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ARTICLE

Trust, but customize: federalism's impact on the Canadian COVID-19 response

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ABSTRACT

This article explores how Canadian federalism, with its complex mix of competencies, and the country's punctuated gradualism policy style interface with urgent, complex decision-making like the COVID-19 pandemic. We find that while punctuated gradualism favors tailored responses to pandemic management it is weaker when coordination and resourcing are to be undertaken during non-crisis situations and that, while the level of cooperation among Canadian jurisdictions has progressively increased over the years, policy is still almost exclusively handled at the federal, provincial and territorial levels. Furthermore, the model appears to have critical 'blind spots' in terms of vulnerable communities that do not emerge as such until after a crisis hits.

KEYWORDS

COVID-19; federalism; Canada; policy Styles

Introduction

Canada observed the novel COVID-19 coronavirus pandemic spread in China, Iran and Western Europe and witnessed the massive scale of the disruption it brought. While the situation is still developing, the pandemic has both caused more deaths and more disruption in the Canadian economic and social fabric than any previous outbreak, arguably on a scale only comparable to the Spanish Influenza in 1918–1920. All Canadian jurisdictions have been very active with political and health leaders rolling out unprecedented public health and economic stabilization and recovery measures and showcasing an unusually high level of inter-jurisdictional cooperation (Merkley et al., 2020).

The analysis of pandemic management in Canada raises two broad questions: why was Canada able to manage the outbreak better than countries like the United States that have much larger resources, but faced much higher death rates? And did Canada's policy style have a role in its successes and failures?

Pandemic management is not a new challenge for Canada (Joint Centre for Bioethics Pandemic Ethics Working [JCBPEW], 2009) but, as it manifests as a complex inter-governmental problem (Paquet & Schertzer, 2020) under conditions of imperfect knowledge, it challenges the punctuated gradualism usually underpinning Canadian policy-making.

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The Canadian brand of cooperative federalism, with its pattern of elite policy negotiation, triggers very high levels of cooperation and unity of intent when actors share a common perception of an emergency and there is a fairly high level of confidence in the system's capacity and level of preparation, as in 2019–2020.

For COVID-19, the emergency level of the situation mattered in two ways, on the one hand, resembling the 'emergency centralism' of earlier era's in federal-provincial relations (Black, 1975), it provided the Government of Canada with uncommon latitude and capacity in terms of policy choices. On the other, depending on the degree to which the perception of the gravity of the emergency is shared among the actors, it generates increased levels of cooperation among them.

This article argues that Canadian policy style punctuated gradualism (Howlett & Migone, 2019) had mixed effects on emergency management, on the one hand, it fosters the progressive development of strategic cooperation and response frameworks but it is not designed to generate a top-down national approach like those seen in New Zealand or Singapore (Weible et al., 2020). This policy style enables specific responses to local realities, which represent an important failsafe in a federal system, but at the same time which can reduce cooperation and misalign critical policy steps. This is especially the case in the early stages of a pandemic when the threat is perceived differently by the different actors involved. This is compounded by the nature of the negotiation process in cooperative federalism: federal and provincial executives are the key players often marginalizing municipal and other actors (Bakvis & Skogstad, 2012).

This argument is presented in the following sections: section two explores the Canadian response to COVID-19 while section three discusses the nature of executive federalism and outlines punctuated gradualism as the constituting elements of the Canadian policy style. The following section then compares the COVID-19 response to previous Canadian pandemic management approaches and relates these to the dynamics of punctuated gradualism, and finally some conclusions are offered.

Canadian responses to the COVID-19 pandemic

As briefly noted above, the Canadian policy response to COVID-19 was both highly cooperative and very broad. There were two different periods within it. The first occurred prior to mid-March 2020 when many policy choices and the framing of the emergency at all institutional levels followed incremental and exhortative patterns. Index cases emerged in Toronto and Vancouver in late January but the only major policy response in February regarded the screening of international travelers and while infections increased only on March 09 the first death was recorded.

Things then accelerated rapidly and the country entered the second phase of its policy response when on March 11th the WHO declared COVID-19 a pandemic, Provincial and the Federal authorities advised against non-essential travel and returning international travelers were told to self-isolate for two weeks. By mid-month Provinces and cities were beginning to implement rules against large gatherings and imposing social distancing measures. Between March 12th and 22nd all Provinces and Territories declared states of emergency, most jurisdictions closed schools and public venues, and a host of business closures followed suit. On March 14th the federal government banned foreign nationals

except US citizens from entering Canada and closed the Canada-U.S. border itself to all non-essential travel (Fife, 2020).

Generally speaking, this response pattern seems to fit what we would expect from jurisdictions that had a relatively high confidence in their capacity to and experience in handling similar crisis, while the jurisdiction-specific timing and intensity of the responses appears to depend on whether economic or health priorities were paramount (Capano, Howlett, Darryl., & Goyal, 2020).

Many responses were effective: Provinces developed policies supporting businesses, people and institutions, and Ottawa announced a series of support measures that were then incrementally developed into the Canada Emergency Response Benefit (CERB), which provides income support for workers who have lost their job or suffered income reduction because of the pandemic and is flanked by a series of measures targeted towards students, self-employed workers and companies both small and large, with the latter being able to access bridge loans (Government of Canada, 2020). Overall, the federal government announced over 35 USD billion in direct intervention and 55 USD billion of tax deferrals between March and April 2020 and Provinces followed approved economic measures worth tens of billions of dollars (Government of British Columbia, 2020; Government of Ontario, 2020; Government of Québec, 2020).

By the beginning of May, Provinces had initiated plans to return towards a less restrictive model of social distancing, especially focusing on reopening businesses as the contagion curve began to flatten. Limitations remain, however, shortages in personal protective equipment for health-care workers and stretched supply lines have increased the level of the emergency and the pace of the decisions in second policy phase, poor communication among health agencies is still a major issue. In April, the Federal Government briefly explored the possibility of invoking the 1985 *Emergencies Act* that would give it extensive capacity to intervene in provincial affairs but all Premiers rejected the approach (Bell, 2020).

