Government Structure, Service System Design, and Equity in Access to Psychotherapy in Australia, the United Kingdom, and Canada

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ABSTRACT

This article reports the results from 22 interviews regarding the relationship among government structure, service system design, and equity in access to psychotherapy in Australia, the United Kingdom and Canada. Key themes focused on the strong relationship between government structure and at least one other factor in shaping psychotherapy reforms in each country, as well the persistence of inequities despite the introduction of universal reforms. These findings suggest that improving equity in access will require explicit focus regardless of government structure or service system design.

Keywords: governance, equity, psychotherapy, Australia, United Kingdom, Canada

RÉSUMÉ

Cet article présente les résultats de 22 entrevues concernant la relation entre la structure gouvernementale, la conception du système de services et l'équité d'accès à la psychothérapie en Australie, au Royaume-Uni et au Canada. Les thèmes clés ont été axés sur les relations étroites existant entre la structure gouvernementale et au moins un autre facteur déterminant dans les réformes de la psychothérapie dans chaque pays, ainsi que sur la persistance des inégalités malgré l'introduction de réformes universelles. Ces résultats suggèrent que l'amélioration de l'équité d'accès nécessitera une attention explicite, quelle que soit la structure gouvernementale ou la conception du système de services.

Mots-clés : gouvernance, équité, psychothérapie, Australie, Royaume-Uni, Canada

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Both Australia and the United Kingdom (UK) have implemented wide-reaching reforms to improve access to psychotherapy for more than a decade. The Australian government launched the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medical Benefits Schedule (Better Access) initiative in 2006, expanding universal Medicare coverage to include psychologists and other mental health professionals (Australia, 2018). Improving Access to Psychological Therapies (IAPT) is a stand-alone psychotherapy service that was launched by the UK government in 2008, and directly implemented in every district of England with oversight from the National Health Service England (NHS England, n.d.). This kind of population-wide reform has yet to be introduced in Canada, where a decentralized government structure has constrained public funding for psychotherapy and other mental health services (Bartram & Lurie, 2017). While physician and hospital services are covered by public health insurance, psychological services and other non-physician mental health professionals are not. As a result, higher-income Canadians either pay out-of-pocket or through employment-based insurance and lower-income Canadians face considerable financial barriers or long waits for limited community-based services. With international reforms drawing attention to these issues and pointing to viable solutions, calls for expanded access to psychotherapy and other community-based services in Canada are growing stronger (Mental Health Commission of Canada, 2018; Canadian Alliance on Mental Health and Mental Illness, 2016; Health Quality Ontario, 2016).

Equitable access to health services is based on need rather than on ability to pay or other factors and is a core objective of the Canada Health Act (s3, 1985). A window of opportunity to address long-standing gaps and inequities in mental health policy has recently opened, with provincial and territorial governments in the early stages of allocating a new targeted federal transfer. In 2017, the Canadian federal government announced a targeted transfer of CDN$5 billion over 10 years to support provincial and territorial governments in improving access to mental health and addiction services (Finance Canada, 2017). As of May 2019, bilateral funding agreements have been signed between the federal government and all 13 provinces and territories and the Canadian Institute for Health Information has begun reporting on six pan-Canadian indicators (Canadian Institute for Health Information, 2019; Government of Canada, 2019). Nevertheless, the indicators are of a very high level and there is considerable variation in the range of mental health and addictions priorities covered by each agreement. Accordingly, it remains to be seen how far this new transfer will go toward improving access to mental health services and how much will go toward improving access (and equity in access) to psychotherapy in particular (Bartram & Chodos, 2019; Bartram & Lurie, 2017). To date, Ontario and Quebec are piloting reforms to directly increase access to psychotherapy and other provinces and territories have introduced initiatives ranging from online psychotherapy services to enhanced primary care. However, no jurisdiction has expanded public insurance coverage nor specifically addressed equity as yet.

Through interviews with subject matter experts in Australia, the UK, and Canada, three parliamentary democracies with universal health systems but contrasting government structures and approaches to mental health reform, this study provides an in-depth exploration and comparison of the relationship between government structure, service system design, and equity in access to psychotherapy. There are two specific research questions. First, what is the relationship between government structure and the design of psychotherapy reforms? This question explores what we can learn from all three countries about how to maximize available policy levers for psychotherapy reform, even in Canada's decentralized government context. Second, what

are the equity impacts of the different service system designs arising in different government contexts? This question explores how efforts to address long-standing equity issues in Canadian mental health policy can be guided by lessons learned from the equity impacts of reforms in the UK and Australia. By hearing directly from people with deep knowledge of these issues in these three countries, this study complements broader policy research about how to adapt lessons learned regarding psychotherapy reforms in Australia and the UK to the Canadian context (Bartram, 2019a; Mental Health Commission of Canada, 2018).

