

Bilateral Federalism, Value-Based Healthcare and the Future of Canadian Intergovernmental Diplomacy on Health

Le fédéralisme bilatéral, les soins de santé axés sur la
valeur et l'avenir de la diplomatie intergouvernementale
canadienne en matière de santé



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Abstract

The COVID-19 pandemic has laid bare some profound challenges facing the preservation of Canada's single-payer, publicly administered healthcare system. At the same time, it may have presented an opportunity to take bold action on system reform. Part of that opportunity may lie in linking recent developments in intergovernmental diplomacy (termed bilateral federalism) with the growing emphasis on value-based healthcare initiatives coming out of some of the provinces. Bilateralism may be a means to steer reform efforts toward a value-based healthcare system that can articulate pan-Canadian values while accommodating provincial asymmetry in a highly decentralized federation like Canada.

Résumé

La pandémie de COVID-19 a mis au jour de sérieux défis pour la préservation du système de santé public à payeur unique du Canada. En parallèle, cela présente peut-être l'occasion de prendre des mesures audacieuses de réforme. Une partie de cette opportunité réside peut-être dans le lien entre, d'une part, les développements récents de la diplomatie

intergouvernementale (appelée fédéralisme bilatéral) et, d'autre part, l'accent mis sur les initiatives de services de santé axés sur la valeur qui émanent de certaines provinces. Le bilatéralisme peut être un moyen d'orienter les efforts de réforme vers un système de santé fondé sur des valeurs qui sait articuler les valeurs pancanadiennes tout en tenant compte de l'asymétrie provinciale dans une fédération hautement décentralisée comme le Canada.

Introduction

By many popular accounts, the Canadian healthcare system is in crisis. Despite well over a decade of increased spending (and regular significant increases in federal transfers) (McIntosh 2021a), the two-plus years of fighting the COVID-19 pandemic has stretched the system to what some feel is its breaking point (Picard 2022).

From one angle, this may be a recipe for despair and resignation that Canada's most cherished social program may not survive to see its 60th anniversary. However, from a different angle, the current state of affairs is also an opportunity to rethink, refinance, restructure and recommit to both the values that created Canada's medicare system and the value that medicare provides to Canada and Canadians. There are processes at work in the political arena (the emergence of a new kind of *bilateral federalism* [McIntosh and DeCorby 2022]), as well as in the health policy world (the increasingly influential debates around "value-based healthcare" [cf. EXPH 2019: 1]) that could, if brought together, provide a means for instituting the reforms that have been called for repeatedly in the past two decades.

The Rise of Bilateral Federalism

Since 2017, the Canadian government has taken what appears to be a new approach to social and health policy renewal that can be described as bilateral federalism. The approach looks manifestly different from the co-operative federalism that built the post-war welfare state (Banting 1987; Hueglin 2021) but also bears some similarity to the bilateralism that Marchildon (2016) noted was used by the federal government to prepare the ground for the larger pan-Canadian cornerstones of medicare – namely, the *Hospital Insurance and Diagnostic Services Act (HIDSA)* (1957) and the *Medical Care Act (MCA)* (1966) (Government of Canada 2019a). It was through bilateral health transfer agreements (HTAs) throughout the late 1940s and the 1950s that the federal government had funded:

... hospital construction, public health, mental health, cancer control, public health services and research, professional training and sexual disease control In 1949, grants for provincial health surveys were added in order to: (1) ensure the effective use of other health grants; (2) plan the extension of hospital utilization; and (3), most significantly, "*plan the proper organization of hospital and medical care insurance*" (Marchildon 2016: 5, quoting Taylor 1978: 163–64).

This can, perhaps, be characterized as bilateralism in service of pan-Canadianism. The bilateral agreements were necessary to get each province to the place where they had the infrastructure and capacity to fully participate in pan-Canadian projects such as the *HIDSA* and the *MCA*. Befitting a prime minister like William Lyon Mackenzie King, bilateral agreements were a policy instrument needed to achieve a goal rather than a reflection of a particular stance toward or approach to both federalism and intergovernmental relations.

In the early 2000s, bilateral agreements again became a feature of the healthcare landscape when they were used to allocate the funding provided in a series of earmarked federal transfers and contribution agreements relating to health reform, wait times, health human resources and internationally educated health professionals (Marchildon 2016: 7–8). Writing about the Primary Health Care Transition Fund of 2000, Marchildon (2016) noted that the bilateral agreements relating to the fund were “tailored to fit the primary care reform priorities, timelines and goals, as well as administrative capacities of the individual jurisdiction” (p. 7). This characterization is interesting because it may well mark the beginning of seeing bilateral HTAs less instrumentally and more as a way of conducting intergovernmental diplomacy.¹

What is true of the pan-Canadian health accords of the early 2000s, and especially true of the 2004 Health Accord (Health Canada 2004) that was touted as “a fix for a generation” (Andreatta 2013), is that they fundamentally failed to buy much in the way of substantive reform despite their price tag. Nor had they ended debates about the size of the transfer (Beland and Tombe 2021; McIntosh 2021a; McIntosh and DeCorby 2022; Ogilvie and Eggleton 2012). It is also the case that the assessments made of the 2004 Health Accord were based on the commitments made in the accord itself, not any bilateral agreement that stemmed from them.

In the years that followed, the Harper government had little interest in intergovernmental diplomacy around health or healthcare reform. It was content to abide by the 6.5% per year increase in the transfer set out in the 2004 Health Accord and indeed extended it until 2017. With that extension came an announcement that after 2017, the transfer would increase by a three-year rolling average of the increase in the GDP or by 3%, whichever was greater. Upon taking office in 2015, the Liberal government of Justin Trudeau initially announced it would stick with the Harper funding arrangement (McIntosh 2021b).

