

Federalism, Failures and the 2008 Listeriosis Outbreak in Canada

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Paper prepared for presentation to the Annual Meeting of the Canadian Political Science Association, Concordia University, Montreal, Quebec, 3 June 2010.

First draft. Comments very welcome. Please do not cite.

Given large-scale manufacturing and processing of food and complex food distribution networks, Ontario and Canada are likely to see more non-localized outbreaks of foodborne illnesses. The current processes and structures for investigating and managing outbreaks are not adequate to support a coordinated response among different jurisdictions and levels of government. Roles and responsibilities at the federal, provincial and local levels are not clear (Government of Ontario, 2009: 4).

Introduction

Food safety refers to the potential risks to human health associated with the consumption of domestic and foreign food products (Ugland and Veggeland, 2004:104). It is a cross-cutting and cross-border issue, involving a variety of policy sectors and levels of governance. Food safety is increasingly recognized as important to, and integrated with, the promotion and protection of public health (WHO 1999). Past food crises affecting human food and animal feed, for example the spread of ‘mad cow’ disease (Bovine Spongiform Encephalopathy) and its transmission to consumers through beef consumption, have exposed serious flaws in governments’ food safety and public health systems and highlighted the intergovernmental nature of risks (Ugland and Veggeland, 2006: 611). As the listeriosis outbreak from June-December 2008¹ showed in Canada, multi-jurisdictional failures to adequately address and respond to foodborne hazards and emergencies can result in foodborne illnesses and deaths. The outbreak resulted in 57 confirmed illnesses, including 23 deaths where listeriosis was the underlying or contributing cause (PHAC, 2010). Although Ontario was the hardest hit (with 41 of the 57 cases and 16 of the 23 deaths), the cross-jurisdictional crisis affected people in seven provinces across Canada (Ontario, British Columbia, Alberta, Saskatchewan, Manitoba, Quebec and New Brunswick) (PHAC, 2010). Almost 50 local, provincial and federal partners were involved in the response, making coordination challenging and especially because roles and responsibilities were so unclear (Government of Ontario, 2009: 6). As Dr. David Williams, Ontario’s Chief Medical Officer of Health, concluded in his *Report on the Management of the 2008 Listeriosis Outbreak in Ontario* (2009:3): “we need to have better clarity of roles and coordination to more effectively manage future outbreaks.” Sheila Weatherill’s *Independent Investigator’s Report into the 2008 Listeriosis Outbreak* (Government of Canada, 2009:39) argues: “There were gaps in the regulatory framework [and multijurisdictional response] that allowed this outbreak to happen” and spread.

Since the listeriosis crisis, food safety has become an increasing public health concern for federal and provincial/territorial (F/P/T) governments, with importance being placed on identifying gaps in the system, learning lessons from failures and taking actions to strengthen the effectiveness of future responses. This paper looks in depth at the nature and effectiveness of the intergovernmental response to the listeriosis outbreak in the cross-cutting areas of food safety and public health. Were failures in the listeriosis crisis, in part, a result of federalism or the particular type of intergovernmental relationship that characterizes food safety and foodborne illness emergency responses in Canada (Birkland and Waterman, 2008:693)? It is argued that some of the problems

governments encountered in managing the outbreak were due to failures in the collaborative form of federalism found in the food safety and public health fields. Collaborative governance in food safety, without adequate federal direction in public health areas such as surveillance and emergency response, contributed to ineffectiveness and democratic failures. The existing collaborative, intergovernmental arrangements may be successful in respecting the jurisdictional sovereignty of the orders of government involved, but they contributed to failures in the outbreak response, and ultimately, did not serve well the interests of public health and the health of Canadians. Accordingly, as recommended in the Weatherill and Williams (2009) reports and other governments'/organizations' lessons learned documents, reforms should focus on strengthening the collaborative system, but equally on complementing this form of federalism with changes toward federal direction and leadership in public health. What is needed is increased creative federalism (Wilson and Lazar, 2008).

To develop this argument, the paper proceeds as follows. The first section details a framework for describing varying intergovernmental relations that exist in areas of public health and evaluating them according to criteria such as effectiveness and impacts on democracy and federalism. The next two sections apply the framework to the cross-cutting areas of food safety and public health to outline the organization and allocation of responsibilities and classify the regime as collaborative federalism, characterized by interdependence and non-hierarchy. The third section evaluates the effectiveness of these forms of federalism in the intergovernmental management of the listeriosis outbreak. To accomplish this, the section takes a look at some of the causes of the outbreak and failures in response, focusing on the examination of factors related to federalism. Recommendations for future improvement, including those put forth by the independent reports and lessons learned documents, are further examined in light of the intergovernmental analysis. The conclusions briefly summarize prospects for future reform. At present, the Government of Canada has not moved toward increased federal direction and leadership in areas of surveillance and emergency response to complement creatively collaborative federalism in food safety and public health.

The Descriptive and Evaluative Framework

In order to describe and evaluate the nature and effectiveness of intergovernmental relations in food safety and public health, the paper relies on a framework developed by Harvey Lazar and Tom McIntosh (1998:4). They focus on describing intergovernmental regimes with regard to two dimensions: the level of interdependence that exists between the orders of government and the extent to which the relationship between orders is hierarchical. As Kumanan Wilson and Harvey Lazar (2008:5) ask when applying a modified version of Lazar and McIntosh's framework to the field of public health: Does the intergovernmental relationship entail either independence or interdependence between the federal and provincial orders of government? And if interdependent, does the relationship reflect the idea that both orders of government are, or are not, sovereign in their own constitutional spheres, and hence does a hierarchical or non-hierarchical relationship predominantly prevail?

First, interdependence "refers to the requirement of one order of government for actions by another order to ensure that policy is successfully developed and implemented" (Wilson, McCrea-Logie and Lazar, 2004:179). For example, to determine the nature of interdependence in an intergovernmental regime in an area of public health,

Wilson and Lazar (2008:6) argue an important first question is whether there is joint federal-provincial decision-making, implementation or funding. A second question is whether the actions of one order of government impact the other and influence its choices (and even if no joint federal-provincial activity exists). As Wilson and Lazar (2008:6) explain

Where...influence requires the second order of government to make modest adjustments only to its...[policy or] program, the relationship is more independent than interdependent. Where...influence effectively ‘forces’ important changes in the priorities or structures of the second order of government, the relationship is more interdependent.

Second, if interdependence is present, the nature of an intergovernmental regime can be further characterized by hierarchy. Hierarchy refers to “the ability of one order of government to effectively coerce another into taking a specific policy action,” for example through legislative authority or financial mechanisms (Lazar and McIntosh, 1998; Wilson, Mc-Crea-Logie and Lazar, 2004:179). In the field of public health, Wilson and Lazar (2008:5-6) stress two considerations when determining the extent of hierarchy between federal and provincial governments.

