

FROM NATIONAL ACCORDS TO BILATERAL AGREEMENTS: TRANSFORMING CANADIAN HEALTH- CARE INTERGOVERNMENTALISM

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SUMMARY

This paper examines the transition from the “era of the health accords” (from 2000 to 2017) to the new regime of individual bilateral agreements between Ottawa and each of the provinces and territories, allocating federal health transfers and setting agreed-upon health-reform priorities in each jurisdiction.

The paper argues that the health accords of 2000, 2003 and 2004 were essentially unsuccessful for a number of reasons. First, they tended to raise expectations among the public, health system actors and health policy experts about the ability to transform health care in Canada in a relatively short period of time. This was, in part, a result of the accords’ very broad and general commitments to change, but also their lack of recognition of the barriers to change that exist within the system.

Second, and related to the first, attention was paid mostly to the amount of the transfer from the federal government to the provinces and territories, rather than to how those dollars were to be spent. At best, governments bought only a modest amount of change in the system, despite the billions of dollars of new investment.

Unlike other industrialized federations, Canada appears to be the only one that relies on an ongoing, highly politicized process of intergovernmental

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diplomacy to negotiate the fiscal relationship in health care. This, combined with a somewhat amorphous and changeable understanding of the federal government's overall role in health care, complicates the process of reform and heightens the political stakes around the negotiations.

The new model of bilateral agreements negotiated under an umbrella statement of common principles around health-reform priorities may yet prove to be an improvement in both process and outcomes. Bilateralism can serve to de-escalate the political stakes inherent in the federal-provincial diplomacy around Canada's most popular social program, by moving away from the "grand bargains" that characterized the accords. In short, there will be less opportunity for the kind of political rhetoric that unduly raises expectations of rapid change.

More importantly, the bilateral agreements, although far from perfect, may actually better serve to focus attention on the specific health-service organization and delivery issues the provinces and territories intend to improve, restructure or expand. Under very broad principles such as "improving access to mental health and community care," the bilateral agreements articulate some very clear plans about specific approaches, programs and policies on which the transfers will be spent. This should provide a much greater opportunity for the Canadian public to hold governments to account for progress in those areas, something the accords never really managed to do.

Going forward, there is still room for improvement. Some provincial plans are decidedly vague, and governments should be urged to be more specific in their commitments and intentions. Common indicators continue to be difficult to develop, although big strides have been made in recent decades. Governments would be well advised to talk seriously and openly about the challenges and barriers to change that exist within the system and, in doing so, marshal public support to dismantle them. And the federal government itself needs to actively engage in assisting jurisdictions in learning from and adapting the successful reforms and initiatives of other jurisdictions. This could be an act of true system stewardship.

GENERAL INTRODUCTION

In 2017, the federal government took a new approach to that taken in the early 2000s to move forward on health system priorities. The government worked with the provinces and territories (PTs) to identify shared health priorities for federal investments, develop common areas of action within these priorities through an FPT framework, and then negotiated bilateral agreements with each PT. COVID-19 has highlighted the need for resilient health care systems that will continue to meet the needs of Canadians today and in the future.

It is in this context that in April 2021, the School of Public Policy convened a group of health policy experts to develop research papers on various aspects of the evolution of health care in consultation with Health Canada. These experts have a diverse range of perspectives on issues related to Canadian health systems. Health Canada was consulted on the list of topics, but the orientation of each paper, the methodology, as well as the substance of the recommendations were left entirely to the discretion of the authors.

We are proud to share the result of this process. Each paper in this series of eight was subject to the intense scrutiny, and discussed extensively following detailed roundtable presentations. Two eminent health policy experts were also asked to conduct a careful double-blind review of the papers, with a special focus on rigor, readability, and relevance. We believe these policy briefs offer a rare combination of original thinking, deep subject expertise, and technical feasibility: a perfect balance between the very practical needs of the end users of the research and the independent and innovative spirit that pervades all the work originating from the School of Public Policy.

INTRODUCTION

In December 2016, negotiations between the federal government and the provinces over a new national “health accord” broke down over the provinces’ refusal to accept a reduction in the size of the annual increase in the federal transfer. As a result, the federal government, represented by then minister of health Jane Philpott, announced its intention to negotiate separate bilateral agreements with each province on federal contributions to each province’s publicly administered health-insurance system. In addition, the federal government and the provinces would sign onto A Common Statement of Principles on Shared Health Priorities that would outline priority areas for service improvement and commit to better performance measurement and reporting to Canadians on outcomes.

The era of national health accords that combined both financing arrangements and health-system reform priorities seemed to be at an end. Some saw this as admission of defeat that substituted a national health-care system bound together by shared principles and funding arrangements with a “balkanized” arrangement of 10 separate systems, each operating independently. They argued that it was the health accord that made the provincial, territorial and federal health-care systems into a “national” system, and a national system was needed if governments were ever to realize long-sought reforms to things such as primary health care, an integrated continuum of care, and improved mental health and community care.

However, this paper will argue that the past accords, including the 2004 “fix for a generation” that expired in 2017, did little to either create a single national health-care system or further the process of significant health reform called for by the National Forum on Health, the Romanow report, the Kirby report or any of a number of provincial studies that had all pushed for more or less similar agendas for change. Indeed, separating the money from the policy priorities and the reporting on performance may actually allow governments to focus on both, rather than letting the system simply absorb all of the new dollars invested without ever achieving the promised reforms, as in the era of the health accords.

“The answer to our health-care system’s lacklustre performance in terms of quality outcomes and patient satisfaction is not to continue to spend at twice the rate of inflation. Rather, it is to take a long, hard look at how we are spending the dollars already allocated and making the choice to fund the system we want, not to simply replicate the one we have.” (McIntosh 2017)

But this does not come without caveats. If the key lesson from the health accords is that money in and of itself does not “buy change,” then we need to focus more determinedly on what does make change. And we need to be able to replicate and share that change across provincial boundaries. That takes a willingness on the part of the provinces to tackle the rigidities and barriers to change in their own systems. Further, it requires a commitment from both levels of government to the kind of co-operation and collaboration that built medicare in the first place. As imperfect as they are, the current bilateral agreements may provide a starting point for this.

THE ERA OF THE HEALTH ACCORDS AND REINFORCING FEDERAL STEWARDSHIP

In 1995, the Canadian federal government rewrote the rulebook on federal funding for Canada's provincially administered public health-care system(s) by unilaterally (and with little notice) amalgamating federal social and health transfers into a single contribution to provincial coffers and, in the following budget years, cutting the amount transferred by over \$6 billion (Commission on the Future of Health Care in Canada 2002, 312). This transformation of federal transfers to the provinces was in line with other actions by the federal government to balance its own books, which also included the restructuring of employment-insurance (EI) eligibility that reduced program expenditures and allowed the so-called "EI surplus" to be used for deficit and debt reduction (Boychuk and McIntosh 2001; Courchene and Allan 2009).

Unsurprisingly, the creation of the Canada Health and Social Transfer (CHST) and the cuts to the size of the transfer infuriated provincial governments. And this made very public the ongoing push and pull between federal and provincial governments over the size and nature of the federal funding envelope for Canada's public health-insurance system. From the creation of a cost-shared system of hospital insurance in the 1950s, to the addition of medical insurance in the late 1960s, through the era of Established Programs Financing (EPF,) to the consolidation and reaffirmation of an intergovernmental commitment to public health insurance under the Canada Health Act (1984), the financing of health care in Canada has been a cogent example of what Simeon (1972) called "federal-provincial diplomacy." While the changes over time in the financing means and amounts for the provincial health insurance systems is outlined in the contribution to this series of Béland and Tombe (2021), suffice it to say that the 1995/96 changes were undoubtedly a watershed moment that heightened the political debate over the future of Canada's public health-care system.

How much does the federal government contribute to the system? How much should it contribute? Do the tax points transferred to the provinces in the 1970s count as an annual federal contribution? What exactly should be the role of the federal government in the oversight of the system? What obligations does the federal contribution impose on the provinces when it comes to the organization and delivery of health services to the public? Is the current structure of the system sustainable into the future? And what, exactly, is meant by "sustainable"?

The often bitter and contentious debates over health-care financing and reform in the late 1990s came to a head in 2000 and 2001 with two significant developments. In September 2000, the first ministers released the Communiqué on Health, which saw major federal reinvestments in health-care funding. The CHST would increase by \$21 billion over five years and included \$2.2 billion for early childhood development, as well as dedicated funds for medical equipment, health information technology and the creation of an \$800-million Health Transition Fund for Primary Care (CICS 2000). The following summer, the federal government appointed former Saskatchewan premier Roy J. Romanow as head of the Commission on the Future of Health Care in Canada, the first full-scale national investigation of Canada's public health-care system since the Royal Commission on Health Services headed by Emmett Justice Hall in the 1960s.

