

Article

Health Care in Federal Systems

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Abstract

How do multilevel health care systems evolve? Do they develop in a similar manner, or are their respective paths of evolution more sui generis? The aim of this article is to compare the way in which Canada and the European Union have attempted to coordinate health policy between their component multilevel jurisdictions over time. This article argues that the EU—despite its limited authority over health care—has been better able than Canada to develop a greater capacity for addressing health policy at a supranational level, notwithstanding Canada’s greater federal involvement in financing health care. While the experience of the EU supports the theoretical premises of neofunctionalism (that a certain level of integration will induce even greater integration in other areas, especially in response to crisis), the experience of Canadian health care federalism does not fit that theoretical paradigm. This suggests a limited applicability for neofunctionalist theory across multilevel systems more widely.

Keywords

Canada; Covid-19; European Union; federalism; health care; health policy; neofunctionalism

Issue

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1. Introduction

Comparative health policy analysis, as a disciplinary field, began to blossom in the 1990s, driven by fiscal strain, rising demand, and increasing technological capacity (Altenstetter & Bjorkman, 1997; Freeman & Marmor, 2003; Ham, 1997; Klein, 1997; Marmor et al., 2005). But comparative health policy analysis at this point focussed only on national comparisons, using national-level data across states. This worked well for health care systems that were highly centralized. But in decentralized states where much of the financing and delivery of health services occurred at the subnational level, these national-level abstractions did not represent the wide diversity in health care policy across regional units. The first serious comparative study of provincial health systems in Canada was published only in 2013 (Lazar et al., 2013). Even so, this is not sufficient: In multi-level systems, a federal/supranational role in health care has become increasingly prevalent (Costa-Font & Greer, 2013; Fierlbeck & Palley, 2015). Thus, comparative health

policy analysis must also attempt to understand the nuances and complexities of the relationship between the relevant actors in multilevel health care systems.

The key question for this article is whether the dynamics facilitating greater supranational governance in health policy within the EU are also apparent in Canadian health care federalism. The dynamics underlying the migration of rule-making authority from member states to the European Union have been studied in some depth, and the primary theoretical paradigm explaining post-Maastricht dynamics has been neofunctionalism (e.g., Sandholtz & Stone Sweet, 2012). Inherent in neofunctionalist theory is the concept of “spillover,” where an initial level of integration requires additional integration in related areas in order to achieve the original objectives (Niemann & Ioannou, 2015). This concept has been especially useful in explaining the development of European health policy (Greer, 2006). But to what extent can this concept explain the trajectory of health policy of multilateral health care systems beyond the EU? Using Canada as a test case, this article argues that

neofunctionalism has limited explanatory force within that jurisdiction.

Section 2 discusses the kinds of instruments generally available to federal bodies in shaping health policy across federal systems (constitutional, regulatory, and financial). These instruments are set out in Table 1. Sections 3 and 4 describe how these mechanisms are employed within the European and Canadian policy contexts, respectively. Section 5 concludes by questioning the overarching utility of neofunctionalist theory in understanding the dynamics of health policy within federal systems as a rule.

2. The Challenge of Understanding Multilevel Health Care Systems

This article employs a comparative case study approach evaluating the degree to which influence over the nature and direction of health care has migrated upward to a supranational or federal level. “Health care” in this article refers to the funding, provision, and regulation of health care services. Each political unit in the two federal systems under review has a different set of rules governing public access to health care. These access rules, set out in legislation, determine who is covered, which health services are covered, and what proportion of costs of covered. Services not covered publicly may be provided in the private sector, but these may also be subject to regulatory conditions.

While the response to Covid-19 by these federal systems is an important part of the discussion, the overarching analytical time frame begins with the key point at which a federal *modus operandi* was established setting out health policy roles and responsibilities for each jurisdiction, up to and including the pandemic response. In the EU, the Maastricht Treaty (1992, Article 129) set out a formal treaty base for the EU in public health although, as Section 3 describes, the development of a substantive federal health capacity was much more gradual and indirect. In Canada, the 1984 Canada Health Act established a formal understanding of the role of federal, provincial, and territorial (FPT) governments, although this document was itself based on earlier FPT legislation and continues to be subject to interpretation through federal “interpretation letters.”

