Collaboration, Competition, and Coercion: Canadian Federalism and Blood System Governance

by

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Abstract

The blood supply occupies a special place within the provincial public health systems: it is something that Canadians expect to be safe, well run, and available when needed. In the 1970s and 1980s, the Canadian blood system dealt with a significant crisis: a tainted blood scandal. The federal *Commission of Inquiry into the Blood System in Canada* issued a report condemning, among other things, the governance structure of Canada's blood system. As a result, the provincial and federal governments worked to make changes to the way they funded, oversaw, and regulated the blood industry in Canada. It appears that the changes they instituted resulted in an improved blood system and improved the relationship between the governments and the blood system. Traditional models of federalism do not account for how the federal and provincial governments interacted. In their response to a crisis that affected thousands of Canadians, there were elements of collaboration, competition, and coercion. It is possible that a new "mode" of federalism is emerging as a result of these changes; it is more likely, however, that the crisis *forced* the governments to collaborate and create a national system to supply Canadian needs.

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Dedication

To the employees and volunteers at Canadian Blood Services. Your dedication and professionalism surely helps to *build a better blood system for Canadians*.

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Chapter 1

Introduction

Canada's health care system has some serious problems. The public wants to spend less and receive more value for its money. More importantly, decisions for funding are politically driven, forcing health care providers to spend money in areas that may or may not be important.[1] There are limitless spending opportunities while there is also a limited amount of money to fund them. Constitutionally, the provinces have responsibility for health care while the federal government tries to set the rules of the game through the *Canada Health Act.*

Much ink has been spilled discussing the conflicts inherent in a system in which one level of government administers health care while both levels of the system contribute in considerably different proportions to its funding. One area that has not received as much attention, however, is the non-hospital sector of health care delivery. Specifically, Canada's blood system and its governance have gone virtually unexamined, particularly by political scientists. In some ways, it is strange that students of politics and federalism have generally ignored an area as politically charged as it has been in recent years. After all, the tainted blood scandal of the 1980s affected profoundly the way in which Canadians view the blood supply. It decreased the trust Canadians placed in the Red Cross Society as a provider of clean blood and blood products; it changed the way in which Canadians view donating blood; it changed the way in which the blood system is administered and governed. As news reports delved deeper into the causes of the tainted blood scandal, public confidence eroded and the governments re-evaluated the role of the Canadian Red Cross Society in Canada's blood system.

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[1] From a presentation in June 1998 by Dr. James Aubuchon entitled, "The Role of Decision Analysis in the Making of Healthcare Policy"

After the Second World War, the Red Cross took responsibility for the administration of the blood system in Canada. Over the course of its work, the Society lost complete control of the system's financial end and the provincial governments gradually took over its funding. When, in the 1980s, the system failed to screen out properly the HIV/AIDS and Hepatitis C viruses, Canadians' faith in the blood supply was sorely shaken.

The changes in the system and the political fallout from the Red Cross make this a subject worthy of study. Specifically, the creation and governance of the current manufacturer and distributor of blood products – Canadian Blood Services (CBS) – should be of interest to students of federalism and public administration. Each government of Canada – provincial, territorial, and federal – has a stake in ensuring that the blood supply remains intact and that Canadians retain their faith in it. After all, the various governments failed in the 1980s and spent a great deal of time in the 1990s trying to prove that something similar could not occur again. This failure is twofold: first, the governments did not act together to govern the blood system under the Red Cross; and second, there was no mechanism in place to ensure effective management and lines of accountability to the Canadian people, who ultimately hold the greatest interest in a safe, cost-effective blood system.

The creation of Canadian Blood Services required the co-operation of each of these governments. The federal government regulates the blood system and oversees the safety of the blood supply pursuant to Good Manufacturing Practices (GMPs) established by Health Canada. The provincial governments act as "shareholders" in that they fund the system and provide broad policy direction for the corporation. In other words, the annual budget and everything CBS plans in a given year requires the co-operation of the provincial governments

through the Ministers of Health.[2] In some ways, that this occurs at all is surprising given the difficulty many governments seem to have in agreeing on other contentious issues facing Canada.

To examine thoroughly the discussions, compromises, and disagreements that go into making Canadian Blood Services work, a number of things need to be considered. In particular, since both levels of government are involved, various theories of government relations in a federal system need to be examined. By reviewing pertinent literature, a theoretical framework can be fashioned.

Next, Canadian Blood Services needs to be placed in historical context. To that end, both an historical review of the governance of the blood supply in Canada and an overview of the blood system under the Canadian Red Cross Society will be given. Its governance, funding formulae, and the causes of the tainted blood scandal will be discussed.

The events of the 1970s and 1980s culminated in a national tragedy of such magnitude as to require an independent commission to report on the events and provide recommendation for systemic reform. A review of these events and the ways in which the federal and provincial governments behaved in this time will help shed some light on the reasons for the changes in the blood system.

An analysis of the Krever Inquiry and its recommendations is also necessary for understanding the creation of Canadian Blood Services. The Krever Report is one of the most important documents in the story of the Canadian blood system, as it changed forever the way in which the blood system operates.

[2] As this thesis will show, the provincial governments do not take a direct part in running the blood system, but their consent is required for the blood system to undertake its mission each year.

The creation, funding, and governance of CBS will also be discussed as its place in Canada's federal system of government is extremely important. After all, it is a national organization run by provincial governments, and as such, is subject to the conflicting views of the different provinces. Its creation was a thought-out response to specific events and criticisms; its funding designed to correct the mistakes of the past; its governance system created with a specific goal in mind: to never again allow the blood system to fail as it did in the 1970s and 1980s.

The goal of this thesis is to examine the role played by the governments of Canada in dealing with the Canadian blood supply. The history, circumstances, and scientific discussions surrounding Canada's blood system and its problems are secondary to this examination. The provinces' benign neglect of the Canadian blood system in the 1980s changed the focus of the different governments; their failure to ensure the safety of the blood supply was a direct cause of the blood tragedy. In neglecting the blood system and its operator, the provincial and territorial governments did not live up their role as the ultimate governors of public health in this country. As a result, they had to examine their roles and responsibilities in the blood supply. In doing so, they also had to examine the intergovernmental relationships that helped cause the tragedy and refocus their efforts on active prevention of problems. They created a blood system from the bottom up in order to ensure that there are mechanisms in place to monitor blood system in a proactive fashion rather than the *ad hoc* and reactive basis on which it was administered in the 1970s and 1980s.

Until the *Commission of Inquiry on the Blood System in Canada*, governments did not pay much attention to the Red Cross's Blood Transfusion Service. In fact, the provinces neglected the system so much that they bear partial responsibility for the scandal and its

aftermath. After a decade of constitutional federalism and collaborative federalism, provincial governments were forced into action and took control of the blood system in an effort to react to the recommendations made by the Commission and to plan for the future of Canada's blood supply. The federal and provincial governments acted as "crisis managers" when dealing with the blood system. Canadians reacted so strongly to the failure of a system they thought was safe that the governments were all forced into action. The emergence of a new form of federalism– "coercive federalism" – from this series of events in blood system reform could even be a new way of looking at federal-provincial relations. It is more likely, however, that it was the crisis that precipitated the change in government behaviour, not a change in the way governments view one another.

Health care in Canada is a responsibility shared by the national and provincial governments. Health issues are so important to the Canadian people that it is incumbent upon federal and provincial governments - at both the political and bureaucratic levels – to work well with each other. Governments could interact with each other in many different ways.

The argument of this thesis is that examination of the development of blood system governance in Canada suggests that federal-provincial relations in the modern period contain three elements: collaboration, competition, and coercion. To date, disagreements have on occasion become acrimonious, but governments have avoided warfare. In so doing they can best be viewed as "interdependent competitors."[3]

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[3] Alan C. Cairns, "The Governments and Societies of Canadian Federalism," *Canadian Journal of Political Science*. 10:4 (1977): 695-725.

Chapter 2

Theoretical Framework

The Canadian system of government is a federal one; that is, there are two distinct levels of government representing the national and provincial arenas. In the Canadian case, the federal and provincial governments are assigned specific responsibilities in the *Constitution Act, 1982* (originally, the *British North America Act, 1867*). One consequence of federalism is that the two levels of government share the same set of voters (that is to say, the same citizens who elect a federal government also elect a provincial one.) This is even more important in a province like Ontario, which has the same ridings as the federal government. This, in turn means that "[c]itizens are expected to be members of and loyal to, both the national community, embodied in the national government, and the provincial communities reflected in their provincial governments."[4] A second consequence of the federal system of government is that the federal and provincial governments must communicate and work in a number of different ways: separately; one dominating the other; as competitors; or as collaborators. The provincial and federal governments have worked in each of these ways over the course of Canada's history.

It is important to examine these themes of federalism to understand more fully *how* Canadian federalism works and how the provinces failed in the 1980s. We will examine each of the phases of Canadian federalism to have a better understanding of their impacts on the governance of Canada's blood supply. This theoretical framework will provide a background into federalism, which will help to explain some of the actions of the provincial governments

[4] Ian Robinson and Richard Simeon, "The Dynamics of Canadian Federalism" in James Bickerton and Alain-G. Gagnon (eds.), *Canadian Politics*, 3rd ed. (Peterborough: Broadview Press, 1999), p. 240.

in running the Red Cross's Blood Transfusion Services and in creating Canadian Blood Services.

"Made in Canada" – A country is born

In 1867, the creation of the Dominion of Canada brought disparate colonies together under one national government. The system of government chosen was the result of negotiation between the colonies. In choosing a federal system over other options, the Fathers of Confederation chose one flexible enough to undergo a series of changes, which is precisely what has happened over the course of Canadian history.

In constructing a political system, the Fathers of Confederation had to contend with a number of issues. They had to unite very different colonies with very different needs; they had to set up a political system that would work across what was then a very large land mass; they had to deal with the political realities of each of the colonies. In short, the Fathers of Confederation had quite a challenge when they set out to build a country.

There were three different approaches to setting up the Canadian government. The first option was a unitary system, wherein all governmental powers were reserved for one level of government, as in the United Kingdom (until recently) or France. The second option was to create a federal system and give powers to two levels of government: national and local. The third option was a confederal system, wherein the parts of the system are supreme; the constituent parts give legitimacy and power to the central government.

The Québec and Maritime delegates to the Confederation conferences were worried that a federal system of government would make the provinces "merely large municipal corporations."[5] In some ways, this assessment turned out to be accurate, as the provincial

[5] Discussion by the Fathers of Confederation in Sir Joseph Pope (ed.), *Confederation Documents Hitherto Unpublished,* (Toronto: The Carswell Co., 1895), p. 84.

legislatures became responsible for "local issues."[6] However, as the welfare state expanded in the 1930s and 1940s, provincial powers grew in importance and provinces became more powerful within the federation.

Even the compromises reached at the Confederation conferences did not change the relative power of the federal over the provincial governments. Although both orders of government had defined spheres of responsibility and each was sovereign within those spheres, the federal government was still more powerful. Unlike the federal-provincial co-operation required today given the overlap in spheres of responsibility, the *British North America Act* (1867) allowed for the possibility of eventual control of the provinces by the federal government.[7]

The federal system created by Confederation placated the provincial desire for autonomy expressed by Nova Scotia delegate Edward Chandler, who argued that provinces had to have a certain amount of power or else they would have "less powers than they have allowed them from England".[8] More importantly, however, the federal government could find a number of different ways to interfere in provincial areas of jurisdiction. Three of the most important were the power of the Crown through the Governor General to appoint the Lieutenant Governors; the powers of reservation and disallowance; and the general powers accorded the federal government "to make laws for the Peace, Order, and good government of Canada."[9] These powers were important in their own way, but are not important to the argument in this

[6] F.R. Scott, "Centralization and Decentralization in Canadian Federalism," in Garth Stevenson, ed. *Federalism in Canada: Selected Readings,* (Toronto: McClelland & Stewart Inc., 1989), p. 53, 58.
[7] Gordon Robertson, "The role of Interministerial Conferences in the Decision-Making Process" in Richard Simeon, ed. *Confrontation and Collaboration – Intergovernmental Relations in Canada Today*. (Mississauga: Imperial Press, Ltd., 1979), p. 78.
[8] Pope, p. 84.
[9] *British North America Act* (1867)

thesis except that they were indicative of the primary role of the national government compared to the provinces.

Another indication was the absence in the 1867 document of any reference to the matter of constitutional amendment, except for the wording in the preamble that the colonies wished to be "federally united … with a Constitution similar in principle to that of the United Kingdom." Despite the reference to federalism within a British parliamentary system, the lack of specific discussion made the implication clear: constitutional change did not necessarily involve the provinces. Soon after Confederation, however, the question of how to interpret the BNA Act became a matter of controversy.

Compact or Confederation?[10]

There are two schools of thought surrounding interpretation of the BNA Act: is it a compact between the English and French to create a single country, or a true federation of provinces united under one Canadian banner through Confederation? The interpretation of the intentions of the BNA Act is important because it has serious implications for the way Canadian governments operate. After all, if Canada is a compact, then intergovernmental co-operation is essential to making the country work; under this theory, the country only exists because the provinces make it work.[11] On the other hand, if the federal government holds power of its own accord, then it can dictate to the provinces using its powers as enumerated in the *British North America Act*.

[10] "Confederation" is used in this sense as the union of the provinces to form the Dominion of Canada. The Dominion is not a confederal system, so the term "Confederation" is somewhat of a misnomer. However, it is also the identifier of a specific event in time and is therefore used in this thesis.
[11] However, intergovernmental co-operation is only "essential" according to the provinces that decide it is. Others could argue that "essential" is a value judgment and not an objective statement of fact under the compact theory.

By the time the Confederation conferences resulted in agreement, it was clear that, despite Macdonald's desire for a legislative union, a federal system was the only one that could be workable. After all, in addition to the Canadian experience of differing cultures, laws, and religion, the Maritime Provinces had equally distinct issues that one Canadian Parliament could not necessarily resolve. Federalism appeared to be the only available option.

Sir John A. Macdonald believed that the federal government would eventually reign supreme over the provincial governments. The mechanisms for doing so were certainly in place within the BNA Act; as far as he was concerned, the federal government should take no note of the local levels of government and that he would triumph in the end.[12] In fact, it is clear that Macdonald's intent was to control the provinces through the federal government's rights and privileges.[13]

As it might be expected, provincial governments were unwilling to give up what they perceived to be their sovereignty. In fact, through decisions of the Judicial Committee of the Privy Council, provincial governments gained a great deal of power; Macdonald was not able to take control as he wished. Provinces, in turn, used their newfound power to great advantage within the federal system.[14] Not only did provinces get control over areas of their jurisdiction, but they also asserted themselves more on the national scene. This, in turn, forced governments to either work together on policy issues or compete with one another for the approval of the electorate.

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[12] Stanley, p. 98.
[13] Richard Simeon, ed. *Confrontation and Collaboration – Intergovernmental Relations in Canada today,* (Mississauga: Imperial Press, Ltd., 1979), p. 78.
[14] Alan C. Cairns, "The Governments and Societies of Canadian Federalism," *Canadian Journal of Political Science*. 10:4 (1977): 695-725.

Why is this important for the discussions in this paper? The federal-provincial relationship is of importance to students of federalism if for no other reason than government interaction and negotiation influences the ways in which policies are made. The evolution of federalism in Canadian history helps to define the ways in which policies were and are made.

Macdonald's vision of folding provincial responsibilities into the federal Parliament was never realized; the issue was whether the division of powers in the BNA Act would result in the separation of the two levels of government (except in areas of concurrent jurisdiction) or would the various Canadian governments interact with each other, either as competitors or collaborators.

In the evolution of the Canadian federation since 1867, there have been a number of changes, sufficiently different in magnitude that one can speak of "stages." Each stage meant a shift in the ways the governments talked to one another about issues concerning both levels. Usually, these matters centred on money and provincial autonomy. As Canada aged and areas of federal/provincial co-operation expanded, differing methods of communication, negotiation, or (non-) co-operation became features of the system

Federalism obviously involves governments. It also involves citizens. As political scientist Ian Richardson says, "Federalism is thus about the coexistence of multiple loyalties and identities and about shared, or divided, authority."[15] The requirement of support for both levels of government frustrates the attempts of one level to work unilaterally towards a goal. It further forces governments to try to work together for the common good of the individual provinces and the nation as a whole. In the following section, there will be an examination of

[15] Robinson and Simeon, p. 241.

how the federation has evolved, focusing on how governments interact with each other in the contemporary system.

Colonial Federalism

The first thirty years of Canadian history are about a country trying to figure itself out. After all, the colonies that formed the dominion had originally been provinces dealing with local issues. The new federal government needed to assert itself and undertake a period of nation-building to consolidate its power.[16] Ottawa did just that through Macdonald's National Policy[17], and through relentless use of all the powers provided by the *British North America Act*. In spite of provincial arguments that Canada was a compact among the provinces, Sir John A. Macdonald treated the provinces as colonies, and tried to keep them in the position of submission implied by that term.[18]

The "colonial federalism" of this period was highlighted by two factors. First, the Governor General and Lieutenant Governors played a much more active role within the federal and provincial governments. The Governor General, as representative of the British government, acted as such within the framework of Parliament. More importantly, the Lieutenant Governors acted on Ottawa's behalf to ensure that the provinces remained as colonies. Politicians at both levels of government treated their respective governors as monarchs with a real role to play in the system of government, something unthinkable today.[19]

The second item ensuring a colonial feel in Canada was the treatment of the provincial governments by the federal government. By using its constitutionally guaranteed powers of

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[16] Robinson and Simeon, p. 247.
[17] http://www.collectionscanada.ca/2/18/h18-2360-e.html
[18] J.R. Mallory, "The Five Faces of Federalism," in J. Peter Meekison, ed., *Canadian Federalism: Myth or Reality*, third ed. (Toronto: Methuen, 1977), p. 20. At the same time, the provinces fought for – and won – many concessions from the Judicial Committee of the Privy Council, which led to an increase in provincial power. Macdonald's strategy was not as successful as he hoped it would be.
[19] Mallory, p. 20.

disallowance and reservation, the federal government retained – technical – control over provincial legislation.[20] This treatment of the provinces as colonies only increased the desire of the provincial governments to stop Macdonald's use of federal powers and to gain real control over their constitutional areas of jurisdiction. As a result, the first federal-provincial conflicts began.

This conflict became more profound after 1890, when the chief nation-building exercises concluded. Linguistic and cultural minorities began to assert themselves; specifically, French Canadians in Québec started to argue that the provincial community – and not the federal – was best suited to defend their specific rights.[21] With this example to follow, the other provincial governments began to strengthen their powers *vis à vis* the federal government. The provinces emphasized that they had exclusive jurisdiction over the powers in section 92, and that the federal government should not use its constitutional powers to stop them. As the level of government empowered to deal with local issues, the provinces argued, they should be left alone to govern as they saw fit.[22] Indeed, Prime Minister Wilfrid Laurier argued that "it would be difficult to find a prominent politician who was not willing to pay at least lip service to the principle of provincial rights and its theoretical underpinning, the compact theory."[23] This notion of provincial rights is important to consider when dealing with colonial and classical federalism. After all, the assertion of provincial rights meant two things: "first, the provincial governments were converted from glorified municipalities into coordinate sovereignties in

[20] Mallory, p. 20.
[21] Robinson and Simeon, p. 247.
[22] Robinson and Simeon, p. 248. The 1896 Local Prohibition reference brought this issue to the fore. A man convicted under the Canada Temperance Act argued that he acted legally because he had a license from the province. Ontario and the federal government took the case to the Judicial Committee of the Privy Council, which ruled that this was a matter of overlapping jurisdictions; both the provinces and the federal government could have enacted legislation.
[23] Filipo Sabetti and Harold M. Waller, "Introduction," in Harold Waller, Filipo Sabetti, Daniel J. Elazar, eds. *Canadian Federalism: From Crisis to Constitution*. (London: University Press of America, Inc., 1983), p. 4.

matters of public policy. Second, the provinces acquired the right to be consulted about, and to share in the choice of, the formula for amending the BNA."[24]

Classical Federalism

The change from colonial to classical federalism did not occur suddenly. Nonetheless, the period from 1896 – the year of the Local Prohibition Case and the election of the Liberals led by Laurier, with a pro-province stance on language rights and the provinces – until the early 1930s can be categorized as "classical federalism." Each level of government kept largely to itself during this period, and the federal government used its powers less and less. Areas of concurrent jurisdiction had little conflict since interference by the state was still unacceptable.[25] In 1930, however, the Great Depression changed the role of government in Canada.

The collapse of the Canadian economy meant that federalism needed to be revised. Provincial governments, responsible for the social welfare of their constituents, "were driven to the brink of bankruptcy."[26] Nor could the federal government do much to help because the Judicial Committee of the Privy Council (JCPC) ruled against it, stating that Ottawa could not use its powers in areas of sole provincial responsibility.[27]

Classical federalism, then, meant that each level of government had its own watertight compartments that could not be penetrated by the other level. This view of federalism came under attack during the 1930s, as the federal government tried to help the provincial governments respond to the Depression of the 1930s, and the debate was opened even further during the Second World War. The emergency powers of the *War Measures Act* gave Ottawa

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[24] Sabetti and Waller, p. 5.
[25] Robinson and Simeon, p. 248.
[26] Robinson and Simeon, p. 248.
[27] Mallory, p. 22.

sweeping powers to interfere with areas of provincial jurisdiction.[28] As Canadians saw the effects of a quasi-unitary state, the governments began to discuss the re-alignment of constitutional responsibilities. Some thought that, with the change from a family-based economy to that of an industrialized one, a central government was better suited to deal with national problems like the Depression.[29] However, the provinces continued to object to this notion of centralizing government, forcing the federal government to re-think its approach.

Co-operative Federalism

This new approach was a period lasting approximately from 1945 until 1960. It was a period characterized by compromise and, as the name implies, co-operation. It was argued the federal government needed to play a greater role in administering the social programs run by the provinces; however, the provincial governments were reluctant to give up any of their powers. Ottawa continued its efforts to centralize political power at the federal level. In doing so, the federal government took over some areas of provincial jurisdiction by negotiating federal control over the provincial tax systems and through extensive use of the federal spending power. Classical federalism broke down as the two levels of government stopped thinking about their jurisdictions as "watertight compartments" and combined their efforts, although Québec had strong objections to the federal government participating (the province would have said "interfering") in provincial programs. Québec, in particular, fought for the continuation of watertight compartments throughout this period, but the federal government controlled the period with its continued dominance over the provinces in terms of social programs.

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[28] Mallory, p. 23.
[29] Robinson and Simeon, p. 249. The Rowell-Sirois Commission, appointed by the federal government to examine the nature of Dominion-provincial relations, did not recommend centralization as a solution to the problems. Instead, it recommended that the provinces retain significant control over how services are delivered within their areas of constitutional jurisdiction. The Commission did recommend, however, that the federal government ensure that services delivered by the provinces could be offered across the country at similar quality from one province to the next.

It was widely assumed that the federal government, using its fiscal and monetary policies along with its spending power, would be able to generate, direct and co-ordinate public policies better than the provinces could on their own.[30] There was an argument that the Canadian constitution was written before the welfare state became a necessity and that the federal government was in a better position to offer many of the social services for which the provinces had responsibility;[31] co-operation was therefore necessary.

The process of blurring the jurisdictional lines between federal and provincial responsibility was generally quite harmonious (Québec was the exception, both in this period and throughout the history of Canada's blood system). The provinces accepted the system because they knew they could keep control of the specific programs while the federal government wanted national standards; trust existed between the participants because they tended to be from the same functional area and had an already-existing level of comfort with their counterparts; federalism was treated as an administrative, not a political issue.[32]

Co-operative federalism, then, was a period of federal/provincial relations marked by very little conflict and a seemingly honest desire to do what was best for the country as a whole, rather than for a particular jurisdictional fiefdom. There were, of course, difficulties in this period. Ottawa had some difficulty convincing the provinces that its way was best regarding, for example, tax collection. Moreover, co-operative federalism was an Ottawa-centric period; the provinces – except for Québec – had very little to say and were often merely secondary players.

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[30] Donald V. Smiley, "Federal-Provincial Conflict in Canada," *Publius*. 4:3 (Summer, 1974), p. 8.
[31] Mallory, p. 25.
[32] Robinson and Simeon, p. 251.

