

Canadian health system reforms: lessons for Australia?

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Abstract

This paper analyses recent health reform agenda in Canada. From 1988 until 1997, the first phase of reforms focused on service integration through regionalisation and a rebalancing of services from illness care to prevention and wellness. The second phase, which has been layered onto the ongoing first phase, is concerned with fiscal sustainability from a provincial perspective, and the fundamental nature of the system from a national perspective. Despite numerous commissions and studies, some questions remain concerning the future direction of the public system. The Canadian reform experience is compared with recent Australian health reform initiatives in terms of service integration through regionalisation, primary care reform, Aboriginal health, the public-private debate, intergovernmental relations and the role of the federal government.

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THE PURPOSE OF THIS ARTICLE is to review the Canadian health reform experience of the last 15 years, and draw parallels with the Australian experience. The modern era of Canadian health care reform began shortly after the implementation of the Canada Health Act 1984. In one sense, this federal legislation locked in a pattern of universal coverage that had been originally set through the Hospital Insurance and Diagnostic

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What is known about the topic?

The Canadian health care system has been the subject of many commissions, studies and reports, some of which have led to reform, while others have served to protect its essential elements.

What does this paper add?

The recent Romanow Commission confirmed that Canadians strongly support the principles of comprehensive benefits, universal coverage and public administration, but also wanted greater efficiency and accountability for their health care system. There are signs that the recommended focus on primary health care is being pursued, through the regional health agencies that serve most provinces. Recommendations for 'rolled-up' funding for Aboriginal health have not (yet) been acted on.

What are the implications?

The potential lessons for Australia include better differentiation between federal and state responsibilities; and the benefits that could accrue from a national arm's-length study. Perhaps one of the most important findings from the Romanow report was the public's fatigue with rancorous blame shifting and fighting over accountability for health between levels of government — the so-called crisis in health care was perceived to be a crisis in governance.

Services Act 1958 and the Medical Care Act 1966. In the first 3 years of operation of the Canada Health Act, the federal government penalised those provinces which permitted health care facilities or physicians within their jurisdictions to charge user fees, and then returned most of the close to \$250 million originally withdrawn after user fees were eliminated. They ensured the "narrow but deep" coverage aspect (ie, cover for all medically necessary physician and hospital care but no other services) of Canadian medicare. Just as importantly, the Canada Health Act's five principles of public administration, accessibility, universality, comprehensiveness and portability provided a framework within which 13 disparate provincial and territorial single-payer medicare systems

could continue to grow and innovate separately while still providing all Canadians with common coverage entitlements.^{1,2}

Over its two-decade existence, the Canada Health Act has achieved near-iconic status in Canada.¹ It has also served as a constant reminder of the continuing federal role in Canadian health care, one much resented by some provinces particularly during the periods when the federal government has reduced its fiscal responsibility for health care even while posing as the defender of the public system.

Public health care in Canada during the past 15 years has been punctuated by stop-go financing, a product of two quite different economic environments. The first phase was marked by public fiscal constraint in an era of high government debt, first at the provincial level and then later at the federal level. The second phase was marked by increasing health

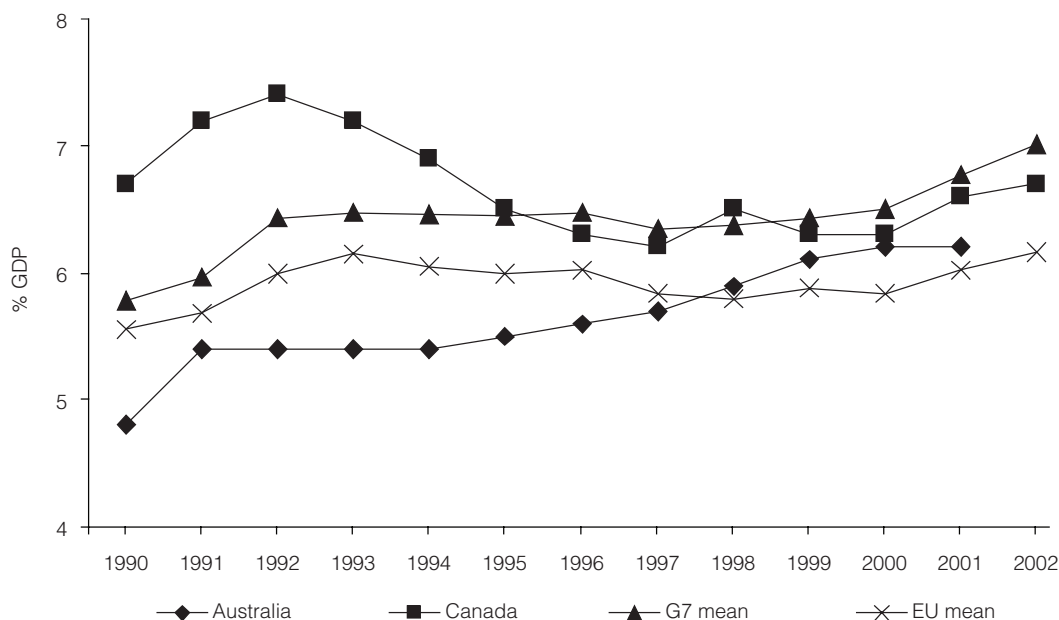
expenditures influenced by a more buoyant economy and lower public debt.^{3,4}

