Romanow in Retrospect
An Analysis of the Royal Commission on the Future of Health Care in Canada

by

Colin Dean Murdock
BA, University of Victoria, 2003

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Abstract

This thesis examines the Royal Commission on the Future of Health Care in Canada (Romanow commission), in particular the ways in which the commission deviates from previous public inquiries. The paper surveys the literature on royal commissions to identify common attributes of commissions and explore the dimensions along which public inquiries vary.

By identifying the dimensions of variation, it becomes possible to conduct an assessment of the Romanow commission according to each dimension. The thesis is framed by an assessment of each dimension. The product of this analysis is a clear understanding of the ways in which the Romanow commission differs from its predecessors.

The thesis identifies three dimensions in which the Romanow commission is unique: it is the first national commission in nearly forty years with a major social policy as its focus; its emphasis on public consultation exceeds recent commissions; and the long-term advocacy role assumed by its chair.

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Acknowledgements

This paper is the product of countless iterations. I began the process of writing, knowing that this was an important story, but was uncertain about the best way to tell it. I think we finally got it right.

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For Keeley.

For all the times I said, "I am almost finished."

Introduction

Symbols of Identity: Health Care and Public Inquiries in Canada

Call it Medicare

It is contentious, expensive, divisive, yet unifying. It inspires the most impassioned political battles. It is a seemingly apolitical, innocuous, public good. Yet it has dominated the Canadian political agenda for more than a decade. As a symbol of Canadian identity it stands next to the beaver and maple leaf.[1] In the United States, some disparagingly call it socialized medicine, while others present it as the goal reformers should be pursuing. In Canada, it is known simply, if mistakenly, as Medicare.

Canada's system of public health insurance developed over a twenty-year period, from 1947 to 1968.[2] Since its inception, it has inspired countless studies and reports. The patchwork of jurisdiction and financing that supports the system has been modified, altered, and re-arranged; yet, still it stands. Canadians are constantly concerned with the health of their health care system and any indication that it is ailing re-ignites the decades-old campaigns for higher spending or reform.[3]

In the mid-1990s, as federal deficits reached historic levels and the government in Ottawa applied spending cuts and budgetary freezes across the board, public opinion polls began showing health care as the number one concern among the electorate. As the decade drew to a close, politicians were feeling mounting public pressure to respond to concerns that the health care system required immediate action.

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[1] An Environics Research Group survery of 2,002 Canadians on Canadian identity (conducted March 15-23, 2003) found that health care was "more important to Canada's identity" than bilingualism, multiculturalism, and the *Charter of Rights and Freedoms*. Jack Jedwab and Chris Baker, "Canadian Identity: Bilingualism, Multiculturalism, and the Charter of Rights." Association for Canadian Studies. Montréal: 2003. http://www.acs-aec.ca/Polls/Poll38.pdf

[2] 1947, the year in which the Saskatchewan CCF government introduced public hospital insurance, is usually cited as the first instance of public health insurance in Canada.

[3] Health care has consistently ranked at the top of the list of concerns among the Canadian electorate for nearly a decade.

Romanow Commission

Several provincial governments responded to the public pressure by creating task forces and commissions of inquiry to examine health care within their respective jurisdictions. The federal government appointed the Royal Commission on the Future of Health Care in Canada on April 3, 2001. Roy Romanow, the former premier of Saskatchewan, was appointed to chair the commission. Romanow was given eighteen months in which to research, investigate, hold public consultation sessions, draw upon expert advice, and submit a final report of recommendations to the government.

The Romanow commission is an interesting example of a public inquiry for multiple reasons. First, as the first federal royal commission to study public health insurance since Emmett Hall's second inquiry two decades prior, the Romanow commission received significant public and media attention. Second, the commission's decision to conduct dozens of public consultation sessions across the country bore a striking resemblance to a political campaign and received the kind of media coverage usually reserved for that kind of event. Third, health care had remained at the top of the list of concerns among the electorate for nearly a decade, which created a climate of high expectation among Canadians. Long after the first ministers had reached agreements arising from the recommendations contained with the final report, Roy Romanow continued to travel the country giving lectures and appearing on panels to discuss the "state of health care in Canada."

Dimensions of Variation

Royal commissions rarely resemble one another. The conduct of commissions tend to vary from one to the next. The literature on royal commissions does not offer a prescribed formula for commission conduct. However, an analysis of the literature reveals the various dimensions along which public inquiries vary. Though, certainly, there is no one way of conducting an inquiry, the literature also suggests that commissions tend to possess some similar attributes.

By identifying the dimensions along which commissions vary, it becomes possible to conduct an assessment of the Romanow commission according to each of these dimensions. This assessment enables an analysis of the aspects of the Romanow commission that are unique and those that are similar to previous royal commissions. The thesis is framed by an assessment of each of these dimensions. The product of this analysis is a clear understanding of the ways in which the Romanow commission differs from its predecessors.

The Plan of the Paper

The paper poses three questions that inform the analysis of the Royal Commission on the Future of Health Care in Canada: First, what are commissions of inquiry and what are the dimensions along which they vary? Second, what was the Romanow commission and why was it established? Third, what are the dimensions along which the Romanow commission varies and in what ways is it unique?

The first chapter discusses the arrangements that produced a public system of health services in Canada and the set of factors that led the Chrétien government to turn to a commission for advice. The discussion will explore the genesis of health care, the

fiscal obligations and conditions for involvement by the provincial and federal governments, the fiscal "crises" and spending adjustments of the 1970s and 1990s, and the renewed commitments of the new millennium.

The second chapter surveys the literature of royal commissions and identifies the various attributes of public inquiries. The second section of the chapter will identify the dimensions along which inquiries vary. The final section will begin to assess the Romanow commission according to the dimensions of variation.

The third chapter is concerned with the recommendations of the Romanow commission. The first section of the chapter discusses the content of the commission's report, including the Health Covenant, Health Council of Canada, "Modernizing" the *Canada Health Act*, Canada Health Transfer, Canada Health Infoway, funding for Health Care Providers, and the creation of Aboriginal Health Partnerships. The second portion of the chapter will explore the public and political reception the report received upon its tabling. The final section of the chapter explores the post-commission activities of the commissioner during the initial weeks in which the report was submitted.

The fourth chapter discusses the potential policy legacy of the commission and Romanow's involvement in the policy debate. This chapter will include a discussion of the post-commission intergovernmental conferences and agreements, and the legal decisions, policies, and programmes that have occurred since the last meeting of the first ministers.

The conclusion identifies the ways in which the Romanow commission is unique and situates the commission according to the eight dimensions of variation. The conclusion reiterates the findings of the thesis by identifying the three dimensions in

which the Romanow commission is unique. First, the Romanow commission is the first national commission in nearly forty years with a major social policy as its focus. Second, the commission places an emphasis on public consultation that exceeds recent public inquiries. Third, the long-term advocacy role assumed by its chair is unlike any previous inquiry.

Chapter One

Road to Romanow: The Development of Public Health Care in Canada

Introduction

The Royal Commission on the Future of Health Care in Canada was appointed by Prime Minister Jean Chrétien in April 2001 to assess the strengths and weaknesses of the Canadian health care system. The final report of the Commission, entitled *Building on Values: The Future of Health Care in Canada*, contained forty-seven recommendations for reforming the Canadian health care system. The thesis will explore the conduct of the Romanow commission and the content of its final report, with an emphasis on situating the royal commission among previous inquiries and identifying the aspects in which it is unique. This chapter documents the development of the system of public health insurance and the decisions and agreements which contributed to the creation of the Romanow commission.

In this chapter we will examine the development of the public health care system to illustrate the roles of the federal, provincial, and territorial governments in the field. Canada's system of public health insurance is not a broad national programme like the National Health Service in Britain. The system Canadians call "Medicare" is actually a patchwork of fourteen autonomous systems, which provide public health services in each jurisdiction across the country. The unifying force behind the system is one piece of federal legislation, the *Canada Health Act*. The first section of this chapter describes the genesis of the public health insurance system. It then examines the conditions that, in the late 1990s, led the Chrétien government to conclude that a royal commission was needed.

Jurisdiction and Responsibility

Canada is a union of ten provinces and three territories. Each provincial government has exclusive powers within its own jurisdiction, as established in section ninety-two of the *Constitution Act, 1867*. Section ninety-one of the *Act* assigns exclusive responsibilities to the federal government.[4] However, jurisdictions cannot be "water tight compartments." The governance of society and functions of the state create opportunities for the jurisdiction of one government to conflict with the other. The management of these opportunities requires an intergovernmental partnership, wherein Ottawa, the provinces, and territories can coordinate their functions to avoid further conflict. In 2000, then Intergovernmental Affairs Minister Stephane Dion described federalism, the system under which intergovernmental relations occurs, as "a system in which two orders of government possess constitutional powers. Each order of government is sovereign within its own legislative sphere, in the sense that the Constitution recognizes it as the only one empowered to legislate in that sphere."[5]

The Canadian union depends upon federal-provincial coordination. The core coordinating mechanism is the first ministers' conference, in which the Prime Minister and the premiers convene to discuss the coordination of state services, finances, and policy objectives. Since the Second World War, first ministers' conferences have become the staple of intergovernmental relations. As Richard Simeon notes, "activities of each level of government often overlap; actions by one level can have major consequences for

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[4] Provisions of the *Constitution Act, 1867* are subject to amendment.
[5] Stephane Dion, Intergovernmental Affairs Minister, Government of Canada, 2000. "Governmental Independence in Canada" address to the Canadian Study of Parliament Group Conference, June 11, 2000.

policies of the other."[6] The first ministers' conference is important because "coherent policies in fields which cut across jurisdictions, or in which the policy instruments to deal with them are shared, can only be achieved if there is some degree of coordination, or of collaborative decision-making."

First ministers' conferences often centre on financial arrangements, bringing core constitutional realities to the forefront. The *Constitution Act, 1867* establishes the power of the federal government to raise revenues by any mode or means. Provincial governments are restricted to the collection of revenue through direct taxation. The federal government has been given the "lion's share" of revenue-raising jurisdiction without the accompanying responsibility for large policy fields. The responsibilities for education and the provision of health services, which have become the most expensive areas of responsibility, are assigned to the provinces.[7] The framers of the Constitution did not forecast the shift and growth in responsibilities which occurred as Canada entered the post-World War I era.[8] The burden of financial responsibility became greater for the provinces, which found their finances severely stretched during the Great Depression.

The fiscal crisis of that period spurred the federal government to seek a remedy to bridge the gap between provincial responsibilities and available revenue. It turned to a Royal Commission on Dominion-Provincial Relations, known as the Rowell-Sirois commission. The commission tabled its final report in 1940. The report contained

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[6] Richard Simeon, "Intergovernmental Relations in Canada Today: Summary of Discussion," *Confrontation and Collaboration: Intergovernmental Relations in Canada Today*. Richard Simeon, ed. Toronto: Institute of Public Administration of Canada, 1979. 4.

[7] Ottawa retains responsibility for marine hospitals and the provision of medical services to the armed forces, veterans, RCMP, and aboriginal peoples.

[8] Donald Smiley, *Canada in Question: Federalism in the Eighties*. Toronto: McGraw-Hill Ryerson, 1980. 19.

recommendations for the transfer of total revenue collection to the federal government, which would then share the revenues with the provinces using a formula for equalization. The recommendations were discussed at a first ministers' conference in January of 1941. The conference was promptly adjourned without agreement. Among the many reasons for its failure, several provinces were not comfortable with many of the report's recommendations, which would expropriate many provincial powers to Ottawa and require constitutional amendments.

In spite of the objections of the first ministers, several of the commission's recommendations reappeared in post-war federal-provincial arrangements. As the two orders of government coordinated the delivery of an increasing number of state services, many of the intergovernmental partnerships that facilitated the development of the services were not unlike the recommendations of Rowell-Sirois. Following the end of the Second World War, Ottawa reached an agreement with the provinces to implement a method of equalization for "have not" provinces, which fell under the economic standards achieved by the "have" provinces. Similarly, the period saw the development of cost-sharing programmes as governments began to play a larger role in the provision of services. Cost-sharing programmes were developed in the 1950s to assist the provinces with social assistance and social services, universities, and medical services.

The issue of fiscal arrangements between the two levels of government has been revisited since the report. Direct taxation, to which the provinces are entitled under the Constitution, is a means of generating revenue through taxation of the income of each citizen. The Second World War created an opportunity for the federal government to assume control over income taxation, so that it could generate revenues to finance its

massive wartime foreign obligations. Until 1962, Ottawa retained exclusivity over income taxation. During the post-war period, the federal government paid the provinces a tax "rental." The payment was equal to, or greater than, the revenue each province could have generated using its own taxation of income.[9] The tax "rental" system allowed Ottawa to distribute funding across the country, working with the provinces to create consistency in the delivery of services in every jurisdiction. The exclusive powers of income taxation meant that provincial partnership with Ottawa in policy implementation was a necessity.

Ottawa's capacity to raise revenues and distribute funding is called the federal spending power. The federal spending power is defined as "the power of parliament to make payments to people or institutions or governments for purposes on which it (parliament) does not necessarily have the power to legislate."[10] Social assistance, education, and medical services, are all assigned to the provinces under section ninety-two of the *Constitution Act, 1867*.[11] Social assistance, education, and medical services are large fields of responsibility. Funding these fields requires an enormous amount of revenue. During the post-war period, the provinces were limited in their capacity to finance the large fields of responsibility. The federal spending power became the means by which the responsibilities were funded. Through an agreement with the provinces, Ottawa transferred funds to be allocated into the identified policy areas.

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[9] E.R. Black, *Divided Loyalties: Canadian Concepts of Federalism*. Montréal: McGill-Queen's University Press, 1975. 69.

[10] *Federal-Provincial Grants and the Spending Power of Parliament.* Government of Canada, 1969. 4. Quoted in Hamish Telford, "The Federal Spending Power in Canada: Nation-Building or Nation-Destroying?," *Working Papers 1999*. Kingston: Institute of Intergovernmental Relations, Queen's University, 1999.

[11] See footnote 7.

Usually the transfer of funds is accompanied by federal guidelines for spending. Ottawa justifies the use of the guidelines with claims concerning the importance of national standards. In 1969, Ottawa argued that the spending power was important "because the people of Canada will properly look to a popularly elected Parliament to represent their national interests, [therefore, Ottawa] should play a role with the provinces, in achieving the best results for Canada from provincial policies and programmes whose effects extend beyond the boundaries of a province."[12] Even though Ottawa does not retain jurisdiction, the spending power provides a method by which the federal government can retain discretion over policy spending. It is through the federal spending power that Ottawa acquired partnership status in policy development.

Genesis of Public Health Care

The Saskatchewan general election of 1944 brought the Cooperative Commonwealth Federation (CCF, the forerunner to the New Democratic Party) to power. Public health care was a central plank in the party platform since the party was created in 1933. The *Regina Manifesto,* the founding document of the CCF, states:

> Health services should be made at least as freely available as are educational services today. But under a system which is still mainly one of private enterprise the costs of proper medical and dental care which would stress the prevention rather than the cure of illness should be extended to all our people in both rural and urban areas.[13]

In 1947, the Saskatchewan CCF government implemented a provincial system of hospital insurance. The following year the federal government introduced the National Health Grant, to assist the province in financing a publicly funded hospital

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[12] *Federal-Provincial Grants and the Spending Power of Parliament*, 34.
[13] *Regina Manifesto*, the founding Constitution of the Cooperative Commonwealth Federation. Adopted at the First National Convention, Regina, Saskatchewan. July 19-21, 1933.

insurance project.[14] In 1949, British Columbia utilized the Grant to create a system of insurance modeled on the Saskatchewan system.

In 1957, Ottawa passed the *Hospital Insurance and Diagnostic Services Act* (HISDA). HISDA was designed to regulate cost-sharing agreements with the provinces. Arrangements, under the *Act*, were modeled on those for funding social assistance programmes, social services, and post-secondary education. HIDSA provided for the equal sharing of hospital expenses by the federal and provincial governments, making funding available to any province that agreed to observe certain standards. Ottawa matched the provinces dollar for dollar on hospital and diagnostic services expenditure.

By 1961 every province had "opted into" the new programme. The New Democratic Party (NDP, formerly the CCF) government of Saskatchewan had expanded its hospital insurance coverage to full public medical insurance with the introduction of the *Medical Care Insurance Act* of 1962.[15] The public medical insurance plan included compensation of physician services. In 1966, Ottawa introduced the *Medical Care Insurance Act* (MCIA). The *Act* brought larger areas for public investment in the health sector, including the compensation of physician services. Again, the new legislation called for equal sharing of costs with provinces that agreed to "opt into" the programme. Ottawa's commitment to match the provinces dollar for dollar on medical services was contingent upon the principles of universality, comprehensiveness, portability, and public administration. Unlike HISDA, MCIA did not require unanimity for implementation. Upon the launch of the new programme, in July of 1968, only Saskatchewan and British Columbia had reached agreements for participation with Ottawa.

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[14] Antonia Maioni and Miriam Smith, "Health Care and Canadian Federalism," *New Trends in Canadian Federalism.* François Rocher and Miriam Smith, eds. Toronto: Broadview Press, 2003. 301.
[15] Ibid.

The MCIA was the product of the recommendations of the final report of the Royal Commission on Health Services, chaired by Justice Emmett Hall. In 1961, Hall had been asked to chair a royal commission with a mandate to explore possible expansion of publicly funded medical services. The Hall report recommended publicly funded, universal insurance not only for doctors' services but also for prescription drugs and home care. These would be in addition to the hospital and diagnostic services already covered under HISDA. The commission recommended that cost sharing should be contingent upon provincial governments committing themselves to observe the principles of universality, comprehensiveness, portability, and public administration.

Fiscal Arrangements, Crises, and Restraint

In 1962, Ottawa discontinued its tax "rental" arrangements with the provinces. Instead of exclusively generating revenues through income taxation and distributing funding to every province, Ottawa created "tax room" for the provinces to generate their own revenues. The federal government introduced the *Federal-Provincial Fiscal Arrangements Act*, which reduced Ottawa's level of taxation of personal income, corporate income, and estates. In exchange, the provinces were invited to establish their own levels of taxation in the income tax field. The *Federal-Provincial Fiscal Arrangements Act* of 1966 gave Ottawa the flexibility of calculating "tax points" into its provincial transfers. The "tax points" were invitations for the provinces to assume abandoned federal "tax room" by increasing their income taxation levels. This created a means by which Ottawa could reduce its "cash" transfer while still maintaining its fifty per cent commitment to programme spending. As "cash" transfers were reduced, "tax points" were increased.

The late 1970s ushered in an era of what could be described as a "fiscal crisis." At the end of the decade, Canadians were witnessing double-digit rates of unemployment and interest. Table 1.1 shows the sharp increase in unemployment rates during the late 1970s and early 1980s. Table 1.2 shows the dramatic rise in interest rates that occurred during the same period. The dual pressures of high unemployment and high interest rates created poor economic conditions that led to falling levels of revenue for federal and provincial governments. Governments were dependent upon economic growth for spending. Slumping economic growth created revenue shortages, meaning that governments would have to incur deficits to pay for state services. Several years of budgetary deficits created rapid debt accrual for both federal and provincial governments.

Table 1.1

Source: Centre for Study of Living Standards

Table 1.2

Source: Rosmy Jean Louis
Department of Economics, University of Manitoba

In 1977, the federal government responded to the fiscal crisis by attempting to reduce government expenditures. Ottawa introduced the *Established Programs Financing Act* (EPF), aiming to consolidate all federal-provincial cost-sharing and transfer programmes in the new arrangement. EPF became a mechanism for Ottawa to transfer funds to the provinces and territories for social assistance programmes and services.

EPF terminated the cost-sharing basis of the previous health care arrangements, introducing block grants to the provinces and territories, the size of which would be determined by the federal Ministry of Finance. The block transfer system allowed Ottawa to "cap" its expenditure in health and education spending. The matching grants programme, under which social assistance, social services, and post-secondary education had been funded, gave the provinces and territories full discretion over spending levels. Each province and territory had been able to spend an almost unlimited amount in a policy area and Ottawa would match the expenditure dollar for dollar. EPF brought that system to an abrupt end. The block transfer froze the federal contribution, so that Ottawa's share of funding was no longer contingent upon provincial and territorial expenditure. In reducing the "cash" transfers to the provinces and territories, Ottawa argued that the transfer of "tax points" maintained its level of commitment[16]

The 1977 budget changed Ottawa's status as a partner in funding. Ottawa was no longer prepared to be an equal partner in financing programme delivery. The capping of transfers disengaged the federal financial obligation of matching dollars, which shifted a greater share of financial responsibility onto provincial and territorial governments. The provinces and territories, themselves facing fiscal crises as a result of the same economic conditions crippling the federal budget, would have to manage their own fiscal expenditures without the matching dollars from Ottawa.

Table 1.3 shows the swift decline in the federal share of cash transfers to the provinces and territories for health expenditure. In 1977, the year EPF was introduced,

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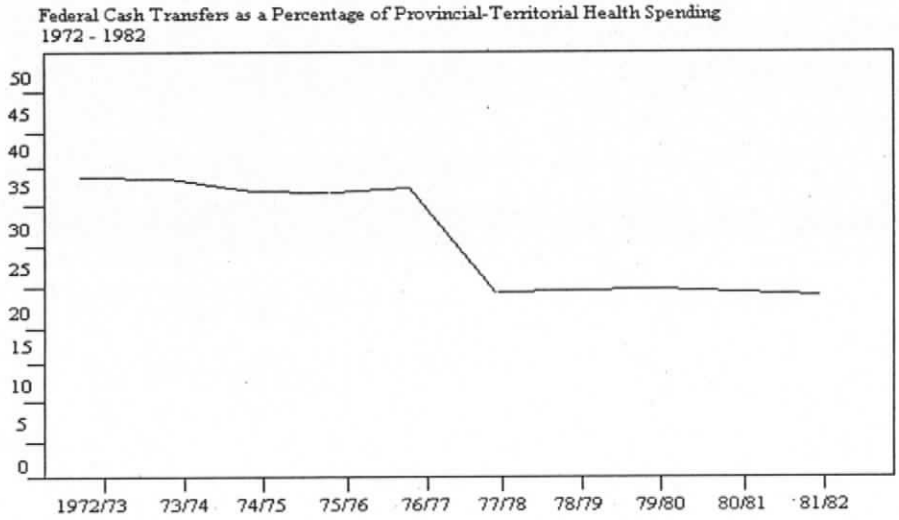
[16] "Tax points" are something of a fiscal phantom. Offering "tax room" to the provinces and territories amounts to a recommendation for a tax increase. "Tax points" came to prominence in 1962 with the *Federal-Provincial Fiscal Arrangements Act*, which was rescinded and replaced with the *Federal-Provincial Fiscal Arrangements Act,* RSC 1985.

the federal cash transfer dropped by almost fifteen per cent from the previous year. Table 1.3 demonstrates the fiscal advantage reaped by Ottawa. The savings for Ottawa amounted to billions of dollars annually.