The first is whether one order of government has the effective capacity to impose policy or program obligations on the second order of government in respect of matters where that second order of government has legislative competence under the division of powers of the constitution. The second is whether the first order of government uses that effective capacity against the will of the other order of government (or at least against the will of some governments from the other order).

Importantly, unilateral action by either order of government when it is acting within its own constitutional sphere would not be characterized as hierarchical.

Based on these two dimensions of interdependence and hierarchy, three main forms of federal-provincial intergovernmental relationships can be described. If no interdependence and hierarchy exists, the relationship is described as disentangled federalism. If interdependence exists, and there is hierarchy, a unilateral relationship exists. And if there is interdependence and non-hierarchy, the relationship is collaborative federalism (Cameron and Simeon, 2002:64). Finally, in public health, it is essential to consider the roles of local governments (the third order), as well as regional/international/supranational organizations, and their respective relationships with F/P/T governments in activities such as policy development and implementation (Wilson and Lazar, 2008:7). Importantly, dimensions of forms of federalism in public health can be combined to varying extents, change over time, and operate differently in distinct stages of the policy process and in theory and practice. For example, scholars like Wilson and Lazar (2008:7) are increasingly mapping creative forms of federalism in the Canadian public health context. Creative federalism “...include[s] federal or national initiatives in which collaboration and coercion are combined [to varying degrees] in areas of unclear or shared constitutional jurisdiction to achieve national plans with reliance on local and provincial capacity” (Wilson and Lazar, 2008:7).

With this framework, the nature of the intergovernmental regime in public health and food safety can be classified. It is important to understand ‘who does what’ and the relationships involved in a particular policy area before assessing how the relationship

‘worked’ or ‘did not work’ in practice. Further, once the regime is described, the effectiveness of intergovernmental relations can be evaluated relying again on criteria developed by Lazar and McIntosh (1998, 4). These criteria examine the impact of the form of intergovernmental regime on policy effectiveness (in terms of reducing risks to human health and improving health outcomes), democracy and federalism (Wilson, McCrea-Logie and Lazar, 2004:185; Wilson and Lazar, 2008:9). In sum, a modified Lazar and McIntosh descriptive framework and set of assessment criteria enables a classification of the nature of the intergovernmental regime in food safety and public health, as well as an evaluation of how well it worked in responding to the listeriosis outbreak.

For example, the Weatherill Report (2009:28) clearly demonstrates the problems in outbreak response that arise when roles and responsibilities in federalism are so “unusually complex” and unclear to many of the actors involved. The Report (2009: iv) points to difficulties in the cooperation, coordination and flexibility of the response because of the numerous organizations and levels of government involved, and especially when “...there is a lack of understanding about intergovernmental protocols to deal with...emergencies,...creat[ing] confusion about who should do what and when.” It also details democracy and public communications difficulties related to the crisis, given Canadians “...generally do not understand which level of government, let alone which organization, has specific jurisdictional responsibility for public health or food safety” and hence who they should turn to seek advice about how best to protect themselves and hold accountable for (in)actions (Government of Canada, 2009:v). Indeed, the Weatherill report (2009), complemented by the work of the House of Commons Agriculture Subcommittee on Food Safety (2009), as well as other governments’/organizations’ lessons learned analyses, have provided important insights into the relevance of intergovernmental relations in public health and food safety for outbreak responses and specific ideas for reform so future crises can be mitigated with more success. Based on information obtained from these primary documents, and interviews conducted in March/April 2005 with relevant policy actors,² analysis of the nature and effectiveness of intergovernmental relations in the response to the listeriosis outbreak can be performed.

Intergovernmental Relations in Food Safety and Public Health in Canada Organization and Allocation of Responsibilities

Foodborne hazards to humans arise during the production, processing and distribution of food (Skogstad, 2006: 160). Foods can become hazardous from natural toxins, chemical and microbial contamination, or when they are mislabeled (e.g. in the case of allergens, additives or preservatives). There are more than 250 illnesses that result from eating food contaminated with bacteria, viruses, parasites and toxins (Government of Canada, 2009:5). Listeriosis is a foodborne illness (a form of disease or invasive infection) that results from eating food contaminated with a bacterium called *Listeria monocytogenes*. In the 2008 outbreak, listeriosis occurred after the 57 individuals involved (many from vulnerable populations) ate contaminated, ready-to-eat, deli meat products from Maple Leaf Foods. Food safety policies and practices are designed to reduce and manage the risks that hazardous food (e.g. food contaminated with *Listeria*) will be eaten and to ensure food products and additives meet acceptable standards. For example, international and national standards and policies to control *Listeria* recognize that the risk of contamination by *Listeria monocytogenes* can only be reduced in food to ‘acceptable’

levels, and that finished products (and food processing plant environments) will not be totally *Listeria*-free or free of the potential for future growth (WHO 2008). If *Listeria* defeats the efforts of the food safety sector and regulatory system, and enters the food supply in unacceptable levels, the focus of food safety in an outbreak is to identify the hazardous food product causing illness and remove it from the market. Public health is involved in finding out what is making people ill and taking emergency response efforts to protect the health of the population (Government of Canada, 2009:xi).

Jurisdiction over food safety policy in Canada is shared among federal, provincial and municipal governments (Moore and Skogstad, 1998: 129). Fragmentation in vertical governance is further accompanied by fragmentation in horizontal governance (Skogstad, 2006:161). For example, historically, jurisdictional complexity has been heightened by the division of responsibility within jurisdictions (e.g. involving agriculture and health organizations and others like fisheries and oceans and natural resources) (Moore and Skogstad, 1998:129; Skogstad, 2006:161). The establishment of the Canadian Food Inspection Agency (CFIA) in 1997 under the *CFIA Act* reduced federal horizontal fragmentation somewhat by consolidating all federally mandated food and fish inspection services and federal animal and plant health activities into a single agency (Prince, 2000). Accordingly, in the Government of Canada, responsibility for food safety is currently assigned to Health Canada, the CFIA and the new Public Health Agency of Canada (PHAC) created in 2004. Agriculture and Agri-Foods Canada (AAFC) primarily supports food safety policies through food quality research.

Health Canada in the Food Directorate, Food Program, Health Products and Food Branch (HPFB) is responsible for establishing science-based policies and standards pertaining to the nutritional composition, quality and safety of food sold in Canada. Food policy decisions are based on scientific data and assessments of risks associated with food products or processes from a public health perspective.³ In some instances, when unacceptable risks are identified, a food product or process may be prohibited. The *Food and Drugs Act* makes illegal the manufacture or sale of dangerous, adulterated or misbranded products. Health Canada has legislative powers to administer and regulate foods under this Act. In terms of constitutional authority, Section 91(27) of the *Constitution Act* gives federal Parliament exclusive authority to legislate with regard to 'criminal law'. This allows Parliament to create criminal legislation directed at legitimate public health evils (Jackman, 2000:99-102). Federal laws pertaining to food safety and quality with regard to specific foods are found in separate Acts.