The Communiqué on Health marked the beginning of the era of “health accords” — intergovernmental agreements combining both financing commitments from Ottawa and health reform priorities to be undertaken by the provinces. This first accord, and those that followed, were subject to significant media attention and political commentary (cf. Bryden and Cryderman 2000; Walkom 2000). Unlike the changes to health financing in the past (e.g., from the cost-shared programs to the creation of EPF), the agreement came after half a decade of significant and very public intergovernmental tension following the 1995 cuts. They could not but be seen as a step toward a truce in the “health-care war” between the federal government and the provinces.

The appointment of the Romanow Commission was another key element in this, not because it had immediate impact on the intergovernmental situation (although it certainly would, as it did its work over the next 18 months), but because it heightened the political and public attention paid to health care, its financing, its reform and medicare’s standing as a key element of the Canadian identity (Mendelsohn 2002; Soroka 2007). Through a combination of traditional public hearings, an innovative process of citizen engagement, and sustained media attention, the commission focused the spotlight on the issue of the state of Canada’s health-care system in an unprecedented manner (McIntosh and Forest 2010). It was aided in this by the presence of a parallel investigation into the health-care system led by then senator Michael Kirby (Canada 2002) that was built upon the idea — as it had emerged from provincial reports in Saskatchewan, Alberta and Quebec — that the health-care system needed serious reforms (Fyke 2001; Mazankowski 2001; Clair 2001).

Health care was a “big issue” that demanded a “big response” — and the idea of national accords that committed both orders of government to various actions, combined with transparent public reporting, certainly fit that bill. By the time of the release of Romanow’s final report in 2002, there was a public expectation that there would be a big response from governments, one that spoke to both financing and reform priorities (McIntosh and Forest 2010). Thus, an intergovernmental mechanism like “a national accord” fit that bill perfectly.

The Communiqué on Health was also important politically, because it was meant to send a signal to the Canadian public that the federal government acknowledged its role in preserving and protecting medicare. Beyond its own constitutional obligations in the area of health and health care, and its legal obligations to contribute to provincial health-care financing, successive federal governments had long insisted that the federal government played an important, although vaguely defined role as the system’s protector or steward.

This role is perhaps best symbolized by the talisman-like status accorded by Canadians to the Canada Health Act (CHA). The CHA was passed at a moment when the medicare bargain, struck in the late 1960s, was fraying as debates were emerging about the size of the transfer, physicians “extra-billing” patients, and the role of private payment for insured services. The act reasserted the federal government as the one actor that would and could preserve medicare’s promise, by enunciating the five principles (conditions) that provinces must meet to receive federal transfers (accessibility, universality, comprehensiveness, portability and public administration). It is this legislation that, in

the eyes of the public at least, ensures that a system composed of 10 provincial and three territorial insurance schemes has a national character. And standing behind that legislation is a federal government willing to enforce those conditions.

Of course, the reality is far from that, as Choudhry (1996) demonstrated. The federal government, except in cases of “extra-billing,” has rarely penalized a province for violating the terms of the CHA. Never has a province been penalized for its health services being “not accessible enough” or “not comprehensive enough.” But the public believes the federal government could do it if it had to (Mendelsohn 2002; Soroka 2007).

The fact of the matter, though, is that the federal role as steward, as ill-defined as it is, relies on more than the terms of the CHA and its potential to bring “errant” provinces in line. What backs up the authority conferred by the CHA is the financial contribution the federal government makes to provincial health budgets. The 1995 cuts lessened the federal government’s ability to portray itself as the system’s steward, because it looked to both provinces and the public as if the federal government was walking away from its role in preserving medicare’s national character. What good is the threat of reducing a province’s transfer if the transfer itself is declining in value?

And this is the heart of the federal-provincial diplomatic dance over health-care financing. The federal government needs to contribute enough to provincial health care to have a voice in shaping its national character (and to back up the necessity of adhering to the CHA’s principles), but not so much as to limit its own fiscal capacity to do other things. The provinces want as much money from the federal government as they can get, but with as few conditions and with as little voice for the federal government as possible, so as to not limit provincial policy choices.

Thus, the health communiqué’s political import lay in its clear signal, by restoring the cuts it had made to the transfer in 1995, that the federal government was back in the health-care business. And that reinvestment bolstered the federal government’s ability to portray itself to the Canadian public, again, as the steward and defender of medicare.

THE 2003 AND 2004 ACCORDS: CONSOLIDATING A NEW BARGAIN

It is worth noting that there are no real analogues in other leading industrialized federations to the Canadian model of periodically renegotiated national accords on health funding. In Germany and Austria, both orders of government transfer funds to the Statutory Health Insurance instruments that allocate funding for services (Blümel et al. 2020; Bachner et al. 2018). The Spanish national government transfers money for health care to the autonomous communities, but this is governed by statute rather than by intergovernmental negotiation (Bernal-Delgado et al. 2018). In Australia, the states share the funds collected from the goods and services tax, as well as additional block funding, based on recommendations of an independent Commonwealth Grants Commission (Healy, Sharman and Lokuge 2006).

The closest parallel to Canada may be the United States. The American federal government has provided funding to the states for the delivery of Medicaid (and its recent expansion to cover more uninsured Americans) but, again, this is a statutory device and subject to voluntary uptake by individual states (Rice et al. 2020).

Canada, it seems, is the only industrialized federation whereby federal-provincial diplomacy in the form of high-level political negotiations (rather than statutory instruments) can be determinative of the size and nature of the transfer for health spending. This leaves the process subject to occasional instances of federal unilateralism, as in the 1995 CHST cuts or the 2014 extension of the 2004 accord, despite the political stakes of such moves. Even barring unilateral action, the Canadian process intensifies and politicizes the diplomatic efforts on both sides of the table, as governments must keep one eye on the perceptions of the public and the media about such negotiations. And, again, this is where the public perception of the federal government as medicare's protector or steward has real political currency, insofar as the public trusts the federal government more to protect publicly administered health care than it does provincial governments.

The first post-Romanow accord arrived in 2003, and continued to combine both funding commitments from the federal government and reform and improvement priorities for the provinces. Perhaps most notably, the 2003 agreement called for the division of the CHST into a Canada Health Transfer (CHT) and a Canada Social Transfer (CST), as well as calling for a federal commitment to predictable annual increases to the CHT. In the interim, CHST cash would be set at \$5.4 billion in 2002/03 and increase by \$1.7 billion in 2003/04 or 18 per cent of health and social expenditures by the provinces. In addition to a vaguely worded commitment that the federal government will "work with Aboriginal Canadians and provinces and territories to fulfill its responsibilities to Aboriginal peoples", the accord set out a long list of investment priorities, including:

- Primary health care: Enhancing first-contact services close to home.
- Home and community care: Providing appropriate care, including seniors' home care, and services at residential centres.
- Community mental health: Improving services through an appropriate mix of community-based and client-centred services.
- Medical diagnostic services: Investing in health technologies.
- Health human resources: Ensuring an appropriate supply and distribution of health human resources.
- Pharmaceuticals: Ensuring access to appropriate, safe, high-quality and cost-effective prescription drugs.
- Shortening wait times for specialized medical and hospital services, including modernizing health facilities.
- Healthy living: Focusing on prevention and wellness. (CICS 2003a)

The accord created a new Health Reform Fund for primary health care, home care and catastrophic drug coverage, as well as a Diagnostic/Medical Equipment Fund,

and promised investments in information technology and electronic health records (all priority areas identified by the Romanow report). The accord called for annual reports to citizens on three priority areas of the Health Reform Fund and an agreement “to use comparable indicators and to develop the necessary data infrastructure for these reports” (CICS 2003b, 4). The accord also included an annex on performance indicators that directed health ministers

“... to develop further indicators to supplement the work undertaken in follow-up to the September 2000 Communique ... to be completed by September 2003 ... to ensure these new indicators measure progress on achieving the reforms set out in this Accord and meet the following objectives:

- “Timely Access: the measurement of access to essential services across the country as well as waiting times;
- “Quality: the measurement of quality of health-care services across the country, including patient safety, patient satisfaction and health outcomes;
- “Sustainability: including measurements of the state of health human resources, equipment, information systems and value for money from the system; and,
- “Health Status and Wellness.” (CICS 2003b, Annex A, 1)

The 2003 accord was, in effect, a stopgap — a quick response to the Romanow Commission and other health-care reports calling for significant refinancing and reform of the system. The “grand bargain” was to come in 2004, after the CHT and CST had been created, with what was billed as “A 10-Year Plan to Strengthen Health Care” that then prime minister Paul Martin famously touted as “a fix for a generation.” It included over \$41 billion in new federal money for provincial health-care systems meant to meet “the financial recommendations of the Royal (sic) Commission on the Future of Health Care in Canada, as well as to address wait times ... (and) ... accelerate and broaden health renewal and reform ... ” (Canada 2004a).