Once again, as with the US (Rocco, Béland, & Waddan, 2020), the existence of a federal system accounts for convergent but not identical responses across jurisdictions: while all of the Canadian Provinces and the Federal government imposed social distancing, and school and business closures, their timing and approach varied and different takes emerged early on. For example, the Province of British Columbia, likely on the strength of a higher confidence in its public health process and expertise, tested and traced patients much more aggressively and its public health and political leaders stressed the need for caution and early action more than in the Provinces of Québec and Ontario as is shown in Figure 4. There, in the two most populous provinces, the initial response was milder and, as a result, these two jurisdictions saw much higher infection rates, more deaths and less coherent communication. Figure 1 highlights the differences that the various jurisdictions had in 'bending the infection curve'.

As this figure shows, larger Provinces did not do as well as smaller ones in containing the spread of the virus with the exception of British Columbia with the likely reason in that case being a much faster and determined early response by experienced public health officials (Porter, 2020). Jurisdictions also progressively increased testing (Figure 2–4).

The resulting levels of COVID-19 mortality also differed among jurisdictions: smaller jurisdictions had much better outcomes while among jurisdictions with higher amounts of deaths, Alberta and British Columbia contained these numbers

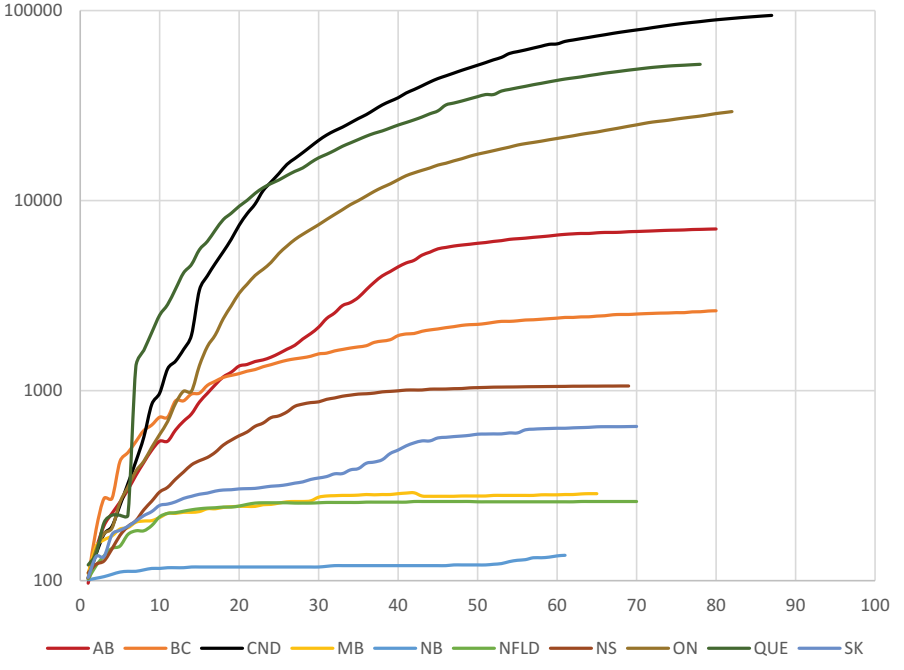

Figure 1. Confirmed cases, select jurisdictions. Source: Health Canada. Logarithmic scale; origin point on the day each jurisdiction reached 100 cases.

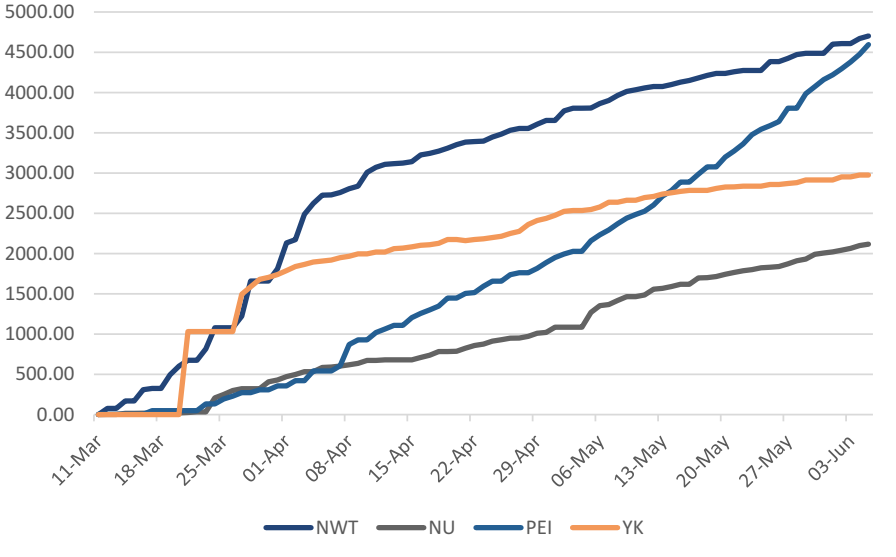

Figure 2. Tests administered per 100 k population, jurisdictions with <250 k pop. Source: Health Canada.

much better than did Ontario and Quebec (Figure 5). Once again early intervention and stricter measures had an impact as did the nature and structure of senior's long-term care residences in each province, which was where most fatalities occurred

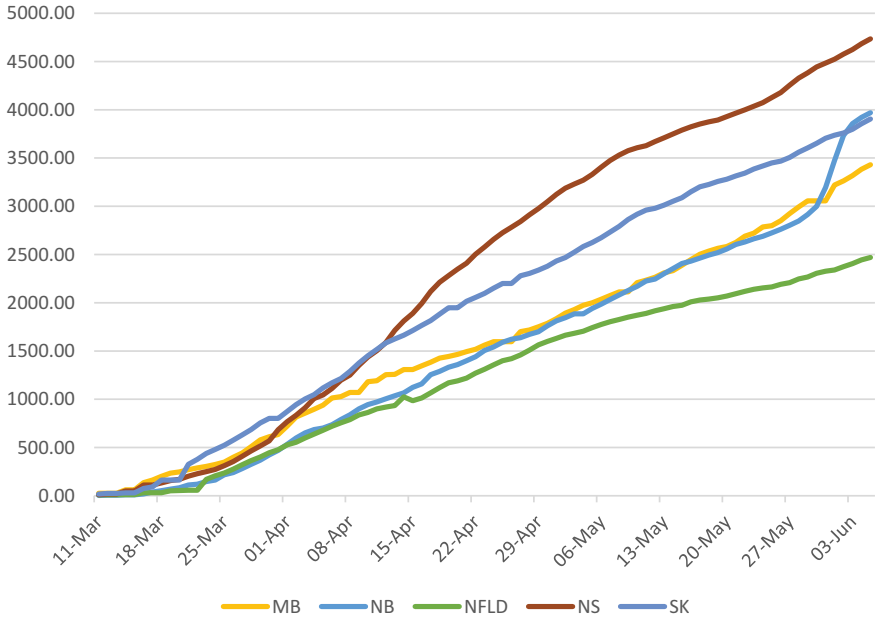

Figure 3. Tests administered per 100 k population, jurisdictions with <4 M pop. Source: Health Canada