At the same time, there were new and emerging challenges for the system (Advisory Panel on Healthcare Innovation 2015; Forest and Martin 2018). This led to a substantive change of tack by the federal government when the 2004 Health Accord came up for renewal in 2017. The federal government proposed a solution to the impasse over provincial demands for unconditional increases to the transfer and the federal desire to push particular reforms. The Canada Health Transfer (CHT) would increase by 3.5% per year but there would be an additional \$11.5 billion under an umbrella Common Statement of Principles on Shared Health Priorities that targeted improved mental health and community-based care in the provinces (Marchildon 2016). In order to access their share of the \$11.5 billion, each province

would be asked to sign a bilateral agreement specifying where and how the money would be spent.²

What differentiated the process stemming from the 2017 agreements was that it was the bilateral agreements that were the story, not the pan-Canadian umbrella statement. For almost two decades, the story had been “pan-Canadian accords” to fund healthcare, even longer if one wants to include the negotiation with the provinces over the tax point transfer as part of the federal government’s *Federal-Provincial Fiscal Arrangements and Established Programs Financing Regulations*, 1977 commonly referred to as the EPF. Indeed, we tend to tell the story of medicare in terms of legislation and agreements meant to create a sense of a single national system – from *HIDSA* to the *MCA* to the *Canada Health Act (CHA)* (1985); from cost-sharing agreements to the EPF and the Canada Assistance Plan to the Canada Health and Social Transfer (CHST) to the CHT and the Canada Social Transfer (CST). We do this despite knowing that the reality is 14 moderately coordinated systems covering mostly the same services but organizing and delivering those services quite differently from province to province.

And this might have been simply a tactical move on the part of the federal government, a case of divide and conquer. Despite the attempts of the provinces to present a united front to Ottawa (especially since the creation of the Council of the Federation [COF]), it is readily apparent that provinces have different interests, different fiscal capacities and challenges and different approaches to health policy. In 2021–22, federal transfers amounted to \$1,500 per capita in Newfoundland, Ontario, Saskatchewan, Alberta and British Columbia but over \$4,400 per capita in New Brunswick and Prince Edward Island (Government of Canada 2022). Negotiating one on one with each province may have been designed to break provincial solidarity. Each time a province signed an agreement, the remaining provinces would be faced with the inevitable question from both the public and the media: “Why are you not getting our province’s share of federal funding?”

However, even if this was simply a tactical move – the best means to get agreements – its impact and its import can be seen to be qualitatively different from the bilateral agreements that came before. By making the bilateral agreements the centrepiece of the process rather than a by-product of the process, it necessarily heightens the import of the specifics of those accords.

Furthermore, an approach that puts the bilateral agreements at the centre of intergovernmental diplomacy can change the very dynamics of that diplomacy and may serve to lessen the tension between those who want a key social program such as healthcare to be seen in pan-Canadian terms, and those who seek to protect and preserve jurisdictional autonomy. It can be a federalism premised on both the symmetry of underlying pan-Canadian values (e.g., the desire for an accessible, universal public healthcare system across the country) and the asymmetry of provincial policy design and program implementation at the coalface of service delivery.

It is this tension between the symmetry of broad policy goals and asymmetry of policy design and implementation that bilateral federalism can seek to accommodate and work within. By creating a process that recognizes both shared high-level goals and individual paths toward those goals, it may actually strengthen the pan-Canadian elements of our social citizenship. And it is fair to say that both the 2017 healthcare agreements and the more recent agreements on child care may be nascent examples of a new kind of intergovernmental diplomacy that is rooted in bilateralism.

The 2017 bilateral agreements vary considerably in terms of their specificity as to the allocation of the funding, and, perhaps most tellingly, they contain no commitment to report on the progress of realizing the commitments to their respective provincial publics (a feature they share with previous bilateral HTAs). While not wanting to downplay those problems, the bilateral agreements should still be seen as a significant improvement over the agreements of the early 2000s that placed a pan-Canadian grand bargain-style accord as the centrepiece. They speak to shared pan-Canadian priorities but recognize a province's right to tackle those priorities with its own policy and programmatic responses.

By noting the areas and programs the provinces committed to adopt, expand or improve, the provinces were, in effect, putting their own conditions on this new money. And they were accepting the need to change the system, not just sustain it.

If bilateralism is to take hold as a viable form of intergovernmental diplomacy, a means to both recognize the realities of asymmetries in the federation while affirming pan-Canadian values, it will need to yield future agreements with greater levels of specificity over where the money is being spent, clearer goals over what will be achieved, better metrics to measure outcomes and, finally, fulsome and accessible reporting to provincial publics. No one should delude themselves into thinking that this is not a tall order.

There is, of course, a legitimate question to be asked as to whether policy and programmatic asymmetries may themselves challenge pan-Canadian goals of equity in access to healthcare. However, if outcomes are rigorously tracked and measured, then they need not. There is no single way to design a high-quality, accessible long-term care system or pharmacare program. If two different (or 10 different) models produce comparable improvements in health, at comparable cost and with comparable levels of public/patient satisfaction, then what would be the rationale to insist on one model over another? And if there are significant variations in quality, cost or outcomes, then those too would become apparent and create the political pressure to adopt best (or at least better) practices from other jurisdictions.³

Indeed, it seems more likely that rather than 10 increasingly divergent systems, Canada would see a coalescing around a small number of models based on political preferences for particular local trade-offs. Quebec's drug plan is designed around the presence of a significant pharmaceutical industry in the province that is economically important to the province even if the program itself may be more costly than other options. That is not a trade-off Saskatchewan needs to make when designing drug policy, and so, it may choose a different

route. Assuming that both provinces can meet the pharmaceutical needs of their residents with programs – the cost of which they are willing to bear – pan-Canadianism is not threatened.

Value-Based Healthcare in Canada

However, if bilateral federalism is going to drive intergovernmental diplomacy in the coming years, then it will need a stronger motivating framework than just simply acknowledging and accommodating asymmetries in the design of public policy in the provinces. It will need a framework that can encompass those asymmetries within a set of clearly articulated and measurable pan-Canadian values.