The CFIA has the responsibility to enforce safety and nutritional quality standards set out by Health Canada (in the *Food and Drugs Act*) for domestic products sold interprovincially and internationally and for foreign food products. The CFIA reports to the Minister of AAFC. Federal jurisdiction here arises from Section 91 (27) of the *Constitution Act*, but also from Sections 95 (concurrent powers in agriculture) and 91 (2) (the power to make laws in relation to the regulation of trade and commerce) (Moore and Skogstad, 1998: 129, Footnote 7). The Agency delivers all federal inspection programs related to safeguarding food, plant and animal health, including in food processing plants.

CFIA meat inspection regulations and directives derive from the *Meat Inspection Act*. The regulations stipulate that meat processing companies that sell their products interprovincially or internationally be federally registered/licensed and required to meet CFIA safety regulations governing the production process. They must also develop their

own food safety plans to ensure the safe production and distribution of food, including Codex Alimentarius Commission-sanctioned Hazard Analysis and Critical Control Point (HACCP) components. The CFIA Compliance Verification System (CVS) sets out the specific procedures that federal inspectors use to verify the design and implementation of processing plants' food safety plans. The *Meat Hygiene Manual of Procedures* (2010) mandates that food processors control pathogens like *Listeria monocytogenes* and sets out specific guidelines for CFIA inspectors and operators of processing plants to follow. In 2004, Health Canada and the CFIA jointly developed the federal *Listeria* policy based on principles of HACCP and an approach that assesses the risks of contaminated foods to human health. The policy guides food processors on food safety standards and risk management approaches to controlling *Listeria monocytogenes*, concentrating on ready-to-eat foods and those that support growth with a greater than ten day refrigerated shelf life (Government of Canada, 2009:21). It also details food processors' responsibilities in terms of using environmental sampling (e.g. in the plant) and end product testing approaches to verify that their control measures (e.g. sanitation) are successful (Government of Canada, 2009:21).

Health Canada and the CFIA share responsibility for federal food packaging and labeling policies under the *Food and Drugs Act*. Health Canada is responsible for establishing food labeling policies with respect to health and safety matters, while the CFIA is responsible for the development of non-health and safety labeling regulations. For example, Health Canada would require mandatory labeling of foods in line with the *Food and Drugs Act* when nutritional or compositional changes are made to products, or when specific health concerns exist, such as the presence of possible food allergens. The CFIA is accountable for protecting consumers from misrepresentation and fraud with respect to food labeling, packaging and advertising and for prescribing basic food labeling and advertising requirements applicable to all foods. For example, under the *Meat Inspection Act*, the CFIA establishes the quality, packaging and labeling of standards for companies selling meat interprovincially or internationally or importing meat to be sold in Canada.

If safety standards are not met or health risks are identified, the CFIA would take enforcement actions such as conducting food investigations and recalling hazardous products. For example, if commercial, federal food products are implicated in a foodborne illness investigation, the CFIA would conduct a food safety investigation to identify the food responsible for causing the illness. This usually includes working closely with the manufacturer to obtain distribution records and food samples for testing (i.e. unopened food packages), and conducting a comprehensive inspection of the manufacturing facility (Government of Canada, 2009:27). The CFIA's Office of Food Safety and Recall would initiate a food recall (with industry) to remove the product from the market (Government of Canada, 2009:28). Health Canada's role is to conduct, at the CFIA's request, an assessment of the health risks from human exposure to contaminated foods and provide any necessary laboratory services. The CFIA is responsible for leading the risk management. These arrangements are spelled out in the August 2000 *Health Canada Decision-making Framework for Identifying, Assessing and Managing Health Risks*. Ultimately, Health Canada (the Bureau of Food Safety Assessment) is responsible for assessing the effectiveness of the CFIA's food safety activities.

Finally, when a ‘notifiable’ illness caused by food is detected in humans, and turns into a cluster or outbreak involving more than one P/T or having an international dimension, the PHAC becomes involved. Notably, listeriosis was not a ‘notifiable’ disease nationally or in many provinces at the time of the outbreak (Government of Canada, 2009: 68). The PHAC’s main role is to respond to public health emergencies and disease outbreaks of national concern, including foodborne illnesses, in collaboration with P/T governments. The national Health Portfolio Operations Centre, which includes the Emergency Operations Centre, in the PHAC’s Centre for Emergency Preparedness and Response, is responsible for central direction, control and coordination during such emergencies (McDougall, 2009: 6). The Infection Disease and Emergency Preparedness Branch (IDEP) would normally be the first point of contact for issues related to foodborne illness outbreaks.

Surveillance and the sharing of information about foodborne illnesses are critical to prevent the spread of infection to susceptible people (Government of Canada, 2009:25). The PHAC’s Center for Infectious Disease Prevention and Control (CIDPC) is responsible for national public health surveillance (CIDPC name change - update). There are several surveillance systems in place for monitoring foodborne illness such as the National Enteric Surveillance Program (analyzes and reports lab-confirmed foodborne illness cases) and Pulse Net Canada (identifies clusters of foodborne pathogens based on DNA fingerprinting). The related national initiative, the Network for Health Surveillance in Canada’s Integrated Public Health Information System’s (iPHIS) Canadian Integrated Outbreak Surveillance Centre (CIOSC), further plays an important role in detecting outbreaks. It receives, posts and distributes electronic alerts about diseases (including foodborne illnesses) to public health practitioners across Canada and related organizations (Government of Canada, 2009:26). Upon the request of the provinces, the PHAC (e.g. the Outbreak Management Division) may assist or lead in epidemiological investigations (that establish the source of the outbreak and how it is being spread). Its laboratories (e.g. the National Microbiology Laboratory, the PHAC/Health Canada Listeriosis Reference Laboratory Service) may further provide reference services and assist with or lead studies (e.g. to link human illness and the implicated foods). The relationships between federal partners in public health and food safety management and emergencies are outlined in the April 2008 *Memorandum of Understanding between CFIA, Health Canada, PHAC for Common Issues Related to Human Health* and the May 2000 *Memorandum of Understanding between Health Canada and the CFIA on Food Safety Emergency Response* (Health Canada, 2010).