The 2004 “action plan” provided immediate investments of \$1 billion in 2004/05 and \$2 billion in 2005/06 and set a new base of \$19 billion for the CHT beginning in 2005/06. An additional \$500 million would be provided in 2005/06 for home care and catastrophic drug coverage, another \$500 million for medical equipment, and \$700 million more over five years for new federal Indigenous health initiatives. Beginning in 2004/05, the federal government would invest \$4.5 billion over six years in a Wait Times Reduction Fund, and in 2010/11 it would provide \$250 million annually for health human resources. But perhaps most importantly, for the first time, the provinces would be guaranteed significant annual increases in the CHT. Beginning in 2006/07, a six-per-cent escalator would be applied to the base until the agreement’s end in 2014 (Canada 2004a).

The 2004 accord reaffirmed the governments’ commitment to the principles of the Canada Health Act and the axioms that “access to medically necessary health services (must be) based on need, not ability to pay” and that “all Canadians (should) have access to health care services they need, when they need them” (Canada 2004b).

The governments also issued a separate communiqué on Aboriginal health. And, in perhaps a hint of what the future held, a separate communiqué was issued between the government of Canada and the government of Quebec regarding the implementation of the 10-year plan, giving Quebec the right to use the new federal investments to ensure “access to quality care in a timely manner and ... (to) reduc(e) wait times” (Canada 2004b).

In addition to the increases in funding, the 2004 accord highlights, again, a series of significant areas of needed reform and improvement in the system, including:

- Development of comparable indicators around access to health professionals, diagnostics and treatment procedures to be done by December 2005.
 - Evidence-based wait times for cancer and heart treatments, diagnostic procedures, joint replacements and sight restoration.
 - Establishing benchmarks for these procedures by December 2007 and reporting on progress to citizens.
- Accelerated work on health human-resource action plans that set targets for increasing the supply of health professionals.
- First-dollar coverage for short-term acute home care, acute mental-health home care and end-of-life case management.
- Establishment of a primary-health-care best-practices network to further the commitment that 50 per cent of Canadians have 24/7 access to multidisciplinary teams by 2011.
- Establishment of a \$150-million Territorial Access Fund to improve health-services access in the North over the next five years.
- The development of a national pharmaceutical strategy that would include:
 - Options for catastrophic drug coverage.
 - Development of a national drug formulary.
 - A variety of measures to lower the cost of pharmaceuticals for Canadians, including accelerating access to non-patented drugs, changing the prescribing practices of physicians, and understanding best practices in drug-plan policies.
- Increased emphasis on health promotion, disease and injury prevention and public health.
- Investments in health innovation, technology and research.

The 2004 accord was met with decidedly mixed reaction by the media and by the health-sector itself. Overall, the criticisms were centred on two different aspects of the accord. First, and perhaps the most prominent, was the concern expressed by many that the very significant financial commitments that were binding on the federal government were not matched by strong enough conditions on the provinces to ensure that the money did, as the Romanow report urged, “buy change” in the system.

For some (Aubry 2004; Coyne 2004a), the money itself was the problem. The commitment was too large and relied on continued federal surpluses to be affordable, especially given the seemingly generous escalator guaranteeing six-per-cent annual increases in the transfer.

For others (Laghi, Clark and Fagan 2004; Hill Times 2004; Dawson 2004), the size of the financial commitment was less of a problem than was the concern that, without stronger commitments to actually achieving the reform goals, the money itself would simply buy more of the same. In the words of then senator Kirby (2004), “the first ministers perpetuated the myth that health-care reform can be achieved painlessly for everyone involved: No one employed in the health-care system will need to change the way they work; all health-care workers will get significant wage increases, and no Canadian will have to pay more in taxes ... None of this is true in reality. There is no painless cure to the problems facing the health-care system.”

An editorial in *The Globe and Mail* (2004) took a similarly skeptical view, looking back at how long it took for the governments to create one of the promised accountability mechanisms of the 2003 accord, the establishment of the Health Council of Canada:

“This deal is stronger on accountability than the previous one, signed by ... (former prime minister) Jean Chrétien, and the premiers in February, 2003. That agreement provided for a host of reforms in return for \$27.5-billion in new federal cash over five years. But a key monitoring group created by that deal, the Health Council of Canada, received its first budget approval (for all of \$6-million) only within the past two weeks. Its long gestation suggests the first ministers’ weak commitment to accountability, and explains why no one has a clear idea of what Canadians received for all that federal money.”

“The new deal may founder in exactly the same way. The accountability language is improved, but still tentative.”

The other key area of concern at the time, but which garnered far less attention as time went on, was the asymmetrical federalism embodied in the accord through the separate agreement with the province of Quebec. This was seen by some as a capitulation to the decentralist forces that had slowly whittled away at federal authority and power over the past decades (Coyne 2004b), and by others as a threat to the very idea of a national health-care system (Walkom 2004a, 2004b).

For still others, the asymmetry of the deal was one of its stronger elements. Pratte (2004) noted the overall satisfaction for the deal within Quebec, and that the asymmetry was open to any province that wanted to take a somewhat different approach to health-system reform or wanted to emphasize different priorities. And for his part, the prime minister defended the deal as a boost to national unity rather than as a threat (Dawson and Curry 2004). Perhaps more interestingly, and certainly a portent of what would come, then Opposition leader Stephen Harper (2004) wrote approvingly of the accord precisely because it appeared to be driven by the premiers themselves, and challenged *The Globe and Mail*’s view about the public-accountability provisions:

“Unfortunately, the accountability measures in the 2004 edition are actually weaker than in its predecessor. The fall, 2003, deadline for developing reporting mechanisms on selected treatments such as cancer care, diagnostic imaging and joint surgery has been pushed back to December, 2005. While the old accord promised to implement catastrophic drug coverage for all Canadians by 2006, the new one merely requires the tabling of a report on pharmacare.

“The Conservative party is disappointed that the new agreement moves backwards, not forwards, in insisting on accountability for the use of taxpayers’ dollars. We will insist that both the federal and provincial governments live up to the commitments in this new agreement that they failed to meet under the previous one.”

For its part, the public was overwhelmingly supportive of the general thrust of the accord in 2004. Polling firm Environics reported that over 78 per cent of Canadians were somewhat or very satisfied with the increase in the size of the transfer. However, when asked about Quebec’s “exemption from some of the new provincial requirements,” some 67 per cent of respondents disapproved of the asymmetry in the agreement. They were more skeptical, but still hopeful, of the chance for progress on health reform, with almost 56 per cent believing the agreement provided an opportunity for some or significant progress, and nearly 34 per cent seeing an opportunity for only a little progress.

THE END OF THE ACCORD (AND MOVING TOWARDS BILATERAL AGREEMENTS)

The era of the health accords had been ushered in and nurtured by successive Liberal prime ministers. So, when the Conservatives formed a minority government in 2006, there was some concern about what the fate of the 10-year 2004 accord would be. Indeed, one of the new Conservative government’s first moves was to withdraw from the Kelowna accord, a series of agreements that sought to improve educational and employment opportunities for First Nations, Métis and Inuit peoples, which were struck between the federal government, the provinces and territories, and the leadership of national Indigenous organizations.

But for both philosophical and political reasons, the new federal government embraced the 2004 accord, albeit with some changes in the overall stance of the federal government toward provincial reform efforts. Politically, the accord effectively took health care off the table. After a decade of intense intergovernmental conflict with the Chrétien and Martin governments, the provinces had long-term, stable funding, with a significant yearly increase in the CHT. Whether the accords bought change in the system will be discussed later, but for the new government, it bought relative peace on the health-care file, at least in terms of spending, and that was sufficient.

More philosophically, the Conservative government of Stephen Harper had little interest in the traditional federal role as the steward or guarantor of Canada’s national health-care system. It fully accepted the federal obligation to contribute financially to

the provinces in support of medicare, but was generally content to let the provinces manage their systems as they saw fit. The asymmetry introduced in the 2004 accord also fit easily into the prime minister's own approach to what was termed "open federalism." Whereas previous federal governments saw their financial contribution to provincial health care as legitimating a federal voice in the overall direction of the system (and its reform), the Harper government defined its role more narrowly, to that of financier.¹ The 2004 accord made it difficult for the provinces to argue that the system was still woefully underfunded. Although health-care costs grew substantially in the first decade of the 21st century, averaging 7.1-per-cent annual increases (driven by the pent-up demand created by the cuts that began in 1995), they would slow to an average of 2.1 per cent after 2010 (McIntosh 2021, 302), all while the CHT continued to grow by six per cent per year.

If the provinces had decried the unilateral nature of the 1995 cuts under the Chrétien government, they were similarly unhappy with the Harper government's unilateral restructuring of health-care financing, which was announced after the 2011 election that secured a Conservative majority. Facing a far more constrained federal fiscal situation than existed at the time of the 2004 accord, then federal finance minister Jim Flaherty told the provinces that his government would extend the six-per-cent escalator until the end of 2017, but that it would then fall to three per cent per year or to the rate of inflation, whichever was greater. It was still an annual automatic increase in the CHT, but a much smaller increase (Bailey and Curry 2011; Fierlbeck 2013a).