Table 1.3



Source: Finance Canada

Canada Health Act

In 1979, the federal government of Joe Clark asked Emmet Hall, author of the 1961 royal commission report on medical services, to review the system of public health insurance and propose recommendations for changes. The next year, Hall submitted his report, entitled *Canada's National-Provincial Health Program for the 1980's: A Commitment for Renewal*. The report found that many physicians were charging additional fees-for-service. British Columbia, Alberta, and Ontario had all developed health policies that charged "premiums" for the use of medical services. "Extra-billing" by physicians and provincial health care "premiums" created a means for provinces to bolster resources without increasing taxes to compensate for the transfer shortfalls generated by the EPF.

Then Ontario Health Minister, Frank Miller suggested that the "premiums" saved his province over a billion dollars a year.[17] The 1980 Hall report recommended the abolition of "premiums" and "extra-billing."

In 1984, Ottawa changed the rules of public health care administration. Without consulting with the provinces and territories, Ottawa introduced the *Canada Health Act* (CHA). The CHA rescinded the *Hospital Insurance and Diagnostic Services Act* and the *Medical Care Insurance Act*, creating new "stand-alone" federal legislation governing health administration. The CHA prohibits "extra billing" and enshrines the four principles upon which Ottawa's participation was contingent in 1966: universality, comprehensiveness, portability, and public administration. The CHA added a fifth principle, accessibility, to reflect the changes prohibiting "extra billing."[18] The CHA became the enforcement mechanism in disputes with provincial and territorial governments over health spending and administration. The *Act* did not restrict the charging of provincial health "premiums," which the Hall report had recommended. Provinces and territories could continue to institute "premiums" for health services.

The *Canada Health Act* made federal funding contingent upon adherence to the five principles. Health Canada, under the auspices of the federal Health Minister, was given the jurisdiction of interpreting the five principles of the CHA. Overseeing the development of provincial and territorial health policy, Health Canada could review the terms for administration and service delivery. If a provincial or territorial government is found in breach of one of the five principles of the CHA, a fine is levied against that government.

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[17] "Canadians react to Emmet Hall's health services review," CBC News Archives. September 7, 1980.
[18] *Canada Health Act* (R.S. 1985, c. C-6), sections 8 to 12.

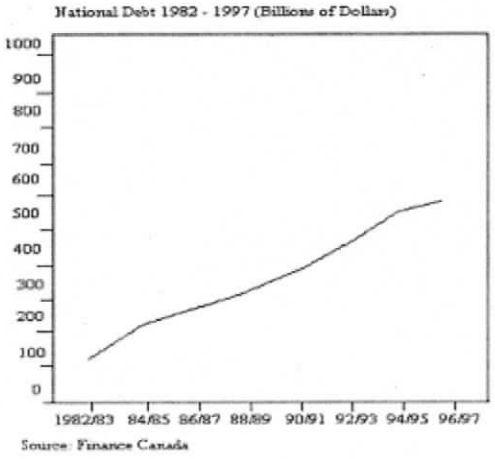
The unilateral federal assumption of authority to interpret and enforce the five principles of the CHA became a lightning rod for intergovernmental conflict. The provinces and territories, shouldering the largest share of health care funding, rallied against the idea that Ottawa should supervize health policy development. As the federal share of funding continued to recede, provincial and territorial anger was amplified. The provinces and territories resented Ottawa's supervisory position, arguing that the reduced federal funding commitment should negate the federal influence in policy development.

Greater Restraint and Crises

Table 1.4 shows the increasing size of the federal budgetary deficits over a fifteen-year period, beginning in 1981. Table 1.5 shows how the annual federal budgetary deficits contributed to a sharp increase in federal debt during the same fifteen-year period.

Table 1.4

Table 1.5



In 1995, determined to eliminate the federal deficit, Ottawa combined the Canada Assistance Plan and the Establish Programs Financing transfers into the Canada Health and Social Transfer (CHST). CHST allowed the federal government to consolidate almost all of its transfers to the provinces and territories into one annual transfer, which

was significantly reduced in terms of "cash" value. Once again, Ottawa argued that it was increasing the "tax points" available to the provinces, by offering "tax room," that would open with impending federal income tax reductions. The "tax points" were compensation for the loss of "cash."

Table 1.6 shows the combined "cash and tax" transfer, which, according to Ottawa, was consistent with its previous obligation.[19] Table 1.7 shows the "cash" transfer for health expenditure, which clearly indicates that the budgets beginning in 1996 reduced "cash" transfer by nearly three and a half billion dollars. Table 1.8 shows the dramatic reduction of federal "cash" transfers as a percentage of provincial and territorial health expenditure. By 1998, the federal share of health costs had dropped to less than ten per cent of provincial and territorial expenditure. After the 1995 federal budget, the provinces and territories took on as much as ninety per cent of the financial responsibility for public health expenditure.

[19] Finance Canada calculates the dollar figures of the CHST as two separate funds: health and social. However, the CHST was a combination of both funds, which did not discriminate between health and social expenditure.

Table 1.6

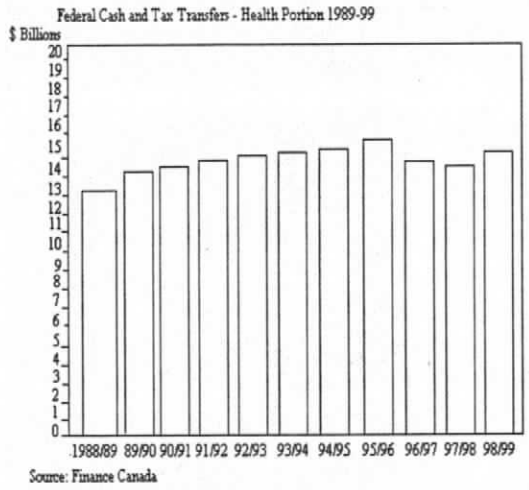


Table 1.7

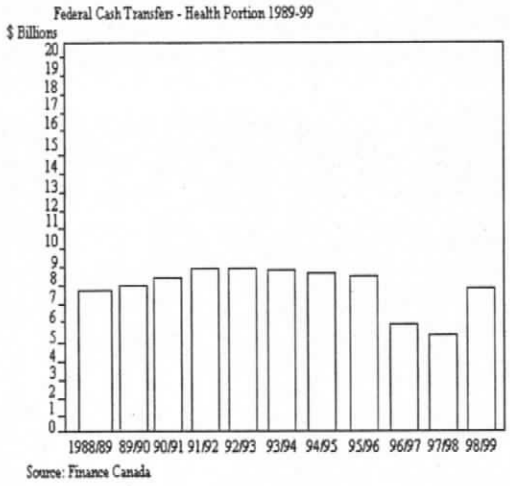
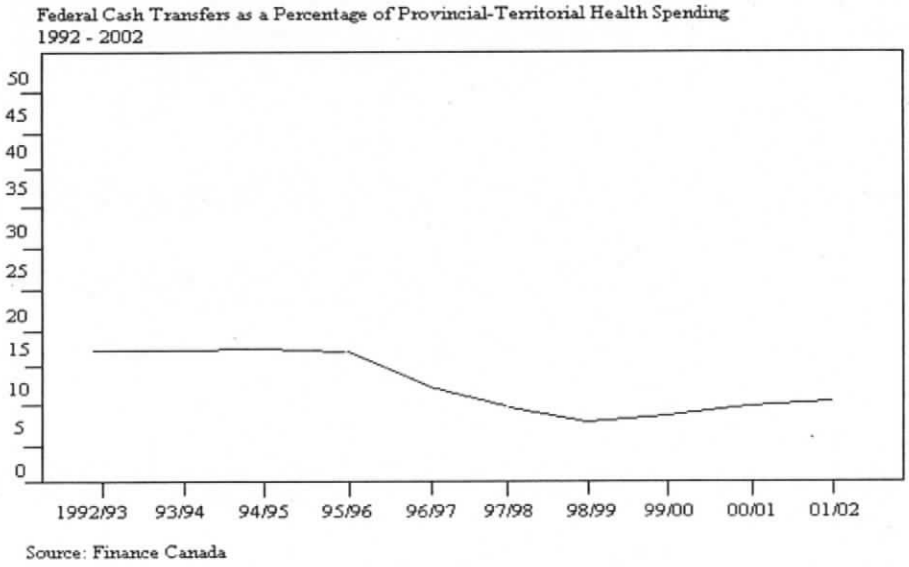


Table 1.8



As it reduced the federal contribution to health and social spending, Ottawa conceded that its influence over policy would have to diminish. CHST came with only two provisions: all health spending must satisfy the five criteria in the *Canada Health Act*; and the provinces could not introduce a "residency requirement" for those receiving

social benefits.[20] Ottawa rescinded all other criteria, which previously applied to the CAP and EPF.[21]

Table 1.9

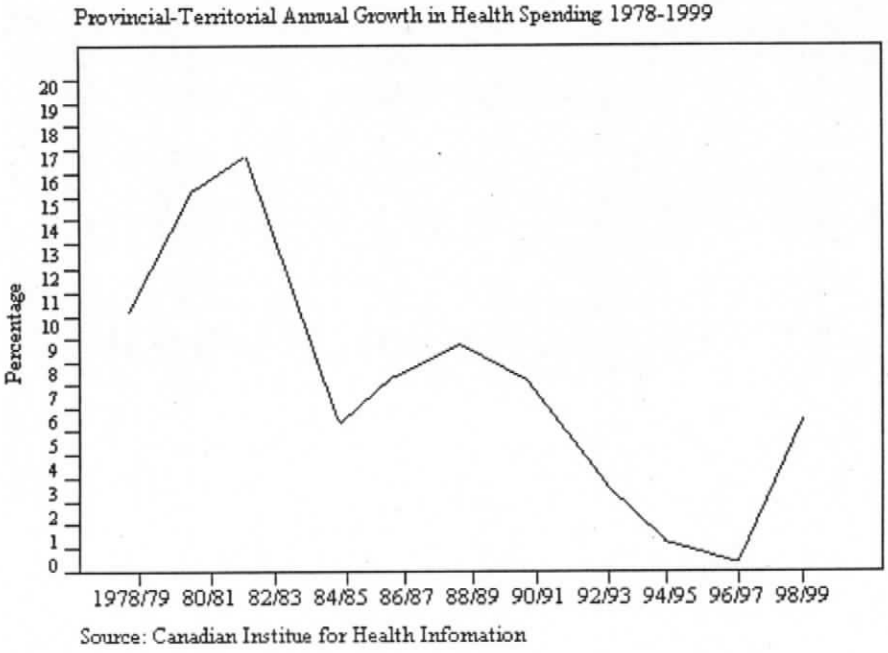


Table 1.9 demonstrates the fluctuation in the annual growth of provincial and territorial health expenditure. Between 1995 and 1997, as the provinces and territories were given a greater share of health expenditure, the annual growth rate in spending dropped. The trend indicates that provinces and territories responded to federal transfer reductions with cuts to health care spending. Growth rates did not increase until the 1998-99 budgetary year, when Ottawa began to increase its transfers.

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[20] *Canada Health and Social Transfer Regulations*. SOR/97-468.

[21] The *Canada Assistance Plan Act* placed several conditions upon provincial and territorial governments, including providing assistance to anyone in "need," prohibition of residency requirements, and a requirement that all provincial and territorial legislation pertaining to CAP had to conform to the federal provisions.

Renewed Arrangements

In 1997, having made cuts to health care in response to Ottawa's fiscal restraint, provincial and territorial health ministers met to discuss a uniform approach to relations with the federal government. At the conference, the health ministers demanded "adequate, predictable, and stable cash transfers" from Ottawa. The ministers also demanded greater transparency and provisions for dispute resolution.[22]

The federal government convened a meeting of first ministers in February of 1999. Having been forced by reductions to the fiscal transfer to make cuts to health and social programmes, the premiers wanted to restrict Ottawa's capacity to act unilaterally. If Ottawa wanted to change its financial relationship with the provinces and territories, the premiers wanted notification. The first ministers agreed to *A Framework to Improve the Social Union for Canadians*, to which nine provincial premiers and the Prime Minister lent their signatures.[23]

The Social Union Framework Agreement (SUFA) stipulates that the federal government must achieve the agreement of a majority of provinces before implementing new programmes which affect the fiscal or social conditions of the provinces within their jurisdiction. The federal government must provide one year of advance notification of renewal or significant changes in transfers. With respect to new programmes, each province and territory may determine the programme design. Where a province or territory already offers the programme, the transfer may be re-invested in a "related

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[22] Antonia Maioni, "Health Care in the New Millennium," *Canadian Federalism: Performance, Effectiveness, and Legitimacy*. Herman Bakvis and Grace Skogstad, eds. Oxford: Oxford University Press, 2002. 95.

[23] The Premier of Québec refused to sign the Agreement.

priority area." Every province and territory is given the option of "opting out" of the new programme.[24]

SUFA signaled to the provinces that Ottawa was through with cuts to transfers and that the budgetary surpluses it had created meant that it would be seeking new arrangements with the provinces and territories. For provincial and territorial leaders, SUFA seemed to assure that Ottawa would be obligated to consult the provinces and territories before making any further fiscal adjustments.

In 2000, the first ministers met again to establish a commitment from all parties to sustainable, predictable, and long-term funding formulae to ensure the success of a public health care system. The product was the 2000 Health Accord, which re-established the commitment of the first ministers to the five principles of the *Canada Health Act* and renewed long-term investment. Ottawa announced an additional two billion dollars to meet provincial and territorial needs. The additional two billion supplemented a previous announcement of an eleven billion-dollar increase to the Canada Health and Social Transfer (CHST) over five years. The Finance Minister suggested that the successive increases in transfers meant that the federal government had "fully restored" its commitment under the CHST.[25]

In 2002, Health Minister Anne McLellan announced that the provinces and territories would have the option of appealing Health Canada rulings on adherence to the principles of the *Canada Health Act* (CHA). The provincial, territorial, and federal governments agreed to a Dispute Avoidance and Resolution mechanism. In the event that

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[24] *A Framework to Improve the Social Union for Canadians*, "New Release, February 4, 1999." Government of Canada. http://socialunion.gc.ca/news/020499_e.html

[25] Antonia Maioni and Miriam Smith, "Health Care and Canadian Federalism," *New Trends in Canadian Federalism.* François Rocher and Miriam Smith, eds. Toronto: Broadview Press, 2003. 306.

a province or territory was found in non-compliance with the CHA, its government could initiate a request for appeal to the federal Health Minister, who would appoint a third-party panel. The federal Minister retains final authority of interpretation.[26]

Fixing Health Care

The Health Accord of 2000 embodied the pledge that federal and provincial dollars would be returning to health care. Despite the agreement, Canadians remained uncertain about the future of the public system. Polls consistently demonstrated that there were growing anxieties about the quality and timeliness of service delivery in hospitals across the country. For example, a poll conducted by the Angus Reid Group in January of 2000 reported that seventy-eight per cent of respondents agreed "that the health care system in their province is currently in a crisis."[27] Years of federal spending cuts and provincial service reductions had shaken confidence in the system. Politicians were forced into a search for solutions that would go beyond pledges of higher spending.

During the spring and summer of 2000, the governments of Québec, Saskatchewan, and Alberta initiated special task forces and commissions of inquiry to investigate possible reforms to their systems. The Clair, Fyke, and Mazankowski commissions of Québec, Saskatchewan, and Alberta, respectively, all supported regionalization of services.[28] The commissions took different positions on the potential role of the private sector in the delivery of medical services.

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[26] "CHA Dispute Avoidance and Resolution," Health Canada. http://www.hc-sc.gc.ca/english/media/releases/2002/health_act/cha.htm

[27] "Health Care in Canada," Ipsos News Center. http://www.ipsos-na.com/news/pressrelease.cfm?id=978

[28] Gregory P. Marchildon, *Health Systems in Transition: Canada*. Sara Allin and Elias Mossialos, eds. Toronto: University of Toronto Press, 2006. 113.

In Ottawa, the Senate began a series of studies into the federal role in the health system. Chaired by Senator Michael Kirby, the Senate Standing Committee on Social Affairs, Science, and Technology delivered a final report in October of 2002. It argued that the diminished federal cash transfers played an integral part in increasing waiting times for surgeries and diagnostic services. The committee recommended that Ottawa should contribute the "lion's share" of new funding to reduce waiting times.[29]

Partially to thwart provincial and senatorial critiques of the federal role in the health system and in response to increasing public pressure, the Prime Minister created a royal commission on April 3, 2001. He called upon former Saskatchewan premier Roy Romanow to chair a Royal Commission on the Future of Health Care in Canada. During his time as Premier, Romanow had been lobbying Ottawa to create a royal commission to study health care.[30] His appointment as chair, after his retirement from provincial politics, was likely the product of his lobbying efforts. The royal commission was given an eighteen-month mandate to explore the strengths and weaknesses of the public health care system and submit a final report of recommendations.

Conclusions

The history of Canada's system of public medical insurance is one of continued debate over jurisdictional and fiscal arrangements. The Constitutional division of powers and revenue-raising authority meant that creating a national system of medical insurance was an impossibility. Health insurance across the country had to rely upon the coordination of service delivery by the provinces in accordance with national guidelines. In a country

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[29] Marchildon, 114.
[30] Edward Greenspon, "PM may ask Romanow to help save medicare," *The Globe and Mail*. March 22, 2001.

where intergovernmental agreements occur through first ministers' conferences, the development of the system would be protracted and subject to political will. Malcolm Taylor, author of *Health Insurance and Canadian Public Policy,* argues that Canada's system of public health insurance is more the product of circumstance than of any grand vision of a national system.[31] It took twenty years to expand medical insurance from a hospital insurance programme in Saskatchewan to a system of coast-to-coast coverage of medical services. Once Canada had established a system of public medical services, the system was subject to constant fluctuation and modifications. Fiscal crises and political conflicts resulted in decades of changes to the system and inspired intergovernmental tension. As the system neared the forty-year mark, it began to show signs that the constant changes were taking a toll. Canadians began to vocalize their concerns about the system's future.

In an effort to demonstrate action on the health policy front, the Prime Minster created a royal commission to explore the future of health care in Canada. The decision to create a royal commission was important. Royal commissions have played a major role in shaping Canada's history. The Prime Minister's decision indicated that, once again, a royal commission would have an integral role in Canada's future.

The next chapter will survey the literature on royal commissions, identify the various attributes of public inquiries and the dimensions along which inquiries vary, and assess the Romanow commission according to the dimensions of variation. The process will enable us to understand the importance of the commission and the ways in which it is unique.

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[31] Malcolm G. Taylor, "Reflections," *Health Insurance and Canadian Public Policy: The Seven Decisions that Created the Canadian Health Insurance System and Their Outcomes*. 2nd ed. Canadian Public Administration Series. Montreal: McGill-Queen's University Press, 1987.

Chapter Two
Dimensions of Variations: Situating Romanow

Introduction

They are disparaged as expensive, cumbersome, and time consuming. They are also demanded as an integral part of our policy development and review process. Royal commissions have been instrumental in shaping the modern social, economic, and political landscapes. Few aspects of life in Canada have not been subject to their scrutiny. Following in that tradition, the Royal Commission on the Future of Health Care in Canada, or the Romanow commission was established to investigate the largest, in both fiscal and political terms, public policy in the country: health care.

The Romanow commission was established after almost a decade without a similar public policy investigation. The commission maintained a high public profile from its creation to the date its final report was tabled and beyond. It traveled extensively across the country and held dozens of consultative sessions with citizens, interest groups, and stakeholder organizations. This chapter explores the Romanow commission in relationship to previous public inquiries.

In this chapter, we will survey the literature on royal commissions to explore the dimensions along which public inquiries vary. The first section of this chapter studies the various attributes of commissions of inquiry. This section explores the rationale for appointing a commission, its composition, conduct, and the actions of its commissioners. The second section reveals the dimensions along which public inquiries vary. The final section will begin to assess the Romanow commission according to the dimensions of variation.

This chapter relies heavily on academic analyses of commissions of inquiry over the last half-century. By uniting the analyses, we are able to create a framework of the creation, composition, and conduct of public inquiries. Academics have studied various aspects of commissions in considerable depth. That depth benefits this analysis, by offering a view of the entire process through multiple lenses.

Tradition of Commissions

Royal commissions are a hallmark of the Canadian political identity. They have been created to explore innumerable aspects of life in Canada. Following the release of the final report of the Royal Commission on National Development in the Arts, Sciences, and Letters (Massey, 1949), one reporter commented that "some nations develop a culture through centuries of accumulated custom and achievement; others forge an identity through revolution or war. Canada established a royal commission. Could there be a more eloquent comment on our national character?"[32] Since Confederation, close to 500 commissions, royal or otherwise, have been created to examine various policies or actions of ministers, public servants, agencies, and interest groups.[33]

The academic analysis of commissions appears to have enjoyed a robust period during the mid to late 1960s, with a resurgence in the late 1980s. This is, perhaps, a reflection of the use of public inquiries, whose rates of utilization have followed a similar pattern. Academics are far from united on the utility of public inquiries. Some champion their use, while others dismiss their efficacy. In her work on royal commissions, Liora Salter offers a summary of the academic understanding of commissions of inquiry:

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[32] Paul Litt, "The care and Feeding of Canadian Culture," *The Globe and Mail.* May 31, 1991. A15. Quoted in Gregory Inwood, *Continentalizing Canada: The Politics and Legacy of the Macdonald Commission.* Toronto: University of Toronto Press, 2005. 49.

[33] Inwood, 9.

> The inquiry is a particularly complex and interesting phenomenon in the political life of western democracies. It offers the public an unlimited opportunity for experiencing direct democracy, that is, widespread political participation in the formation of specific policies. It offers an opportunity to define specific public issues, in the public view, with the participation of the clients of those policies. It provides an avenue for a public investigation of public and private conduct, far in excess of that conducted by the Ombudsman. At the same time, of course, inquiries provide governments with the opportunity to delay, obfuscate, and defuse political controversy, and with advice that they are free to ignore. [34]

Salter has nicely captured the division among academics, and Canadians generally, regarding the value of public inquiries. It is a common criticism of royal commissions that they are a means for governments to stall action or deflect negative publicity. They can also be expensive and time-consuming exercises, whose recommendations may ultimately be ignored. Conversely, they provide an autonomous, apolitical examination of crucial policy matters. In spite of their considerable costs, their exposure of, and contribution to, the literature on a given policy issue can be invaluable. Commissions of inquiry have been examining and recommending policy and processes in Canada since Confederation and will very likely to continue to do so in the future.