Competitive Federalism

It is somewhat surprising that competitive federalism is not the *only* period of federalism in Canada. Even without federalism in place, Canada's political system is based on competition between parties. Responsible government and the party system require that governments be held to account and another party act as a "government-in-waiting." Federalism adds another dimension to governmental competition by asking all governments to "search for popular support"[33] while they try to govern.

In 1960, the Quiet Revolution began in Québec as a logical extension of the province-building that went on in the years after Confederation.[34] The social and political changes created by the Jean Lesage government extended to federal-provincial relations as well as the internal politics of the province. Lesage's policy agenda had one simple theme: *maîtres chez nous*. Québec, as a province, would arrange its own affairs without the assistance of the federal government. At first, this policy dealt solely with federal-provincial fiscal policies. The rise of the Parti Québécois, however, meant that constitutional arrangements were also part of the discussion. By 1970, Prime Minister Pierre Trudeau and his view of a united Canada interfered with the Québec notion of a decentralized Canada. The two opposing views of a centralized *versus* decentralized nation spilled over onto the national arena with the other provinces challenging the Trudeau vision of Canada.[35]

The discontent of other provinces with the centralizing nature of the government in Ottawa came because of the "growing resources, competence, and confidence of provincial governments and their bureaucracies, which, fuelled by federal transfers, had been growing

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[33] Albert Breton, "The Theory of Competitive Federalism" in Stevenson, p. 463.
[34] Edwin R. Black and Alan C. Cairns, "A Different Perspective on Canadian Federalism," *Canadian Public Administration*, XI:1 (March, 1966), p. 29.
[35] Robinson and Simeon, p. 253.

much faster than the federal government."[36] Provinces began to see themselves as independent states, capable of performing the tasks assigned to them by the electorate. In spite of desires on the part of Ottawa to create national programs, provincial governments were unwilling to give up any measure of their sovereignty.

Instead, the provincial premiers spent time building their own fiefdoms. The regions of Canada became more powerful by pushing their concerns on the national stage and competing with the federal government on national issues. Another reason for the surge in province building was the electoral success realized by the provincial premiers when Ottawa was accused of interfering with provincial jurisdictions.[37]

A process that started with the Quiet Revolution rapidly became an exercise in reform of intergovernmental relations. While old rivalries rose up between the regions and the central government, two competing visions of Canada arose. The federal government saw itself as the superior level of government, one in charge of keeping Canada whole. Conversely, the provinces saw all eleven governments as equal partners in the federation.[38] The Canadian federalist state had changed. The two levels of government no longer had distinct areas of responsibility; instead, they were engaged in what Robinson and Simeon call "competitive state-building." Simply put, this is the notion that both levels of government seek to expand their powers and become *de facto* unitary states.[39] This is not to suggest that the governments were engaged in open warfare; rather, they were each attempting to carve out a specific and defined role for themselves.

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[36] Robinson and Simeon, p. 253.
[37] Mark Sproule-Jones, *Governments at work: Canadian Parliamentary federalism and its Public Policy Effects*. (Toronto: University of Toronto Press, 1993), p. 90.
[38] Robinson and Simeon, p. 253. It should be noted that this view is notwithstanding the Québec argument of "two founding nations."
[39] Robinson and Simeon, p. 253. This argument follows from the Black and Cairns article cited earlier.

Moreover, the competitive state building in which all governments were engaged changed the nature of intergovernmental relations. Instead of the negotiations over administrative details characteristic of co-operative federalism, intergovernmental meetings erupted into fundamental policy debates. Each level of government wanted to position itself as the defender of constituent interests rather than seek specific, real compromise.[40]

Constitutional Federalism

The state-building process that the governments underwent in the 1970s impacted directly on their constitutional responsibilities. It was inevitable, then, that the constitutional debates of the previous half-century returned. Ironically, the successful constitutional deal brokered by Pierre Trudeau does not fall under the umbrella of constitutional federalism, but under competitive federalism. After all, he designed his constitutional proposal to strengthen the powers of the federal government at the expense of the provincial governments, although he had to make a number of concessions to the provinces in order to do so.[41] Instead, the Mulroney government (1984-1993) occurred within the period of constitutional federalism.

This period was one of turmoil because of Prime Minister Brian Mulroney's obsession with constitutional reform. Federal/provincial relations were centred around the desire to bring Québec into the constitutional fold and the specific interests of individual provinces. Federalism also changed: instead of just being discussions between governments, the system expanded to include discussions between citizens and their governments.[42] However, the period dealt only with constitutional reform, not with the nature of intergovernmental relations outside a re-writing of the constitution.

[40] Robinson and Simeon, p. 254.
[41] Adam D. McDonald, "Constitution-Making as Intergovernmental Relations: A Case Study of the 1980 Canadian Constitutional Negotiations," *Federal Governance* 1:1 (October 2002), p. 12.
[42] Robinson and Simeon, p. 255.

Collaborative Federalism

Collaborative federalism is distinct from co-operative federalism in that the two levels of government have carved out specific fiefdoms for themselves. Instead of the situation of the 1960s, where the governments had very little debate before agreeing to co-operate, a joint venture must show itself to be politically viable for all concerned. After all, with the downloading of responsibilities started n the late 1950s under Diefenbaker (and continued to the recession of the early 1990s), governments had to re-think their economic priorities; as a result, the federal government lost the ability to dictate to the provinces through the use of its spending power.[43] A national outlook on any given policy, then, was impossible without real negotiation and discussion. Provinces became more powerful in relation to Ottawa because they had the programs *and* the money. Provinces needed to collaborate on national programs such as health care; although they controlled the money spent on the programs, Ottawa could claim that the provinces needed a "national" approach, which then required inter-provincial collaboration. Instead of the federal system under which governments had worked, a more collaborative structure was taking shape.[44] The social agreements of the mid-1990s were part of this renewed collaborative spirit. The federal government acted as a facilitator to get the provinces to form a national set of social policies. In particular, the spending power was no longer to be used in a carrot-and-stick approach to governance.

Collaborative federalism, then, is a more respectful way of ensuring that intergovernmental relations work. It is not based on one level of government dictating to another. It is not based on the argumentation, rhetoric, and fights characteristic of competitive federalism. It is, however, appropriate, given the political tone of the 1990s. It provides all

[43] Robinson and Simeon, p. 257.
[44] Robinson and Simeon, p. 258.

governments with the ability to say that their goals have been met at the end of federal-provincial summits, although there is an element of competition involved in collaborative federalism. Each level of government has an incentive to be seen as providing a given set of benefits to the public while at the same time avoiding the costs involved in providing that set of benefits.[45] The collaborative spirit of federal-provincial relations may just be an attempt by both levels of government to avoid being seen as an antagonist at home and to be able to proclaim victory after first ministers' conferences.

It is at this stage Canadian politics sits at the beginning of the twenty-first century. Having evolved through the various stages of federalism, the federal and provincial governments have reached a stage of *détente*, or an uneasy peace. Attempts by one government or another to carve out more political territory for itself would likely mean that a new phase in federalism has begun. A discussion of what makes the federal-provincial dynamic work – or not work – is necessary to complete the theoretical framework.

Competitive federalism can most simply be defined in this way: "governments are rivals among themselves and with private institutions in seeking to supply policies to meet the preferences of citizens."[46] As has been stated several times throughout this chapter, federal and provincial governments compete for the support of the same voter base. Since governments are political creatures, they want credit for good initiatives and want to divert attention from bad ones. Competition, therefore, is not always the best option for governments. Instead, they must sometimes collaborate on initiatives. Competition is enhanced by the co-operation of

[45] Sproule-Jones, p. 97.
[46] Sproule-Jones, p. 97.

governments. Without it, the efforts of each level of government "will increasingly frustrate the policies of each other by inadvertence or even in some cases by deliberate design."[47]

The issue of competition with the federal government also affects provinces. The Constitution gives significant levels of power to the federal government. Not only are its responsibilities defined, but the fact that the federal government has concurrent jurisdiction with some provincial responsibilities means that Ottawa has significant clout when it comes to federal-provincial disputes.[48] Health care is one of these areas. As Donald V. Smiley notes, "nationalist and egalitarian sentiments propel the federal government into action directed toward establishing minimum Canada-wide standards in respect to such public services as are from time to time defined to be vital to the welfare of all citizens."[49] There is significant incentive, then, for the provincial governments to do one of three things:

1. Co-operate individually with the federal government to ensure that the province in question gets credit for any given initiative.

2. Co-operate with one another to gain public opinion and force the federal government to follow the provincial lead.

3. Provide resistance to "bad" ideas to show the voters that the federal government is forcing the provincial governments into a bad situation.

The federal and provincial governments have their own reasons for choosing whether to co-operate. They have specific goals when it comes to intergovernmental relations. Provincial governments will always press provincial interests and the federal government federal interests. Moreover, provinces want to "safeguard and if possible extend the range of

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[47] Donald V. Smiley, *Canada in Question: Federalism in the eighties, third edition*. (Toronto: McGraw-Hill Ryerson Limited, 1980), p. 92.
[48] Although this may be true in a constitutional sense, it could be argued that Ottawa has almost no political clout in these disputes. After all, anything but unanimity in a federal-provincial conference is seen as failure, while provincial premiers are often rewarded for opposing Ottawa's demands.
[49] Smiley, p. 92.

jurisdictional autonomy, including of course the revenues that provinces have under their unshared control."[50]

It is also important to note that party affiliation does not appear to matter when it comes to federal-provincial relations. The federal government has no stake in ensuring that its provincial cousins are in power, as they will push for provincial interests. When it comes to specific policies, governments of a similar stripe are not necessarily more open to negotiation than parties of opposing ideological views.[51]

Carl Hodge expands on this point when he points out that, unlike the presidential-congressional system in the United States, Canada's Parliament has very specific party discipline. Members of Parliament (MPs) cannot vote based on regional affiliation, such as the American "cotton bloc" or "corn belt." Moreover, the Canadian Senate is not a voice for the provinces or regions, as the American Senate is. Instead, the provincial governments, in intergovernmental negotiation, are responsible for promoting provincial or even regional interests. Even though federal party leaders are obligated to recognize significant regional support, said recognition does not have to translate into legislative action. Party discipline ensures that a party leader will carry the day. The leader cannot, however, affect the positions of the regional – or provincial – governments.[52] Thus, provinces can portray themselves as the only valid voice of regional interests. Similarly, the federal government can say it is the defender of national interests.

Finally, it is important to note that, while provinces complain about federal encroachment on their jurisdictions, a return to the watertight compartment theory is

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[50] Smiley, p. 113.
[51] Smiley, p. 148.
[52] Carl Cavanagh Hodge, *Canadian Regionalism or Canadian Federalism?* (Ottawa: Carleton University Press, 1984), p. 26-27.

unworkable. There is too much overlap in responsibility, and – more importantly – one cannot always place public affairs issues in easily identifiable pigeonholes. This can benefit Canadian society; after all, "shared responsibility opens up the possibility that the federal and provincial governments might compete to respond to citizens' problems. In this competition, the need to win popular support can temper the self-interest of governments."[53]

One example of the competition and collaboration themes in action can be found in the history of Canada's blood supply. Throughout the history of the publicly-funded blood system, each level of government has been involved. At first, they simply encouraged the Red Cross; as time went on, governments became involved in funding and, eventually, governing the blood system. The competitive and collaborative spirits embraced by the provincial governments both destroyed and rebuilt the system. Its successes and failures reflect on the ability of the provinces to define and work toward a national system run by provincial interests.

[53] Murray Forsyth, ed. *Federalism and Nationalism* (New York: St. Martin's Press, 1989), p. 162.

Chapter 3

Blood Transfusion Medicine

Blood tragedies are not new. As human beings studied blood, they experimented and made mistakes as they made progress. The mistakes made throughout the history of blood transfusion medicine seemed to amplify as time went on. Intuitively, this makes a lot of sense. Early on, blood transfusions were rare; while the risks were great to the individual(s) being transfused, there appeared to be no great risk to society as a whole. As blood transfusions became more common, so too did accidents. Greater numbers of transfusions also meant more accidents and the associated risks increased.

Even the type of blood accident changed with time. In the first blood transfusions, patients often died because doctors did not understand the basic principles of transfusion. Once scientists understood the process of transfusion, the problem became one of collection, transportation, production, and delivery. With these problems mastered, blood-borne diseases became the problem. The spread of HIV, AIDS, Hepatitis, and other blood-borne pathogens resulted in an enormous study and overhaul of the Canadian blood system and is the indirect focus of this paper.[54]

Canada was not the only country affected by a blood tragedy. In fact, just about every industrialized nation had a highly-publicized tragedy related to its blood system:

> In America, patients have filed hundreds of civil suits against doctors, drug companies, and even their own patient organizations … In England, AIDS-infected hemophilia patients castigated their national transfusion service … In Japan, patients charged that the government and drug companies criminally concealed the contamination of blood products…[55]

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[54] For further reading, please see *The Report of the Commission of Inquiry on Canada's Blood System* or the 1993 report from the House of Commons Standing Committee on Health and Welfare, Social Affairs, Seniors, and Women.

[55] Douglas Starr, *Blood: An Epic History of Medicine and Commerce*. New York: Knopf, 1998, p. x.

Canada's Krever Inquiry (discussed at length in Chapter 5) discussed the blood systems of other countries and the ways in which they dealt with the HIV/AIDS tragedies. Although each of the systems failed the victims, each system is different: the Red Cross ran the blood system in many European countries; the United Kingdom ran its own blood system through a state monopoly; the United States allowed a combination of both not-for-profit and commercial organizations to collect, manufacture, and distribute blood.[56]

The point is that while the federal nature of the Canadian system allowed some specific problems to occur, both in the competitive nature of politics and the negligence of the provinces, Canada was not alone in its systemic problems.

These events, while tragic, brought to light some important facts in these countries. First, they showed that the blood supplies of these countries required better protection. Second, the public reaction to the blood scandals revealed a significant lack of education as to blood and its products.[57] Finally, the problems in the blood supplies of these countries showed that the blood service providers had significant problems to overcome.

Blood transfusion medicine underwent a different evolution depending on the specific country involved. In the Canadian case, the experiences in both Europe and the United States influenced the systemic changes. Before embarking on a discussion of the Canadian blood experience, it is important to understand how its governance came about.

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[56] Horace Krever, *Commission of Inquiry on the Blood System in Canada: Final Report*. (Ottawa: Minister of Supply and Services Canada, 1997), p. 721.
[57] Starr, p. x.

A New Science: Blood Transfusion Medicine

Although Wilfrid Laurier said that the twentieth century would belong to Canada, it is certain that the United States was the nation most likely to take the new century by storm. Technology, science, industry, and economics were all booming with all the excitement the new century could bring. Blood transfusion medicine was no exception. With the decline in popularity of bloodletting in the previous century, scientists continued to examine ways to use human blood for practical purposes.

One such way was through was through human blood transfusion. In the early decades of the twentieth century, blood donations were difficult for both patient and donor, and so it was difficult to find donors willing to provide blood.[58] Obviously, donors and patients did not enjoy the procedure as it existed, and the doctors wanted to find ways to improve it.

Doctors at research hospitals across North America worked to improve the science of blood transfusion through the early years of the twentieth century. Their efforts were, for the most part, successful, and they managed to find ways to keep blood "fresh" outside the human body long enough to do some good.

While scientists were involved and interested in discovery, the fact remains that the adage "necessity is the mother of invention" has roots in basic truth. When it came to transfusion science, necessity truly *was* the mother of invention. War made it necessary to step up research and experimentation in blood transfusions, just to keep soldiers alive. War became a major reason to study blood and change the way civilians viewed its collection, storage, and distribution.

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[58] Starr, p. 43. Donations were direct, donor-to-patient affairs, meaning that doctors cut open both the donor and patient, stuck a tube inside each of them, and watched as the blood passed from one to the other.

A Call to Arms: Blood Services expand across the Globe

Blood transfusion medicine had come a long way from the days of bloodletting and crude experimentation. Nonetheless, there was not yet a system whereby blood could be collected and distributed in an efficient manner. Blood donations were collected on an *ad hoc* basis so when blood was needed, the doctor still had to find a compatible donor and use the blood almost immediately.[59] There was no system in place to collect and store the blood until needed.

The issue of blood storage became more important during and just after the First World War. Dr. Geoffrey Keynes, a British surgeon based in London, saw the techniques used by American doctors to transfuse patients injured on the field of battle. Although the actual number of transfusions was relatively small, they made an impression upon Keynes. He returned to London determined to increase awareness of blood transfusion medicine among British doctors.[60] Keynes wrote and spoke extensively on the need for blood transfusions and started to amass a pool of donors.

At the same time, a member of the British Red Cross was beginning to organize blood donors elsewhere in London. Percy Oliver had been part of a dramatic incident in 1921. When doctors needed blood for a surgery, a call went out to the city – as was the custom – asking for donors to provide help for the patient. Oliver and three other men from the Red Cross went to the hospital to help. One was a match for the patient, and so a life was saved.[61] More importantly, however, an idea began to germinate in Oliver's mind. Doctors who wanted to transfuse blood had to contend with an unreliable supply, and there was always a risk that donors would not be available at the exact moment blood was needed.

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[59] Starr, p. 53.
[60] Geoffrey Keynes, *The Gates of Memory* (Oxford: Clarendon Press, 1981), p. 144.
[61] British Red Cross Society, *Report of the Blood Transfusion Service for the Year Ended Dec. 31st, 1926* (London: Petley & Co. Printers, n.d.), p. 5-9.

Transfusion science had evolved to the point where blood could be stored for a short time until it was needed. All that was required was a steady supply to meet the demand.[62] Oliver believed that he could recruit people who would make themselves available when blood was required. He set out to recruit, pre-screen, and pre-type a list of people who would be called. In 1922, Oliver and twenty professional acquaintances were called thirteen times. By 1926, he had been called almost 800 times, so he set out to expand operations.[63] The Greater London Red Cross Blood Transfusion Service was established as the first organized donor panel.

In its early days, Oliver's organization was loose and completely run by volunteers: Percy Oliver and his wife. Together, they kept a list of people willing to be called on at all hours of the day; they collected donations, paid donor expenses, wrote reports, interviewed visitors, canvassed for donors, and gave lectures on the need to donate blood.[64]

Oliver's donation scheme and Keynes's desire to increase the popularity of transfusion in the medical profession came together under the Blood Transfusion Service when Oliver asked Keynes to serve as a medical advisor. The two of them helped increase the size of the donor panel to serve more than 160 hospitals in Greater London by the 1930s; their efforts even inspired other countries throughout the world, including Germany, Russia, Japan, France, and the United States.[65]

In the 1920s, a new organization called the Blood Transfusion Betterment Association was formed in New York City in order to develop some perception of dignity and safety in the

[62] It was always possible to find people willing to give blood. The tricky part was in finding the correct type quickly enough to do some good.
[63] *British Red Cross Report*, p. 4.
[64] Red Cross report, p. 18.
[65] Starr, p. 57. In contrast to the voluntary spirit epitomized by Oliver and the London Blood Transfusion Service, the Americans determined that the collection of blood could be a profitable industry. They were not wrong: students donated blood to pay tuition, while others sold their blood to purchase alcohol.

donor supply. Rules were codified and enforced to ensure that donors were providing the highest quality "product." Donors were screened for diseases and alcohol or drug problems. Donors were expected to be available by telephone, and they were also under an obligation to give blood; if they did not donate when called upon, the donor lost the right to sell his blood.[66]

In spite of the differences between the London and New York systems, the basic problem of finding blood suitable for transfusion was solved, however temporarily. Hospitals could rely upon a blood supply whenever they needed it, and organizations existed to ensure that the hospital received what it needed. Unfortunately, it only solved the problem in cities with both the hospitals and the infrastructure to support the blood collection organization. If blood ever needed to be transported for longer distances, or if donors were not readily available, the system would collapse. Of course, in the 1920s, this was not a problem at all because blood did not have to travel very far!

"Start Bleeding": Blood Transfusion on the Move

Blood Transfusion Services underwent a revolution in the 1930s with the Spanish Civil War. Dr. Norman Bethune saw soldiers who needed blood being moved to the rear when he thought it made more sense for them to remain at the front while the *blood* came forward to the front. He obtained a van with refrigeration and storage equipment suitable for keeping blood fresh for up to a week. He and his fellow doctors were on call twenty-four hours a day and prepared to take blood wherever and whenever it was needed.[67] Although Bethune's system was innovative, it was not the standard for mobile blood services. Others learned from Bethune's example, believing that blood could be supplied even in the midst of the confusion of war.

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[66] "The Blood Transfusion Betterment Association of New York City," *Journal of the American Medical Association* 110 (1938): 1248-52.
[67] Roderick Stewart, *The Mind of Norman Bethune* (Westport, Conn.: Lawrence Hill, 1977), p. 56-57.

As war with Germany became more likely, the British government prepared its citizens in a number of ways: it cleared hospitals, distributed gas masks, and recruited civilians to act as leaders in their communities. Blood collection and distribution, however, had not changed substantially in the fifteen years since Oliver. Even by 1938, the emergency stockpile in London totalled eight pints for projected casualties of 37 000 during the first week of a war.[68]

A young pathologist named Janet Vaughan, believing that the government should do more to stockpile blood, began her own blood collection service in Hammersmith. She argued that doctors could better spend their time as healers rather than waste time drawing blood if Britain did go to war. Vaughan worked with other private blood bankers to create a proposal outlining the ways in which the government could ensure an adequate wartime blood supply. Using the estimates from the Ministry of Defence and the Ministry of Health, Vaughan could provide information on how many lives would be saved with specific investments from the government. The ministry was finally convinced, and on June 5, 1939, provided Vaughan with her funding.[69] With this step, the British government became among the first in the world to get directly involved with the national blood supply.

Blood collection in Europe and North America, up until the twentieth century, had been a haphazard and imprecise process at best. This was mostly the result of superstition and a misunderstanding of the properties of this most precious human liquid. When the superstitions abated in the late nineteenth century and scientists began to examine more fully the uses of blood to human health, the question of responsibility for the collection, processing, organization, and distribution of blood became an important one.

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[68] Alistair H. B. Masson, *History of the Blood Transfusion Service in Edinburgh* (Edinburgh and South East Scotland Blood Transfusion Association, n.d.), p. 24.
[69] Starr, p. 87.

As we have seen, the Red Cross took a leading role in organizing both ends (collection and distribution) of the blood supply in Europe and North America. This, however, was not by design but by happenstance. The Red Cross took responsibility in Britain because an employee decided to take it upon himself to begin the donor recruitment process in an off-the-cuff manner. As knowledge about blood increased, the ability to store blood for longer periods did as well. This would prove invaluable during the Second World War, when the United States needed to ship blood overseas to Europe and the Pacific. The model created by Percy Oliver was improved and expanded to allow donors to give blood to be used as needed, instead of collecting "on-the-hoof."

The war did a great deal to improve blood systems worldwide, but did not settle the question of governance. Volunteer organizations took control of the blood supply, but there was no governmental direction to create a cohesive system. As the organizers of the blood supply created a system based on immediate needs, there was no specific plan except to improve the blood system piece by piece. This had important implications in Canada, as we shall see in the next chapter.

Chapter 4

The Canadian Red Cross Society

In 1863, the International Committee of the Red Cross was born. It consisted a group of Swiss citizens who – appalled by the aftermath of European war – wanted to make the world a better place. In regard to warfare, the Red Cross

> monitors the laws of war; visits prisoners-of-war and political detainees; acts as go-between and negotiator during hijackings and hostage takings; campaigns to control weapons; takes relief and medical help to the victims of conflicts; traces the 'disappeared'; puts families separated by war in touch with each other and acts as custodian of the Geneva Conventions.[70]

In addition, as we will see, it acted as a collector and distributor of blood in many Western countries.

A Helping Hand: The International Red Cross

The First and Second World Wars saw great advances in the field of transfusion medicine. As a consequence, organizations that devoted part or all of their time to collection and distribution of blood and blood products worked harder to get their product out and to obtain "market share" in this necessary field.

In the inter-war period, scientists and entrepreneurs took time to learn about what others in the same field were doing and they improved upon the already established methods for the collection and distribution of blood.

Transfusion medicine specialists across the globe were busy in the twenty years following the First World War and were laying the groundwork for what would become a vital national service in Canada: the Canadian Red Cross Society (CRCS). This groundwork took

[70] Caroline Moorehead, *Dunant's Dream: War, Switzerland, and the History of the Red Cross*. (New York: Carroll & Graf Publishers, Inc., 1998), p. xxi. Although the cross in the Red Cross is taken from the Swiss flag and not the Christian symbol, the Red Cross is known as the Red Crescent in many non-Christian countries.

the form of an international Red Cross, which gave authority to national societies such as the CRCS.