The stop-go aspect is evident from the Canadian Institute for Health Information's expenditure data. From 1990 until 1997 (as measured in constant 1997 Canadian dollars), the average annual growth rate was negative, a reflection of the provinces putting the brakes on health spending to an extent largely unmatched among OECD (Organisation for Economic Cooperation and Development) countries (see Box 1). From 1998 on, real growth suddenly moved up to between 6 and 7 per cent per year.⁶

Rationalisation and integration: Phase I of Canadian health reforms, 1988–1997

By 1987, Canada had the second highest level of per capita health care expenditure in the

I Trends in public health care expenditures as a share of GDP in Canada, Australia, the European Union (EU) and the G7, 1990 to 2002



Note: OECD 2002 figure for Australia unavailable. EU and G7 mean figures subject to limitations in data availability for some member states.

Source: OECD Health Data 2004⁵

world as measured in US purchase power parity dollars.⁷ The federal and provincial governments combined had accumulated one of the highest public debt loads in the G7 group of large and wealthy national economies. By the time of the recession of the early 1990s, provincial governments were constraining health care spending, joined by the federal government by the mid-1990s, which cut its cash transfers for health care to the provinces.

During this first phase, in the words of one deputy minister of health, most provinces were

racing two horses simultaneously: a 'white horse' of substantive health reform to improve both quality and access through a more thorough integration of services across the health continuum along with a rebalancing from illness care to 'wellness', and a 'black horse' of cost cutting through health facility and human resource rationalisation.⁸ To the extent that cost cutting prevented provinces from investing in substantive new initiatives, such as primary health care delivered by multidisciplinary teams, this form of rationalisation undermined real

2 Phase I of major health reforms, 1988–1997

Year	Government	Health reforms/policy changes	Impact
1988	Québec	Québec is the first province to begin establishing regional health authorities (RHAs)	Provides first example of how geographically-based RHAs will operate in improving allocation of local health resources and better integrating and rationing health services
1989	Canada	Federal transfer escalator reduced from GNP minus 2% to GNP minus 3%	Further reduces relative federal contribution to provincial health expenditures
1990	Canada	Federal transfers frozen. This freeze would be extended to 1995	Freeze has disproportionate impact on wealthier provinces and Ontario becomes a leading advocate for change in transfer system
1992	Saskatchewan and New Brunswick	Introduction of major regionalisation and wellness reforms accompanied by transformation or closure of rural hospitals	Integrates various health care organisations along with illness promotion and public health services under RHAs, although size of RHAs increased in 2002. Cost cutting through rationalisation of acute facilities including hospital closure
1993–94	Alberta, Newfoundland and Prince Edward Island	Introduction of regionalisation and wellness reforms	As in other provinces, RHAs vertically integrated health care organisations while attempting to introduce illness prevention and public health services. Rationalisation of acute care services
1994	All	Canadian Institute for Health Information (CIHI) created in response to National Task Force on Health Information report (1991), approved by federal, provincial and territorial ministers of health	In partnership with Statistics Canada, CIHI is responsible for major health databases concerning health spending, health services and human resources, as well as public reports on indicators and population health
1995	Canada	Unilateral decision by federal government to reduce cash transfers to provinces and territories through a new Canada Health and Social Transfer mechanism with no escalator	Major reduction in federal cash transfers to provinces. By 2000, the clash over 'health funding' becomes the dominant federal–provincial issue and continues through the Romanow Commission
1996–97	Nova Scotia, British Columbia and Manitoba	Last provinces (other than Ontario) to implement a regionalised system of health service delivery	Similar rationale as other provinces to integrating service delivery across diverse health organisations within geographic regions

health reform. To the extent that cost cutting closed health facilities and reduced the supply of doctors and nurses without providing alternative institutions or modalities of treatment, it reduced public confidence in the quality of the existing acute care system and tarred the health reform agenda. And as can be seen in Box 1, Canada witnessed a much more severe decline in public health expenditures than Australia or the average of G7 or European Union countries.

