Federalism-E

The Role of Federalism in Development of National Healthcare: A Comparison of Canada and Australia

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THIS PAPER WILL
DRAW EXTENSIVELY
UPON THE WORK
OF GWENDOLYN
GRAY, WHOSE
WORK ON
FEDERALISM IN
AUSTRALIAN AND
CANADIAN HEALTH
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Introduction

In many narratives of the development of the Canadian healthcare system(s), Saskatchewan's policy experimentation is a major driving force behind federal policy. Yet, this idea is not universally accepted. Gerard Boychuk questions the role of provincial experimentation, arguing "the effects of provincial innovations...were much more ambiguous in their implications for future federal reform" (Boychuk 2). Boychuk's argument is at the crux of a larger issue: the effect of provincial experimentation on federal healthcare policy. To put this question into a larger historical perspective, this paper will compare the historical development of healthcare in Canada and Australia, focusing on the role of federalism in this development. The goal of this comparison is to demonstrate how greater provincial autonomy in health policy in Canada has contributed to a relatively stable progression in federal health policy, while the centralized nature of the Australian state has contributed to one of the most tumultuous developments of national healthcare in the world. Because the history of "health policy" is too broad a subject, this paper will focus on hospital care, provision of medical services, and health insurance. From this historical comparison, one can see two major reasons that greater decentralization contributes to stability. First, it allows for provincial experimentation which helps create a national consensus on policy. Second, it reduces the stakes in federal policy, paving the way for a smaller, but more popular and stable federal role.

Canada and Australia's political, geographic, and social similarities make these two countries an obvious comparison. Both have low population densities, robust industrialized economies, parliamentary electoral systems, first nations communities, and are constitutional monarchies with ties to Britain (Huo 171). Both are federal states, but their *forms* of federalism distribute power quite differently. While Canadian provinces have a great deal of autonomy in health policy, Australia

passed a constitutional amendment in 1946 substantially impeding on state control of health. There are other differences as well, notably the role of Québec, the nature of the bicameral parliamentary systems, and the different number of major political parties. Because of these differences, this argument relies on a looser version of the 'most-similar-systems' comparative method (Huo 168). Instead of isolating one variable and showing how it affects continuity in federal health policy, this will instead show why that one variable (decentralization) is important despite the presence of other potential explanations. I will proceed by presenting the history of the development of Australian and Canadian healthcare, respectively, and then explaining what lessons one can draw about federalism from this comparison.

In Australia pre-1946, the government role in health was focused on service provision, not insurance. During this period, Australia's health policy was determined almost entirely on a state level. The major feature of the Australian system was the development of public hospitals. As hospitals and medical science improved, more people wanted hospital care, putting strain on hospital finances (Gray 53). States took the lead in solving this excess demand. South Australia and Western Australia both created two types of hospitals. "Government" hospitals still functioned for people who could not pay medical fees, and "government-subsidized" hospitals were created for people who could afford to pay fees (Gray 56). In New South Wales, the McGowan Labor government promised to introduce free and universal hospital care in 1911, but was not able to because Labor had only a slight majority. Still, New South Wales managed to implement several public services (including a maternity scheme and school medical service) and New South Wales and Victoria both established intermediate and private wings to public hospitals. Lastly, Tasmania and Queensland succeeded in nationalizing their hospitals and providing free universal hospital care (Gray 59). Before WWII,

states pursued different paths but were all generally moving towards greater government involvement in provision of health services.

In 1941, Labor came to power on a national level and began trying to increase the constitutional powers of the commonwealth. In 1946, each state approved a referendum question which “empowers the Commonwealth to legislate with respect to ‘the provision of maternity allowances widows pensions, child endowment, unemployment, pharmaceutical, sickness and hospital benefits, medical and dental services (but not so as to authorize any form of civil conscription), benefits to students and family allowances” (Gray 64). Another crucial change in federal-state relations was the effective transfer of income-tax powers from the states to the commonwealth (the Australian federal state) in 1942 (Carling 9). While the social service amendment gave the federal government the right to intervene in health policy, the change in financial powers radically limited states’ roles in developing independent policies.

The federal government was able to implement free hospital care without much political opposition even before the 1946 constitutional amendment. In 1945, the Commonwealth implemented a scheme which paid states a subsidy of six shillings per occupied bed per day if they agreed to provide free accommodation in public hospitals. (Browning) New South Wales and Victoria had reservations about the plan but they ultimately accepted the terms of the offer. During this process, state-led experimentation helped make passing this policy easier. As Gwendolyn Gray points out, “there was no radical departure from existing practice. People were familiar with the provision of free hospital care for low-income earners” (Gray 73). Also, this period illustrates how Australian health policy paralleled Canada’s before the federal government formally had power over health policy. This cost sharing agreement passed relatively easily, and even states who did not agree to the principle of free hos-

pital care, like Victoria, agreed because of financial incentives. The commonwealth’s lack of authority over the issue of hospitals limited potential federal policy to a conditional funding agreement. While this directly funded hospitals (whereas Canada funded hospital insurance), Australia’s political difficulty in implementing the hospital-benefits scheme mirrors the implementation of hospital insurance in Canada.