The International Committee of the Red Cross (ICRC), the parent organization from which all other Red Cross Societies sprang, provided guidance and direction for the other Societies in their humanitarian works. Among other things, the ICRC provided them with guiding – and inviolable – principles, forming the credo of all Red Cross Societies around the world. Its principles would prove to cause a number of problems in the Canadian situation because of the nature and operation of Canadian federalism. It is sufficient for now, however, to simply list the principles of the International Committee of the Red Cross:

- *Humanity*
  The International Red Cross and Red Crescent Movement, born of desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health to ensure respect for the human being. It promotes mutual understanding, friendship, co-operation, and lasting peace amongst all peoples.

- *Impartiality*
  It makes no discrimination as to nationality, race, religious beliefs, class, or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

- *Neutrality*
  In order to continue to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

- *Independence*
  The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

- *Voluntary Service*
  It is a voluntary relief movement not prompted in any manner by desire for gain.

- *Unity*
  There can only be one Red Cross or one Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

- *Universality*
  The International Red Cross and Red Crescent Movement, in which all Societies have equal status and share equal responsibilities and duties in helping each other, is world-wide. [71]

All National Societies derive their legitimacy from the International Red Cross and must abide by these principles. As an aside, only countries that are signatories to the Geneva Convention for the Amelioration of the Condition of the Wounded and Sick in Armies of the Field (1864) (and as revised later) may have National Societies. The implication is that only countries agreeing to a particular set of principles as laid down in the Convention may enjoy the protection and services of a Red Cross Society. The corollary here is that signatories to the Convention will also respect the principles of the Red Cross.[72]

The Canadian Red Cross Society

The Canadian Red Cross, like so many other national societies, was born out of a major war and the perceived need to fill a gap that government neglected. In Canada's case, the war in question was the 1885 Northwest Rebellion. At the time, army medical services were almost unknown. Indeed, a great deal of mistrust lay between the Red Cross and the armed services, which believed that civilians had no place "blundering around battlefields."[73]

The Red Cross in Canada had its unofficial start in 1885 when Dr. George Sterling Ryerson, seeking protection for his ambulance, hoisted a makeshift Red Cross flag.[74] In the

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[71] http://www.redcross.ca/article.asp?id=000318&tid=001 *About the Red Cross – Canadian Red Cross*
[72] P.H. Gordon, *Fifty Years in the Canadian Red Cross*, p. 20-21.
[73] André Picard, *The Gift of Death: Confronting Canada's Tainted Blood Tragedy*. (Toronto: HarperCollins Publishers, 1995), p. 19.
[74] http://www.cbc.ca/news/indepth/facts/red_cross.html, *Indepth Backgrounder: Canadian Red Cross*, April 2001.

finest traditions of the Red Cross, the flag offered protection and comfort to the wounded on both sides of the conflict.[75]

Ten years later, when Ryerson was Surgeon-General, he wrote to the British National Society for Aid to the Sick and Wounded, also known as the British Red Cross Society. Ryerson wanted to establish a branch in Canada. He says in his memoirs that the St. John Ambulance Association, while capable, could not participate in military hostilities. He added, "its work was training men and women in first aid and home nursing and must in time of war be subsidiary to the Red Cross."[76] By 1896, however, Ryerson obtained permission from Britain to organize a Canadian branch of the Red Cross.[77] After approving its formation, the British Red Cross Society suggested that the new branch incorporate itself under the following principles:

1. That the branch shall be called 'the Canadian Branch of the British National Society for Aid to the Sick and Wounded in War.'

2. That a council shall be formed of sufficient influence to give public confidence.

3. That it be recognized that the primary work of the branch is to render aid to the sick and wounded in time of war by offering supplemental assistance: (a) To the Army Medical Department of Canada or (b) to the Parent Society, should England be engaged in war, (3) To the belligerents of any other countries engaged in war, who recognize the neutrality of the Red Cross and express their willingness to accept aid through the British Society by its Canadian Branch.

4. That all its domestic affairs, such as enrolling members, collecting subscriptions, appointing officers, training nurses, etc., be entirely under its own control.

5. That the work of the Red Cross Branch be kept entirely distinct from any branch of the St. John Ambulance Association, in Canada.

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[75] Picard, p. 19.
[76] George Sterling Ryerson, *Looking Backward*. (Toronto: The Ryerson Press, 1924), p. 117.
[77] John Murray Gibbon and Mary S. Mathewson, *Three Centuries of Canadian Nursing*. (Toronto: The Macmillan Company of Canada Limited, 1947), p. 341. The Canadian Red Cross had to start off as a *branch* of the British Red Cross as Britain was the only country in the British Empire to have signed the Geneva Convention. As the colonies gained independence, they could sign the Convention and create Red Cross Societies in their own right.

6. That the special use for which the Red Cross badge was designed, under Article 7 of the Geneva Convention, 1864, shall be borne in mind and all possible means taken to ensure its non-abuse.[78]

The Canadian Red Cross Society was formed in October, and the British Society officially recognized it in December.

In 1898, the new Society performed its first active function by fundraising for the provision of aid in the Spanish-American War. However, no other work was done by the Society until 1899, when war broke out in South Africa. The CRCS sprang into action and organized the collection of supplies for the sick and invalid.[79]

Wealthy members of the board funded the Red Cross until 1909, when the Canadian government passed the *Canadian Red Cross Society Act*, establishing the Canadian Red Cross Society. Under the Act, the CRCS had four purposes:

1. To furnish volunteer aid to the sick and wounded of armies in time of war, in accordance with the spirit and conditions of the conference of Geneva of October, 1863, and also of the treaty of the Red Cross or the treaty of Geneva of August twenty-second, 1864, to which Great Britain has given its adhesion;

2. To perform all the duties devolved upon a national society by each nation which has acceded to said treaty, but in affiliation with the British Red Cross Society;

3. To succeed to and take over all the rights and property heretofore or now held and enjoyed by and all the duties heretofore performed by the unincorporated association known as The Canadian Red Cross society;

4. In time of peace or war to carry on and assist in work for the improvement of health, the prevention of disease and the mitigation of suffering throughout the world.[80]

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[78] Ryerson, p. 118
[79] Ryerson, p. 121. Ryerson also notes that he "advocated work in time of peace to prepare for war." If nothing else, this could have provided the CRCS with an opportunity to educate the public as to its purpose, something that Ryerson indicates had to be done anyway.
[80] *Canadian Red Cross Society, An Act to incorporate The* (1909, c. 68)

The Canadian Red Cross Society had a very broad mandate under the law, but nowhere does the Act give the CRCS the right to collect and distribute blood and blood products. The Society's involvement with blood collection came gradually and haphazardly, to disastrous results in the 1980s.

During the First World War and in the inter-war period, the Red Cross was busy all around the world promoting its goals and providing medical services to civilians and soldiers alike. Ironically, however, the Red Cross became linked with patriotism instead of impartial humanitarianism, which helped the Red Cross raise money to further its goals. In Canada, $35 million was raised.[81] The Canadian Red Cross made further increases in the peace that followed in 1919, beginning a "post-war program of [public] health education"[82]

By 1918, the Red Cross worked to fight the influenza pandemic by providing comfort to the sick and dying and by producing a vaccine. Although this was not the only major work done by the Red Cross, the major publicity that the CRCS and other organizations brought to health issues suggested to the Canadian government that, although the provinces had jurisdiction over health, a national Department of Health was necessary.[83]

By the start of the Second World War, the Red Cross had determined that it would find a peacetime role to play in addition to the wartime role it already had. When war broke out in 1939, the CRCS put these plans aside and contributed to the war effort in a number of ways, which included providing processed blood to the armed forces. The Red Cross collected the whole blood product and shipped it to Connaught Laboratories for processing. Connaught had

[81] Picard, p. 20. This is not to suggest that the Red Cross acted unethically. However, the association of the Red Cross with helping sick and wounded in time of war led many people to believe that it was acting for nationalist purposes instead of the good of all people.
[82] http://www.redcross.ca/article.asp?id=007834&tid=019, *1900-1950 – Canadian Red Cross*
[83] Picard, p. 21.This department would not interfere directly with the provinces, but was instead designed to deal with public health issues.

found a way to produce dried human blood serum, the only way to transport blood products to the armed forces.[84] The Red Cross then sent the serum on to the armed forces. Of course, as the war effort required more and more blood, further donations were required. As donations increased, so too did the Red Cross's role in actually processing the donations it collected.[85]

It is important to note a number of things about this wartime collaboration and the role that the Red Cross played in collecting and distributing blood. As we observed in the previous chapter, the British Red Cross had already played a role in collecting blood for *civilian* hospital use in Great Britain. The Canadian Red Cross was only collecting blood on behalf of the military.

By 1940, the Red Cross had opened a permanent blood donor clinic in Toronto, where many of today's standard donor practices were established. By 1942, clinics opened in six different provinces, but still more were needed. After all, to meet the increasing demand, clinics would have to be set up across the entire country. This move meant that the Red Cross was becoming an invaluable national program and one that required ever-increasing amounts of money, jumping from approximately $50 000 per year in 1940 to $700 000 by 1943.[86]

By war's end, the Canadian Red Cross Society had proved its worth to the military with its blood transfusion service. Medical authorities in the armed services listed blood as the single greatest factor in saving lives, above penicillin and sulfa drugs. As a result, the Canadian

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[84] Horace Krever, *Commission of Inquiry on the Blood System in Canada: Final Report*. (Ottawa: Minister of Supply and Services Canada, 1997), p. 44.

[85] http://www.bloodservices.ca/CentreApps/Internet/UW_V502_MainEngine.nsf/resources/CBS+Performance+Review/$file/2002Review-1.pdf, *CBS Performance Review*

[86] Picard, p. 25.

Hospital Council, the National Research Council, and the CRCS formed a special committee to examine the possibility of forming a peacetime blood transfusion service.[87]

The Canadian Red Cross Society did some very good work over the course of the war. It had created a national blood supply and had a division devoted solely to providing safe blood and blood products. It had developed a relationship with a private laboratory to ensure that blood products that the CRCS could not create were manufactured in a safe environment. Up until this point, it is important to note that the Red Cross Blood Transfusion Service (BTS) was totally separate from any government. The only relationship it had with a government was that the federal government – through the military – was the BTS's only "customer." The blood supply was run entirely by non-governmental organizations without directly receiving government money or support. That would all change dramatically in the post-war years.

Blood Boom: The Red Cross, 1945-1973

Before the war, there was no civilian blood system in place in Canada. Each hospital was responsible for supplying its own needs and generally did not look to other agencies for help in meeting a demand for blood.

Provincial governments and hospital associations, having seen the success of the Red Cross in dealing with the military's blood supply, asked the organization to continue its work by operating a civilian collection service to meet the needs of both civilian and military hospitals. Dr. W.S. Stanbury studied the needs of Canadian hospitals with respect to blood, and

[87] McKenzie Porter, *To All Men: The Story of the Canadian Red Cross* (Toronto: McClelland & Stewart, Limited, 1960), p. 141.

his report created the system under which the Red Cross would operate: “the Red Cross should supply blood and blood products, free-of-charge, to all Canadian hospitals.”[88]

The war had allowed the Red Cross to create a monopoly for itself in the Canadian blood system. The geography of Canada allowed the Red Cross to do what no independent blood bank could do: it used an already-existing national organization to mobilize Canadians into giving blood for the war effort. The CRCS, using goodwill and a system established through its decades
of work in Canada, answered the military’s call to provide blood for the war effort once again. When the war ended, independent blood banks did not have a chance to get set up as they did in the United States[89] because the CRCS moved quickly into the civilian blood business as “the first free national blood service in the world.”[90]

It is important to recognize a few things about the Canadian blood system at this point. First, there was no system as we understand it today. An organization had sprung up to fill a need. The Red Cross Blood Transfusion Services (BTS) continued to meet this need after the war was finished; no one else stepped in to take the role away from them.

[88] W. Stuart Stanbury, *The Canadian Red Cross Society: Survey of Blood Transfusion Facilities in Canadian Hospitals and Proposed Plan for a Canadian National Blood Transfusion Service*, (Toronto: The Canadian Red Cross Society, 1945), p. 16.
[89] Ironically, the independent blood banks competing in the United States with the American Red Cross mobilized to form the American Association of Blood Banks (AABB), an organization to which both Canadian Blood Services and the American Red Cross now belong for the furthering of transfusion medicine knowledge.
[90] Porter, p. 145.

The blood system was also not under the control or strict supervision of any government, in spite of the fact that provincial governments provided significant funding to the blood system.[91] The blood system certainly should have been, as the provincial and federal governments had shared responsibility for it. The federal government, through the *Food and Drugs Act*, regulates blood and blood products while the provincial governments provide funding through their individual health care services.[92] However, since the federal government could not tell the provinces how to design and implement a national blood system, the Red Cross had to act independently of government in order to provide its services. This was certainly consistent with its charter, but not necessarily a good thing for the public it was trying to serve.

Finally, the system was created on an *ad hoc* basis; that is, as problems were encountered, they were fixed. There was no specific intent to create a "blood system"; the Red Cross simply created something as it went on: a permanent clinic here, a new blood centre there, a testing lab built as necessary. Unlike today's world, a business plan, cost-benefit analysis and risk management programs were not necessary.

By its very nature, the Red Cross Blood Transfusion Service was a political creature. The Red Cross was generally voluntary in nature and required both people and large infusions of cash to stay afloat. The Red Cross expanded rapidly, and costs soon escalated out of control. The CRCS provided blood to the hospitals at no charge. This policy decision, combined with

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[91] Sandra Rodgers, "The Canadian Blood Delivery System: Liability for Blood Related Injuries," in J. Robert S. Prichard, *Liability and Compensation in Health Care: A Report to the Conference of the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care; Appendix B: Research Papers Volume 3: Reform Proposals and the Canadian Blood Delivery System.* (Toronto: University of Toronto Press, 1990), p. 5.
[92] Gilmore and Somerville, p. 130.

the expense of keeping up with advances in transfusion medicine, meant that the Red Cross required a serious amount of capital funding just to stay afloat.[93]

By 1958, the financial burden had proven to be too much for the Red Cross. Repeated pleas to the provincial Ministers of Health were finally heard and Canadian governments started to provide some money for the blood transfusion service; the Red Cross continued to fund the blood donor recruitment end of the business.[94] The governments began by paying thirty percent of the operating costs, but over fifteen years, the total amount of funding went up to ninety percent.[95]

In the first few years of operation, the Red Cross's Blood Transfusion Service was simple: Red Cross volunteers recruited donors while its paid employees collected, tested, and distributed the blood. The mission of the Red Cross was simply to get the blood out. Safety, government regulations, and standardized procedures were not yet introduced into the blood system. Moreover, the role of the federal and provincial governments was both undefined and almost non-existent. It seems the only role of the provincial governments was to pay for the capital costs of blood centres within the province; the Red Cross was responsible for all operating costs.[96]

[93] http://www.bloodservices.ca/CentreApps/Internet/UW_V502_MainEngine.nsf/resources/CBS+Performance+Review/$file/2002Review-1.pdf, *CBS Performance Review*, p. 18.

[94] http://www.bloodservices.ca/CentreApps/Internet/UW_V502_MainEngine.nsf/resources/CBS+Performance+Review/$file/2002Review-1.pdf, *CBS Performance Review*, p. 18.

[95] Krever, p. 46.

[96] Krever, p. 45.

Loss of a Kingdom: The Red Cross, 1973 – 1982

It is important to remember that there was a great deal of shared governance responsibility between the federal and provincial governments. Constitutionally, it was (and is) the responsibility of the provincial governments to provide health care. Hospitals are governed by the provinces; hospitals need blood as a part of their operations, and so the provision of blood and blood products is therefore a provincial responsibility. On the other hand, the federal government has responsibility for the regulation of pharmaceuticals, of which blood is one. However, Red Cross Blood Transfusion Service operations were funded and overseen by the provincial governments. The only real influence the federal government had was in the provision of funds to the provinces and/or to license and inspect the Red Cross operations.[97]

1973 was the last year the Red Cross retained any financial responsibility for the Canadian blood system. In its twenty-five years of existence, the Red Cross blood services had gone from having almost total control over the blood system to abdicating it entirely to government. In 1948, the Red Cross had responsibility for the blood system under the very general supervision of the provincial governments. In 1974, the Canadian Hematology Society released a report suggesting that the Red Cross might not be doing the best job it could in running the Canadian blood system. This independent report led the provincial governments to create the Federal-Provincial Program and Budget Review Committee, which committed the provincial governments to pay for all of the technical costs and forty percent of donor recruitment costs for the Red Cross.[98] Because of the increased funding, the governments also started to take a more active role in the governance of the Red Cross as a provider of blood and

[97] Norbert Gilmore and Margaret A. Somerville, "From Trust to Tragedy: HIV/AIDS and the Canadian Blood System," in Eric A. Fedman and Ronald Bayer, eds. *Blood Feuds: AIDS, Blood, and the Politics of Medical Disaster*. (New York: Oxford University Press, 1999), p. 130.
[98] Picard, p. 35.

blood products. This is not to suggest that the provincial governments were not already interested in the governance of the blood system. However, the Canadian Hematology Society's report led the provinces to take more control over the blood system; the Red Cross lost some of its independence and started providing a service to the ministries of health. This move, in turn, required still more government intervention in the workings of the blood system.

The federal Minister of National Health and Welfare (now called the Minister of Health) articulated the federal government's position on the Red Cross's governing principles for the Canadian blood system in 1976. He said that Canada's blood supply should be based on three main points:

- Voluntary donation
- National self-sufficiency
- Gratuity of blood products to recipients

The provincial governments agreed, and at a conference the following year added a fourth:

- Desirability of non-profit domestic fractionation[99]

This additional principle was a part of the Red Cross's murky relationship with Connaught Laboratories, which could be described as a "marriage of convenience" early on. However, it became a very different marriage in the late 1970s. Connaught had been a successful private laboratory for decades, but started losing money and was no longer viable as a private enterprise. The federal government purchased Connaught through the Canada Development Corporation, meaning that all facets of the Canadian blood supply were under the direct or indirect control of *a* government. The Red Cross was funded and regulated by the

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[99] http://www.bloodservices.ca/CentreApps/Internet/UW_V502_MainEngine.nsf/resources/CBS+Performance+Review/$file/2002Review-1.pdf, *CBS Performance Review,* p. 18

provincial governments, while federally-owned Connaught provided the Red Cross with a product called fractionated plasma.[100]

This, then, was the situation at the end of the 1970s: the Canadian blood supply was in the hands of an independent organization that had administered and funded the collection of blood for approximately thirty years. The Red Cross, while independent in its operations and principles, had its blood services in turn audited and overseen by the federal government and funded by the provincial governments. The federal government also owned Connaught Laboratories, which sold the Red Cross a finished product created from plasma provided *by* the Red Cross. In other words, "the Canadian blood system was a world unto itself."[101] On the other hand, it could be argued that, for the first time, the governments responsible for health care and regulation were fully overseeing the Canadian blood system.

Once government got more involved in the blood system, governance became more difficult. In addition to the bureaucratic structures already in existence at the Red Cross, the national organization reported to federal, provincial and territorial ministers of health. Efforts to streamline the process got worse under both the Canadian Blood Committee and the Canadian Blood Agency, both of which will be discussed below.

A brief look at the governance structure of the Red Cross and its Blood Transfusion Service in the late 1970s reveals a number of competing jurisdictions. First the Red Cross served the principles outlined at the beginning of this chapter. As we know, adherence to these principles was a requirement for carrying the name "Red Cross." Moreover, the Canadian government underscored that requirement in the *Canadian Red Cross Society Act*, when it

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[100] The Krever Report goes into some detail on what blood products were created by the Red Cross and Connaught, but this information is not important for the purposes of a discussion on Red Cross/CBS governance.
[101] Gilmore and Sullivan, p. 130.

referred to the Red Cross treaty, Geneva Conventions, and even the British Red Cross Society, from whom the Canadian Red Cross Society originally received legitimacy.

The principles of the Red Cross required that it be an independent, neutral body, free from government regulations. However, when the federal and provincial governments started to provide funding to and regulation of the Society, the spirit of the principles was somewhat compromised. However, there was nothing to suggest to the Red Cross that it should change its *modus operandi*; there was no national blood policy among so many actors.[102]

This is not a new concept in Canada. The federal system under which the governments operate ensures that, when national interests compete with provincial jurisdiction, difficulties will occur. A prime example is the state of Canadian highways, where the *Canada Highway Act* (1919) allows the federal government to both impose nationwide standards and help co-ordinate provincial efforts on this score.[103] In some ways, this was difficult because the provinces have primary jurisdiction on roads, but the federal government wanted to ensure a national standard. Ultimately, the provinces were able to co-operate on building the Trans-Canada highway (with financial help from the federal government), and a national highway policy came about. This is similar to the federal government's role in the Canadian Red Cross Society's Blood Transfusion Service. Although the federal government could have taken a leadership role within the Canadian blood system because of its regulatory role, it did not, leaving policy and governance decisions up to the other actors, although in this case, the governments never created an explicit national blood policy.

[102] *Commission of Inquiry on the Blood System in Canada: The Canadian Red Cross Society Submissions, Volume I*. (Toronto: Canadian Red Cross Society, 1996), p. 5. (Hereafter known as *CRCS Submissions*)
[103] Mathieu Turgeon and François Vaillancourt, "The Provision of Highways in Canada and the Federal Government," *Publius: The Journal of Federalism*. 32:1 (Winter 2002), p. 163.

The Blood Transfusion Service department of the Canadian Red Cross was part of a larger bureaucratic structure and was, in some ways, just part of a larger organization whose head was not necessarily a transfusion medicine expert or someone who completely understood the ways in which the blood service worked. The head of the Red Cross might very well not understand the importance of the blood system and its peculiar regulatory requirements. This is important, as the blood system was not always the top priority for an organization whose primary mission moved from wartime work and disaster relief to include public health programmes after the First World War.[104]

The next major problem was that the governments responsible for governing the Red Cross during this time "didn't feel compelled to regulate the Red Cross because of its reputation."[105] The only organization to which the Red Cross blood program was responsible did not force the responsibility while the Red Cross, as shall be seen, did not always know what it was doing. By not acting, the provincial governments allowed an unspeakable tragedy to occur. "Benign neglect" is the phrase that best sums up the governmental custody of the Canadian blood supply.

Finally, the basic reporting structure of the Red Cross to the federal and provincial governments underwent a number of changes in fifteen years. Not even the major players always knew how to react or when they should have been reacting in the first place.

These three factors determined the root causes of the massive blood tragedy that would follow and the horrible consequences for thousands of its victims. Let us take each one of these governance issues in turn.

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[104] *Canadian Red Cross in War and Peace*. (Toronto: Canadian Red Cross Society National Headquarters, 1935), p. 25.
[105] Gilmore and Sullivan, p. 131.

The Canadian Red Cross Society is a part of the larger International Red Cross, which has its base in Geneva, Switzerland. Its creation has already been discussed, so what is important to note is the international character of the Red Cross; it is designed to span all borders and do work as an impartial body.

The International Red Cross is governed by the International Committee of the Red Cross. This committee is responsible for creating the general policy of the Red Cross and performs a number of useful functions for all the Red Cross Societies around the world. Structurally, however, it is an enigma. As Caroline Moorehead put it, the International Committee:

- Calls itself international; yet is a private Swiss company, based in Geneva and governed by twenty-five Swiss citizens.
- Has its roots in precedence and institutional memory; yet thrives on action and sometimes seems curiously uninterested in history.
- Employs 'delegates' – some eight hundred in 1997, for the most part Swiss – who gather information about torture, 'disappearances' and summary executions that no one else has access to; yet under its mandate cannot reveal to the public or media what they know.[106]

The International Committee's responsibility was and is to maintain

> close relations with the National Societies, cooperating with them in areas of mutual interest such as preparedness for situations of armed conflict, respect for, development and ratification of the Geneva Conventions, and dissemination of the Fundamental Principles. The ICRC also assumes the general management and coordination of international relief operations conducted by the Red Cross and Red Crescent in situations of armed conflict.[107]

The International Committee does not govern the Red Cross Societies of each country directly; instead, it co-ordinates their work and acts as an administrator of the Red Cross brand name so

[106] Moorehead, p. xxi, xxii.
[107] http://www.icrc.org/web/eng/siteeng0.nsf/iwpList140/D81C252443CE59BEC1256B660058D535, *The ICRC and the International Red Cross and Red Crescent Movement.*

that signatories to the Geneva Convention can be sure that the Red Cross Society from one country acts in the same way as a Red Cross Society from another.