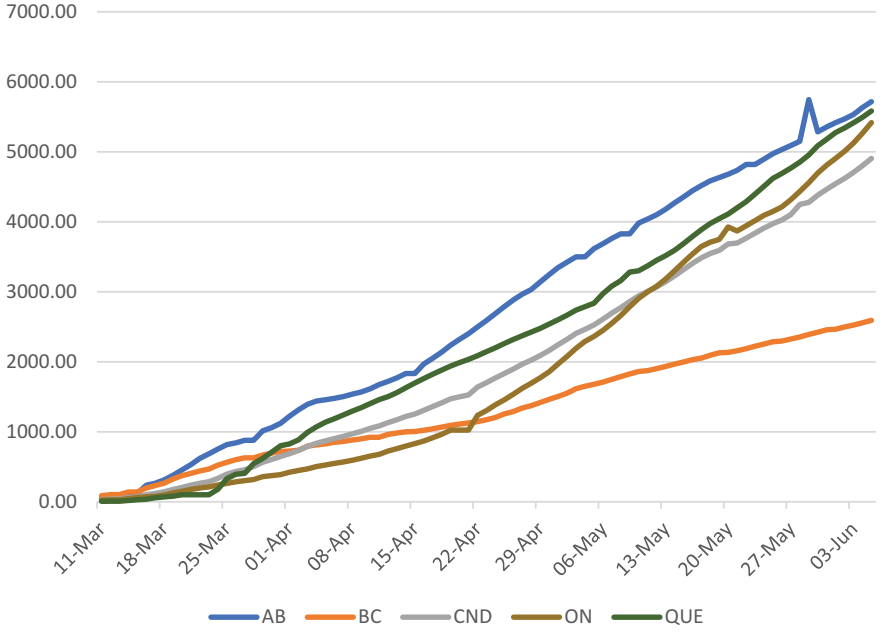

Figure 4. Tests administered per 100 k population, jurisdictions with >4 M pop. Source: Health Canada.

(Harris & Burke, 2020). That is, as is well-known worldwide, COVID-19 mortality is highest among the elderly, especially in larger long-term care homes where multiple outbreaks and many fatalities were reported. Although all jurisdictions in Canada

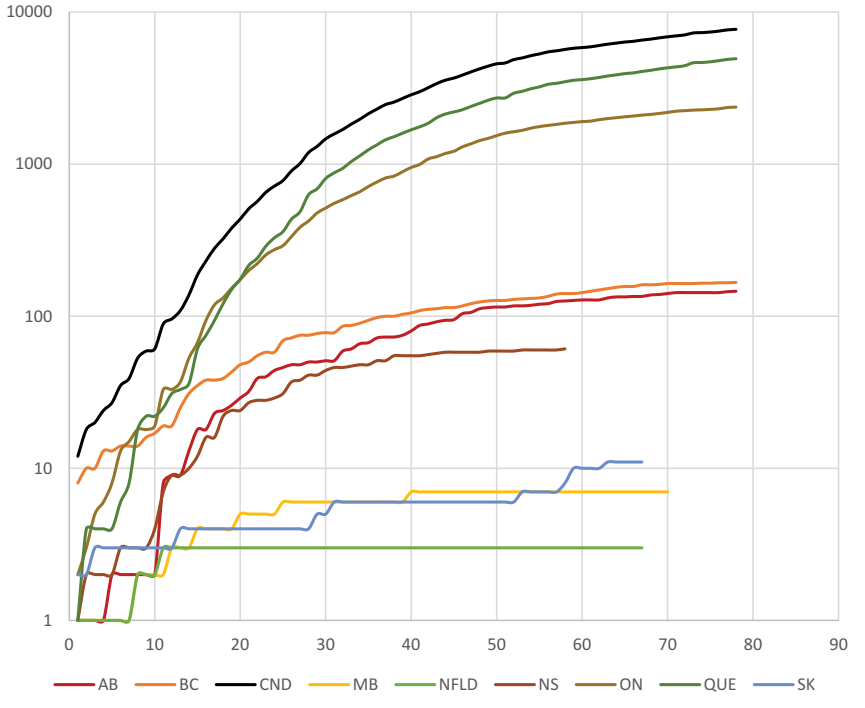

Figure 5. COVID-19 deaths, select jurisdictions. Source: Health Canada; Logarithmic Scale from first death. Jurisdictions not shown have no deaths.

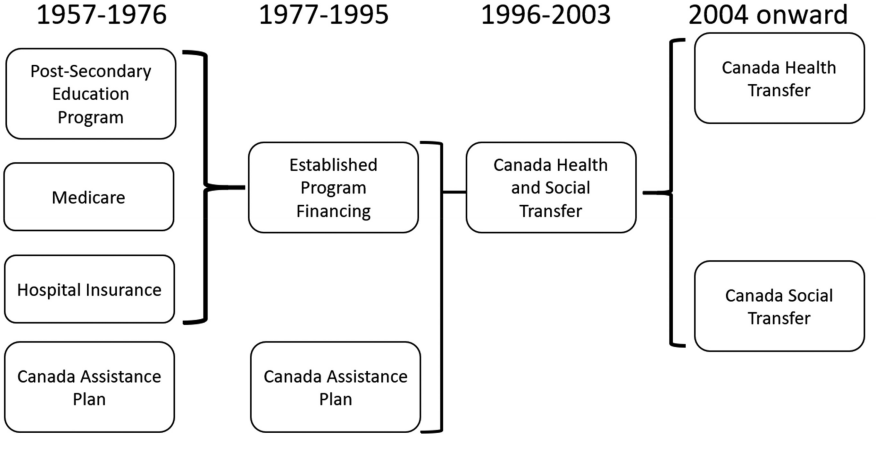

Figure 6. Timeline of major Canadian financial transfer programs.

suffered losses among seniors, a combination of lack of inspections, diverse regulations, poor labor practices and reporting requirements in Quebec and Ontario contributed to very high infection and mortality rates (CITE). According to the Ryerson University's National Institute on Ageing COVID-19 Tracker (https://ltc-covid19-tracker.ca/), these facilities accounted for over 80% of Canadian deaths representing a glaring and dramatic policy failure across the country. Like health-