Inquiries in Canada

Royal commissions are exploratory bodies created under Part I of the federal *Inquiries Act*. Provincial legislation governing the creation of royal commissions, though typically borrowing the federal title, varies from province to province. The royal commission, or commission of inquiry, is an instrument available to governments to explore policy areas or investigate allegations of misconduct. As the prefix of the term might suggest, the royal commission was originally a British convention. Many scholars have contemplated

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[34] Liora Salter, "The Two Contradictions in Public Inquiries," *Commissions of Inquiry*. A.P. Pross, I. Christie, and J.A. Yogis, eds. Toronto: Carswell, 1990. 174.

the rationale behind the inconsistent use of the term "royal." Nicholas d'Ombrain suggests that "there are important differences [between royal commissions and commissions of inquiry], but they are not differences that can be detected in the formalities and legalities attaching to the two varieties."[35] Each type enjoys the same powers and privileges conferred by the *Inquiries Act*. The Canadian tradition has been to attach the "royal" prefix to policy inquiries, whereas investigative inquiries tend to be simply called "commissions."

Royal commissions were playing a part in Canada's history even before Confederation.[36] The first post-confederation royal commission was established only three years after the creation of the union. The commission reported to the new Dominion government on inland navigation.[37] The infant years of the union brought investigative inquiries almost exclusively. Invariably these commissions were established to investigate allegations of corruption and scandal related to "frontier" expansion.[38] In the early twentieth century, twenty-eight commissions were created to investigate natural resource exploration in the western regions of the union.[39]

Until the Great Depression, royal commissions were typically headed by a justice of the courts. The change in appointments in the 1930s reflects the changing subject matter of public inquiries. Whereas the early part of the century featured investigations necessitating legal expertise, the post-Depression era required public policy explorations, which employed social science research. John Courtney characterizes this shift as "one

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[35] Nicholas d'Ombrain, "Public Inquiries in Canada," *Canadian Public Administration*, vol. 40 (1997). 90.
[36] J.C. Courtney, "In Defence of Royal Commissions," *Canadian Public Administration* XII – 2 (1969). 198.
[37] *Ibid.*
[38] *Ibid.*
[39] Courtney, 199.

away from 'intensive' inquiries of only limited significance to one of 'extensive' inquiries of national significance."[40]

The 1950s and 60s are considered the "golden age" of royal commissions.[41] Governments during the two-decade period utilized public inquiries more frequently than their predecessors. In its seven years, the Diefenbaker government alone created sixteen royal commissions. Subsequent governments utilized public inquiries considerably less often. By the 1970s, many academics considered it to be a dormant instrument. Nicholas d'Ombrain suggests that "the large issues of public policy, where governments have sought and taken the advice of persons outside of government on matters that have affected the overall course of national life" were virtually non-existent "prior to 1930s, and there have been few since the end of the 1960s."[42]

Investigative and Policy Inquiries

Commissions of the nineteenth century were often exercises in exposing wrongdoing and finding fault among politicians and bureaucrats engaged in the rapidly developing resource and transportation industries. These commissions were almost always investigative in scope. One hundred years later, the situation has little changed. Although, investigative inquiries rarely address matters related to resource and transportation, the intention of finding guilt remains foremost on the agenda of commissions.

Recent investigative commissions have been extensive efforts to sort through the hundreds of "persons of interests" in an effort to assign blame to one or two individuals.

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[40] Courtney, 200.

[41] V. Seymour Wilson credits Maurice Western of the *Winnipeg Free Press* for coining the phrase "golden age" in his April 10, 1970 article "The Cost of Royal Commissions." "The Role of Royal Commission and Task Forces," *The Structures of Policy-Making.* G. B. Doern and P. Aucoin, eds. Toronto: Macmillan Company, 1971.

[42] d'Ombrain, 87.

The inquiry into the conduct of Canada's Armed Forces in Somalia is a famous recent example of a commission that spent millions of dollars and years of time investigating. The commission failed to arrive at a timely conclusion before its work was terminated by the same government that appointed it. Politicians and bureaucrats remain the favourite subject of investigative commissions. Most recently, the government established an investigative inquiry, chaired by Justice John Gomery, which attempted to find blame related to funds directed at promoting Canadian "unity," which were misappropriated.

Of the close to 500 inquiries that have been commissioned in Canada's history, by far the greatest portion belongs to the investigative category. For the purposes of this analysis, we will not explore further the investigative inquiries of Canada's past and focus on those related to policy.

Beyond the Rim of the Saucer

Royal commissions are an option available to governments for policy or investigative inquiries. The commission is an instrument that transcends the traditional bureaucratic-political search for solutions. In the Westminster model of governance, on which the Canadian system is based, the cabinet is the "political tier" of government. The public service, or bureaucracy, is the tier of government responsible for the formulation and administration of policy. Under most circumstances, the cabinet will establish a political agenda and utilize the public service to formulate policy options to address its objectives.[43]

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[43] Gregory Marchildon "Royal Commissions and the Policy Cycle in the Canada: The case of Health Care," *Saskatchewan Institute of Public Policy: The Scholar Series* (Fall 2001). University of Regina. 7.

The cabinet may be inclined to create a royal commission to formulate policy options under extraordinary circumstances.[44] Tom MacLeod argues that governments would be ill-advised to utilize a royal commission except under the most exceptional circumstances. By-passing the public service, which is endowed with specific and detailed policy knowledge, can be counter-productive. The bureaucracy is the in-house policy formulation machinery, whose capacity to construct and implement policy options should not, in the eyes of the taxpayer, be duplicated.[45] Neil Bradford argues that the public service is not "an instigator of change." It is "a conservative force for continuity."[46] To Bradford, royal commissions represent an obvious alternative to the champions of the status quo; the bureaucracy. Drawing upon outside expertise in the quest for policy options is preferable to recycling the same policies.

Table 2.1 (Non public service) Mechanisms of policy development and analysis

Legislative Bodies	Governmental Bodies	External Bodies
Parliamentary (House of Commons) Committees	Ministerial Task Forces	Permanent Advisory Bodies (ie. former Law Reform Commission)
Senate Committees	Advisory Councils (ie. National Advisory Council on Aging)	Public Inquiry

By seeking outside assistance, a government is indicating, or attempting to signal, that the particular policy area requires "independent" and "objective" assessment.[47] As Table 2.1 demonstrates, there are several options available to a government when looking

[44] For further elaboration on "extraordinary circumstances," please see "Creating Commissions" in the subsequent portion of this chapter.
[45] T.H. MacLeod, "Glassco Commission Report," *Canadian Public Administration*, v. 6 (1963). Quoted in Marchildon.
[46] Neil Bradford, "Innovation by Commission: Policy Paradigms and the Canadian Political System," *Canadian Politics*. 3rd ed. James Bickerton and Alain-G. Gagnon, eds. Peterborough: Broadview Press, 1999. 546.
[47] Marchildon, 8.

"beyond the rim of the saucer."[48] One option is the parliamentary committee. It is composed of members of the House of Commons. The committees are usually tasked with studying and revising legislation and are rarely the site for innovative policy formulation. Governments are reluctant to entrust a committee of the House, constrained by partisan loyalties, with a major policy. The Senate committees are another option available to governments. Senate committees are often the site for significant legislative consideration and are disproportionately endowed with legal expertise that is eminently valuable in the shaping of legislation. The Senate's democratic shortcomings make an exploration into public opinion somewhat problematic for a government that is attempting to solicit public engagement.

A third option is a ministerial task force. Task forces are temporary bodies struck by a minister, or even Prime Minister, to address a particular problem arising within a ministry. They are effective because they are able to draw upon the in-house expertise of the ministry without incurring significant costs beyond the ministry's operating and capital expenses. The shortcoming of task forces is that they are merely extensions of the ministry or government and fail to establish the desired appearance of "objectivity" or "independence." A fourth option is an advisory council or committee, which operates under a department. Unlike task forces, advisory councils tend to be permanent bodies. The councils are bodies composed of individuals with expertise in a policy field. The council is established to provide on-going advice on policy options to government departments. The shortcoming of the advisory council is that it, too, fails to create an appearance of "objectivity" or "independence."

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[48] Robert M. Fowler, "The Role of Royal Commissions," *Economic Policy Advising in Canada: Essays in Honour of John Deutsch*. David C Smith, ed. Montréal: CD Howe Institute, 1981. 95.

Finally, permanent external advisory body, such as the former law reform commission. These external bodies offer expertise in policy fields that require constant monitoring and modification. These groups are often the product of the recommendations of royal commissions studying a policy area in which on-going analysis is necessary. These permanent bodies are valuable within their field, but would not serve the interest of a government confronted with exceptional circumstances.

The royal commission has two great advantages over the other instruments available to government: it is legally autonomous and independent from the government by which it is appointed, with few constraints beyond its terms of reference; and it is given the resources to commission its own research teams and conduct public consultation sessions. Peter Aucoin calls royal commissions the "most effective option available to government for policy analysis undertaken by an independent and objective, yet official, organization."[49]

Creating Commissions

Governments address concerns related to all aspects of life in Canada. The majority of those concerns can be dealt with within the usual framework of policy development. In rare circumstances, faced with exceptional challenges, a government will reach out for advice. Nicholas d'Ombrain tells us that "[p]olicy inquiries are usually set up because of a confluence of circumstances that makes it desirable for the government to act in the public interest by going beyond the confines of the normal policy process."[50]

Greg Marchildon concurs and elaborates with criteria for using an "off ramp from the

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[49] Peter Aucoin, "Contributions of Commissions of Inquiry to Policy Analysis: An Evaluation," *Commissions of Inquiry*. A.P. Pross, I. Christie, and J.A. Yogis, eds. Toronto: Carswell, 1990. 197.
[50] d'Ombrain, 93.

regular policy life cycle."[51] He believes that a royal commission should be confined to cases where a policy problem is so "significant and fundamental in nature" that it requires the government to make a directional decision; it should be "fully aired in public;" its solutions require "research and analysis from individuals and groups outside government;" "a legally independent third party" would be the best option for conducting public consultation; the government "has fundamental questions about the direction and options" available to it; and the government desires a "creative road map…to get from the status quo to a new and quite different policy destination."[52]

Bruce Doern presents six purposes for which governments would create a royal commission: to "secure information," "educate the public," "sample public opinion," "investigate the judicial or administrative branches of government," allow the "voicing of grievances," and "postpone action."[53] He argues that ultimately, these six purposes result in one outcome: the securing of information. Regardless of a government's motivations for creating a royal commission, once the final report has been submitted, the policy decision is the government's alone.[54]

Once the decision has been made to step outside the boundaries of traditional policy formulation, a government moves quickly to appoint commissioners and write a terms of reference. d'Ombrain writes that this process is often conducted in a "disorderly way."[55] Typically, the minister and his or her political staff will confer with the political

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[51] Marchildon, 14.
[52] *Ibid.*
[53] G. Bruce Doern, "The Role of Royal Commissions in the General Policy Area and in Federal-Provincial Relations," (1967) X *Canadian Public Administration*. 421. Doern cites the work of J.E. Hodgetts and V.C. Fowke as the inspiration for his list.
[54] Though the government which establishes a commission is the final arbiter of its implementation, the scope of the implementation may require a government to enter into an agreement with another government.
[55] d'Ombrain, 93.

staff of the Prime Minister's Office (PMO) The PMO, the minister's staff, and the secretary to the cabinet will discuss "precedents, risks and,...possible terms of reference."[56] The Privy Council Office (PCO) will then advise on the appropriateness of a justice of the courts and the backgrounds of potential commissioners. The political staff will construct a list of candidates for possible appointments, while the PMO and minister's staff will collude to draft a terms of reference.

While politically-favourable candidates are of paramount importance to a government, another obvious consideration is that of representation. In a country as regionally, linguistically, and ethnically diverse as Canada, a government would be remiss were it to appoint a commission composed entirely of middle-aged, middle class, Anglophone, white men from Ontario.

The terms of reference is drafted for the guidance of commissioners, but largely serves as a map rather than a steering wheel. An important component of the terms of reference is the deadline for reporting. A government is careful to create a reasonable timeframe in which a commission can consult, research, and report, without allowing the process to become a protracted political embarrassment.

Commissioners

All the important calculations and considerations for the composition of the commission and its terms of reference are made in rapid succession. "Often, within twenty-four hours, the decision to have an inquiry will have been made, a chairperson and fellow commissioners identified and approached, and terms of reference drafted."[57] In haste, the

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[56] *Ibid.*
[57] d'Ombrain, 94.

government may take poorly-chosen steps to create a commission, "none more serious than ill-considered choices of commissioners."[58]

Investigative commissions are usually composed of more than one commissioner. One commissioner will usually be an experienced member of the legal profession, while another will be an expert in the particular field the commission is investigating. Conversely, it can often be politically desirable to appoint one commissioner to a policy commission. A single commissioner sends a signal that the government desires a concise and restricted set of policy options rather than a brokerage of ideas. JE Hodgetts comments that a single-member commission focuses on representation "in the witness box rather than on the commission itself."[59] For this reason, governments have traditionally favoured justices, who are practiced in delivering measured decisions. Recently, governments have tended to shy away from the appointment of justices in favour of commissioners trained in the social sciences. This departure from the legal community to the social science community is indicative of the shift of subject matter addressed by commissions. It is also the product of the growth in universities since the Second World War and the abundance of social scientists available to governments.

John Courtney makes another important observation with respect to the selection of commissioners. The cabinet, in choosing among a list of candidates, is likely to appoint commissioners whose political sympathies are with the government.[60] The obvious advantage of appointing a commissioner with a pro-government allegiance is that he or she will likely deliver a report that favours the government's position on an

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[58] *Ibid.*
[59] J.E. Hodgetts, "Should Canada be De-Commissioned?" *Queen's Quarterly*, LXX (Winter, 1964). 477.
[60] Courtney, 208.

issue. This, of course, assumes that the government has a pre-determined position, which in many cases, according to Greg Marchildon, it likely does not.[61]

Every commissioner establishes his or her own path. Some commissioners become so enraptured with the content of their exploration that they remain the champion of the issue long after the final report has been tabled. Robert Fowler believes that this approach is a mistake: "He [or she] has conducted a lengthy inquiry, heard all the evidence, and he [or she] and his [or her] colleagues have had a full chance to formulate their recommendations and set out the reasons for them. Any later attempt to expand the argument or put a gloss on it is bound to create confusion in the public mind."[62] Other commissioners have chosen to simply submit their final report and walk away to let the report speak for itself.

Research and Public Consultation

The shift to social science research, which Hodgetts believes "may be ascribed to the coming of age of the social sciences in Canada," has meant exponential growth in the research teams supporting royal commissions.[63] Commissioners approach an issue with the notion that they are formulating the final word. Robert Fowler argues that this tends to make the research effort disproportionately larger than the issue itself. "In the end, a more extensive – and expensive – research program is undertaken than is really necessary."[64] The upshot from the extensive research projects is that it contributes

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[61] Marchildon, 14.
[62] Fowler, 96.
[63] Hodgetts, 483.
[64] Fowler, 97.

volumes of expertise to an area that might previously have lacked the attention or resources.

Another significant component of the royal commission is the exercise in public consultation. Unlike almost any other instrument of government, the royal commission is encouraged to conduct interviews with experts, interest groups, and the general public. Jane Jenson believes that this creates a form of representation that is woefully unavailable in other political arenas. For Jenson, "providing access to individuals and groups to a forum of debate and policy-making" is a breath of democratic fresh air.[65] She believes that the exercise defines "the terms of who we are, where we have been and what we might become." More cynically, Greg Marchildon argues that the process can sometimes be an attempt, by government, to seek out "external validation for a policy direction already decided but not yet acceptable to the general public."[66]

It is a common criticism of commissions that they are far too expensive for the, often lackluster, results they produce. The high-cost of commissions is a direct result of the ambitious exercises in research and public consultation. Nicholas d'Ombrain charts the ever-increasing costs of royal commissions and finds that in the last forty years, ten policy commissions have exceeded the ten-million-dollar mark. Of those, two have exceeded fifty-million-dollars.[67] These are large figures when one considers that the final product amounts to little more than a book, or books, of ideas. It stands to reason, however, that, in search of meaningful ideas and options, a government would prefer to

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[65] Jane Jenson, "Commissioning Ideas: Representations and Royal Commissions," *How Ottawa Spends, 1995-95: Making Change*. S. Phillips, ed. Ottawa: Carleton University Press, 1994. 43.
[66] Marchildon, 8.
[67] d'Ombrain, 98. The figures he uses are adjusted to 1986-dollars.

be overly informed when it comes to making a decision on an issue of "national consequence."

The Final Report

As the commission conducts its interviews, research, and formulation of ideas and arguments, it is writing a final report. The report is the most important component of the commission's work. It is the public record of all its efforts and the location for its ideas and recommendations. JE Hodgetts remarks that, in spite of what can be an incredible amount of public attention centred on it, a royal commission possesses no powers of implementation: "The royal commission dies as it gives birth to its reports; the research apparatus, assembled at such cost and brought to a productive working peak, is dismantled and scattered; the report is left to the tender mercies of the executive with no continuing pressure group remaining behind to urge decision and action."[68]

The decision to implement the policy options is the government's alone. Depending upon the content of the report, a government may need to negotiate with another order of government in order for implementation to occur. It is, therefore, advantageous for the royal commission to shape its recommendations in consideration of, what Liora Salter calls, its "silent partner" or "partners."[69] As an expert contributor to a commission, Salter experienced first-hand the necessity of formulating arguments according to "what the government will want to hear" or "what the government will buy." When intergovernmental agreements will be a necessary part of implementing the recommendations, it is particularly important that the commissioners appreciate the

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[68] J.E. Hodgetts, "Public Power and Ivory Tower," *Agenda 1970: Proposals for a Creative Politics*. Trevor Lloyd and Jack McLeod, eds. Toronto: University of Toronto Press, 1968. 276.
[69] Salter, 183.

conditions under which each order of government is likely to agree. Inserting that foresight into the language of the recommendations is an important part of the development of the final report.

When commissioners close the doors on the public process and begin constructing the final report, much of the research and consultative materials are often condensed into evidence that advances a determined policy argument, or series of policy arguments. Salter argues that the materials can sometimes be "lifted out of context and used strategically to advance particular arguments. Words or phrases from the submissions become disconnected from the analysis in which they are generated."[70] For Salter, this is a disservice to the research and expert testimony, but is a product of the "self-censorship" that is often necessary when forwarding recommendations to the government.

The composition of the report is generally a product of "horsetrading," in which the concepts and ideas become subject to the "give and take" of negotiations. [71] This is true of both single- and multi-member commissions. A commissioner will debate the value of specific recommendations with his or her research and support team. The advantage for a single-member commission is that the commissioner is the final arbiter of the content of the report. Once again, the "horsetrading" represents an effort, on the part of the commissioners, to package sometimes competing ideas into a concise argument. For Daniel Drache and Duncan Cameron, this process is a symptom of the design of commissions. They argue that "[g]overnments need to defuse explosive issues. Since

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[70] *Ibid.*
[71] Salter, 184.

royal commissions are perceived to operate impartially, they are the ideal instrument of brokerage politics."[72]

Once the policy ideas and arguments have been massaged into an articulate stream of linear recommendations, the commission must deliver its recommendations to the government. This process can be a major media event, or it can transpire without a single flash of a camera bulb. Depending upon the subject matter, reports can become the subjects of intense media speculation and analysis. Public policy areas of significant public interest will generate significant media interest. Areas where the public interest tends to fall below the radar, will garner little attention from the media. The degree of public interest and media scrutiny is also reflected in a government's interest in receiving and implementing the recommendations of the report.

The tabling phase of a royal commission is the final contribution of the commissioner. Once again, the course of action a commissioner chooses to take at this stage is dependent upon his or her personality. Some commissioners will submit the report to the government and quietly walk away, declining to comment to the reporters that have gathered to report the event. Other commissioners take advantage of the opportunity to champion the recommendations contained within the report. In these cases the commissioner will accept invitations from media outlets to appear as an "expert" and explain and defend the rationale behind certain recommendations.

Implementation

When the work of the royal commission is completed and the report has been tabled, the onus belongs, once again, to the government. If the royal commission was established as

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[72] Daniel Drache and Duncan Cameron, quoted in Inwood. 52.

an opportunity to delay a difficult decision, the extended period in which the government set the issue aside will likely have built up expectations about implementation. A government that appointed the commission to establish a clear policy path, may be reluctant to steer the ship of state onto the commission's chosen course.

Irrespective of a government's motivation for appointing a commission, a failure to commence the process of implementing the commission's recommendations, or at least a version thereof, will inspire critiques of wasted resources. Typically, governments are unlikely to fully implement the recommendations presented by a royal commission. The recommendations contained within a final report are often turned over to the public service, which the government originally shunned in preference of an outside body, in order to formulate the recommendations into tangible steps.

In the process of translating recommendations into government policy, the intricacies of the argument contained within the report are often lost. The product is a synthesized, watered-down approach that often bears little resemblance to the original recommendations. For this reason, it is a common criticism of royal commissions that for all the time and resources invested in the work they performed, few, if any, of the recommendations will ever be implemented.

Robert Fowler argues that this should not amount to a criticism of the process. The royal commissioners and the government are each doing the jobs each is prescribed. The royal commission is meant to focus on an issue as if it were the only pressing matter faced by a government. A government must make important political calculations, which includes the consideration of vast areas of public policy, before making any long-term decisions. Fowler suggests that a commissioner "should not be concerned if his [or her]

proposals – desirable and reasonable though they may be – are overborne by valid political factors that he [or she] was not required or competent to take into account."[73]

Commission Legacy

Neil Bradford and Greg Inwood have both published case studies of the work of the Rowell-Sirois and Macdonald commissions and the influence each commission had on policy development in the years subsequent to the tabling of their final reports. Bradford's and Inwood's studies illustrate the confluence of circumstances and conditions that enable the recommendations of a commission to become politically viable for implementation. Neither author argues that policy development in the periods following the reports of the commissions is necessarily influenced by the work of the commissions. Rather, the commission and subsequent policy development might well be the product of a multitude of circumstances, which contributed to a commitment to a particular philosophy or set of ideas. In Bradford's and Inwood's case studies those ideas were economic.