National Societies all fall under the auspices of the International Federation of Red Cross and Red Crescent Societies. The Federation deals with the international aspects of the National Societies, promoting co-operation between them and providing an opportunity for the sharing of ideas to serve their respective countries better.[108]

In terms of national blood programs, these two organizations were not directly involved with the Canadian blood supply. Instead, the Federation worked to give "assistance to national societies in the establishment and development of blood transfusion services"[109] The Federation provided a forum for international discussion and co-operation between the different National Societies, each of whom had a different blood program, different needs, and a different level of involvement in their nation's blood supply.[110] Ultimately, it is up to the individual Society to run itself within a given country. In other words, the Canadian Red Cross Society, though part of a larger group of Red Cross Societies, was on its own when dealing with blood problems in the 1970s and 1980s.

In 1982, just before the blood tragedy started, the Red Cross was organized in an extremely complicated manner in Canada. This is shown in two somewhat simplified diagrams on the next two pages (Figures 1 and 2).

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[108] http://www.ifrc.org/who/movement.asp, *Red Cross Red Crescent – a history*
[109] S.R. Hollan, W. Wagstaff, J. Leikola, F. Loth, eds. *Management of Blood Transfusion Services*. (Geneva: World Health Organization, 1990), p. 222.
[110] Hollan et. al., p. 222.

Figure 1: Red Cross Organizational Chart

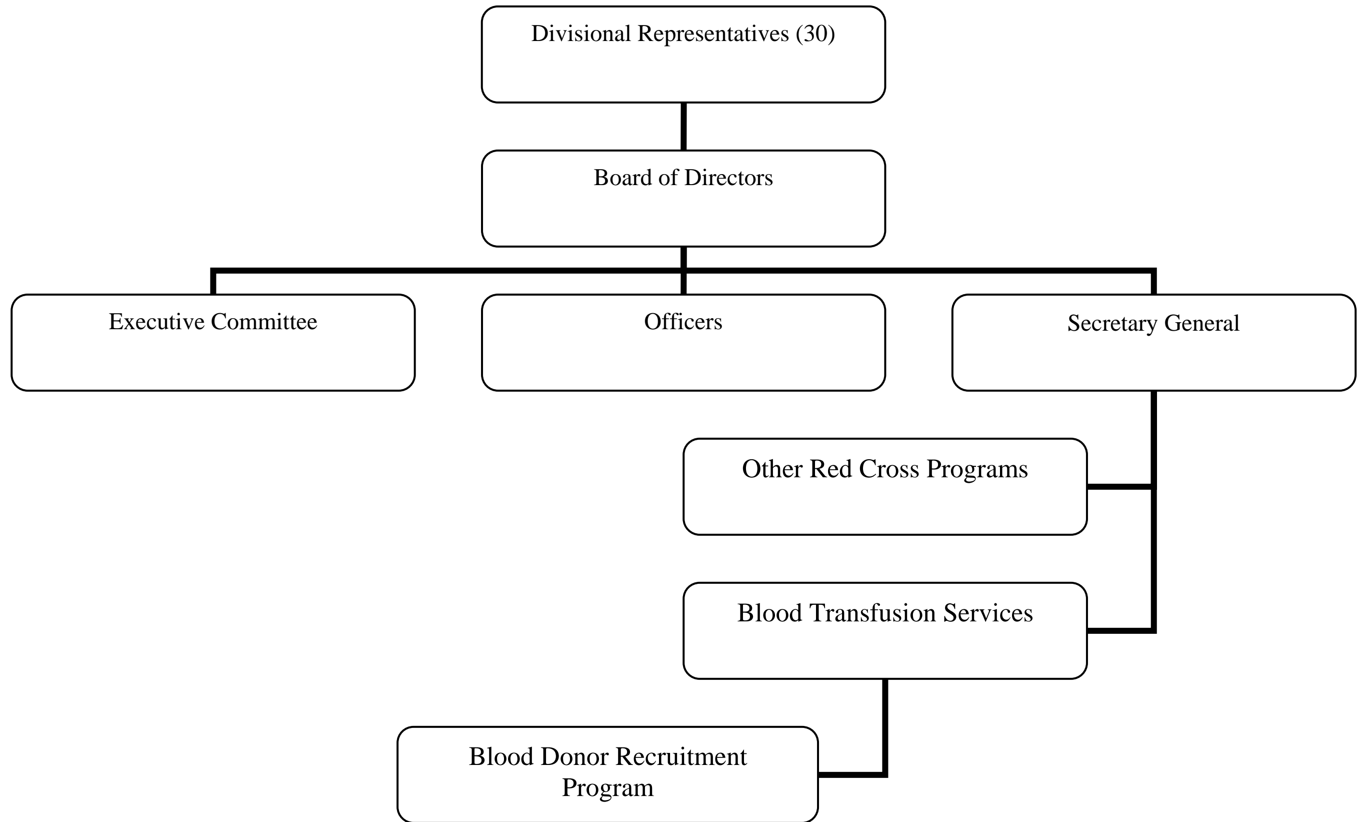
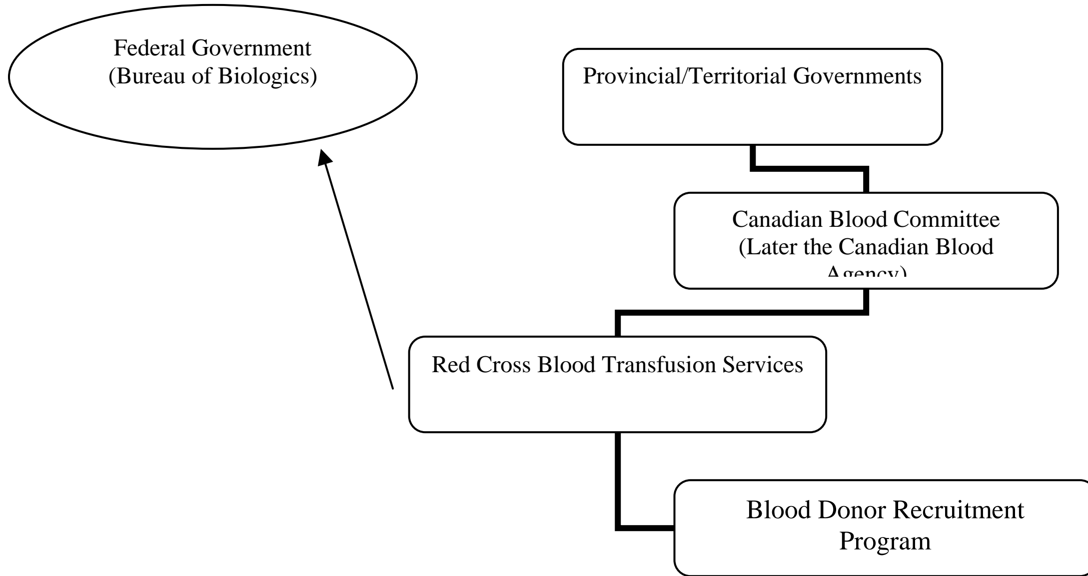


Figure 2: Red Cross and its relationship to the governments



The various divisions of the Red Cross elected three members to represent their interests at a national meeting. These people (thirty in all) elected the officers of the organization: the president, vice-president, treasurer, counsel, chair of the national planning and budget review committee, chair and vice-chair of the national blood transfusion service advisory committee, and the chair of the national field services committee. This group also made up the executive committee of the board of directors. The board of directors included each of the officers and one person from each of the ten provincial divisions and one to five other persons. The board also hired a secretary general to assist with day-to-day operations.

The Red Cross blood program had two branches: the blood transfusion service and the blood donor recruitment program. Only the former had direct representation on the board of directors, although this changed after 1986 with a reorganization that moved the blood donor recruitment committee to a subcommittee of the blood transfusion service committee.

The blood donor recruitment program was almost entirely volunteer-based, in accordance with the Red Cross's long-standing policy on voluntary service. Volunteers recruited volunteer donors under the general direction of the paid national co-ordinator of blood donor recruitment and the national blood donor recruitment committee. The committee was made up of volunteers who represented constituent interests and paid employees who had expertise in recruitment issues. The total number on the committee fluctuated between nineteen and twenty, but was still a rather large working group.

The blood transfusion service was made up almost entirely of paid employees, with the exception of the blood transfusion service advisory committee, which was made up of volunteer medical and scientific experts. The committee provided advice to the national director of the blood transfusion service and reported to the board of directors.

The Red Cross blood program, however, was just one small part of the larger Red Cross, fitting in as one small part of an enormous operation that included disaster relief, emergency services, water safety services, first aid services, and homemaker services.[111] Although some of the smaller committees had medical and scientific experts, the board of directors ultimately responsible for the Red Cross's direction were not always experts and the blood program only had two votes on a board of thirty.

The federal Ministry of Health is responsible for regulating the blood program and ensuring that it meets the health and safety standards set for it by the federal government. The Ministry of Health and Welfare Canada's Health Protection Branch was responsible for a number of different health branches, including the drugs directorate. The Bureau of Biologics was responsible for regulating the Canadian blood system, as blood is considered by the federal government to be both a drug and a "biologic." The regulatory agency has undergone a great deal of change over the last thirty years, but one thing that is striking is the approach to enforcement of regulations: it was considered one of "voluntary compliance." The Health Protection Branch (of which the Bureau of Biologics was a part) wanted to work *with* the Red Cross and other entities to ensure that complex issues could be dealt with adequately.[112]

In addition to the issue of voluntary compliance – as opposed to forced compliance – the Red Cross's blood products were not even regulated by the federal government until 1989, when blood was added to the *Food and Drugs Act*. The Red Cross was responsible for the safety and quality assurance of all its operations: collection, testing, processing, storage, and distribution of whole blood and its components.[113]

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[111] Krever, p. 52-54.
[112] Krever, p. 113. The argument for voluntary compliance was that one tended to comply when the inspector could say, "Do this voluntarily, or else…"
[113] Krever, p. 116.

This is not to say that the federal government and Red Cross did not communicate about issues relating to the blood system's regulation. Rather, the Bureau and Red Cross held regularly scheduled meetings and the Red Cross invited Bureau personnel to advisory subcommittee meetings so that the Bureau of Biologics would be kept up-to-date on issues facing the Red Cross. Testimony at the Krever Inquiry said: "We [the Bureau] were still aware of what the Red Cross was doing. We had contact with them. But it was not as good as if they would have been licensed."[114]

At the Krever Inquiry, testimony touched on two reasons for treating the Red Cross's blood program as a special case: the Red Cross's reputation and the complicating factor of provincial involvement in the blood system. Put simply, the Red Cross's reputation as a humanitarian organization was such that a change in Bureau policy would require a decision at the highest levels. Moreover, the Bureau was already seen as overworked and understaffed; since the Red Cross was self-regulating and since there had been no problems to that point, extending regulatory control over the Red Cross was not seen as a priority.[115] Unfortunately, this meant that anything the Red Cross asked for, it got. The federal government put a rubber stamp on any requests sent to it for licences, operating procedures, and even self-inspection.[116]

De-regulation was a hot topic in the early 1980s, so the federal government tried to download regulatory authority to the provinces. The provinces did not want to pay the costs associated with federal regulation, so self-regulation continued unabated.

[114] Krever, p. 136.
[115] Krever, p. 139.
[116] Picard, p. 185.

In the run-up to the Krever Inquiry, arguments were made that the blood program was a national system co-ordinated by the Red Cross and paid for by the provinces, which were responsible for health care: "Blood and blood products are freely exchanged between provinces; distribution, therefore, is on a national basis."[117] However, the Red Cross centres mostly kept the blood within the province from which it was collected. Exceptions were made in cases of emergency, but since the program was paid for separately by each province, "the inventory of collected blood was managed as nine separate entities rather than as one national resource."[118]

Ironically, the provinces were also one of the most important components to the Red Cross organization. Dr. Roger Perrault, who was the national director of blood services from 1974 until 1986, said that policy and funding were the primary roles for the provinces.[119] Of course, this also meant that the provinces had to have a significant say in both the regulation and the overall policy direction of the Red Cross.

The provincial role in the governance of the Red Cross Blood Transfusion Service changed over time. Initially, the provinces played no role in funding or governing the Red Cross, but as provincial and federal requirements for blood changed, so too did the provincial role in the blood system.

Over the course of almost thirty years, the provincial and federal governments went from being disinterested spectators to actors engaged in the blood supply system. As governments invested more and more public money into the Red Cross operation, provinces necessarily became more interested in the ways in which their money was spent. Moreover, the

[117] Parsons, p. 19.
[118] Krever, p. 54. By this time, Québec had pulled out of the national system to deal with the Red Cross on its own.
[119] Parsons, p. 19.

federal government owned Connaught Laboratories, making the entire blood supply system an arm of the federal and provincial ministries of health.

The move to own and operate Canada's blood system came gradually to the provinces and was always in response to an external force requiring them to become more involved in some aspect (usually financial) of the blood system.

By 1974, it was clear that the Red Cross was no longer a charitable activity and so government support increased in recognition of this new reality. The Federal-Provincial Program and Budget Review Committee voted to cover all of the Red Cross's technical costs and forty percent of its donor recruitment costs. Governments were all on side with the notion of the Red Cross as a government-supported supplier of blood and blood products. The governments believed that they were so fortunate that their arrangement with the CRCS set up the road for disaster later on. By giving the Red Cross an open-ended, unwritten contract with assurance that governments would pay the bills, they lost the opportunity for political oversight at this critical stage. [120]

In 1976, the provincial, territorial, and federal Ministers of Health articulated their four principles that should govern the Canadian blood supply.[121] However, these principles did not embody a national blood policy, making Canada one of the few industrialized countries that did not have a national policy.[122] As Dr. Perrault, former head of the Red Cross's Blood Transfusion Service, said, "So essentially what you had was a national system for blood delivery in a system that was strictly provincial."[123] He further noted that there were a number of governance factors, including the pan-Canadian nature of a Red Cross-run blood supply, the

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[120] Picard, p. 35.
[121] See page 44. The fourth principle was not added until 1979.
[122] *CRCS Submissions, Volume I*, p. 48.
[123] Dr. Perrault's testimony in *CRCS Submissions, Volume I*, p. 5.

funding responsibility of the provincial governments, and the regulatory responsibility of the federal government. His conclusion was that the only group that could be in charge of the Canadian blood supply was the Red Cross; no other actor in the system understood blood in the same way as the CRCS.[124]

The federal/provincial group responsible for governing the blood supply was called the Federal/Provincial Program and Budget Review Committee. Its mandate was very specific:

> In recognition of the principle that this service constitutes a national program, the federal government, with regional advice and in consultation with provincial health insurance authorities, shall have authority to evaluate the budgets and programs of the Blood Transfusion and Donor Recruitment Services of the Canadian Red Cross Society.
>
> The federal government, in conjunction with at least one provincial representative, shall approve the final budget annually and advise the provinces of the total cost of the programs, the approved new programs and respected provincial allocation of costs on an agreed basis of allocation.[125]

This new committee reported to the deputy ministers of health and was made up of representatives of the civil service in western Canada, Ontario, Québec, and Atlantic Canada. Québec pulled out of the committee in 1979, and the Red Cross had to make a separate report and budget for the work it did in the province.[126] From that point on, Québec dealt with the Red Cross on its own terms, although it did periodically participate in decisions with the other provinces.

Quebec's withdrawal from the inter-provincial committee is another indication of politics at work in the Canadian blood system. Ironically, the decision to sign an independent deal with the Red Cross led to yet another study of the blood supply: the Inter-Provincial Ad Hoc Committee on a Canadian Authority on Blood Policy. Both this committee and the earlier

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[124] *CRCS Submissions, Volume I*, p. 5.
[125] *CRCS Submissions, Volume I*, p. 23.
[126] Krever, p. 49-50.

Ad Hoc Committee on Plasma Fractionation (called the Chapin Key Committee after its chair, British Columbia's deputy minister of health) recommended that representatives from all the provinces and the federal government form a board that would carry out some of the tasks previously carried out by the governments. It would "create broad policy guidelines, allocate funding, and ensure compliance with standards. It would not, however, operate or manage the blood system [but would] approve budgets and audit expenditures."[127]

The Committees also recommended that this group be a not-for-profit organization to which the governments would delegate authority to enter into contracts with the CRCS and any Canadian fractionators. It would, in essence, co-ordinate all activities related to the Canadian blood supply, including collection, manufacturing, distribution, and regulation.

However, Ontario, Québec, and Manitoba opposed what they saw as a loss of control. In fact, the Ontario Minister of Health said:

> … It seems to me that, certainly, a lot is to be said for an ongoing inter provincial advisory body, but, as far as this key issue is concerned, I just can't see that my Government could turn that over and lose any direct control of what happens in our Province.[128]

Compromises were made, and the provincial governments ultimately agreed on a slightly modified version of the Chapin Key recommendation.

Quebec's decision to pull out of the inter-provincial decision-making conferences led directly to these reports and their recommendations. Because the province used its bargaining power to push for what it wanted, other provinces started asking the question, "who controls the blood system?" and started working to ensure that they put in place a structure to deal with "command and control" issues.[129]

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[127] Krever, p. 94.
[128] *Conference of Provincial Health Ministers, September 30 October 1, 1981, St. John's, Newfoundland.*
[129] Picard, p. 89-90.

In 1982, the provinces created a new committee: the Canadian Blood Committee. Its purpose was "to direct the Canadian blood system in accordance with the principles established by the Ministers of Health for the therapeutic use of human blood, blood products or their substitutes."[130]

Governments had stopped working together for a common good as they had in the war years and were engaged in direct competition over every tax dollar. The Red Cross, in the provincial view, could be a source of jobs for a poorly performing economy and every province wanted a direct say in its governance. Moreover, they each wanted credit for the success of the Red Cross.[131]

The competitive nature of provincial politics was a small part of the neglect inherent in the Canadian blood system. From the Red Cross's entry into the civilian blood system in 1946 until 1981 when the Canadian Blood Committee was created, there was a combination of politics and neglect at work. Provinces gradually took over governance and funding for the Red Cross Blood Transfusion Service, but never took responsibility for it. The Red Cross lost some of its neutrality and independence when it accepted money from the provinces for providing this vital service; unfortunately, the Red Cross did not see that the provinces left responsibility for the proper functioning of this service up to the CRCS.

[130] *CRCS Submissions, Volume I*, p. 31.
[131] Picard, p. 88.

Chapter 5

A New National Blood System?

The provinces created the Canadian Blood Committee (CBC) in order to help them deal more effectively with the Red Cross. The Red Cross had but a single view: to deliver blood and blood products to those who needed them. Provinces, however, had a responsibility to deliver all kinds of health care services to their citizens, and the Canadian Blood Committee could have played a role in both arenas.

Krever notes that the Red Cross had a somewhat poor relationship with the Canadian Blood Committee, due in part to the complex nature of the CBC and in part because of the principles by which the Red Cross had to operate. The Red Cross opposed the creation of the committee under the argument that it had to remain independent according to its founding principles. The fact that the provinces paid the bills and thus made the Red Cross a contractor for the operation of the blood supply seems to have been irrelevant.[132]

The Canadian Blood Committee: A Government Failure

Tensions between the Canadian Blood Committee and the Red Cross were evident at the outset, when the CRCS rejected the phrase “to direct” in the CBC’s purpose. Moreover, while the CRCS did not object to government oversight of its operations, it did have some concern that “government funding of the Canadian blood program was now evolving into government direction and control.”[133]

[132] Picard, p. 90-91.
[133] *CRCS Submissions, Volume I*, p. 33.

The committee's terms of reference were approved before the CRCS had an opportunity to comment, but the provinces – in a 1981 conference of ministers of health – approved the eleven objectives by which the CBC would operate:

1. To establish policies with regard to the following:
   a) the collection of blood, including plasmapheresis;
   b) the processing of blood;
   c) the distribution of blood products;
   d) the utilization of blood products;
   e) operational research; and
   f) support and maintenance of the four enunciated principles concerning blood and blood products.

2. To recommend allocation of resources to meet costs of implementing the above policies.

3. To assure adherence to established policies by the Canadian Red Cross, plasma fractionation plants, and others involved in the collection, processing, distribution, and utilization of blood and blood products.

4. To consult with the Department of Industry, Trade and Commerce on appropriate policies for the export and import of human blood and blood products.

5. To consult with the Bureau of Biologics, Department of National Health and Welfare, on appropriate policies for the regulatory control of the collection, processing, and distribution of blood, blood products and their substitutes.

6. In the short term, to monitor the development of fractionation plants to ensure that their establishment is in accordance with the recommendations of the Ministers of Health and allocate resources and priorities for their implementation.

7. To determine the real costs of producing blood fractions for Canadians and the shareable portion of capital costs to be added to the price of blood fractions.

8. To ensure that standards for blood, blood products and blood substitutes are developed, and to monitor that such standards are met.

9. To review and approve the programs and budgets of the Blood Donor Recruitment and Blood Transfusion Services of the Canadian Red Cross Society, subject to the concurrence of all Provinces and territories.

10. To report annually to the Ministers of Health on all activities of the Committee

11. To be a national forum for the various organizations and associations of the Canadian blood program to discuss issues, and to coordinate the activities related to the management of the Canadian blood system.[134]

The Canadian Blood Committee was clearly an ambitious step designed to solve a number of the problems that had plagued the Canadian blood supply to this point. Its purpose was defined, and its objectives, while not necessarily measurable, were clear. The governments of Canada and the provinces were taking steps to ensure that the Canadian blood supply had clear policy objectives and the resources to fulfill them. However, the collaborative facade of the CBC quickly started to crack under a variety of pressures.

The CBC should have been a forum for the provincial, territorial, and federal governments to determine blood policy for the country. In reality, however, the territories never sent a representative to the meetings, and Québec did not join the committee until 1983, although it did send observers starting December, 1982. Public accountability was practically unheard of behind the committee's closed doors.[135]

To make matters worse, the committee was powerless, since it was unable to make major budget determinations, to enter into contracts, or to bind the provinces to a decision made at the CBC. Essentially, the Canadian Blood Committee acted as a common meeting point for the various government representatives to receive information and report back to their respective governments for instructions. Provinces at that point had the opportunity to concur with the committee's recommendations or make separate arrangements with the Red Cross. Nowhere was this more evident than in the creation of a national blood policy.

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[134] Krever, p. 95-96.
[135] Gilmore and Somerville, p. 131.

In the midst of a national blood system, the Canadian Blood Committee was a confederacy: provinces appointed representatives to a national body, but they retained all decision-making powers.

The creation of a national blood policy was understandably a complex issue. Numerous requests from the CRCS had gone unheeded and the country's blood supply had no formal guiding mechanism. As one of its first tasks, the Canadian Blood Committee set out to rectify the problem. Minutes from a December, 1982 meeting speak to the committee's intent: "Members of the CBC recognized the need and the urgency of developing such a policy, as approved by the Conference of Ministers of Health."[136] As this policy was never created, however, the truth of this statement remains in doubt.

Certainly, however, the CBC set up a framework for the creation of this policy. They agreed that any national blood policy should be far-reaching and include the four elements of such a policy created by the Ministers of Health in the 1970s as well as eight other components:

- The terms of reference of the Canadian Blood Committee and its authority;
- The applicability of the policy to the Canadian Red Cross Society, the fractionation and related industry, and all governments;
- The role and corporate principles of the Canadian Red Cross Society and its contractual relationship with governments and hospitals;
- International provisions;
- Authority for product standards development, implementation, and control;
- Authority for policy decisions, implementation, monitoring and appeal;

[136] Krever, p. 102.

- Recognition of blood as a public, national, and limited resource;
- Research and development[137]

Over the next six years, the CBC drafted and re-drafted its policy, requesting input from some forty stakeholder groups in the process.[138] By 1989, however, the committee believed that the 1979 objectives enunciated by the ministers of health were insufficient and that a new framework for the blood system had to be created. These new components, signed off by the Ministers, were:

1. The voluntary system should be maintained and protected.
2. National self-sufficiency in blood and plasma collections should be encouraged.
3. Adequacy and security of supply of all needed blood components and plasma fractions for Canadians should be encouraged.
4. Safety of all blood, components, and plasma fractions should be paramount.
5. Gratuity of all blood, components and plasma fractions to recipients within the insured health services of Canada should be maintained.
6. A cost-effective and cost-efficient blood system for Canadians should be encouraged.
7. A national blood program should be maintained.[139]

Many of these seemed to be "motherhood and apple pie" issues, as they were a part of what the Red Cross had done all along. The Ministers of Health readily accepted the new principles, but no national blood policy was forthcoming.