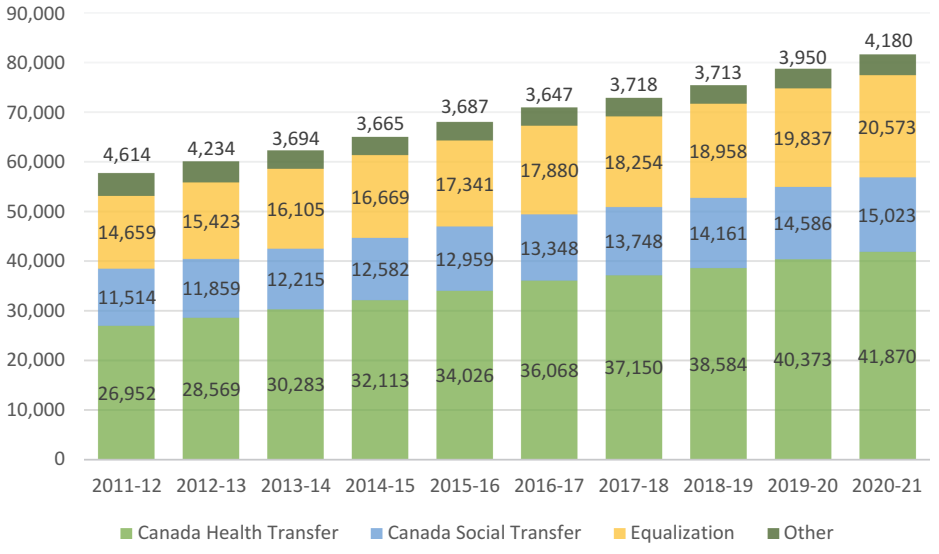

Figure 7. Federal support to provinces and territories (billions of dollars). Source: https://www.canada.ca/en/department-finance/programs/federal-transfers/major-federal-transfers.html#notes

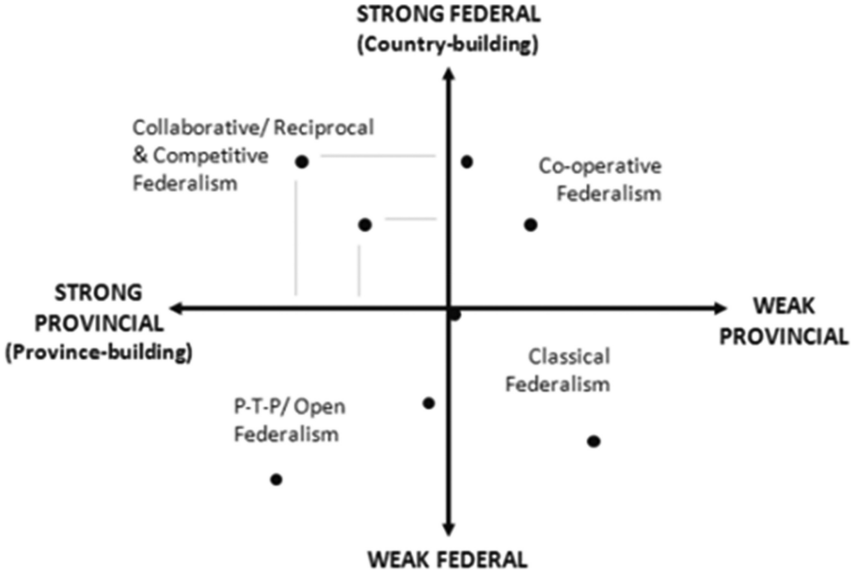

Figure 8. Centralist and decentralist dynamics in Canadian federalism. Source: Wilder and Howlett (2015, 25).

care workers during SARS, these facilities represented n 'blind spot' in Canadian pandemic management and planning, falling between the cracks of a complex system of responsibilities and competencies and paid the price for that omission.

Economic support policies also received strong support and benefited from the increased climate of federal-provincial cooperation which emerged around pandemic

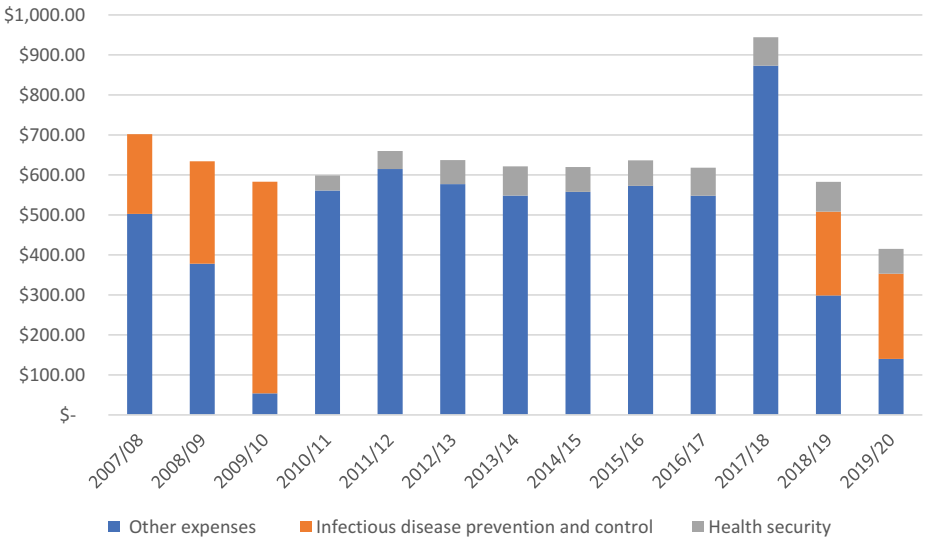

Figure 9. PHAC budget categories ($ millions). Source: PHAC budgets

management. However, observers questioned whether some jurisdictions underestimated COVID-19 and responded too slowly, and an undercurrent of concern also emerged in terms of Canada's over-reliance on international supply chains for resources like PPE and ventilators. Both funding and resources for PPE were and remain weaknesses in pandemic preparedness: in 2020 the Canadian strategic stockpile was limited notwithstanding its critical importance. And the familiar crisis-related notes about clarity of institutional roles, communication, data collection and data sharing also resurfaced in this area.