It may be possible to bring the debates over “value-based healthcare” (cf. EXPH 2019: 2; Smith et al. 2020) to bear on Canada’s emerging model of bilateral federalism to move the political conversation on healthcare reform into a more productive form. At first blush, and perhaps especially to the non-health economist, the phrase *value in healthcare* may conjure up economic discussions of cost-benefit analyses aimed at reducing costs, enhancing competition and limiting consumption of care – a neo-liberal skill meant to disguise nefarious intentions to dismantle public healthcare systems. However, value-based healthcare encompasses both *value* as a financial consideration and *values* as non-monetary expressions of the kind of society in which we want to live.

Thus, the European Commission’s framework of a value-based healthcare system encompasses four kinds of value: “personal value” (it meets patient’s needs), “technical value” (it achieves the best outcomes with available resources), “allocative value” (resources are distributed equitably across the population) and “societal value” (it contributes to social solidarity and cohesion) (EXPH 2019: 5).

This kind of talk should not be unfamiliar to Canadians. Roy Romanow’s Commission on the Future of Health Care in Canada’s final report was titled *Building on Values* precisely because this was how Canadians saw their system; it is the embodiment of a range of different values (Romanow 2002). Making those links explicit and unpacking what those values mean and how they interact could move us (indeed might force us) to make the necessary changes to a system that is costing forever more and lagging in its ability to deliver (Sutherland 2019).

Four successive issues of *Healthcare Papers* published in 2019 and 2020 provide important lessons, cautions and prescriptions on how we might think about value-based healthcare in Canada. This sustained discussion begins with the admission that this is a difficult task to operationalize – it is “complex, multilayered and multidimensional” (Wodchis 2019: 12) and “has a high hype-to-system transformation ratio” (Duckett 2019: 15). Knowing how to conceptualize value-based healthcare means little if you can neither measure the value to patients and caregivers of different types (Gilmore et al. 2019; Kuluski and Guilcher 2019; Raveendran et al. 2019), nor the value of different medical technologies (Horne and Manion 2019), nor understand where the gaps in data exist (Wong et al. 2019).

Even seemingly successful local case studies aimed at improving the integration of care and value all speak to the complexity of the challenge (cf. Downey et al. 2020; Lewanczuk et al. 2020; Zwicker 2020), both in making the necessary changes to service delivery and organization and to scaling these changes. As Sutherland (2020a) stated, “there is a dearth of concurrent cost and outcome data that inhibit comparisons of provinces’ strategies for improving value” (p. 5). The lessons that emerge when moving back from the local to the national level are that the challenges remain immense in terms of the kind of collaboration and coordination needed at all levels inside the system (Strumpf 2020), the need to think about how overall determinants of health link to getting value in healthcare (Wodchis and Reid 2020) and, tellingly, the disconnect between the logics that motivate health policy researchers outside government and policy makers inside government (Forest 2020).

Bilateral Federalism and a Framework for Value-Based Healthcare

So far, value-based healthcare is not part of either the political conversation or the inter-governmental dynamics around healthcare reform in Canada; it is not about how either Canadians or Canadian leaders speak about healthcare. And for that reason, it is worth thinking about how one might use the ideas behind value-based healthcare to articulate a vision of the system’s future that can be linked to and perhaps drive forward the ongoing initiatives underway in different parts of the country. What follows then is an outline of how these ideas could be used to further the processes of bilateral federalism and, in turn, provide a framework for accelerating value-based health system change.

Let us start with some basic parameters around the nature of intergovernmental diplomacy in healthcare. First, we can say that, *de facto*, there may now be two health transfers. There is the CHT, which is essentially unconditional and is used for the overall operation of the healthcare system. Then, there is the transfer of money that is earmarked in some way for priorities agreed to by the parties (e.g., the \$11.5 billion given in 2017). The existence of two transfers may be important to providing a focal point to a value-based reform initiative precisely because they can be differentiated and put to different purposes.

Second, the once crucial distinction that the CHT was meant for the financing of physician and hospital services under the *CHA* and not for other health programming offered by the provinces no longer holds water. Both the provinces and the federal government, perhaps for different reasons, have an interest in focusing on the whole of the system in the diplomatic negotiations over health financing.⁴ Furthermore, if value-based healthcare is a goal, then the distinction between *CHA* services and non-*CHA* services only hinders the kind of integration that value-based healthcare works toward.

Third, provincial governments have to accomplish two if not contradictory then at least friction-laden things at once. They have to sustain and operate the system as it is while also working to transform the system into something better and more efficient with better outcomes and better managed costs. This is difficult, messy and complicated and likely means

that we are talking about various incremental changes over time that, if well managed and thought out, can accumulate into substantive change.

Finally, any commitment to value-based healthcare must respect the relative jurisdiction of each order of government and recognize the asymmetry within the federation. That recognition makes bilateral federalism a workable process for Canada, and it will need to be accommodated in a Canadian understanding of value-based healthcare. And to return to an earlier point, a value-based healthcare framework would be the very set of instruments that would keep bilateral federalism from spinning out 10 highly divergent, highly unequal healthcare systems in the provinces.

To date, the landscape of value-based healthcare is one of relatively localized change. What is needed is the ability to both scale those achievements across provincial systems and replicate/adapt them interprovincially. Neither of these things is something Canadians are particularly good at. We remain “a country of perpetual pilot projects” (Bégin et al. 2009: 1185). Again, this is where an intergovernmental commitment to value-based healthcare and the resources and capacities of the federal government could help.