What is interesting about the new principles is that no one seems to have objected to the mutual exclusivity of numbers 4 and 6. The provinces required that safety be paramount; if it is truly the most important issue, how does cost play a role? As a result of this dichotomy, trade-

[137] Krever, p. 103. The provinces and Krever both use the word "principles" to describe these elements of the blood system, but it does not seem to be the best possible descriptor.
[138] Krever, p. 103.
[139] Krever, p.103-104.

offs had to be made to reconcile competing requirements. If safety is paramount, who defines safety? Moreover, who defines what costs need to be incurred to provide this safety? Without further explication, the Ministers of Health put the Red Cross into a position where it could be condemned for actions it did not take while at the same time allowing the Red Cross a way out if things went bad by couching the principles in vague, ambiguous language.[140]

Why was a national blood policy so important to the organizations within the system, especially the Red Cross? As the principal actor in the blood system, the Red Cross had run its operations with very little oversight from governments of any level. Although the operation of Canada's blood supply came under the jurisdiction of the provincial Ministers of Health, the Red Cross was still largely unaccountable for its actions.

However, since governments were now (with the full funding provided to the Red Cross's blood program) at least technically responsible for the blood supply, it became more important to have the roles and responsibilities of each actor clearly identified. Otherwise, there was the potential for the Red Cross to be micromanaged by government ministries, which was clearly in contradiction to its governing principles.[141] This did not even appear to matter all that much because the CBC was incapable of responding to the problems it did face. Individual provincial ministers did not press the committee for action, but the committee at the same time did not demand answers from the different governments.[142]

A national blood policy would give the Red Cross a measure of autonomy in that its role would be clear and it would also provide a means to ensure that it was acting within the principles of the International Red Cross.

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[140] John Hoey, "The sensibility of safety: reflections on the Krever inquiry's final report," *Canadian Medical Association Journal*. Jan. 13, 1998; 158(1), p. 60.
[141] See pages 34-35 for a fuller discussion.
[142] Gilmore and Somerville, p. 134.

The lack of a national blood policy was only one of the points of tension between the CRCS and the CBC. As a result, the relationship between these bodies deteriorated to an unacceptable level. The Red Cross required at once both policy guidance from the provincial governments but at the same time needed independence from them. Moreover, the CBC had its own internal conflicts to deal with. It had competing political agendas from the thirteen governments playing their own roles and was a toothless body, subordinate to the whims of the same government agendas. Ultimately, the CBC would complete some good work but fail because of its relationship with the Red Cross and its relationship with the provincial governments.

The two parties primarily responsible for the Canadian blood system rarely had a good relationship with one another, stemming from competing perceptions about their respective roles in the Canadian blood supply. On the one hand, the Red Cross believed that it should have a great deal of autonomy in the blood supply, owing to its historic role and in the principles defined by the International Red Cross. The CBC, on the other hand, had a claim to running the system because of the governmental role played in its makeup.

Ultimately, of course, it was the responsibility of both the federal and provincial governments to ensure that the blood supply was safe; the federal government was responsible in a general nature for the regulation of blood products, while the provincial governments were responsible for the actual delivery of health services.[143] These governments had delegated their responsibility for the blood system to the Canadian blood committee. However, the CBC did not have the resources, authority, or accountability to fulfill its mandate.[144]

[143] The federal Ministry of Health did not completely regulate the blood industry until 1989.
[144] *CRCS Submissions, Volume I*, p. 86.

In the opinion of the Red Cross, the role of the CBC was to provide direction "in the form of policy development so as to provide a framework for the CRCS to fulfil its function as the operator of the blood program and distributor of blood products."[145] In reality, however, the CBC exercised a great deal of control over the Red Cross. Although this sounds strange, given the inability of the CBC to fulfil its mandate, it is all a matter of perspective. The Red Cross believed that the CBC spent a great deal of its time interfering with blood program operations, but the provincial governments did not provide it with the ability to do much of anything. In fact, in spite of the noble-sounding principles in the committee's terms of reference, its real purpose was for governments to keep a measure of control over the CRCS:

> For Canada's ministers of health, protecting the blood system from the threat of disease wasn't an issue worth exploring, but determining the 'shareable portion of capital costs to be added to the price of blood fractions' was a priority. With no legislative authority, no scientific knowledge and no public accountability, the CBC did little more than approve the funds it turned over to the Red Cross each year…[146]

In some ways, this approach made sense: Red Cross costs were paid by the province in which they were incurred, and as a result there was a great deal of opposition to transferring blood and blood products across provincial borders without the approval of the Canadian Blood Committee.[147] Unfortunately, the provincial representatives on the committee were not as equal as their positions on the committee would otherwise indicate. Some representatives were as high as the Deputy Minister level, but others were two, three, or four levels below that. Often, they had to delay a decision while consulting with the provincial offices to which they were responsible.[148]

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[145] *CRCS Submissions, Volume I* p. 35.
[146] Picard, p. 93.
[147] Krever, p. 104.
[148] *CRCS Submissions, Volume I* p. 37-38.

The CBC and CRCS never came to an agreement regarding the roles each would play within the Canadian blood system. While the CBC was primarily responsible for approving the CRCS budget, it also meant a great deal of uncertainty when it came to the responsibilities of the Red Cross. The former National Director of the CRCS's Blood Transfusion Services, Dr. Roger Perrault, wrote:

> In 1982, we felt that the role of the Canadian Blood Committee could well evolve towards that of a "Management Board" for the Blood Programme: this was raised in the C.R.C.S. April 1982 response to the C.BC. terms of reference…
> What are the exact decisions that the C.R.C.S. can make? Number of <u>staff appointments</u>, rate increases, increases in the use of supplies and allocations of equipment, programme expansion (e.g. Plasmapheresis), choice of fractionators, conditions under which fractionators will be paid, etc. are all areas where C.R.C.S. has very little choice in the matter. The choice between one supplier and another is subject, in certain circumstances, to the political process of the governments.[149]

Throughout the 1980s, the CBC took control of the Canadian blood supply by stealth. Although it did not really run the system, it made all budget decisions for the CRCS in a line-by-line examination of each year's budget (a process that could take six months to complete). The budget was submitted to the Canadian Blood Committee in September for the start of the CRCS's fiscal year in January.[150] CBC members, responsible to their provincial governments, saw the budget broken down province-by-province and centre-by-centre. Each representative had limited budgetary approval authority, requiring them to ask for justification of budget items, ask for a reduction in the budget requests, or time to consult with their province's Treasury Board. As a result, budgets were almost never approved prior to the beginning of a fiscal year.

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[149] *Position Paper by Dr. Perrault,* December 2, 1985. Emphasis in original.
[150] Krever, p. 104.

In addition to the complex nature of the budgeting process, the scrutiny given to the Red Cross budgets by the CBC meant that any changes to the budget in the fiscal year required prior approval. Even issues as small as permitting the Red Cross to hire full-time staff members in entry-level positions required approval of the committee. Moreover, the budgets were approved on a province-by-province basis; funds allocated to one provincial centre could not be transferred to another. Within a centre, however, funds could be reallocated without justification as long as the bottom line remained the same.[151]

Part of this was due to the lack of a national blood policy and part of it was because of the murky lines of authority between the CBC and Red Cross. Indeed, an *ad hoc* working group of Deputy Ministers of Health concluded in 1989 that a new group with the authority to operate the blood system on behalf of all the governments in Canada needed to be created. It noted:

> The separation of funding responsibility from the management decisions of the CRCS inevitably results in governments becoming involved in some day-to-day management issues and the CRCS being unable to pursue corporate objectives due to lack of financial resources under direct control.[152]

The Red Cross submissions to the Krever inquiry provide a number of examples of cases in which the provincial governments, through the CBC's oversight, interfered with Red Cross management decisions. Generally, these involved specific areas of funding: human resources, where the Red Cross could not hire full time personnel without specific authorization; provincial budget lines, which required the CRCS to keep money from one province for use by the blood centres within that province; major capital expenditures required CBC approval, as did almost any unexpected expense.[153]

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[151] *CRCS Submissions Volume I*, p. 67-72.
[152] *Final report of the* Ad Hoc *Working Group of Deputy Ministers of Health,* August 25, 1989.
[153] *CRCS Submissions Volume I*, p. 72-73.

The Canadian Blood Committee was a good idea implemented poorly. It sought to create a body accountable for the operation of the Canadian blood system, but it micromanaged the provider of this national resource in such a way as to make the delivery of a national blood system all but impossible. The Red Cross could not do the job it needed to do under the constraints of the Canadian Blood Committee's often cumbersome processes. The provinces retained their authority for health care while at the same time demanding a national blood system; the two objectives were mutually exclusive.

In 1991, the unworkable relationship between the Canadian Blood Committee and the Canadian Red Cross Society was dissolved and the Canadian Blood Agency was created. The goals of the new blood authority were laudable, but the damage to Canada's blood supply had already been permanently done.

By 1991, it was apparent that the Canadian blood system was not working as well as it could otherwise. The federal government had just started fully regulating the Red Cross through its Bureau of Biologics. The provincial governments funded the Red Cross BTS and were supposed to provide broad policy direction through the Canadian Blood Committee. However, the CBC took on a greater than intended role by examining the budget to such an extent that it interfered with the CRCS's operations. This in turn led to resentment on the part of the Red Cross which led to a poor relationship between the two organizations.

Ultimately, the Canadian Blood Committee and the Canadian Red Cross could not work together because of ambiguity surrounding their roles in the Canadian blood supply. The lack of a national blood policy coupled with an overreaching oversight committee led to a constant tug-of-war between the two. The federal government formed the Canadian Blood Agency (CBA) in 1991 to replace the CBC.

Before the CBA could be formed, the actors within the system had to make some specific determinations as to what the Canadian blood system was and the role that each would play within it. First, however, they had to determine what was meant by the seemingly interchangeable phrases "Canadian blood system" and "national blood supply program." The latter phrase, however, has a more narrow definition, consisting of Health Canada's Bureau of Biologics and Radiopharmaceuticals (the regulator), the Canadian Red Cross Society (the operator), and the new Canadian Blood Agency (the co-ordinator/funder). The Canadian blood system has a broader reference, including ministries of health, hospitals, private blood groups, physicians, patients, blood donors, and blood advocacy groups.[154]

This distinction between two terms is important because it helps to remind the actors within the blood supply that they are a part of a bigger cause: the safety of the blood system is dependent on them and their actions. It is with this distinction in mind that we move to discuss the creation of the Canadian Blood Agency.

Too little, too late: the Canadian Blood Agency

In contrast to the Canadian Blood Committee, the CBA entered into existence with some forethought. The provincial governments created it as a federal not-for-profit corporation. Unlike the CBC, the new Agency could enter into contracts independently of governments and fund the blood agency on their behalf. Specifically, the Canadian Blood Agency existed

> To direct, coordinate and finance the various elements of the Canadian Blood System requiring national direction in accordance with the principles established by the Honourable Ministers of Health of the Provinces and Territories of Canada for the therapeutic use of human blood, blood products or their substitutes.[155]

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[154] *CRCS Submissions, Volume IV*, p. 5.
[155] Krever, p. 1004.

The Red Cross remained as the medium through which the blood system operated, but the CBA operated as the governmental link. The Canadian Blood Agency was a creature of the provinces, designed to work on their behalf to direct the Red Cross's blood system from vein to vein (i.e. the recruitment, collection, processing, and distribution of blood and blood products).

The ministers of health were all members of the new agency, but there was still contention between the Red Cross and its government overseers over the issue of Red Cross independence. Former Red Cross secretary general Douglas Lindores testified at the Krever Inquiry: "we will do the best we can to cooperate with the Canadian Blood Agency, but … we do not consider ourselves bound by directives received from the Canadian Blood Agency."[156]

The Red Cross was also reforming itself at the same time. Its blood operations had evolved over time in a mostly *ad hoc* fashion, and the Blood Transfusion Service business model had not been particularly well thought out. This was consistent with the way the Red Cross saw itself (that is, as a medical service) but was not conducive to the national demands of blood donor recruitment and manufacturing. As a result, the Red Cross underwent a series of internal changes in the early 1990s, including recruitment of professional managers to run the blood centres instead of physicians and the implementation of the Good Manufacturing Practices program.[157]

In spite of these reforms, the working relationship between the CRCS and the CBA did not improve from the relationship with the CBC. This problem became apparent during the Krever Inquiry when a safety audit committee investigated the relationships in the blood supply. It concluded that one of the reasons for the problems within the Canadian blood supply

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[156] Krever, p. 1005.
[157] Krever, p. 1005. Medical doctors still held positions at the CRCS but they were advisory in nature. The Good Manufacturing Practices model is similar to ISO standards in that they produce a quality product safely and consistently.

was the structural arrangement between the regulator, operator, and funder. It noted specifically that the CBA appeared to have been created solely to act as a way to keep costs under control and that the CRCS was used to a sense of historical independence. The safety audit committee also said that the antagonistic relationship between the two bodies and the attendant governance difficulties could have affected safety issues.[158] In other words, the "new" governance structure achieved none of the goals it set out to accomplish.

Within two years of its creation, the CBA-CRCS relationship came under additional fire because of the Krever Inquiry into the catastrophe of the mid-1980s. The Krever Inquiry will be more fully discussed, but it is important to remember that all of the of the decisions made by the CBA and CRCS as of this point came under intense public scrutiny before the blood system changed hands yet again in 1998.

Justice Krever's safety audit committee noted three things that needed to change before progress could be made in the Canadian blood supply system:

- The federal and provincial governments had to create some sort of governing document clearly outlining responsibilities;
- The parties involved had to come to an agreement on an interpretation of the principles set out by the Ministers of Health;
- Planning, priorities, and funding issues all had to be better developed between the CBA and CRCS.[159]

[158] Krever, p.1007.
[159] Krever, p. 1006.

None of these items was resolved before 1995, when the provinces, territories, Canadian Blood Agency, and Red Cross finally created a master agreement between themselves. Under the Master Agreement, the governments would provide the CBA with funds with which to pay for the blood system (although the governments had representation on the CBA, they did not have a direct role in determining budget policy); the CBA would create policy, determine the collection targets, and pay for the Red Cross Blood Transfusion Services; the CRCS would comply with all Health Canada regulatory requirements and ensure the safety of the national blood supply.

The Master Agreement, however, did not solve some of the problems already inherent in the system. For example, it did not differentiate between broad policy direction and specific management issues affecting the safety of blood. This put the CRCS and CBA into conflict almost immediately.[160]

These issues were not resolved even a year later, when the federal, provincial, and territorial governments undertook a study on the blood system to recommend reform. The conflict between the Red Cross and the CBA and the governments was foremost on everyone's mind. The Canadian Blood Agency, for example, speculated that the problem lay in the Red Cross's demand for independence from governments. It argued that any national blood supply program had to report directly to a government or to the Agency in order to eliminate this problem. The Red Cross, however, said that the problem lay in its lack of control over policy and funding co-ordination. The CRCS pointed out that the federal government requires a certain level of safety for which it has no role in funding, while provincial health ministries that

[160] Krever, p. 1011. A team of management consultants hired by the Inquiry believed that the Master Agreement was not a great change and that the construction of the blood system did not allow for anything but conflict (p. 1015).

want to lower costs control the CBA. The Red Cross is caught in the middle, and is least able to create a solution.[161]

The Red Cross and CBA did not have a good working relationship from the beginning. There was too much baggage carried over from the Canadian Blood Committee. By the time reform could even begin, the Krever Inquiry started, putting all the actors of the blood system under a microscope.

After fifty-one years of working with Canadian governments, the Red Cross found itself in the middle of an important debate over the future of its role in the Canadian blood system. It was continually in conflict with the governments ultimately responsible for the Canadian blood supply and was now at the Centre of a massive controversy. Ultimately, it would withdraw from the blood system, but not before considerable damage had been done.

In 1992 and 1993, the House of Commons Standing Committee on Health and Welfare, Social Affairs, Seniors, and the Status of Women held hearings into the Canadian blood system to both reassure the Canadian public and to determine the causes of the contamination of the blood supply. Its report, however, produced more questions than it answered. Its recommendation was that a judicial inquiry be held; it further said that all governments should agree to its terms of reference, but Ottawa must also be prepared to act alone if necessary. This was due to the fact that the provincial governments chose to drag their feet. The governments all knew that they were culpable in the blood tragedy and wanted to avoid the political consequences of such an inquiry.[162]

By September 1993, all the governments of Canada (with the exception of Québec) recommended that a public inquiry be established. Justice Krever says in his report that,

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[161] Krever, p. 1020.
[162] Picard, p. 189.

although the Québec government was not part of the original call for an inquiry it did co-operate when the hearings came to the province.[163] Although the move to establish the Krever Inquiry was a good one politically, the provincial governments also tried to cover their backs. While the Inquiry would review all aspects of the blood system, the mandate also ensured that there would be no findings of fault. The health ministers also committed very little money and time to the Inquiry. They even went so far as to commission their own ninety-day review, hoping to make internal changes quickly enough to "solve" the problem.[164]

The Krever Inquiry

In October, 1993, the Governments of Canada, Ontario, Prince Edward Island, and Saskatchewan separately appointed Justice Horace Krever to investigate the tainted blood tragedy.[165] This thesis has not explored the events surrounding the tainted blood scandal because it is not directly germane to the issues of governance in Canada. Essentially, the Red Cross and the governments of Canada and the provinces were slow to act in implementing testing for the HIV/AIDS and Hepatitis C viruses in the early 1980s. Although other industrialized countries put these tests into place, the Canadian blood system did not use the safeguards available to it. Suffice it to say that the Red Cross and its government overseers had not done what they needed to do to protect the blood supply from the hepatitis and AIDS viruses.

Justice Krever was to "review and report on the mandate, organization, management, operations, financing and regulation of all activities of the blood system in Canada, including

[163] Krever, p. 5 and 1108. Québec held its own inquiry, the Gélineau Commission, which recommended a number of things that are now part of Héma-Québec.
[164] Picard, p. 191.
[165] Each of the three provinces had its own legislation applicable to Royal Commissions, so each had to appoint Justice Krever separately.

the events surrounding the contamination of the blood system in Canada in the early 1980s."[166] The Commission's terms of reference gave Justice Krever almost unlimited authority to investigate the blood system by examining the organization, both past and current (at the time) of the blood system, any relevant interest groups, and asked him to investigate the structures present in other countries.[167]

Justice Krever was asked to report to the Cabinet by September 30, 1994 with recommendations for the future of the Canadian blood system, including the roles and responsibilities of the governments and the Red Cross and actions required to implement his recommendations.[168] Ontario, PEI, and Saskatchewan also appointed Justice Krever to provide them with similar information under applicable provincial laws.

The Krever Commission heard from 474 infected people, the Canadian Red Cross Society, the Canadian Blood Committee, the Canadian Blood Agency, provincial and local public health officials, community organizations, physicians, and medical experts. More than sixty groups and individuals submitted reports to the Commission.

The hearings started in November, 1993 and ended in December, 1995, more than a year after Justice Krever's final report was due.[169] An interim report outlining the basic facts of the blood tragedy and some early recommendations was submitted to the federal government on 15 February 1995. In the interim report, Justice Krever outlined some of his recommendations to the various governments of Canada. The governments, in turn, used Justice Krever's interim report as a basis on which to start reform of the system. We will

[166] Government of Canada Commission to Justice Horace Krever (Appendix A, p. 1081 of the Krever Report)
[167] Government of Canada Commission to Justice Horace Krever (Appendix A, p. 1082 of the Krever Report)
[168] Government of Canada Commission to Justice Horace Krever (Appendix A, p. 1083 of the Krever Report)
[169] Ironically, the politics surrounding the tainted blood tragedy continued right up to the end of the Inquiry. The federal government refused to turn over a number of Cabinet minutes. These documents would have shown that the federal government did not act quickly to extend regulatory control over the CRCS in the early 1980s. (Gilmore and Somerville, p. 147.)

discuss these recommendations (along with Justice Krever's final recommendations) in the next chapter.

Justice Krever's final report, tabled on November 26, 1997, changed the face of the Canadian blood supply forever. It forced the governments of Canada to take a systematic look at the organization that had provided this vital service for over half a century. The governments had to look at their relationships with each other and the ways in which they governed a national blood supply. No longer could the governments rely on the goodwill of Canadians when it came to the blood supply. The Red Cross could no longer claim to be the best judge of what was good for the blood supply; it had clearly failed in its task.

However, there was some good coming out of the report. The federal and provincial governments now had an opportunity to construct a blood system from the ground up, learning from the mistakes of the past and demonstrating to Canadians that a single, national blood system could earn their trust and fulfill its task. In spite of the long way a new blood authority had to go, governments could see opportunity rising. It is the efforts of these governments and the result of their labours – the formation of Canadian Blood Services – that we will discuss in the next chapter.

Chapter 6

Canadian Blood Services

The Krever Inquiry shook the very foundations of the Canadian blood supply. It brought to the fore issues that had been simmering for decades. The Red Cross lost the trust it spent fifty years accumulating and its role in the Canadian blood supply was severely damaged. The provincial, territorial, and federal governments had to take a close look at their roles in funding and governing the blood system, and Justice Krever's interim and final reports offered them the opportunity to do so. The only questions remaining were: would the governments' more active role in the blood system make things better and would the governments be able to co-operate when they had thus far failed to do so?

By 1994, the blood controversy had had an effect on operations at the Red Cross. Donations were down considerably and various organizations criticized the level of safety within the Red Cross.[170] This criticism led to threats from the Red Cross that it would leave the blood business entirely unless the federal and provincial governments made significant changes to the system.[171]

Even before Justice Krever issued his final report, the public discussion over the blood system and its governance led to a number of different improvements on the way the blood system worked. These improvements started when the Red Cross made its intentions public.

Doug Lindores, the Secretary General of the Canadian Red Cross Society, said that the CRCS had plans to update its equipment and procedures to meet the significantly more stringent requirements in the United States. One of the reasons the CRCS had not already implemented these plans was that the Canadian Blood Agency refused to approve the new

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[170] *Maclean's*, Sept. 19, 1994, p. 22
[171] *Toronto Star*, October 2, 1994, p. A3.

funds. Lindores further argued that it was this inability to fund the blood system properly that led to the breakdown in the 1980s and that if the provincial governments did not find a way to co-operate on blood issues, the Red Cross would withdraw entirely.[172]

Although we already know the outcome of this ultimatum, it is important to reflect on what it meant at the time and what it shows us about the nature of the blood system in the mid-1990s. Governments responsible for funding a toothless Canadian Blood Agency were also in the midst of dealing with crushing deficits and cries for greater fiscal responsibility. Political realities meant that new funds were not available, even to improve safety in the blood system. The Red Cross, however, did not want to lose the battle for public opinion just because the provinces would not provide the necessary money to create even the *illusion* of safety.

The word "illusion" is used advisedly in terms of politics; in this case, its use does not presume an intent to defraud the public. As the saying goes, politics is perception. This is even more true when it comes to issues of health as the public wants nothing more than to be sure its safety is of the highest importance to governments and service providers. These same governments failed in the 1980s to ensure that the blood system operated the way it needed to. The Red Cross, in an effort to salvage its own reputation and in order to ensure its continued place as the operator, made it clear to governments and the public that it would no longer take on the tasks assigned to it without more appropriate funding levels. Its threat to leave the operation of the blood system completely to the governments never came to pass, as the governments tried to work towards a better funding and governance arrangement; the situation was *supposed* to improve and the actors in the blood system tried to correct the mistakes of the past.

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[172] *Toronto Star*, October 2, 1994, p. A3.