After the 1946 constitutional amendment, the Chifley national labor government tried to implement a free comprehensive national medical service (Browning). The Chifley government’s proposal gave the Commonwealth the responsibility of funding, providing policy direction, and the establishment of a federal health authority, and left implementation to the states (Gray 77-78). Ultimately, the Commonwealth could not reach an agreement with the (Australian Branch of the) British Medical Authority (BMA), who were staunchly opposed to this plan. Gray notes that “the plan for a national health service was an extension and expansion of policies and ideas that had seriously developed in the more innovative states” (Gray 81). So, in 1946-7, when the days of state experimentation were still relatively recent, and relevant to the current system, the Commonwealth looked to old attempts at policy experimentation within states. One of the reasons that this proposal failed could be that no state was able to establish a comprehensive medical service. While they created momentum for state intervention in the provision of services, state policy experimentation had not yet succeeded in familiarizing the public with a National Health Service.

In 1949, a Liberal-Country coalition government led by Robert Menzies came into power. They were aligned with the BMA and ideologically opposed to Labor’s vision for healthcare. The Menzies government introduced a plan for subsidized voluntary insurance. To create demand for private insurance, they eliminated subsidies to hospitals based on the previous hospital care plan. Every state except for Queensland was unable or unwill-

Federalism-E

ing to maintain free hospital care (Gray 93). This dramatic reversal of policy begins to show how the more centralized federalism post-1946 contributed to instability in health policy. In this instance even free hospital care, which grew out of state experimentation and encountered little political opposition, was not safe from reversal. The new division of power in health and financing gave the Commonwealth the ability to implement an entirely different vision of health policy without any meaningful opposition from states (Gray 95).

In 1972, the Whitlam labor government came into power and reversed course again. The Whitlam government introduced a universal compulsory insurance program administered by a statutory authority, Medibank. (Gray 135) The (now) Australian Medical Association (AMA) focused on defeating the bill in the Senate because Labor only had a majority in the House. After two rejections in the Senate, the government called a joint sitting of both Houses, and the "Health Insurance Bill and the Health Insurance Commission Bill" passed. The Commonwealth also pressured states into accepting a joint hospital financing agreement. It is notable that the Whitlam government introduced a bulk-billing scheme for paying doctors, which was imported from Saskatchewan. One can see that when states lost the financial and constitutional power to experiment, the Commonwealth turned to Canada for ideas in health policy (Gray 134).

The next two changes of government had similar results. The Fraser government (non-Labor) was elected in 1975. Since Medibank had only been operating for a brief period of time, Fraser dismantled it relatively easily. Fraser's government restricted federal benefits to those with private insurance, and established schemes

for pensioners, poor people, and those eligible for sickness benefits (Gray 150). Then, in 1982, the Hayden labor government essentially reintroduced Medibank with minor changes. In this entire process, the will of states was basically irrelevant. As Gray puts it, "compared with their Canadian counterparts, the states appear to accept federal domination as inevitable." However, since the Hayden government's Medicare plan, Australian health policy has not encountered any major shifts in its fundamental principles (Gray 151).

In Canada, prior to WWII the federal government had little involvement in healthcare. Eastern and Central provinces were also not particularly involved in the provision or funding of health services potentially due to higher levels of philanthropy and greater population density (Gray 27). Western provinces on the other hand were active at this time. In 1932, the Cooperative Commonwealth Federation (CCF) formed, and advocated free access to health services. The CCF pressured the Saskatchewan liberals to introduce health insurance legislation in 1944. Alberta was actually the first province to *pass* a health insurance bill (1935), but the act was never implemented. In Manitoba, a committee recommended a mix of insurance and directly provided services. In British Columbia, health insurance legislation was introduced several times and a report recommended compulsory insurance for people with incomes below \$200 per month. While none of these initiatives resulted in a comprehensive healthcare scheme, they did generate public support for some sort of scheme in the future (Gray 29).

Support for the CCF increased as public opinion shifted left during WWII (Gray 93). This pushed the Liberals and the (newly named) Progressive Conserva-

tives to address the issue of health and social policy. While the liberal Prime Minister at the time, William Lyon Mackenzie King, nominally supported increased social services, the cabinet member most committed to national health insurance was Ian Mackenzie. Mackenzie helped establish the Heagerty Committee, which in 1943 produced a report recommending universal compulsory health insurance and federal-provincial cost sharing (Gray 31). The Mackenzie government decided to drop attempts at health insurance legislation in 1944 as a result of electoral concerns (Taylor 53). While the federal government would not attempt a major health insurance policy again until 1955, in 1945 every major party platform included health insurance plans, and public support for a national plan was at 80% (Gray 32).