Further, in 2004, the *Canadian Foodborne Illness Outbreak Response Protocol (FIORP) to Guide a Multi-jurisdictional Response* was endorsed by the F/P/T Committee on Food Safety Policy, the Council of Chief Medical Officers of Health and the F/P/T Deputy Ministers of Health. It was revised in July 2006. It outlines the roles and responsibilities between F/P/T and regional/local jurisdictions in national foodborne illness emergencies. According to the FIORP, the CFIA takes the lead in food safety investigations (with assistance from Health Canada’s HPFB and the PHAC). However, the PHAC’s CIDPC (update name) heads up public health surveillance, epidemiological studies and the management of the CIOSC. The PHAC can further establish an ad hoc Outbreak Investigation Coordination Committee (OICC) to lead the affected P/T and/or international partners/organizations. The PHAC’s IDEP handles public health-related

external communications; the CFIA takes the lead for food safety investigation and recall-related external communications. The PHAC/Health Canada 2006 *Strategic Risk Communications Framework* and handbook and draft 2003 *Crisis/Emergency Response Communications Guidelines* are applicable here (PHAC, 2008:20). The Government of Canada has obtained legislative authority in public health and health protection from Sections 91(27) (criminal law), 91(2) (trade and commerce) and 91(11) (quarantine and marine hospitals) of the *Constitution Act* (Wilson, 2004:409-410). The peace, order and good government power (POGG) in the Preamble of Section 91 further allows the federal government to pass legislation to regulate matters of national health and welfare (Wilson, 2004:409). Key federal acts governing public health surveillance and emergency response, for example, are the *Department of Health Act* and the *Quarantine Act* (McDougall, 2009). Finally, the spending power provides the federal government with another avenue to involve itself in public health programs and initiatives. The extent of these specific powers and the constitutional jurisdiction for federal involvement in public health remains unclear (Gammon, 2006).

At the provincial level, responsibility for food safety and inspection is generally divided among Ministries responsible for health and agriculture (among others). That said, there is significant organizational variation in public health and food safety across provinces and especially when taking into consideration the local and regional levels. Regardless of the organizational set-up, P/T governments' food safety measures have to be compatible with federal policies and standards pursuant to the *Food and Drugs Act*. However, when observing federal food safety guidelines and policy recommendations, provinces can create standards that exceed the Government of Canada's (Skogstad, 2006:160). P/T governments can further set their own food safety standards for plants licensed in their jurisdiction and enact and enforce food safety laws that apply to food products produced, distributed and sold within their borders, including local food processing, the food service industry, and the food retail industry (Moore and Skogstad, 1998:130; Skogstad, 2006:161). P/T governments, in collaboration with regional/local public health authorities, contribute to food safety by performing a host of regulatory activities and inspecting local food processors, food service and food retail establishments that are not federally registered.

In a foodborne illness emergency contained within a local region or P/T, provincial governments have the authority to lead an investigation and take action to control its spread. Here, the affected province (the health ministry, chief medical officer) would generally create and chair the OICC. Several P/T have Memorandums of Understanding with the federal government to guide investigations/responses to outbreaks within their borders. Usually, confirmed cases of foodborne illness are first identified and monitored at local/regional levels by 'front-line' public health officers/authorities then reported to provincial ministries of health. Local/regional public health authorities carry out the initial epidemiological investigations, supported by health ministries and provincial (and federal⁴) laboratories. They further help investigate complaints about unsafe food products, collect food samples and send samples to labs, and if the implicated food linked to the illness is discovered, assist with product removals and the communication of health hazards to the public (with industry, their relevant P/T authorities and the CFIA).

An important difference in intergovernmental (and interagency) approaches here is that some P/T public health systems are authorized, on the basis of epidemiological evidence, to take more precautionary approaches to protect the public than the CFIA (and Health Canada) (Government of Canada, 2009: 69-70). For example, when there are reasonable and probable grounds to believe that health hazards exist (e.g. a food source is contaminated and has caused illness), some P/T health acts authorize the immediate destruction or seizure of the food source. In the listeriosis outbreak in Ontario, "...positive test results from opened packages of meat were enough to trigger public health units and the Chief Medical Officer of Health to require...hold[s] on the product, while [the] CFIA needed positive test results from unopened packages of meat to confirm that the course of the contamination was in the plant and to support a wider product recall" (Government of Ontario, 2009:6). The earlier, independent actions of public health authorities in Ontario to place precautionary holds on the hazardous meat products thus presumably saved people from eating foods contaminated with *Listeria* and possibly even lives. In contrast, the CFIA 'unopened packages' approach to issue a food recall, based on criteria that requires definitive proof established by laboratory confirmation that a specific food is contaminated, caused delays in response.

Provincial legislatures have obtained the authority to pass public health and food safety legislation from their power over property and civil rights in Section 92(13) of the *Constitution Act*. Further provincial authority in these fields is derived from the power they are given over matters of a local or private nature in the province (Section 92(16)) and their concurrent power in agriculture (Section 95) (Wilson, 2004:409; Gammon, 2006; Skogstad, 2006). Of course, these provincial powers have to be reconciled with the federal government's powers to enact food safety legislation in relation to the regulation of trade and commerce (Section 91(2)) and criminal law (Section 91(27)) (Moore and Skogstad 1998, 129-130). Accordingly, the distinction made is that the federal government is responsible for food safety standards and inspection with regard to domestic products sold interprovincially and internationally as well as imports; P/T governments are responsible for foods sold intraprovincially (Skogstad, 2006: 160-161). Finally, provinces have authority to legislate in relation to municipal institutions in the province by Section 92(8) of the *Constitution Act*.

Form of Federalism

The current relationship in food safety and public health between the three orders of government is interdependent. F/P/T governments and regional/local health authorities must work together to ensure that Canada has a comprehensive and integrated food safety and inspection system (Gabler, 2008). Similarly, the PHAC and emerging approach to epidemic surveillance and emergency response is "...based on the recognition of the mutual interdependence of the different orders of government when it comes to developing and implementing public health policies" (Wilson, McCrea-Logie and Lazar, 2004:190; McDougall, 2009). In the case of a multi-jurisdictional foodborne illness emergency, a successful response ultimately depends on clear communications and coordinated actions in both food safety and public health among all levels of government. Here, "the unusual characteristics of a listeriosis outbreak underscore the need for maximum collaboration" (Government of Canada, 2009:65).

The relationships between F/P/T governments in food safety and inspection and public health surveillance and emergency response are also non-hierarchical (Gabler,

2008; McDougall, 2009). The federal government, through Health Canada and the CFIA, currently has the legislative authority to ensure and enforce the safety of food products sold interprovincially and internationally and to undertake F/P/T cooperative efforts in the area. However, the provinces are equally responsible for introducing and implementing legislation to ensure the safety and quality of food products sold intraprovincially. All three levels of government participate in food safety regulation and risk assessment/management, inspection and information provision, and albeit to different extents, pay for the cost of these measures.

For example, many observers generally characterize the historical relationship between the F/P/T governments in food safety and inspection as non-hierarchical and as a "...partnership...based on the equal status of participants [:]...the goal has been to create national – not federal – standards and an integrated – not single-level – system" (Moore and Skogstad 1998, 146-7). Past intergovernmental efforts to formally coordinate and harmonize food safety standards and inspection systems, such as the 1994 *Canadian Food Inspection System Blueprint* and its accompanying *Guidelines*, were cooperative initiatives, based on a partnership of governments (with industry) (Moore and Skogstad 1998, 146-7; Skogstad, 2006). Moreover, the Interagency Program and F/P/T governments involved continue to work together in food safety through the *Canadian Food Inspection System Blueprint's* intergovernmental structure arriving at cooperative initiatives such as the 2001 *Agricultural Policy* and 2007 *Growing Forward Frameworks*. As one federal official explained, "...it's very interdependent,...non-hierarchical...and collaborative" (Confidential Interview 1 April 2005).