It is difficult to argue that the work of a commission had a specific impact on policy development. The policy development might be the product of several contributing factors. The legacy of a commission, in so far as the commission's recommendations subsequently contributed to the development of policy, is difficult to measure. Neil Bradford has surveyed hundreds of commissions in Canada's history and the legacy of their research and recommendations. He argues that the final report of the commission and the policy development that ensues, can usually be sorted into two categories. The

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[73] Fowler, 95.

first category he calls "the universe is in trouble."[74] These commissions "have been central to social learning on fundamental questions of state-society relations and catalysts for major policy innovation." "The universe is in trouble" commissions are appointed at "critical junctures" in history and are efforts to find "something new" in the formulation of policy options. Bradford places six commissions in this category: Royal Commission on Dominion-Provincial Relations (Rowell-Sirois, 1937), Royal Commission on Bilingualism and Biculturalism (Laurendeau-Dunton, 1963), Royal Commission on the Status of Women (Bird, 1967), Mackenzie Valley Pipeline Inquiry (Berger, 1974), Royal Commission on Economic Union and Development Prospects in Canada (Macdonald, 1982), and the Royal Commission on Aboriginal Peoples (Erasmus-Dussault, 1991).

Bradford's second category is the "guide to decision." These commissions "provide advice in the form of programmatic ideas to assist governments in making policy adjustments within the existing public philosophy."[75] These commissions are not meant to break new ground in policy formulation. Instead, governments will appoint these commissions to create a roadmap for implementing policy options within the framework of the larger, pre-established, policy course. Bradford believes that there have been countless commissions of this variety. He points to a few obvious examples: Royal Commission on Health Services (Hall, 1961), Royal Commission on Government Organization (Glassco, 1960), Royal Commission on Financial Management and Accountability (Lambert, 1976), and the Commission of Inquiry on Unemployment Insurance (Forget, 1987).

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[74] Bradford, 548.
[75] Bradford, 549.

Dimensions of Variation

Commissions rarely resemble one another. The preceding sections expose the variety of commissions that have been created to explore issues of policy or allegations of misconduct in the century and half since the creation of the first royal commission. This section will utilize the literature survey to reveal the multiple dimensions along which public inquiries vary. These dimensions are summarized in Table 2.2.

One dimension of variation concerns the creation of a commission. Policy inquiries are appointed for innumerable reasons. Scholars have debated the importance of the royal commission as an instrument of government for decades. There is little consensus about the value of commissions, but there appears to be an agreement that commissions are an expensive and cumbersome means of assessing policy options. Bruce Doern argues that only "non-recurring" policy concerns should be subject to an inquiry.[76] Doern believes that governments have, or should establish, permanent advisory bodies that can be utilized to address "recurring" policy concerns.[77]

This delineation between "recurring" and "non-recurring" themes is useful. It also suggests that, in fact, there have been many commissions created where governments could have opted for another means. Robert Fowler takes this view, arguing, that "[n]o doubt some royal commission should never have been created. The government has adequate information within its own establishment to determine an appropriate policy, and the delay involved in a policy inquiry is not justified, nor is its substantial cost."[78]

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[76] Doern, 420.
[77] The Law Reform Commission has been twice cited as an example of a permanent advisory body. These bodies are often the product of a commission that has recommended the establishment of an advisory committee to prevent the need for further investigation.
[78] Fowler, 94.

Bruce Doern suggests another basis for categorizing commissions, listing six purposes for the creation of a royal commission. He argues that commissions are created to "secure information," "educate the public," "sample public opinion," "investigate the judicial or administrative branches of government," allow the "voicing of grievances," or "postpone action."[79]

Our second dimension concerns composition. Commissions can be multi-member bodies, composed of experts in the field of the policy area. Other commissions are single-member inquiries, where one individual assembles a research team and conducts the interview process. Single-member commissions are rarely chaired by an individual with expertise in the field. Often these commissions are chaired by a justice or former politician.

When selecting commissioners, a government will often consider issues of representation on the commission. For multi-member commissions, careful considerations are made to ensure representation by region, ethnicity, language, and gender. Single-member commissions are slightly more problematic and it is often left to the commissioner to appoint a representative research team.

Another dimension focuses on the amount of time a commission dedicates to researching, conducting interviews, and deliberating on a policy area. Some commissions are restricted to a short timeframe by their terms of reference. A government constrains the deliberation period to expedite the delivery of the final report. This is typical of a policy area where public attention creates pressure on governments for timely action. In other cases, commissions are given a broad mandate and an equally broad timeframe in

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[79] Doern, 421.

which to report. Famously, the Rowell-Sirois commission was created in 1937, as Canada was bearing the brunt of an economic depression. When the commission reported four years later, in 1940, Canada was in the midst of a world war and no longer facing the economic perils that necessitated the creation of the commission.

The duration of a royal commission is rarely less than one year and is often more than three. According to Nicholas d'Ombrain, who has prepared a graph plotting the timeline of dozens of recent policy commissions, the Macdonald commission was two years in duration, Hall was almost four years, while the Laurendeau-Dunton commission proceeded for almost seven years before finally rendering a final report.[80]

Inquiries also vary in their costs. Royal commissions are disparaged because they are extremely expensive. The costs of establishing a fully-functional research team, a cross-country consulting exercise, and the composition of a timely final report, are considerable. Nicholas d'Ombrain has calculated the costs of dozens of recent policy commissions and concluded that their costs are always in the millions of dollars. While some policy commissions cost less than five million dollars, others have been ten times that amount. The most expensive royal commission to date was the Erasmus-Dussault commission, coming in at almost sixty million dollars.[81] The Macdonald commission is a close second at a little over fifty million. The Laurendeau-Dunton commission is third with a cost of almost forty million dollars. Though d'Ombrain does not propose an "average cost," based upon his figures we can assume that an average cost is in the twenty million dollar range.

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[80] d'Ombrain, 97. For a list of the proper titles of each commission, please see page 46 of this paper.
[81] d'Ombrain, 98.

A fifth dimension of variation focuses on the degree of reliance upon "experts." Most recent policy commissions have approached their mandates through social science research and by conducting extensive interviews with "experts" in the field. Some commissions consider submissions from experts in the field while constructing a massive infrastructure of researchers. Other commissions cross the country, stopping frequently to hear the testimony and accounts of citizens with concerns about the particular area of public policy. In recent years, many policy commissions have opted for the former approach rather than the latter. The Erasmus-Dussault commission, the most expensive commission in Canadian history, dedicated the majority of its time to research and expert testimony.

Commissions also vary in their public profile. Though it is beyond the control of the commission, some royal commissions generate far more attention than others. Some royal commissions have delivered their final reports with little public attention. For other commissions, the ceremony of tabling the report have been broadcast on radio and television stations across the country. The commissions of Glassco, Lambert, and Forget all submitted a final report with little or no public attention. The Hall commission, however, received prolonged media analysis and speculation.

A seventh dimension of variation concerns the post-commission role of the commissioner. Once the commission has tabled its final report, many commissioners become silent on the issues they have studied. This is, perhaps, a product of the judicial influence on royal commissions. Historically, as noted above, public inquiries have been chaired by justices of the courts. Judicial convention dictates that justices must maintain an appearance of impartiality. Were a justice to intervene in the process of political

decision-making, it would reflect poorly on his or her appearance of impartiality. In rarer circumstances, a commissioner will assume an advocacy role. For example, Donald Macdonald, chair of the Macdonald commission, involved himself extensively in the free trade debates of the late 1980s.

Finally, commissions generate varying policy legacies. As Bradford and Inwood point out, a multitude of factors influence the development of public policy. Hindsight offers the advantage of revealing details about a commission and the political and economic circumstances that contributed to the commitment to a particular set of ideas. Bradford's delineation between "the universe is in trouble" and "guide to decision" commissions is useful for an analysis of the legacy of a commission. It may, however, be difficult to apply without the benefit of hindsight.

Table 2.2 Eight Dimensions of Variation and the Methods of Assessment

Dimension	Method of Assessment
Reason for creation	A. Brucè Doern's typology: 1. Secure information 2. Educate the public 3. Sample public opinion 4. Investigate the judicial or administrative branches 5. Voicing of grievances 6. Postpone action B. Recurring and Non-recurring
Composition	Single Member or Multiple Members
Duration	From Short-term (less than one year) to Long-term (more than three years)
Cost	From five to sixty million
Degree of reliance on experts	From Heavy to Light
Public Profile	From High to Low
Post-commission role	From Active to Inactive
Legacies	From Pronounced to Non-existent

The survey of the literature on public inquiries has revealed that commissions vary along multiple dimensions. We have discussed eight dimensions that must be considered in an analysis of a public inquiry: the reason for creation, composition, duration, cost, degree of reliance on experts, public profile, post-commission role, and policy legacy. As table 2.2 demonstrates, for each of these dimensions, we will utilize different methods of assessment. For most of the dimensions, we need to situate Romanow along a continuum, or in terms of a multiple category typology.

These dimensions, though viewed in isolation for the purpose this assessment, are certainly not independent. There are interconnections between most or all of these dimensions. For example, the duration of a commission would have a direct correlation with its cost. A prolonged period of research or public consultation will necessarily influence the cost associated with completing the analysis. For the purpose of this analysis, we will explore each of these dimensions separately.

Situating Romanow

The Romanow commission can, without further research, be situated on five of the eight dimensions enumerated above. The remaining three dimensions raise more interesting questions that will require further analysis. This section will situate the Romanow commission on the reason for the creation of the commission, its composition, its duration, its cost, and the degree of reliance upon "experts." The remaining three dimensions, those focusing on the public profile of the commission, the post-commission role of the commissioner, and the legacies of the commission, will define the framework of the remainder of the thesis.

The first dimension we will assess is the reason for the creation of the commission. For this assessment we can utilize two methods for evaluating the creation of the commission. The first method of assessment utilizes Bruce Doern's six reasons for creation. The second method determines whether the commission was created to examine a "recurring" or "non-recurring" policy issue.

The Royal Commission on the Future of Health Care in Canada was appointed by the Privy Council on April 3, 2001. The government's rationale for creating a commission cannot be attributed to one particular factor. There are multiple factors that

likely influenced the federal government, or, more precisely, Prime Minister Jean Chrétien. First let us consider Bruce Doern's typology. He argues that commissions are created to "secure information," "educate the public," "sample public opinion," "investigate the judicial or administrative branches of government," allow the "voicing of grievances," or "postpone action."[82] In setting up the commission, Chrétien seems to have been motivated by a mixture of motives. The government makes it clear that it is interested in public opinion and directs the commission to engage in a "dialogue with Canadians."[83] It is also possible that the Prime Minister was attempting to "postpone action" on a troublesome issue for the government. The government may have been seeking some "breathing space" from the contentious issue of health care. A royal commission would provide an eighteen-month window in which Ottawa could demonstrate that action was being taken, while waiting for more positive conditions.

In my view, we must go beyond Doern's typology to consider a seventh possible reason for creating a commission. The government may have also been attempting to obfuscate and overshadow the findings of the reports of the public inquiries and task forces established by several provinces, which were likely to implicate Ottawa as the culprit for the reduction in revenues that contributed to the perceived deterioration of the system.[84] The appointment of a federal royal commission would detract attention from the provincial inquiries and enable Ottawa to secure a dominant footing in the pursuit of policy options for the future of the system.

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[82] G. Bruce Doern, "The Role of Royal Commissions in the General Policy Area and in Federal-Provincial Relations," (1967) X *Canadian Public Administration*. 421.

[83] "Order in Council – PC 2001-569," contained within Canada. Royal Commission on the Future of Health Care in Canada, *Building on Values: The Future of Health Care in Canada - Final Report.* Saskatoon: Saskatchewan Queen's Printers, 2002. xi-xii.

[84] For an elaboration of the provincial task forces and commissions please see page 24 of this paper.

The second part of this dimension one assessment is determining whether the commission was interested in a "recurring" or "non-recurring" issue of public policy. Though the public policy matter, in which the commission was interested, is continuous, the commission was particularly concerned with its future. That the commission was tasked with recommending modifications to the system of public health insurance suggests that the concern was "non-recurring."[85] However, it could be argued that Romanow's was one among dozens of inquiries into the public health care system over recent decades, which might be indicative of a recurring problem. Conversely, the multitude of inquiries could serve as a reminder of the political significance of health care. The many inquiries could be interpreted as efforts, by governments, to demonstrate their commitment to health care. Few previous inquiries have studied a policy issue of such fiscal and political magnitude. It is, therefore, difficult to form a standard, as it applies to this question, against which the Romanow commission can be measured.

On the basis that the commission recommended a fixed percentage of fiscal contributions and the creation of standing agencies, which I will discuss in the following chapter, I contend that the commission was non-recurring. I am prepared to concede that an inversion of this argument is possible and that another analysis could determine that the commission was recurring.

Dimension two focuses on the composition of the commission. The Royal Commission on the Future of Health Care in Canada was composed of a single commissioner: Roy Romanow. The former Premier worked with a team of about fifty researchers, analysts, communication managers, consultants, and administrators. The

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[85] Romanow did identify potentially recurring issues, for which he recommended the creation of intergovernmental agencies or councils, such as the Health Council of Canada.

team reported to executive director Greg Marchildon, a professor at the University of Regina and former deputy minister to Romanow during his tenure as Premier of Saskatchewan. Romanow appointed seven directors who reported to Marchildon. Dr. Pierre-Gerlier Forest, a professor at the University of Laval in Québec, and Steven Lewis, professor at the University of Calgary, headed research. Tom McIntosh, professor at the University of Regina, was the Research Coordinator. Michel Amar, a policy strategist and consultant, headed media relations. Jennifer Bayne, now the Director of Knowledge Management for Canada Health Infoway, held the same position for the Romanow commission.[86] Andrew Noseworthy, Deputy Minister of Intergovernmental Affairs for the government of Newfoundland and Labrador, was the Director of Intergovernmental Relations for the commission. Nicole Viau-Cheney, who went on to serve as Director of Finance and Administration in the Arar Inquiry, directed administration for the commission.[87] Cécile Allard was the Director of Corporate Support Services.

Romanow commissioned a large team of researchers and analysts in addition to his directors and executive directors. His appointments suggest that considerations for regional, linguistic, ethnic, and gender representation were part of the selection process. The final chapter will discuss the post-commission involvement of members of the commission's staff.

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[86] Canada Health Infoway is a Pan-Canadian collaborative on electronic health information, which will be discussed in a subsequent chapter.

[87] The Arar Inquiry was a public inquiry into the actions of Canadian officials in relation to the deportation, by the United States' government, of Maher Arar, a Canadian citizen. It was alleged, and later substantiated by the inquiry, that the Canadian Security Intelligence Service and the Royal Canadian Mounted Police shared classified and potentially inaccurate information with the US Central Intelligence Agency that led to Mr. Arar's deportation to, and torture in, Syria.

Turning to dimension three, the facts concerning duration are transparent. The commission was created on April 3, 2001 and its terms of reference required that its final report be submitted to the government within eighteen months. Unlike many prominent commissions of the past, the commission would have to conduct its research, public consultations, deliberations, and submit a final report within a very narrow timeframe. Romanow delivered an interim report on February 2, 2002, followed by the final report on November 28, 2002.

Dimension four concerns costs. The cost of the Royal Commission on the Future of Health Care in Canada was significant, but pales in comparison to many major policy inquiries of the past.[88] For the eighteen-month duration of the commission, the Privy Council allocated $18,876,400.[89] Even when adjusted for inflation, the expenditure of the Romanow commission is less than one-third of the Erasmus-Dussault commission. The costs of the Romanow commission are below the "average cost" of twenty million dollars.[90]

The final dimension we will assess in this section is the degree of reliance upon "experts." Many modern commissions depend upon the advice of experts to construct a final report of recommendations. The Romanow commission does not vary from that convention. During the eighteen months of research and consultation, the commission visited dozens of health care stakeholders and advocacy groups, and commissioned forty discussion papers, written by a broad cross-section of "experts." Romanow also placed a signficant emphasis on public input into the process. This is evidenced by his twenty-one

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[88] See page 49 on the costs of royal commissions.
[89] "Privy Council Office – Performance Reports for the period ending March 31, 2003." Treasury Board of Canada Secretariat. http://www.tbs-sct.gc.ca/rma/dpr/02-03/pco-bcp/pco-bcp03d01_e.asp
[90] Based upon d'Ombrain's figures, 98.

open public hearings, nine expert workshops, three regional forums, twelve "Partnered Dialogue Sessions," and nine public surveys. The commission traveled the country for months, stopping in dozens of cities, towns, and villages to hear the testimony and accounts of citizens with concerns about the future of their health care system.

It is not uncommon for commissions to encourage public participation. Florence Bird, chair of the Royal Commission on the Status of Women (Bird, 1967), focused particular attention on drawing the media into the commission's public consultation sessions.[91] The result of her efforts was wide-spread exposure of the commission's work and considerable public input into the process. The Royal Commission on Bilingualism and Biculturalism (Laurendeau-Dunton, 1963) and the Royal Commission on Taxation (Carter, 1962) also depended heavily on the media and public consultation to gather information.[92] The Mackenzie Valley Pipeline inquiry (Berger, 1974) dedicated considerable time and effort to soliciting involvement of aboriginal nations.[93]

Romanow is the first commission in several decades to utilize public consultation sessions so extensively. Like Bird, Romanow understood the importance of soliciting public participation. As a former politician, Romanow likely appreciated the opportunity to engage citizens in a discussion about a policy issue that has become so central to the Canadian identity.[94] Though he possessed a capable staff and commissioned an enormous number of discussion papers, his focus was not solely on research. As the next chapter will demonstrate, the strategy of the commission was that the report, though replete with

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[91] Maureen O'Neil, "Why we need more royal commissions," *Herizons*. Winnipeg: Fall 2001. v 15, i 2. 14
[92] *Ibid.*
[93] Peter Puxley, *A Model of Engagement: Reflections on the 25th Anniversary of the Berger Report.* August, 2002. Ottawa: Canada Policy Research Networks.
[94] For a further elaboration on this point, please see the opening comments in the Introduction to the paper.

expert advice, would reflect the voices of the thousands of Canadians who offered their opinions to the commission during the months of public consultation.

Table 2.3 Five Dimensions Assessed in Chapter Two

Dimension	Assessment
Reason for creation	A. 1. Sample public opinion 2. Postpone action 3. Obfuscate other commissions' findings. B. Non-recurring policy issue
Composition	Single Member
Duration	18 months
Cost	$18,876,400.00
Degree of reliance on "experts"	Heavy reliance on "experts" and equal reliance upon public consultation

Table 2.4 Remaining Dimensions for Assessment

Dimension	Method of Assessment
Public Profile	From High to Low
Post-commission role	From Active to Inactive
Policy legacy	From Pronounced to Non-existent

Situating Romanow on these five dimensions has been relatively straightforward. These assessments, as identified in Table 2.3, have allowed us to begin situating the royal commission in relation to its predecessors. The remaining three dimensions, as shown in Table 2.4, will require further analysis and will frame the discussion for the remainder of the thesis. The following chapter will discuss the final report of the Romanow commission and the public and political reception it received. The chapter will include a

discussion of the dimensions of the commission's public profile and the post-commission role of the commissioner. The final chapter will discuss the legacies of the commission.

Conclusions

Royal commissions have played an integral part in shaping modern Canadian society. They have been created to study innumerable aspects of life in Canada. The survey of the literature on public inquiries demonstrates the variation across commissions. This chapter relies heavily on academic analyses of commissions of inquiry over the last half-century. Distilling these analyses, we have revealed eight dimensions along which public inquiries vary.

The five dimensions that we have assessed in this chapter reveal interesting aspects of the commission, which set it apart from previous inquiries. The commission was created for multiple reasons, some of which may be beyond this assessment. The information that we do have leads us to the conclusion that the commission was created to "sample public opinion," enable the "voicing of grievances" regarding the state of the health care system, to "postpone action," and possibly to obfuscate and distract from other commissions of inquiry created by the provinces. Whereas many recent royal commissions that have examined policy areas have focused on research and expert testimony, the Romanow commission made an effort to hear from Canadians. The emphasis on public consultation is likely a reflection of Romanow's years in politics and desire to engage citizens in the decision-making process. The conduct of the commission sets it apart from many of its predecessors. The difficulty in labeling the policy concern in which the commission was interested as "recurring" or "non-recurring" suggests that on this dimension, the commission might be unique.

The remainder of this thesis will be framed by the three outstanding dimensions of inquiries. The next chapter will discuss the final report of the Romanow commission and the public and political reception it received. It will include a discussion of the dimensions of the commission's public profile and the post-commission role of the commissioner. The final chapter will discuss the dimension of the policy legacy of the commission.

Chapter Three

Buying Change: An analysis of the Final Report of the Romanow Commission

Introduction

When the Romanow commission submitted its final report to the federal cabinet, it did so with considerable public and media attention. The commission had spent eighteen months interviewing, researching, deliberating, and writing its final report. This chapter focuses on the content of the final report and the reception the commission and its report received upon submitting its final report.

The first section of this chapter will explore the arguments Romanow puts forward in preparing the report, and the major recommendations contained within the final report. The second section of the chapter examines the public and political reception the commission and its final report received when the report was tabled. The final section of this chapter documents the activities of Roy Romanow in the week in which the final report of the commission was submitted to the cabinet. We will be able to situate Romanow along two of the three remaining dimensions of variation: the public profile of the commission and commissioner; and the post-commission role of the commissioner.

Building on Values

On November 28, 2002, the Royal Commission on the Future of Health Care in Canada delivered its final report, entitled *Building on Values: The Future of Health Care in Canada*, to the federal cabinet. The final report of three hundred and ninety-two pages contains forty-seven recommendations. Table 3.1 provides a table of contents of *Building on Values.*

Building on Values centers on the durability of public health care in Canada. Romanow uses the term "sustainability" to describe the longevity of the health care system. To ensure that the system remains sustainable, he recommends that Ottawa begin "buying change" with a series of actions, the sum of which would assist in reshaping the intergovernmental relationship as it pertains to health care. The recommendations for a renewed relationship between Ottawa and the provinces include a Health Covenant, the Health Council of Canada, a "modernized" *Canada Health Act*, a stable and predictable Canada Health Transfer, the Canada Health Infoway, and funding for Health Care Providers.