This really marks the end of the era of health accords, for all intents and purposes. The 2015 election put the Liberals back in office with a majority government, and while there was some initial interest in a renewed accord prior to the expiration of the existing arrangements in 2017, there were a number of factors that mitigated against it. First, federal coffers were not nearly as full as they were in 2004, when the government was running annual, albeit manageable deficits. Provincial demands for an increase to the three-per-cent escalator beginning in 2017 were not going to be met.

Second, while overall health costs were tracking GDP growth in the economy, there were areas that needed investment and there was a concern that increases to the CHT could simply be absorbed by those parts of the system (such as physician compensation) that did not need substantial increases.

Third, provincial governments were backing away from the idea of another accord and the attendant political attention such agreements created, while the federal government itself was looking at its experience with different models in intergovernmental agreements in different sectors. In both early learning and in child care, the idea of an umbrella "statement of principles," followed by individual bilateral

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The one major exception to this approach to health-care intergovernmentalism on the part of the Harper government came with the government's commitment to "care guarantees" to reduce wait times. This was a promise made in response to the Supreme Court ruling in *Chaoulli v. Quebec (Attorney General)* that some saw as potentially allowing the creation of a parallel private-pay system of service provision in light of access issues in the public system. In the 2006 federal election, both the Liberals and the Conservatives promised action to reduce wait times, and the Conservatives provided additional funds to reduce wait times in key elective services in its 2007 budget (McIntosh 2021).

agreements covering detailed funding and reflective of provincial policy priorities and choices, were showing to be more promising than a single “grand bargain” that tried to cover principles, priorities and financing. And, after all, the separate accord with Quebec in 2004 had not shattered the ideals of medicare. Indeed, by 2015, none of those fears raised by the critics in 2004 had come to pass.

DID THE ACCORDS BUY CHANGE?

Beyond the questions surrounding the politics of national health accords, and the manner in which they tended to shape both the public and intergovernmental conversations about health care in Canada, is the more fundamental question of whether they achieved what they set out to do. Yes, they most certainly fixed the financing question to some great extent. The longstanding demand from provincial governments for stable and predictable financing, as echoed by Romanow, Kirby and the various provincial studies, was met. But that raised a subsequent question of whether general increases in how much was spent would change how it was spent. And here there are strong limitations to how directive the federal government can be with the provinces in that regard, and rightly so.

Perhaps the biggest criticism of the accords, from the media and the public, was that they were not conditional enough in terms of forcing provinces to (a) spend the money in the areas deemed to be priorities, and (b) report back to Canadians on the progress of reform. As appealing as the idea of putting strong conditions on the transfers might be to some significant section of the public and the media, however, there are real administrative, political and constitutional reasons why the debate over conditionality is something of a red herring when it comes to federal transfers.

First, because transfers go into provincial general revenues, it becomes nearly impossible to trace where the dollars go from there in terms of identifying which piece of a provincial health budget is funded in whole or in part by dollars originating as a federal transfer. Second, provincial resistance to conditionality is near unanimous as a matter of principle, insofar as conditionality would place provinces in the subordinate role of at least appearing to have to report to Ottawa on how they spend their money. Thus, the accords talk about reporting “to Canadians” or “to the public,” and not from one order of government to another (Lahey 2013). Third, the organization and delivery of health services is primarily within provincial jurisdiction and the federal government’s role in those aspects of it is somewhat limited (Leeson 2004; Braën 2004). The perception of the federal government as the system’s steward, regardless of how much it captures the public imagination, is not one it has played all that successfully in the past, and is certainly not how provincial governments see the federal role (McIntosh 2021).

But even if we dismiss some form of strong conditionality as a possible component of intergovernmental agreements on health care, the question remains whether the accords did indeed buy needed change in the system. It is fair to say the 2000 Communiqué on Health did what it was meant to do, at least politically. It dampened the intensity of the intergovernmental conflict over health care by restoring many of the

cuts made in the 1995/96 federal budget and calmed public concerns over the system's survival. As to change in the organization and delivery of care, it is impossible to judge the communiqué's effect, as it was soon superseded by both a somewhat different reform agenda (stemming from the health reports noted above) and subsequent accords. Similarly, the 2003 accord was mostly a fiscal stopgap that (as was admitted outright) was about filling the so-called "Romanow gap" in federal contributions. The accord that had the only real chance of buying change was the 2004 10-Year Plan to Strengthen Health Care.

There is also a methodological quandary in assessing the amount of change the accords brought to the system. The commitments themselves are vague, and the accords have no benchmarks that would indicate what success should look like. So it becomes nearly impossible to empirically say "we got X amount of change in area Y at a cost of Z dollars." What we have instead is a series of qualitative judgments rendered by persons of varied expertise looking at the overall impact of the accords on the systems' structures, organizations and outcomes. And what appears to frame most of the analysis is the question of whether the change achieved, be it modest or substantial, was worth the overall investment made. The sheer size of the reinvestment of funds made in 2004 colours virtually all of the analysis.

A 2012 review of the 2004 accord by the Senate's standing committee on social affairs, science and technology provided a commitment-by-commitment review of the 2004 accord and the communiqué on Aboriginal health. The results are decidedly mixed. The report notes improvements in access through reduced wait times for some services, such as joint replacements and diagnostic imaging, and some progress on the development of electronic health records. However, it noted that primary-care reform had not moved much past pilot projects in most jurisdictions. Further, much of the reforms were focused on increasing services rather than transforming their organization and delivery, so that the integration of health-care sectors and the focusing of attention on population health needs and the social determinants of health remained unattended to. Small progress had been made on pharmaceutical safety, but progress had stalled on both a national formulary and catastrophic drug coverage for Canadians (Canada Senate 2012a, 82-84). The chair of the committee summed up the assessment this way:

"The committee heard consistent testimony that there is sufficient funding in the health care system to meet the reasonable expectations of Canadians, but that has yet to occur ... Testimony also revealed that the system is replete with silos, with no overall accountability, and that true innovation is rarely recognized and implemented within the system. This must change." (Canada Senate 2012b)

The relatively sparse academic literature tells pretty much the same story. If there are consistent themes in those assessments, they are:

1. A lack of a fulsome accountability framework to report to Canadians (often linked to the inability of the Health Council of Canada to serve as a conduit for such reporting) (Vogel 2011 and 2014; Collier 2011).

2. Positive progress on the development of evidence-based benchmarks and comparative indicators, but little progress on making those relevant and available to the public in a manner that helps the public assess system performance (Fierlbeck 2013b).
3. Limited progress on substantive primary-care reform (Hutchinson et al. 2011; Fierlbeck 2013b).
4. The lack of progress on pharmaceutical access (Morgan et al. 2016).
5. Stalled progress on wait times (Fierlbeck 2013b; Collier 2013).

By no means was the 2004 accord an abject failure, but it was also far from a resounding success in moving the system towards the kind of vision provided by Romanow and others. There was some positive change, but it came at a very high cost in terms of dollars invested. And, as Hoffman and Fafard (2016) noted, it did little to improve the overall quality of care or the timeliness of access to care. But it is also perhaps fair to note that perhaps the accord overpromised what it could reasonably deliver and, by being framed as “a fix for a generation,” raised expectations from the public and health-policy experts about what could be achieved. The consensus view among both the commentary on the accord and the Senate committee’s review is perhaps best summarized as the accord having overpromised and under-delivered, especially in relation to the very large amounts of cash put into the system.

The other challenge in assessing the overall impact of the 2004 accord is that it tried to do two things simultaneously, which complicates the assessment of its effectiveness. On the one hand, it is about financing the day-to-day status quo — the delivery of medically necessary services to provincial residents. It is about financing the system as it is. But, on the other hand, it is also about financing the system Canadians want in the future. It is about primary-care reform, changing how physicians are paid, improving home care and mental-health care, etc. And this mix of intentions highlights how complicated it is to change how health-care systems do what they do. To change a manufacturing process, you might choose to close the factory, retool to make a new product, and then resume production. But you can’t do that with a health-care system. It has to continue to provide services, while also implementing new ways or approaches to how those services are delivered. And in such circumstances, the status quo has an upper hand. It is difficult for provinces to, for example, move doctors off of fee-for-service if the incentives to move are undercut by renegotiated fee schedules that improve compensation. And governmental attempts to realign those incentives risk messy political fights with powerful (and publicly popular) interests within the system. So the 2004 accord enunciated an extremely complex agenda to bring about its “fix for a generation” — funding the system as it was, while also funding a perhaps overly ambitious and complicated agenda for reform that did not take into account the ability of the status quo to eat the reform agenda’s lunch.

And related to this is the fact that there is nothing in any of the accords that speaks honestly to the Canadian public about the barriers to change in the system. These are the same barriers well documented by the very scholars and experts that testified

to the Senate committee and who published critiques of the progress. The barriers include, but are not limited to, the dominant role that physicians (and to some extent nurses) play in maintaining the status quo, the centrality of hospitals and institutions (rather than patients) to the functioning of the system, and the incomplete nature of the original medicare bargain that left much that is important to the future of health care outside of the bounds of the Canada Health Act.