Bringing a value-based healthcare approach to intergovernmental health diplomacy will require an agreed-upon framework of what it means in a pan-Canadian sense. Canadian governments could do worse than to start with some variation of the four pillars enunciated above from the European Commission along with a fifth around data, measurement and metrics. This would be a vision of a system:

- that meets the needs of patients, providers and payers;
- that achieves the best outcomes at the individual and population levels with the available resources;
- that allocates resources equitably across the country and within provinces;
- that contributes to social solidarity, social cohesion, reconciliation and population health; and
- that is built upon robust and comparable data collection, shared measurement and interoperable information technology.⁵

Like the principles in the European Commission report, or indeed like the five principles of the *CHA*, these cannot or should not be read as separate or distinct goals. They are integrated, overlapping and mutually reinforcing. And they all involve trade-offs both internally and with other policy objectives of governments. Put together into a common statement of principles from Federal-Provincial-Territorial (FPT) governments, akin to the Common Statement of Principles on Shared Health Priorities in 2017, it might begin to frame a conversation about how intergovernmental diplomacy can move a healthcare reform agenda forward.

However, to be effective, such a framework will have to move beyond a mere intergovernmental agreement. The experiences with the Agreement on Internal Trade (*Agreement on Internal Trade Implementation Act* 1996) and the Social Union Framework Agreement (CICS 1999) show us quite clearly that such agreements can be easily abandoned or forgotten about when political priorities shift. Even in the realm of healthcare itself, governments have a long history of embracing reform ideas one day and forgetting about them the next. Outside of restoring federal funding and splitting the CHST into its component parts, the recommendations of the Romanow Commission (Romanow 2002) got little buy-in from either order of government. More recently, neither the Naylor report (Advisory Panel on Healthcare Innovation 2015) nor the Forest and Martin (2018) report has prompted much government action on their respective recommendations.

What might make a value-based healthcare agreement different, though, is the particularity of the moment we are in when it comes to healthcare. The system, battered by the COVID-19 pandemic and years of unmet reform proposals, is floundering. And citizens have noticed and so, too, have the hucksters selling magical “all you have to do is ...” solutions to complex, multifaceted problems. The calls for governments to take action are growing.

In the best instance, a *New Canada Health Act* that enshrines these principles, bolstered by provincial legislation articulating what and how those principles will be operationalized in each province, would give the necessary heft to the ideas of value-based healthcare and make them hard(er) for governments to ignore. Such a legislative web could also bridge the *CHA*/non-*CHA* service divide and further the necessity of seeing provincially funded services such as community-based care, home care, pharmaceuticals and long-term care as part of a continuum with *CHA*-governed hospital and physician care. Value-based healthcare cannot, if it is to mean much of anything, be limited only to *CHA* services. Any restructuring or expansion of provincial services outside the *CHA* needs to reflect those values.

There is, also, a political dynamic to all of this that goes beyond the specifics of the healthcare system and its financing. As was already noted, different provinces have different degrees of reliance on federal transfers, and this may create a built-in advantage for the federal government in a system focused on bilateral arrangements. The simple fact is that some provinces need the federal resources more than others and may, therefore, be more likely to acquiesce to federal priorities. But it has always been thus. That is the realpolitik of Canadian federalism and the uneven regional political economies that have been a feature of Canadian federalism since at least 1867.

The counter to this federal government advantage may lie in a more active and collaborative COF, one that is more engaged in collaborative efforts by provincial governments in areas of shared concern. There was some of this in the Harper years when provinces looked for ways to lower drug prices through better and more bulk purchasing (McIntosh 2021b), but it has never amounted to much. At present, the benefits of a united front against Ottawa are quite unevenly distributed. If it had to, Alberta could, at present, finance healthcare in

the province without federal assistance, but there would be no pay-off for New Brunswick, Nova Scotia or Manitoba to act in solidarity with Alberta and similarly forego federal health transfers.

The other overarching political dynamic is the issue of partisan politics as it plays itself out in the arena of intergovernmental diplomacy. Can governments of such different ideological and political convictions ever come to an agreement? But to return to Simeon's (2006) metaphor of intergovernmental relations as a form of diplomatic negotiation, the clear answer is yes. Internationally, the Liberal government of Prime Minister Justin Trudeau, the Republican administration of US President Donald Trump and the left-progressive coalition headed by Mexican President López Obrador negotiated and signed a new free trade agreement in 2020 (Chapell 2018). So too, domestically, Canadian intergovernmental processes have demonstrated a capacity to ignore the day-to-day partisan differences between Liberal, New Democratic Party (NDP) and Conservative (of whatever stripe or label) governments to reach agreements on shared issues.

If pan-Canadian policy making relied on a confluence of ideological outlooks across jurisdictions, then there would never have been a post-war welfare state or a constitutional agreement in 1981. In the latter case, only two Progressive Conservative (PC) provincial governments supported the Liberal federal government's constitutional package. A coalition of five PC, one Social Credit, one NDP and one separatist Parti Québécois premiers opposed the federal plan. Yet in November of 1981, thanks in part to compromises proposed by a federal Liberal minister, a PC and an NDP Attorney General, a deal acceptable to nine of the 10 provinces and the federal government was reached (Romanow et al. 1984). The deal was not perfect. It has had both foreseen and unforeseen consequences. But on the whole, there can be little doubt that Canadians would balk at a return to the status quo ante. Yes, partisan and personal differences between actors may complicate, delay or even derail such processes (as they sometimes do on the international front as well), but they do not have to be an insurmountable hurdle.

The saving grace in the current political dynamic may prove to be the very crisis the healthcare system currently faces. No jurisdiction, regardless of the political stripe of the government, appears untouched by the various dimensions of the health human resource challenges, the infrastructure challenges, the access challenges or the wait-time challenges that have come to the forefront since the height of the COVID-19 pandemic. A pan-Canadian values-based framework that can be adapted to the specific organizational and delivery mechanisms of each jurisdiction and which speaks directly to the increasingly urgent concerns expressed by citizens about the future of the healthcare system has the potential to drive governments to an agreement.