The next section delves in more detail into the way in which the institutional and organizational characteristics of the Canadian system led it to this partially successful response in 2019–2020 and how its policy style adapted to the specific situation the country faced due to previous learning and its impact upon the evolution of pandemic management planning and execution.

Canada' history of executive federalism and its punctuated gradualist policy style

Health care in Canada has a long, complex history, one that often was about the sustainability of the system. Political debates on the issue have been strongly ideological (Stuart & Adams, 2007) and, like most Canadian policy fields, hinges on a punctuated gradualist approach to policy-making consistent with Canada's high de-centralized system of governance. Constitutionally, the *British North America Act* (BNA) gave the Federal Government authority to manage marine hospitals and impose quarantines (Sec. 91), while Provinces license physicians and establish, maintain and manage hospitals and other health-care institutions (Sec. 92). However, health protection and public health are less clearly articulated and Ottawa has allowed provincial governments to hold jurisdiction in areas like sanitation and prevention of diseases while, in turn, provinces devolved much of the day-to-day work to local administrations (Tuohy, 1992).

Only after World War 2, and after two decades of strife did the private health-care model which existed prior to then morph into a publicly funded/privately delivered one. This occurred because of the combined pressure from provincial governments and voters (Taylor & Maslove, 2009). The field relied on a variety of policy instruments (Marchildon, 2013) and was always a dual financial and political matter (Deber, 2018; Thompson, 2020), with multiple financial transfer approaches, see Figure 6, following one another as economic pressures and increasing delivery costs threatened the capacity of the Provinces to sustain the system and deliver cheap and reliable high quality healthcare to Canadians.

Elite accommodation was always key here, often fostering substantial financial and policy decisions like the 1960s Hall Royal Commission which recommended state-provided medical insurance and the 2002 Romanow Commission which made many recommendations for how the system could be sustained (Commission on the Future of Health Care in Canada, 2002). This was followed by developments such as the First Ministers' Accord on Health Care Renewal of 2003, which provided 36 USDB in new funding and the ten-year federal-provincial agreement signed in 2004 that increased funding by 6% and generated priorities that – albeit without much enforcement capacity on any side – at least suggested a specific policy dynamic (Thompson, 2020). This was followed by a more recent wave of bilateral agreements between the federal government and the various regional jurisdictions that replaced the previous agreements under the current federal administration.

Canada's cooperative federalism

Partially, the success of the Canadian policy response to COVID-19 depends on the patterns of executive cooperation embedded in Canadian federalism which were a central feature of the evolution of the country' public health system.

Canada's federal system is decentralized and somewhat fragmented: the country's 10 Provinces, three Territories and a federal government enjoy a broad set of organizational and jurisdictional options. Constitutionally and politically, policy competencies are complex, interconnected and overlapping and are implemented in a system that concentrates fiscal capacity at the federal level. This imbalance requires substantial fiscal transfers from Ottawa to the Provinces (see Figure 7), which have very diverse economic capacities, to maintain policy sustainability in key policy areas. These transfers that are often linked to specific political and regulatory conditionalities. The federal government provides substantial monetary support to Provinces in health care, education, social transfers, and equalization transfers, which redistribute a portion of provincial tax payments from 'have' provinces to 'have-not' ones and have generally worked as a partial supplement to provincial spending rather than to reach full equalization (Tombe, 2018).

This type of federalism emerged over time as early institution building layered French and English regulatory and legislative models and colonial practices which remained largely intact when, in 1867, Britain granted Canada autonomy as a Dominion within the Empire through the *British North America Act* (BNA). The BNA superimposed a model of decentralized federalism onto a British Parliamentary system and – over time – joined

together the various Provinces and Territories in the Canadian federation (Cairns, 1990; La Selva, 1996).

This system relied on elite accommodation to achieve coordination and convergence on policy goals, and also generated a pattern of competing nationalisms and regionalisms within Canada while introducing the need for shared decision-making (Black, 1975; Smiley, 1987; Thornbun, 2000). Montpetit, Rothmayr, and Varone (2005) suggest that, in systems like these, coordinating discourses eventually emerge enabling agreement by providing participants through the development of a common language and a recognition that all perspectives are relevant. In Canada, this was embodied in the alternance of centralist and decentralist dynamics between provincial and federal authorities (Wilder & Howlett, 2015), who developed the model shown in Figure 8. Early federal dominance was progressively mitigated in the 1950 s and 1960 s into a quasi-diplomatic process of intergovernmental relations (Simeon, 1972) kickstarting the age of *Executive Federalism*, which highlighted a process of negotiation dominated by government executives at the provincial and federal levels that could yield either collaborative or competitive results (Simeon, 1980; Smiley, 1987; Watts, 1989).

Punctuated gradualism

Canada's parliamentary democracy and first-past-the-post electoral system – replicated throughout its federal and regional units – supported the development of executive dominance (Savoie, 1999) where First Ministers (Premiers and the Prime Minister), who generally control both the agenda and timetable of Parliament and provincial legislatures and have power of appointment over all major political and administrative positions, are the key policy actors.

This system engages multiple policy fields and often looks like 'institutionalized ambivalence' where cooperation and order can be difficult to discern (Tuohy, 1992) and whose particular dynamics are subject to change based on historical and political conditions. However, federalism generally dampens the central executive dominance characteristic of the British system, especially when the complexity and scope of decision-making hinder executives from controlling all the decisions and regulations needed by administrators (Kernaghan, 1979).

That is, the operation of the Canadian system requires governments at different levels to co-operate if they are to achieve most of their policy goal. Recently, for example, First Ministers engaged in considerable fiscal and economic cooperation, which was facilitated by the high degree of decentralization of the model (Hogg, 2007) and by the relatively small number of jurisdictions involved (Carty & Wolinetz, 2004) even as the federal government was extremely selective in choosing whom to engage with (Ditchburn & Graham, 2016).

These structural imperatives are key to understanding Canada's policy style. The idea of a policy styles emerged as a concept during the 1980 s (Vogel, 1986), linking dominant decision-making approaches to state's relations with societal actors (Richardson, 1982). They represent a meso-level analytical tool to study public policy and to understand not only how policies emerge and are maintained (de Vries, 2005) but also to explain national differences in policy outputs (Castles, 1998), policy outcomes (Peters, Doughtie, & Kathleen McCulloch, 1978) and policy processes. As a component of policy regimes,

they shed light on why policy dynamics tend to develop a distinctive and enduring set of decision-making processes (Larsen, Taylor-Gooby, & Kananen, 2006), they also affect national administrative styles (Knill, 1999), administrative traditions (Painter & Peters, 2010), and international administrative organizations (Knill, Bayerlein, Enkler, & Grohs, 2019).