Table 3.1 Building on Values: Table of Contents

Source: *Building on Values: The Future of Health Care in Canada.*

The Report begins with an unequivocal endorsement of the "values" of a public health care system. Romanow believes that Canadians share these values and want the system preserved:

> Early in my mandate, I challenged those advocating radical solutions for reforming health care – user fees, medical savings accounts, de-listing services, greater privatization, a parallel private system – to come forward with evidence that these approaches would improve and strengthen our health care system. The evidence has not been forthcoming…Some have described it as a perversion of Canadian values that they cannot use their money to purchase faster treatment from a private provider for their loved ones. I believe it is a far greater perversion of Canadian values to accept a system where money, rather than need, determines who gets access to care…Canadians want their health care system renovated; they do not want it demolished.[95]

Sustainability

In his first chapter, Romanow defines sustainability as "ensuring that sufficient resources are available over the long term to provide timely access to quality services that address Canadians' evolving health needs."[96] He refutes the idea that the system is "unsustainable" because of its financial costs. Likewise, he challenges the notion that it represents too great a share of government budgets. Conversely, he dismisses the idea that money alone will solve the problems in health care. Romanow describes the three dimensions of assessing sustainability in health care: services, needs, and resources. He points out that "balancing" these three dimensions is the task of government, which is the most critical dimension of sustainability.

Addressing services, Romanow concedes that "more needs to be done to ensure timely access to quality services. The answer, however, is not to look to the private sector for solutions. Instead, governments should... ensure that adequate resources are available and services are accessible to all."[97] To assess the system's success at addressing the needs of Canadians, he compares Canada to the UK, Sweden, the Netherlands, France,

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[95] Canada. *Building on Values: The Future of Health Care in Canada - Final Report.* Saskatoon: Saskatchewan Queen's Printers, 2002. xvi and xx.
[96] Romanow, 1.
[97] Romanow, 8.

Germany, Japan, Australia, and the US. He finds that Canada compares well with these eight countries in addressing the needs of Canadians. However, there are disparities in access and outcomes between regions in Canada. Finally, on resources, Romanow compares Canada's allocation of resources to the same eight countries. He finds that reliance on taxation is standard among these countries. He argues that alternative funding sources would "shift the burden of funding from governments to individual Canadians."[98] He stresses that the imbalance of federal and provincial funding contribution levels needs to be addressed. Canadians, he finds, "are prepared to pay more… to ensure the system's sustainability, provided the system is prepared to change to meet their needs and expectations."[99]

Health Covenant

In his consultation with Canadians, Romanow was struck by the displeasure citizens expressed with their governments' constant disagreement over the management of the health care system: "The corrosive and divisive debates must end. If the status quo continues, the result will be the eventual unravelling of Canada's health care system into a disparate set of systems with differing services, differing benefits and differing ways of paying for health care across the country. This is not what Canadians want or expect for their health care system or for their country."[100]

To end the bickering, Romanow proposes a National Health Covenant. The National Health Covenant would establish "a common declaration of Canadians' and their governments' commitment to a universally accessible, publicly funded health care

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[98] Romanow, 43.
[99] *Ibid.*
[100] Romanow, 46.

system."[101] The Covenant would include a commitment to universality, equity, solidarity, responsiveness, wellness and responsibility, efficiency and value for money, accountability, and transparency. The Covenant would also establish "responsibilities and entitlements" of Canadians, health care providers, and governments.

Health Council of Canada

Romanow argues that the relationship between the two levels of government is "dysfunctional" because the jurisdictions of Ottawa and the provinces do not fit into "neat boxes." Both orders of government have responded to the obstacle of intruding jurisdictions by introducing "working groups," which have proliferated into more specialized advisory bodies. Romanow does not wish to consolidate these groups, but would like to see their efforts channeled in one direction. To provide this direction, he recommends the implementation of a Health Council of Canada.

The Health Council would "act as an effective and impartial mechanism for the collection and analysis of data on the performance of the health care system; provide strategic advice and analysis to federal, provincial and territorial health ministers and deputy ministers on important and emerging policy issues; and seek ongoing input and advice from the public and stakeholders on strategic policy issues."[102] The Council would serve as a "de-politicizing" and "collaborative mechanism" that would direct reforms for "modernizing" health care. The Council would also "provide analysis and advice on key national health issues."[103] He warns that the Council's mandate should not be limited to "monitoring" health care.

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[101] Romanow, 48.
[102] Romanow, 54.
[103] Romanow, 55.

Romanow divides the Council's mandate into two categories. He enumerates "immediate" priorities to be included in the Council's mandate and provides a list of "medium- and longer-term" priorities. The immediate priorities include establishing performance indicators, reporting on access and quality, and assessing new technologies. The medium- and longer-term priorities include facilitating primary care, providing advice on, and directing, the distribution and supply of health care providers, and assisting in dispute resolution. Romanow concedes that the implementation of the full mandate of the Health Council is contingent upon intergovernmental cooperation.

The Health Council of Canada, as Romanow envisions it, would be a fourteen-member board appointed by the federal, provincial, and territorial governments. The composition would be three public representatives, four health care providers or experts, and seven government appointees.[104] Board members would serve for a three-year term; the chair of the board should be selected from among the fourteen members.

"Modernizing" the Canada Health Act

During his interviews with Canadians, Romanow found that citizens view the *Canada Health Act* as a "hallmark" of their values. In reviewing the five principles of the CHA, he determines that each continues to serve the purpose it was intended to achieve and should not be removed from the *Act*.

Of the principle of "Public Administration," he argues that it ensures that a single-payer system will continue to be "the cornerstone of the Canadian system." He determines that a single-payer system "does a better job of controlling costs and it

[104] One representing the three territories, one representing the four western provinces, one representing Ontario, one representing Québec, one representing the four Atlantic provinces, and two appointed by the Government of Canada

facilitates equitable access."[105] The principle of "Universality," ensures that the public insurance schemes, in each province and territory, provide coverage "in the same manner and under the same terms" across the country.[106] "Accessibility" is an important principle, he suggests, because it ensures that the system remains free of barriers to quality health care, such as user fees and extra-billing. The principle of "Portability" addresses three situations: coverage for illness or injury in another province, coverage for residents moving outside their respective province or territory, and coverage for those traveling outside the country. He believes that governments should work towards improving coverage in the first two situations. However, it is infeasible to provide coverage to Canadians travelling abroad. Finally, the principle of "Comprehensiveness" does not live up to its definition. Romanow recommends that the definition be expanded to include "medically necessary diagnostic and home care services," with the possibility of further revisions and expansions in the future.[107]

Because he found that Canadians are suspicious of the means by which their governments manage health services, Romanow recommends that the *Canada Health Act* be amended to include the addition of a sixth principle of "Accountability." This principle should serve as a clarification of "the roles and responsibilities of governments," "ensure adequate, stable, and predictable funding," and provide information on the performance of the system.[108]

A modern *Canada Health Act* (CHA) would clarify coverage that Canadians are eligible to receive under the public system. Under-funding of diagnostic services has

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[105] Romanow, 60.
[106] Romanow, 61.
[107] Romanow, 63.
[108] *Ibid.*

created a "private market" of service providers, for which Canadians have to pay "out-of-pocket." It is necessary to explicitly identify diagnostic services as "medically necessary" under the CHA. This would negate the possibility of private investment in diagnostic services, such as magnetic resonance imagining (MRI) technology. Similarly, the report recommends that home care be included as a "medically necessary" service. Romanow breaks home care into three categories: mental health case management and intervention services, post-acute management and rehabilitation services, and palliative care.

Canada Health Transfer

Romanow addresses the "hotly contested" issue of health spending. He determines that the Canada Health and Social Transfer has served to complicate the issue. Using "tax point" formulae only adds to the confusion about spending levels. The "tax point" transfers restrict Ottawa's "ability to act as a catalyst in protecting and extending the national dimensions of medicare [which] is directly proportional to the size of its cash contribution to provincial expenditures."[109] To overcome this confusion and restriction, he recommends the implementation of a dedicated health transfer that only accounts for "cash" contributions. The dedicated health "cash" transfer will provide the necessary clarification of "where the money goes."[110]

Romanow recommends that the Canada Health Transfer be included within a "modernized" *Canada Health Act*, just as the original funding formula was included within the *Medical Care Insurance Act* of 1966. The Canada Health Transfer should be a consistent cash contribution of twenty-five per cent of the total provincial and territorial

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[109] *Ibid.*
[110] Romanow, 68.

expenditure: "This increased investment by the federal government is not only consistent with the original medicare commitment, it is essential to protect, promote, and enhance the national dimensions of public health care in Canada."[111]

Recognizing the complications involved in implementing a new transfer that is part of a "modernized" *Canada Health Act*, Romanow recommends the establishment of five interim federal transfer funds. Two of those funds would be utilized to facilitate immediate access to health services and expansion of diagnostic services. The Rural and Remote Access Fund and the Diagnostic Services Fund would be made available to provinces and territories on the basis of population size, demographic (age and gender), and general health.

The remaining three funds are all transfers that should be utilized for the immediate allocation of funding to targeted priorities. In the long-term, all three transfers would be consolidated within the Canada Health Transfer. The Primary Health Care Transfer would be accompanied by four conditions: continuity and coordination of care, early detection and action, better information on needs and outcomes, and new and stronger incentives.[112] The Home Care Transfer would provide funding for mental health case management and intervention services, post-acute management and rehabilitation services, and palliative care.[113] The Catastrophic Drug Transfer would consist of a federal reimbursement of provincial drug costs, which cover expenses greater than one thousand five hundred dollars for each individual in each year. The transfer would enable provinces and territories to "expand access to prescription drugs within their own drug

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[111] Romanow, 70.
[112] Romanow, 122-3.
[113] Romanow, 177.

insurance plans by reducing their deductibles or co-payments, or by extending coverage to people who are not now included under their plans."[114]

Policy Changes

Prescription Drugs. To address the ever-increasing costs of prescription drugs, Romanow recommends four approaches. First, utilize the new Catastrophic Drug Transfer to eliminate disparities in prescription coverage across the country.[115] Second, create a National Drug Agency, whose mandate would include the evaluation of new and existing drugs to ensure that all drugs meet a national standard for quality, safety, and cost-effectiveness.[116] Third, create a national formulary for prescription drugs that would harmonize the work currently undertaken separately in each jurisdiction.[117] The formulary would create a common prescription drug insurance plan, to ensure that each province and territory received equally coverage. Four, integrating prescription management with primary care to ensure that patients' prescription drugs are provided in tandem with their treatments.[118] By integrating these two areas, health professionals can monitor the effectiveness of prescription drugs in relationship to treatment. Finally, federal drug patent legislation must be reviewed to ensure the efficacy of drugs and costs to the system.[119]

Canada Health Infoway. To upgrade access to health information, he recommends that Canada invest in Personal Electronic Health Records (PEHR), which would provide an

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[114] Romanow, 198.
[115] Romanow, 197.
[116] Romanow, 199.
[117] Romanow, 205.
[118] Romanow, 206.
[119] Romanow, 208.

electronic file for every patient. The file would be accessible across the country through an electronic database. PEHRs would benefit "clinical processes, efficiency of workflow, and continuity of care."[120] Utilizing the five hundred million dollars it was allocated in 2000, Canada Health Infoway could "act as a catalyst in moving forward on essential information management and technology initiatives."[121]

Health Care Providers. To address the recruitment, distribution, remuneration, education and training, skills, and patterns of practice of health care providers, Romanow recommends the utilization of the Rural and Remote Access Fund, Diagnostic Service Fund, Home Care Transfer, and Primary Health Care Transfer. With these funds and transfers the provinces and territories can distribute health care providers in various areas, ensure the "right mix" of skilled and specialized service providers, properly fund education and skills training for new health care providers, and offer improved remuneration for workers in the health care field.

Waitlist Reduction. To address waiting lists, Romanow recommends a centralized "list management," which would be operated by a regional or provincial authority. The placement of a patient on the waitlist should be assessed by "standardized" criteria. Beyond the immediate management of wait lists, Romanow envisions national standards for wait list reduction. The Health Council of Canada would be given the task of working with the provinces and territories to develop a "national quality performance assessment framework."[122]

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[120] Romanow, 78.
[121] Romanow, 80.
[122] Romanow, 153.

Aboriginal Health Partnerships. Romanow addresses the issue of access to quality health services for Canada's aboriginal population by recommending a consolidation of the resources for aboriginal health into one budget. The budgets would be administered through the provinces and territories. The new budgets could be allocated to fund Aboriginal Health Partnerships (AHP). The AHPs would work towards restructuring health services to employ resources, integrate services and resources to address social and health policy dimensions of illness and health, organize networks to ensure continuity of services, deliver stable and predictable funding, and develop a management structure for the health and social functions of communities.[123]

Implementation

To convince governments that the investments he recommends are worthwhile, Romanow challenges the notion that health spending cramps economic development and that only tax cuts can stimulate the economy. In fact, he suggests, the opposite is true: "In the early 1990s, rising health care costs were seen in many countries as an obstacle to balancing budgets and cutting taxes. This created the view that health care costs were a threat to future national competitiveness… Health care investments not only lead to longer and more productive working lives on an individual basis; properly targeted public health care investments can also provide countries with a competitive advantage."[124] In the discussion on spending, he cites a letter he received from the "Big Three" automakers. The letter supports Canada's public health care system because it is "more

[123] Romanow, 226.
[124] Romanow, 42.

economical for the employers to pay taxes in support of medicare than to be forced to buy private health insurance for their workers."[125]

In concluding the report, Romanow defies governments to ignore his recommendations:

> If Canadians come to believe that their governments will not honour their part of the bargain, they will look elsewhere for answers. And the grave risk we will face is pressure for access to private, parallel services – one set of services for the well off, another for those who are not. Canadians do not want this type of system. The changes I am proposing are intended to strengthen and modernize medicare, and place it on a more sustainable footing for the future. They are based on a vision of medicare as a national endeavour, where governments work together to ensure timely access to quality health care services as a right of citizenship, not a privilege.[126]

Receiving the Final Report

This section assesses the sixth dimension along which public inquiries vary, the public profile of the commission and reception of the final report. On this dimension, the commission received considerable public attention. Unlike many previous royal commissions, the subject matter of the Romanow commission made it a lightning rod for public attention.

When Commissioner Roy Romanow submitted his final report to the government of Canada,[127] he did so with extensive national television (and in the case of the CBC, radio) coverage. Millions of Canadians watched and listened to experts providing speculation, commentary, and analysis on the report's recommendations, shortcomings, and potential impacts.

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[125] Romanow, 43.
[126] Romanow, 247.
[127] An event which coincides with the tabling of the final report in the House of Commons.

Politicians lined up to make statements about the report. Bloc Québécois leader Gilles Duceppe called the report "a tool the government has been waiting for to impose their bureaucracy [on the provinces], which won't help the system." [128] Canadian Alliance leader Stephen Harper believed that "essentially what Mr. Romanow has proposed comes out of a time warp…he is proposing that we have an ideological model from the sixties." The New Democratic Party could not have been more pleased. Party leader Alexa McDonough praised the report: "I think what is wonderful about the report is that it puts behind us the ideological battles and it puts before us a solid prescription and a treatment plan."

The premiers received the report with mixed emotions. Alberta premier Ralph Klein criticized Romanow's vision of Ottawa's role in health care: "We don't need someone to tell us how we should spend our health care dollars and address the priorities of the province." [129] Manitoba Premier Gary Doer disagreed, saying "the federal government should expect accountability for the money they spend."

The Canadian Medical Association called the commission's report a "blueprint" and pressured Ottawa to convene a discussion with the provinces within one hundred days.[130] Senator Michael Kirby, chair of the Senate Standing Committee on Social Affairs, Science, and Technology, which had written its own report of recommendations, criticized the Romanow commission for "remaining silent on how [it] would pay for implementing [its] proposals."[131]

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[128] "Reaction from Political Leaders," CBC News Archives. http://www.cbc.ca/healthcare/
[129] "Key players' reaction to the report," *Ibid.*
[130] Mark Kennedy, "Doctors set deadline for deal on health reform," CanWest News. November 29, 2002.
[131] "Senator Michael Kirby criticized Romanow's report," CBC News. December 2, 2002.

Initial public opinion polls found broad support for Romanow's proposals. Frank Graves of the Ekos Research Group suggested that Canadians "are receiving the report quite well…In fact, you would be hard pressed to find an issue that in recent history has an event or a report which has garnered such high levels of public recognition."[132] Pollara, a national polling group, released a report on December 3, which placed popular support for the recommendations at sixty-six per cent.[133]

Selling the Recommendations

It is not unusual for commissioners to become involved in a public relations exercise in the days leading up to, and immediately following, the release of the final report. Depending on the policy issue studied by the commission, the media are usually eager to obtain a quote from the commissioner pertaining to the recommendations of his or her commission.

For the sake of comparison, it is noteworthy that the release of the final report of the Royal Commission on Health Services generated considerable public and media interest.[134] The submission of the report was an occasion for Emmett Hall, the chair of the commission, to appear on numerous radio and television segments, discussing the recommendations of the commission. Hall spent months appearing before a multitude of stakeholders and interest groups, including the Ontario Hospital Association, defending

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[132] "What do Canadians think of Romanow's report," CBC News. December 5, 2002.
[133] Mark Kennedy, "Poll shows widespread support for Romanow recommendations," CanWest News. December 4, 2002.
[134] The final reports of the Hall Commission were split into two volumes. The first, and perhaps most controversial, volume was released on June 19, 1964. The second volume was released six months later, on December 7.

his recommendations.[135] He was criticized by his colleagues on the Supreme Court, for intervening in the political process.[136]

To take another example, Donald Macdonald, chair of the Royal Commission on Economic Union and Development Prospects for Canada, became heavily involved in the free trade debates of the late 1980s.[137] Macdonald did not dedicate his time to defending his recommendations. Instead, he worked in coalition with several prominent business leaders and politicians to persuade Canadians that free trade with the United States would provide considerable economic benefit.

Similarly, Laura Sabia, member of the Royal Commission on the Status of Women, championed the cause of implementing the recommendations of her commission. Along with a coalition of feminist organizations, she formed the National Action Committee on the Status of Women (NACSW).[138] The NACSW is dedicated to the implementation of the recommendations of the Royal Commission on the Status of Women.

Likewise, André Laurendeau and A. Davidson Dunton, co-chairs of the Royal Commission on Bilingualism and Biculturalism, became champions of the cause of creating a bilingual society and public service. The commission reported in six volumes, which were released over a three-year period. During the drafting of the reports, Laurendeau and Dunton traveled the country raising awareness about the linguistic and cultural cleavage in Canadian society.[139] As Pierre Trudeau ascended to the leadership of

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[135] Dennis Gruending, *Emmett Hall: Establishment Radical*. Toronto: Macmillan of Canada, 1985. 97.
[136] Gruending, 98.
[137] Gregory Inwood, *Continentalizing Canada: The Politics and Legacy of the Macdonald Royal Commission*. Toronto: University of Toronto Press, 2005. 302.
[138] "Herstory," Nation Action Committee on the Status of Women. http://www.nac-cca.ca/about/his_e.htm
[139] André Laurendeau, the original co-chair, passed away in the final year of the commission. Jean-Louis Gagnon replaced him as co-chair.

the Liberal Party and the government of Canada, he elevated many of the commission's recommendations to a high policy priority for his new government.[140]

In the weeks leading up to the release of *Building on Values*, Romanow visited the United States and delivered several high profile speeches at Harvard, Yale, and George Washington Universities. Though, not specific to the recommendations contained in the forthcoming report, the content of the speech hinted at the proposals he would be making to the government.[141] The speeches fueled speculation about the final report. Two days before the release of the report, *The Globe and Mail* newspaper and CTV News offered stories on the possible recommendations rumoured to be part of the report.[142] On the eve of the report's release, all the major television and print media networks were speculating on the content of the report.[143]

As noted above, the public and political reception of the final report of the commission was considerable. All the national radio, television, and print media networks covered the event. Roy Romanow held a press conference, which immediately followed the delivery of the report to cabinet. In his comments Romanow suggested that "the new money that I propose investing in health care is to stabilize the system over the

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[140] J .L. Granatstein, *Canada 1957-1967: The Years of Uncertainty and Innovation*. Toronto: McClelland and Stewart Limited, 1986. 255.

[141] "In Canada, publicly funded health care is 'moral enterprise,' says official," *Yale Bulletin and Calendar*. V 31, n 8. October 25, 2002.

[142] "Romanow Commission is about to deliver its diagnosis," CTV News - CTV Television. Scarborough: Nov 26, 2002.
"Romanow commission to recommend medicare watchdog, says Globe," Canadian Press NewsWire. Toronto: Nov 26, 2002.

[143] "The Romanow report will be released tomorrow," The National - CBC Television. Toronto: Nov 27, 2002.
"Will Romanow's report succeed," CTV News - CTV Television. Scarborough: Nov 27, 2002.
"Romanow's health care report will be released tomorrow," CTV News - CTV Television. Scarborough: Nov 27, 2002.
"Romanow seeks to target "health-care" change," Mark Kennedy and David Vienneau. CanWest News. Don Mills, Ont.: Nov 27, 2002. 1.
"Globe: Romanow to recommend provinces receive $7 B more in health funding," Canadian Press NewsWire. Toronto: Nov 27, 2002.

short-term, and to buy enduring change over the long-term. I cannot say often enough: that the status quo is not an option! If the only result of these past 18 months of collective effort by Canadians is simply more dollars for health care, our time will have been wasted."[144]

As Table 3.2 shows, from the moment Romanow exited the National Press Theatre on Parliament Hill, he would spend the better part of the next week in front of microphones and cameras discussing and, in some cases, defending his commission's recommendations. First, he appeared on RDI TV for an interview in English and French.[145], then on CTV NewsNet with Kate Wheeler, which was followed by an interview with *The Economist*. Romanow then conducted several radio interviews with stations in Ottawa, Toronto, Regina, and Saskatoon. Later in the afternoon, he appeared on CPAC with Peter Van Dusen. Afterwards he participated in an interview with CTV News in Halifax, which was followed by an appearance on CTV NewsNet with Dan Matheson. He concluded the afternoon with appearances on various television networks across the country, via satellite.

In the evening, he was a guest on the CBC radio network's "As It Happens." After the interview, he joined Don Newman on CBC "Inside Politics." He conducted more interviews with CBC "NewsWorld Morning" and CBC Radio "The House" with Anthony Germain, appeared on Global News with Kevin Newman and then a CBC News Special with Peter Mansbridge. His final interview of the day was with Lloyd Robertson on CTV News.