As noted above, the theoretical framework here is influenced by the role that neofunctionalism has played in explaining EU integration in general, and the direction of EU health policy more specifically. The key claim embedded in this approach is that a level of existing integration will lead to conditions and incentives facilitating spillover in related policy areas (Greer, 2006; Nicoli, 2020; Niemann, 2021; Niemann & Ioannou, 2015; Schmitter, 2004). The methodology used here is a comparative review of articles discussing the nature and extent of health care authority over time in each jurisdiction. The first case study, of the EU, will outline the ways in which neofunctionalism has been employed to explain

the dynamics of EU health policy, with specific reference to the reaction to the Covid-19 pandemic. The second case study, of Canada, will argue that there has been no discernible spillover effect following the initial period of FPT shared-cost funding nor during the Covid-19 pandemic. The final section will suggest reasons why greater integration in Canada has not occurred.

In looking at the EU and Canada side by side, the usual methodological caution must apply here: It can be very tricky to compare a national federal state and a supranational federal system (Fierlbeck & Palley, 2015). An analytical armature can nonetheless be constructed focusing on the constitutional division of powers, regulatory authority, and financial capacity (Table 1).

In terms of the *formal division of power*, authority over health care was initially clearly situated in the member states in the EU and PTs in Canada. Under the provision of the current TFEU (2012), Article 168 sets out limited authority for the EU in public health (with clearly stated limits). Canada’s Constitution of 1867 (revised in 1982) also delineates the respective powers of federal and PT governments but, as Section 4 notes, the division of powers over health care is not as watertight as may appear to a casual reader. That Canada is perhaps the most decentralized nation within the OECD in the area of health care (Requejo, 2010) makes it a useful comparator to the EU’s federation of member states. The formal division of power in each case sets out the regulatory and financial capacity of each jurisdiction, and it is here that the differences between the two entities become distinct. As explained in Section 3, the regulatory capacity of the EU may be quite restricted in the area of health services and delivery, but its oversight of other regulatory functions gives it considerable capacity to shape health at a supranational level more indirectly. As Table 1 clearly outlines, the EU has considerable authority to regulate in areas that indirectly have an effect on health. These areas include the regulation of standards of goods (such as blood products, pharmaceuticals, or food safety) and services (including working conditions). Its mandate to ensure the effective functioning of free markets, as Section 3 notes, was a key causal factor in the establishment of the 2011 Cross-Border Directive on patient mobility as well as the free movement of health care professionals. Finally, the EU’s authority over fiscal governance mechanisms has given it considerable influence over member states’ spending on health care within their own borders. In Canada, the federal government holds authority over pharmaceuticals (patents), food safety standards, and some very limited authority based on its jurisdiction of criminal law (safe injection sites) and public health (under very circumscribed conditions). Because Canada has no formal mandate to secure an open economic union, the free movement of health care professionals across borders is much more constrained.

However, the narrative is quite different when addressing financial capacity. Canada’s federal government has considerable ability to levy taxes, especially

Table 1. Dimensions of federal authority over health care.

	Legal authority	Regulatory power	Financial capacity
Canada	The Constitution Act (1867)	<p>Provincial authority:</p> <ul style="list-style-type: none"> • Article 92(7) gives authority over “hospitals, asylums, and eleemosynary institutions” to the provinces and territories (PTs); • Article 92(16) gives “all matters of a merely local or private nature” to the PTs, and was interpreted to include health services which, at the time, were both “local and private”; • Article 92(13), on “matters of property and civil rights,” gives jurisdiction over the regulation of insurance (interpreted to include public health insurance). <p>Federal authority:</p> <ul style="list-style-type: none"> • Article 91(23), which confers authority over patents to the federal government, is the basis for the federal regulation of pharmaceuticals. 	<ul style="list-style-type: none"> • Articles 91(3), “the raising of money by any mode or system of taxation,” and 91.1(A) give the federal government the authority to tax subjects and is often referred to as Ottawa’s “expenditure power.” Federal taxation streams include personal and corporate taxes, employment insurance contributions, taxes on goods and services, and excise taxes. • Article 92(2) authorizes provinces to levy “direct taxation within the province in order to the raising of a revenue for provincial purposes.” These sources of taxation include personal and corporate income tax, province-specific goods and services taxes, property taxes, excise taxes, and resource revenues.
EU	Treaty on the Functioning of Europe (TFEU; 2012)	<p>EU authority:</p> <ul style="list-style-type: none"> • Market regulation: Articles 21 and 26 protect freedom of movement (ie, for health care workers and patients) and Article 106 addresses competition in the provision of health services (although public health care has a carve-out under Article 14); • Fiscal governance: Article 121 permits the EU “to ensure that fiscal policy is conducted in a sustainable manner” and Article 126 allows the EU to “examine compliance with budget discipline”; • Social policy: Articles 151, 153, and 156 highlight “improved living and working conditions”; • Public health: Article 168 gives the EU a treaty base in “improving public health,” but recognizes member state authority over health care funding (although Article 9 is also a general statement that EU activity must take into account a “high level” of human health); • Consumer protection: Articles 169 addresses “the health, safety, and economic interests of consumers”; • Environment: Article 191 includes a focus on “protecting human health” (eg, air quality); • Civil protection: Article 196 is the treaty basis for RescEU. 	<p>According to Articles 311 and 322(2), the EU cannot raise or set direct taxes on EU residents. It depends largely on national contributions, supplemented by import duties and fines. Its expenditure cannot exceed its revenue. The EU’s budget is less than 1% of the EU’s gross national product.</p>