By 1995, the Red Cross, provincial and territorial governments, and the Canadian Blood Agency entered into a Master Agreement that was designed to clarify the roles and responsibilities of each actor within the blood system. Under the agreement, the provinces provided appropriate levels of funding to the Canadian Blood Agency after the CBA approved the Red Cross's budget plans. The CBA would create policy for the blood program on behalf of the provincial governments, while the Red Cross would ensure that its blood products met both Health Canada's requirements as well as the highest possible standards for safety, efficiency, and efficacy.[173]

The Master Agreement also clarified and interpreted the seven principles governing the Canadian Blood System that had been affirmed in 1989. Although the clarification did help eliminate some ambiguities, it did nothing for others. The conflict between safety and cost was not resolved, for example, and the CRCS and CBA continued their uneasy relationship. If safety was truly paramount, as the principles articulated by the Health Ministers stated, then the Red Cross must go about providing the safest possible product at whatever cost was necessary (unless, of course, the governments provided direction on how to deal with the cost issue). However, policy guidance and money were both provided by the Canadian Blood Agency, which was itself "tightly controlled by health ministries who are preoccupied with lowering costs."[174] It is important to note once again that the federal government was not involved with the governance of the CRCS, but was instead responsible for regulating the use of blood and blood products. Decisions it made about safety requirements – and the Red Cross was responsible for complying with those requirements under the Master Agreement[175] – had

[173] Krever, p. 1011.
[174] *Red Cross Submissions, Volume IV*, p. 12.
[175] Krever, p. 1011

no effect on the federal budget but had a huge impact on the provincial governments responsible for providing funds to the Red Cross. As the CRCS argued in its submissions to the Krever Inquiry, it is required to provide a national service without any input into either funding levels or regulatory requirements.[176]

The 1995 Master Agreement took a problematic relationship and formalized it without solving the basic structural issues. The Red Cross *Submissions* document pointed out that the cost and safety debate is one that should place governments front and centre. Too often, however, this responsibility was downloaded to the Red Cross because the CBA and governments required too much information, delayed funding decisions, and did not provide clear direction to the CRCS.[177]

As required by the original Order-in-Council, the Krever Commission released an interim report early in 1995. Although the report did not lay blame or draw any conclusions, it did report on the state of affairs found at many blood centres across Canada. Moreover, the interim report made a number of recommendations to the governments to improve safety and communication within the blood system. These recommendations formed the basis of the negotiations among the provincial ministers of health to create a new blood authority.

The Interim Report

Order-in-Council P.C. 1993-1879, which established the Commission of Inquiry on the Blood System in Canada, required the Commissioner, Justice Horace Krever, to "submit an interim report … on the safety of the blood system, with appropriate recommendations on actions that

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[176] *Red Cross Submissions, Volume IV*, p. 12.
[177] *Red Cross Submissions, Volume IV*, p. 12. One such example occurred shortly after the Master Agreement came into effect. A new test for Creutzfeld-Jakob disease came available. The Red Cross determined that it needed money to implement this test, but the CBA could not make a decision about the policy or funding.

might be taken to address any shortcomings."[178] Although this report was due in May, 1994, Justice Krever did not submit it until February, 1995. Even with the extra ten months, the report was not complete, as Justice Krever himself admitted in the opening pages.

The Commission did not draw conclusions or pass judgment on the blood system in Canada, but it did address a number of shortcomings and made recommendations as to possible solutions. The first, most obvious conclusion has been noted earlier: the blood system did not have a cohesive structure, existing as it did with responsibilities delegated to a number of different parties, each with varying levels of power and obligation.

The interim report discussed a number of things related to the safety of the blood system in Canada. As a result of the preliminary hearings and discussions, Justice Krever made forty-three recommendations to the Governor-General-in-Council, all dealing with safety and technical issues. In fact, he noted that "the decision-making structure of the [blood] system, referred to by the safety audit committee as 'governance,' is an issue that I expressly leave open for my final report."[179]

Even though governance is not specifically addressed in the interim report, it was still affected by the report's 1995 release. This report was the catalyst for change and action among the governments, providing specific recommendations to the Red Cross and Canadian Blood Agency as well as a hint of what might come in the final report.

The Commission highlighted some of the safety shortcomings of the blood system (it focused specifically on the introduction of the Good Manufacturing Practices Quality System) which led the provincial premiers to step in and work with the Red Cross, CBA, and other

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[178] Government of Canada Commission to Justice Horace Krever (Appendix A, p. 1083 of the Krever Report).
[179] Horace Krever, *Commission of Inquiry on the Blood System in Canada: Interim Report*. (Ottawa: Minister of Supply and Services Canada, 1995), p. 40.

stakeholders to reform the blood system in such a way that these safety concerns, along with other structural issues, could be addressed.

Enter the politicians: The Ministers of Health begin talks of reform

A year after the interim report came out, the federal Minister of Health called on his counterparts to start planning for the Krever Commission's final report and the changes to the blood system it would require. On March 11, 1996, Health Minister David Dingwall announced the opening of discussions on the future of Canada's blood system. The announcement said that all groups involved with the blood system should be represented in restructuring, but wanted to meet specifically with the provincial and territorial ministers of health to discuss a governmental response to the issues raised in the interim report.[180]

It is interesting to note that this is the first time governments took an active part in a policy issue concerning blood services in Canada. While governments were involved in previous discussions, the blood system had always been under the control of the Red Cross, and the federal and provincial Ministers of Health played only a small part. With the early recommendations from Justice Krever's report and the resulting political fallout – after all, governments were *supposed* to protect the Canadian public from dangers in the blood system! – the provincial, territorial, and federal health ministers took action.

[180] Health Canada news release. March 11, 1996.

When the ministers met in Ottawa on April 25, they started the process to transform the Canadian blood system. As with any process, a clear "big picture" was more important at the beginning than a fine-tuning of the existing blood system. Although it is tempting to treat the ministerial discussions and negotiations as part of an inevitable chain of events as part of an overall plan, these discussions took place in the mid-1990s, *before* the final Krever Report and *before* the creation of Canadian Blood Services.

Both the Canadian Blood Agency and the Canadian Red Cross Society were still responsible for Canada's blood system. The Red Cross continued to collect, manufacture, and distribute blood.

Before dealing with the results of this first post-interim report meeting, it might be instructive to recall the main players of the day:

Table 1: Ministers of Health in 1996

Government	Party
Canada	Liberal
Newfoundland	Liberal
Prince Edward Island	Liberal (Progressive Conservatives elected 18 November 1996)
Nova Scotia	Liberal
New Brunswick	Liberal
Québec	Parti Québecois
Ontario	Progressive Conservative
Manitoba	Progressive Conservative
Saskatchewan	New Democratic Party
Alberta	Progressive Conservative
British Columbia	New Democratic Party

The group of people making decisions about the blood system came from very different political backgrounds, believing in different ideologies and believing different things about the place of the governments (both federal and provincial) in Canadian society. They were all politicians, however, with a desire for re-election and retaining power for their respective

parties. As a result, any changes to the blood system required both a resolution to the problems Justice Krever identified in his interim report and the acceptance of those solutions by the Canadian people.[181]

On April 25, 1996, the federal, provincial, and territorial ministers of health (except Quebec)[182] announced a number of general principles related to reform of the blood system. They reaffirmed the four basic principles governing the health system:

- Safety of blood supply is paramount
- A fully integrated approach is essential
- Accountabilities must be clear
- The system must be transparent[183]

None of these principles was new; they had been part of the official doctrine of the blood system since the 1970s, when the governments began funding the Red Cross on a more regular basis. It was, however, important to re-state these principles as a starting point for reform. The ministers added that any reforms should include governments and should ensure that all roles and responsibilities are clear for all parties. Specifically, they said that they wanted agreement on how blood and blood products would be used and managed nationally; what parts of the blood system would be integrated into provincial health systems and what parts would be managed nationally; they also wanted agreement on a single agency responsible for the blood system. After this meeting, the ministers of health tasked their departments to look for options,

[181] There is no direct evidence to suggest that partisan politics played a great role in the decision-making process of the ministers of health in 1996, but politicians have constituencies and a responsibility not just to “the system,” but to their governments, constituents, and parties. The logical link is clear: any response to the problems of the blood system had to be on solid political ground.
[182] Québec pulled out of national blood initiatives at this point and started to work on its own blood arrangements. Some of the details of the “made-in-Québec” system are discussed below.
[183] Health Canada News Release, April 25, 1996.

consult with stakeholders, and report back so that real work on reform could begin in September, 1996.[184]

Changing of the Guard: Transition from Red Cross to Canadian Blood Services

When the ministers of health met again in Toronto on September 10, they agreed on a plan to create a brand new national blood authority. Specifically, the new authority would be accountable to Canadians, but would also operate "at arm's length [sic] from all governments."[185] Very little mention has been made of the seeming incompatibility of this idea. How can an organization that purports to be accountable to Canadians operate at arm's-length from the only institutions which are legitimately held responsible by the citizens who elect them? After all, this very issue is one of the reasons the Red Cross ran into trouble: it did not want to compromise its neutrality and independence from governments, but at the same time ran the blood system with money from the provincial ministries of health.

Many people initially thought that the Red Cross would remain a part of the Canadian blood system. As the problems inherent to a voluntary, politically impartial organization running a highly technical, politically charged, governmental service came to light, more and more people questioned the need for blood services to remain a part of the Canadian Red Cross Society.

Even the Red Cross Board of Governors questioned it, although they did so for their own reasons and much earlier than did the governments and staff of the CRCS. In October, 1995, the governors met to discuss an impending fiscal crisis. Specifically, funding the blood programme was draining the scarce resources of the charity and the board looked at making major financial changes. There were two options: the Red Cross could pull out of the blood

[184] Health Canada News Release, April 25, 1996.
[185] Health Canada News Release: "New blood system announced," September 10, 1996.

system to stop the drain, or it could push the governments for more money and borrow until the money arrived. When the gambit to obtain more money from the governments failed, Red Cross president Janet Davidson informed the provinces that they would need a new blood services provider unless they put up more cash.[186] In fact, the Red Cross had a significant financial problem for a number of years leading up to this point:

Table 2: Red Cross Blood Transfusion Service Revenues/Expenditures

Fiscal Year	Revenues	Expenditures	Surplus/Deficit
1990-1991	$197,340,000.00	$200,034,000.00	-$2,694,000.00
1991-1992	$213,235,000.00	$218,720,000.00	-$5,485,000.00
1993-1994	$244,626,000.00	$248,179,000.00	-$3,553,000.00
1994-1995	$265,386,000.00	$289,490,000.00	-$24,104,000.00
1995-1996	$311,343,000.00	$326,839,000.00	-$15,496,000.00
1996-1997	$305,976,000.00	$308,776,000.00	-$2,800,000.00

Source: Red Cross Annual Reports, 1990-1997 (Reports unavailable for 1992-1993)

With the Red Cross pushing for more money, agency officials publicly suggesting that the Red Cross pull out of the blood system, and cash-strapped governments looking for ways to save money and save public face in light of the tainted blood scandal and Justice Krever's interim report, the time had come to consider other options for the blood system.

It is important to remember that it was not just negative factors influencing the departure of the Red Cross from Canada's blood system. There were two major considerations that led to the decision of the Red Cross to remove itself from the system in which it had been a central component. First, the provincial governments had to re-define the blood system in such a way that it met the criteria of the principles they set down in the spring of 1996. The Red Cross could certainly have been involved in a more accountable system, except that it could not violate its principles of impartiality and political neutrality, as discussed in chapter 4.

[186] André Picard, "Internal Bleeding," *Saturday Night* (October 1996), p. 31. Interestingly, although the provincial

As a result, it would be extremely difficult to create a system whereby the blood system's governance was ultimately accountable to the Canadian people through the provincial ministers of health. A second matter, perhaps more important, was that the blood business in Canada – and worldwide – was no longer just a charitable function. Although the Red Cross garnered fame for its charitable work, the blood business required a particular kind of expertise that the Red Cross could not – or would not – necessarily provide.[187]

The negative publicity, the interim Krever recommendations, the governance issues, and the new perceived requirement for a specialized agency meant that the ministers of health began considering new options for Canada's blood supply. In February, 1997, the ministers issued a press release detailing the work done so far and their plans for the future. This release included all the provincial and territorial ministers except Quebec, whose plans did not include direct co-operation with the other governments. This is discussed more fully below. The ministers' announcement came a full two months before Justice Krever's report was due. As a result, they informed Canadians that, though their work continued, it would be subject to reviewing the recommendations of the Commission of Inquiry.[188] The backgrounder attached to the news release made a number of significant points:

- The deputy ministers of health from the federal, provincial, and territorial governments oversaw the transition to the new blood system;
- The implementation team consulted with community groups, medical and technical experts, and many other stakeholders to create a completely new system;
- Discussions with the Red Cross as to its role in the system were ongoing;

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governments kept increasing funding to the blood system, the Red Cross still ended up with a $24 million shortfall in 1994-1995.

[187] Picard, "Internal Bleeding," p. 37.

[188] Health Canada News Release: "Work on national blood system continues," February 10, 1997.

- The Canadian Blood Agency continued in its role until a new system could assume its responsibilities[189]

The steps the ministers of health took to create a new blood system were remarkable. For the first time in Canada history, the governments were approaching the blood system with a significant amount of planning instead of the *ad hoc* system the Red Cross created. The governments were directly involved with the creation of the system, rather than the inheritors of it; they consulted with all the affected groups – particularly hemophiliacs and those most affected by the tainted blood scandal – as to the most effective way to provide blood and blood products; they kept the agencies working on the blood system until such time as they could be replaced, instead of rushing into a solution that could have had even worse consequences. The federal/provincial/territorial ministers of health were approaching this problem in a more by-the-book way than any previous changes.

Over the course of the summer, the ministers continued their work on the blood system. In August, the Red Cross officially withdrew from any part of the new blood system. As its President, Janet Davidson, said, "it is in the best interest of all Canadians to allow the new agency to keep all the blood program operations integrated."[190] The Red Cross agreed to help with a smooth transition to the new blood system and to continue its many other humanitarian efforts in Canada.[191] For their part, the ministers continued with preparations to build a new blood system.

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[189] Health Canada News Backgrounder: "New Blood System: Planning Update," February 10, 1997.
[190] Health Canada News Release: "Joint statement by Health Ministers and the Red Cross on plans for the new blood system," August 1, 1997.
[191] Health Canada News Release: "Joint statement by Health Ministers and the Red Cross on plans for the new blood system," August 1, 1997.

In November, 1997, the ministers and the Canadian public received Justice Krever's report and recommendations. The report was three volumes and 1100 pages long. It covered a massive amount of material, ranging from a history of the Canadian blood system, to its governance flaws, to the technical ways in which blood is used, to the approaches taken by other countries in dealing with the AIDS virus in their blood systems. Some of this information has been covered elsewhere in this thesis, while other information does not bear directly on the subject of blood system governance. The Krever Report is certainly the biggest, most comprehensive study of the Canadian blood system, and as such is a most valuable resource.

The report made fifty recommendations for the governments. Although all are important to the blood system, only some are germane to the issues of intergovernmental relations. The rest of the recommendations deal with the specifically scientific nature of the blood system and are unimportant to this discussion.

Before examining each of the recommendations related to the governments, it is important to note that the overall thrust of Justice Krever's recommendations was to both fix the specific problems he discovered and to ensure that such a tragedy could never again occur in Canada. All of these governance recommendations focus on the need for any blood authority to be independent, focused solely on the blood system, completely national, and operating at arm's length from any government or government agency.

Each of the recommendations made in the report speak to a particular deficiency of the Red Cross/CBA-run blood system. Had the recommendations been in place during the 1970s and 1980s, it is conceivable that the blood tragedy might not have occurred. If nothing else, their earlier implementation could have helped create a better blood system.

In any case, the recommendations are listed in Appendix 1. The recommendation number Justice Krever used is included, as is a brief rationale and discussion on the use of that particular recommendation. In the report, Justice Krever goes into some detail as to the reasons for making these particular recommendations; this table has only some of his reasons, as they pertain to subjects outside the scope of this thesis.

The Krever Report, when released in November 1997, began a firestorm of controversy over who was responsible for compensating victims of the tainted blood tragedy. Although this was an important debate across the country – and although it will come up in this paper – it is incidental to a discussion about Canadian Blood Services specifically because it was a debate that occurred outside the governance issues raised by the Krever Inquiry.

When federal Minister of Health Allan Rock released the Report of the Commission of Inquiry into the Blood System in November 1997, he sought to reassure Canadians that the federal government was working to ensure that the blood system was safe and would continue to be safe under governmental leadership. He reiterated the federal/provincial/territorial governmental commitment to reform the system under four principles:

- Safety of blood is paramount;
- A fully-integrated approach is essential;
- Accountabilities must be clear;
- The system must be transparent[192]

[192] Health Canada News Release: "Federal leadership to reform Canada's blood system since Justice Krever's interim report," November 6, 1997.

In the news release, Rock emphasized the role of the federal government in providing leadership for reforming the blood system. He said that Health Canada "carefully monitors developments at all levels in the blood system"[193] and that it would take a leadership role in ensuring the safety of the blood system. Minister Rock established a Blood Safety Council to advise the government on blood safety so that his ministry could continue leading other governments in ensuring the safety of the Canadian blood system.[194]

Although Rock did not misrepresent any of the facts in his press release, it is clear that he wanted the federal government to take credit for any changes resulting from the Krever Report. For example, the release opened by saying that "Health Canada played a key role in reforming the national blood system, by helping the provinces, territories, consumers and technical specialists focus on the need for a better, more effective system."[195] Although the provinces and territories had ultimate responsibility for changing the blood system, the *federal* Minister of Health suggested that it was the federal government that was more responsible for any success than the provinces and territories.

It was certainly proper for the federal government to take a lead role in implementing the Krever Report (both the interim and final reports) as the Commission was a federal Commission – although both Ontario and Prince Edward Island commissioned Justice Krever separately – and thus the reports were issued to the federal government. The federal Minister of Health, however, forced the provincial governments to take action when he released the final report on November 26, 1997: he emphasized "the government's commitment to provide

[193] Health Canada News Release: "Federal leadership to reform Canada's blood system since Justice Krever's interim report," November 6, 1997.
[194] Health Canada News Release: "Federal leadership to reform Canada's blood system since Justice Krever's interim report," November 6, 1997.
[195] Health Canada News Release: "Federal leadership to reform Canada's blood system since Justice Krever's interim report," November 6, 1997.

Canadians with a full response to Justice Krever's report as soon as possible."[196] Since the federal government could not implement all the recommendations by itself (although it could implement the regulatory recommendations, as Health Canada is responsible for blood regulations), provinces had to be involved with any structural changes to the Canadian blood system and its governance.

The* Memorandum of Understanding: *a National Blood Authority

Over the course of 1997-1998, the federal and provincial governments worked together to create a new National Blood Authority, based on the discussion they had already had and on the recommendations of the Krever Report. The result of their negotiations was Canadian Blood Services. The federal, provincial, and territorial governments recorded their responsibilities and requirements in a *Memorandum of Understanding* (MOU) so that, as Justice Krever stated – and as the provinces affirmed in their guiding principles – accountabilities could be clear. The MOU set in place a framework both for the new National Blood Authority and a mechanism for moving the blood program to it from the Red Cross Blood Transfusion Services.

This mechanism – called the Transition Bureau – was created by the provinces, and had a slightly different set-up than the new National Blood Authority (on which more later) because of its rather different mandate. In October, 1997, Health Canada announced its creation, informing Canadians that it would "manage all aspects of transition and the steps required to set up the national blood services."[197] To perform its task, the Transition Bureau had eleven members, appointed from three regions of Canada (Atlantic Canada, Ontario, and

[196] Health Canada News Release: "Krever Commission report – Federal Government Releases Report of the Commission of Inquiry on the Blood System in Canada," November 6, 1997.
[197] Health Canada Information Release, "Bureau to manage smooth transition to the new blood system," October 1997.

Western Canada), the federal government, and a consumer representative (this last representative could come from hospitals or from an organization such as the Hemophilia Society; any organized group using blood or blood products was technically eligible). If Québec chose to join the Transition Bureau, it would also have received three seats.

All the regions, then, had an opportunity and a voice in the new system's creation. The three members from each region would not only speak on behalf of that region, but they would also have authority and expertise to make that voice heard. The MOU requires that the three seats be held by "a Deputy Minister or a designate, a representative from the business community and a health care administrator from each area."[198] Three critical components of the business/governance framework could then be in place. A representative from government allowed each of the provinces to retain direct contact with the Bureau; a business representative helped ensure the creation of a good business model; a health care administrator could speak to the issues directly affecting the public health system in each province.

The creation of the Transition Bureau proves that the governments wanted to set up a new national blood system in a thoughtful, meaningful way. As we have already established, the Red Cross Blood Transfusion Services had no formal structure at first; what structure it did have was largely created on an *ad hoc* basis, usually in response to a specific need or set of events. Provinces were not proactive in dealing with blood-related problems, nor did they have a formal say in its governance until the Red Cross required money.

[198] *Federal/Provincial/Territorial Memorandum of Understanding*, 1997, p. 33.

The Transition Bureau was an attempt by the provinces to do two things. First, it assured that the move from the Red Cross to the National Blood Authority could occur in an orderly fashion. Second, the negotiations with the Red Cross and the implementation of the *Memorandum of Understanding* occurred under the watchful eye of the governments; the blood system, which had grown up independent of governments and with very little oversight by them, was directly responsible to the provincial governments for its creation and its mandate.

In creating the Transition Bureau, the provinces gave it a wide mandate. Other than the composition of the first Board of Directors – approved by the federal, provincial, and territorial ministers of Health in July, 1997 – the Bureau had wide-ranging authority to complete its task by September, 1998. It appointed a negotiator to deal with the Red Cross and managed all resources dealing with the transition. Interestingly, though, the Ministers retained authority to both determine the negotiator's mandate and ratify the results of these negotiations.[199] This is logical, given the responsibility of provincial governments for the blood resources held by the Red Cross. Although governments did not undertake negotiations specifically, they remained responsible for the outcome of those negotiations.

What is Quebec's place?

From the very beginning of reform efforts, Québec decided it would find its own path and make its own determinations as to the future of a Québec blood system. This was clear in 1996, when the other health ministers stood together and announced they would work together on reform. The Québec Minister of Health "agreed with his colleagues that there are problems in the current blood system, specifically the lack of clarity of responsibilities of the various

[199] *Federal/Provincial/Territorial Memorandum of Understanding*, 1997, p. 34.

partners."[200] As has become customary, the Québec government took the position that the blood system falls under the auspices of the provincial government and thus any solution would be made in Québec, for Québec, by Québeckers. The Parti Québecois government undertook its own research to "establish mechanisms for operating and organizing the blood management system that are integrated within the reorganization of its health care system."[201] As the provinces announced their own plans, Québec did not rule out the possibility of collaboration, but made it very clear that the province would operate its own system.[202]

How does CBS work?

Although CBS is a corporation created under the *Canada Corporations Act*, the document setting out a framework for its creation is the MOU signed by the governments in late 1997. The agreement is 34 pages long and signed by every Minister of Health in the country (with the exception of Québec). As a guiding document, it is the first of its kind in the Canadian blood system. For the first time, the NBA could know exactly how governments were involved in governing it and how it could be independent of those same governments. A brief review of the text of the MOU is certainly in order at this point.

The provincial and territorial governments, represented by the ministers responsible for the health portfolio in each government, set up an agreement with the federal government (through the Ministry of Health), to provide blood services across the country. The MOU itself stated that the federal, provincial, and territorial ministers of health wanted a record of their "understandings and commitments … regarding their respective roles and responsibilities in a renewed national blood system, including their future relationships with the National Blood

[200] Health Canada News Release, April 25, 1996.
[201] Health Canada News Release, April 25, 1996.
[202] Health Canada News Release, "New blood system announced," September 10, 1996.

Authority (NBA) and its function and structure."[203] From the very start, the governments wanted to set the right tone for a new blood agency. They wanted to show that they learned from the mistakes of the past and were stating in the clearest possible language that they would provide clear lines of accountability for and sharp oversight of the new system.

Section 2.0 of the MOU defined "blood system," "blood supply system," and "blood" so that there would be no confusion in the future. "Blood supply system" is defined as "all activities and functions managed and operated on a national basis by the NBA."[204] These functions are described in Annex A of the MOU. Suffice it to say that the governments tasked NBA with the recruitment, collection, processing, and distribution of blood and blood products. To support these tasks, the provinces required the NBA to provide for standard policies and procedures meeting or exceeding federal and provincial guidelines; to create a research and development program; to provide for professional and public education; to create a risk management system within the Authority.[205]

Not only did the governments provide clear lines of accountability, but they provided a specific role for the National Blood Authority instead of allowing it to add a piece here and a piece there. In other words, the governments gave the Authority a job to do, unlike the Red Cross, which created jobs for itself in addition to its humanitarian causes.