Cost cutting was mainly accomplished through reducing the number of hospital beds and health providers. Hospitals were closed, converted or consolidated into larger units as new surgical techniques and new prescription drug therapies combined with home care reduced the demand for hospital beds. Provin-

cial governments along with provider organisations and educational institutions strove to decrease the supply of nurses and physicians through various means that included restricting access to education and increasing the time required for education and training. By the time that demand for nurses and physicians was beginning to surge again in the late 1990s, the domestic supply of health human resources was inadequate. Between 1991 and 2000, the number of registered nurses had declined by 8% while the number of licensed practical nurses had declined by 21%. Although physician growth was zero over this period, the growth in population translated into an effective decline in the number of physicians per capita.¹

3 Arm's-length provincial system reports underpinning Phase I health system reforms, 1988–1991

Year	Name and province	Report title	Main recommendations
1988	The Rochon Commission, Québec	Rapport de la Commission d'enquête sur les services de santé et les services sociaux ¹¹	Supports regionalisation reforms and decentralisation already being implemented. Emphasis on evidence-based decision-making, needs-based funding, improved professional collaboration and primary care reform
1989	The Gallant Commission, Nova Scotia	The Report of the Nova Scotia Royal Commission on Health Care: towards a new strategy ¹²	Shift priorities to primary care through limiting funding for institutional and physician care. Urges regionalisation to improve service integration and resource allocation. Recommends a provincial health council
1989	The Rainbow Commission, Alberta	Rainbow Report: our vision for health ¹³	Urges regionalisation to shift resources from institutional care to primary care and illness prevention. Recommends some private financing to increase choice and competition and redefinition of insured services
1990	Ontario Task Force on Health, Ontario	Final report of the Task Force on the Use and Provision of Medical Services ¹⁴	Hospital restructuring to gain cost efficiencies, better human resource planning, improved health information and health technology assessment and some organisational change
1990	The Murray Report, Saskatchewan	Future directions for health care in Saskatchewan ¹⁵	Regionalisation as means to obtain cost savings, improve service integration, and shift resources for institutional care to primary care and illness prevention services. Change fee-for-service remuneration for physicians
1991	The Seaton Commission, British Columbia	Closer to home: report of the British Columbia Royal Commission on Health Care and Costs ¹⁶	Place resource limits on institutional and physician care and shift some resources to illness prevention and public health. Recommends regionalisation and health council to establish goals and report to public

In most provinces, however, a constructive program of health reform was already under way by the time that health ministries were required to cut costs (Box 2). The most significant initiative at the time, often thought to be a condition precedent to other reforms, was structural reorganisation through regionalisation. At its most basic, regionalisation combines a devolution of funding from the provincial government to regional health authorities (RHAs), now made responsible for the allocation of resources based on the needs of the regional population, with a centralisation of delivery management from individual health facilities to the geographically-based RHA.⁹ Beyond introducing resource allocation based upon population needs, regionalisation was intended to deepen integration of services across the continuum of health, improve service quality, increase access, instill evidence-

based decision-making, shift resources to health promotion and prevention, improve accountability and increase public participation in health policy decision-making.¹⁰

The creation of RHAs facilitated the horizontal integration of hospitals and enabled careful planning in the downsizing of acute care facilities. Such horizontal integration of acute care conferred some potential economies of scale to the more populous RHAs. The main purpose of the regionalisation reforms, however, was to gain the benefits of vertical integration; that is, managerially consolidating facilities and providers across the continuum of care into a single administrative organisation capable of improving the coordination and continuity of health services including prevention, public health and health promotion activities. As can be seen in Box 3, these health reform objectives were consistently recommended by the arm's-

4 Phase II of major health system changes, 2000–2004

Year	Government	Health reforms/policy changes	Impact
2000	Canadian	Canadian Institutes of Health Research (CIHR)	Medical Research Council replaced by CIHR. New research strategy and increased funding to make Canada one of top five health research nations
2000	All	September 2000 First Ministers' Health Agreement ²¹	Federal cash transfer funding increased. New conditional funding for primary care reform and medical equipment has mixed results. Creation of separate national corporation (Health Infoway) to accelerate integration of new IT systems including electronic health records also has mixed results
2002	Saskatchewan	Establishment of a provincial Quality Council in response to the Fyke Commission's recommendations ²²	By 2004, beginning to measure and report on quality performance through standardised indicators for Saskatchewan. Use of Quality Improvement teams to improve quality performance in key areas including primary care, cancer, surgery and chronic disease
2003	All	First Ministers' Accord on Health Care Renewal ²³ focuses on Health Reform Fund for primary care, home care and catastrophic drug coverage and creation of national Health Council in response to the Romanow Commission ¹	Limited progress on home care and primary health care reform. New investment in advanced diagnostic services. Delays in establishing Health Council but ultimately proceeds without participation of Québec and Alberta
2004	Canadian	Canada Public Health Agency established in response to SARS crisis and desire for more effective federal role in public health coordination ²⁴	Implemented in 2004 and results not yet clear

length commissions and task forces that reported to the governments of Québec, Nova Scotia, Alberta, Ontario, Saskatchewan and British Columbia between 1988 and 1991.⁷