compared to PTs, which have the formal responsibility for high-cost programs such as health, social services, and education, with a much more limited capacity to raise taxes. Thus Ottawa's influence has rested largely in its ability and willingness to transfer health funds to the provinces (under the aegis of its "expenditure power"). In contrast, the EU has no major capacity to levy taxes directly; its limited funding capacity rests upon the negotiated contributions of nation-states. How are these elements constituted so differently in the EU and Canada such that the policy dynamics in the former have facilitated the migration of authority over health policy to the EU level, while this same level of shift of authority to the federal level has not been occurring in Canada despite the considerable (and increasing) financial involvement of the Canadian federal state?

3. The European Union

Within the EU, health care is the responsibility of individual member states; there is no "European health care system" as most national health care systems were established well before the consolidation of the EU as a formal political entity. Nonetheless, while there is no European health *system* there is, as Greer et al. (2022) note, an increasingly discernible European health *policy*. Throughout the gradual creation of the European Union as a coherent political body from the postwar Coal and Steel Community to the 1992 Maastricht and 2009 Lisbon Treaties, jurisdiction over health care has remained firmly and explicitly under the purview of member states. The point of greater European integration was to secure an economic union facilitating the freer movement of goods and services. Nonetheless, gradually and incidentally, the coordination and integration of health governance in the EU have progressed such that, by 2021, the first formal articulation of a potential "European Health Union" appeared.

The formal legitimacy of European policy-making rests in various "competencies" ratified by all members and set out in the TFEU. The key health competence, public health, is explicit but limited: Article 168 of the TFEU (2012) clearly requires "a high level of human health protection" on the part of member states but, at the same time, also stipulates that "the organization and delivery of health services and medical care" are under their authority. Nonetheless, this article also encourages member states voluntarily to coordinate activity within the field of health and places a formal requirement upon the EU to facilitate this coordination between states whenever possible.

But while the formal application of the public health treaty base was limited (Greer & Jarman, 2021), the gradual formation and coordination of public measures developed as a contingent consequence of the burgeoning internal market. The increasing trade in livestock, for example, generated widespread agreement (especially in the shadow of mad cow disease) that all mem-

ber states should reasonably expect a high level of food safety across the EU. The "level playing field" assumptions of internal market competition also meant that no member state should be able to game the internal market by permitting a lower standard of worker safety. Furthermore, the internal market was not simply about the free movement of goods, but also of services; and where medical professionals provided health care services on the open market, they logically could expect the same level of unfettered movement as other workers. This, of course, required some standardization across the EU in the training and licensing of health care professionals. And as these professionals began to be able to cross national borders with ease, so did patients demand the same right to avail themselves of medical services across state boundaries.

While the directives facilitating these flows took the form of political agreements (such as the 2011 Cross-Border Directive on Patients' Rights), the battleground for the expansion of these kinds of integration across the EU took place more so in the courts in the first instance (especially in the area of competition law). While fully public health care systems are protected from the legal requirements facing private health care delivery, most national health care systems in the EU have some level of private care, and thus the question of where competition law applies can become quite complicated. The extent to which a health care service is an "economic" (i.e., market-based) activity—and thus subject to competition law—rather than a "solidaristic" one (i.e., public) activity is often a matter for judicial interpretation. A clear integrative function, in this way, has been gradually established in health care through EU case law. To understand EU health policy, then, one has to understand not only the formal (and limited) treaty bases for "European" health policy but also the wider *acquis* of case law and soft law that provide the contours determining where the EU can influence health care.