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[144] "Speech: Statement by Roy J. Romanow,Q.C. Commissioner," Ottawa: November 28, 2002. Royal Commission on the Future of Health Care in Canada.
http://www.hc-sc.gc.ca/english/care/romanow/hcc0402.html

[145] "Media Schedule – Final Report," from "Confidential Planning" document courtesy of Gregory Marchildon.

Friday brought an interview with Canada AM live, followed by a series of interviews with editorial boards at the *Globe and Mail, National Post, Toronto Star*, and Rogers Media. Saturday afternoon was an interview with Katherine Legg for "Global Sunday." On Sunday, Romanow appeared on "Question Period" with Craig Oliver and John Ibbotson on the CTV network. [146] That same afternoon, he was a guest on the CBC radio network's "Cross Country Check Up," where he joined Rex Murphy to discuss the report and answer questions.[147] Monday was filled with meetings with editorial boards at the *Saskatoon Star Phoenix, Edmonton Journal,* and *Halifax Chronicle Herald.* On Tuesday he gave a speech at Queen's University and met with the editorial board of the *Vancouver Sun and Province* newspapers.

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[146] "Interview with Roy Romanow," Question Period, CTV News. December 1, 2002.
[147] "A CBC News Inquiry into Health Care: Problems and Cures," CBC Program Guide. http://www.cbc.ca/healthcare/programguide/

Table 3.2 Roy Romanow – Media Itinerary: November 28 to December 2, 2002

Date and Time	Interview or Event
Nov. 28 – 12:00pm	RDI TV
Nov. 28 – 12:30pm	CTV NewsNet with Kate Wheeler
Nov. 28 – 12:45pm	*The Economist*
Nov. 28 – 1:05pm	CFRB with Paul and Carol Mott
Nov. 28 – 2:05pm	CBC Radio Regina, CJME Regina, and CKOM Saskatoon
Nov. 28 – 3:00pm	CPAC
Nov. 28 – 3:30pm	CTV Halifax, CTV NewsNet with Dan Matheson, CJOH Ottawa, CFQC Saskatoon, CFTO Toronto, CFCN Calgary, CTV News with Mike Duffy, and BC CTV Vancouver.
Nov. 28 – 4:45pm	CBC "As It Happens"
Nov. 28 – 5:05pm	CBC "Inside Politics"
Nov. 28 – 5:25pm	CBC "NewsWorld Morning"
Nov. 28 – 6:30pm	Global News with Kevin Newman
Nov. 28 – 8:00pm	Prime Time CBC News Special with Peter Mansbridge
Nov. 28 – 9:00pm	CTV News with Lloyd Robertson
Nov. 29 – 6:15am	Canada AM Live
Nov. 29 – 10:00am	*Globe and Mail, National Post, Toronto Star,* and Rogers Media editorial boards
Nov. 30 – 2:00pm	"Global Sunday" with Katherine Legg
Dec. 1 – 10:00am	CTV "Question Period"
Dec. 1 – 3:00pm	CBC Radio "Cross Country Check Up"
Dec. 2 – All Day	*Saskatoon Star Phoenix, Edmonton Journal*, and *Halifax Chronicle Herald* editorial boards
Dec. 2 – Evening	Queen's University
Dec. 2 – Evening	*Vancouver Sun and Province* editorial boards

Source: "Media Schedule – Final Report," "Confidential Planning" courtesy of Gregory Marchildon

In the next week, the media attention on Romanow and his recommendations quickly gave way to coverage of the reaction by stakeholders, interest groups, and politicians. As discussed above, Senator Michael Kirby criticized the report as

"irresponsible."[148] Gordon Campbell, Premier of British Columbia, called the report a "disappointment."[149] The Canadian Association of Academic Healthcare Organizations criticized Romanow for failing to deliver proposals for teaching hospitals.[150] The Ontario Medical Association criticized the report for failing to address the shortage of physicians in Canada.[151]

By the end of the week, the recommendations of the report were no longer items for discussion. The broad theme of funding took centre stage in most media coverage. The recommendations were calculated at fifteen-billion dollars. The figure gained considerable prominence in media coverage.

Greg Marchildon, the commission's executive director, suggests that Romanow took every effort and opportunity to explain and defend the content of the final report. He explains that Romanow felt compelled to defend his recommendations: "the impetus to set the record straight became quite powerful in the weeks following the commission."[152] Romanow argues that the commission had "one shot only, in which to advocate or to sell the recommendations."[153] "The best and only vehicle I had, since I was not in an elected office, was to try to get as much publicity as I could on the solutions as I saw them."

Romanow's attempts at generating publicity for the solutions contained in the final report became a permanent pursuit. As the weeks gave way to months, Romanow remained on the road and continued to generate attention by advocating the adoption of

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[148] David Rider, "Romanow report 'irresponsible,' says Senator," CanWest News. December 2, 2002.
[149] Dirk Meissner, "BC government issues health report to counter Romanow, NDP opposition," Canadian Press NewsWire. December 3, 2002.
[150] "Romanow Report Fails to Recognize or Address Immediate and Future Pressures Facing Teaching Hospitals/Centres, says ACAHO," Canada NewsWire. December 4, 2002.
[151] "OMA warns Romanow doesn't go far enough for patients today," Canada NewWire. December 4, 2002.
[152] Greg Marchildon, interview with the author, February 28, 2007.
[153] Roy Romanow, interview with the author, March 2, 2007.

the report. It is the duration of his involvement that separates Romanow from Hall, Macdonald, Sabia, Laurendeau, Dunton, and Gagnon. These commissioners folded up their advocacy campaigns within six months of the release of their reports. Roy Romanow continues to travel across the country and abroad, delivering speeches and interviews, and defending and advocating his final report.

This section has provided us with a glimpse of the activities in which Romanow was engaged in the initial weeks that followed the tabling of the final report. It is not possible to render a full assessment of the post-commission activities of the commissioner without considering his long-term involvement in the health policy debate. The next chapter will continue to assess the post-commission activities of the commissioner and discuss the impact of Romanow's activites on the implementation of the report's recommendations. The chapter will also chronicle the first ministers' agreements, legal decisions, and new policies and programmes that have occurred in the years since the final report was tabled. The final section of the chapter will discuss the legacies of the commission.

Conclusions

The Romanow commission generated considerable public and political attention. The recommendations of the final report were received with a mix of enthusiasm and pessimism from politicians, stakeholders, interest groups, and the public. Romanow became a prominent figure on television, radio, and in newspapers for weeks after the final report was tabled. He took every opportunity to advocate and defend the recommendations in the final report. The commissioner was keenly aware that he would have to maintain a public presence to ensure that the content of his final report was not

lost in the analysis and speculation that inevitably follows a commission's report. Unlike many of his predecessors, Romanow embraced the opportunity to engage in a campaign to raise awareness about the details of his proposals.

Though, Romanow's initial involvement in the public debate is unusual, there are examples of commissioners remaining involved beyond the mandate of the public inquiry. Both Emmett Hall and Donald Macdonald remained prominent figures in the media for months after the submission of their final reports. Similarly, commissioners from the Bird and Laurendeau-Dunton commissions became advocates for the implementation of the recommendations of their respective commissions. Where Romanow deviates from their path, and for which there is no precedent, is his perseverance. As we will see in the next chapter, Romanow has maintained a very public profile in the years since the commission completed its work. He has travelled across the country and abroad, delivering speeches and interviews, and defending and advocating his final report. The next chapter will provide a further assessment of Romanow's post-commission activities.

Chapter Four

Romanow in Retrospect: The Legacy of the Romanow Commission

Introduction

The Romanow commission created a significant impact on Canadians, health policy, and the intergovernmental agreements that followed the tabling of its final report. This chapter discusses the post-commission intergovernmental conferences and agreements, and the legal decisions, policies, and programmes that have occurred since the last meeting of the first ministers. We can complete our assessment of the remaining dimensions of variation: post-commission role of the commissioner; and the legacies of the commission.

The first section will document the first ministers' 2003 Health Accord and 2004 Ten-Year Agreement on Health Care, as well as the decision of the Supreme Court of Canada in *Chaoulli v. Québec*, and the new policies and programmes introduced in several jurisdictions. The second section of this chapter discusses the role Roy Romanow and his staff have played in promoting the recommendations contained in the final report. The section will assess the post-commission role of the commissioner by focusing on Roy Romanow's decision to remain active in the health debate by giving interviews, speeches, and lectures on the "state of health care in Canada." The final section assesses the policy legacy of the commission by considering the influence of the commission in shaping the intergovernmental agreements and policy decisions that occurred following the submission of the final report.

Health Accord

Upon the submission of the final report of the Royal Commission on the Future of Health Care in Canada, Prime Minister Jean Chrétien convened a meeting with his provincial and territorial counterparts. February 2003 brought an agreement between the ten provinces, three territories, and Ottawa, which would add seventeen billion dollars to the Canada Health and Social Transfer (CHST) over a period of five years. The only "strings" placed upon the money were an allegiance to the *Canada Health Act* (CHA) and a commitment that the additional money would be directed toward "targeted areas." Ottawa does not retain discretion over spending in the "target areas." "Targeted areas" include primary care, home care, catastrophic drug coverage, the purchase of diagnostic and medical equipment, and investment in information technology. The individual outcomes from spending in the areas are recorded and reported within each province and territory.

The additional money is allocated to the provinces and territories through a Health Reform Fund. The fund is utilized to support primary health care, home care, catastrophic drug coverage, the purchase of diagnostic and medical equipment, and information technology, such as electronic health records. The federal government agreed to separate its transfer into a dedicated Canada Health Transfer and Canada Social Transfer. Ottawa also committed to funding increases to address deficiencies in access to health services for Canada's aboriginal population. The first ministers agreed to the creation of a Health Council, whose mandate consists of "reporting" on health care. Finally, Ottawa agreed to release the equalization programme from the fiscal "ceiling" restraining its increase. Concluding the announcement of the new agreement, Prime Minister Chrétien enthused,

"[Canadians] want to see where their health care dollars are being spent and that their money is buying real change. My colleagues and I are committed to strengthening our health care and ensuring it is more accountable to the citizens who fund it."[154]

Accounts of the proceedings are not readily available, as first ministers' conferences are traditionally held in "closed door" sessions. However, breaking confidentiality, several Premiers emerged from the meetings ready to share the details of the agreement. Prince Edward Island Premier Patt Binns suggested that "[the agreement] falls far short of what the provinces believe is needed for long-term sustainability and to complete the reforms envisioned by commissioner Romanow."[155] Ontario Premier Ernie Eves took a further swipe at the Prime Minister, indicating that the Premiers would have to talk to Chrétien's "successor."

The disaffected Premiers arrived at the bargaining table hoping for a massive increase in federal spending. Several Premiers indicated that they expected to receive at least fifteen billion dollars in addition to the CHST, which they calculated in accordance with the Romanow report. Subtracting increases, to which the first ministers had already agreed, many of the Premiers estimated that the provinces would receive about twelve billion dollars of additional transfers over five years. The discrepancy between Romanow's recommended transfer increase and Ottawa's final offer was described as "the Romanow gap."

Before 2003 was out, Ottawa, the provinces, and territories succeeded in achieving the implementation of one more of Romanow's recommendations. In

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[154] "First Ministers Agree on 2003 First Ministers' Accord on Health Care Renewal," Health Canada Online. March 3, 2003.

[155] Quoted in Brian Laghi and Shawn McCarthy, "Premiers grumble, but PM gets deal on health," *The Globe and Mail*. February 6, 2003.

December 2003, Health Minister, Anne McLellan announced that she had reached an agreement with the provinces and territories for the creation of a twenty-seven-member board, which would be the Health Council of Canada.[156] The terms of reference for the Council focus on "independence and objectivity," "a cross-selection of perspectives," and "accountability and transparency."

> The Council should possess the following characteristics to be successful and garner public support:
>
> Be independent and objective. The Council will not undertake or direct work on behalf of third parties, nor is it permitted to accept funding of any kind from third parties.
>
> Be accountable and transparent. To enhance its legitimacy, the Council itself should operate in an accountable and transparent manner (e.g., issue progress reports, publicly report its financial records).
>
> Have representation from a cross-section of perspectives, including academic, scientific and professional communities, and reflect in reasonable manner Canada's diversity, including linguistic and Aboriginal representation.
>
> Have an effective relationship with the Canadian Institute for Health Information (CIHI) and the F/P/T Advisory Committee on Governance and Accountability (ACGA). This is essential to ensure the Council has the necessary information to fulfill its mandate, and that it does not duplicate the work or function of these organizations, or create unnecessary bureaucracy.
>
> Have appropriate support structures. The Council will have a Chair and councillors who will serve for specified terms and on a part-time basis. The Council will need full-time staff, including an executive director, to carry out its mandate to monitor and report on the implementation of the Accord.[157]

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[156] The provinces of Alberta and Québec refused to participate in the creation of the Council. The Québec government announced that it would be creating its own Council, which would collaborate with the national Council.

[157] "Framework for Health Council," Health Canada. December 9, 2003. http://www.hc-sc.gc.ca/english/media/releases/2003/2003_97bk1.htm

Romanow on the Health Accord

Commissioner Romanow praised the agreement as "a landmark achievement that provides a strong foundation for revitalizing our health care system."[158] However, he took issue with Ottawa's financial commitments, which, he said, provided "less money than is needed for the federal government to contribute its historical federal share of the medicare bargain." He criticized the lack of accountability associated with the grouping of transfers into a Health Reform Fund, arguing that it provides "too few details:" "the only real guarantee that the additional… monies will in fact be devoted to health care will be hard public scrutiny." He stressed the "inability of First Ministers to agree on a method for financing health care that results in stable, predictable funding that supports long-term planning."

The Ten-Year Agreement

A little more than a year later, Prime Minister Paul Martin invited the premiers to meet with him on September 13, 2004. In advance of that meeting the premiers met to unify their front. The three-day planning meeting produced a common objective among Canada's ten provincial premiers: a national pharamacare plan. Provincial and territorial agreement with Ottawa would be contingent upon a nationally funded pharmaceuticals plan, for which the federal government could assume full responsibility. The premiers also expected Ottawa to extend the Canada Health Transfer to cover twenty-five per cent of provincial costs associated with health care.[159]

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[158] Roy Romanow, "Notes for a Presentation at the National Press Club," April 3, 2003.
[159] "Communiqué: Premiers' Action Plan for Better Health Care: Resolving Issues in the True Spirit of Federalism," The Council of the Federation. July 30, 2004.

On September 13, the Premiers and Prime Minister sat down to another conference on health care. This time the conference was televised. It was the first intergovernmental conference on a policy issue to be broadcast.[160] The three-day conference produced a forty-one billion-dollar "deal for the decade that will lead to better health care for all Canadians."[161]

The provisions of the agreement, which included six per cent annual funding "escalator," include a commitment to the five principles of the *Canada Health Act*:

> access to medically necessary health services based on need; reforms focused on the needs of patients to ensure that all Canadians have access to the health care services; collaboration between all governments, working together in common purpose to meet the evolving health care needs of Canadians; advancement through the sharing of best practices; continued accountability and provision of information to make progress transparent to citizens; and jurisdictional flexibility.[162]

To reduce wait times, the provinces and territories agreed to establish indicators, comparable to other jurisdictions, for measuring access to health care providers, diagnostic services, and treatment procedures, with reports to citizens to be implemented prior to December 31, 2005. It said:

> Evidence-based benchmarks for medically acceptable wait times starting with cancer, heart, diagnostic imaging procedures, joint replacements, and sight restoration will be established by December 31, 2005 through a process to be developed by Federal, Provincial and Territorial Ministers of Health; Multi-year targets to achieve priority benchmarks will be established by each jurisdiction by December 31, 2007; Provinces and territories will report annually to their citizens on their progress in meeting their multi-year wait time targets.

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[160] Initially, the proceedings of the intergovernmental conferences to patriate the Constitution were televised. It was later agreed that the atmosphere was not conducive to discussion for an agreement and the television cameras were removed.

[161] Quoted in Brian Laghi, Campbell Clark, and Drew Fagan, "PM, Premiers sign $18-billion deal," *The Globe and Mail*. September 16, 2004.

[162] "A 10-Year Plan to strengthen health care," Health Canada. September 16, 2004. http://www.hc-sc.gc.ca/hcs-sss/delivery-prestation/fptcollab/2004-fmm-rpm/index_e.html

To address recruitment and retention of health care providers, the provinces and territories committed to identify "gaps" in the supply of health professionals, which can be utilized in the formulation of action plans, and the establishment of targets for training, recruitment and retention. Reports on progress would be made available by December 31, 2005. The federal government committed to accelerating and expanding "the assessment and integration of internationally trained health care graduates for participating governments; targeted efforts in support of Aboriginal communities and Official Languages Minority Communities to increase the supply of health care professionals for these communities; measures to reduce the financial burden on students in specific health education programs; and participate in health human resource planning with interested jurisdictions."

For home and primary care coverage, each government committed to "short-term acute home care for a two-week provision of case management, intravenous medications related to the discharge diagnosis, nursing and personal care; short-term acute community mental health home care for two-week provision of case management and crisis response services; and end-of-life care for case management, nursing, palliative-specific pharmaceuticals and personal care at the end of life."

For remote and rural access, Ottawa committed to increase funding to the territories by one hundred and fifty million dollars over five years through a Territorial Health Access Fund. And, the National Pharmaceuticals Strategy would consist of Health Ministers establishing a task force to develop and assess cost options for catastrophic pharmaceutical coverage. They would:

> establish a common National Drug Formulary for participating jurisdictions based on safety and cost effectiveness; accelerate access to breakthrough drugs for unmet health needs through improvements to the drug approval process; strengthen evaluation of real-world drug safety and effectiveness; pursue purchasing strategies to obtain best prices for Canadians for drugs and vaccines; enhance action to influence the prescribing behaviour of health care professionals; broaden the practice of e-prescribing through accelerated development and deployment of the Electronic Health Record; accelerate access to non-patented drugs and achieve international parity on prices of non-patented drugs; and enhance analysis of cost drivers and cost-effectiveness, including best practices in drug plan policies.

It is important to note that a separate agreement was included within the appendices of the first ministers' agreement. The separate agreement between Ottawa and Québec includes a commitment to the five principles of the CHA. It acknowledges, "Quebec supports the overall objectives and general principles set out by the federal, provincial and territorial first ministers..."[163] The separate agreement exempts Québec from the Wait Time Reduction Strategy, which it will implement on its own terms, and will include comparable indicators of performance. The agreement also specifies that the province will implement its "own plan for renewing Québec's health system." The province will work with other jurisdictions on sharing "best practices."

Romanow on the Ten-Year Agreement

When attention returned to Roy Romanow, the former commissioner proclaimed that the agreement was on the right track. He even endorsed Ottawa's initial proposal for thirteen billion dollars, which was subsequently abandoned. But the funding was not Romanow's primary concern. He worried aloud, "[t]here needs to be much more co-operative sharing

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[163] "Asymetrical [sic] federalism that respects Quebec's jurisdiction," appended to the first ministers' "10-year plan to strengthen health care." September 16, 2004. http://www.scics.gc.ca/cinfo04/800042012_e.pdf

of information and vigilance and less acrimony."[164] Before the conference got under way, Romanow argued that money alone was not going to fix health care: "If you just simply transfer the money without any, ah, guidelines -- and I'll use that soft word, guidelines -- you do not get change. What happens is the money gets taken in, absorbed like an ink blotter, soaked up into the traditional system."[165]

Summary of Agreements

When the Prime Minister convened a first ministers' conference in 2003, it addressed several of the policy changes recommended by Romanow, including those pertaining to primary health care, home care, catastrophic drug coverage, the purchase of diagnostic and medical equipment, and information technology. Using the five separate funds and transfers, Romanow recommended that Ottawa assist the provinces and territories in strengthening health care in a number of these policy areas. The 2003 Health Accord created a single Health Care Reform Fund, from which all six areas would receive funding. In spite of Romanow's recommendation, Ottawa did not retain control over the allocation of spending. The only caveat attached to the new funds was a commitment to establish performance indicators in the five areas. The new fund increased Ottawa's share of health care expenditure by seventeen billion dollars over five years. The additional funding from Ottawa was still below the twenty-five per cent commitment Romanow recommended.

Eighteen months after the first conference, the first ministers met again. The 2004 first ministers' conference on health care was another opportunity to implement the

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[164] Quote in Brian Laghi and Simon Tuck "The prognosis is good, Romanow says," *The Globe and Mail.* September 17, 2004.
[165] Quoted in Graeme Smith, "Romanow warns PM: Don't cave in," *The Globe and Mail.* July 9, 2004.

Romanow recommendations. Ottawa increased its share of funding by forty-one billion dollars over ten years. The Health Care Reform Fund would continue to be the vehicle for addressing reform in primary health care, home care, catastrophic drug coverage, and would assist in the purchase of diagnostic and medical equipment, and information technology.

Legal Decisions, Programmes, and Policies

This section discusses the decision of the Supreme Court in *Chaoulli v. Québec* and the new policies and programmes that have been announced since the 2004 first ministers' agreement. The discussion documents the opinion of the Supreme Court and the reaction of the health ministers. It also explores the policy directions spearheaded by various jurisdictions. This section appears within the paper to provide a full account of the decisions, policies, and programmes that have occurred since the final report was tabled in Ottawa.

Having reached an agreement for forty-one billion dollars over ten years, the first ministers returned to their capitals to begin constructing the policies and programmes. The additional federal dollars came with new guidelines and provisions for measuring performance. The provinces and territories would have to establish benchmarks and begin tracking the reduction in the number of patients on waiting lists for diagnostic and surgical procedures; targets for the recruitment and retention of health service providers; and the delivery of short-term home and acute care services.

In October, the health ministers gathered in Ottawa to discuss the ten-year agreement of the first ministers. The ministers agreed to reconvene in January of 2005 to discuss the progress being made in each jurisdiction on reduction in wait times and access

to treatment. The ministers established a Ministerial Task Force, chaired by the federal health minister, to develop and implement a National Pharmaceuticals Strategy. The Task Force would develop regular reports on its progress. The conference also marked the first occasion in which the ministers shared information about performance indicators for reducing wait times and accessing services.[166]

The work of the first ministers, health ministers, and public service was eclipsed by an ominous legal challenge that had found its way to Canada's highest court. On June 10, 2005 the Supreme Court of Canada rendered its decision in *Chaoulli v. Québec*. The case was initiated when George Zeliotis and his physician, Jacques Chaoulli, sought a declaratory judgment on the Québec *Health Insurance Act* and *Hospital Insurance Act*. The complainants claimed that the Acts contravened the Québec *Charter of Human Rights and Freedoms*. The court rendered three separate opinions in the decision. The first opinion, written by Justice Marie Deschamps, reasoned that the life of a patient is compromised when he or she is placed on a waitlist for critical surgery. Justice Deschamps reasoned: "the government has failed to act [and] the situation continues to deteriorate."[167] Deschamps found that the Acts violated the "right to life, and to personal security, inviolability and freedom" in the Québec *Charter of Human Rights and Freedoms*.