The literature regarding the relationship between government structure and capacity for policy reform suggests that the UK should have considerably more capacity for psychotherapy reform than Australia and Canada, and that Australia should be in a stronger position than Canada. As parliamentary systems, these governments should all be better able to push through controversial reforms than less centralized presidential systems (Weaver & Rockman, 1993). However, federal parliamentary systems require agreement from both regional and national levels of government, which in turn creates incentives for shifting blame and gives rise to jurisdictional tensions (Banting & Corbett, 2002; Pierson, 1995). Of the three parliamentary systems in this study, the UK is by far the most unitary (at least as far as England is concerned), with a command-and-control health system run by the National Health Service. While the Australian federation is less centralized, the federal government has jurisdiction over Medicare and contributes 61% of total public spending on health (Australia, Australian Institute of Health and Welfare, 2017). The Canadian federation is much more decentralized than Australia and experiences a high degree of tension between levels of government, particularly over health policy (Banting & Corbett, 2002; Ouimet, 2014). Public health insurance falls under provincial and territorial jurisdiction and overall federal transfers amount to only 23% of provincial and territorial spending on health (Phillips, 2016). As evidenced by the diffuse impact to date of a targeted federal mental health transfer, the federal government has few policy levers to push through health reforms. Provincial and territorial governments do have strong health policy levers, but their appetite for reform is constrained by the weakness in their overall fiscal position relative to that of the federal government (Parliamentary Budget Officer, 2018).

As with government structures, there is also a mix of broad similarities and important differences in social policies in Australia, the UK, and Canada. According to Esping-Andersen's 1990 theory regarding welfare state regimes, redistributive social policies in these three countries (along with the United States) fall under the so-called liberal regime. Such regimes are characterized by a relatively minimal role for the state and stronger role for the market and families, and as such are less redistributive than European corporatist and Scandinavian social democratic approaches to social policy. New welfare regime typologies have more closely examined the complex mix of social policies and program designs within particular countries and have also zeroed in on important variations in healthcare systems (Bambra, 2005; Mahon, 2008; Myles, 1998; Wendt, Frisina, & Rothgang, 2009). Despite being liberal regimes, all three countries in this study have highly redistributive universal healthcare systems. At the same time there are significant differences in which services are covered and to what extent, with Canada providing first-dollar coverage but only of physician and hospital services, Australia providing broader coverage but with significant copayments, and the UK falling somewhere in between.

Other literature on service system design and equity has taken a more normative approach, assessing the redistributive effectiveness of different social policy approaches. Korpi and Palme (1998) argue that there

is a paradox of redistribution, whereby the more social policies are targeted to the most disadvantaged, the less effective they are at reducing inequality. Targeted approaches generate less political buy-in and thus a smaller pool of financial resources to support redistribution than more universal models. By contrast, Marmot (2010) advocates for proportional universality which works to improve everyone's health while at the same time working to flatten the health gradient by improving the health of those who are most disadvantaged the fastest, and which also has the advantage of garnering broad political support (NHS Scotland, 2014).

For more than a decade both Australia and the UK have implemented universal programs, with some features of proportionate universality through targeted outreach to disadvantaged communities. The universal Better Access program in Australia features a mix of co-payments and first-dollar coverage according to the preferences of service providers and was originally complemented by the more targeted Access to Allied Psychological Services (ATAPS) program (Bartram & Stewart, 2018; Diminic & Bartram, 2019). Overall treatment rates went up between 2006 and 2010 from 37% to 46% of Australians with mental disorders, but the equitable distribution of these gains has proved to be more challenging (Whiteford et al., 2014). While a 2011 evaluation of Better Access found fairly equitable distribution of access based on a small sub-sample (Pirkis, Harris, Hall, & Ftanou, 2011), other studies have identified significant issues with access in rural and more socially-disadvantaged communities (Bartram & Stewart, 2018; Meadows, Enticott, Inder, Russell, & Gurr, 2015; Meadows et al., 2019). In an effort to address these concerns, the federal government has expanded telehealth access and has also rolled ATAPS into Primary Health Networks as part of its efforts to better tailor programming to regional needs (Australia, 2015; Australia, 2018; Australia, Australian Institute of Health and Welfare, 2019).