In 1988, Québec was the first province to initiate structural reform, but by the mid-1990s, virtually every other province in the country had adopted, or was in the process of adopting, similar reforms. The degree of inte-

gration accompanying the reforms varied considerably from province to province. However, even in Alberta and Saskatchewan, jurisdictions that went the furthest in terms of vertically integrated RHAs, some funding programs continue to be administered directly by provincial governments including physician remunerations and provincial prescription drug plans.¹⁰

5 Arm's-length provincial and national health system reports in Phase II, 1997–2004

Year	Name and jurisdiction	Report title	Main recommendations
1997	The National Forum on Health, Canada	Canada Health Action: Building on the legacy. Volume 1: The Final Report of the National Forum on Health ²⁰	Integrate a national pharmacare program as well as home care services into the continuum of care by making them insured services under the Canada Health Act. Adhere to tax-based, single-payer scheme administered by the provinces but delivered on a population-needs basis through regional bodies
2000	The Ontario Health Services Restructuring Commission, Ontario	Looking back, looking forward: seven points to action and the Legacy Report ^{27,28}	Hospital restructuring due to changes in patient needs. Improved health and management information as well as outcomes and performance measurement. More resources for home care and long-term care. Some decentralisation
2000	The Clair Commission, Québec	Rapport de la Commission d'étude sur les services de santé et les services sociaux: les solutions émergent ²⁹	Private financing options, limiting scope of coverage and restructuring. Improve recruitment and retention of health human resources. Renews commitment to regionalisation with some organisational changes. Sees primary care as centre of modern system
2001	The Fyke Commission, Saskatchewan	Caring for Medicare: sustaining a quality system ²²	Establishment of Quality Council to improve outcomes. Reduce number of small (rural) hospitals for reasons of cost and quality. Accelerate primary health care through provider teams and alternative physician remuneration
2002	The Mazankowski Task Force, Alberta	A framework for reform: report of the Premier's Advisory Council on Health ³⁰	Recommends private financing of services rather than rationing through public system; would provide more choice and competition. More decentralisation from provincial government to regions. Accelerate primary care reform. Emphasise performance measurement
2002	The Senate Committee, Canada	The health of Canadians – the federal role: recommendations for reform by the Standing Senate Committee on Social Affairs, Science and Technology ³¹	Increase federal funding. Improve primary care, expand home care and introduce catastrophic drug coverage. Change hospital funding to needs/service-based funding. Care guarantees to address waiting list problems. More health research
2002	The Romanow Commission, Canada	Building on values: the future of health care in Canada ¹	Redefine federal role. Increase federal transfer funding to provinces. Accelerate primary care changes. Expand home care to include mental health as well as post-acute and palliative care. Establish National Drug Agency, national drug formulary, catastrophic drug coverage and medication management. Consolidate funding and experiment with Aboriginal Health Partnerships

Ontario, with almost 40% of the Canadian population, is the major exception to the early regionalisation reforms.¹⁷ Instead, the provincial health ministry and some of the independent not-for-profit health organisations that deliver most health care within the province have pursued integration through other means.⁹ These methods have focused on the networking of specialised services such as cancer and cardiac care across the province and the consolidation and horizontal integration of hospitals and similar institutions into larger units such as the University Health Network, the Trillium Centre and the William Osler Health Centre. Although regional planning councils advise the Ontario Ministry of Health and Long-Term Care, they have had no authority with respect to the allocation of resources.

At the same time, too much can be made of Ontario's 'lone wolf' status. The province did regionalise community and long-term care services on a geographic basis in the late 1990s, with funding calculated on a population needs-based formula.¹⁸ In recent months, the Ontario government has established Local Health Integration Networks to coordinate the delivery of a broader range of health care services within 14 geographical regions. However, it is too early to assess whether the new geographic networks will create a regionalised system similar in most fundamental respects to the nine other provinces.

To support health services integration during the 1990s, both federal and provincial governments strove to improve their health information and data management infrastructures. Towards the end of the first phase, most provinces were investing heavily in health information networks, including initial efforts at establishing electronic health records. In 1994, the federal government in concert with the provinces established the Canadian Institute for Health Information (CIHI) to better understand and diagnose their respective public health systems. CIHI was initially a consolidation of activities from Statistics Canada, health information programs from Health Canada, the

Hospital Medical Records Institute and the MIS group. In partnership with Statistics Canada, CIHI has grown into one of the world's premier health information agencies with extensive databases on health spending, health services and health human resources.

