total of 79 active

cases in Nova Scotia and a daily total of about 4200 new cases in the province of Ontario alone which accounts for 70% of new cases nationally (Liu, 2021). Now more than ever, it is pressing that all jurisdictions take the pandemic seriously to ensure that citizens are protected and as former Premier of Nova Scotia, Stephen McNeil, said: "[…] all we have to do is stay the blazes home" (Benjamin, 2020).

A Pan-Canadian Strategy as A Promising Policy Approach

Much of Canada's COVID-19 response plan was established by revisiting what was learned from the SARS outbreak of 2003 and the 2009 H1N1 pandemic. With its sudden arrival in 2003, the SARS outbreak revealed several problems in coordinating the public health system which led to a major restructuring of Canada's public health institutions (Fierlbeck & Hardcastle, 2020, p. 31). The 2009 H1N1 pandemic put these reforms to the test and revealed even more inconsistencies in government coordination, and now COVID-19 has sparked yet another reassessment of the public health system (Fierlbeck & Hardcastle, 2020, p. 31). According to Fierlbeck and Hardcastle, SARS revealed the need for a more sophisticated institutional structure to facilitate coordination between jurisdictions, and H1N1 showed that having too many intermediate organizations can lead to confusion in establishing roles and responsibilities (2020, p. 35). Upon analyzing the policy developments and response mechanisms established during previous pandemics; although each one is different in nature and scope; our governments continue to face the same problem in our response each time. The lack of a coordinated response and information sharing among jurisdictions is familiar to SARS (2003), H1N1 (2009), and COVID-19. This lack of coordination marks a great downfall of the federation and it will require a strategic, evidence-based policy framework to

effectively compete against these highly communicable viruses. The fragmentation of Canada's federation has been no match against the microscopic fragments of the coronavirus and therefore it is pressing that institutional change is made to effectively manage both.

COVID-19 has impacted all Canadians and is not particularly localized to one part of the country. Therefore, containing the pandemic requires a joint approach between the central government and the provinces, territories, and Indigenous communities of Canada to establish shared commitments to follow in containing the pandemic. A pan-Canadian strategic policy framework is one method that could foster better cooperation between the federal and provincial governments to streamline some of the core pandemic policies that are needed to contain the virus, such as mask wearing, physical distancing, and travel restrictions at the international, national and at inter/intra-provincial levels. To help implement policy restrictions of this nature, the policy approach that is argued for by this thesis is a bottom-up policy approach. According to Drummond and Calder (2017), in establishing a pan-Canadian health policy framework, a bottom-up approach that is based on establishing best practices between provincial/territorial jurisdictions would be ideal in terms of ensuring that the provinces take the lead as to not infringe on their jurisdictional powers (p. 238). This approach has a great potential to foster effective health policy on pandemic containment as best practices are determined by comparing health data and health policy between the provinces/territories with the purpose of being emulated across Canada (Drummond & Calder, 2017, p. 238). This approach would also ensure that improvements are made to the capacity of health information and data sharing across provinces as a central component to accurately identify best practices by

comparing the efficiency and assessing outcomes of their healthcare systems while also identifying jurisdictions who fall behind in the quality and efficiency of care (Drummond & Calder, 2017, p. 238). In the context of the pandemic, best practices could be determined based on the number of cases or presence of community spread in each province or territory. Given the historic tensions between F/P/T powers and the regionalization of health care that is prominent across Canada, this approach ensures that provinces collaborate and work with one another towards shared health care targets and heeds from the potential restrictions that a top-down approach could impose.

Throughout the pandemic, many have called on the government to enact the Federal Emergencies Act or to put in place federal legislation based on the premise of "peace, order and good government," under section 91 of the Constitution Act. However, these top-down actions present some limitations that could direct them away from what they intend to do. For example, both the Federal Emergencies Act and legislation under section 91 of the Constitution face the risk of being illegitimated by the provinces and causing national tensions that could jeopardize the cooperation needed to combat the virus; both also have an eventual end meaning that provinces could struggle if they cannot maintain stability when the federal intervention is removed (Mathen, 2020, p. 125-126). Another issue is that the Emergencies Act can only be implemented if a province has failed to respond appropriately on their own to a public health emergency, therefore putting the lives of their own citizens and other Canadians at risk (Flood & Thomas, 2020, p. 105). Although they may seem minor, these limitations are enough reason for the provinces to instinctively protect their jurisdictions from federal encroachment and continue on with the way they have always dealt with their health care dealings. As a

result, a bottom-up-approach to national pandemic containment is ideal and more realistic in terms of the willingness of provinces to follow through and to ensure that they can withstand the transition to "rebuild," after the pandemic without having to adjust to the absence of federal intervention.