From 1944 to 1955, provinces were active in introducing hospital insurance policy. The Saskatchewan CCF led by Tommy Douglas won the 1944 provincial election. Tommy Douglas campaigned on free universal comprehensive healthcare. Because of strong opposition by the Saskatchewan College of Physicians and Surgeons and limited finances, though, the CCF began with a more modest hospital insurance plan. This policy was relatively uncontroversial, yet it was cited in the Hall Commission as a "testing ground for the solution of many problems associated with universal coverage and administration in a government body" (Gray 35). British Columbia and Alberta followed with hospital insurance plans in 1948 and 1950, respectively. Unlike British Columbia and Saskatchewan, Alberta's plan involved 50-50 cost sharing between municipalities, and had less comprehensive coverage. These provinces studied Saskatchewan's system for inspiration. These innovations came with high costs, and provincial pressure for a national hospital insurance plan to ease

the financial burden of universal hospital care increased (Goffman 6). This also demonstrated the high public support for provincial hospital insurance, as premiers focused on making hospital insurance a smaller financial burden instead of turning against the principle of universal hospital insurance. In 1957 the federal government introduced a hospital insurance plan based on the principle of cost-sharing, and began to sign individual agreements with provinces. The House voted 165-0 to implement the hospital insurance plan, and parliament erupted in applause, potentially showing the strong public support (Gray 37).

With a smaller hospital insurance burden facing provinces, it became possible to consider comprehensive national medical insurance on a provincial level. Medical insurance was more controversial, though, since it altered the remuneration of physicians and required agreement from the Canadian Medical Association (CMA). Nevertheless, Tommy Douglas announced a medical insurance plan in Saskatchewan in 1959 (Gray 39). The CMA strongly opposed such a plan, and “the provincial election of 1960 was virtually transformed into a referendum on the proposed scheme” (Gray 40). The CCF won a majority of seats, and proceeded to implement a universal medical insurance program. The government and the CMA were initially unable to come to an agreement, and most physicians in the provinces withdrew non-emergency care. However, as public opinion turned against the physicians, the two parties were able to come to the bargaining table and agree to a medical insurance program (Gray 41). Other provinces implemented rival medical service plans in the aftermath of Saskatchewan’s adoption of universal medical insurance. Alberta introduced an income-based subsidy of private insurance. Ontario and British Columbia introduced public insurance plans which would be subsidized for low income per-

sons (Boychuk 6). Québec also supported a policy of subsidized voluntary insurance for low income-persons (Boychuk 8). Boychuk rightfully points out that Saskatchewan’s system of medical care insurance was in the minority, but the implications of this for the general argument must be further explored.

A number of conditions facilitated the process of implementing Medicare on a national level. The new Liberal leader, Lester Pearson, supported medical care for all Canadians. Also, the CMA, trying to slow down the implementation of Medicare in Saskatchewan, called for a government inquiry into healthcare. This resulted in the Hall commission, which ironically recommended the establishment of provincially administered health insurance funds financed by general revenue (Gray 42-43). Despite opposition from the CMA, Québec and Ontario, and the minister of finance Mitchell Sharp, the House passed the Medical Care Act by a margin of 172-2 in 1966. The Medical Care Act was essentially a cost-sharing agreement conditioned on provincial implementation of universal medical-insurance plans. The CMA then focused its efforts on provinces which still had to agree to the federal plan, but each province eventually approved to the federal government’s terms. As shown in both Canada and Australia, cost-sharing provides powerful financial incentives for provincial acceptance of federal agreements (Gray 45).

Québec’s decision to eventually agree to the terms of Medicare is particularly interesting for studies of provincial experimentation. When the liberal government passed Bill 8, effectively accepting the federal offer, they included a concession for physicians: up to 3% of physicians within each specialty and 3% of general practitioners could opt out of the public health insurance system. This

compromise failed to satisfy the Québec specialists, and three quarters of them left the province in protest. The government soon ordered them back to work, though, during the Front de libération du Québec crisis (Taylor 172). In the aftermath of this fiasco, Québec actually gained more control over medical fees than originally proposed and (at least nominally) banned fees at the point of service (Gray 47). This policy experimentation laid the groundwork for the Canadian Health Act, which (among other things) banned user fees and extra billing. Gray points out that pro-reform activists specifically referred to Québec’s system as the one they wanted implemented in all of Canada (Gray 118). As with Saskatchewan’s demonstration that medical insurance and hospital insurance would not destroy the system, Québec showed the same for user fees and extra billing.