The economic crisis that descended globally in 2008 led to the development of fiscal measures that permit the EU to exert more pressure on member states to address or modify aspects of their health care systems. The European Semester, for example, is an iterative exercise designed to monitor and assist member states to avoid the outcomes experienced by countries such as Greece following 2008. Member states are now expected to report a granular level of economic activity to the EU Commission, whereupon the Commission can helpfully assist each state to preserve or re-establish its economic health. Because health care tends to incur a heavy outlay of expenditure and has such a direct impact on the well-being of a population, the EU can exert a certain degree of influence on member states' health care systems through its responsibility to assist in the general fiscal well-being of each jurisdiction (for a fuller discussion, see Greer et al., 2022).

By 2020 the contours of a distinctly "European" health care policy had taken shape. This was partly due

to member states taking advantage of the requirement that the EU facilitate collaborative endeavours between member states whenever possible (see, e.g., Schmidt et al., 2022). But it was also due to the development of a substantial *acquis* that was more the contingent outcome of the regulation of market competition than the application of the formal health provisions of the TFEU. Even so, the contours began to shift once more as Europe grappled with the Covid-19 pandemic.

The first three months of the Covid-19 pandemic were a disheartening period for those who had hoped that European states would use structural advantages provided by existing EU frameworks to present a coordinated response to the public health threat. But, as Quaglia and Verdun (2023) observe, the pandemic—like the financial crisis a decade earlier and the political crisis occasioned by Brexit—led the EU to address the threat of greater disintegration by reconfiguring the EU into a more integrated unit. And health policy, which had for decades remained a relatively peripheral policy area, became the focal point for a reinvigorated imagining of a more integrated Europe.

At the heart of EU health policy formulation is the tension articulated by Article 168 of the TFEU (2012) which, on one hand, explicitly forbids the EU from harmonizing or otherwise directly engaging with member states' delivery of health care services and, on the other, legitimizes and supports the role of the EU in coordinating and facilitating complementary activity (including "incentive measures") to address "major cross-border health scourges." The EU, in other words, cannot impose harmonization of public health measures upon member states, but it can certainly coax them into it with the right incentives.

How did the EU pivot from a brief but tense period of devil-take-the-hindmost to the development of integrative policies that, according to some, could serve as the basis for a coherent European Health Union? As Brooks et al. (2022) explain, the pandemic presented challenges that the EU was able to address, not through the creation of (potentially contentious) bodies with new powers, but rather through the expansion of capacities in existing bodies and legislation. This development, they note, had several identifiable aspects. One of these was the extension of the authority of the European Medicines Agency (EMA) and the European Centre for Disease Control. The EMA oversees the regulation of pharmaceuticals and medical devices, while the European Centre for Disease Control's function is to identify, assess, and communicate potential risks presented by circulating pathogens. Because the Covid-19 pandemic utilized a full array of vaccines, anti-virals, and testing mechanisms on a massive scale, the salience of the EMA became very pronounced. Given the deep interdependence of European supply chains prior to Covid-19, the ability of member states to access new drugs and technologies depended to a considerable degree on the capacity of the EMA. The EU's clinical trial network, for example, was highly fragmented, which meant that it was challenging to establish

Covid-19-related clinical trials as well as compile and analyze their data quickly and effectively. While the EU's DisCoVeRY trial struggled to recruit 3,100 patients across seven countries, for example, the UK's RECOVERY trial was able to recruit 48,287 participants in the UK alone (Tani, 2022). The EMA's existing mandate was thus expanded to address emergency situations, including the development of an Emergency Task Force to provide scientific advice and a Medicines Shortages Steering Group to monitor the availability of essential products.

Like that of the EMA, the European Centre for Disease Control's purview was extended to deal with pandemic management, including the creation of the Early Warning and Response System and the EU Health Task Force. A third body, the European Health Emergency Preparedness and Response Authority was created at the Directorate General level to "prevent, detect, and rapidly respond to health emergencies...through intelligence gathering and building the necessary response capacities" (European Commission, 2021). Introduced in 2020 under the aegis of the German presidency of the EU, the European Health Emergency Preparedness and Response Authority was viewed as a key pillar of the newly conceptualized European Health Union.