At the core of a bottom-up pan-Canadian policy approach on pandemic containment is ensuring that it is effectively communicated and understood by all provinces, territories and actors involved as well as the inclusion of the public and stakeholders (Drummond & Calder, 2017, p. 238). The method that Drummond and Calder put forward for establishing a new policy initiative is to create a public document in the form of a policy statement. In establishing a policy statement on best practices in health care during the pandemic the document would follow Drummond and Calder's approach to ensure that the statement defines the problem(s) to be addressed, the objectives, defines the steps to be taken, and contains an outline of how progress will be measured (2017, p. 241). However, none of this is new, bottom-up versus top-down approaches to health care reform have been proposed before to match the debate on centralization. For instance, a pan-Canadian approach was originally outlined in Health Canada's 2004, "10-year Plan to Strengthen Health Care,*"* and data sharing between provinces and the federal government is an issue that has persisted throughout the past two health emergencies in this country (SARS & H1N1) that we have failed to implement. For example, in establishing the David Naylor Report; the first report established in response to the management of the SARS outbreak, the commission considered a centralized model "in which the federal government, through legislative mechanisms or strong financial coercion, would direct provincial/territorial or local

public health activities," however, this option was rejected due to the potential to cause intergovernmental conflict (Wilson & MacLennan, 2005, p. 5). The SARS report also explored how federal legislation could be used to achieve desired health policy goals (Wilson & MacLennan, 2005, p. 5), a suggestion put forward once again during the COVID-19 pandemic. However, the prospective for change towards any kind of national policy initiative on health care was made even more unlikely with the changes made to the Canada Health Transfer in 2011. These changes meant that transfers would be limited based on Canada's rate of economic growth, allocating provincial shares on a per capita basis, along with the announcement that the federal government would no longer use its spending power "to encourage or set health system goals," rather, the provinces would establish their own reform priorities" (Marchildon, 2013, p. 127). As a result, the promising policy approach set out in the 2004 "10-year framework," was quashed and gave way to a "wave of bilateral agreements between the federal government and the various regional jurisdictions," to replace previous federal agreements (Migone, 2020, p. 390). Therefore, in the absence of much needed institutional change to promote F/P/T collaboration on health care in Canada, the emergence of the COVID-19 pandemic and its abrupt spread across Canada has highlighted the need for national cooperation once again.

The Evidence: How and Why A National Strategy Could Be Effective?

According to Carson, under our collaborative, decentralized mode of federalism, Canada's healthcare system is underperforming as: "[…] across the OECD'S standard measures of health system performance – efficiency, effectiveness, access, and equity – Canada is mediocre at best" (2017, p. 2). With the arrival of the COVID-19 pandemic in

Canada, these inconsistencies have only worsened as a variety of policy approaches are being taken across the country. In terms of establishing more collaboration between provinces through a national strategy on containing the COVID-19 virus, there is already evidence within our own country to determine best practices on how to effectively achieve this. In Atlantic Canada, the province of Nova Scotia has exercised these practices which are encouraged by Dr. David Naylor as the province reset their cases to zero and then entered "containment mode," where the aim is to capitalize on and "completely smother" any cases that arise thereafter (Kirkey, 2020). This approach has also been taken in countries where what is referred to as "zero COVID," has been achieved, such as New Zealand, Vietnam, Taiwan, and Australia (Kirkey, 2020). Countries who have achieved this level of containment have all taken strict, streamlined approaches to crack down on cases nation-wide, setting a standard for what is needed to reach "zero COVID," worldwide. In New Zealand, this strict policy action to contain the pandemic has been dubbed the "elimination approach," which occurs when the spread of a disease is reduced to zero in a "defined geographical area," in which any new clusters of COVID or imported cases are resolved as soon as possible (Baker et al., 2020, p. 1). Using this approach, New Zealand was considered to have achieved zero COVID by late July of 2020 with no cases of community spread for over 80 days (Baker et al., 2020, p. 1). Although there is no "end all be all," approach that can ensure permanent elimination of the virus, this approach is extremely promising in terms of its ability to achieve long periods of virus elimination in multiple countries. An 80-day period of zero COVID virus elimination could be ground-breaking in terms of reducing the global impact of COVID-19 because during this time, countries can scale up their response plans and resources

allowing them to increase their capacity to effectively contain the virus. As there are no new active cases or community spread of the virus during zero COVID and assumingly no new COVID-related hospital admissions, any added pressures would be temporarily removed from exhausted healthcare systems allowing them to focus on the recovery of those who are currently in hospital to gradually transition individuals out of hospitals and Intensive Care Units.