THE 2017 BILATERAL AGREEMENTS

Given the limited success of the 2004 accord, one of the striking elements of the 2017 negotiations is the way in which it separated the necessary funding of the status quo (the system as it is) and the agenda for reform. The federal government agreed to a 3.5-per-cent increase to the CHT, plus an additional \$11.5 billion to be allocated through bilateral agreements (Marchildon 2017). The Common Statement of Principles on Shared Health Priorities, which serves as the umbrella document for 10 bilateral agreements, commits governments to two broad health policy priorities. First is improving access to mental health and addiction services, and second is improving access to home and community care. In both of these areas, the statement focuses on the need to expand existing services, but also on knowledge-sharing and spreading innovations that are deemed successful. This is linked to a further commitment to continue intergovernmental work on indicators to measure pan-Canadian progress on the priorities, one of the areas where the 2004 accord had made real and substantive progress. There is a further, albeit somewhat vaguer commitment to improving the health status of Indigenous Peoples in Canada, with greater involvement from Indigenous Peoples in the development of programs and policies.

But the real substance in terms of how things will get done, and what change is expected, comes in the individual bilateral agreements signed between Ottawa and each province. These are summarized in Appendix I. Within each agreement, provinces are able to speak to province-specific priorities in the areas of mental health and addictions and home and community care. Each agreement then articulates a plan that identifies where the new federal investments will be utilized and the kinds of improvements that should be expected. Some agreements speak to specific investments in specific programs and policies, while some speak more generally about the kinds of programs and policies to be targeted or developed.

It is also worth noting that the reform agenda that comes out of the bilateral agreements is much more incremental than that of the 2004 accord (or at least how the 2004 accord was perceived by the public and health policy analysts). For some, maybe many, this is disappointing after nearly two decades of effort to shift the system more fundamentally in a specific direction. But, given the limited success of the 2004 accord in buying significant change, it is at least arguably a more realistic approach to what can be accomplished over the short to medium term. And it has the advantage of giving the provinces the ability to build on work already underway. In other words, it meets the provinces where they are.

For example, Manitoba's mental health strategy is to be built on the recommendations of the province's own review of services, which moves toward a provincial mental health strategy, whereas New Brunswick wants to expand existing programs and services already initiated under a pre-existing provincial strategy. At the same time, some of the plans and commitments are certainly much vaguer than others. Some commit very specifically to expanding specific mental health or addiction services, such as harm-reduction strategies and building safe-consumption sites. Newfoundland and Labrador goes so far as to talk about hiring specific numbers of health professionals to do specific tasks. Others speak more generally about the kinds of programs that will be supported or expanded. Alberta commits to a "focus" on a range of improved services for children, youth and families in crisis, but provides little explanation of what that means.

But taken as a first iteration of a different strategy towards health reform, there is some reason for optimism. In some ways, the provinces have in fact created their own conditions for how they will spend federal funds and they have given those who want to assess their progress greater ammunition for holding them to account. The bilateral agreements allow for more province- and territory-specific detail on where the money is supposed to go and thus create a paper trail for provincial residents to follow in terms of where specifically there should be improvements.

The bilateral agreements do not so much create asymmetries in the system as attempt to account for those asymmetries that already exist. It is one thing to get all boats rowing in the same direction, but it is another to account for the fact that the boats all sit at different places on the lake.

This may prove a much stronger form of public accountability (or conditionality, if one wants) than could be achieved in a single agreement meant to cover all provincial and territorial health systems. But it is also much harder to make apparent to the Canadian public any progress or change. Tracking the myriad of commitments made in 13 bilateral agreements, accounting for federal contributions to those commitments and incremental funding from provincial and territorial governments, and then communicating that to the public in an accessible fashion will be a massive undertaking, if it is undertaken at all. So the opportunity for greater accountability may be present, but operationalizing it in a manner the public(s) can see is far from assured.

BILATERAL AGREEMENTS GOING FORWARD (WITH CAVEATS)

There appears little appetite on the part of any of the parties to resurrect grand bargains in the form of national health accords. For the foreseeable future then, expect the continuation of the current model of predictable increases in the CHT coupled with bilaterally negotiated allocations of additional funds for key priorities for reform, thus separating the funding for the status quo from the funding for change. What remains to be seen is whether this model can move the system in a more positive direction in terms of actual reform than the one it replaced. But there is a risk with bilateralism as an overall approach. While it may strengthen the federal hand insofar as it can undercut provincial governments uniting against it, it also comes with the risk of not reaching

agreements with one or more provinces, which could result in a significant political price to be paid, especially given how much the public cherishes medicare.

But it is worth noting that in areas other than health, the model does not seem to be causing the kind of concerns raised with the rather limited asymmetry of the 2003 accord. The current bilateral negotiations between the federal government and individual provinces in the area of child care seem to be yielding positive results that the public appears ready to accept. And as Ontario holds out on reaching a deal with Ottawa on child care, pressure may be growing for the province to come around, given the heightened attention the issue received after the COVID-19 pandemic laid bare the challenges of accessing affordable, safe and effective child care. But, as a note of caution, child care does not loom as large in the Canadian imagination as does medicare, and acceptance of asymmetry in one area of social policy does not predict it in another.

It may well be, however, that the general principle of separating the two kinds of health-care funding provides a way to move things forward that their linkage in “grand bargains” never did. But that hope also comes with some caveats that will need to be thought through as the process unfolds.

The principles and the priorities in the umbrella document will need to be backed up with good indicators that are readily comprehensible by a public that wants to see change. Accountability for how dollars are spent, not just how many dollars are spent, remains one of the biggest challenges. As the federal Advisory Panel on Health Care Innovation (2015) reported, perhaps the biggest threat to the sustainability of Canada’s model of public health insurance is the creeping concern that Canadians are paying ever increasing amounts for a system that is declining in quality and accessibility. The need for innovation, not just in technological terms, is growing, as confidence in the system is eroding. For this reason, as the bilateral agreements get renewed, provinces need to be encouraged to make their commitments more substantive and specific.

Getting accessible information to the public about the changes being made also needs to be a priority. If tracking how dollars were spent and the results of that spending was difficult with the 2004 accord, then it may be even harder with the bilateral agreements. Indeed, it would be an enormous undertaking to track and account for every program and policy impacted by the \$11.5 billion being spent in the bilateral agreements, and even more difficult to compile it all into a single national assessment. Even harder would be making province-by-province comparisons of where things stand, given the different starting points in each province. But outside of Canada Health Act services, this has always been true of the Canadian system(s). Home care in New Brunswick has always been different than home care in British Columbia. What is important is not that they converge into identical programs and policies, but that they meet the needs of their own residents and that we understand that there may be different ways of achieving similar levels of satisfaction with how various services are organized and delivered.

What matters, then, is whether the provinces can make the case to their own residents that the money has improved the services they already had, or created new or different

services that they needed, and whether the access to and quality of those services have improved. Again, not an easy task, but also not an insurmountable one. If people experience better access (measurable in a variety of ways), and quality indicators improve, then we should have some confidence that the money was being well spent. Insofar as the bilateral agreements are, in most cases at least, more specific about where improvements can be expected, this should be an improvement over trying to discern where the improvements to the 2004 accord occurred within the system.

It is for this reason that governments may need to explicitly signal to the public that they intend to take action on the barriers to change in the system. The accords (and the current Common Statement of Principles on Shared Health Priorities) are all very good about articulating where it is governments want the system to move toward, but they lack any acknowledgement of what stands in the way of change. And, again, if one is to have realistic expectations of how much change can be accomplished when and at what cost, then perhaps it is time to begin to be explicit about what is preventing change. By naming those barriers, governments can gain the leverage needed to reduce them.

As to the priority areas in the Common Statement of Principles on Shared Health Priorities, their current focus on mental health, addictions, home care and community care are perhaps more relevant now than they were in 2017. The COVID-19 pandemic has exposed significant shortcomings in the delivery of mental health services, disconnects between community mental-health services and the health-care system (McIntosh et al. 2021) and horrific problems with long-term care (particularly in the for-profit sector). It has also exacerbated an addictions crisis, especially around opioids (Novotna et al. 2021). And if reconciliation with Indigenous Peoples is ever going to mean substantive policy change, then Indigenous health continues to be an area where real progress needs to be made. All of these priorities speak to the need to keep the focus on areas that move the system towards a more citizen- and patient-centred approach to organizing and delivering services, and away from one focused on medical and institutional care.