IAPT in the UK is free at the point of delivery and is now rolled out across all districts in England, with some tailoring to local needs at the district level. Where Better Access is similar to a one-size-fits-all approach with very limited outcome monitoring, IAPT is more of a stepped care model. IAPT offers both lower-intensity online and group therapies and higher-intensity face-to-face therapies, with close monitoring of progress against clear targets at all levels. While IAPT has met its targets for reach (15% of the population with mild to moderate mental disorders) and clinical recovery (50% of clients served; Clark, 2018), its equity results have also been mixed. Rates of referral to IAPT are similar across the population, but recovery outcomes have been poorest among ethnic minorities and more socially disadvantaged communities. For example, recovery rates in the most deprived decile have only been 35% compared with 55% in the least deprived decile (Community and Mental Health team, 2016). In response, the program has focused on improving the quality of service delivery in underperforming districts (Clark et al., 2018).

Population-level inequities in access related to both income and education have been found under Canada's two-tier psychotherapy system (Bartram, 2019; Vasiliadis, Tempier, Lesage, & Kates, 2009). Universal public funding is limited and targeted services to disadvantage groups only exists for populations under federal jurisdiction such as veterans and Indigenous peoples. Two out of three Canadians are estimated to have some form of employment-based benefits for services such as psychotherapy, with the remaining third being the most likely to be unemployed or underemployed (Canadian Life and Health Insurance Association, 2018). The strong role of employment-based insurance also increases the strength of the debate between proponents of targeted and universal reforms to address gaps in public insurance such as psychotherapy and prescription medications (Canada & Health Canada, 2019; Speer, 2019).

METHODOLOGY

Against this backdrop of psychotherapy reform, evolving theory regarding government structure and redistribution, and the evidence regarding ongoing equity challenges, what can we learn from people who have deep knowledge of these dynamics in Australia, the UK, and Canada? This study is a small-N comparison of the relationships among government structure, service system design, and equity in access to psychotherapy in Australia, the UK, and Canada. These three countries were selected for their mix of shared features such as parliamentary democracy and broadly universal healthcare, and key differences in government structure and psychotherapy reform. The analysis of UK policy was limited to England where IAPT has been implemented. Psychotherapy is defined broadly to include psychotherapy, psychological therapies, clinical counselling, and talk therapy.

The primary source of data comprises 22 interviews with three types of subject matter experts with deep knowledge of these relationships: senior policy officials from within government, stakeholders such as service providers or representatives of advocacy organizations, and researchers with relevant expertise. Participants were selected through purposive sampling, with particular attention paid to the mix of policy officials, stakeholders, and researchers from all three countries, the mix of service users and service providers, and the mix of central and regional/local levels of governance. Semi-structured interviews were conducted via Skype, telephone, or, where feasible, in person between April 1, 2017 and June 30, 2017 with approval from Carleton University's Research Ethics Board. Quotes are attributed by country and type of participant (for example, AUS_R1 is an Australian researcher, UK_P1 is a policy official from the UK, and CDA_SH1 is a Canadian stakeholder). Interviews were transcribed and validated by participants, and then analyzed by the author using NVivo. Initial coding was based on the themes identified in the literature on government capacity, service system design, and equity as reviewed above, and refined by the author over the course of the analysis.

RESULTS

In keeping with the research questions, key themes from the interviews fall under two groups: government structure and psychotherapy reform, and equity and psychotherapy reform (see Table 1 for a summary).

Government Structure and Psychotherapy Reform

Participants were asked to identify the key factors that have either enabled Australia and the UK to introduce wide-scale initiatives to expand access to psychotherapy over the past decade, or that have prevented Canada from doing the same. Prompts included stakeholders, evidence, professionals, stigma, business case, constitutional structure, economic context, and political context.

Reforms are aligned with policy levers available in particular government contexts. Participants' responses suggested that psychotherapy reforms are strongly aligned with the policy levers that are available in each government context. In Australia, participants suggested that the Commonwealth government's full jurisdiction over Medicare was a deciding factor in extending Medicare coverage through the Better Access program, rather than opting to build a universal grant-based program along the lines of ATAPS.