III: Coast to Coast: A Case Study of N.S. & B.C.'s COVID Response

Throughout the pandemic, the Canadian provinces have taken different approaches to public health policy that range in timing, scale, degree, and overall outcome. The case studies in this section aim to put these differences into perspective through a comparative analysis of the provinces of Nova Scotia and British Columbia to analyze the interplay between public policy and the state of provincial health care in these provinces before the pandemic to understand the extent to which existing institutional structures influenced their first-wave pandemic responses. The provinces of Nova Scotia and British Columbia were selected due to the many differences found between them, such as, they are on two opposite sides of the country; they differ in size as B.C. is much larger than N.S.; they differ in terms of demographics, financial capacity, and political culture; the current party representation is different between them, as B.C has an NDP government and N.S has a Liberal government; as well as notable differences in their provincial healthcare systems (Fierlbeck, 2018, p. 2). Another difference is the insurmountable discrepancy in the number of cases faced by each province during the first wave; with B.C. facing several cases early on while N.S. was one of the last provinces in the country to develop cases. Despite these differences, their public policy

approaches to the first wave of the pandemic employed a similar urgency and immediate action which helped them to achieve a certain degree of success and control in their containment of the virus when compared to the rest of the country. To analyze this further, the most different systems design of the comparative method will be used to analyze how despite the number of differences between the political cultures and provincial healthcare systems of N.S. and B.C., they achieved (temporarily) a similar outcome of effective pandemic containment early on.

Nova Scotia: A Snapshot of the Political Dynamic & Healthcare System

In terms of their healthcare system, the province of Nova Scotia is quite vulnerable as a small province with a relatively small population when compared to the rest of the country. According to Fierlbeck, Nova Scotia has less than a quarter of the population of larger provinces such as B.C. and Alberta and therefore they maintain little political influence at the federal level (2018, p. 7). As a result, N.S. has minimal say when confronted with national policies and strategies, like the 2011 funding formula for the Canada Health Transfer that disadvantaged provinces with weaker economies and older populations (Fierlbeck, 2018, p. 7). For this reason, Nova Scotia has gradually transitioned its healthcare system away from the regionalization that was prominent across the country in provinces such as B.C. and Québec in the 1990s, to a more centralized model (Fierlbeck, 2018, p. 25). This policy initiative was taken by the Liberal government under Former Premier Stephen McNeil in 2015. To track the transition away from regionalization in the province, in 1994, N.S. established four regional health authorities which were expanded into nine district health authorities in 2001, and in 2015, these nine districts were amalgamated into one provincial health authority, the Nova

Scotia Health Authority (Fierlbeck, 2018, p. 55). This is a rare occurrence when compared to most other provincial healthcare systems in Canada that continue to employ a regionalized model. According to Marchildon, the shift away from regionalized health care often occurs as governments have an increased desire to get more value for their health care spending (2015, p. 236). As Nova Scotia receives significantly less money than other provinces, this transition seems to correspond with a desire to increase the value they get out of less funding.

British Columbia: A Snapshot of the Political Dynamic & Healthcare System

As a much larger province, the provincial healthcare system in British Columbia is much different from the province of Nova Scotia as it continues to follow a regionalized model. Consisting of five regional health authorities, B.C. health care is delivered to the population based on geographic location in terms of the respective region an individual resides in (Province of B.C., 2021). Given its increase in size and population, B.C. experiences a fiscal advantage over the province of N.S. as the 2011 changes to get rid of the equalization model and allocate shares to provinces on a per capita basis had a very negative impact on smaller, less wealthy provinces like Nova Scotia (Fierlbeck, 2018, p. 13). This also means that provinces such as B.C. and Ontario will be better equipped from a financial standpoint to handle the rapidly aging population in the country (Fierlbeck, 2018, p. 13). Another great difference between B.C. and N.S. according to Curry (who referenced Smith & Stewart, 2009) is that unlike other provinces, the B.C. legislature tends to delegate large (often conditional) amounts of power and control to municipal governments in health care and other policy areas (2018, p. 114). This is most likely due to the size of the province and an overall desire to ensure

regional satisfaction and fulfill economic interests. However, the province ultimately holds the financial power which it has used to regulate municipal relations that either help or hinder the actions they can take (Curry, 2018, p. 114).