The implementation of the *Blueprint* and *Frameworks* is the responsibility of the Canadian Food Inspection System Implementation Group (CFISIG), with a membership that is intergovernmental and interdepartmental. It reports to the F/P/T Ministers with food safety and inspection responsibilities and develops model regulations and codes of practice to move Canada toward a unified food inspection system. The CFISIG works with other interagency and F/P/T committees to achieve the *Blueprint's/Frameworks'* goals. For example, as part of the Interagency Program at the federal level, there is the Health Canada/CFIA Committee on Food Safety and Nutrition and the Steering Committee on Food Safety and Nutrition (among other Councils/committees). The two main F/P/T technical food committees are the Committee on Food Safety Policy and the Agri-Food Inspection Committee. Interagency and intergovernmental information-sharing and coordination on emerging food safety issues and the multi-jurisdictional management of foodborne illness emergencies is done through this existing committee structure.⁵ For example, the Food Safety Committee, composed of, and chaired by, assistant deputy ministers from health and agriculture ministries across Canada, released in September 2008 a draft *National Strategy for Safe Food*. Once finalized, it promises to provide a framework to focus the efforts of F/P/T governments towards a common vision for the Canadian food safety system.

Likewise, in public health surveillance and emergency response the relationships between F/P/T governments are largely non-hierarchical (McDougall, 2009:20). Although the PHAC (and its 2006 enabling *PHAC Act*), as well as the 2005 Pan-Canadian Public Health Network (PCPHN) and *Blueprint*,⁶ are still in their infancy, the federal government is now responsible for managing national outbreak surveillance and emergency response and furthering F/P/T cooperation in these domains (Gammon,

2006:5). The FIORP designates the PHAC the lead in national foodborne illness outbreak investigations and national surveillance systems and the sharing of laboratory information like PulseNet are used through formal agreements between PHAC and the P/T. However, local or provincially contained outbreaks still remain the purview and management of local/regional and P/T authorities (with these authorities having the option to seek federal assistance). All three levels of government participate in various standard-setting and implementation activities in public health surveillance and emergency response, and albeit to varying extents, pay for the cost of these measures. And even though F/P/T relationships might appear more hierarchical in emergency plans for a national crisis (with the federal organizations theoretically leading), Ottawa does not have the constitutional authority to require P/T authorities to cooperate with, or transfer public health surveillance data to, the PHAC (Wilson, 2004:410; PHAC, 2008:16; McDougall, 2009).⁷ Transfers and cooperation must occur voluntary and thus F/P/T relationships in surveillance and outbreak emergency response remain predominantly non-hierarchical.

As Katherine Fierlbeck (2010:6) argues: the PCPHN *Blueprint's* intergovernmental structure

is a clear manifestation of collaborative federalism in public health...The network is governed by a council, which is co-chaired by the chief public health officer of Canada (the federal co-chair) and a provincial co-chair. Each P or T is also represented on the council, usually by an assistant deputy minister of health or a chief (or associate) medical health officer. The council is accountable to the F/P/T deputy ministers of health (thence to the Council of Ministers)...[T]he Council of Chief Medical Officers of Health...exists in a scientific and advisory capacity and reports through the PCPHN council to the F/P/T deputy ministers of health. Also acting in an advisory capacity are four F/P/T liaison committees and three limited-term task groups...The body of the Network comprises six 'expert groups' (communicable disease control, emergency preparedness and response, Canadian public health laboratories, surveillance and information, chronic disease and injury prevention and control, and health promotion).

The first four expert groups above are conceptually linked to issues of foodborne illness, yet their terms of reference, status and work plans remain in draft form (PHAC, 2008 15). As Fierlbeck (2010:7) describes, the eventual purpose of this complex network is to prepare, maintain and implement inter-governmental public health policies and strategies while "respecting the authority and limitations of individual jurisdictions and their right to manage their own public health functions and operations." Hence, the form of intergovernmental regime that best characterizes the current relationships surrounding food safety and inspection, and related public health dimensions like surveillance and emergency response in the case of foodborne illness outbreaks, is collaborative.

Reasons for the Listeriosis Outbreak and Failures in Response

The Weatherill and Williams (2009) reports, as well as other governments'/organizations' lessons learned exercises, have implicated the nature of intergovernmental relations and form of federalism in some of the failures of response to the listeriosis outbreak. The rest of this paper concentrates on the potential explanations

for intergovernmental ineffectiveness during the crisis, focusing on collaborative federalism in public health and food safety and related problems of coordination (gaps and overlaps), flexibility and responsiveness, and adaptability. Democratic assessment centers on issues surrounding the balance of majority rights versus minority rights and transparency and accountability in decision-making and communications. And finally, issues related to federalism are considered, including whether the jurisdictional sovereignty of the orders of government was generally respected in the response (Lazar and McIntosh, 1998; Wilson and Lazar, 2008). Through this analysis, some of the disadvantages of a collaborative approach to foodborne illness emergency response are demonstrated. Some of the advantages of moving toward a hierarchical approach, in which the federal government takes a greater lead in public health surveillance and emergency response, are further considered.

Truly, there were many causes that contributed to the listeriosis outbreak and the overall readiness and effectiveness of the response. Although the following analysis concentrates on factors related to federalism, equally noteworthy in reports like those of Weatherill (2009) and the SubCommittee (2009) were roles played by the private sector and key government organizations involved in the food safety regulatory system. Maple Leaf Foods meat processing management and staff erroneously thought their food safety plan, *Listeria* control program and sanitation efforts to contain occurrences of *Listeria* from 2007 to 2009 at their Bartor Road plant were effective. At the same time, Maple Leaf Foods did not voluntarily track trends or notify CFIA inspectors about their periodic incidents with increased levels of *Listeria*, nor were they required to do so in the federal CVS. Accordingly, the CVS suffered from problems of design and planning as well as a lack of resources and capacity needed to implement inspections effectively. Federal *Listeria* controls (e.g. in the CFIA's *Meat Hygiene Manual of Procedures* and Health Canada's *Listeria* policy) and other food safety programs, regulations, directives, monitoring programs and manuals were also in need of clarification and strengthening; a lack of integration within and coordination between federal organizations' policies created gaps and overlaps in the system (Government of Canada, 2009: xii). Both the private and public sectors were further slow in adapting to (or in the case of Health Canada approving) new approaches, technologies and food additives to control *Listeria* and increase system effectiveness, including some already deemed successful by international and other national jurisdictions. The food processing equipment used by Maple Leaf Foods was further plagued by design and operation complications, which made cleaning and sanitation difficult, thereby implicating the manufacturers. Finally, relevant P/T ministries and regional/local organizations, establishments selling food or providing food services (especially those catering to vulnerable populations), food handlers and consumers: all played varying roles in this food safety crisis (Government of Canada, 2009; Government of Ontario, 2009; Toronto Public Health, 2009). Thus, the causes of the listeriosis outbreak and its manifestation were numerous and complex. Indeed, many of the reform recommendations from the Weatherill (2009), Williams (2009) and other reports offer remedies to rectify these private/public sector problems, and interagency regulatory dilemmas, in the food safety system.