The goal should be a health reform framework that both appeals to the public desire for real and substantive action on healthcare and meets potential objections from provinces concerned about jurisdictional autonomy. While Canadians have long put "healthcare" at or near

the top of their list of most important political issues, the pandemic has not only heightened public concern but also illuminated how little reform has been accomplished over the past two decades despite the billions spent. But that has not (yet, perhaps) diminished their commitment to the basic principles of universal publicly administered and financed healthcare. Furthermore, the public has clearly concluded that both orders of government need to take action; the federal government has to contribute more, and provincial governments have to actually implement the reforms they have long promised but failed to deliver (Hahn 2022).

Thus, it may well be the governments (at either level) that take these messages to heart and seek out a new way of conducting intergovernmental diplomacy around healthcare that win the day politically. Indeed, in an interview with CTV News, Nova Scotia Premier Tim Houston recently said he would offer “no pushback” to the idea that the province “guarantee[s] outcomes and performances” in a new healthcare financing arrangement with Ottawa (Wentzell 2022).

As the 2017 agreements come up for renewal, there is an opportunity to put these principles (or some variation of them) into practice. Setting out value-based healthcare principles in an intergovernmental agreement could then guide the allocation, in the first instance, of the “second” health transfer on specific FPT priorities. These would be the subject of more detailed commitments in subsequent bilateral agreements that, as in 2017, specify where and how the monies will be spent to operationalize the principles. Within those agreements, unlike in 2017, there would need to be clear requirements for provinces to report to their residents on progress toward the specified goals. The public needs to see the value in the reform,⁶ especially given the current state of the system post the COVID-19 pandemic.

Going forward, a process would be needed to move funding for successful innovations under the “second transfer” into the general CHT, perhaps tied to federal commitments to assist in funding, scaling and adapting what works to other jurisdictions. This would free up governments to move to other priorities as the focus of the “second transfer” without abandoning successful pilots. Such a process could be outlined as a *New Canada Health Act* and in companion legislation in the provinces.

Again, this is potentially a massive undertaking and one that will take significant intergovernmental goodwill to achieve. Only the federal government has the fiscal capacity to fund the scaling of successful innovations, and only the provinces have the knowledge of how to best deliver services in their specific contexts. Scaling innovations will take working both bilaterally (scaling a local innovation within a province) and multilaterally (scaling innovations across provinces). Taking a page from collective impact theory (Cabaj and Weaver 2016), what one may need to accomplish this is a *backbone organization* that can, in service of the collective, provide the resources, data and evaluation components necessary to effectively scale and adapt innovations across jurisdictions with different policy design and implementation capacities. Such a backbone organization would have to be both embedded in FPT

governments and independent from them – embedded in order to understand the local context in which an innovation succeeded and to have access to the data needed, but independent enough to thoroughly evaluate effectiveness and compliance with the value-based framework that would guide it.

Concluding Thoughts and Caveats

What has been attempted here is, at best, a sketch of where and how we might consider taking an emerging (and I believe positive) development on the intergovernmental front and use it to help operationalize and extend positive developments down on the ground in terms of reform efforts around value-based healthcare. And admittedly, there is much more that would need to be thought through to make it a reality.

But the future of bilateralism is far from assured. Statements by provincial premiers at the recent COF meeting in British Columbia made no mention of subsequent rounds of bilateral agreements (COF 2022). And, too, the federal government has said little about its own agenda when it comes to any adjustments to the CHT (Owen 2022).

Undoubtedly it is true that bilateralism has, to date, been driven by the federal government. Given the current efforts being put into maintaining provincial solidarity over the current demand for a \$28 billion unconditional increase in the CHT, it may be fair to say that some provinces felt, perhaps, bullied into the 2017 arrangement, especially after it was unilaterally extended in 2014. The federal government's current task is to make the case that bilateralism is not federal interference in provincial jurisdiction but is, in fact, a means to the kind of partnership that the premiers have called for.

And this puts the onus on the federal government to be the kind of reliable, knowledgeable and engaged partner that it has not often been in the past, perhaps first by working with provinces to create the kind of backbone organization needed to successfully move a value-based framework forward. What we know about operationalizing value-based healthcare in Canada comes from the provinces' own initiatives and experiments. The federal response should be to understand that its best role in replicating and scaling achievements is to follow the provincial lead. The provincial response should be to understand that if they are driving the reform process, then there is an obligation to both the other funder and their own residents to be more transparent and accountable about the direction the system is going and the destination. An intergovernmental framework for value-based healthcare that is focused on agreed reform priorities could be a starting point for this.

Sutherland (2020b) characterized the search for value-based healthcare as perhaps a choice between seeking a "Holy Grail" (p. 3) and "incremental progress" (p. 4). But perhaps it is both. Grail quests are long, arduous and filled with detours, but even if the Grail is never completely in our grasp, we can get progressively closer to it over time. The emergence of bilateral federalism could be one means by which we bring value-based healthcare into a national conversation about the future of Canadian healthcare.

Epilogue: The 2023 Healthcare “Deal”

On February 7, 2023, the federal government presented to the premiers its proposal for a new national health accord (Health Canada 2023a). It included an immediate \$2 billion top-up to the CHT and a guaranteed 5% annual growth in the CHT for the next five years to be paid as annual top-ups. Access to those top-up funds would be conditional on provinces committing to increased and more transparent data collection.

An additional \$25 billion would be allocated to four priority areas (Health Canada 2023a):

- expanding access to family health services (including in rural and remote areas);
- supporting health workers and reducing backlogs;
- improving access to quality mental health and substance use services; and
- modernizing the healthcare system with standardized health data and digital tools.

This money would be accessed via tailored bilateral agreements that include “action plans,” “the addition of targeted results with indicators” on which “provinces and territories would publicly report on results to their own residents” (Health Canada 2023a). The initial provincial reaction was to refer to the federal offer as a “starting point” and a “down payment” (Aiello 2023). But by March 20, 2023, all jurisdictions but Quebec and the territories had signed agreements with Ottawa.