The first phase of reform came to an end with the introduction of the Canada Health and Social Transfer (CHST) in 1995–96 and, with it, substantial reductions in cash transfers to the provinces. Paradoxically, this drop in transfer funding came just before the provinces began to loosen their own purse strings for health care after years of restraint. By reducing the federal government's risk for provincial health expenditures, the CHST changed the assumptions on which the original federal–provincial medicare bargain had been struck.¹⁹ Importantly from an intergovernmental perspective, no automatic escalator was included in the new transfer. As a consequence, the country was subjected to a series of episodic and unpredictable negotiations producing one-time agreements that were little more than cease-fires in the continuing war between Ottawa and the provinces.⁴

The change initiated by the CHST all but derailed the National Forum on Health, a health reform advisory body that the federal government had established in October 1994. When it became evident that the National Forum was on a clear track to recommending a more expansive (and expensive) federal role in creating a national Pharmacare program and a national home care program, the federal government forced the advisory body to wrap up its work earlier than scheduled.²⁰

Despite this, the National Forum on Health did influence Canadian health policy by highlighting the dismal health outcomes of Canada's many First Nations, Inuit and Métis communities. In response to the Forum's call for a national health information system, Canada Health Infoway Inc. was established to accelerate the development of health information systems in general, and electronic health

records in particular, throughout the country. In the long term, the Forum's call for a cash floor for federal cash transfers as well as its analysis of the gaps in prescription drug coverage and home care would influence subsequent national studies and commissions.

Phase II of Canadian health reforms, 2000–present

The second phase saw rapidly growing health care expenditures rebounding from years of austerity (Box 4). Canadians are in the midst of the second phase of health reform and, as a consequence, it is too early to describe with any precision the directions it will take. This period is marked by a significant lift in public health expenditures in an environment of higher economic growth and lower government debt accompanied by growing concerns about the fiscal sustainability of public health care. More importantly, some have questioned the assumptions and values underpinning the Canadian model of medicare and have urged market-based reforms predicated either on private finance or private delivery, to address what they see as the deficiencies of public health care. Although a minority, this group constitutes an influential sector within Canadian society and has found at least one provincial government responsive to this message.²⁵

With the growth in expenditures as well as the demand for health services, particularly in the acute sector, many provinces suffered from health human resource shortages in certain sectors and professions. By 2000, waiting lists for elective surgery had grown longer as the demand for services such as orthopaedic surgery grew faster than expected. A dramatic increase in the use of advanced diagnostic imaging such as computerised tomography (CT) scans and magnetic resonance imaging (MRI) created a demand that outstripped the available supply of equipment and specialised medical and allied personnel,²⁶ causing delays in access to treatment.

Provincial reviews

By the second phase of reform, provincial governments were responding to patient and voter dissatisfaction by investing heavily to address human resource and medical equipment shortfalls. At the same time, some governments became concerned about the pace and impact of their earlier reforms. In the spring and summer of 2000, three provinces — Québec, Saskatchewan and Alberta — established major arm's-length commissions or task forces to provide recommendations to the three provincial governments on the future direction of their reforms (Box 5).

Québec's Clair Commission was the first to report, suggesting that more private finance was needed in light of demographic ageing, particularly for long-term care and home care. While the Clair Commission agreed with the basic thrust of regionalisation, it made a number of recommendations to fine tune or alter aspects of the province's RHA system.²⁹

The next to report was Saskatchewan's Fyke Commission. It recommended that the provincial government increase the pace and depth of the regionalisation reforms as well as establish a Health Quality Council to assist the RHAs to improve the quality of care in priority areas. It also urged that no new money should be pumped into the system until further efficiencies were obtained through the rationalisation of existing facilities and the implementation of more effective approaches to primary care and prevention.²²

The Mazankowski Task Force also supported the direction of Alberta's regionalisation reforms, suggesting that the next logical step was to place the budgets for physicians and prescription drugs in the hands of the RHAs. However, the Task Force's assumptions and recommendations diverged significantly from the Fyke Commission, including the assumption that there were few if any efficiencies yet to be gained through publicly administered integration.³² Concluding that new funding would be required, the Task Force recommended that it come from private sources rather than

through additional taxation. In addition, the Task Force concluded that the private competition emerging from private sources of finance could improve both efficiency and the quality of care.³⁰

National inquiries (see Box 5)

Commencing in 1999, one of the Canadian Senate's standing committees produced a series of reports reviewing the state of Canadian health care and setting out various policy options for Canadian governments. Delivered in October 2002, the Senate's final report concluded that more money was required for the system. After highlighting the extent to which federal cash transfers had fallen over two decades, the Senate argued that Ottawa had an obligation to deliver the lion's share of needed new funding to the provinces.³¹

This recommendation was similar to that ultimately made by the Commission on the Future of Health Care in Canada, commonly known as the Romanow Commission.¹ Established in April 2001, the Romanow Commission was an independent royal commission established by the Prime Minister, partly in response to the provincial reports and studies then reporting or under way that either ignored or challenged the national dimensions of public health or care.