Comparative Analysis

The cases of N.S. and B.C. make for a notable comparison by which to analyze Canada's largely fragmented pandemic response, as these two provinces managed to achieve a similar level of success and effective control of the COVID-19 virus in the first wave of the pandemic (January 2020 – September 2020). Both have a great number of differences between them in terms of their geographic size, population, financial capacity, political culture, their provincial healthcare systems, the arrival of the virus in their province, as well as the amount of cases they experienced. But despite these differences, both provinces were able to significantly reduce the level of spread and case counts of COVID-19 by the end of the first wave. As provinces across Canada and countries around the world have struggled to contain the virus for any particular period, the question of how these provinces could achieve this similar level of success at the same time becomes of interest. In my current time of writing this, B.C. has had a large spike in cases since October when the second wave was declared, and from this change, there are certain factors to pinpoint in the political and public health dynamics of these two provinces that correlate to the similar results they experienced during the first wave.

The first presumptive case of COVID-19 to occur in British Columbia was identified on January 28 and the patient was a man in his 40s who travels to and from China for work (The Canadian Press, 2020). On March 15, 2020 Nova Scotia confirmed its first three cases of COVID-19 (The Canadian Press, 2020). In response, both

provinces acted accordingly and took significant public health measures to begin to contain the virus. In Nova Scotia, under the leadership of former Premier Stephen McNeil and Chief Medical Officer of Health (CMOH) Dr. Robert Strang, the provincial government immediately closed all public schools, childcare centres, and more, as well as banning visits to long-term care facilities, gatherings of more than 150 people, and they mandated businesses to keep patrons six feet apart (Vogel, 2020). In British Columbia, under the leadership of Premier John Horgan and CMOH Dr. Bonnie Henry, the provincial government ramped up COVID-19 testing and tracing capacities for patients and they stressed the need for caution and early action (Migone, 2020, p. 384). According to Berman, given their close ties to China, the province of B.C. was quick to develop tests that could be produced and used locally based on the publication of the genetic composition of the virus (Young, 2020). However, B.C. was much later than other provinces to enact a state of emergency relative to the number of cases present in their province. By contrast, Nova Scotia declared a state of emergency on March 22, seven days after their first presumptive cases in which they enacted a 14-day self-isolation order mandatory for people travelling into the province (Vogel, 2020). To this day, the only mandatory quarantine measures that exist in this country are in Atlantic Canada, aside from the mandatory isolation period that is set for people who are coming into Canada via international travel. However, despite the lack of self-isolation requirements for inter provincial travellers and a slower act to declare a state of emergency, B.C. accounted for just 2% of Canada's deaths during the first wave (Freeman & Freeman, 2020).

What may have led to the similar success of pandemic containment in the provinces of N.S. and B.C. during the first wave is that the CMOHs between both

provinces had a strong institutional backing from the provincial government and the Premiers to make the right public health decisions and act immediately to exercise their agency and implement effective public health measures. Increased support from the provincial government allowed the CMOHs in N.S. and B.C. to exercise their legislative authority and make strict public health decisions without backlash. However, when restrictions were loosened in both provinces, B.C. loosened them much more and missed some key steps needed to ensure that there was a plan in the instance of a potential spike in cases again. As a result, in the beginnings of a third wave in B.C. we are seeing that Dr. Bonnie Henry has lost the institutional backing to implement more restrictive public health measures and the Premier has been much more involved in briefings and decision-making (Attaran & Hardcastle, 2020). Politics and economy focused decisions have therefore prevailed over public health. In effect, executing her legislative authority could result in immense backlash from the public and the government without the support of the Premier.

The CMOHs in N.S. and B.C. have similar legislative authority however, the CMOH of N.S. has more managerial authority than that of B.C., which has fared well in terms of Nova Scotia's ability to maintain strict public health measures in the province. As previously mentioned, a legislative analysis by Fafard and colleagues (2018) examines this issue extensively through a comparative study of CMOH roles across the provinces assessing factors such as "[…] the presence and degree of advisory, communication, and management roles […]" (p. 586). The difference in the extent of each of these roles as a part of a CMOHs mandate can therefore result in great differences in the public health measures of provinces during health emergencies. However, the