It seems clear that the federal government very much wants to continue to move down the bilateralism road with an essentially bifurcated health transfer – the CHT proper is to remain more or less unconditional, while a second pot of money offered for more specific health reform priorities (including both *CHA* and non-*CHA* services) will be dependent on greater levels of transparency and accountability written into bilateral agreements. Whether those transparency and accountability mechanisms are sufficient to meet public demands that health transfers are indeed spent on healthcare remains to be seen.

Furthermore, the federal offer amounts to about \$50 billion in “new” spending over a decade, which is far short of the provincial demand for an immediate annual increase of \$28 billion per year. The difference between what provinces wanted and what the federal government offered likely means that the “who-is-paying-how-much-and-for-what” debate will continue. This does not bode well for the prospects of real reform or for furthering any discussion of value in health as it might pertain to the Canadian system.

Interestingly, on March 10, 2023, the federal government announced that it was making the first deductions to provincial transfers under the Diagnostic Services Policy (DSP), which articulated a commitment to curb the private payment for magnetic resonance imaging and computed tomography scans by individuals by deducting their cost from provincial transfers (Government of Canada 2019b; Health Canada 2023b). A total of \$82.5 million is to be clawed back, mostly from British Columbia (\$23.1 million), Alberta (\$13.8 million) and Quebec (\$41.9 million). The government of Saskatchewan publicly stated that it will

not change its private MRI policy (Mantyka 2023), becoming perhaps the first province to explicitly commit to the ongoing violation of the terms of the *CHA*. For nearly 50 years, provincial governments of all stripes swore fealty to the five *CHA* principles, and to have the province known as the “birthplace of medicare” be the first to unapologetically shrug off federal enforcement may constitute a new front in the intergovernmental struggle over Canada’s ailing system and the values that underpin it.

Acknowledgement

The author would like to thank the two anonymous reviewers who provided important feedback that helped shape the final version of this article.

Notes

1. I use the term “intergovernmental diplomacy” as a contemporary variation on “federal-provincial diplomacy” used by Simeon (2006) to refer to the processes of “executive federalism” that, akin to international diplomatic negotiations, work to achieve pan-Canadian policy consensuses on specific issues. The “cost-sharing” arrangements that created Canadian medicare in the 1960s, the tax-point transfer that underpinned the EPF changes in 1977 and the Health Accords of 2002, 2003 and 2004 are all products of these kinds of negotiations. I chose intergovernmental rather than federal–provincial as the descriptor only to acknowledge the presence of the territorial governments at the table.
2. A summary of each of the 13 bilateral agreements, showing the nature and degree of specificity of each province’s commitments, can be found in the Appendix to McIntosh and DeCorby (2022).
3. This, in fact, could be an important role for the federal government – encouraging provinces with financial and other incentives to adopt best practices and to facilitate the transfer of “what works” across provincial boundaries.
4. The provinces prefer to talk about “healthcare spending” as a whole because it strengthens their case for increases in the transfer from the federal government. The federal government has expressed a desire to see (and invest in) expanded public pharmacare and dental care programs that are clearly beyond the confines of the *CHA*. The blurring of the lines between *CHA* and non-*CHA* services serves both sets of political interests.
5. It is worth noting that in many of the reviews of what was accomplished with the 2004 Health Accord, the one area that was consistently seen as a high point was the steady improvement of the system’s ability to produce high-quality, comparable data across jurisdictions (McIntosh and DeCorby 2022).
6. One might also consider principles like “transparency,” “accountability” and “public reporting” as additional principles to the five listed above, which would form part of the overall framework for value-based healthcare in a highly decentralized federation like Canada.