In addition to the repurposing of existing bodies and the introduction of new ones, existing legislation was tweaked to address the pressing needs precipitated by the pandemic. One major piece of legislation, the Health Threats Decision, "extends the EU's role in national policy, strengthens its role in the event of an emergency, and lays the foundation for integration beyond the field of a crisis response" (Brooks et al., 2022, p. 13). Somewhat similar to the EU's role in financial management, the Health Threats Decision gives the EU the capacity to monitor member states' plans for emergency response and preparedness and—significantly—hands the EU the authority to declare a state of public health emergency on behalf of the entire EU. Notable changes to legislation also occurred outside of the specific purview of public health. As Brooks (2022) explains, a major provision in the TFEU (2012) focusing on the protection of the free movement of goods and services (Article 36) also legitimizes *barriers* to this free movement where it can be shown to be necessary to protect the health of the European population as a whole. This remarkable shift, seeming to contradict the very *raison d'être* of the EU as a free market, was a direct response to the attempts by some member states in the early stages of the pandemic to ban the export of Covid-19 medical supplies. Further, Nabbe and Brand (2021) document the considerable public concern with the fact that the EU lacks primary competence in health. This level of public support has facilitated the moves by EU actors to provide more authority over health care at the EU level. Backman and Rhinard (2018, p. 270), for example, note the "strong indications of Commission entrepreneurship, using crises as windows of opportunity to advance previously stalled initiatives, assembling networks of national

officials interested in crisis-related tasks, and promoting analysis of European vulnerability in the face of increasingly complex threats.”

Perhaps most significantly, Covid-19 response measures included EU-level funding programs that directed a substantially higher amount of funding into public health functions. Since 2003, the EU’s flagship Health Programme in public health had limped along with minimal funding, and it was slated to be absorbed into the European Social Fund in 2021. As the profound effects of Covid-19 on member states became recognized, officials made the decision to repurpose the Health Programme into EU4Health—presented as another key aspect of the new European Health Union—and provide it with a budget 10 times higher than its predecessor. While part of this fund is dedicated to crisis response, it also incorporates more integrative functions such as a common data infrastructure. Bazzan (2020) lists a number of instruments across domains and levels of government that have been established by the EU4Health policy.

It is important not to focus too sharply on Covid-19: As Bengtsson and Rhinard (2019) argue, a successive series of health crises had for the previous two decades established a resonant “health securitisation” strategy that moved beyond the simple collection and sharing of national surveillance data to the establishment of a comprehensive “all hazards” approach that addressed a much wider conceptualization of cross-border “threats to health.” Nevertheless, the response to the Covid-19 pandemic was singularly significant. Brooks et al. (2022, pp. 6–7) draw on the neostructuralist framework to establish three hypotheses: First, that a “neofunctionalist theory of any kind would predict integration as a result of the pandemic”; second, that the costs of “failing to integrate and coordinate responses” to the pandemic would generally affect all member states equally; and, third, one would expect to see three integrative responses “spillover (an increase in competence and supranational governance), spill-around (an increase in the scope of competence but based on an intergovernmental governance structure), or build up (an increase in supranational governance but confined to the existing scope of competences).” The authors conclude that neo-functionalism can well explain the behaviour of EU actors during the pandemic:

The level of integration within the EU meant that member state governments had no disintegrating response available to them, and so invested heavily in EU public health...The EU showed why governments in a well-integrated economy might want to rapidly constitute a supranational system capable of managing that integrated economy’s public health. (Brooks et al., 2022, p. 736).

Similarly, Bazzan (2020, p. 726) concludes that “the new EU4Health policy...can be regarded as the result of the creation of a more conducive environment for the occur-

rence of mechanisms that could, in turn, result in greater policy integration,” while Fraundorfer and Winn (2021, p. 10) argue that “the European Health Union might be a way for the EU to gain further traction in health policy.”

4. Canada

While health care in Canada is highly fragmented and remains largely under the jurisdiction of PTs, we can nonetheless reference a Canadian health care “system” because the 1984 Canada Health Act (and the financial transfers supporting it) facilitates a voluntary coherence to general principles of governance and delivery. The necessity for such an act was due to the formal distribution of constitutional authority in 1867 (see Table 1), which explicitly gave jurisdiction over hospitals to the provinces; authority over “health care” more broadly was inferred with reference to matters of a “local and private” nature.