Federalism and Failures: Evaluating the Response Effectiveness

In terms of federalism, explanations for governmental failures during the outbreak and response center on effectiveness issues related to coordination (gaps and overlaps), flexibility and responsiveness, and adaptability. First, the creation of the FIORP by F/P/T partners – in theory - reduced important gaps in the food safety system dealing with the management of national foodborne illness outbreaks and multi-jurisdictional emergency response. However, in practice, few of those involved in the listeriosis outbreak were familiar with the FIORP (and the relevant, complementary bilateral agreements such as the *Ontario Foodborne Health Hazard and Illness Outbreak Investigations Memorandum of Understanding* and the *Food Premises Plant Investigation: Multi-Agency Roles* document) (Government of Canada, 2009: 64; Government of Ontario, 2009:20). For those who were aware of the FIORP, many did not recognize it as “the protocol to be used during the outbreak to avoid duplication or to fill gaps” or to coordinate activities nor did they widely understand it (Government of Canada, 2009: xii, 66). In fact, the FIORP was never activated formally by the Governments of Ontario and Canada in the outbreak (Government of Ontario, 2009; Government of Canada, 2009).⁸ Governments (e.g. the Ontario Ministry of Health and Long-Term Care and the PHAC) thus did not establish OICCs with clearly identifiable leads. Provincial emergency response plans were also not fully utilized during the outbreak (Government of Ontario, 2009:20). This means that “...no single organization took the overall role of coordinating the actions of the various parties involved” (Government of Canada, 2009:64). Instead of relying on the formal intergovernmental agreements to share information about the emergency in a timely way, coordinate activities and work collaboratively, F/P/T partners conducted ad hoc communications and management via informal mechanisms like conference calls (Government of Canada, 2009: 64-65). The independent and lessons learned reports cite numerous instances where information (e.g. surveillance information, epidemiological and laboratory data) was not shared adequately among F/P/T partners to maximize the effective execution of the response (Government of Canada, 2009; Government of Ontario, 2009). Without sufficient knowledge or routine practice of the emergency plan, the protocol did little to increase the flexibility, responsiveness and ability of public health and food safety officials to adapt effectively to the outbreak (Government of Canada, 2009: 66). The response also demonstrated how F/P/T information-sharing agreements are incomplete and did not assure the receipt of timely, accurate and complete data.

Of course, once cases of listeriosis were identified nationally, the PHAC did assume the coordinating role for surveillance and the epidemiological investigation in line with the FIORP (on August 15, 2008; Government of Canada, 2009:55). In part, delays in identifying the outbreak occurred because listeriosis was not included in the list of ‘nationally notifiable’ diseases. There are also significant gaps in surveillance and laboratory systems and hence major problems with F/P/T information flows (Government of Canada, 2009:72-74; McDougall, 2009:37). Earlier, the CFIA initiated the food safety investigation once the (federally regulated) food plant/product was suspected (on August 7, 2008; Government of Canada, 2009: 51). And with the salient exception of leadership, it seems that the roles and responsibilities of the federal partners and interagency relationships between the PHAC, CFIA and Health Canada were relatively clear to each other during the outbreak (CFIA, 2009; Health Canada, 2009; PHAC, 2009:12). Importantly, however, they were not clear to the P/T partners, media and public (PHAC,

2009:12). Likewise, interagency roles and responsibilities at the P/T level were often not fully understood by the federal partners, media and public.

With regard to public health leadership, Williams (2009:20) reports:

It was not clear to the partners which responsibilities rested with the PHAC and the federal Chief Public Health Officer, and which ones with the Chief Medical Officer of Health in Ontario. It was also not clear whether the lead federal agency was PHAC or the CFIA, or to what extent local medical officers of health or the Chief Medical Officer of Health in Ontario could act alone to protect public health.

Accordingly, Weatherill (2009:xii) concludes:

The lack of a clear understanding about which organization or level of government was responsible for doing what – including which organization should lead the response to the crisis – contributed to the inconsistent management of the outbreak.

The Subcommittee (2009) and lessons learned reports from F/P/T partners and regional/local health organizations reiterate this message.

Moreover, the FIORP (and bilateral agreements) themselves contain a lack of clarity about the specificity of roles/responsibilities and leadership (CFIA, 2009; Government of Ontario, 2009: 24; Government of Canada, 2009; xii; Health Canada, 2009; PHAC, 2009:12). Recall the FIORP essentially divides responsibility for the management of a foodborne illness emergency between the PHAC and CFIA. However, if the PHAC formally activates an OICC, it essentially performs the central coordination role at the national and federal levels. Certainly, the PHAC could have activated an OICC as envisioned by the FIORP and *PHAC Act* and assumed the leadership role. It did not. Indeed, this is unfortunate because one of the goals of creating the PHAC (and revising the FIORP in 2006) was to avoid problems of a lack of coordination, which Canada had learned when confronted with Severe Acute Respiratory Syndrome (SARS) (Government of Canada, 2009:65; Wilson, 2008). As the Weatherill (2009:65) report argues: “We are convinced that strong national leadership for foodborne emergencies is required as a national priority. We conclude that the PHAC is the organization best placed to take on this role.” The Williams (2009:3.2) report concurs: “In the event of a...national/international outbreak, the federal Chief Public Health Officer [of the PHAC] should chair a National Outbreak Coordinating Committee...In the event of a...P/T outbreak, the P/T Chief Medical Officer of Health [e.g. of the Ontario Ministry of Health and Long-Term Care] should establish and chair a P/T Outbreak Coordinating Committee.” F/P/T partners thus desire stronger federal leadership in public health and national foodborne illness emergencies to increase the effectiveness of response. They further argue that the federal authority of the Minister of Health and Chief Public Health Officer to protect the health of Canadians in such emergencies is derived legitimately from the *Food and Drugs Act* and *Department of Health Act* (Government of Canada, 2009: 66). Whether desired by P/T partners or not, the listeriosis crisis also illustrated how increased federal direction in surveillance is urgently required (McDougall, 2009).