Table 1

Summary of Key Themes Regarding Psychotherapy Reform

	Australia	UK (England)	Canada
Government Structure			
Reforms aligned with policy levers	Medicare expansion aligned with Commonwealth government jurisdiction	Centrally administered program aligned with unitary state jurisdiction over the NHS England	Limited levers for health reform under decentralized federation with provincial/territorial jurisdiction over health
Coupled with second key factor	Survey data showing high rates of unmet need	Strong case for public investment	Canadian Medicare and fiscal federalism
Shapes accountability	Medicare data and one-off evaluation	Clear targets and on-going outcome monitoring	Little accountability without strong stakeholder advocacy
Equity			
Gap persists even as access increases	Inequities in access in rural and low SES populations even with absolute increases in access	Inequities in outcomes for socially disadvantaged and ethnic minority populations	NA
Shaped by service system design	Medicare's private practice model a disincentive for outreach	Centrally set targets a disincentive for outreach	Two-tier model inherently inequitable

> The Commonwealth government wanted something done and wanted something done quickly. There is the question of what levers they can pull. The levers of things like the ATAPS services were more complex… In contrast … you create some Medicare benefit schedule entitlements and … the rest of it is done by the private sector. (AUS_R1)

Participants from Canada were particularly likely to make the connection between government structure and reform approaches, including the connection between England's more centralized structure and the role of the NHS England in the design of IAPT and jurisdictional tensions as a key barrier to reform in Canada's highly decentralized federation.

> Australia and the UK have both been more nimble. The reason why, I think, is that the UK has the NHS, and in Australia primary care is also a federal responsibility. It is easier to get it done, there is only one governmental authority for the service. (CDA_SH2)

> There is … an underlying dysfunctional relationship between the federal, provincial and territorial governments, where provinces and territories have greater autonomy and don't want conditions, and the federal government is increasingly needing to be more accountable for public investments. It is a prisoner's dilemma which prevents us from moving forward. (CDA_P3)

While Canadian participants identified the new targeted federal transfer as a significant opportunity for reform, they also expressed skepticism.

> The new [$5 billion for mental health] that has been promised in the bilateral agreements of 2017 may be so dissipated that it has little impact. …[I]t will be up to provinces and territories and they only have so many levers. (CDA_R1)

Government structure is coupled with another key factor. In all three countries, participants identified another key factor that combined with government structure in shaping psychotherapy reform. In Australia, participants pointed to the 1997 National Survey of Mental Health and Wellbeing, which found that one out of every five Australian adults had experienced one or more mood, anxiety, or substance use disorder in the past year, but that nearly two thirds of people with these mental disorders were not using health services (McLennan & Australian Bureau of Statistics, 1998).

> That was the first time we'd done a big national, epidemiological survey of that kind. And one of the findings was for anxiety and depression, and they hadn't been catered for very well in the early national mental health plans. But also, people with those conditions, the vast majority of them didn't go anywhere near mental healthcare. (AUS_R3)

Participants in the UK identified the high potential return on investment as a key factor in the development of IAPT. The case for investment was essentially that if access to evidence-based treatments endorsed by the National Institute for Health and Care Excellence (NICE) could be increased, people's mental health status could improve such that productivity would increase (Layard, Clark, Knapp, & Mayraz, 2007). This case for investment aligned with political interests to make IAPT a compelling option.

> The thing that probably swung it, influenced the government, is that [Lord Richard Layard] … got in to see Gordon Brown who at the time was Chancellor of the Exchequer…. He made an economic case that if we were more effective at implementing NICE guidelines, it would get people back into work and therefore it would increase the tax income and reduce the benefit costs to the country. (UK_R1)

Canadian participants identified specific policy legacies that are related to Canada's decentralized structure as barriers to reform in and of themselves, including the scope of Medicare and fiscal federalism.

> The key factor was that Medicare was defined as covering doctors and hospitals. That is how it got defined, there are reasons in history for that, and that is what we are stuck with. (CDA_SH1)

> Most provinces and territories (except Quebec) would love to have the federal government take on full responsibility for some aspect of the health system. The fiscal pressures they face are greater than their concerns about jurisdiction. (CDA_R1)

By shaping service system design, government structure also shapes accountability. Participants from all three countries identified a strong relationship between service system designs, which were originally shaped by government structure, and accountability for public investment in psychotherapy reform. In the UK, where monthly public reporting against clear targets and centralized implementation supports have been critical to the success of psychotherapy reform, the importance of a strong and centralized approach to accountability was assumed by some participants.