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References

- Advisory Panel on Healthcare Innovation. 2015. *Unleashing Innovation: Excellent Healthcare for Canada: Report*. Health Canada. Retrieved May 7, 2023. <<https://www.canada.ca/content/dam/canada/health-canada/migration/healthy-canadians/publications/health-system-systeme-sante/report-healthcare-innovation-rapport-soins/alt/report-healthcare-innovation-rapport-soins-eng.pdf>>.
- Agreement on Internal Trade Implementation Act* (S.C. 1996, c.17) [Repealed 2917, c.17, s. 288]. Government of Canada. Retrieved May 8, 2023. <<https://laws-lois.justice.gc.ca/eng/acts/A-2.4/>>.
- Aiello, R. 2023, February 8. PM Trudeau Presents Premiers with \$196B Health-Care Funding Deal, with \$46B in New Funding over the Next Decade. *CTV News*. Retrieved May 7, 2023. <<https://www.ctvnews.ca/politics/pm-trudeau-presents-premiers-196b-health-care-funding-deal-including-46b-in-new-funding-1.6263042>>.
- Andreatta, D. 2013, September 19. "Health Care's 'Fix for a Generation' a Disappointment, Report Says." *The Globe and Mail*. Retrieved May 7, 2023. <<https://www.theglobeandmail.com/life/health-and-fitness/health/health-cares-fix-for-a-generation-is-a-disappointment-report-says/article14406063/>>.
- Banting, K.G. 1987. *The Welfare State and Canadian Federalism* (2nd ed.). McGill-Queen's University Press.
- Bégin, M., L. Eggertson and N. Macdonald. 2009. A Country of Perpetual Pilot Projects. *CMAJ* 180 (12): 1185. doi:10.1503/cmaj.090808.
- Beland, D. and T. Tombe. 2021. Three Policy Pathways for Federal Health Care Funding in Canada. School of Public Policy Publications. *SPP Research Paper* 14(1): 36. doi:10.11575/spp.v14i1.74016
- Cabaj, M. and L. Weaver. 2016. *Collective Impact 3.0: An Evolving Framework for Community Change*. Community Change Series 2016. Tamarack Institute. Retrieved May 7, 2023. <https://cdn2.hubspot.net/hubfs/316071/Events/CCI/2016_CCI_Toronto/CCI_Publications/Collective_Impact_3.0_FINAL_PDF.pdf>.
- Canada Health Act*, R.S.C., 1985, c. C-6. Government of Canada. Retrieved May 3, 2023. <<https://laws-lois.justice.gc.ca/eng/acts/c-6/page-1.html>>.
- Canadian Intergovernmental Conference Secretariat (CICS). 1999, February 4. *AGREEMENT – A Framework to Improve the Social Union for Canadians*. Retrieved May 7, 2023. <<https://scics.ca/en/product-produit/agreement-a-framework-to-improve-the-social-union-for-canadians/>>.
- Chappell, B. 2018, November 30. USMCA: Trump Signs New Trade Agreement with Mexico and Canada to Replace NAFTA. *NPR*. Retrieved May 7, 2023. <<https://www.npr.org/2018/11/30/672150010/usmca-trump-signs-new-trade-agreement-with-mexico-and-canada>>.
- Council of the Federation (COF). 2022, July 12. *Canada's Premiers Looking to Partner with Federal Government on Health Care Sustainability*. Retrieved May 7, 2023. <https://www.canadaspremiers.ca/wp-content/uploads/2022/07/COF_2022_Health_Communique_July11.pdf>.
- Downey, S., S. McKay and P. Feng. 2020. Towards Value in an Integrated Care Environment: Early Lessons from an Ontario Health Team. *HealthcarePapers* 19(1): 11–18. doi:10.12927/hcpap.2020.26159.
- Duckett, S. 2019. Value-Based Healthcare: Fad or Fabulous? *HealthcarePapers* 18(3): 15–21. doi:10.12927/hcpap.2019.25930.
- Expert Panel on Effective Ways of Investing in Health (EXPH). 2019. *Defining Value in "Value-Based Healthcare"*. European Union. Retrieved May 8, 2023. <https://health.ec.europa.eu/system/files/2019-11/024_defining-value-vbhc_en_0.pdf>.
- Federal-Provincial Fiscal Arrangements and Established Programs Financing Regulations, 1977* (SOR/78-587). Government of Canada. Retrieved May 25, 2023. <<https://laws-lois.justice.gc.ca/eng/regulations/SOR-78-587/index.html>>.

- Forest, P-G. 2020. The Value of Health Policy. *HealthcarePapers* 19(2): 36–42. doi:10.12927/hcpap.2020.26260.
- Forest, P-G. and D. Martin. 2018. *Fit for Purpose: Findings and Recommendations of the External Review of the Pan-Canadian Health Organizations*. External Review of the Pan-Canadian Health Organizations. Retrieved May 7, 2023. <<https://www.canada.ca/content/dam/hc-sc/documents/services/health-care-system/reports-publications/health-care-system/findings-recommendations-external-review-pan-canadian-health-organization/findings-recommendations-external-review-pan-canadian-health-organization.pdf>>.
- Gilmore, K.J., F. Pennucci, S. De Rosi and C. Passino. 2019. Value in Healthcare and the Role of the Patient Voice. *HealthcarePapers* 18(4): 28–35. doi:10.12927/hcpap.2019.26031.
- Government of Canada. 2019a. Canada's Health Care System. Retrieved May 2, 2023. <<https://www.canada.ca/en/health-canada/services/health-care-system/reports-publications/health-care-system/canada.html>>.
- Government of Canada. 2019b, January 31. Backgrounder: New Canada Health Act Initiatives (August 2018). Retrieved March 16, 2023. <<https://www.canada.ca/en/health-canada/services/health-care-system/canada-health-care-system-medicare/canada-health-act/new-initiatives.html>>.
- Government of Canada. 2022, December. Federal Transfers to Provinces and Territories. Retrieved May 7, 2023. <<https://www.canada.ca/en/department-finance/programs/federal-transfers.html>>.
- Hahn, P. 2022, December 1. Health Care Surpasses Inflation as Top National Issue of Concern: Nanos. *CTV News*. Retrieved May 7, 2023. <<https://www.ctvnews.ca/health/health-care-surpasses-inflation-as-top-national-issue-of-concern-nanos-1.6176739>>.
- Health Canada. 2004, September 16. A 10-Year Plan to Strengthen Health Care [Archived]. Retrieved May 7, 2023. <<https://www.canada.ca/en/health-canada/services/health-care-system/health-care-system-delivery/federal-provincial-territorial-collaboration/first-ministers-meeting-year-plan-2004/10-year-plan-strengthen-health-care.html>>.
- Health Canada. 2023a, February 7. Working Together to Improve Health Care for Canadians: Backgrounder. Retrieved May 7, 2023. <<https://www.canada.ca/en/health-canada/news/2023/02/working-together-to-improve-health-care-for-canadians.html>>.
- Health Canada. 2023b, March 10. Canada Health Transfer Deductions and Reimbursements – March 2023: Backgrounder. Retrieved May 7, 2023. <<https://www.canada.ca/en/health-canada/news/2023/03/canada-health-transfer-deductions-and-reimbursements---march-2023.html>>.
- Horne, F. and R. Manion. 2019. A Made-in-Canada Approach to Value-Based Healthcare. *HealthcarePapers* 18(4): 10–19. doi:10.12927/hcpap.2019.26033.
- Hueglin, T.O. 2021. *Federalism in Canada: Contested Concepts and Uneasy Balances*. University of Toronto Press.
- Kuluski, K. and S.J.T. Guilcher. 2019. Toward a Person-Centred Learning Health Care System: Understanding Value from the Perspectives of Patients and Caregivers. *HealthcarePapers* 18(4): 36–46. doi:10.12927/hcpap.2019.26030.
- Lewanczuk, R., A. Chuck, K. Todd and V. Yiu. 2020. Value in Healthcare: Designing an Integrated Value-Based Healthcare System. *HealthcarePapers* 19(1): 59–64. doi:10.12927/hcpap.2020.26154.
- Mantyka, W. 2023, March 13. Province to Continue to Allow Residents to Purchase MRI Services at Private Clinics. *CTV News*. Retrieved May 7, 2023. <<https://regina.ctvnews.ca/province-to-continue-to-allow-residents-to-purchase-mri-service-at-private-clinics-1.6311890>>.
- Marchildon, G. 2016, December 6. *Bilateral Health Agreements between the Federal and Provincial/Territorial Governments in Canada*. IRPP Insight No. 13. Retrieved May 7, 2023. <<https://irpp.org/wp-content/uploads/2016/12/insight-no13.pdf>>.
- McIntosh, T. 2021a, March 28. The Disingenuous Demands of Canada's Premiers for \$28 Billion in Health-Care Funding. *The Conversation*. Retrieved May 7, 2023. <<https://theconversation.com/the-disingenuous-demands-of-canadas-premiers-for-28-billion-in-health-care-funding-157024>>.