The MOU reconfirmed the seven principles of the blood system adopted in 1989,[206] and added the following four:

- The safety of the blood supply is paramount;
- A fully integrated approach is essential;

[203] *Federal/Provincial/Territorial Memorandum of Understanding*, 1997, p. 5.
[204] *Federal/Provincial/Territorial Memorandum of Understanding*, 1997, p. 6.
[205] *Federal/Provincial/Territorial Memorandum of Understanding, Annex A*, 1997, p. 20.
[206] See page 65.

- Accountabilities must be clear;
- The renewed blood supply system must be transparent.[207]

It is under these principles that the provincial and territorial governments (along with the federal) created a new blood system. The governments wanted this to be a brand new system; they wanted it so much that clauses 4.7 and 4.8 indemnify the new agency from anything done or not done by previous incarnations of the blood authority. The National Blood Authority, erected under the MOU, was truly a new blood agency.

Sections 5 and 6 of the MOU re-confirm the constitutional responsibilities of the federal and provincial governments and cover "motherhood and apple pie" issues, such as the responsibility of the federal Minister of Health to regulate the blood industry and the responsibility of the provincial governments to ensure that their respective public health systems integrate the NBA as efficiently as possible.

Section 7 covers financial arrangements for both the transition from the Red Cross to the new National Blood Authority and the ways in which the provinces will continue to fund it. The Red Cross, Canadian Blood Agency and Canadian Blood Committee, it will be remembered, had difficulty dealing with the continual need to change fiscal arrangements. Section 7 of the MOU clearly moves to address these issues. The governments defined the transition funds specifically so that all parties involved would be aware of upcoming costs. More important, however, is Section 7.2.2 of the *Memorandum of Understanding,* which says the provincial and territorial Ministers of Health will provide funding based on the blood and blood products that they each use. According to Sophie de Villers, Executive Director for Policy and Planning at Canadian Blood Services, the breakdown of funding looks like this:

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[207] *Federal/Provincial/Territorial Memorandum of Understanding*, 1997, p. 6.

Table 3: CBS Funding by Province

Province	Percentage of CBS funding
Newfoundland	2.7
Prince Edward Island	0.5
Nova Scotia	4
New Brunswick	3.8
Ontario	50.2
Manitoba	5.2
Saskatchewan	4
Alberta	15
British Columbia	15
Nunavut	0.04
Yukon Territory	0.07
Northwest Territories	0.006

Ms. de Villers added that the numbers include "total budget (blood operations, fractionated products, patient services and Captive Insurance)…The numbers are very much proportionate to the overall population of each province."[208]

Finally, the MOU addresses the need for the NBA's Board of Directors to be incorporated and able to borrow money; it also addresses specific funding for research and development and for the federal government to improve "federal capacity for regulation and national disease surveillance in relation to blood and blood products."[209] These all respond directly to criticisms of the Red Cross made by Justice Krever's report.

[208] Email from Sophie de Villers, February 25, 2003.
[209] *Federal/Provincial/Territorial Memorandum of Understanding*, 1997, p. 14.

The *Memorandum of Understanding* also contains provisions for a review of blood operations within five years of the NBA's creation. In addition, any party to the MOU can leave after providing one year's written notice and after negotiating for the disbursement of that party's assets and liabilities within the NBA. Moreover, the Members of the NBA can admit new Members with unanimous consent, leaving the door open for Québec to join at a later date.

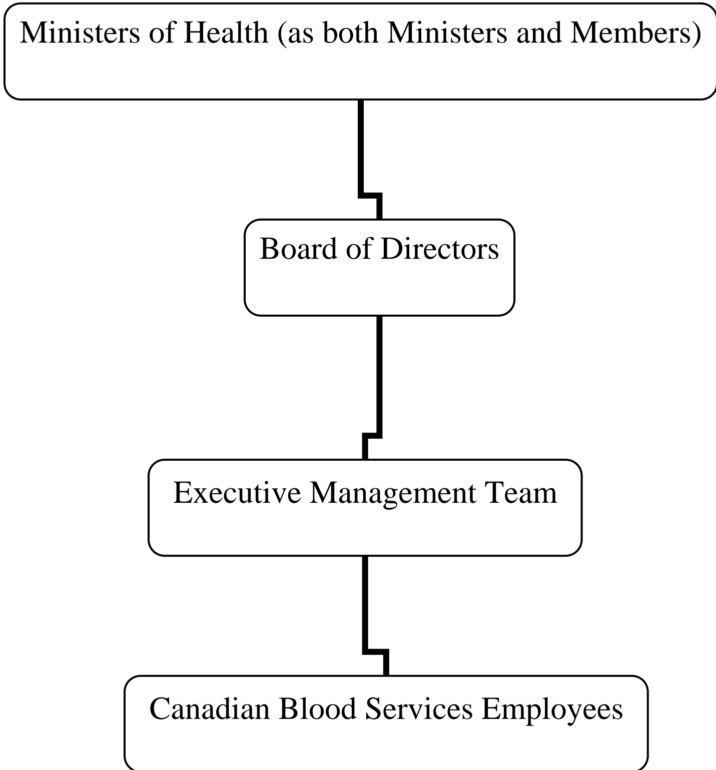
There are also three annexes to the MOU, which are actually the most important parts of this discussion. The first Annex (Annex A) defines the functions and responsibilities of the National Blood Authority. In short, the NBA is required to do everything involved with "ensuring access to a safe, secure and affordable blood supply."[210]

The MOU Annex B is divided into five different sections: the features of the new system, a description of the new National Blood Authority, the responsibility of provincial governments as Members, the responsibilities of Ministers, and the set-up of and initial direction for the Board of Directors.

Annex B lays out a governance model for the NBA in clear language so that there can be no misunderstanding as there was under the Red Cross, CBA, and CBC. Before embarking on a discussion of this governance model, it would be helpful to see how exactly how this model works for Canadian Blood Services:

[210] *Federal/Provincial/Territorial Memorandum of Understanding*, 1997, p. 20.

Figure 3: CBS Governance Structure



Ultimately, the National Blood Authority is responsible to the Canadian people. Its employees report to an Executive Management Team, who report to a Board of Directors, who are appointed by and responsible to the provincial health ministers as Members of the Corporation, who are responsible to their respective legislatures, who are responsible to the provincial electorates.

The provincial and territorial Ministers of Health, in their role as Members of the Corporation, shall "play a role similar to shareholders."[211] As the MOU says, however, this role complements that of Minister of Health; the individuals holding the health portfolio would then seem to have dual roles within the NBA. Of course, the *Memorandum* anticipates this potential conflict of interest (i.e. that the same person is responsible both for a ministerial portfolio *and* has a role running a business) and defines the roles and responsibilities of Ministers as Ministers and then as Members of the Corporation:

As Ministers[212]	As Members[212]
• Responsible for the effectiveness of the blood supply within the provincial/territorial health care systems • Funding the NBA as directed by its Members • Recommending to the federal Minister of Health proposed changes in NBA legislation	• Responsible for the mission and mandate of the NBA • Approving the NBA's 3-year business plan submitted by the Board of Directors • Selecting the Board of Directors • Holding the Board accountable for its decisions • Retaining the power to remove some or all of the Board • Making available to the public the NBA annual report

This dichotomy between the Ministers' responsibilities as Members and as representatives of their government is an interesting one. After all, it would be easy to ask the

[211] *Federal/Provincial/Territorial Memorandum of Understanding*, 1997, p. 24.
[212] *Federal/Provincial/Territorial Memorandum of Understanding*, 1997, p. 27-28

question, “Although Members are forbidden from interfering with operational decisions, can’t they exert influence over the Board they appoint and remove?” This question is even more important in the context of the creation of Canadian Blood Services: the Krever Inquiry created a climate of fear surrounding the blood system and forced the governments to take a long look at their responsibilities to the Canadian public. This is not to say that a “climate of fear” did not already exist. In fact, recipients of blood and blood products had reason to fear the blood supply, which is what led to the Krever Inquiry. In this case, however, the climate of fear moved from the general public into the political sphere. Those most responsible for managing the blood system were afraid of another preventable tragedy and were also afraid of making a lasting mistake.

The MOU requires that the Members fund the NBA through “grants and contributions” and that governments have “appropriate safeguards to ensure fiscal accountability.” However, once they provide this money to the NBA, it “must be able to exercise complete management discretion over all operation blood system decisions.”[213] It will be remembered that the paralysis over some Red Cross management decisions requiring approval by the CBC led to the blood tragedy in the 1980s. This is a step to ensuring that this cannot happen again.

Moreover, the MOU’s next bullet states that “management discretion” includes health and safety issues and decision-making capability to ensure the continued safety of the blood system. The bullet even defines a decision-making matrix for the NBA: “Decisions in this regard will be made within a health risk management framework which places on an equal footing the three critical elements of cost, benefit and risk.”[214] This provides the NBA with some cover in the event of difficulties with the blood system. First, it requires that cost be only

[213] *Federal/Provincial/Territorial Memorandum of Understanding*, 1997, p.25.
[214] *Federal/Provincial/Territorial Memorandum of Understanding*, 1997, p.25.

one part of the decision-making framework. One of the difficulties Justice Krever identified was that the Red Cross could not always act when it needed to because of cost issues. Under the MOU, cost has to be weighed against the benefits of action as well as the risk of not taking action in a given situation.

The MOU also requires the National Blood Authority to maintain its federal license and to "comply with federal regulations, and meet the same health and safety standards that apply to all manufacturers of biologic pharmaceuticals."[215] In many ways, this clause is not required as it simply repeats what is required under federal law. However, it also provides the Board, NBA, and provinces with an obligation to implement whatever the federal government requires under the annual *Food and Drugs Act* inspections. The Red Cross, as noted in an earlier chapter, could not always implement the federal decisions because the provinces would not or could not act to fund them. The MOU now required them to.

In addition, the MOU provides the National Blood Authority with a mechanism for dealing with emergencies. The Members approve a 3-year plan submitted by the Board of Directors, which includes a plan for dealing with emergencies and a budget line to fund NBA responses. According to the MOU, the CEO, in consultation with the Scientific Advisory Committee, can make use of this fund without consulting with the Ministers beforehand. The NBA must report "significant emergency expenditures"[216] to the Members, who can then approve of the actions taken, audit the NBA, or replace the Board of Directors. The MOU also reminds us that Ministers as Ministers have the option to withdraw from the NBA under the applicable clauses.[217]

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[215] *Federal/Provincial/Territorial Memorandum of Understanding*, 1997, p. 26.
[216] *Federal/Provincial/Territorial Memorandum of Understanding*, 1997, p. 31.
[217] *Federal/Provincial/Territorial Memorandum of Understanding*, 1997, p. 31-32.

As Ministers, the provincial and territorial ministers of health have a number of responsibilities regarding the National Blood Authority. First is their obvious responsibility as a Minister of the Crown. They have direct responsibility to the Legislature of their province and through them, the people, to ensure that public funds are well spent. There is therefore a political interest in ensuring that the blood program is well-run. With a well-run blood system, the Ministers could take credit for taking a lead role in resolving one of the biggest health problems in the last thirty years. The provincial and territorial ministers of health also have a responsibility for providing an appropriate amount of funding and support to the National Blood Authority. They are required to ensure that the NBA takes it place as a part of the health care system of each province. Without support from the provincial and territorial governments, the NBA's involvement in the Canadian health systems is doomed.

The Ministers are also responsible as Members of the Corporation. In this role, they are each required to temper their provincial political instincts and work together for the good of the national blood system. Their specific responsibilities as Members are outlined above, but it is interesting to note the dichotomy between their roles as Ministers and their roles as Members. As Ministers, the provincial and territorial health ministers have provincial interests and accountability to their respective legislatures in mind. As Members, however, they must all concentrate on the national outlook and work to ensure that the blood system is national in scope.

As the MOU says, membership in the Corporation is similar to a role of shareholder in an incorporated company. As shareholders have a specific interest in ensuring that the company in which they have invested runs under sound leadership, so too do the Ministers as Members have an interest in ensuring that the National Blood Authority operates efficiently

and within the bounds of its obligations to the Canadian people. The Ministers must put aside their partisan roles as advocates of a party platform within one province and work with the other health ministers for a *national* good. The *Memorandum of Understanding* removes the ability of the Ministers to pursue provincial needs at the expense of the Canadian blood system.

Most significantly, forcing the provinces to take a national outlook on their provincial roles changes a dynamic inherent to Canadian federalism. In many federal-provincial conferences, such as those dealing with the Social Union Framework, health accords, or even discussions on funding for municipalities, provincial representatives can return home, saying that Ottawa would not give them what the province needs, so they said "no." Alberta Premier Ralph Klein has made a political career of this strategy. Ottawa has no place in the governance model of the National Blood Authority. Provinces no longer have a built-in scapegoat and must therefore take responsibility for their own actions. This new model then forces provinces to look at both the national good *and* at the provincial good. Although provincial interests define the "national good", the provinces also have a responsibility to at least consider the needs of other provinces when acting as shareholders.

Under the MOU, the Board of Directors is made up of representatives from each of the regions (British Columbia and Yukon; Alberta, Saskatchewan, Manitoba and the Northwest Territories; Ontario; and New Brunswick, Prince Edward Island, Nova Scotia, Newfoundland, and Nunavut), consumer representatives, and medical and scientific experts.[218] The whole point, of course, was to ensure that two of the major problems under the Red Cross were solved: first, that the blood system be directed by people who knew a little something about

[218] *Federal/Provincial/Territorial Memorandum of Understanding*, 1997, p. 27-28.The Transition Bureau only had one consumer representative, no technical representatives, one federal representative, and three representatives from each of the regions. Nunavut was added to the representation from the Atlantic provinces after its creation in 1999.

blood, blood products, and running a blood system. The Red Cross's board was made of people who ran the entire Red Cross program, not just the blood system; this new initiative would put an end to that practice.

The second problem this approach solved was that the Board has representation from the provinces that were directly empowered to run a blood system. Neither the CBA nor the CBC could make any decisions affecting the blood system without first seeking the approval of the provinces. Under the MOU, the Board had direct authority to run the system within the budget parameters set by the provinces. Even then, however, while the provinces as Members ultimately approve the overall use of public funds, the Board of Directors has authority to approve budget documents for submission to the Members of the Corporation.[219]

Even though the Board is technically independent on an operational level, it is still accountable to the provincial governments as Members. Additionally, three Board members are regional representatives and so can communicate with the provinces they represent. In fact, some provinces required them to communicate regularly, so the Board of Directors required regional directors to submit regular reports on their contacts with the provinces.[220] Two different clauses of the Annex speak directly to the authority held by the Ministers over the Board, and a third has implications for their independence:

- Should objectives for the blood program not be met satisfactorily, Members will hold the Board accountable to take corrective action.
- Members retain the power to remove some or all of the Board.
- Members shall have the authority to require direct external comprehensive management audits and targeted special audits of the NBA at their discretion.[221]

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[219] *Federal/Provincial/Territorial Memorandum of Understanding*, 1997, p.30.
[220] Minutes of Board of Directors meeting dated May 19, 1999, p. 3.
[221] *Federal/Provincial/Territorial Memorandum of Understanding*, 1997, p. 28.

The first clause listed allows the Board to take responsibility for satisfying the provinces as to the suitability of a given set of actions. Although the provinces may require changes to Board policies, an independent Board is ultimately accountable for making those changes. The second clause provides the Ministers with some power in dealing with an unsatisfactory Board of Directors; the Members retain final authority over who sits on the Board. Although the provincial governments cannot intercede directly on operational decisions, it would appear that they can hold a certain amount of influence over those who do. Further, the third clause could provide the provinces with a way to ensure they use quantifiable data in their decision to remove some or all of the Board; they can ask for a specific audit to find something good or bad about the Board's actions and can then take action based on the audit report. There is, however, a corollary to this statement: changes to the Board's structure require agreement from a majority of Members, so decisions affecting only one province cannot occur unless the Membership agrees.

The *Memorandum of Understanding* provides the provincial governments, National Blood Authority, and Canadian public with a certain level of assurance that the blood system has a solid base on which to be run. This document marked a major change in the development of the Canadian blood system. After all, the Red Cross had taken responsibility for the blood supply as a charitable organization and ran it without government support for many years. As costs grew, the blood system grew up around ever-changing needs instead of basing decisions on a master plan on which everyone agreed.

This is not to suggest that the MOU anticipates every eventuality or that it is a perfect system. Instead, it provides clear accountabilities for actions taken (or not taken) and ensures that those who are responsible for governance, funding, and administration of the blood system

know who they are and to whom they report. It solves a number of problems inherent under the Red Cross system and puts control of the blood system firmly in the hands of the provincial governments. The Red Cross's need for impartiality and independence from governments could no longer stand in the way of governmental requirements; the blood system, under the MOU, could finally become an integrated part of the public health system, with many of the same regulatory requirements, fiscal frameworks, and responsible heads.

The question at this point is: now that the theoretical model for a National Blood Authority has been established, how does it work in practice?

Canadian Blood Services and the Government(s)

When Canadian Blood Services was established in September, 1998, it ushered in a new way of looking at Canada's blood system. The blood supply, as a part of the provincial health networks (although run on a national level), was fully under the control of the governmental apparatus. The federal government retained its responsibility for regulation and approval of new initiatives while the provincial and territorial governments exercised total control over the new system (although not directly over the operation of it). In other words, the governments could all tell themselves and the Canadian people that the blood system was well on its way to being fixed.

Although this certainly was true to some extent, the Ministers of Health and the new Executive Management Team (EMT) had to tread very carefully to avoid the mistakes of the past. The Canadian Blood Services website takes great pains to illustrate the differences between the Red Cross Blood Transfusion Services and the new, non-profit corporation dedicated only to the collection and distribution of blood and blood products. The "Frequently Asked Questions" (FAQ) section of the site discusses some of the changes and the

organizational requirements laid on CBS by the governments. Specifically, the website points out that the Ministers of Health may not direct specific operational decisions of CBS, but must remain responsible for the use of public funds they authorize.[222]

CBS Annual Reports also point to a new thinking surrounding the way the blood system works. Each of the reports is entitled, "A Report to Canadians," indicating an understanding of the corporation's special relationship with the public. Unlike many corporations, Canadian Blood Services is not only accountable to its shareholders, but also to the public whose trust it holds.

CBS issued its first Annual Report six months after opening its doors. Obviously, its first task was to introduce the new corporation to the country and illustrate some of the differences between CBS and its predecessor, the Red Cross. Indeed, the new blood agency recognized its unique position by stating that its mission includes gaining "the trust, commitment and confidence of all Canadians by providing" safe blood and blood products.[223] The report calls additional attention to the goal of regaining the trust of Canadians with a brief discussion of the events that led up to the creation of Canadian Blood Services. In its introduction to Canadians, CBS notes some of the major changes from the old system to the new, including the autonomy of the Board of Directors, openness in operations, and clear lines of accountability.[224]

Each of the Annual Reports issued over the last six years makes reference to the special relationship between Canadian Blood Services and the federal, provincial, and territorial

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[222] http://www.bloodservices.ca/CentreApps/Internet/UW_V502_MainEngine.nsf/page/FAQs+Operations?OpenDocument, *Canadian Blood Services –FAQ's Operations*

[223] Canadian Blood Services Annual Report, *A Report to Canadians: Our first six months 1998/1999* (Ottawa: Canadian Blood Services, 1999), p. 1.

[224] *A Report to Canadians 1998/1999*, p. 3.

governments. It is this relationship that makes the corporation work and it is this relationship that is the focus of our study. It appears that each of the provincial and territorial governments adheres to the terms of operation set out in the *Memorandum of Understanding*. Given the public attention given to the blood system in recent years, it would be irresponsible for the Ministers to be seen to violate any portion of the agreement. In fact, inquiries to the provincial governments asking specific questions about the policy and funding processes for the purposes of this study met with strikingly similar responses.

Each province and territory has a contact within the ministry responsible for health whose job it is to deal with Canadian Blood Services. Each contact was asked a number of different questions, including:

1. How is your province or territory's portion of CBS's budget determined?
2. What role does your province have in creating policy for CBS?
3. How does your province determine its policy agenda with respect to CBS funding and governance?

Although the actual words varied from province to province, the message was the same from each of them: the MOU provides direction on each of these issues. Each province and territory looks to the MOU as a guide and takes great pains to follow the rules as set out in this agreement. To the provinces and territories, Canadian Blood Services truly seems to be an arm's-length agency.

Additionally, the provinces have appointed one of their number to act as "lead province" in dealings with Canadian Blood Services. The lead province is appointed every two years, although Ontario was lead province for three years, and British Columbia has been lead

province for almost four.[225] The provinces co-ordinate their agendas and communicate them to CBS through the lead province, and CBS reports to the provinces through this lead. The lead province is currently British Columbia.

The British Columbia Ministry of Health Services provided further information on the responsibilities of the lead province through some email correspondence:

> The PT [provincial/territorial] lead for the blood system is the main liaison between the PTs, CBS, and other stakeholders. As such it performs issues management functions and works toward PT consensus on all matters involving the blood system. This is done through the PT lead's organising, chairing and addressing outcomes of meetings and teleconference calls for which it provides secretariat responsibilities. The PT lead also provides representation on behalf of PTs on national committees such as the NTWG [National Technical Working Group] as well at conferences and workshops.[226]

It is somewhat strange that, in a system replete with government regulation, there is no mention of the lead province or its functions in the MOU. In some ways, though, this is appropriate, as the lead province has no special status or governance relationship with CBS. Instead, the lead province takes an administrative leadership role by co-ordinating the issues of the other provinces.

Since the creation of Canadian Blood Services six years ago, there has been virtually no evidence to suggest that the same kind of dysfunction that existed under the Red Cross has manifested itself in the new blood system. This does not mean to suggest that conflicts do not exist; it simply appears to be at a much lower level than under the Red Cross. In fact, some conflicts could even be explained away as "growing pains" for the corporation. For example, when the provinces and territories received the Canadian Blood Services budget submissions

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[225] Email from Wendy Trotter, Director, Blood and Laboratory Services Directorate, Ministry of Health Services, British Columbia. August 31, 2004.
[226] Email from Wendy Trotter, Director, Blood and Laboratory Services Directorate, Ministry of Health Services, British Columbia. May 11, 2004.

for the 1999/2000 fiscal year, the Atlantic provinces and Alberta had some concerns from their respective Treasury Boards. Until the Treasury Boards approved the changes from the previous fiscal year, the budget request was on hold.[227]

Another such example occurred in 2000, when British Columbia's Deputy Minister of Finance requested both a Performance Plan and annual report of activities from CBS. The CEO of Canadian Blood Services had to "clarify the relationship between CBS and the B.C. government as one of the Corporate Members."[228]

Of more concern is something noted by the Performance Review of Canadian Blood Services (see below for more information on the Review). Even though the federal, provincial, and territorial governments took great pains to design a new blood system, some of the difficulties under the Red Cross remained or took new form. Specifically, communications problems seemed to plague the new organization in its first four years. One reason for this is that CBS and its members have but one official meeting each year, during the annual Ministers of Health meetings, usually held in the fall. Otherwise, communication between the two groups is limited to teleconferences, which can lead to a less-than-perfect situation for discussions of great importance. The result is what the Performance Review called a strained relationship.[229]

Additionally, the review noted instances where "members do not always feel they get the information they need to make budget decisions and sometimes there is a lack of confidence in the information that is provided. CBS does not always feel they get appropriate policy direction."[230] Interestingly, this is one of the difficulties identified under the Red Cross,

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[227] Minutes of Board of Directors meetings dated May 19, 1999 p.2 and June 16, 1999, p. 5.
[228] Minutes of Board of Directors meeting, June 21, 2000, p. 5.
[229] *Canadian Blood Services Performance Review*, p. 3.
[230] *Canadian Blood Services Performance Review*, p. 4.

although – at least in this case – the mechanisms for providing direction and expertise are a little more clear.

The Memorandum of Understanding defines the role the Members are to play in policy direction and funding approval for Canadian Blood Services. This, however, is an area in which the problems identified by the Performance Review become more evident. Specifically, the Members periodically require more information on which to base funding decisions and do not get it, while CBS believes that the information requests are not always as precise as they need to be. CBS has also maintained that it responds to specific requests for information.[231]

In spite of this sometimes strained relationship, the level of involvement by ministers and ministerial offices in the provinces and territories is extremely low; the political masters of the blood system are, in almost all cases, listening to the experts running the blood system and allowing them to do their jobs.[232] This appears to be in direct response to the criticism that the Red Cross itself did not have enough experts running the blood system and that the provinces and territories deferred to the CRCS on too many issues. Although the provincial and territorial governments are keeping out of the operations of the blood system, they have appointed a Board of Directors representing regional, consumer, and scientific interests. The Board, in turn, has appointed experts to run the blood system.