Policy styles are connected to a country's institutional, material, and jurisdictional elements and the processes through which they developed and operate, since their relative 'permanence' is determined by its connection with both (Howlett, 2002). Different national political systems affect both how power is distributed, and how policies are processed in the administrative and political systems leading them to generate and maintain specific policy styles.

As discussed above, traditionally, Canada's policy style has consisted of interactions between lead government agencies at the federal and provincial levels, and the main business and labor groups they worked with (Panitch, 1977; Whitaker, 1992). Over time, a national style of 'punctuated gradualism' emerged that periodically re-fashions structures and processes under the influence of electoral, political and economic issues but always from a federal perspective, ultimately generating a process of slow policy innovation and re-invention across different levels of government (Howlett, 1999).

Two characteristics of this style are worth noting: first, while innovations tend to be touted and promoted very aggressively – leading to early adoption – they are often dropped relatively quickly if provincial resistance is encountered. This tends to contrast with long-standing policies that generally develop through a long, syncretic process of negotiation and reciprocal adjustment. Ultimately, this dynamic leads to a process of gradual reform punctuated by bursts of 'over-promising and under-delivering' (Howlett and Migone 2018).

Given this pattern, Canadian policy cycles often are set around 5 to 10 years timeframes beginning with the pursuit of innovative policy instruments or ideas and supported by a search for thought leaders, who are often asked to provide examples and frameworks for these changes. Usually, the cycle continues with the arrival of reports and program ideas – whether produced by public servants or by consultants – and with announcements or policy reforms sometimes not supported by strong implementation analysis. A mix of failures and successes ensues, involving delays and calls for intergovernmental negotiation in turn lead to both elite and popular disaffection with the policy, ultimately restarting the cycle (Howlett & Migone, 2019). As Howlett and Migone (2019, p. 144) noted, this policy-making process, among other things leads to peak bargaining among governments, which follow relatively closed patterns that are open to limited public scrutiny. This was easily observable in the development of the Canadian health system which emerged from multiple repeated bouts of innovation and stalemate.

Canada parliamentary traditions and its federal context ensured that much of the power over the direction of policy regimes, including the health care one, still sits with traditional actors, notwithstanding the pressure from the proliferation of many more policy-capable players in policy advisory systems such as NGOs and think tanks (Howlett et al., 2017).

However, history of Canada also shows that centralizing pressures still tended to return during a period of emergency or stress as a different form of 'crisis centralism' or 'emergency federalism' (Black, 1975; Mallory, 1965). This arrangement justifies greater

capacity for the federal executive at a time of distress for the system as a whole and was a central feature of the country's response to war and other national security challenges. Emergencies also tended to provide policymakers with an opportunity to distance themselves from the haggling and drawn out negotiations that at times surround Canadian 'normal' policy making processes, especially if there is a shared federal-provincial perception of the gravity of these situations.

This article argues that the emergence of COVID-19, at least since mid-March 2020, can be classified as just such a situation of emergency decision-making where the drawn-out process of elite negotiation typical of punctuated gradualism was temporarily replaced with closer cooperation among the top decisionmakers.

Pandemics and emergency management in Canada

Pandemics imply the national or global prevalence of a disease and require multi-layered policy responses which overlap the health care, public security and economic policy fields and challenge policy-makers (Carney & Bennett, 2014). Key decisions address the health and well-being of individuals, ranging from populations at risk (O'Sullivan & Phillips, 2019), to health-care workers (Maunder et al., 2008) and the general population.

Policy-wise, pandemics management, especially early on, is often undertaken when available scientific knowledge is limited, while preexisting beliefs about factors like disease severity and the impact on the health-care system can influence choices deeply (Rosella et al., 2013). Pandemic preparedness is difficult to achieve for public health organizations not only because of the need to deploy emergency responses rapidly but also because epidemics are difficult to predict (Kilbourne, 2006), particularly in a globalized system (Saunders-Hastings & Krewski, 2016), and are rare and short-lived events where trial-and-error approaches are not feasible (Keller, 2019). However, the level of confidence in the processes in place and previous experiences can have a very important impact on how pandemic management unrolls. This is especially so in a consultative democracy like Canada (Howlett & Tosun, 2018) where politicians are often a more important policy actor than experts.

The economic impact of pandemics is another important consideration in a globalized world where international production chains, travel and services depend on cheap, reliable transportation and interconnection. While precise calculations vary, individual costs, work disruptions, increased hospital care, and sick days claims all increase during pandemics (Gasparini, Amicizia, Lai, & Panatto, 2012; Kim, Yoon, & Oh, 2013; Schanzer, Zheng, & Gilmore, 2011), which can strain the socio-economic fabric of a country. This is particularly true in Canada where, for example, health-care capacity in remote rural communities is much lower than in cities. Over the last two decades, Canada faced various influenza outbreaks epitomizing public health responses to communicable disease in a globalized world (see Table 1)

While unforeseen issues emerged in all instances when infections were recorded, improvements tended to follow the outbreak and the level of confidence in the system and in the processes for pandemic management increased over time.

The Canadian health-care model blends responsibilities and roles across jurisdictional levels: while Provinces formally hold constitutional competency, the federal government runs important agencies like the Public Health Agency of Canada (PHAC), uses the

Table 1. Recent influenza outbreaks.

Outbreak	Period	Global Cases	Global Deaths	Canadian Cases	Canadian Deaths
SARS	2002–2003	8,098	774	438	44
H5N1	2003–2013	630	375	0	0
H1N1-09	2009–2010	1,632,258	18,036[1] 151 k-575k[2]	33,509	428
MERS	2012 ->	2,519	866	0	0
COVID-19[3]	2019 ->	6,906,157	399,538	94,790	7,738

Source: WHO for global cases, Health Canada for Canadian data. Cases only include laboratory confirmed cases.
1 reported; 2 estimated; 3 as of 5 June 2020.