The second opinion, written by Chief Justice Beverley McLachlin and Justice John Major with Justice Michel Bastarache concurring, agreed with the reasoning of Justice Deschamps on the Québec Charter. The opinion also found that the Acts violated the *Canadian Charter of Rights and Freedoms*' sections seven and one. Section seven

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[166] "News Release – Annual Conference of Federal/Provincial/Territorial Ministers of Health," Health Canada. October 2004. http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2004/2004_52_e.html

[167] *Chaoulli v. Quebec (Attorney General),* [2005] 1 S.C.R. 791, 2005 SCC 35. 97.

guarantees the "right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice."[168] The Justices found that the Acts' violation of section seven was outside the "reasonable limits" in section one, which "guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society." The opinion reasoned that the threat to the lives of patients on waiting list could not be considered a "reasonable limit" of the Acts.

The dissenting opinion, written by Justices Ian Binnie and Louis Lebel with Justice Morris Fish concurring, reasoned that the case was not a matter for the courts, but rather an issue of public policy. The opinion disagreed with the findings of the other two opinions, in so far as there is no means of determining a "reasonable" wait time for surgeries.

The impact of the *Chaoulli* decision remains unclear. Policy makers and pundits disagree about the decision's consequences for a system of state-delivered health services. The opinion of the Supreme Court did not pertain to the *Canada Health Act*. The court only accepted the argument that waiting lists for surgeries threaten the lives of patients and that governments are responsible for ensuring patients receive timely access to critical procedures. If private service providers can deliver a service that the state cannot, then, legally, the state cannot prevent them from doing so. Furthermore, as the majority of justices agreed only on the violations to the Québec *Charter of Human Rights and Freedoms* and not the Canadian *Charter of Rights and Freedoms*, the decision does not apply outside of Québec. However, provinces with legislation similar to the Québec *Health Insurance Act* and *Hospital Insurance Act,* could also be at risk of a legal

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[168] "Canadian Charter of Rights and Freedoms," *Schedule B, Constitution Act, 1982*, Part I.

challenge. [169] Whether these Acts will become the subjects of similar legal challenges remains to be seen.

When the health ministers convened their annual meeting in October of 2005, the *Chaoulli* decision was uppermost in the minds of those in attendance. Though, not specifically in response to the ruling of the Supreme Court, the ministers confirmed their commitment to provide "evidence-based benchmarks" for reducing waiting times, involve physicians in the list-management process, a new joint research programme to generate clinical evidence examining the effects of wait times on the health of patients, and working with the Canadian Institute for Health Information to develop comparable indicators for each jurisdiction.[170]

The commitment to the benchmarks might be interpreted as an articulation of the level of "reasonableness" in waiting times. By establishing benchmarks and comparable indicators, the ministers are bolstering the evidence that waiting times are manageable and within acceptable, or reasonable, limits. If a future legal challenge arose, governments could argue that the benchmarks and comparable indicators provide evidence that waiting times are defined and within reasonable limits.

The ministers also agreed to a Canada Pandemic Influenza Plan, a Blueprint on Aboriginal Health, future consideration of a Canadian Mental Health Commission, and

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[169] Antonia Maioni and Christopher Manfredi, "When the Charter Trumps Health Care – A Collision of Canadian Icons," *Policy Options*. September, 2005. Montréal: Institute for Research on Public Policy. 52-56.

[170] "News Release," "Annual Conference of Federal-Provincial-Territorial Ministers of Health Toronto, Ontario," October 22-23, 2005. Canadian Intergovernmental Conference Secretariat. http://www.scics.gc.ca/cinfo05/830866004_e.html

the Health Goals for Canada that envision a twenty per cent increase in the portion of physically active Canadians.[171]

The Ministerial Task Force on the National Pharmaceutical Strategy (NPS), co-chaired by federal health minister Tony Clement and British Columbia health minister George Abbott, delivered its progress report to the Council of the Federation, the collaborative body of Premiers from each jurisdiction, on July 5, 2006. The report outlined the NPS five priority areas, which will animate the next phases of development and implementation. The five priorities are "catastrophic drug coverage," "expensive drugs for rare diseases," "common national formulary," "drug pricing and purchasing strategies," and "real world drug safety and effectiveness."[172] The report marks the conclusion of phase one; planning and recommendations. The second phase, currently underway, involves further assessment of international approaches, engagement of stakeholders for short-, medium-, and long-term strategies, engaging the public in consultation, and developing a framework of ethics, regulations, and reimbursement.[173]

In February of 2006, the province of Alberta unveiled a new *Health Policy Framework*, referred to as the "third way" for health service delivery. It recommended ten "directions for moving forward." The ten directions include "putting patients at the center" of policy reforms; creating a Health Professionals Act, allowing patients to choose the most "responsible caregiver;" introducing new "compensation models" that "provide incentives for quality of care, efficiency and inter-professional collaboration;" promoting specialized institutes to "combine leading edge research with advanced

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[171] *Ibid.*
[172] *National Pharmaceuticals Strategy: Progress Report*. Federal/Provincial/Territorial Ministerial Task Force. June, 2006. Victoria: National Pharmaceuticals Strategy Secretariat, 2006. 9.
[173] *National Pharmaceuticals Strategy: Progress Report*, 36.

clinical care;" shifting some hospital services to "community settings;" "establishing parameters for publicly-funded health services," (including moving some services out of the scope of public funding); creating "flexible funding options" for some services; expanding "system capacity and consumer choice" in public and private delivery systems; amending the Alberta *Health Care Insurance Act* to remove restrictions for "opting out" for physicians in "certain circumstances;" and "deriving economic benefits from health services and research."[174]

In August, the Alberta Ministry revised its approach and released a new report entitled, *Getting on with Better Health Care: Health Policy Framework.* The new report was stripped of references to amending the *Health Care Insurance Act* and "opting out," shifting services out of the scope of public funding, and "flexible funding options."[175] The government was now concerned with scientific assessments for new procedures and their value to the public system, rather than moving existing procedures out of the public funding framework. Physicians and surgeons would still be required to practice within, and receive remuneration from, the public system. Opportunities for "flexible funding options" were no longer on the agenda.

The government of Québec also announced its new health policy in February of 2006. The highlight, at least in the eyes of the media, was a commitment to a six-month maximum waiting time limit for cataract, hip and knee replacement surgeries. If the procedure is not conducted within the six-month period, the government will provide the funds for the procedure to occur in a private surgical facility. If the procedure is not

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[174] *Health Policy Framework.* Government of Alberta. February, 2006. Edmonton: Alberta Queen's Printer, 2006. 3.

[175] *Getting on with Better Health Care: Health Policy Framework.* August 2006. Edmonton: Alberta Queen's Printer, 2006.

conducted within nine months, the government will provide the funds for the procedure to occur in the United States. "We chose to maintain the principles of the public health-care system within which the private sector can play a role," Premier Charest told reporters during a media scrum following the announcement.[176]

The government of British Columbia made a different kind of policy decision in 2006. In the Speech from the Throne, the government announced that it would create a "Conversation on Health Care." The "conversation" would consist of Regional Public Forums, Health Professionals Meetings, and Patients Focus Groups, occurring across the province over an eighteen-month period. The "conversation" was launched in September, with government media materials stressing: "If we don't act, health spending could consume 71 percent of the provincial budget by 2017."[177] The government estimated the cost of the exercise would be ten million dollars.

In January of 2006, the Conservative Party of Canada won enough seats to form a minority government in Ottawa. During the election campaign, the Conservatives promised to create a "Patient Wait Times Guarantee." The "Guarantee" was the leading recommendation of the Senate Standing Committee on Social Affairs, Science, and Technology's final report, also known as the Kirby report. The "Guarantee" would establish maximum waiting times for procedures. If a procedure is not conducted within the public system within the maximum waiting time, the government will provide funds for it to occur in a private facility. In November of 2006, the government announced that "pilot projects" have been established in First Nation communities. The projects are

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[176] Rhéal Séguin, "Québec opens door to private health care," *The Globe and Mail.* February 17, 2006. A1.
[177] "Launch of the Conversation on Health," Gordon Campbell. September 28, 2006. "BC Government Media Room,"
http://www.gov.bc.ca/bcgov/content/docs/@2T64v_0YQtuW/Conversation%20on%20Health.pdf

specifically tailored to diabetes and prenatal care in up to ten communities.[178] In April of 2007, the Conservative government announced that it had finalized an agreement with each of the ten provinces and three territories for a "wait times guarantee." Each jurisdiction committed to setting waiting limits for one type of medical treatment.[179] The "wait times guarantee" will be in place by 2010.

Table 4.1 summarizes the legal, programme, and policy developments that have occurred in each jurisdiction since the first ministers' meeting in September of 2004. Each of the developments has the potential to set the provinces on diverging courses. The National Pharmaceutical Strategy follows in the path marked by the Romanow commission. The *Chaoulli* decision and Wait Times Guarantee mark a significant departure from the recommendations of the commission. Perhaps, more than any other development, the *Chaoulli* decision has the potential to create the largest impact on policy development. As discussed above, it implications remain unclear. Each jurisdiction's response to the decision could represent a significant departure from the recommendations contained in the Romanow report and the first ministers' agreements of 2003 and 2004.

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[178] "News Release - Canada's new government launches historic first wait times guarantee in First Nations prenatal project." Health Canada. November 20, 2006. http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2006/2006_110_e.html
"News Release - Canada's New Government moves toward second wait times guarantee: for First Nations diabetes care." Health Canada. ," November 20, 2006. http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2006/2006_118_e.html

[179] Each jurisdiction committed to waiting limits for one of five types of treatment: Cancer care, hip and knee replacement, cardiac care, diagnostic imaging, and cataract surgeries. "Critics say wait-times deal falls short of promise," CTV News. April 4, 2007.

Table 4.1 (Post-First Ministers' Agreements) Legal, Programme, or Policy Development by Jurisdiction

Legal, Programme, or Policy Development	Jurisdiction
Chaoulli v Québec decision of Supreme Court of Canada.	Québec, but with implications for every province and territory.
National Pharmaceuticals Strategy	Pan-Canadian
Health Policy Framework	Alberta
Waiting Time Limits Policy	Québec
Conversation on Health Care	British Columbia
Wait Times Guarantee	Pan-Canadian

Romanow Roadshow

In the previous chapter we began to assess Romanow's post-commission activities, examining his appearances in the weeks following the submission of his final report. That preliminary assessment revealed Romanow's commitment to advocating the recommendations contained within the final report. This section will continue that assessment by considering Romanow's long-term involvement in the health policy debates. The discussion will consider the actions of the commissioner in comparison to those of his predecessors and one of his successors. The discussion will also consider the conduct of members of Romanow's team of researchers and analysts following the submission of the final report.

When the commission submitted its final report, Roy Romanow and his team of researchers and analysts had completed the task they were commissioned to accomplish. After eighteen months, Romanow and his staff had travelled across the country, conducted interviews with hundreds of "experts," held dozens of public consultation

sessions, and written a three-hundred and fifty-seven page report containing forty-seven recommendations for reforming health care. The commissioner and his team would have been entitled to say that their work was finished.

The previous chapter has demonstrated Romanow's commitment to retaining a public presence in the first weeks in which the report was submitted. As the five-year anniversary of the submission of the final report approaches, Romanow is still travelling the country giving speeches, lectures, and participating in debates on the "state of health care in Canada."

Beginning in the spring of 2003, Romanow began a speaking tour that continues to this day. Many of his speeches allude to the recommendations of the final report. Typically, he juxtaposes contemporary policy discussions with an alternative offered by his report.[180] His own estimates put the number of speeches in the hundreds. Tables 4.2, 4.3, 4.4, and 4.5 show a few dozen of his public lectures since 2003.

Table 4.2 Key Romanow Speeches in 2003

Date	Location	Topic
Feb 13/03	University of Regina	"Assessing the 2003 Health Accord"
May 8/03	International Foundation Awards, Ottawa	"Connecting the Dots: From Health Care and Illness to Well Being"
June 3/03	Killam Lecture, Halifax	"Towards a Health nation: Being Determined about the Determinants of Health"
Sept 21/03	Canadian Institute for Health Research, Ottawa	"Fairness and Health"
Sept 23/03	George Washington University	"Access to Quality Care: Assuring the Success of Canada's Health Care System"
Nov 6/03	University of Ottawa	"Directions in Canadian Healthcare"
Nov 27/03	Hart House, Toronto	"Remarks on the Eve of the Anniversary of *Building on Values*"

Source: Atkinson Charitable Foundation

[180] A large portion of the content of Romanow's speech appears in Roy Romanow, "A House Half Built," *Walrus Magazine*. Toronto: June, 2006. 48-54.

Table 4.3 Key Romanow Speeches in 2004

Date	Location	Topic
Jan 29/04	Inaugural Health Council Meeting	"A Cure for Hardening of the Categories"
Apr 23/04	Registered Nurses of Ontario, Toronto	"Alice Through the Looking Glass: Standing Up for the Future of Medicare"
May 11/04	Conference on Canadian Index of Wellbeing, Toronto	"How are we doing, really? Developing a Canadian Index of Wellbeing"
May 17/04	National Primary Health Care Conference, Winnipeg	"Medicare: Now is the time for Action"
Aug 18/04	Canadian Medical Association, Toronto	"Do No Harm: Towards Healthy Health Care Reform"
Sept 28/04	Six Nations Vision 2020 Symposium	"Moving Forward on Aboriginal Health"
Sept 30/04	University of Toronto	"The Health of Medicare and the Health of Canada"
Oct 14/04	Canadian Council on Social Development, Ottawa	"The New Canada Social Transfer: Impetus for a Renewed Era of Innovate Social Policy in Canada?

Source: Atkinson Charitable Foundation

Table 4.4 Key Romanow Speeches in 2005

Date	Location	Topic
Feb 9/05	Carleton University	"The Elephant in the Living Room: Evidence over Ideology in Health Care Delivery"
Feb 18/05	St. Jerome's University,	"Health Care and Canadian Values"
May 6/05	United Way of Canada, Toronto	"The Canadian Index of Wellbeing: Taking measure of the Things that Count"
June 18/05	Carleton University	"Vision, Values and the Future of Canada"
Sept 16/05	University of Toronto	"In Search of a Mandate? The Supreme Court's Decision in *Chaoulli v. Attorney General of Québec*"
Nov 4/05	Council of Canadians, Ottawa	"Recommitting to the Miracle of Canada"

Source: Atkinson Charitable Foundation

Table 4.5 Key Romanow Speeches in 2006

Date	Location	Topic
June 2/06	Association of Early Childhood Educators / Ontario Coalition for Better Childcare, Toronto	"Child Care and the Future of Canada"
June 8/06	United Way of Saskatoon	"Shared Destiny: Focusing on what matters for our Communities"
Sept 13/06	Oil Refining Industry, Houston	"The Canadian Health Care System: Successes and Future Challenges"
Oct 12/06	University of Victoria	"Health Care and Canada's 'Shared Destiny'"
Oct 27/06	University of Western Ontario	"What Kind of Society Do We Want? Social Values and the Health and Well-Being of Canadians"
Nov 8/06	Canadian Index of Wellbeing Workshop, Toronto	"Measuring Success"

Source: Atkinson Charitable Foundation

The submission of the final report is typically the point at which commissioners choose to disengage. The tendency to remove oneself from the process upon the completion of the report is, in part, a product of the judicial underpinnings of the tradition of public inquiries. The tradition of judicial impartiality discouraged justices from participating in the post-commission discussion. Particularly where it involved criticizing governments, a justice's appearance of impartiality could be compromised. It was, therefore, prudent to abstain from publicly commenting once the commission's work had come to an end.

Many commissioners abstain from public comment can also be attributed to a lack of resources of staffing, funding, office space, or equipment, that are necessary to retain a public presence. If a commissioner wishes to pursue further public involvement, he or she does so without financial or staff support.

Finally, commissions are creatures of the government that establishes them. Once the commission has submitted its final report, it has completed the task for which it was created. Commissioners are effectively rendered silent by the absence of a public platform from which to comment on policy issues.

There are examples of commissioners that have chosen to depart from this practice. In the months after he tabled his final report, Emmett Hall, chair of the Royal Commission on Health Services, actively defended his recommendations in interviews, lectures, and appearances on television and radio.[181] Like the Romanow commission, the Hall commission dealt with a politically sensitive subject matter. Hall defended his recommendations against considerable opposition. He was criticized by his colleagues on the Supreme Court for intervening in the political process.

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[181] Dennis Gruending, *Emmett Hall: Establishment Radical*. Toronto: Macmillan of Canada, 1985. 97.

Donald Macdonald, chair of the Royal Commission on Economic Union and Development Prospects for Canada, is another example of a commissioner who assumed a post-commission advocacy role. Macdonald became heavily involved in the free trade debates of the late 1980s.[182] Like Romanow, Macdonald was a former politician. The recommendations of the Macdonald commission represented a serious departure from the status quo economic policy. Macdonald, along with several dozen prominent business leaders and former Alberta Premier Peter Lougheed, championed the implementation of the commission's primary recommendation: a free trade agreement with the United States.[183]

Another example of advocacy is the work of André Laurendeau, A. Davidson Dunton, and Jean-Louis Gagnon, co-chairs of the Royal Commission on Bilingualism and Biculturalism.[184] The commissioners remained engaged in an awareness campaign during the three-year period in which their five volumes of reports were written and released. Their work came to an end when Pierre Trudeau's election as leader of the Liberal Party and Prime Minister of Canada led to an elevation of bilingualism as a government priority.[185]

A fourth example is the work of the commissioners of the Royal Commission on the Status of Women. Commissioner Laura Sabia championed the cause of implementing the recommendations of her commission. She formed the National Action Committee on the Status of Women (NACSW), along with a coalition of feminist organizations, in the

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[182] Gregory Inwood, *Continentalizing Canada: The Politics and Legacy of the Macdonald Royal Commission*. Toronto: University of Toronto Press, 2005. 302.
[183] Inwood, 301.
[184] André Laurendeau, the original co-chair, passed away in the final year of the commission. Jean-Louis Gagnon replaced him as co-chair.
[185] J .L. Granatstein, *Canada 1957-1967: The Years of Uncertainty and Innovation*. Toronto: McClelland and Stewart Limited, 1986. 255.

early 1970s.[186] The NACSW is dedicated to the implementation of the recommendations of the Royal Commission on the Status of Women.

It is also important to note the work of former Justice Thomas Berger, chair of the Mackenzie Valley Pipeline Inquiry. Berger is unlike the previous four examples, in that his advocacy work does not exclusively relate to his recommendations. The Berger Inquiry's prominent recommendation was a moratorium on pipeline projects, which was adopted by the Trudeau government.[187] The report of the commission was an important part of a career dedicated to the issue of aboriginal land title. Rather than advocating the implementation of his recommendations, his is a form of legal activism that has played an integral role in shaping the legal framework of aboriginal reconciliation.

Many commissioners of public inquiries have retired from public involvement upon the submission of their final reports. For example, Georges Erasmus and René Dussault, co-chairs of the Royal Commission on Aboriginal Peoples, have remained almost silent in the ten years since their final report was tabled. Another recent example is that of retired Justice John Gomery, chair of the Commission of Inquiry into the Sponsorship Program and Associated Activities. Gomery refrained from public comment after submitting the report containing his findings. He is a useful example because the work of his commission began shortly after Romanow's concluded.

Whereas Romanow welcomed the opportunity to become an advocate for the recommendations contained within his final report, Gomery submitted his findings on February 1, 2006, and has remained silent on the issue ever since. Romanow continues to give speeches, lectures, and participate in roundtable discussions. He has never shied

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[186] "Herstory," Nation Action Committee on the Status of Women. http://www.nac-cca.ca/about/his_e.htm
[187] Peter Puxley, *A Model of Engagement: Reflections on the 25th Anniversary of the Berger Report.* August, 2002. Ottawa: Canada Policy Research Networks.

away from the opportunity to criticize intergovernmental agreements and policy decisions. Gomery is a prototypical example of the former justice, who retains an appearance of impartiality throughout the process. Romanow is an atypical example of a commissioner, choosing to utilize the spotlight to advance the recommendations contained in his final report.

The former Premier has clearly chosen to diverge from the path of maintaining impartiality. For Romanow, contributing to the public debate on reforming the system of public health insurance is a logical extension of a lifetime of speaking out on issues. His has been an active political career marked by strong stances on issues such as the patriation of the Constitution, fundamental human rights, economic justice, public health insurance, and state-delivered health services.

Romanow describes his motivation for remaining actively engaged in the policy debate as a desire "for the public to know more about what the royal commission really said."[188] "My view is that, if I hadn't spoken out, there would not have been any public voice speaking out." His determination to remain engaged in the public debate on health care is a product of his political background: "I knew this from my political life…you have to explain what you mean." He explains that his long-term advocacy is the result of public demand for information: "There was an absolute desire… by the public at large" to hear the commissioner's arguments for reforming the health care system.

Like Romanow, several members of the commission have remained active in health policy development or advocacy. Though, none of Romanow's staff members have been as vocal as Romanow himself, several members did go on to serve in health agencies and organizations and as consultants for governments. For example,

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[188] Roy Romanow, interview with the author, March 2, 2007.

Pierre-Gerlier Forest, the commission's director of research, was given a position at Health Canada as special advisor to the Deputy Ministry on "emerging health issues."[189] Jennifer Bayne, knowledge management director for the commission, became the director of knowledge management for Canada Health Infoway. Stephen Lewis, another of the commission's research directors, and Andrew Noseworthy, director of intergovernmental relations, returned to their work at the University of Calgary and government of Newfoundland and Labrador, respectively. Tom McIntosh became the Director of the Health Network for the Canadian Policy Research Network.