This changed drastically mid-century. Saskatchewan established the first public insurance model in Canada in 1947. When federal legislation covering hospital insurance was finally implemented in 1958 (with legislation for primary care insurance coming into force in 1968), the federal stipulations for PTs receiving federal health transfers provided voluntary uniformity across the country. The 1984 Canada Health Act (consolidating the previous two acts) further clarified the conditionality of receiving federal health funding.

Health care as a coherent *system* in Canada has thus been shaped by national legislation that is not binding on any of the provinces or territories. Provinces have unique and idiosyncratic perspectives on the delivery of health care; the most substantial lever the federal government has to influence the way in which health care is delivered is expenditure. Constitutionally, Ottawa has the legal ability to fund activity outside of its jurisdiction, within certain parameters; financially, its taxation capacity far exceeds that of the PTs. In some small areas, including health care for those in federal penitentiaries and the military, health insurance for refugees, and pharmaceutical regulation, Ottawa does have clear jurisdiction over health care; in others, such as regulation of health insurance for migrant workers, health insurance for Indigenous Canadians, and public health, the nature of health care is much more complicated and overlapping (Fierlbeck & Marchildon, 2023).

That Canadian health care is as consistent across jurisdictions as it is largely because of federal financial outlay. By 2023–2024, the federal health transfer to provinces amounted to C\$49.4 billion. This mechanism would seem to be straightforward and unproblematic: The federal government has the ability to offer money to the PTs for certain purposes, and the PTs, in turn, are free to accept or reject these funds as they wish. Yet this relationship is a highly acrimonious and unstable one. Why?

While provinces were initially keen to take advantage of shared-cost programs, their experiences with the

program over time began to temper their enthusiasm. The key lesson for provinces was that what was given easily could be rescinded equally easily. The initial design of 50/50 cost-sharing between federal and provincial governments was reconfigured in 1977 when Ottawa perceived that the open-ended arrangement was becoming too expensive. Ottawa informed the provinces that it would henceforth distribute a defined amount each year while giving the provinces more tax room to raise the remaining funds themselves. In the mid-1990s, the federal government unilaterally reduced the rate of increase for health transfers; upon the expiration of the Canada Health Accord in 2014, Ottawa, without warning, cut the health transfers' rate of increase by half. The problem with cutting program funding, of course, is that those who use these programs get used to a certain level of service, creating set expectations. When provinces running the programs cut back on them, they are punished politically. Thus, provinces have learned to be wary of federal government proposals for new shared-cost programs (including certain iterations of pharmacare or "denta-care"): There is simply no guarantee that these programs will continue to be funded federally, but once a sense of social entitlement to services has been established, it is exceptionally difficult to rescind them. "Provinces often balk when Ottawa tries to attach strings to health-care funding" (Wright, 2022), and this reluctance is generally most evident in the provinces of Quebec and Alberta, which demand unconditional funding for social programs (e.g., French, 2021). Both provinces are especially adamant about the ability to opt out of any proposed federal pharmacare program (Aiello, 2019).

The federal government has also gained a clear understanding of the disadvantages of this kind of funding relationship. By opening up tax room for the provinces in lieu of cash funding in 1977, for example, one expectation was that provinces could spend more on cost-effective services such as home care rather than on medical services (Naylor et al., 2020). They did not do so. Over two decades later, in an attempt to build bridges with the provinces after squeezing health transfers in the mid-1990s, the federal government introduced the Canada Health Accord in 2003 and the 10-Year Plan in 2004, which distributed an additional C\$41 billion of federal funds in addition to existing health transfers. The purpose of the additional funding was explicitly to "buy reform" of the health care system. But the attempt at comprehensive reform fell well short (Health Council of Canada, 2011); rather, much of the funding went into improving the salaries of existing health care workers or replacing old equipment. Federal politicians became even more concerned when provinces demanded more federal funds for health care at the same time that they cut their own tax rates, thereby decreasing the revenue stream that would have allowed them to pay for health programs from their own revenue.

The dynamics of federal-provincial health transfers are strongly influenced by the federal party in power.

Conservative governments have recently been less willing to shape the direction of health care at a national level through economic incentives. And, while the Liberal government since 2015 has been interested in providing direction in health care through its expenditure power, it has been reluctant to provide greater unconditional funding for health care. It sees unconditional increases in health transfers as a form of moral hazard, where provinces are divorced from the consequences of their actions. For example, using additional funds to raise the salaries of physicians in the hope of attracting health professionals from other provinces merely results in a beggar-thy-neighbour situation of some provinces attempting to outbid others with no net increase in health providers. Rather, the Trudeau government has focused on offering either bilateral deals for specific purposes or comprehensive health transfer increases tied to specific programs such as health data management and health human resource management. These are evident areas of need, yet many provinces are loath to accept the condition that additional funds be used for these purposes.