> Why would you want to invest in something that's set up in a way where you won't know whether it works? Aren't you accountable to your electorate? You want to be able to show when you next run for office that it worked. (UK_R3)

Other participants expressed concerns that IAPT, in focusing so tightly on targets and quantitative outcome data, does not pay enough attention to the experience of service users and providers.

> When IAPT was set up, there were very, very strict targets and expectations set …, and it's tight and managed within an inch of its life. Often, what strikes me is it's set up to work in a way that really work[s] against what's best for the patient... You end up distorting good clinical practice to meet targets. (UK_R2)

In Australia, the Commonwealth government has taken a more hands-off approach. Accountability for Better Access has been limited to one formative evaluation and high-level Medicare billing data. While these accountability measures have been sufficient for sustaining public funding, some participants expressed concerns regarding quality.

> I think we're getting access to care by paying more providers, but that is only the first step. … [T]he missing thing is peering inside the box of the services that you'll be paying for, if you put taxpayer's money into it. The thing we commonly don't know is what actually, what intervention the person gets. (AUS_R4)

In Canada, where accountability for federal transfers to provincial and territorial governments has proved to be particularly challenging, the role of stakeholders in holding governments to account is viewed as particularly critical.

> There was no way you could track [federal investments in childcare], except, and this is where it is effective, the childcare advocates in the provinces could go to the province and say, hey the federal government gave you $200 million. …In the same way that you could hope that if there was a coordinated mental health lobby, tell us, where is the money going? (CDA_P2)

Equity and Psychotherapy Reform

While equity concerns were only mentioned occasionally as contributing factors in the introduction of reforms, several interview questions specifically asked about the equity impacts of current policies and efforts to address such impacts. Prompts included income, rurality, education, cultural background, and language spoken. Despite the introduction of major reforms in Australia and the UK, all three countries have struggled in different ways with equity issues related to the provision of psychotherapy services.

Equity gap persists with universal approaches, even as absolute access improves. Participants in both the UK and Australia noted that universal approaches are no guarantee of equitable access.

> We did wonder if there could be an irony, if while you are simultaneously improving access you are also simultaneously further increasing health inequalities. We wondered whether actually you are increasing access for the white British middle classes who already have lots of advantages in terms of health, there are already marked health inequalities in the UK, and whether that would just further widen. (UK_R2)

> In theory, access is equitable, in practice it is much more limited. You are much more likely to get that if you live in a capital city as opposed to in a rural area, and you are much more likely to get it if you are in a higher socio-economic group. (AUS_SH2)

> I think as an example of trying to get services out in an equitable way, this a train wreck. It is getting more services to more people, but those funds are not in a targeted way blowing to the areas that need it most. (AUS_R1)

Notwithstanding this recognition of inequities, participants also stressed how many people living in rural and/or socio-economically disadvantaged areas were benefiting from universal access to psychotherapy.

> It made psychological services including psychotherapy affordable to the masses. …Farmers tell me that they will sit on their tractors and nobody knows that they are participating in an e-mental health program. … [F]rom my experience from the streets of highly multicultural disadvantaged communities to outback towns, … I know the difference people having access to psychological services is making. (AUS_R2)

Equity issues are shaped by service system designs. Participants identified a strong relationship between equity issues and service system designs in each country. For example, in the UK some participants associated continuing equity challenges with the way in which targets act as a disincentive for local IAPT programs to reach out to more disadvantaged people.

> When IAPT was set up, the mandate was to go for big numbers and get big coverage and get the first … 15% of the population. …Some of the groups that we are talking about would be the bottom 15% not the top 15%. That requires a lot more effort, and so that is going to vary enormously from borough to borough. (UK_R1)

> This is where public health supposedly does a needs assessment of the local area and the priorities, and in so doing should be trying to ensure that people who may benefit from the service but are less likely to take it up even if it's been offered get a chance. That isn't as strong as it could be. There is still work going on to try and improve it. (UK_PM1)

In Australia, participants associated ongoing equity issues with the Medicare model's reliance on private practitioners and lack of incentives to practice with rural and socially disadvantaged populations.