- McIntosh, T. 2021b. The Continuities and Discontinuities of Disentanglement: Federal-Provincial Health Care Dynamics in the Harper Era. In J. Farney and J.M. Simmons, eds., *Open Federalism Revisited: Regional and Federal Dynamics in the Harper Era* (pp. 294–314). University of Toronto Press.
- McIntosh, T. and A. DeCorby. 2022. From National Accords to Bilateral Agreements: Transforming Canadian Health Care Intergovernmentalism. The School of Public Policy Publications. *SPP Research Paper* 15(1): 4. doi:10.11575/sppp.v15i1.74113.
- Ogilvie, K.K. and A. Eggleton. 2012, March. *Time for Transformative Change: A Review of the 2004 Health Accord*. Standing Senate Committee on Social Affairs, Science and Technology. Retrieved May 7, 2023. <<https://sencanada.ca/content/sen/Committee/411/soci/rep/rep07mar12-e.pdf>>.
- Owen, B. 2022, July 13. Trudeau says Ottawa Wants to Make Sure Health Spending Delivers “Tangible Results.” *Global News*. Retrieved May 8, 2023. <<https://globalnews.ca/news/8988905/trudeau-health-care-spending-canada/>>.
- Picard, A. 2022, June 21. Can We Stave Off the Collapse of the Canadian Health Care System? *The Globe and Mail*. Retrieved May 7, 2023. <<https://www.theglobeandmail.com/opinion/article-can-we-stave-off-the-collapse-of-the-canadian-health-system/>>.
- Raveendran, L., M. Koyle and M. Brindle. 2019. Developing a Value-Based Approach to Outcome Reporting in Pediatric Surgery. *HealthcarePapers* 18(4): 20–27. doi:10.12927/hcpap.2019.26032.
- Romanow, R.J. 2002. *Building on Values. The Future of Health Care in Canada*. Commission on the Future of Health Care in Canada. Retrieved May 3, 2023. <<https://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf>>.
- Romanow, R.J., J.D. Whyte and H.A. Leeson. 1984. *Canada ...Notwithstanding: The Making of the Constitution, 1976–1982*. Carswell/Methuen.
- Simeon, R. 2006. *Federal-Provincial Diplomacy: The Making of Recent Policy in Canada*. University of Toronto Press.
- Smith, P.C., A. Sagan, L. Siciliani, D. Panteli, M. McKee, A. Soucat et al. 2020. *Health Systems and Policy Analysis: Building on Value-based Health Care: Towards a Health System Perspective*. Policy Brief 37. World Health Organization. Retrieved May 7, 2023. <<https://apps.who.int/iris/bitstream/handle/10665/336134/policy-brief-37-1997-8073-eng.pdf?sequence=1&isAllowed=y>>.
- Strumpf, E. 2020. “You Can’t Get There from Here”: Is There a Need for Value-Based Healthcare in Canada? *HealthcarePapers* 19(2): 16–23. doi:10.12927/hcpap.2020.26262.
- Sutherland, J.M. 2019. Value from Healthcare and Why It Is Needed in Canada. *HealthcarePapers* 18(3): 4–7. doi:10.12927/hcpap.2019.25932.
- Sutherland, J. 2020a. Value from Healthcare: No Silver Bullet. *HealthcarePapers* 19(1): 6–9. doi:10.12927/hcpap.2020.26160.
- Sutherland, J. 2020b. The Search for Improving Value in Canadian Healthcare: Holy Grail or Steady Progress? *HealthcarePapers* 19(2): 3–8. doi:10.12927/hcpap.2020.26264.
- Taylor, M.G. 1978. *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System*. McGill-Queen’s University Press.
- Wentzell, S. 2022, December 29. Nova Scotia Premier Open to Guaranteeing Outcomes to Get Health-Care Funding from Feds. *CTV News*. Retrieved May 7, 2023. <<https://atlantic.ctvnews.ca/nova-scotia-premier-open-to-guaranteeing-outcomes-to-get-health-care-funding-from-feds-1.6210908>>.
- Wodchis, W.P. 2019. Principles to Improve Value in Healthcare. *HealthcarePapers* 18(3): 9–14. doi:10.12927/hcpap.2019.25931.
- Wodchis, W. and R. Reid. 2020. Improving Value Means Increasing Population Health and Equity. *HealthcarePapers* 19(2): 10–15. doi:10.12927/hcpap.2020.26263.
- Wong, S.T., S. Johnston, F. Burge and K. McGrail. 2019. Value in Primary Healthcare – Measuring What Matters? *HealthcarePapers* 18(4): 58–67. doi:10.12927/hcpap.2019.26028.
- Zwicker, J. 2020. Value for Who? Value-Based Healthcare for Children and Families. *HealthcarePapers* 19(1): 48–58. doi:10.12927/hcpap.2020.26155.