After conducting extensive consultations as well as twelve intensive citizen dialogue sessions, the Romanow Commission concluded that the vast majority of Canadians still supported the pan-Canadian principle underpinning the Canada Health Act that access be based solely on need. At the same time, it became clear that Canadians wanted their governments to pursue greater efficiencies and to exhibit a higher degree of accountability to the public as the ultimate funders and consumers of Medicare. Contrary to most government, policy expert and provider expectations, the citizen dialogues demonstrated that Canadians were willing to:

- be rostered within a primary care network under clear conditions of entry and exit;

- have their personal health information stored on an electronic health record and shared with health professionals as well as governments; and
- become more responsible, individually and collectively, for preventing illness and injury as well as pursuing greater health literacy.^{33,34}

The final report of the Romanow Commission recommended a series of changes beyond increased federal funding, including:

- creating a national health council to provide advice to governments and provide progress and performance reports on key aspects of the pan-Canadian reform agenda to the general public;
- updating, clarifying and strengthening the Canada Health Act;
- pushing primary health care and prevention to the centre stage of the Canadian health system including a national immunisation strategy;
- focusing on the access and quality of care challenges faced by rural and remote communities through targeted funding for training, education and improvement of infrastructure;
- addressing the fragmentation of Aboriginal health care funding and delivery and its cultural relevance through integrated Aboriginal health organisations;
- creating a national platform for targeted home care services for mental health, post-acute care, and palliative care;
- providing catastrophic prescription drug coverage and addressing current prescription and utilisation patterns through improved medication management;
- creating a National Drug Agency and a national drug formulary.

Health Reform in Canada after Romanow: two years on

The future in terms of most provincial health reform on the ground is relatively clear. The structural reforms initiated through regionalisation in nine provinces and through service networking and hospital consolidation in

Ontario will continue. For the most part, these are iterative changes, in which adjustments and fine-tuning will continue for a generation or longer. While debate continues on the governance and structural dynamics of RHAs, all governments as well as health reform studies since the late 1980s have promoted the benefits of both horizontal and vertical integration combined with some degree of devolved decision-making, either through geographically-based regional authorities or through readily identifiable disease groups within more specialised health organisations.³⁵

Since the case for these structural reforms had been made, and all provinces were well down the road of restructuring their systems, the Romanow Commission focused instead on primary health care as the fundamental catalyst for future reform. It recommended that both levels of government direct a substantial share of new public investment into primary care changes.

Within three months of the tabling of the Romanow report in Parliament, the Prime Minister and the premiers agreed to focus their efforts on primary care reform as the key to achieving efficient, timely and quality health care. In addition, both levels of government agreed to develop new performance indicators to measure their progress, including increases in the number of multidisciplinary primary health care teams or organisations and the percentage of their respective populations routinely receiving care from such primary care teams or organisations.²³ In the 2004 First Ministers' summit on health care, the prime minister and premiers agreed to establish a "best practices network to share information and find solutions to barriers to progress in primary health care reform such as scope of practice".³⁶ Two years after Romanow, primary care reform has been revitalised, with some provinces and territories beginning to move well beyond pilot projects to system-wide reforms.³⁷

With the second largest land mass in the world, Canada faces huge challenges in providing equitable access to a roughly similar range of health

services to all its citizens. In reality, as in Australia, those populations living in the larger urban conglomerations receive a broader range of health and health care services delivered by more specialised health providers. As a consequence of this stubborn fact, the Romanow report devoted a chapter on how to improve access to, and the range and quality of, health services for rural and remote communities. The report recommended the establishment of a dedicated Rural and Remote Access Fund that would allow provinces and territories to finance new initiatives aimed at attracting and retaining providers, expanding telehealth and initiating novel demonstration projects to improve health outcomes in rural and remote areas. A part of this suggestion was adopted through the creation of a Territorial Health Access Fund financed by Ottawa alone.³⁶

In light of dismal health outcomes and the historic marginalisation of Canada's Indigenous population from the mainstream health care system, the Romanow report devoted a chapter to Aboriginal health issues.^{1,38} Major recommendations called for fundamental change in the approach to health care delivery that would have involved the pooling of funding. Currently, funding is highly fragmented, with the federal government funding the bulk of health services and insurance for First Nations people living on reserves and Inuit people living in northern settlements. A considerable portion of funding flows directly to First Nations and Inuit through self-governing agreements.³⁹ In addition, provinces and territories continue to provide a range of health services to Aboriginal peoples, particularly Canada Health Act services. Through pooling, it would become possible to pay for a broader range of services to be provided by Aboriginal-directed health management organisations to enrolled populations. To date, none of the recommendations have been implemented. Moreover, there has been very limited public discussion of this part of the Romanow report, nor has any government initiated a public study concerning the feasibility of implementing such a radically different approach to Aboriginal health.