Democracy

Democracy issues center on balancing majority rights versus minority rights and transparency and accountability in public health decision-making and communications. The division of responsibility for direction in the FIORP between the CFIA (AAFC) and PHAC further presented problems for democracy as the protection of public health and the rights of the majority of Canadians seemed often not to be the overarching priorities in the outbreak response. Recall the CFIA and P/T and local/regional public health authorities have differing criteria and methods to inform decisions about whether to advise consumers and organizations to suspend consumption of suspected hazardous food. In the case of Ontario, the local and provincial officers of health, based on epidemiological information and food sample tests of opened packages, placed precautionary holds on suspected foods to protect public health, acting independently from the CFIA and other P/T partners. Accordingly, the federal/CFIA approach to such decisions, to wait for more stringent laboratory evidence based on unopened packages to issue a national food recall, and its prioritization and protection of minority rights (e.g. those of the food industry) over majority rights (e.g. those of the entire population) was widely criticized. In order to ensure public health is the priority, the Weatherill (2009:71) report recommends federal organizations reform "...the criteria for proceeding with a food recall to ensure that the weight of evidence takes into account epidemiological information, including suspected illnesses and deaths, geographic distribution, and food sample test results whether packages are opened or unopened."

In addition, the CFIA did not promptly disclose the results of its investigation of the implicated plant, the distribution of the products implicated in the outbreak, and corrective actions taken to P/T food safety partners, local/regional public health authorities and the public (Government of Canada, 2009: 66). As the Williams (2009:3) report notes: "If public authorities had had timely access to this information, they might have been able to take additional targeted steps to reduce possible exposure among the general public." Hence, decision-making processes in times of crisis need to be more transparent and accountable to all partners and the public in order to better respect democratic principles. To be effective in protecting public health, decision-making also needs to be based on multiple approaches and sources of evidence, involving the adequate sharing of information between public health and food safety F/P/T partners. In the Williams (2009) report, there is discussion of strengthening Ontario's statutory authority to manage a provincial outbreak, so that it can continue to act independently from other F/P/T partners in a more precautionary way to protect public health. Of course, if the federal approach were to change toward precaution under increased leadership in public health, this would be less of a concern for P/T partners.

Similarly, F/P/T governments' public communication efforts were less effective and democratic because of the focus on food safety and the inadequateness of the FIORP in assuring communication leads and coordination. For example, federal communications were "...not oriented enough toward informing the public of a potential hazard, but instead focused on gathering scientific evidence to confirm the foodborne illness and its source" (Government of Canada, 2009:77). The federal government further sanctioned the Minister for AAFC to head communications, in combination with the head of Maple Leaf foods (supported by the CFIA), thought by some to be a 'conflict of interest' and privilege the interests of the food industry (Government of Canada,

2009:80). It also contradicted the FIORP, which designated responsibility for national communications to both the CFIA and PHAC. Questions arose during the outbreak from the public health community, Canadians and the media about whether public health was being adequately protected and why the Chief Public Health Officer was not the “leading national voice for public health” as intended by the 2003 National Advisory Committee on SARS and Public Health and the *PHAC Act* (Wilson, 2008; Government of Canada, 2009:80; Government of Ontario, 2009:6). In contrast, communications at the local and P/T levels were being managed by health ministries and public health authorities.

As Williams (Government of Ontario, 2009:5) argues:

Communications were not well coordinated among these different levels of government. The lack of coordination contributed to public confusion and created the impression that the outbreak was not being well managed, which affected public trust and confidence in the public health system.

Specifically, without a designated OICC and chief communications coordinator/strategy, F/P/T and local public health authorities’ communications were “fragmented” and plagued with “inconsistent messaging” and misunderstandings about the division of roles and responsibilities among partners and organizations (Government of Canada, 2009:81). Thus, the public and private sectors, as well as citizens, were unclear about the lines of accountability within organizations and levels of government. Citizens in particular were confused about where to go for food safety and public health information in order to protect themselves from the hazardous food and who to hold responsible for the outbreak and response. In order to rectify these effectiveness and democratic dilemmas, the Weatherill, Williams (2009) and other lessons learned reports recommend that public health priorities and principles of risk communication should definitely drive F/P/T communications in the future (e.g. from the Health Canada/PHAC *Strategic Risk Communications Framework* and handbook). They also stress that in a national outbreak, a new FIORP should clearly designate the PHAC the lead of communications and coordination and the Chief Public Health Officer the official media spokesperson (Government of Canada, 2009:81; Government of Ontario, 2009:6). In a P/T outbreak, the P/T Chief Medical Officer of Health should be the central communications spokesperson (Government of Ontario, 2009:6).

Impacts on Federalism

Issues related to federalism address whether jurisdictional sovereignty was respected in the response. Although the current, collaborative intergovernmental regime in food safety and public health suffers from effectiveness and democracy dilemmas evident in the outbreak management, it was generally perceived by F/P/T partners to respect the formal divisions of powers contained in the Constitution as well as the political sovereignty of the orders of government. The intergovernmental structures and systems in both food safety and public health were specifically designed to respect the shared (or ambiguous) jurisdictional sovereignty of partners and promote a “principled, spirit of cooperation” (Gabler, 2008; McDougall, 2009; PHAC, 2009:12). In theory, they are also in place to ensure effective intergovernmental communication is maintained and any disagreements can be adequately addressed through ongoing dialogue and negotiation.⁹ Importantly, P/T governments’ talk of concerns about respect for the primacy of their

jurisdictional sovereignty was limited primarily to instances when they perceived the federal government not to be effectively leading and serving the interests of public health over food industry concerns (Government of Ontario, 2009). Federal officials pointed mainly to concerns with P/T governments about surveillance and the sharing of information about public health in the emergency (e.g. epidemiologic and other laboratory data). P/T officials' criticisms here rested on the CFIA and its inadequate disclosure of information. Despite such disagreements, discourse about violations of jurisdictional sovereignty was minimal to non-existent in the governments'/organizations' lessons learned reports. Concerns were voiced more about the effectiveness of the response than issues related to jurisdictional sovereignty.

Analysis of Form of Federalism

Looking back historically, collaborative federalism in food safety has been somewhat successful, if slow, in furthering agreement among F/P/T governments to develop the preliminary components of a nationally integrated system (Gabler, 2008). As Wilson, McCrea-Logie and Lazar (2004:189) argue: "Collaborative approaches appear to be successful in designing and...developing widespread consensus." Conversely, in public health, success through collaborative federalism in terms of facilitating consensus and ensuring concrete work toward integration and comprehensiveness in national systems is less evident at this early stage (e.g. surveillance and emergency response) (McDougall, 2009). What is clear is that the 2004 Working Group on a PHAC ultimately rejected (federal) unilateralism over collaboration. It reasoned it was "neither appropriate nor practical" and would bring "intergovernmental discord and...make the effective and coordinated delivery of services...problematic." As Fierlbeck (2010:9, 7) argues: "...the decision was clearly made to proceed on the grounds...[of] collaboration" in order to respect the shared (or ambiguous) constitutional authority of the jurisdictions and rely jointly on national, P/T and local capacity and funding to achieve public health goals. As pertains to the listeriosis outbreak, for example, the Weatherill (2009:93-94) report calls for enhanced collaborative efforts in federalism (e.g. through the existing F/P/T Food Safety Committee and PCPHN network) "...to address current gaps in the multi-jurisdictional management of foodborne emergencies" and revise related national strategies and the FIORP. She also recommends the creation of a new F/P/T committee dealing with programs on foodborne illness and national preparedness for foodborne outbreaks, composed of health and agriculture officials, reporting regularly to the federal Minister of Health (Government of Canada, 2009:xxiii).