The funding aspects of the new model will likely continue to have the same challenges as those of the accords, and indeed the arrangements that preceded the accords. The provinces will demand as much as they think they can secure and the federal government will try to limit its fiscal exposure so as to retain control of its own finances. There is likely no escaping things like the recent demand from the provinces for a \$28-billion increase in the CHT, but there is a way to minimize the extent they disrupt the ongoing federal-provincial diplomacy in health. The key innovation of the accords was not the amount that was (re)invested in health care, but rather the stability of the investment over the medium to longer term. Stable and predictable funding with an annual escalator is a relatively easy counter to poorly thought-out proposals like the recent provincial demands.

And that leaves some room for some asymmetry in the bilateral agreements regarding how much a province gets and how it chooses to allocate it or prioritize its spending in specific areas. Kept within reasonable limits, this is unlikely to cause the kind of public angst that was seen a decade ago when Quebec signed its own accord with Ottawa.

Indeed, it can be used to emphasize that different parts of the country, with different population demographics and different situations, demand somewhat different approaches to meeting the shared principles and priorities we have as a nation when it comes to health care. Every province has a rural health-care challenge, but every province's rural health-care challenge is different in important ways. Providing room for provinces to meet those challenges in a way that best meets their needs is an asymmetry that the public can likely understand and accept. Indeed, one could say it is not really asymmetry at all; it is just federalism at work.

Where both the accords and the current bilateral regime remain relatively silent is on a clear role for the federal government beyond that of financier of the system. And here, the current set of arrangements may offer an important opening. It is perhaps time to abandon the federal government's ill-defined role as "steward" of the system. What the bilateral agreements offer is the potential for the federal government to take seriously its potential to act as a clearing house for the transfer of innovations across jurisdictions, something the Canadian system has had particular difficulty achieving and which Lazar et al. (2013) characterized as a "paradigm freeze." There is no reason why, having seen what works in one jurisdiction, the federal government could not offer within the bilateral agreements funding for similar pilots in other jurisdictions, along with mechanisms to roll successful pilots into the overall funding arrangements over time. This could be a major force for integrating change across the system in a more systematic, evidence-based manner, while also driving better performance and quality indicators and enhancing public reporting. By maximizing the capacity inherent in our federal arrangements to create a network of policy laboratories, the federal government could have far more impact on sustaining publicly administered health care than any of the mostly rhetorical powers associated with its current notion of stewardship.

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APPENDIX: REFORM COMMITMENTS IN 2017 BILATERAL AGREEMENTS BY PROVINCE OR TERRITORY AND CATEGORY

Prov. or Terr. (P/T)	P/T Mental-Health and Addictions Priorities	Key Elements of the P/T Plan	P/T Home- and Community-Care Priorities	Key Elements of the P/T Plan
BC	<ul style="list-style-type: none"> Strengthen the capacity of primary care to respond to mental health and addictions, with a focus on prevention, early intervention and children/youth Expand access to culturally safer and trauma-informed mental-health and addictions services for Indigenous communities across B.C. Improve seamlessness across systems of care so that people can ask once and get help fast Increase access for students to mental-health, addictions-prevention and early-intervention services Expand access to evidence-based treatment and recovery options for vulnerable populations 	<ul style="list-style-type: none"> Support evidence-based virtual-care interventions designed to prevent and intervene early with behavioural and anxiety problems/disorders in childhood and depression and anxiety problems/disorders in adults Strengthen the capacity of primary-care providers to embed the latest research in adverse childhood experiences into practice and improve pathways of care in the child and youth mental-health and substance-use care system Resource the initial integration of mental health and addiction programming into the province's new primary-care networks Evaluate the potential of in-person group, low-intensity cognitive behavioural sessions Co-design an Indigenous-focused Mental Health and Addictions Strategy Continued expansion of integrated youth centres by one site per year Seed the development of a virtual-clinic access point through eFoundry Improve all aspects of the provincial crisis-line network Develop and deliver mental-health and -wellness training to school communities to reduce stigma and discrimination Increase the number of mental-health and substance-use professionals within school settings Expand best-practice community-based interventions for pregnant women who use substances Increase access to treatment and recovery options for adults at higher risk of poor health and death due to substance use 	<ul style="list-style-type: none"> Community-care services Palliative and end-of-life care 	<ul style="list-style-type: none"> Establish formal linkages with primary-care networks Ensure health-care assistants are providing home-support services with assigned client caseloads Enable health-care assistants to work across all services within a specialized community-services program Ensure home-support schedules permit sufficient time for client-focused care and are flexible to meet unscheduled or urgent care needs of clients Increase capacity to provide both responsive in-home services and unscheduled in-home respite Enable staff to work to a full range of competency when providing direct client care Ensure professional staff within the specialized community-services program are working as a multidisciplinary team Ensure allied health resources are working across all specialized community-services programs Ensure clinical educators and consultative resources are working across all specialized community-services programs Support early intervention and post-hospital-discharge care Expand hours of operation for evenings and weekends, and/or increase adult day-program spaces, overnight respite facility care and in-home respite services for both preplanned and urgent care Examine currently provided local, community-based/NGO programs and identify new programs, or expand existing programs, that bridge gaps in service and formally link them to the health system Provide new funding for contracts and/or resources to enable health authorities to increase investments to link local community-based services to primary care, with clear and uncomplicated referral patterns Develop educational materials and methods for sharing information to ensure the public and all stakeholders are aware of local community-based services and how to access them Increasing the use of technology to improve access to care Increase the use of technology to improve interdisciplinary teams' communications Increase the availability of mobility equipment to reduce barriers to hospital discharge Accelerate progress in the area of community-based palliative-care services

Prov. or Terr. (P/T)	P/T Mental-Health and Addictions Priorities	Key Elements of the P/T Plan	P/T Home- and Community-Care Priorities	Key Elements of the P/T Plan
BC (cont.)				<ul style="list-style-type: none"> • Improve and expand client access to 24/7 palliative and end-of-life services • Increase generalist clinicians' access to 24/7 pain and symptom management and clinical consultation • Ensure clients with complex conditions returning to the community post-hospitalization have the supports necessary to support them as quickly as possible and with optimal functioning • Increase education/orientation/training for all care providers
AB	<ul style="list-style-type: none"> • Provide community treatment services to Albertans in need • Provide addiction and mental health supports in home care and supportive living environments • Enhance appropriate use of crisis and emergency service • Provide specialized interventions for complex and high-risk populations 	<ul style="list-style-type: none"> • Implement evidence-informed models of community care by translating research, introducing innovations and supporting the spread of effective models of care • Increase access to community treatment services, including specialized community services and follow-up from emergent or crisis situations • Enhance the appropriate use of crisis and emergency services, to support Albertans at risk of or in the process of emergent or crisis situations • Focus on community-based mental health services for children and youth, such as promotion and prevention, specialized community services, and follow-up from emergent or crisis situations • Focus on crisis and emergency services to support children, youth and families at risk of or in the process of emergent or crisis situations • Focus on intensive and specialized interventions for high-risk children and youth • Increase housing and home-based supports to assist recovery for people with addiction and mental-health needs • Increase availability of intensive interventions to improve short-term, acute, and intensive-care options. Increase specialized care options for complex and high-risk adult populations 	<ul style="list-style-type: none"> • Spreading and scaling evidence-based models of home and community care • Enhancing access to palliative and end-of-life services • Increasing support for caregivers through in-home respite and adult day programs 	<ul style="list-style-type: none"> • Implement a standard basket of home-care services accessible by all Albertans, regardless of where they reside in the province, including more intensive services and restorative care • Offer more client-directed funding options, with more flexible funding limits • Expand the Assess, Treat and Refer (ATR) community-based Emergency Medical System (EMS) program and EMS Urgent Response Teams • Expand virtual-hospital and integrated-care teams for clients with complex chronic conditions • Expand interdisciplinary community support teams that maximize health-care workers' scopes of practice and co-ordinate with a client's primary-care provider as necessary • Focus on the scale and spread of palliative and end-of-life services in home and hospice • Increase the provision of in-home respite services, as well as basic and comprehensive adult day program spaces
SK	<ul style="list-style-type: none"> • Improving access to community mental-health supports • Enhancing delivery of evidence-based services • Improving mental-health and addictions services for youth and young adults 	<ul style="list-style-type: none"> • Expand addictions-medicine services in central and northern Saskatchewan • Expand Police and Crisis Team (PACT), a strategy that sees a police officer paired with a mental-health clinician for service calls related to mental health and/or addictions • Establish residential options that include intensive supports for individuals with serious and persistent mental health issues 	<ul style="list-style-type: none"> • Community health centres and teams • Palliative-care enhancements 	<ul style="list-style-type: none"> • Expand Community Health Centres into Regina, Saskatoon, Prince Albert and other Saskatchewan communities • Hire interdisciplinary teams • Develop outreach services • Enhance palliative-care enhancements • Create palliative-care co-ordinator positions • Follow any recommendations made by the Palliative Care Working Group, established in 2017