The Romanow report also addressed some of the more contentious issues concerning the role of private funding and private delivery. On the former, the Romanow report came down firmly in favour of continued public funding for those services deemed medically necessary under the Canada Health Act, historically limited to hospital, physician and diagnostic services, and rejected the introduction of user fees or other methods of 'patient participation'. In addition, the report recommended that the boundary of Canada Health Act services be extended immediately to include a group of targeted home care services and, over time, prescription drugs.¹ Despite an earlier debate concerning the alleged benefits of introducing user fees or medical savings accounts, this recommendation, and the evidence as well as the growing consensus which stood behind it, largely dispelled the 'user fees' debate. Moreover, in 2003 and 2004, all governments formally re-stated their commitment to the principle of access to health services being based on need rather than ability to pay.^{23,36}

This result stood in stark contrast to the issue of private delivery on which debate and disagreement continue. The Romanow report recommended that a distinction be drawn between direct and ancillary health services, a distinction not accepted in the Senate report which was more supportive of expanding private-for-profit health care delivery.³¹ In a passionate foreword to the main report, Commissioner Roy Romanow argued that advocacy for expanding private-for-profit delivery of direct health services was based more on ideological predisposition and assumption than on any hard evidence of higher quality or greater efficiency relative to public and private not-for-profit modes of delivery. He also set out some of the dangers of incorporating private-for-profit incentives in a system in which the public interest should be paramount. However, because health care delivery is entirely within the constitutional purview of the provinces, it was impossible to recommend that the private-for-profit delivery of direct health services be constrained or eliminated through the Canada Health Act.¹

Since the Romanow report, a minority of provinces continue to encourage limited involvement of private-for-profit organisations in the delivery of ambulatory care, specialised surgery and advanced diagnostics. The scope of such services has remained relatively limited, particularly when compared with the private finance initiative (PFI) in the United Kingdom, in large part because of strong popular opposition in all parts of the country. The second reason is the fact that most health organisations in Canada have always been arms-length from the state, whether defined as not-for-profit private or public organisations, thus eliminating the argument that hospitals, nursing homes and other health institutions are a monopoly of the state.⁴⁰ At the same time, the interests at stake are so powerful, and the terms of the debate so confusing to the general public, that this controversy is likely to continue for years without resolution.⁴¹ Not surprisingly, the issue of private-for-profit delivery was avoided in the First Ministers' meetings communiqués of 2003 and 2004.^{23,36}

In recommending that the provincial and federal governments collaborate on a more constructive and integrated health policy agenda, the Romanow report reflected the public's fatigue with the rancorous blame shifting and fighting over intergovernmental transfers for health, the dominant theme in Canadian federalism since the late 1990s. To many, it seemed that the so-called crisis in health care was in reality a crisis in governance. Since the Romanow report, both levels of government have come together through First Ministers' meetings, invariably followed up by health ministers' meetings, to identify and resource that collaborative health agenda. The first, in February 2003, targeted primary care and home care as key reform areas but did little to change the basic governance and funding problems that posed a structural challenge to improved relations between levels of government.^{4,42} The second, in September 2004, while not pushing the health policy agenda much beyond the 2003 agreement, did finally improve the stabil-

ity and predictability of the transfer funding mechanism, thereby reducing the possibility of future dysfunctional federal–provincial conflict.

The 2004 agreement also ended speculation that the federal government might fundamentally change its role, either by removing itself (and its transfers) and leaving health care policy in the sole hands of the provinces, or by carving out a new and more direct role for itself. Instead, the federal government went with the traditional position of supporting the provinces — through a larger and more targeted health transfer — while protecting the national dimensions of the system through the Canada Health Act. As well as its traditional role in medicare, the federal government maintains responsibility for First Nations and Inuit health and prescription drug regulation.

Australian comparisons

It is tempting to draw some simple comparisons between Canada's recent health reform experience and the Australian experience, in large part because of the number of similarities between the two countries. Both countries are among the wealthiest of OECD countries and devote comparable portions of their respective gross domestic products to public health care as illustrated in Box 1. Both countries have gone through significant structural reforms to health care at the provincial/state level during the last two decades. Both countries have enormous rural and remote areas that are expensive to service and raise challenging questions concerning access and quality. Both countries have within them Aboriginal communities with third-world health outcomes which demand more culturally relevant services controlled and delivered by their own populations.^{43,44} Both countries have similar public–private funding mixes at an aggregate level, just under 70% in both cases, although they differ substantially in their allocative mechanisms and service delivery institutions.⁴⁵ And both countries have federal systems within a Westminster model of cabinet government, with a recent history of intergov-

ernmental infighting that has focused more on blame pointing and cost shifting than on a constructive agenda of national health reform.