Thus, the federal expenditure capacity was an effective instrument in establishing the parameters of the Canadian health care system initially, but the federal and provincial experience of unforeseen and disadvantageous externalities has gradually resulted in a dynamic of distrust exacerbated by a sociopolitical context which inhibits political negotiation between jurisdictions. How did the pandemic affect federal dynamics within Canada? Formally, each PT was responsible for emergency responses, and each jurisdiction addressed the crisis differently (some provinces, for example, closed their border to interprovincial travel; others did not). During the pandemic, there was considerable discussion (Flood & Thomas, 2020; Mathen, 2020) about whether the federal Emergencies Act could or should be used in pandemic management (Canada was the only federal country that did not issue a national lockdown, nor was a national emergency declared in response to Covid-19). Federal bodies such as the Public Health Agency of Canada and the National Advisory Committee on Immunization provided guidance for those provinces desiring it, but no directives were imposed on the provinces. C\$72 billion of extra federal funding was provided by the federal government to support the health and safety of Canadians over the course of the pandemic, and Ottawa played a major role in securing vaccines, antivirals, and testing supplies. Despite the considerable outlay in federal funding during the pandemic, however, federal authority in the field of health care did not increase, nor was Ottawa able to use its considerable expenditure to consolidate health policy across the country.

5. Discussion and Conclusion

As with any comparison of state systems, any extrapolations of the juxtaposition of Canada's health system

with that of the EU must be done with caution. In both instances, the demand that the responsibility for the delivery of health care by member units be observed by the central authority is tempered by the recognition that there is much to be gained (and potentially lost) through greater coordination. Beyond this, the specific dynamics in each case are quite different. The Canadian Constitution and the TFEU specify differing authorities and competencies, and the component units in each case have different capacities and interests. Analytically, the most interesting question is perhaps whether both federal health care systems are subject to the same kinds of dynamics and, if not, why not? If the pandemic led to greater integration in the EU, why do we not see the same dynamics in Canada?

Brooks et al. (2022) use neofunctionalism as a lens through which one can understand the move toward greater health policy integration in the EU: A “neofunctionalist theory of any kind,” argue Brooks et al. (p. 6), “would predict integration as a result of the pandemic.” Because the EU’s only formal treaty base for health rests on public health, and because pandemic management sits absolutely squarely within the public health domain, the conditions for the expansion of this public health mandate in the EU were perfect. The limitation of neofunctionalist theory is that it cannot explain why integration does *not* occur when one might expect it should. Looking at Canadian and European health care federalism side by side, it becomes apparent that Covid-19 might have been an important, and possibly even necessary, causal factor in facilitating greater integration in federal health policy, but it was not sufficient. What other factors might explain why the EU seems to have been more successful in achieving greater integration in the area of health policy?

One explanation for this difference lies in the historical dynamics of power—and the lessons learned from these historical relationships. Neofunctionalism might suggest that PTs, already somewhat integrated through the mechanism of the Canada Health Act, would clearly benefit from even greater integrative measures such as national pharmacare, dental care programs, or long-term care standards. But PTs have learned, over time, that federal program spending is both a blessing and a curse. The putative gains—such as increased funding—may look very attractive at the outset for the PTs by increasing their health capacity. However, as time progresses, they may become more aware of how vulnerable they become by depending too heavily on federal resources that can be so easily discontinued, and the short-term gains are increasingly tempered by fears of the political havoc caused by the sudden reduction in federal program funding. Thus, while neofunctionalist approaches may focus on the short-term logic of greater integration, the historical experience of these political actors over time makes them more likely to act on the perceptions of potential longer-term consequences. To the extent that integration rests on the financial largesse of a fed-

eral or supranational entity, there may be a threshold of integration beyond which the potential costs of accepting funding become apparent, changing the behaviour of the discrete political units. Theorists viewing the current capacity of the EU to dedicate much higher levels of health-related funding to member states should thus be cautious in extrapolating the *current* integrative dynamic (facilitated by greater EU-level expenditure) over the longer term. As the Canadian experience suggests, the mere capacity for a federal authority to fund health initiatives does not mean that member states, over time, may always be receptive to accepting these funds if they perceive that the potential longer-term externalities are not worth the shorter-term gains.