Table 2. Policy patterns in COVID-19 management.

b	March 15		May 15
Level of Federal-Regional Cooperation	Traditional	High	More space for local differentiation
Perceived Threat	Normal but growing	Very High	Declining
Dominant policy instruments	Nudging with some restrictive tools	Restrictive with continued nudging	Restrictions eased, more relevance of nudging
Policy Style	Traditional policy punctuation	Crisis collaboration	Collaborative but at a lower level

Public Safety Canada ministry to manage the global and national sides of the emergency, while exerting a notable 'power of the purse' upon the provincial level, and local authorities are the major 'on-the-ground' implementers. Furthermore, the whole construct tends to align to framework international recommendations such as the World Health Organization's ones (WHO 2017).

While the PHAC certainly increased national capacity and provided direction in pandemic management, it focuses on multiple areas beside pandemics including building public health infrastructure, health promotion and chronic disease prevention. As Figure 9 shows, funding explicitly directed to infectious diseases and health security, which comprise more than just influenza, has varied throughout the years. A large commitment after the H1N1 pandemic was followed by incremental increases more recently.

It was these organizations which faced the COVID-19 pandemic. Although not built specifically for emergency management, they did have experience with several earlier disease outbreaks which positively affected their level of preparation for, and expertise in, dealing with the 2019–2020 coronavirus outbreak.

SARS and its effects

An important precursor to COVID-19 for these agencies was the SARS outbreak in 2003–2004. As Severe Acute Respiratory Syndrome (SARS) index cases emerged in Toronto and Vancouver, influenza pandemic preparedness in Canada was not particularly high, after all the last pandemic has occurred in 1968 (H3N2 virus) (Health Canada, 2004). Both persons initially infected in the country were infected in Hong Kong. But, while the Vancouver patient saw a doctor immediately, who picked up on a possible connection with an atypical pneumonia that had been recently noted in China, and was isolated, the Toronto one went home triggering a series of infections both in the

community and later at the hospital (McDougall, 2014). Ontario reported many deaths, significant stress to the health-care system, and underwent a shutdown costing the Province about 1 USDB. Additionally, over 40% of those infected by SARS were health-care workers, a category that represented a 'blind spot' in the planning (Low, 2004).

Such was the institutional concern that a provincial commission was appointed to review the events. The report's opening remarks were beyond blunt:

> SARS showed that Ontario's public health system is broken and needs to be fixed. Despite the extraordinary efforts of many dedicated individuals and the strength of many local public health units, the overall system proved woefully inadequate. SARS showed Ontario's central public health system to be unprepared, fragmented, poorly led, uncoordinated, inadequately resourced, professionally impoverished, and generally incapable of discharging its mandate. (Campbell, 2004, p. 1)

SARS demonstrated the need for a dedicated public health agency, highlighted how clear competencies needed to be established, coordination and communication among actors improved, and resource allocation optimized (Health Canada, 2004; MacDougall, 2007). In particular, risk communication was at times problematic with conflicting messages given to the public (Tyshenko & Paterson, 2010) and information exchange with Asian countries that faced the outbreak early was spotty, thereby missing the opportunity to learn from those experiences.

Canada's federal structure played a role too: British Columbia, where a provincial Center for Disease Control had been established early on, confidence in the procedures and experts was well established, responded almost automatically and was more successful. Generally, however, intergovernmental roles and responsibilities in the area were found to be unclear, hindering collaboration and integration and impacting the effectiveness of responses. For example, a lack of formal reporting protocols among municipal, provincial, and federal governments limited data sharing both nationally and with the WHO. SARS also stressed the new 'interconnected' nature of modern outbreaks, which were likely to spread very fast, especially due to broadly available international flights (Thompson, 2020).

SARS was not a pandemic but it triggered significant reactions and learning on the part of both the domestic and international public health systems. In Canada, the recognized need for national guidance (Health Canada, 2004) led to the creation of the Public Health Agency of Canada (PHAC) in 2004 (O'Sullivan & Phillips, 2019) and contributed to the creation of Ontario's own public health agency in 2008. In 2005, updated International Health Regulations were agreed upon by 196 states, entering into force in 2007.

By 2006, when the particularly deadly H5N1 outbreak occurred, the PHAC had substantially revised the Canadian Pandemic Influenza Plan for the Health Care Sector (CPIP),[1] which contains a strategic approach to pandemic management and various regularly updated annexes dealing with areas including planning, clinical care, vaccines and so forth. The CPIP has two overarching goals: the first is minimizing serious illness and overall deaths through both individual and community choices and to deliver care for pandemic patients while supporting regular health-care delivery. The second is

[1]The original CPIP was drafted in 1988 and was limited to a vaccine strategy. In 1997, after the Hong Kong H5N1 outbreak, it was updated to provide a more comprehensive approach to public health management.

minimizing societal disruption by ensuring that stakeholders do not lose trust in the system and that the latter maintains capacity throughout the crisis, while working to return it to normal functioning levels as soon as possible (Public Health Agency of Canada [PHAC], 2018, p. 21). Operationally, it relies upon four core principles: cooperation with a broad range of stakeholders, use of evidence-informed decision-making, a proportional response to the severity of the threat, and – within a nationally coherent plan – the flexibility to develop specific responses in areas that are affected differently by the pandemic. In turn, the strategy would also be supported by three further principles: first, the commitment to use, especially early in the pandemic when information is scarce, a precautionary/protective approach that can be replaced by evidence-based choices as knowledge of the threat progresses. This would be flanked by the preferential use of established practices and systems owing to the difficulty to implement innovative solutions during an emergency, and finally to ensure that 'all actions respect ethical guidelines tailored to the concerns of public health, while respecting the rights of individuals as much as possible' (PHAC, 2018, p. 22).

These changes fit within a broader rehauling of Canada's multilateral emergency management process that occurred between 2001 and 2010 pitting a policy coalition favoring enhanced emergency response effectiveness over traditional administrative and political governance approaches, against one arguing that those historical governance approaches were needed to create effective public action. The latter ultimately succeeded and marginalized municipalities in this policy area in favor of the improved federal and provincial coordination and action (Juillet & Koji, 2014).

H1N1-09

This system was tested in 2009, when the H1N1-09 influenza spread further and faster than SARS, causing more deaths than previous outbreaks. While relatively mild it behaved atypically, presenting increased mortality rates for children, young adults, and pregnant women (Girard, Tam, Assossou, & Kieny, 2010), and disproportionally affecting remote communities (Moghadas, Pizzi, Wu, Tamblyn, & Fisman, 2011; Saunders-Hastings & Krewski, 2016).