CMOHs across Canada have specific legislative authority allotted to them in the time of a health emergency, which in the cases of N.S. and B.C. are quite similar. During a public health emergency, the CMOH of Nova Scotia has the power to: "Order any person who owns or occupies premises or any organization, corporation or municipality to control disease vectors in the manner prescribed in the regulations" (2004, c. 4, s. 14). Based on the relative success of the province to maintain relative control over case counts for the duration of the pandemic, the legislative authority allotted to the CMOH of N.S appears to match the approach that has been taken for the entirety of the pandemic thus far. In fact, this authority seems to have been extended as Dr. Strang has been present in largely all COVID-19 media briefings in the province and has taken on a strong advisory role, which according to Fafard et al., the CMOH in N.S. traditionally lacks the authority to communicate publicly (2018, p. 588). By contrast, the emergency authority allotted to the CMOH of B.C. states that: "[…] the CMOH may order a person to take any preventative measures he/she feels are necessary" (Fafard et al., 2018 p. 587). In the first wave Dr. Bonnie Henry was able to effectively exercise this legislative authority however, once the second wave hit the pre-existing public health restrictions from the first wave began to lack significantly. Outside of a public health emergency, the legislative authority of the CMOH of B.C. contains larger emphasis on an advisory and communicative role that lacks extensive managerial responsibility as "they can report on any public health issue in any manner that they feel appropriate […]" (Fafard et al., 2018, p. 586) and they have the authority to "[…] communicate directly to the legislature and/or the public" (2018, p. 5.88). From the second wave forward, it seems that Dr. Bonnie Henry began to fulfill only her baseline legislative authorities, due to the tensions that could arise by exercising

her emergency powers. In this case, a national strategy could be beneficial in terms of creating a joint understanding of the necessary, best practice public health measures that are needed and/or expected by provinces to allow for CMOHs to exercise their emergency authority without backlash.

Conclusion

Upon analyzing how the provinces and territories have attempted to navigate and manage the pandemic through the case studies of Nova Scotia and British Columbia, this essay has shown that due to the inherent tensions in the institutional framework of health care federalism and the fragmentation of jurisdictional healthcare systems, the Canadian provinces have struggled to make evidence-based policy decisions in a timely manner to combat COVID-19. Instead, it has been a process of trial and error in which provinces have relied on "horizontal," communications with one another as they come up with new ways to manage the virus. As a result of the historic protection of the federal, provincial, territorial distribution of powers outlined in the Constitution Act, it is clear that moving toward centralization and top-down policy is an unrealistic solution to containing the pandemic in Canada as this can cause more problems in the long-term when federal intervention is scaled back. Therefore, pandemic containment on a nation-wide scale in this country should consist of a pan-Canadian, bottom-up policy framework in which provinces establish increased communication and data sharing amongst each other to determine best practices while allowing them to protect their provincial autonomy as they have historically prioritized.

Better collaboration on health care is needed between the federal, provincial, and territorial governments and Indigenous communities to be able to quickly adapt to public

health emergencies in an effective manner. This is a necessary change that is needed because as Marchildon and Bleyer (2020) put forward, the provinces run many programs and services that have "policy spillovers," and benefit from national collaboration as these are often dealt with by any combination of federal/provincial/territorial processes and organizations. In the case of a pandemic, a bottom-up, pan-Canadian health framework would ensure that the Chief Medical Officers of Health across Canada can confidently implement necessary public health measures by following a national plan of best practices agreed upon by the provinces of the baseline measures that are needed to contain the virus. Under this model, provinces would be able to receive federal assistance in terms of money and resources, so long as they meet established policy targets. Such policy targets would ideally consist of mask wearing protocols, social distancing, imposed gathering limits based on national location, isolation requirements after international and inter/intra provincial travel, and COVID-19 data sharing between provinces.

As a country, we know the right thing to do from watching countries such as New Zealand and Australia achieve zero-COVID and from the drafting of similar policies and frameworks in our own country that we failed to implement. Additionally, there are provinces and territories who have been able to keep their cases at a minimum for the duration of the pandemic, such as Nova Scotia and Prince Edward Island. There has never been a better time for an institutional shift and increased collaboration than now. As the province of Nova Scotia has stood out in terms of its public health policy and pandemic restrictions throughout the pandemic; being compared to the successful measures taken by countries such as New Zealand and Australia (who have achieved

zero-COVID during this pandemic) by top doctors in Canada such as Dr. Naylor and Dr. Attaran, it is time that the Canadian provinces, territories, and the federal government work together and look no further for effective containment measures. For the answer to evidence-based, effective COVID-19 containment can be found on our own soil, on the East coast of Canada. Now is the time to cut the threads of patchwork policy, to increase collaboration and data sharing between the provinces and territories to streamline provincial and territorial health policies on COVID-19, so that zero-COVID can be reached across Canada.

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