Prov. or Terr. (P/T)	P/T Mental-Health and Addictions Priorities	Key Elements of the P/T Plan	P/T Home- and Community-Care Priorities	Key Elements of the P/T Plan
SK (cont.)		<ul style="list-style-type: none"> Develop and standardize the implementation of Community Recovery Teams in eight communities with in-patient mental-health units Expand access to internet-delivered cognitive behavioural therapy services and work to develop new internet-delivered supports Facilitate the province-wide implementation of a mental-health and addictions electronic client record Support community-developed strategies aimed at preventing suicide in targeted communities and building clinical capacity to recognize, assess, and treat mental health concerns in children and youth Introduce a targeted training program for physicians and pediatricians, aimed at strengthening skills and knowledge in the area of child and adolescent mental health and improving interactions with specialists 	<ul style="list-style-type: none"> Implementation of a shared care plan that can be accessed by health professionals across the continuum of care (subject to a fulsome evaluation) 	<ul style="list-style-type: none"> Additionally, the implementation of a shared care plan will aim to remove the barriers to clinical information flow between hospital and community- or home-based settings, while promoting a team-based approach to patient care
MB	<ul style="list-style-type: none"> Increasing timely access to co-ordinated care for mental-health and addictions services for Manitobans Implementation of peer support in formal health settings Implementation of a pregnancy- and infant-loss program 	<ul style="list-style-type: none"> Implement a mental-health and addictions strategy guided by the Virgo report Increase access across the province to treatment through Rapid Access to Addictions Medicine (RAAM) clinics Improve opportunities for prescribers to enhance their competencies in addiction medicine Support the regional health authorities to contract with a community-based agency to deliver formal peer- and family-support services in emergency departments and crisis/urgent-care centres Redesign and enhance the Emergency Department Violence Intervention Program through a collaboration between Winnipeg's Health Sciences Centre and the Winnipeg Regional Health Authority (Downtown-Point Douglas Access Centre) Employ peer-support workers in the crisis-response centre/emergency departments Contract a community-based program for families dealing with the loss of a child during pregnancy or infancy, which will include a network to share knowledge 	<ul style="list-style-type: none"> Expand Manitoba's proven model of home care Promote intensive community-focused care: developing a community- and home-care support system Promote supports for rural palliative care 	<ul style="list-style-type: none"> Support the ongoing service-delivery expansion to meet the needs of home-care recipients Support increased service provision of home- and community-care services Shorten hospital stays by providing clients with intensive at-home care and supports within the familiar surroundings Continue to implement Priority Home and Pathways to Home programs that provide intensive, but time-limited support to individuals being considered for personal-care-home placement Expand end-of-life-care service delivery for rural Manitobans, including increasing access to hospice services and after-hours access to resources
ON	<ul style="list-style-type: none"> Child and youth community-based mental-health and addictions services 	<ul style="list-style-type: none"> Increase access to structured psychotherapy and counselling support programs Expand addictions services for adults, with a focus on addressing opioids, alcohol and cannabis 	<ul style="list-style-type: none"> Expanding access to home care (includes palliative and end-of-life care) 	<ul style="list-style-type: none"> Provide additional supports for palliative and end-of-life care in the community Implement cross-sector models of palliative and end-of-life care Provide new base funding to improve access to home-care services in Indigenous communities across Ontario

Prov. or Terr. (P/T)	P/T Mental-Health and Addictions Priorities	Key Elements of the P/T Plan	P/T Home- and Community-Care Priorities	Key Elements of the P/T Plan
ON (cont.)	<ul style="list-style-type: none"> Community-based core mental-health and addictions services Integrated community-based mental-health and addictions services for people with complex needs 	<ul style="list-style-type: none"> Increase access to early psychosis intervention programs Expand programs for priority populations by increasing existing services and creating new services Increase capacity of mental-health and justice teams to respond to people with mental-health and addictions issues by supporting mobile crisis rapid response Expand hostel outreach programs and hiring more case managers Increase supports in supportive housing units Reduce wait times by enhancing community-based child and youth mental health services Implement a new province-wide eating-disorders early-intervention program Increase capacity for residential treatment services for youth 	<ul style="list-style-type: none"> Caregiver supports Information technology 	<ul style="list-style-type: none"> Provide additional caregiver supports, including education, training and resources Enhance support to navigate existing services and resources Provide additional caregiver in-home respite Deploy digital tools to improve client and caregiver participation in care Expand the capacity of the Client Health Record and Information System
QC	<ul style="list-style-type: none"> The 2018-28 Interdepartmental Action Plan on Addiction Mental health program 	<ul style="list-style-type: none"> To improve access to treatment for opioid-addiction and intoxication- and withdrawal-management services Offer cyber-addiction services in all integrated centres with a Quebec addiction rehabilitation-centre mission Deploy responding addiction professionals across Quebec Improve access to addiction rehabilitation services and reach an additional 4,500 people per year Set up the Quebec psychotherapy program Improve accommodation and community-retention services to prevent psychiatric hospitalizations Consolidate assertive community treatment and variable-intensity support services Enhance access to psychologists for youth (ages 0-18) Consolidate first-psychotic-episode services for young people aged 12 to 35 Enhance community crisis services Broaden the range of support services to establishments that provide mental-health services from the Centre national d'excellence en santé mentale 	<ul style="list-style-type: none"> Increase the number of people receiving home support services and enhance services to better meet their needs 	<ul style="list-style-type: none"> Allow people to remain in their homes as long as possible by providing higher-quality and a greater quantity of readily available care and services Make home assistance services more accessible Increase the number of hours of service during times where people require more intensive services
NB	<ul style="list-style-type: none"> Enhanced Action Plan on Addictions and Mental Health Integrated community mental-health-care services for youth 	<ul style="list-style-type: none"> Enhance addictions and mental health services to help bridge gaps and remain consistent with established priorities Develop and implement a comprehensive framework for the delivery of services along the continuum of care 	<ul style="list-style-type: none"> Integration of community care systems Community- and home-care support system 	<ul style="list-style-type: none"> Bring the Extra-Mural Program (EMP), Ambulance New Brunswick and Tele-Care 811 programs under one management structure to eliminate silos among these services, and create additional capacity to care for citizens in the community by avoiding hospital admissions and decreasing existing hospital length-of-stays

Prov. or Terr. (P/T)	P/T Mental-Health and Addictions Priorities	Key Elements of the P/T Plan	P/T Home- and Community-Care Priorities	Key Elements of the P/T Plan
NB (cont.)		<ul style="list-style-type: none"> • Build community capacity by supporting NGOs and community organizations • Provide additional training to better integrate addictions and mental health into primary health care • Expand after-hours mobile mental-health services • Develop and implement a culturally appropriate and competent framework for the delivery of mental health services to First Nations • Establish e-mental health services throughout the province • Implement mental health senior-care services across the province • Provide training and professional development to integrated-service-delivery multidisciplinary teams • Fund integrated service-delivery teams customized to the varying needs of each of the First Nation communities • Ensure that the planned provincial treatment centre will be adequately staffed based on service requirements 	<ul style="list-style-type: none"> • Palliative-care strategy 	<ul style="list-style-type: none"> • Integrate the new system with eHealth, allowing care providers to benefit from a more holistic understanding of a patient's health history • Implement a point-of-care electronic clinical information system to support EMP • Ensure equitable funding and access to palliative care, and support a paradigm shift towards care and death out of the hospital setting and preferably in the home; ensure co-ordination and navigation capacity and provide essential information on care and options to patients; engage and provide services to families and caregivers, including direct care and support services in the home to relieve caregiver burden in end-of-life care, as well as bereavement services; provide palliative-care education for family physicians, as well as frontline providers working in hospitals, EMP, nursing homes, and home-support services • Support communities to enhance hospice services and create new capacity and alternative models for rural areas through related infrastructure investments. The province has also developed requirements and a three-year implementation plan to respond to EMP's need for the integration of technology and innovative business processes into the daily delivery of home-care services
NS	<ul style="list-style-type: none"> • Enhance integrated service delivery for children and youth • Enhance access to community-based mental-health and addiction supports 	<ul style="list-style-type: none"> • Support the expansion of SchoolsPlus • Expand the CaperBase model in Cape Breton and expand to other health zones to better meet the needs of youth • Support costs associated with the delivery of programs and services and additional human resources • Support the development of a standardized model for youth health care • Increase the number of mental-health clinicians in the community sector • Support the development and implementation of a standardized care model that will integrate community-based mental-health and addiction supports into the collaborative primary-health-care model • Support provincial investments targeted at improving access to mental-health and addiction crisis services • Invest in information-technology and management solutions and support the implementation of central intake that will improve access to mental-health and addiction services • Invest in technology-based interventions that will improve access 	<ul style="list-style-type: none"> • Improving access and enhancing continuing-care services for clients • Supporting caregivers • Supporting integrated care • Enhancing sustainability, accountability and system performance 	<ul style="list-style-type: none"> • Ensure that services respond to client needs by offering more flexibility and choice, aligning with resources that support health outcomes, promote efficiencies, and leverage community-based resources • Support caregivers by ensuring they are aware of and have access to services and supports that address their distinct needs; strengthen partnerships, systems and processes to enable a co-ordinated, holistic approach to care • Ensure system design, services, and performance are based on evidence, data, sector knowledge, and client experience