The pandemic responses and strategies enshrined in the CPIC were implemented early: this involved advice on vaccines, protocols for health-care workers, discussions about school closures and foreign travel restrictions. For the first time in its history, Canada enlisted the help of mathematical epidemiologists to increase its response capacity (Moghadas et al., 2011, p. 84) and, during the Fall 2009 wave of the pandemic, the federal government invested 400 USD million in a broad vaccination campaign.

The PHAC took a leading role in the process providing guidance in clinical decisions and fulfilling the coordinating role that it had been assigned, supporting the idea that better confidence in the lessons learned with SARS led the system to better outcomes.

However, challenges still emerged. Specific responses varied, for example; partially this depended on which among three ideological takes about emergency management prevailed among stakeholders: an evidence-based one that gave primacy to scientific knowledge, a policy-based one that saw scientific evidence as informing but not determining policy choices, and a hybrid, pragmatic approach (Rosella et al., 2013, p. 3).

Secondly, Canada's institutional complexity continued to play a role: school closures were considered but, partially because H1N1-09 mortality was much lower than SARS, not explicitly advocated by provincial authorities (Moghadas et al., 2011) leaving the choice to School Boards, which generally opted against it. The same applied to community control measures, which were covered by 2009 PHAC guidelines, but Provinces and Territories were responsible for deciding what would be implemented and how, resulting in a mix of approaches.

However, we also find evidence of policy 'stickiness': when, during the outbreak, epidemiological models used did not match the emerging evidence, plans still were adhered to because of a mix of inflexibility and desire to avoid potential conflict (Rosella et al., 2013) in a system where interjurisdictional coordination is a hard-fought result. With H1N1 we also notice that the overall level of confidence affecting pandemic management responses in Canada is a function of local, regional and federal levels of confidence, which vary and are affected by political factors and the role of experts in each jurisdiction.

Institutional complexity also hindered a smooth integration among those who dealt with scientific evidence and policy-makers both at the communication level and in understanding how evidence affected policy decisions (Rosella et al., 2013). Finally, pandemic response preplanning for hospitals certainly helped the response by making a strategic framework available across the country but implementation was a different matter. Many Ontario hospitals reported that their influenza planning processes were not adequately resourced or complete (Zoutman, Ford, Melinyshyn, & Schwartz, 2010) and the PHAC pandemic surveillance and data generation capacity resultingly was inadequately resourced, which was compounded by unclearly defined roles and responsibilities for the various agencies (Saunders-Hastings & Krewski, 2016). So, while the quality and reach of pandemic response had improved since SARS, providing better central coordination and improving the capacity of health-care structures to cope with the increased numbers and severity of cases remained an issue. And other important challenges remained with regards to common communication, policy convergence in areas like community mitigation strategies, in appropriately resourcing the system, and in defining the roles and responsibilities of the actors.

Many of these problems were overcome in the case of COVID-19; however, by the transition of policy-making from 'business-as-usual' federalism to emergency federalism, which allowed the country to transcend its usual punctuated gradualist style. Economic interventions and social distancing rules that would have been absolutely unthinkable under day-to-day federalism were speedily adopted, a wave of unprecedented interjurisdictional cooperation emerged and while the response was far from perfect, citizens generally approved and supported of this approach.

Conclusions

Policy responses to pandemics vary enormously at the national level (Silva et al., 2015), and these responses are culturally and historically mediated (Tyshenko & Paterson, 2010). In some cases, though, like COVID-19, their sheer speed and scale represent critical opportunities for changes in policy-making and overcoming limits to existing policy styles. While this process, as the article on Italy contained in this issue shows

(Capano, 2020) is not automatic, it can and did occur in Canada. Canadian pandemic management evolved throughout the 21st century outbreaks towards a more integrated policy system as the SARS and H1N1 experiences showed it did not – and likely could not – overcome either regional differences in capacity and policy approaches or the natural policy fragmentation of a federal system when normal policy-making processes, norms and structures remained in place. By the same token, when jurisdictions were confident in the capacity of their institutions and management approaches, they could react in a faster and more coherent fashion, which appears to have positively influenced health outcomes, when these norms and traditions were over-ridden by the nature of the emergency.

Like the traditional Canadian policy style, pandemic management shows a pattern of punctuated gradualism: incremental negotiation, where federal-provincial actors are dominant, followed by short bursts of hyper-activity during emergencies and changes immediately afterward, which we can classify as adaptive policy learning. During emergencies, however, when the level of the threat is high and the perception of the danger is shared among the key policymakers, the process becomes much more cooperative (See Table 2), shelving much of the negotiation and haggling that is present during periods of 'normal' policymaking while the federal government takes on a policy scope and capacity resembling 'emergency centralism' (Black, 1975).

Outside of emergency periods, punctuated gradualism favors a progressive improvement in the strategic frameworks grounding cooperative action, and this was evident in the reviews undertaken of the country's efforts during the SARS and H1N1 events. Policy cooperation among federal and provincial authorities, however, was especially evident during COVID-19, but this policy style does not ensure or even foster top-down approaches to future pandemic management. In general, the existing management model's strength lies in its ability to tailor responses to different needs, but in exchange for a weakness in areas where coordination is key. These include communication among key stakeholders in the medical, administrative and political realms, which was an issue throughout the past 20 years (Moghadas et al., 2011; Rosella et al., 2013; Tyshenko & Paterson, 2010) and in the struggle Canada's jurisdictions faced in building a national infectious disease surveillance system (McDougall, 2014). Resources on the ground can be limited and very differently distributed among jurisdictions, with cities remaining marginal in the policy discussion (Juillet & Koji, 2014) and extremely vulnerable financially to lockdowns. Most concerning from a policy perspective, is that outbreaks regularly highlight extremely costly 'blind spots' in the model: tracing and health-care workers protection with SARS, the impact on remote communities during the H1N1 pandemic, and long-term care homes during COVID-19.

COVID-19 is the exception that proved this rule, undertaken on a one-off emergency basis, the Canadian government's response to the pandemic, while basically successful, highlighted that the Canadian policy style is optimized to nudge diverse approaches closer as opposed to creating a single policy response. Initial approaches, policy tools, communication, institutional roles and data existed in a fluid space where negotiation and difference are a constant. Such approaches may function well in most instances and address the diverse nature of the country but are unsuited to once in a century crisis of the kind caused by COVID-19. As the pandemic showed, different approaches can be

a benefit but policy learning also requires drawing lessons from such emergencies and this should be a key policy focus going forward.

Disclosure statement

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