There are important parallels between the Canadian and Australian experiences with regionalisation, including similarly stated policy goals. However, while about 60% of Australians receive health services from a regionalised public health system, a figure almost identical to the percentage of Canadians living in regionalised jurisdictions, almost all of these services do not have devolved governance, but are owned and operated as arms of state government departments of health. More importantly, unlike Canada where a clear trend towards regionalised governance and service delivery has emerged since the late 1980s, the Australian trend is towards centralisation at the state level. In both countries, however, there has been a clear trend over the last two decades away from 'atomised' hospitals and health care structures (ie, stand-alone single service institutions) with autonomous boards and management structures to organisations that are connected in their governance or policy structures through networks or hierarchies.⁴⁶

As in Canada, primary care reform has been identified as a precondition to major change within the Australian health system. Through the Divisions of General Practice initiative of the early 1990s, initiated and funded by the Commonwealth government, Australian primary care reforms were, at least initially, more dramatic than most earlier reform efforts in Canada.^{45,47} With recent changes in Canada since the Romanow report, however, particularly the governmental commitment to multi-disciplinary teams, the Canadian reforms might ultimately prove more radical. It should be noted, however, that, unlike Australia, the provinces and territories rather than the federal government are responsible for primary care reform, and this will likely create significant variations across jurisdictions.

At the time the Romanow report was being prepared, the evidence indicated that Australia had produced more innovative policies and

programs to address the equity, access and quality challenges faced by those living in rural and remote areas. The reality, however, is that both countries face persistent differences in terms of urban and rural health outcomes.⁴⁸ In addition, health reform, particularly primary care reform, is made more difficult by the degree to which rural communities in both Canada and Australia perceive their sustainability as inextricably linked with their ability to attract and retain physicians.⁴⁹

Health outcomes for Australian Aboriginals have followed a trajectory that is remarkably similar to that in Canada, but the life expectancy gap in Australia is significantly worse.⁵⁰ While improvements have been made in the post-war era, a large gap continues to separate Aboriginal citizens from the majority population. As in Canada, the Australian federal government has the primary responsibility for Indigenous health. Aboriginal health services in both countries suffer from the complexities of multiple funding sources and sometimes difficult interfaces with mainstream (state or province level) health services.

Unlike Canada, Australia has a parallel private tier of hospital and physician care. Only a minority of Australians appear to question the legitimacy of this private tier, but a lively debate surrounds the existence and size of public subsidies for private insurance that underpin this private tier of care. This debate is highly partisan, with the Liberal/National Coalition that governs the Commonwealth at odds with the opposition Labor Party as well as Labor governments, currently in office in all six states and two territories. This is in stark contrast to Canada, where all federal parties, and virtually all provincial and territorial governments, at least officially, reject the idea of a separate private tier for Canada Health Act services. However, the populations in both countries are highly polarised concerning the merits and demerits of increasing private-for-profit health care delivery.

Intergovernmental bickering over health care transfers from the federal government to the

states appears to be a prominent fact of life in Australia as it is in Canada. Indeed, the increasingly sharp debate over the level of transfers as well as jurisdiction has done much damage to the desire of the federal and state governments to collaborate constructively in the critical statecraft of reshaping this system. At the same time, however, the role of the federal government in health care is much more central in Australia than is the case for the Canadian federal government. The Australian federal government has been funding and administering a prescription drug program — the Pharmaceutical Benefits Scheme — since 1950. In addition, the federal government has been directly administering primary physician care since the early 1950s.⁴⁵

The Canadian experience also highlights the role of major studies and commissions in supporting difficult, and often unpopular, reforms to health care. While inquiries abound at the state level, in recent times Australia has not had a national arm's-length study to determine what Australians really want in terms of the future of their public health system and the values they feel should underpin this system. In its citizen engagement exercise, the Romanow Commission demonstrated how a royal commission can go beyond traditional public hearings to determine, in a somewhat more scientific manner, the difficult choices and trade-offs a national population is willing to make in order to achieve the public health care system it wants.

In Australia, there has been some discussion concerning the establishment of a national health reform commission. Such a temporary body would provide the opportunity for the general public, not just organised interests and well-funded stakeholder organisations, to shape the long-term direction of the Australian health care system based upon a revealed set of values and vision. It could also provide a neutral forum to get beyond issues of jurisdiction and commonwealth-state financing that will inevitably be part of a non-arm's-length process conducted by both levels of government.

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Competing interests

None identified.

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