A second explanation focuses on the specific constitutional distribution of powers and how this distribution of authority is affected by a particular type of crisis. The Covid-19 pandemic was obviously a public health crisis, and the EU was able to expand areas of authority where it already had *some* competence. The pandemic led to greater EU authority for the EMA, for example, due to the agency’s role in managing pharmaceuticals; but in Canada pharmaceutical regulation is the one health-related area over which it already has considerable authority. Similarly, the EU’s authority expanded with the establishment of the European Health Emergency Preparedness and Response Authority but, again, international disease surveillance is a function that already rests at the federal level in Canada (although the Global Public Health Information Network was poorly managed prior to the pandemic; see Robertson, 2021). One key aspect of increasing EU capacity has been the budgetary increases in the area of health: As noted above, for example, programme spending on health (and particularly EU4Health) has increased tenfold. This has required buy-in by member states, whose contributions fund these spending increases. In Canada, in contrast, federal revenue is raised independently of PTs, and Ottawa thus continues to control the level of health transfer spending at its own discretion. In sum, those public health-related areas that the EU was able to leverage to its advantage are not areas that Canada could similarly exploit. In this way, the utility of neofunctionalism as an analytical construct may depend on the existing structural context of a federal system: Some entities could have more room for integration, while others have reached a point of equilibrium where further integration requires considerable political effort.

Another condition that may be necessary for greater integration across regional health systems is the existence of a broad, underlying “fascia” of supportive administrative bodies that serve as informal channels of communication and coordination. Much of the coordination and harmonization in specific areas of EU health are not done at the level of first ministers. As the EU has the *formal* function to facilitate harmonization of health policies between member states where and when member states are willing to go in this direction, it can often

achieve this through the web of administrative bodies that perform the quotidian bureaucratic functions of EU activity. This vast integrated “governance architecture,” which has evolved to develop and harmonize standards across member states, expanded considerably following the 2008 financial crisis in order to monitor and manage the fiscal performance of individual member states. As such, it provides horizontal coordination between member states. Less conspicuously, the European Commission plays an active role in networks and agencies, using them as a “back road” to both the informal harmonization of regulatory practices and as a strategy for solving compliance problems (Schrama et al., 2022). The fascia of European Administrative Networks, which vary in role and competencies, are organizations comprised of national administrative units (which could be national agencies, ministries, or civil servants). Canada does not enjoy the same extensive administrative network. There are some examples of pan-Canadian sharing of information (such as FPT committees), but cross-jurisdictional health policy bodies that include the active partnership of federal and provincial governments are much rarer (the only notable exceptions being the Canadian Agency for Drugs and Technologies and the pan-Canadian Pharmaceutical Alliance).

More speculatively, the political culture of these two federal entities may also be a variable in determining how well they are willing to coordinate or harmonize health policy within their domains. Canada, as a first-past-the-post parliamentary system, is a more adversarial political culture in which winners in electoral contests have the scope and authority to pursue policy initiatives tailored to their preferences. With few exceptions, minority governments are seen as holding periods until one party can regain the ability to shape the policy landscape. Canadian politicians are highly unused to the nuances of having to negotiate power-sharing arrangements between parties. In contrast, most European states have some form of shared national governance, which means that the normal governance style must be more consultative and collaborative. These are also competencies that allow them to undertake collective activity in policy areas beyond their borders.

There are, in sum, a number of confounders that can facilitate (or constrain) greater integration within federal systems. This supports the argument presented by Greer et al. (2023) that “federalism is too complex to make a good independent variable” (p. 6) and that federalism as an explanatory factor “only makes sense as part of the configuration of factors that makes up a case” (p. 20). The logic of functional spillover does provide a reasonable explanation for why the component units of a federal system might agree to the expansion of authority at the federal level. But we should be careful not to give it too much of a determinist explanatory force. The EU has seen a gradual but remarkable level of integration over the past three decades in health policy, and the Covid-19 pandemic has brought the EU even closer to a European

Health Union (although this trend itself should not be overstated; for a more sobering perspective, see Greer, 2020). But it may be that the logic of neofunctionalism only takes root in fertile soil. A comparison with Canadian health care federalism suggests that additional variables, such as the constitutional framework, historical experiences, and even political culture, might be relevant in determining the extent to which this neofunctional logic is able to unfold.

Conflict of Interests

The author declares no conflict of interests.

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