Prov. or Terr. (P/T)	P/T Mental-Health and Addictions Priorities	Key Elements of the P/T Plan	P/T Home- and Community-Care Priorities	Key Elements of the P/T Plan
PEI	<ul style="list-style-type: none"> • Student well-being program • Mobile mental-health-crisis program 	<ul style="list-style-type: none"> • Establish and embed multidisciplinary teams within families of schools across the island • Provide direct service to children and youth who are struggling with mental, social and physical health issues • Increase collaboration for student wellness by increasing information sharing, networking and communication in government, identifying and addressing gaps in services among professionals and programs, and building capacity of existing services within schools • Improve access to government and community services by reducing or eliminating timeline gaps and duplication of services among professionals and programs • Establish a flexible child-, youth- and family-centred program that strengthens capacity in youth and families by developing an array of programming and services offered at school sites and identifying and responding to children, youth and families in need of additional supports and services in a timely manner • Establish a 24/7 provincial mobile mental-health-crisis program and support additional practitioners who would staff the 24-hour response units 	<ul style="list-style-type: none"> • Mobile Integrated Health Initiative • Home Care IT Infrastructure Initiative • Implementation of InterRAI (Resident Assessment Instrument) home-care assessment tool 	<ul style="list-style-type: none"> • Provide support for post-acute palliative clients • Arrange facilitated transports to home from hospital • Focus on treating and supporting patients in community through the mobile integrated-health initiative • Implement a cost-effective, cloud-based electronic medical-records tool to support the needs of patients, health-care providers, and administrators within the home-care system • Standardize client assessment and ensure consistency and evidence-informed decision-making • Create a detailed implementation plan for adoption of the InterRAI (Resident Assessment Instrument) home-care assessment tool to be developed and then executed within the province's home-care and long-term-care system
NL	<ul style="list-style-type: none"> • Student well-being program • Mobile mental-health crisis program 	<ul style="list-style-type: none"> • Establish and embed multidisciplinary teams within families of schools across the island • Provide direct service to children and youth with mental, social and physical health issues • Improve student wellness by increasing information sharing, networking and communication between government, identifying and addressing gaps in services among professionals and programs and building capacity of existing services within schools • Improve access to government and community services by reducing or eliminating timeline gaps and duplication of services among professionals and programs • Establish a flexible child-, youth- and family-centred program that strengthens capacity in youth and families by developing an array of programming and services offered at school sites and identifying and responding to children, youth and families in need of supports and services • Establish a 24/7 provincial mobile mental-health-crisis program composed of trained mental-health professionals • Support additional practitioners who would staff the 24-hour response units 	<ul style="list-style-type: none"> • Mobile Integrated Health Initiative • Home Care IT Infrastructure Initiative • Implementation of InterRAI Assessment tool 	<ul style="list-style-type: none"> • Provide support for post-acute palliative clients • Arrange facilitated transports to home from hospital • Focus on treating and supporting patients in community through the mobile integrated-health initiative • Implement a cost-effective, cloud-based electronic medical-records tool to support the needs of patients, health-care providers, and administrators within the home-care system • Standardize client assessment and ensure consistency and evidence-informed decision making • Create a detailed implementation plan for adoption of the InterRAI (Resident Assessment Instrument) home-care assessment tool to be developed and then executed within the province's home-care and long-term-care system

Prov. or Terr. (P/T)	P/T Mental-Health and Addictions Priorities	Key Elements of the P/T Plan	P/T Home- and Community-Care Priorities	Key Elements of the P/T Plan
YK	<ul style="list-style-type: none"> Improved access to community-based mental-wellness and substance-use services Culturally appropriate and integrated interventions 	<ul style="list-style-type: none"> Plan and design sessions with communities to identify service-delivery models and staffing supports to improve access to mental wellness and substance-use services Initiate the first phase of integration of mental-health and addiction services Add clinical counselling positions to support child, youth and family counselling and treatment capacity in communities Roll out community wellness plans to improve capacity in rural communities with the addition of new positions working within a collaborative care team or “hub” model Implement child and youth programming in schools, youth programs, youth drop-ins and other locations that youth access in communities outside of Whitehorse Implement and expand the use of a mental-health nurse in the emergency department at Whitehorse General Hospital to triage, assess, determine appropriateness (to reduce unnecessary admission), redirect and co-ordinate referrals to community programs and provide other needed supports for individuals presenting at the hospital with a mental health and/or addiction issue Implement an electronic client-information data system to ensure effective case management, co-ordination of services and monitoring of key performance indicators to support the client’s journey Partner with the Department of Education and youth-service providers to identify innovative approaches to use technology in classrooms to allow teachers and youth workers to deliver mental-health and substance-use information to youth, in many cases providing for unique cultural needs Develop an initiative for culturally appropriate child and youth tele-psychiatry supports for rural communities outside of Whitehorse 	<ul style="list-style-type: none"> Home First and Complex Client Supports Initiative Rural-community home-care enhancements Technology support 	<ul style="list-style-type: none"> Increase quality of life for clients; reduce frequency and length of hospital stay; maintain or improve the client’s current level of function; reduce admissions to emergency department and acute care; decrease caregiver burden; better the transitions between home, hospital, and facility-based respite; improve access to care in community; strengthen relationships with community partners through the Home First and Complex Client Supports Initiative Develop a Home Care Community Profile for each of 15 Yukon communities Complete a community visit to each rural community in Yukon and meet with key stakeholders to identify home-care needs Analyze and interpret data obtained from the stakeholder meetings and develop recommendations for home-care services for each community in the Yukon Apply technology enhancements in order to expand accessibility to mobile charting and support a new quality-improvement initiative aimed at increasing efficiency of home-support-worker scheduling Promote social inclusion and reduce feelings of social isolation for clients, and explore how more regular contact with clients supports symptom management and avoids acute-care intervention
NWT	<ul style="list-style-type: none"> Prevention Intervention Postvention 	<ul style="list-style-type: none"> Develop and implement a Territorial Suicide Prevention and Crisis Support Network (TSPCSN). The TSPCSN plan is to: support communities in proactive suicide-prevention activities, as well as provide expert and timely intervention in times of crisis Enhance culturally appropriate approaches to the prevention of suicide-related crises Improve the ability to respond to community and family needs when a crisis does occur 	<ul style="list-style-type: none"> International Resident Assessment Instrument (InterRAI) Paid family- and community-caregiving option pilot 	<ul style="list-style-type: none"> Implement the International Resident Assessment Instrument (InterRAI) throughout the Northwest Territories, across all continuing-care programs, facilities and processes, in order to directly support improved access and service delivery of home- and community-care services by ensuring that home- and community-care services are allocated to individuals based on their assessed care needs, and that the amount and quality of services they receive are meeting their needs so as to avoid admission into long-term care for as long as possible

Prov. or Terr. (P/T)	P/T Mental-Health and Addictions Priorities	Key Elements of the P/T Plan	P/T Home- and Community-Care Priorities	Key Elements of the P/T Plan
NWT (cont.)		<ul style="list-style-type: none"> Establish a comprehensive process for providing community-based suicide prevention and intervention, as well as postvention (follow-up) supports for individuals and communities when deaths by suicide occur Train local professionals, paraprofessionals and community members in critical-incident management Build on existing resources and partnerships, better integrate supports and services, and introduce new training and resources for NWT communities Create two new full-time employee positions, to be located within the Health and Social Services System 		<ul style="list-style-type: none"> Develop and implement a paid family- and community-caregiver program that will provide individuals with an option of who will care for them to meet their unmet care needs and access home supports that are currently not available to them through the traditional home- and community-care program, due to limited resources and/or scope of service providers
NVT	<ul style="list-style-type: none"> Expanding access to community mental-health and addiction services for children and youth 	<ul style="list-style-type: none"> Support community-driven projects and develop a model in which the strengths of community-driven programs are recognized and shared across the territory Designate a program co-ordinator who focuses specifically on assessing, developing, and delivering youth programs Support child and youth workers by providing more resources and facilitating peer-support network annual summits Develop a website specific to child and youth mental health, which can act as a resource hub for clients and an ongoing support forum for professionals Support youth and their families in finding relevant information on mental-health and addictions topics online Continue the SickKids Tele-link Program Support new projects and initiatives with nationwide partners 	<ul style="list-style-type: none"> International Resident Assessment Instrument (InterRAI) 	<ul style="list-style-type: none"> Acquire and implement InterRAI in order enhance the territory's ability to integrate home-care services within the primary-health-care model, as well as to better identify and respond to the needs of Nunavummiut with increased investment in home-care infrastructure.

Source: Copies of the individual bilateral agreements can be found here: <https://www.canada.ca/en/health-canada/corporate/transparency/health-agreements/shared-health-priorities.html>.

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