Equally, however, governments'/organizations' reports and lessons learned speak to the advantages of increased hierarchical (federal) leadership in prioritizing public health and ensuring more effective and coordinated surveillance and emergency response. In a future national/international outbreak, F/P/T partners' and organizations' recommendations appear in agreement that the FIORP (and PHAC structure) be revised to ensure the PHAC and Chief Public Health Officer direct and determine how public health matters should be addressed, and to ensure they are fully prioritized in a response (Government of Canada, 2009; Government of Ontario, 2009). Here, the P/T governments involved seem to actually desire stronger federal leadership in public health, surveillance and emergency response. Concerns about increasing hierarchy in the collaborative approach, for example as a violation of P/T jurisdictional sovereignty, were not explicitly voiced by Williams (2009) and government officials in Ontario.

Likewise, the Weatherill (2009:66) report argues that the federal government should better rely on its significant powers and legislative authority in the future to lead nationally in public health and address foodborne illness emergencies. The PHAC is again singled out as the organization to lead. These recommendations speak to the benefits of more unilateral (federal) direction in surveillance and emergencies that were considered (but ultimately rejected) by the 2004 Working Group on a PHAC. As Wilson, McCrea-Logie and Lazar (2004:189) argue: a more "...hierarchical approach has the advantage of clearly allocating roles and responsibilities across orders of government, producing better defined accountability and allowing for the introduction of reform in a faster manner." Getting creative with federalism in foodborne illness emergency response reforms could certainly reap some of these advantages.

In terms of lessons learned about the form of federalism, therefore, the overall message is that collaboration without adequate federal direction and leadership in public health contributed to failures in the response to the listeriosis outbreak. The advice for reform is further clear: strengthen the extant, collaborative systems, but also complement them with increased federal direction in public health and initiatives in areas such as surveillance and emergency response. Of course, where the advice remains silent is on the mechanisms the federal government should take to achieve movement toward increased leadership, for example through legislation, conditional spending or both. Whether the federal government is willing to undertake substantial reform and use these instruments to change the current form of collaborative federalism also remains unclear. What seems to be needed is increased creative federalism in public health (Wilson and Lazar, 2008). For as this intergovernmental analysis of the listeriosis outbreak has shown, the current collaborative form of federalism alone does not seem to be prioritizing public health and ensuring the most effective response to foodborne illness emergencies.

Conclusion

Relying on a framework to classify and evaluate intergovernmental relationships in public health, this paper has demonstrated that the present arrangement in the cross-cutting areas of food safety and public health can be best described as collaboration, characterized by interdependence and non-hierarchy. The paper has further argued that some of the failures of the multi-jurisdictional response to the 2008 listeriosis outbreak were a result of this form of federalism. Specifically, the evaluative analysis showed that collaborative federalism, in the absence of complementary hierarchical (federal) commitment and leadership in public health areas such as surveillance and emergency response, created ineffectiveness and democratic dilemmas. Ultimately, public health took a back seat to food safety and industry concerns in the outbreak response. Further, the extant, collaborative, intergovernmental arrangements generally respected jurisdictional sovereignty, yet did not facilitate effective coordination, cooperation and flexibility/adaptability in response management, nor did they preserve democratic principles such as transparency and accountability in communications. Following from the Weatherill and Williams (2009) reports, as well as other governments'/organizations' lessons learned, the advice for reform is that collaborative federalism needs to be first strengthened and second combined with increased federal direction in public health areas such as surveillance and emergency response. This sort of creative federalism will increase the effectiveness of governments to address public health priorities and respond to foodborne illness emergencies in the future.

Unfortunately, scholars like Fierlbeck (2010:12) argue that the current Harper Conservative government's open federalism stance does not easily embrace alternative models of federalism for public health such as federal unilateralism and presumably combinations of collaboration and coercion (creative federalism). So far, the federal government's approach to act on the 57 recommendations of the Weatherill Report is to move toward strengthening collaborative arrangements in managing food safety risks and the food safety system and in enhancing surveillance and emergency response through extant intergovernmental structures (See the CFIA's Progress on Food Safety as of March 31, 2010 at <http://www.inspection.gc.ca/english/fssa/proge.shtml>). For example, F/P/T partners are reportedly taking steps to improve laboratory networks and disease reporting networks and revise the FIORP. To accomplish these goals, the Government of Canada committed \$75 million dollars in September 2009. However, change toward increased federal direction and leadership in developing a truly integrated and functional national surveillance system and an effective emergency response plan through some sort of new creative federalism is not forthcoming (McDougall, 2009).

Notes

The author acknowledges with thanks the research assistance provided by Joshua Mandryk.

¹ F/P/T officials estimate the first case of the outbreak began in June 2008 (Ontario). The outbreak was officially declared over in jurisdictions differently. Ontario's Chief Medical Officer of Health declared the outbreak over in December 2008.

² Telephone and personal, semi-structured interviews were conducted with a total of sixteen policy officials: ten federal (Agriculture and Agri-Food Canada, the Canadian Food Inspection Agency, Health Canada), five provincial (Ontario and Saskatchewan) and one expert.

³ Increasingly, food safety policies and standards are based on scientific principles and risk assessment procedures developed through expert consultation in international standard setting organizations such as the Food and Agricultural Organization/World Health Organization's joint Codex Alimentarius Commission and the Organization for Economic and Development Cooperation. By nature of its treaty-making power, the Government of Canada can enter into international agreements and participate in these international organizations' initiatives in food safety and public health (Wilson, 2004:410).

⁴ The sharing of F/P/T laboratory information occurs through the Canadian Public Health Lab Network.

⁵ Notably, there is a 2001 F/P/T *Protocol on Information-sharing and Collaboration on Food Safety Matters*.

⁶ The blueprint for building the PHAC came from the 2003 and 2002 reports issued by the Special Committee on Severe Acute Respiratory Syndrome and Public Health chaired by Dr. David Naylor and by the Senate Standing Committee on Public Health chaired by Senator Michael Kirby respectively.

⁷ There is a draft F/P/T *Memorandum of Understanding on Information Sharing during a Public Health Emergency*, among other draft *Information Sharing Agreements related*

to Public Health. There is also a F/P/T Memorandum of Understanding (MOU) on the sharing of information in preparing for and responding to a public health emergency.

⁸ The outbreak first emerged in Ontario and was originally under provincial leadership. It then expanded to, eventually, 57 cases across seven provinces, falling under federal leadership.

⁹ Like the FIORP, the extant intergovernmental structures were minimally relied on during the outbreak response. One exception was the task group on pandemics communications. It was used regularly by PHAC and P/T communications officials throughout the outbreak (PHAC, 2008:16).

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