> There aren't a lot of psychologists sitting around twiddling their thumbs waiting for someone to walk through the door. Just because they make it available it doesn't necessarily mean that the psychologists are going to have the free spots. (AUS_SH2)

> Why would you as a business person trying to make a livelihood, why would you go and earn [considerably less] in a poorer area, when you can go and earn [considerably more] treating people who are more like you and who are also quite needy and have needs for care, but they have more control over their lives, are more likely to turn up for appointments, and they pay more? (AUS_R1)

Under Canada's two-tier system, participants considered income-based inequities in access to psychotherapy to be self-evident, and any increase in public funding to be an improvement over the status quo.

> Obviously there is a profound lack of equity of access, of parity, when you have treatments that are out of sight financially [and] when they require private payment for people in lower SES groups. (CDA_SH1)

> When you are starting at the floor, no one has access, arguably anything we do is better. (CDA_SH2)

DISCUSSION

This comparative analysis of Australia, the UK, and Canada provides strong evidence of the alignment between the capacity for psychotherapy reform and the policy levers available in different government structures. While IAPT is not without critics, participants associated the unitary nature of the UK government (and NHS England) with the launch and sustainability of a program with a strong record of success. In Australia's less unitary federation, participants spoke to how the Commonwealth government's jurisdiction over Medicare has made it politically expedient to expand Medicare coverage of psychotherapy with Better Access. While strictly speaking the Commonwealth government could have implemented stronger

accountability measures, its choice of a fee-for-service Medicare reform shaped the reliance on claims data as the main source of outcome monitoring. In Canada, participants confirmed the critical role of Canada's decentralized government structure in impeding reform and significantly complicating accountability for new public investments. At the same time, participants from all three countries provided insight into the interplay between government structure and at least one other critical factor for policy reform, whether the survey evidence regarding high rates of unmet need in Australia, the strong case for public investment put forward in the UK, or policy legacies from Medicare and fiscal federalism in Canada.

With regard to equity, this comparative study suggests that neither centralized governments nor universal funding can guarantee equitable access to psychotherapy. Rather, progress in providing equitable access to psychotherapy requires making equity an explicit objective whatever the context. Moreover, this objective should be built into the design of psychotherapy reforms from the outset, whether by considering unintentional effects of targets or by considering provider incentives under a Medicare model. At the same time, participants spoke to how universal approaches can result in higher absolute levels of access at lower income levels even as equity gaps remain. Proportionate universalism (Marmot, 2010), which combines universal public funding with targeted services for those with the greatest social disadvantage, may well be the most effective approach to reducing inequities in access to psychotherapy.

While these interviews were completed in 2017, the responses point to more recent criticisms that have emerged about both Better Access and IAPT. Like the participant who spoke about IAPT "being managed within an inch of its life," there are growing concerns in the UK regarding overestimation of clinical outcomes and high levels of stress among service providers under such a target-driven system (Marks, 2018; Marzouk, 2019). In Australia, much as the participant who spoke about the need for Better Access to "[peer] inside the box," a recent mental health report from the Productivity Commission (2019) raises several concerns about the quality of the program, from outcomes to equity to the need to better adopt more of a stepped care approach. While these concerns have long been debated in Australia, they have recently gained force (Hickie, Rosenberg, & Davenport, 2012; Meadows et al., 2019; Pirkis, Harris, Ftanou, & Williamson, 2011; Rosenberg & Hickie, 2019).

This qualitative study has limitations and strengths. While participants included senior government officials from all three countries, the inclusion of politicians would have provided additional insights into political and ideological considerations driving psychotherapy reform or the lack thereof in each country. A larger research team would also have reduced the risk of bias from the reliance on a single researcher for the interviewing, coding, and analysis. Nevertheless, this study is highly policy relevant at a time when psychotherapy reforms are being considered in Canada and refined in the UK and Australia. The rich insights provided from interviews with diverse participants with deep knowledge of psychotherapy reform also provide a strong complement to quantitative research on inequities in access and higher-level policy reports.

CONCLUSION

This comparative study of the relationship between government structure, service system design, and equity in access to psychotherapy in Australia, the UK, and Canada provides timely and relevant guidance to Canadian policy makers early on in a 10-year targeted federal transfer. The findings highlight the

importance of aligning reforms with the strongest available policy levers and making equity an explicit object from the outset. While the federal government in Canada does not have access to the same levers as its UK and Australian counterparts, provincial and territorial governments do at least have jurisdiction over both Medicare and mental health service delivery even if their overall fiscal position is weak. High-level accountability mechanisms are already being implemented through bilateral agreements and a common set of performance indicators, but clearer equity objectives need to be set and monitored for significant progress to be made in reducing long-standing inequities in access to psychotherapy.

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