The first pattern in this historical development is that Canadian federal health policy has been based on provincial experiments in healthcare, while Australian federal health policy has been based on foreign experiments. As mentioned, Canadian federal hospital insurance and medical insurance both resembled Saskatchewan’s policy experimentation. The Canadian Health Act’s ban on extra billing was facilitated by prior experimentation by British Columbia and Québec (Taylor 173). Australian federalism also resembled this pattern before 1946. Before the constitutional amendment, the federal hospital care plan was based on free hospital care in Tasmania. After the constitutional amendment, Australian federal developments in health policy did not resemble state initiatives, as states had little resources to experiment with. In fact, Australia’s national health insurance program borrowed its billing scheme directly from Saskatchewan.

Federalism-E

This difference logically contributes to the difference in the continuity of Australia's and Canada's health policy development processes. The public and policymakers are much more likely to support a policy that has proven effective within the *same* country than one that is effective in foreign experiments. It was very difficult for physicians or opposition parties to convince the public that Medicare could not work after it proved effective in Saskatchewan. As a result, public support for Hospital Insurance, Medicare, and banning extra billing in Canada was high. This pattern thus demonstrates that provincial experimentation can

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contribute to stability by generating support for federal programs that have proven effective at a sub-federal level. The second pattern in this historical development is that greater federal power facilitates policy reversal. Centralization actually made it more difficult for the Australian Commonwealth to institute popular, lasting health reform. The Commonwealth was involved directly in implementation and details, unlike the Canadian federal government which gave conditional funding to provinces. Gray explains that in Canada "federalism gave the central government an opportunity to take highly popular policy action to defend universal insurance without incurring the

political costs of implementation that fell to the provinces" (Gray 104). The political consequences of the federal government's involvement in health are thus higher in Australia, and the Australian Commonwealth simply has the power to implement system-wide change rapidly. Federalism (generally) exists to lower the stakes of extremely contentious (or even irreconcilable) federal politics, while letting sub-national units make controversial decisions independently. Canada's more decentralized version of federalism thus contributed to stability in federal health policy, whereas Australia's more centralized version facilitated multiple policy U-turns.

Boychuk claims that Saskatchewan's medical insurance plan created backlash or "negative feedback" which negated the positive effects of the policy on the prospects of a federal universal health insurance bill. He first claims that the CMA became stronger in its opposition after Saskatchewan's medical insurance plan. The CMA had long been opposed to this sort of policy, though, and it is obvious that they would react strongly when a government actually succeeded in passing it. At some point in the development process, the CMA inevitably had to react this way. Next, he argues that other provinces responded with different plans, and Saskatchewan's plan was actually in the minority. (Boychuk 6) However, the demonstration effect was actually *more effective* as a result of this. The other provinces provide an easy point of comparison for Saskatchewan's policy. For example, while Saskatchewan's policy was universal, the Hall Commission noted that "at the end of 1963, some 628,290 of Alberta's estimated population of 1,398,000 were insured" (Royal Commission on Health Services v. 1 395). Hall Commission could obviously tell which plan best achieved

universality; it was not a random choice. Finally, Boychuk notes that the Saskatchewan medical service plan showed federal policymakers that any federal plan would be subject to intense opposition from physicians. (Boychuk 8) However, as Saskatchewan's developed further, this opposition was shown to be less reasonable. In Boychuk's main example against a progressive provincially-led healthcare development, he erroneously over-magnifies the "negative feedback" from Saskatchewan's plan.

Other explanations for these developments cannot convincingly deny the role of federalism in different policy development. Some may argue that the AMA was substantially stronger than the CMA, but a major reason that the CMA was not as strong in Canada is public support. This public support is partially a function of provincial experimentation, which familiarized and popularized people with new health policy. The strong cultural differences between English-Canada and Québec could only logically make the system in Canada *more* unstable, so this is not a difference that could explain the tumultuous development of health policy in Australia. Also, while Australia did not have a third party like the CCF/NDP to push reform, Labor placed healthcare on the agenda in the same way as the CCF (Gray 51). Lastly, while Australia has a true bi-cameral system, the only time this was a potential problem (Whitlam's Medibank), Australia combined both houses in a joint-sitting and it was overcome (Gray 138).

Conclusion

This historical comparison supports the idea that provincial experimentation and the federal distribution of power in Canada truly was a driving

force in the road up to Medicare and the Canadian Health Act. However, one should be cautious in generalizing the conclusions of this study. The differences in policy development were determined by multiple factors, not *just* differences in federalism. Also, Australia's multiple policy reversals are an extreme example of what can happen. Still, this comparative analysis shows how decentralization can contribute to the development and progression of health and social policy.

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