Greg Marchildon, the commission's executive director, has remained an active voice for health reform in the academic community. He was a panelist on CBC radio during the 2004 first ministers' conference. In the spring of 2006, Marchildon published a book entitled *Health Systems in Transition: Canada*, in which he documents the policy decisions and agreements that have contributed to the current state of health care in Canada. He has also authored numerous articles pertaining to the reform of the system. For example, one of his articles responds to the *Chaoulli v. Québec* decision. In it he argues that governments would be wise to re-write their medical insurance legislation to offer an explanatory note on the principles enshrined in the legislation to protect state-funded and -delivered services.[190]

Romanow's determination to remain active in the field is the most strikingly unique feature of the commission. Previous commissioners have become engaged in advocacy. Hall and Macdonald carried out very public advocacy campaigns for months

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[189] "News Release - Dr. Pierre-Gerlier Forest named to post at Health Canada," Health Canada. August 5, 2003. http://www.hc-sc.gc.ca/ahc-asc/media/nr-cp/2003/2003_64_e.html

[190] Gregory P. Marchildon, "The Chaoulli Case: A Two-Tier Magna Carta?," *Health Care Quarterly*, 8, v 4. (2005). 420-8.

after their commissions submitted final reports. Laurendeau, Dunton, and Gagnon were actively engaged in an awareness campaign until Trudeau became Prime Minister and became the champion of their cause. Laura Sabia's determination led to the creation of the Nation Action Committee on the Status of Women. [191] The duration of Romanow's advocacy and his perseverance as an activist makes him distinct from these commissioners. Unlike Hall, Macdonald, Laurendeau, Dunton, Gagnon, and Sabia, Romanow's engagement in the policy debate has been a sustained effort. Whereas these commissioners became disengaged from the process after six months or a year, Romanow has remained involved for nearly five years with no indication of retirement. His long-term involvement separates him from previous commissioners and sets the Romanow commission apart from its predecessors.

Legacy of the Romanow Commission

The Romanow commission was an influential force in the agreements of the first ministers in 2003 and 2004. In order to argue that the commission had a direct impact we must show two things. First, do the policy changes made after 2002 match the main recommendations contained within Romanow's final report? Second, assuming that they do, can we make a strong argument that the commission's report had a direct causal impact (ie. That there are not credible alternative interpretations of the correlation). Let us consider each question.

Several key recommendations contained within the report have arrived in the form of commitments by the first ministers and their health ministers. Among these

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[191] Thomas Berger's involvement is distinct from advocating the implementation of his recommendations. Berger has dedicated years to the issue of aboriginal land title.

recommendations is the Health Council of Canada, a central component of Romanow's report, was established within one year of tabling of the report. Though the composition of the Council deviates slightly from the plan created in the report, its establishment seems to demonstrate the influence the commission had in shaping intergovernmental agreements.

Another example is the Canada Health Transfer, designed to separate federal health funding from other transfers, was implemented in the Health Accord of 2003. The commission originally recommended the creation of five separate interim transfers, which could be consolidated into a single transfer equaling twenty-five per cent of provincial health spending. The Canada Health Transfer was also meant to exclude "tax points" as a component of the transfer. The agreement of the first ministers in 2004 brought the transfer to twenty-five per cent, excluding "tax points."

A third example is the National Pharmaceuticals Strategy, whose development is governed by a special Ministerial Task Force. It was initiated as part of the 2004 first ministers' Ten-Year Agreement on Health Care. The strategy integrates several components of Romanow's recommendations, including the idea of a common prescription drug plan and his notions concerning the assessment of the efficacy of prescription drugs for inclusion within the plan. Romanow advanced the idea within the report and it came to fruition through the 2004 first ministers' agreement.

Other recommendations have been formalized in the form of agreements, as well. Though, they are not precisely as the commission designed them, the commission's work is evident in their implementation. Among these recommendations is the development of electronic health records, which is coordinated by a pan-Canadian agency known as

Canada Health Infoway. Another example is the waitlist reduction strategies that have been developed in each jurisdiction, with national collaboration and sharing of information. The framework of the Wait Times Guarantee has the potential to deviate from the recommendation contained within the Romanow report. However, as the Guarantee will not be operational until 2010, it is premature to make an assessment about its alignment with Romanow's recommendation. A final example is the training and retention of health care providers. Strategies are being developed in each jurisdiction, with national collaboration and sharing of information.

Table 4.6 First Ministers' Agreements by Recommendation

Romanow's Recommendation	First Ministers' Agreement	No Agreement to date
Health Council of Canada	Created in 2003	
Canada Health Transfer	2003 Health Accord	
Prescription Drug Formulary	2004 Ten-Year Agreement	
Electronic Health Records	2003 Health Accord	
Waitlist Reduction	2004 Ten-Year Agreement	
Training and Retention of Health Care Providers	2004 Ten-Year Agreement	
Health Covenant		No Agreement
"Modernizing" the *Canada Health Act*		No Agreement
Aboriginal Health Partnerships		No Agreement

Table 4.6 shows the main recommendations of the Romanow commission and their implementation by agreement or lack thereof. Six of the nine main recommendations discussed throughout the thesis have been formalized in an agreement in some form or another. That these developments share a commonality with the recommendations of the Romanow commission does not enable us to conclude that the agreements and arrangements are the product of the report.

Few academics in Canada have studied the role of a royal commission with respect to its influence on policy formulation. Neil Bradford writes about the Rowell-Sirois and Macdonald commissions and the role that each played in shaping economic policy in the subsequent decades.

Bradford's analysis considers the role of the Rowell-Sirois commission in serving as a conduit for economic ideas in the post-depression era. Bradford argues that the period was one in which the economic philosophy described as "Keynesian economics," became embedded within state economic policy development.[192] Rather than attribute the emergence of Keynesian economics in Canada to the commission, he believes that the commission reflected the shift that was occurring within the public service in Ottawa and across the country. The changing public service enabled new economic ideas to permeate the economic policies that would give shape to the post-war economy.[193]

Bradford offers a similar analysis of the Macdonald commission. He argues that the commission was created at a time in which a new economic philosophy was capturing the attention of the public service. Once again the commission is seen as reflecting, rather than influencing, the emerging economic ideas of the period.[194]

In both cases, Bradford suggests that the governments' decisions to embrace the ideas offered by the commissions was the culmination of larger circumstances. The policy decisions that followed the reports of the commissions can, in part, be attributed to

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[192] British economist, John Maynard Keynes, is the eponym for the economic theory. Keynes is particularly remembered for his notion that governments possess the capacity to mitigate economic recession and depression with fiscal spending.

[193] Neil Bradford, "Innovation by Commission: Policy Paradigms and the Canadian Political System," *Canadian Politics*. 3rd edtion. James Bickerton and Alain-G. Gagnon, eds. Peterborough: Broadview Press, 1999. 552.

[194] Bradford, 558.

the commissions. However, Bradford insists that multiple factors contributed to the commitment to new economic ideas.

The evidence, as shown in Table 4.6, suggests that the Romanow commission had a causal relationship with the agreements of 2003 and 2004. However, we cannot rule out, with certainty, the causal relationship of other factors during the development of the agreements. Unlike Bradford's analysis, the opportunity to view the decisions of governments in response to the reports of the royal commission within the context of the multiple factors that, over the long-term, influenced the governments' decisions is not available here. It has been fewer than five years since Romanow submitted his final report to the cabinet. In that short time, significant changes have occurred in the health policy field. Many of the ideas contained within the report have found their way into the intergovernmental agreements and policy decisions, announced since the commission completed its work.

Would the Health Council, Canada Health Transfer, and National Pharmaceuticals Strategy have been developed were the commission never created? The answer is likely yes. In some form or another, each of these developments would probably have occurred at some point, regardless of the commission's work. As Bradford suggests of the Rowell-Sirois and Macdonald commissions, it appears that the Romanow commission has served as a kind of conduit for ideas to become policy. The commission provided a vehicle for ideas to be delivered to the first ministers for discussion. The commission can be credited for creating an opportunity for intergovernmental collaboration on a variety of health policy reforms in response to its final report.

It is premature to make a long-term assessment of the type of commission Romanow will prove to be. However, this discussion is an attempt to speculate on the legacy of the commission in retrospect. In twenty years, what will the legacies of the commission be? How will the commission be remembered?

Neil Bradford argues that there are two types of public inquiries: "the universe is in trouble" and "guide to decision." "The universe is in trouble" commissions "have been central to social learning on fundamental questions of state-society relations and catalysts for major policy innovation."[195] "Guide to decision" commissions "provide advice in the form of programmatic ideas to assist governments in making policy adjustments within the existing public philosophy."[196] The latter types are not meant to break new ground in policy formulation, but are established to create a roadmap for implementing policy options within the framework of the larger, pre-established, policy course.

The Romanow commission will likely be remembered as a "guide to decision" commission. The commission fits within Bradford's definition, as it provided "advice in the form of programmatic ideas to assist [the government] in making policy adjustments within the existing public philosophy."[197] The commission did not offer recommendations for fundamental reform to the system of public health insurance and services. The forty-seven recommendations contained within the final report are all embedded within a single-payer framework for the administration and delivery of health services. The commission did not forecast a critical shift in the ways in which health services are provided. Instead, the commission offered ideas for modifying the current

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[195] Bradford, 548.
[196] Bradford, 549.
[197] *Ibid.*

methods for delivering services to preserve what it believed to be the positive attributes of the system.

In my view, we must go beyond the confines of Bradford's two categories to properly assess Romanow's legacies. In addition to producing a report that could serve as a "guide to decision" for governments, the commission made a significant contribution to the health policy networks that existed prior to its creation. Health policy is an incredibly expansive field, in which experts are proliferated into various areas of interest. The commission re-configured the policy networks and, perhaps, expanded them, by creating an extensive research project on which various networks could collaborate. The product of that research is another contribution of the commission. Forty discussion papers were created for the commission's consideration. The expert analysis contained within those papers is an invaluable resource to the health policy community.

Further to the reconfiguration of the health policy network and the contribution to research and analysis, the commission was symbolically important. In requesting expert testimony and engaging the public, the commission succeeded in capturing the attention of a large number of Canadians. The attention given to the commission is very likely a product of the importance of the health care system as a symbol of Canadian identity.[198] In the 1960s, the Hall commission generated considerable public interest with its exploration into the health system and recommendation of a system of public health insurance. The Hall commission is often cited as an integral component of the development of the health system in Canada. Emmett Hall's name has become

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[198] For an elaboration on the importance of the health system among Canadians, see the introductory chapter of this thesis.

synonymous with public health insurance. The Hall commission has assumed a critical symbolic position in the development of the health system.

Is the Romanow commission destined for a similar symbolic status? Like Hall, Romanow's work touches on a subject matter of significant importance to Canadians. It seems that, simply by association with the health care system, the commission will be regarded as important. The commission's engagement with citizens and the attention it captured will likely ensure that the commission is remembered for its influence on health policy development. The discussion of values that is embedded within the pages of the report speaks to the symbolic legacy the commission has likely created. Romanow understood the symbolic importance of public health insurance as a statement of Canadian values.[199] By weaving his recommendations into that values framework, Romanow has integrated himself into that values system. In twenty years, a discussion about the public health care system is just as likely to include Roy Romanow as Emmett Hall and all the other names attributed to the development of public health insurance.

It terms of policy legacies that could be attributed to the commission, the most tangible example is the increased federal contribution to health spending. The commission recommended a consistent "cash" contribution of twenty-five per cent of the total provincial and territorial expenditure. The two first ministers' agreements met that target and included a six per cent funding "escalator." The "escalator" ensures that the federal contribution remains consistent. It also effectively ends decades of funding disputes.

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[199] On this point, one need not look any further than the tile of the commission's report: *Building on Values.*

Another long-term policy legacy will likely be the intergovernmental collaboration that is a product of the two first ministers' agreements. The Ten-Year Agreement is particularly insistent that each jurisdiction develop indicators and targets for waitlist reductions and recruitment and training of health care professionals. Each jurisdiction will share these indicators and targets in annual progress reports. More than ever before Ottawa, the provinces, and territories are collaborating and sharing information. In addition to the consistent federal funding, the new level of collaboration is a likely long-term policy legacy.

Conclusions

The system of public health insurance and service delivery has been the subject of speculation, discussion, and decisions for decades. Recent years have not been different. The decision of the Supreme Court of Canada in the *Chaoulli v. Québec* case has re-ignited speculation about the role of private operators in the delivery of health services. The consequences of the decision are still unclear. The decision has contributed to new policy frameworks in two jurisdictions to date, and will likely contribute to future policy development across the country.

Roy Romanow has actively maintained a role in the discussion on health policy since the tabling of the final report of the commission he chaired. His decision to assume an advocacy role rather than retire from the debate on health care separates him from other commissioners. Romanow's speeches, lectures, participation in public debate, and public comments on the decisions of governments, are the defining attributes of this episode of Canadian policy history. Few commissioners have maintained a public profile following the conclusion of the commission's work. Romanow's advocacy role has

helped to define the commission he chaired. His active engagement in the public debate certainly contributed to the pressure on the first ministers to reach an agreement on two separate occasions. Romanow remarks that, in his absence, "there would not have been any public voice speaking out" in defence of the commission's recommendations.[200]

The Romanow commission will have many legacies. In terms of the policy legacies that can be attributed to the commission, the consistent federal funding and the new level of collaboration will likely be the commission's long-term policy legacy. A second legacy is that it will likely be remembered as a "guide to decision" commission that assisted governments in making important decisions to reform the health care system. A third legacy will be the re-configuration of the health policy networks and its contribution to the literature on research and analysis. The symbolic importance of the commission is another of its legacies. By weaving his recommendations into a narrative of Canadian values, Romanow has integrated himself into that values system. In twenty years, a discussion about the public health care system is just as likely to include Roy Romanow as Emmett Hall and all the other names attributed to the development of public health insurance.

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[200] Roy Romanow, interview with the author, March 2, 2007.

Conclusion

Situating the Romanow Commission

Genesis of Public Health Care

The history of Canada's system of public medical insurance is one of jurisdictional and fiscal arrangements. The Constitutional division of powers and revenue-raising authority meant that creating a national system of medical insurance was an impossibility. Health insurance across the country is regulated by each jurisdiction, necessitating the coordination of service delivery in each province to align with national guidelines. It took twenty years to expand medical insurance from a hospital insurance programme in Saskatchewan to a system of coast-to-coast coverage of medical services.

Once Canada had established a system of public medical services, the system was subject to constant fluctuation and modifications. Fiscal crises and political conflicts resulted in decades of changes to the system and inspired intergovernmental tension. As the system neared the forty-year mark, it began to show signs that the constant changes were taking a toll and Canadians began to vocalize their concerns about the system's future. In an effort to demonstrate action on the health policy front, the Prime Minster created a royal commission to explore the future of health care in Canada.

Royal Commissions

Royal commissions have played an integral part in shaping modern Canadian society. They have been created to study innumerable aspects of life in Canada. The survey of the literature on public inquiries demonstrates the remarkable variations among commissions. Inquiries, by any name, are bodies of various forms. There is an important distinction between investigative and policy inquiries. Both have made significant contributions to

Canadian society, but their conduct and composition are radically different. The subject areas of interest to a commission also create distinctions. Commissions can be given a mandate to explore "recurring" and "non-recurring" policy matters. Commissions are also distinguished by their composition. Commissions can be multi-member bodies, in which governments attempt to make considerations for the appointment of commissioners representing regional, ethnic, linguistic, and gender differences. For single-member commissions, the commissioner will attempt to create a representative research team. The cost of a commission is another key indicator of its type. Every commission conducts its research, interviews, and deliberations differently.

Beyond the work of the commission, the public reception given to the final report of the royal commission is a useful measure of the importance of the public policy area and a means of classifying the commission. The extent to which a commissioner involves himself or herself in the post-commission process is another indicator of typology.

This framework has proven to be useful for a case study of this type. It could serve as a framework for further comparative analysis of commissions. Such research, for example, might explore the interconnections between the dimensions explored in this thesis.

Building on Values

The Romanow commission was appointed in April of 2001 for multiple reasons. The commission spent eighteen months travelling the country, researching, and composing a report of forty-seven recommendations for changes to the health care system. When the commission tabled its final report, the reception was mixed.

When the Prime Minister convened a first ministers' conference in 2003, it addressed several areas where Romanow had recommended policy changes. Primary health care, home care, catastrophic drug coverage, the purchase of diagnostic and medical equipment, and information technology are all areas in which Romanow recommended policy changes. Using the five separate funds and transfers, Romanow recommended that Ottawa assist the provinces and territories in strengthening health care in a number of policy areas. The 2003 Health Accord created a single Health Care Reform Fund, from which all six areas would receive funding. The new fund increased Ottawa's share of health care expenditure by seventeen billion dollars over five years.

Eighteen months after the first conference, the first ministers met again. The 2004 first ministers' conference on health care was another opportunity to implement the Romanow recommendations. Ottawa increased its share of funding by forty-one billion dollars over ten years. The Health Care Reform Fund would continue to be the vehicle for addressing reform in primary health care, home care, catastrophic drug coverage, and assist in the purchase of diagnostic and medical equipment, and information technology.

The two first ministers' conferences drove federal funding upwards by more than fifty billion dollars, meeting Romanow's target of twenty-five per cent of public health spending. The conferences produced a multitude of policy reforms that affect both levels of government. The decision of the Supreme Court of Canada in the *Chaoulli v. Québec* case has re-ignited speculation about the role of private operators in the delivery of health services. The consequences of the decision are still unclear. The decision has contributed to new policy frameworks in two jurisdictions to date, and will likely contribute to future policy development across the country.

Situating Romanow

The Romanow commission can now be situated along the eight dimensions of variation. As indicated in Table 5.1, the Romanow commission was a royal commission concerned with the exploration of a matter of public policy. Though the public policy matter is continuous, the particular concern of the commission was its future. That the commission was tasked with recommending modifications to the system of public health insurance suggests that the concern was "non-recurring." The commission was created on April 3, 2001 and its terms of reference required that its final report be submitted to the government within eighteen months. Romanow delivered an interim report on February 2, 2002, followed by the final report on November 28, 2002.

For the eighteen-month duration of the commission, the Privy Council allocated $18,876,400.[201] According to Nicholas d'Ombrain's calculations, the costs of the Romanow commission are below the average costs of a modern policy inquiry.[202] Romanow commissioned a large team of researchers and analysts in addition to his directors and executive directors. His appointments suggest that he was careful to consider regional, linguistic, ethnic, and gender representation.

The commission placed an emphasis on public input into the process, which is evidenced by the twenty-one open public hearings, nine expert workshops, three regional forums, twelve "Partnered Dialogue Sessions," and nine public surveys. In addition to hearing from the general public, the commission visited with dozens of health care stakeholders and advocacy groups and commissioned forty discussion papers, written by a broad cross-section of "experts."

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[201] "Privy Council Office – Performance Reports for the period ending March 31, 2003." Treasury Board of Canada Secretariat. http://www.tbs-sct.gc.ca/rma/dpr/02-03/pco-bcp/pco-bcp03d01_e.asp

[202] d'Ombrain, Nicholas, "Public Inquiries in Canada," *Canadian Public Administration*, vol. 40 (1997). 98.

Roy Romanow has actively maintained a role in the discussion on health policy since the tabling of the final report of the commission he chaired. His decision to assume an advocacy role rather than retire from the debate on health care separates him from other commissioners. Romanow's decision to remain engaged in the long-term public debate on health care is the most strikingly unique attribute of the commission. There is no precedent for long-term advocacy of a commission's report. In this respect, the Romanow commission, and Romanow himself, have broken new ground.

The Romanow commission will have many legacies. In terms of the policy legacies that can be attributed to the commission, the consistent federal funding and the new level of collaboration will likely be the commission's long-term policy legacy. A second legacy is that it will likely be remembered as a "guide to decision" commission that assisted governments in making important decisions to reform the health care system. A third legacy will be the re-configuration of the health policy networks and its contribution to the literature on research and analysis. The symbolic importance of the commission is another of its legacies. By weaving his recommendations into a narrative of Canadian values, Romanow has integrated himself into that values system. In twenty years, a discussion about the public health care system is just as likely to include Roy Romanow as Emmett Hall and all the other names attributed to the development of public health insurance.

The Royal Commission on the Future of Health Care in Canada was created at a crucial point in the history of the health system. The commission was unique in that few royal commissions had been created to study major public policy areas since the 1960s. The conduct of the commission was unusual, by modern inquiry standards, in that it

dedicated a considerable amount of time and resources to traveling across the country to conduct workshops, surveys, public forums, and consultation sessions. The most strikingly unique attribute of the commission has been the post-commission involvement of the commissioner. Since the tabling of the final report, Roy Romanow has traveled the country giving speeches, lectures, participating in public debate, and publicly commenting on the decision of governments.

Table 5.1 Assessment of the Romanow Commission by Dimension

Dimension	Assessment
Reason for creation	A. 1. Sample public opinion 2. Postpone action 3. Obfuscate other commissions' findings. B. Non-recurring policy issue
Composition	Single Member
Duration	18 months
Cost	$18,876,400.00
Degree of reliance on "experts"	Heavy reliance on "experts" and equal reliance upon public consultation
Public Profile	High
Post-commission role	Extremely Active
Legacies	1. Consistent federal cash transfers 2. Pan-Canadian Collaboration 3. "Guide to Decision" Commission 4. Re-configuration of health policy network and literature contribution 5. Symbolic importance

Medicare Champion

Romanow's presence in the health policy field has made him an enduring figure, championing reforms that preserve the public system. Upon assuming the chair of the

royal commission, Romanow suggests, "I had no intention of wanting to be a leading health care advocate… I was a passionate believer in health care."[203] After a long political career, the opportunity to defend the public system was an obvious next step: "When the issue came up, as a potential royal commissioner, when I stepped out of political life, it was natural for me to take it." "I didn't assume that I would be the leading spokesperson." His considers the decision to remain engaged the product of the debate, which the commission's report helped to frame: "I think it is the consequence of the subject matter. It is a very important subject matter. It is dear to Canadians' hearts. It is a contentious subject matter…In the consequence somebody takes the lead on one side or the other." Romanow may not have chosen the role, but he was, perhaps, the most logical choice to assume it. His involvement over the past five years suggests that he will likely continue to advance his position and remain the champion for the public system.

[203] Roy Romanow, interview with the author, March 2, 2007.

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Index of Acronyms

AHP – Aboriginal Health Partnerships

CAP – Canada Assistance Plan

CHA – Canada Health Act

CHST – Canada Health and Social Transfer

EPF – Established Programs Financing

HIDSA – Hospital Insurance and Diagnostic Services Act

MCIA – Medical Care Insurance Act

MRI – Magnetic Resonance Imaging

NACSW – National Action Committee on the Status of Women

NPS – National Pharmaceuticals Strategy

PCO – Privy Council Office

PEHR – Personal Electronic Health Record

PMO – Prime Minister's Office

SUFA – Social Union Framework Agreement