Based on the available information, Canadian Blood Services appears to be running strictly according to the MOU. Governments do not appear to be interfering with the operation of CBS, even when it would benefit citizens in their respective provinces. In fact, Watson Gale, the Corporate Secretary, on a visit to Hamilton Centre in early 2004, told a story about CBS's

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[231] *Canadian Blood Services Performance Review*, p. 158.
[232] The conflict noted above could be as a result of CBS staff looking for specific requests in order to provide answers for the Members, while the Ministers of Health are not always aware of what their precise needs are. As

consolidation of functions in the Atlantic provinces. Although this operational decision involved a net loss of jobs in Nova Scotia, he said that the Minister of Health in Nova Scotia contributed to the discussion and ultimately approved of CBS's corporate plan.

Performance Review

No study of Canadian Blood Services would be complete without discussing the Performance Review undertaken at the behest of the provincial/territorial ministers of health in 2002. In fact, the MOU required that a review take place within the first five years of CBS's mandate in order to determine whether the National Blood Authority was operating the way it was supposed to. It is important to remember that the Review was primarily a review of CBS operations and not a study of the relationship between the Members and CBS or between the Members themselves.

Overall, the Performance Review is positive, noting that Canadian Blood Services has done a great deal, especially restoring the public's faith in the Canadian blood system. The review particularly noted that 81% of poll respondents in a 2002 survey agreed that "the blood system in Canada is safer today than it was five years ago."[233]

However, the review notes a number of areas in which both Canadian Blood Services itself and the Ministers of Health could improve. The most important of these is to clarify the roles and responsibilities of each party to the *Memorandum of Understanding*. After all, there are several ambiguous sections of the MOU, including issues of safety and who is ultimately responsible for the blood system in Canada.[234] The Review points out that clarification of these

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in many occupations, the experts cannot always answer a general question well, but are happy to provide all kinds of information in response to a specific inquiry.

[233] *Canadian Blood Services Performance Review*, p. 2.

[234] The issue of safety is not strictly relevant to this study, but the ambiguity surrounding responsibility for the blood system is certainly important. After all the MOU says that the NBA is responsible for operating the blood system in one place, while stating that the NBA is simply a tool with which the *governments* will deliver a national blood system in another.

kinds of issues is extremely important so that all parties are aware of both process and their particular roles.

Although the governments had a great deal of work to do in restructuring the blood system after the Krever report was issued, the National Blood Authority they created appears to be functioning well. In spite of a few “glitches” along the way, the ministers of health appear to have an amicable relationship with both Canadian Blood Services and each other in dealing with a provincially-created, nationally-run blood system.

Canadian Blood Services was a remarkable creation. It came out of a disastrous set of circumstances, when confidence in the Canadian blood system was at an all-time low. The provinces (and the federal government to a limited degree) were able to answer the criticisms laid by the Krever Commission and begin the work to restore confidence among Canadians. They worked together to create a well-defined system of governance in which roles and responsibilities of each party to the system are defined. We will discuss the successes and failures of the Ministers of Health in this endeavour, as well as the place of the blood system in the literature of federalism in the Conclusion.

Chapter 7

Conclusions

It seems certain that, when the Canadian Red Cross Society set out to collect blood for the military during the Second World War, it did not intend to become an agent for governments and ultimately to have a huge impact on the ways in which transfusion medicine is governed in this country. The Red Cross signed up to help, as was its mandate; it signed up to do some good and help ease the suffering of those injured in war; it signed up to collect blood.

As we have seen, the desire to provide a public service had disastrous consequences for the Red Cross, the provincial and territorial governments, the public health system, and for the many people infected with HIV/AIDS and Hepatitis C in the 1970s and 1980s. The Canadian health system is still dealing with the consequences of this blood tragedy; the *Toronto Star* reported on July 10, 2004 that thousands of hepatitis C victims have yet to receive compensation from the various governments.[235]

Although governments have not entirely dealt with all the issues surrounding the tainted blood scandal, the creation of Canadian Blood Services was motivated by the desire to address a number of the deficiencies identified by the Krever Report. Even though Justice Krever himself wrote that no blood system could ever be truly safe – "safety" being the absence of risk – the new blood agency was set up to make it as safe as possible. Stakeholders, governments, transfusion medicine experts, and the Krever report itself all contributed to the creation of an entirely new system. Said system took the lessons of the past and applied them to the present and to future considerations to avoid the failures apparent in the Canadian blood system.

[235] Rob Ferguson, "Hepatitis C help pledged," *Toronto Star*, July 10, 2004.

The Red Cross first collected blood as a charitable organization and as part of its mandate to ease human suffering in war. When peace came back to the world, the Red Cross continued to collect blood from civilians because it both identified a need and had an infrastructure in place to meet that need. As the need for blood grew, so too did the costs associated with it; the Red Cross turned to the provincial governments, as providers of health care in Canada, for help. As we have already noted, this was the first step in the violation of some Red Cross principles, including the principle of independence from government.

When the provincial governments started spending public money on the blood system, they also started playing a role in determining how that money was spent. Unfortunately, the system built itself up piecemeal, requiring more provincial involvement as the Red Cross spent more money. As a result, the system changed on a regular basis, adding committees, provincial oversight, and muddying the waters of accountability. Furthermore, the Red Cross had greater responsibility for the blood system than for most of its other programs; the Board of Governors, however, had to provide expertise for *all* the Red Cross's divisions.

By the time of the tainted blood scandal, there were so many different groups of people involved in the blood system that it was hard to know who was really in charge. The Red Cross bears partial responsibility for this, but the governments have a much greater culpability; they did not set in place appropriate mechanisms for the governance and funding of Canada's blood supply and relied too much on a private organization for managing the blood system. What mechanisms were in place – the Canadian Blood Committee and the Canadian Blood Agency – were ineffective in providing policy direction to the Red Cross and unable to act without information and orders from their respective provincial governments.

The provinces and territories did not live up to their responsibility to provide adequate health care when it came to the blood system. They and their representatives did not fully understand how to manage the Red Cross's blood program, nor did the representatives have equal power at the boardroom table. The relationships between governments and between governments, representatives, and Red Cross were completely dysfunctional; no one was in charge during the 1970s and 1980s.

The Krever Commission, formed by the federal government to examine a provincial creation, issued a scathing report that condemned the players in the blood system for not living up to the public trust they held. The report made a number of specific recommendations which led to intergovernmental negotiations to create a brand new organization to take over management of Canada's blood supply, Canadian Blood Services.

The federal, provincial, and territorial ministers of health set out to create a system that would address the recommendations of the Krever Commission, meet the needs of Canadians who expect blood to be available when needed, and be adaptive to unknown future needs and demands on the blood system. To do so required a significant amount of thought on the part of all these ministers, but they succeeded in designing a brand new system.

Unlike the blood system under the Red Cross, the governmental oversight of this arms-length agency was present from the very start. The governments ensured that they drew lines of accountability that made the Ministers responsible for their respective health care systems while also responsible as shareholders of the blood system. The provinces also appointed a Board of Directors who took responsibility for overseeing the actual operation of the system after obtaining funding and general policy direction from the provinces.

Over its almost-six-year history, CBS has taken over operations from the Red Cross, regained the trust of most Canadians, and has taken strides to increase blood donations from year to year. A lot of this success has to do with the improvements made to the system by the provincial governments when they signed the *Memorandum of Understanding* in 1997.

Although Canadian Blood Services has been a qualified success, the question of how successful the provincial governments have been in overseeing it at arm's length is more important to this discussion. There is certainly no publicly available evidence to suggest that the provincial and territorial governments have advanced their own interests at the expense of the blood supply. Indeed, as we have seen, Canadian Blood Services has received a great deal of co-operation from the governments, even when their actions might result in negative consequences to CBS employees in a given province.

There have been some clear successes in the change of governance structure. One obvious example is the financing arrangements for the blood agency. Under the Red Cross, money provided for one province's blood centre could not be used in another province. The so-called "national" system was only national because the Red Cross provided services in every province. Canadian Blood Services, on the other hand, is a truly national organization. Governments provide funding based on an entire organization's budget, not on the provincial government's willingness to contribute. Additionally, the national nature of the system allows CBS to undertake efforts to consolidate functions and provide a more cost-effective organization. In other words, the blood supply is now truly national.

Accountabilities within the system are also clearer, although there is still some ambiguity in interpreting the MOU. While the National Blood Authority is putatively responsible for the operation of the blood system in one section, other clauses state that the

provinces and territories are to use the NBA as a tool for maintaining the blood supply. It is clear that this issue must be addressed to ensure that lines of accountability are as clear as possible.

Some problems will never disappear without major changes to the division of responsibilities in Canadian federalism. The federal government remains responsible for regulating the blood industry while the provinces must fund it. The federal Ministry of Health, then, has no financial stake in the way it recommends changes to operations; it looks out specifically for safety issues and compliance with GMP regulations. While this is certainly good from a safety standpoint (recommendations are made based on safety, not on potential cost to the provincial/territorial governments), it does require the provinces to fund solutions to deviations from regulations over which they have no say.

The provincial and territorial Ministers of Health, acting as Members of the Corporation, appear to operate as a group and not as individual ministers. Although they do obtain funding from their respective Treasury Boards as Ministers of Health, said funding is based in large part on blood product usage within that province. There is very little room for Ministers to act in the best interests of only their province when working as Members of the Corporation. In other words, the Ministers so far have acted collaboratively to provide policy direction for Canadian Blood Services instead of competing with one another for the best possible provincial deal.

That being said, there are a number of records not available even through Freedom of Information requests as they fall under the category of “intergovernmental negotiations” or are part of confidential records. The absence of the same kind of dysfunction as occurred under the Red Cross cannot be construed as proof of a successful organization. Canadian Blood Services

is only a few years old, and the players are all still acutely aware of the issues that led to the creation of a new blood agency. As long as there are those who remember the tainted blood scandal of the 1980s, and as long as stakeholder representatives sit on the Board of Directors of Canadian Blood Services, it will be very difficult for political interests to take over the direct operation of CBS.

It is impossible to be sure that the future will not bring a new scandal to the Canadian blood supply. As the organization and its relationship with the provincial governments mature, the evolving nature of the blood system will undoubtedly bring changes in the ways that governments deal with one another and the blood system. If, for example, a recession similar to that of the 1990s occurs again, governments may again find themselves strapped for revenues, which might aggravate the difficulty of sustaining the health care systems. Such an eventuality could mean problems for the funding and governance relationship between provincial/territorial governments and the blood agency.

These issues, however, are hypothetical. The question of where the governance of Canadian Blood Services fits in the story of Canadian federalism has not yet been fully answered. In creating the new blood agency, there was certainly disagreement on the best methods to address the needs of the Canadian Blood system. Québec, for example, believed that the individual provinces were best suited to integrating the blood supply into the provincial public health system. The other provinces, however (along with the federal government), presented a united front to Canadians. It is clear that the provincial governments had to co-operate in order to create the new blood agency, but one wonders how amicable the closed-door negotiations really were. However, the evidence points to a fair distribution of costs and

representation for the provinces on the Transition Bureau and Board of Directors. Whatever competition occurred behind closed doors resulted in a *prima facie* fair settlement.

Canada's blood system occupies a unique place within the history of the Canadian federation. It is an exclusively provincial system that must operate on a national level. No other provincial program has the same requirement. The public health care system, although governed by the federal *Canada Health Act*, is still provincial in nature. The federal government can impose national standards because it provides the financial resources necessary for the provinces to conform to those standards (just as the Trans-Canada highway, ostensibly a national highway, exists because of the co-ordinating efforts of the federal government with provincial public works).

Federalism in Canada changed regularly, usually in response to external events. It was not a planned process, but instead was a reinvention, moulded by circumstance and need. Each of Canada's various phases of federalism affected the relationships between the provincial and federal governments; the competition, collaboration, or communication between governments had its roots in an adversarial mentality found in the tension between governments within the federal model.

Canadian Blood Services is the exception to this rule. Traditional models of federalism do not work in this because the federal government is not a direct part of the CBS governance equation. While Ottawa does play a role in regulating the blood industry, it has no direct role in policy or funding; the provinces must act together to ensure the stability of the blood system and the blood supply in Canada. Ottawa's role is limited to the regulatory requirements for blood and blood products. The federal government could certainly require – for example – that the blood system enact more stringent safety precautions, but could not tell the provinces how

to change their funding formulae or how to implement the changes. If Canadian Blood Services is to succeed, the provincial governments need to work together. Canadian Blood Services requires funds and general direction from the provincial governments; as long as they remain shareholders, the provinces have a responsibility, as defined by the *Memorandum of Understanding*, to co-operate with one another. The provinces, in turn, have little choice but to ensure its success; after all, the tainted blood scandal ensured that the goal of a safe blood supply remains in the collective consciousness of the Canadian public. Moreover, the provinces have a constitutional responsibility to ensure the provision of health care within their borders. As long as there is a public health system, the provincial governments have a duty to ensure that the hospitals are adequately supplied with the materials they need to function. Finally, the national nature of the blood program as created by the Red Cross meant that the infrastructure for a national system was already in place. It was certainly simpler to take over existing programs and structures from the CRCS than it would have been to design and implement new ones. When Canadian Blood Services took over the blood system from the Red Cross, the staff, office buildings, and physical plants did not change; the Executive Management Team, Board of Directors, and governance system did. It made logical sense for the provinces to take over a working system; it should be remembered that the Krever Report's greatest criticisms were about the relationship between the governments, the CBA, and the Red Cross and about the regulatory framework for the blood system, not about the employees and facilities actually performing the work. The provinces, then, had to take over systems within their borders that interacted on a national level with systems in other provinces. This was a final compelling reason to work together.

It certainly seems clear that the collaborative federalism ushered in with the 1990s played a great part in the creation of Canadian Blood Services. As we have seen, collaborative federalism was essential in creating national programs like the Trans-Canada highway. The federal government was also instrumental in both solving the tainted blood crisis and in creating the new blood agency. Ottawa's move to lead and co-ordinate provincial efforts is certainly in keeping with the traditional definition of collaborative federalism. However, in commissioning Justice Horace Krever, the federal government set in motion a series of events that helped create a new blood system and — potentially — open the door for a new mode of federalism.

Ottawa's decision to both commission and release the Krever Report forced the provinces to take action. The public outcry after the discovery of the blood system's failure compelled the provinces to make radical changes in the way they governed the Red Cross's Blood Transfusion Services. In making those changes, the provincial governments responded to pressure both from their citizens and lobby groups such as the Canadian Hemophilia Society. The decision by the provinces to meet and discuss changes to the blood system was a *reaction* to external events: the tainted blood tragedy, the release of the Krever Report, and the subsequent public reaction to the deficiencies of the Red Cross.

Although the federal government could not act unilaterally to make changes to the governance of the blood system, it could force the provinces to act by manoeuvring them into a situation where they had no choice but to react. This could even be a new stage in federalism: "coercive federalism," although some scholars could argue that Ottawa acted in a similar fashion during the Second World War and in the post-war era. By forcing the provinces to act, Ottawa was able to position itself as being part of the solution to the problem – the federal

Minister of Health was, after all, the one who announced the changes to the blood system as they occurred – without actually having to solve the problems.

In this set of events, the provinces and federal government acted as crisis managers. They reacted to an event unprecedented in Canadian history and tried to ensure a lasting solution. The nature of federalism could very well be starting to shift, because of the co-operative and coercive elements involved in creating the new blood agency. The evidence, however, is not yet clear on this point: Canadian Blood Services is a unique case; safe blood is something Canadians expect to have on demand, and the visceral reaction to the tainted blood scandal required an equally strong response.

Even if federalism *is* starting to shift again, there is not yet enough evidence available to make that conclusion. The response to the blood crisis in the 1990s has thus far been unique in Canadian federalism; other policy areas have not shown the same tendency to collaboration and coercion as the blood file.

The provinces have thus far managed to work together to fund and govern Canadian Blood Services. In spite of being coerced into action by external events and the federal government, the provincial governments have been able to deal with the ongoing issues within the blood agency. Coercive federalism worked in this instance; the provinces had to act together or face potential political repercussions. If and when the nature of federalism changes again, for whatever reason, the amicable relationship formed by their roles as shareholders in the blood system may be dissolved and the Ministers may find themselves co-operating less or pushing a provincial agenda at the boardroom table. Of course, this can only occur if the benefits of promoting provincial interests outweigh the political costs associated with using the blood system as a provincial platform. Québec, for example, succeeded in making the blood

system an exclusive provincial matter. Although Héma-Québec co-operates with Canadian Blood Services, it is a creature of Québec politics.

Although we cannot be certain that governments are always co-operating to run the system, the evidence is undeniable: the system is working far better than it used to and exactly as it was designed to. The themes of competition and collaboration work together (along with coercion) to ensure that governments continue to responsibly operate the blood system. The federal government forced them to take action on the blood system (although Ontario did react earlier than Ottawa on the compensation of victims of the tainted blood scandal, and several provinces followed Ontario's lead in providing more generous compensation than the federal government); as competitors, the provinces each wanted credit for helping solve the problems plaguing the blood system; as a part of the solution, the provinces worked together both for political credit and for the good of Canadians. For the first time in a very long time, governments are getting along with one another and with the blood system.

Each of the governments had a role to play in resolving the issues made public by the Krever Report. The provincial governments are continuing to play their roles as defined by the Memorandum of Understanding and do not allow political factors to interfere with good business decisions. This is somewhat ironic, as political factors appear to have been of importance in operating the blood system in the pre-Krever world, and even in forcing governments together to determine a solution.

The blood system is one of the most critical components of the public health system. Without readily available blood, surgeries would not happen, research could not occur, and hospitals could not do their jobs. If the national blood system does not work the way it is supposed to, provincial health networks can easily fail. The provincial governments must co-

operate in order to make this happen, and in the brief history of Canadian Blood Services, they have done just that. As Canadian Blood Services staff often say, the governments are working to "build a better blood system for Canadians."

Appendix 1: Selected Krever Recommendations

	RECOMMENDATION[236]	RATIONALE
2	It is recommended that the Canadian blood supply system be governed by five basic principles: a) Blood is a public resource. b) Donors of blood and plasma should not be paid for their donations, except in rare circumstances. c) Whole blood, plasma, and platelets must be collected in sufficient quantities in Canada to meet domestic needs for blood components and blood products. d) Canadians should have free and universal access to blood components and blood products. e) Safety of the blood supply system is paramount.	These recommendations are similar to those produced by previous meetings of Ministers of Health. It reaffirms the public, voluntary nature of the blood system as well as reinforcing the notion that blood, once given, is something that should be available to everyone. An interesting change from previous sets of principles is in recommendation 2 e). Specifically, it says that the competing factors of risk and cost should play no part in compromising safety. In making this recommendation and providing this rationale, Justice Krever responded to the difficulties at the Red Cross, which required full knowledge of a hazard before taking action *and* required a debate over costs. The rationale for 2 e) says that ensuring the blood system is safe may require substantial sums of money and must be governed by already-existing public health policies.[237]
3	It is recommended that Canada have a national system for the collection and delivery of blood components and blood products.	The Red Cross's so-called national system had a number of flaws associated with it. First, the provincial nature of its funding meant that, except in emergencies, blood had to stay within the borders of the province. Additionally, provincial money could only be spent on blood centres within the province providing the money. If the centre in Winnipeg required facility upgrades, only Manitoba money could be used, even if Ontario had a surplus. Justice Krever argues that a national blood system is better suited to dealing with the national health problems associated with blood donation and distribution.[238]
4	It is recommended that the core functions of the national blood supply system be performed by a single operator and not be contracted out to others.	In the mid-1990s, the Red Cross mused publicly that it might withdraw from the blood system. Governments responded positively and talked about asking the Red Cross to operate the blood donor recruitment portion of the blood system. This recommendation speaks directly to that possibility. The efficiencies inherent in dealing with only one operator instead of several make this recommendation somewhat self-explanatory.
6	It is recommended that the blood supply system be operated in an open and accessible manner.	This is the cornerstone of almost any government-associated organization. In any organization that spends public funds, it is incumbent upon it to

[236] Krever, p. 1046-1073. While the wording of the recommendations is lifted verbatim from Krever's report, the rationale is often paraphrased.
[237] Krever, p. 1048-1049.
[238] Krever, p. 1049-1050.

	RECOMMENDATION[236]	RATIONALE
		ensure that it is open to public scrutiny. By the end of the Krever Inquiry, Canadians had very little faith in the blood system. Justice Krever recommended that any new system be operated as openly as possible in order to reassure Canadians that the blood system changed and improved over the Red Cross.[239]
7	It is recommended that the operator of the blood supply system be independent and able to make decisions solely in the best interests of the system.	Under the Red Cross, authority was ill-defined and often murky. While the Red Cross operated the system, the mechanisms by which major decisions were made were poorly laid out. The Red Cross could try to make a decision in response to a growing threat or based on a business need, but the Canadian Blood Committee, Canadian Blood Agency, or one of the governments could easily overrule it for political considerations. Justice Krever recommended that the operator be able to make decisions independently, although the decision-making authority would ultimately be vested in the governments funding the blood supply.
8	It is recommended that the authority for the operation of the blood supply system be clearly defined.	Recommendation 8 is similar to recommendation 7. There is nothing more to add except to say that this recommendation responded to the problems of the Red Cross days when no one really knew who was responsible for carrying out what function within the blood system.
10	It is recommended that the blood supply system be publicly administered by a national blood service, a corporation to be created by an Act of Parliament.	This recommendation stems from the difficulties inherent in the Red Cross's multi-faceted role in a provincially-administered system. Justice Krever believed that the blood system should be integrated into the public health system, not on the fringes, as the Red Cross frequently was. He further believed that it should be truly national in nature, not a national system operated by the provinces.[240]
11	It is recommended that the provincial and territorial ministers of health be the members of the corporation.	Since the provinces have constitutional responsibility for health care, and since the blood system is part of Canada's health system, it seems only natural that the provincial and territorial ministers of health play an important role in any blood service provider.
12	It is recommended that the members of the corporation appoint an independent board of directors to supervise the management of the service and that the members of the board carry out their duties at arm's length from government.	Although the ministers of health have ultimate authority for provision of blood services as a part of the public health system, they should not be directly involved with the operations of the blood supply. They can retain their democratic legitimacy by appointing a board of directors, but can help to ensure that the corporation is not politically charged by ensuring the board is

[239] Krever, p. 1051.
[240] Krever, p. 1053.

	RECOMMENDATION[236]	RATIONALE
		independent of government.
15	It is recommended that the national blood service be funded by payments from hospitals for the blood components and blood products supplied to them by the blood service.	In some ways, this recommendation makes the most intuitive sense, and makes one wonder why it was not implemented earlier as a part of the Red Cross systems. After all, blood is collected for two purposes: research and for use by hospitals. If hospitals paid for what they required, it could make the system that much more efficient. As Justice Krever notes, it can also ensure that the blood provider can remain in charge of its own budget by charging for the products and services it provides and funding itself from the revenues thus generated.[241]
16	It is recommended that the provinces and territories, no longer bound to finance the blood supply system by making grants to the Canadian Blood Agency, increase the budgets of hospitals using blood components and blood products by amounts that will enable them to pay the national blood service for these components and products without affecting their other programs and services.	This recommendation is the corollary to recommendation 15; if the national blood provider charges for its services, its customers need the ability to pay for them. Accordingly, provincial hospitals require extra funding to pay for the extra services.
18	It is recommended that the operation of the national blood service be managed by both administrative and medical personnel.	Recommendation 18 makes a great deal of intuitive sense. After all, a public health company requires medical personnel with the expertise to ensure safety, potency, purity, and efficacy of its products and services. Additionally, it requires administrative experts to see that the corporation is run in as efficient a manner as possible. Just as non-medical experts cannot attest to the scientific issues attendant to providing blood services, non-administrative experts are not necessarily the best people to actually run the programs required by the scientific experts. Put another way, Justice Krever wanted to ensure that the system was run by the best people in the fields important to running a blood system operation.

[241] Krever, p. 1056.

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