

Opening up Canadian Federalism the European Way
Coordination of Health Care Policy
May 16th, 2014, Halifax, Nova Scotia

Workshop report by Melissa Bonga, Carleton University Student Rapporteur

On May 16th, 2014, approximately thirty individuals gathered at the Dalhousie University Club to reflect on how health care policy is managed in Canada using the Open Method of Cooperation (OMC) of the European Union (EU) as a frame of reference. The discussion focused on how health care policy is currently developed in Canada and whether the informal policy making processes of the OMC could be useful within the context of Canadian federalism.

As described by Donna Wood, Adjunct Assistant Professor of Political Science at the University of Victoria, the EU has facilitated supranational conversations about social policy between twenty-eight Member States, in part through the use of the OMC model. Dr. Scott Greer, Associate Professor of Health Management and Policy at the University of Michigan's School of Public Health, provided an overview of the OMC's evolution. Dr. Greer described the OMC as a soft law mechanism used to circumvent the legal and fiscal constraints of the EU and insert social concerns, such as health care, into the broader economic agenda. Although the OMC is not without its weaknesses, having any kind of platform to discuss social issues in EU politics is no small thing. Dr. Greer explained that the OMC allows Member States to set joint targets in specific areas of concern. While there is little evidence for the OMC changing policy in member states, the evidence for the OMC changing European debates is better, presenting bigger opportunities for change.

Katherine Fierlbeck, McCulloch Professor of Political Science at Dalhousie University, elaborated on the EU's approach to health care policy through the OMC. By focusing on non-binding exercises in mutual learning, such as joint ventures, research networks, high level reflections and health forums, the OMC enables networks of experts to address health care issues in ways that strict legal harmonization does not allow. Reflecting on Canadian health care practices, Dr. Fierlbeck expressed that Canadians need to avoid thinking about progress only in terms of hard constraints at the federal level. Dr. Fierlbeck believes that an expected federal budget surplus next year could be an opportunity to incentivize provinces to improve their performance. Provincial funding could be provided, in a non-competitive fashion, based on that province's performance, which would be measured by commonly developed indicators. Since many provinces do not have the fiscal or policy capacity to operate beyond the day-to-day, funding in this way might encourage provinces to make use of pooled networks of experts in some kind of voluntary federal discussion body so that they can get more funding.

Reflecting further upon the Canadian health care system, Bill Lahey, Associate Professor at the Schulich School of Law and the School of Health Administration at Dalhousie University, noted that while health laws across Canada are already significantly coordinated for a decentralized system, there is a lack of national approaches to issues that have a pan-Canadian dimension. Reflecting upon whether Canada could implement an OMC style approach to encourage national, and not necessarily federal, level coordination, Dr. Lahey offered the following four considerations:

- 1) Target cooperation between provinces and the federal government in specific areas where national cooperation is important (such as pharmaceuticals; health human resource planning; and health information systems);

- 2) Look to the OMC to help address policy issues that cut across sectors beyond health care where the federal government does have jurisdiction, such as seniors.
- 3) Consider a regional OMC process, for example in Atlantic Canada, to bring more attention to the region's distinctiveness; build local capacity; and respond to pressures created by new federal funding formulas. This could be more feasible in practice.
- 4) Look to developing an arms-length institution that is independent and possessed of real authority to direct change and to encourage accountability for that change. This is necessary in order to ensure follow-up and place a permanent ongoing focus on conversations between jurisdictions.

Speaking from a civil society perspective, Krista Connell, Chief Executive Officer (CEO) of the Nova Scotia Health Research Foundation, stressed the need for better evidence to fuel collaborative and creative decision making when it comes to health care. Ms. Connell reflected upon the need to create spaces where various actors from academic, policy communities and health care providers can connect to share knowledge. She also talked about the need to deconstruct the system to look at issues preventing evidence currently available from being fully used.

Vijay Bhashyarkarla, Director of Intergovernmental Affairs for the Nova Scotia Department of Health and Wellness, stressed the need for an incentivized model of some kind to encourage collaboration in our decentralized federal system. From an intergovernmental affairs viewpoint, Mr. Bhashyarkarla sees the federal government as a bonding agent. Provinces at the negotiating table tend to focus on their geographic uniqueness, and what can be gained from that uniqueness, rather than advancing health care at a national level. Having the federal government present creates an incentive for the larger provinces to collaborate with smaller provinces. Furthermore, as the federal government withdraws from the conversation between provinces, the absence of a clear mechanism to understand how funding is being sent means that less funding is provided and some provinces provide better care than others. In this way, Mr. Bhashyarkarla believed there may be a role for an OMC type approach in terms of encouraging and institutionalizing discussion between high-placed experts and individuals, such as Deputy Ministers.

The discussion among workshop participants centered on the four considerations provided by Professor Lahey. There were some concerns that an OMC style approach would inevitably conflict with economic and funding realities in Canada; that without political will an OMC model would not translate to policy; and that ultimately the involvement of the federal government would be the determining factor in changing health care policy. There were also some hesitations about an arms-length institution overseeing change in health care policy and how they would ensure accountability if they reflected the government of the day's agenda. However, most participants agreed that there was something to be learned from EU coordination efforts. For example, the idea of a regional OMC model was well received to facilitate coordination in specific areas. Participants believed that undertaking targeted initiatives in a cross cutting agenda, as the OMC model does, is needed at the national level. Overall, participants found that the OMC model provides an informal structure that enables interested parties, especially civil society organizations, to be involved in the policy making process by making it clear when these parties can provide input and by giving them the space to do so. Participants found that a clearer structure in this regard would be useful in Canada.