The Atkinson Letter

…a periodic newsletter promoting social and economic justice in the tradition of Joseph E. Atkinson.

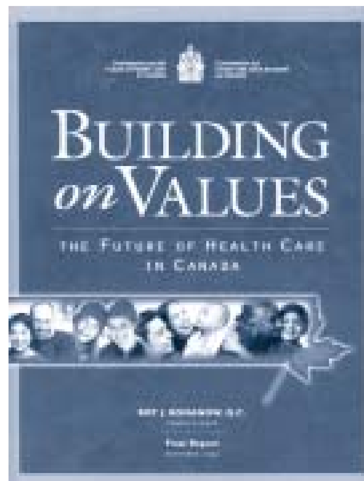
November 2003

The Romanow Report: One Year Later

November 28, 2003 marks the one-year anniversary of the tabling of *Building on Values*, the groundbreaking report of the Commission on the Future of Health Care in Canada.

This edition of the Atkinson Letter features an interview with the report's author, The Honourable Roy J. Romanow, on the progress that has been achieved—real and illusory—in implementing the report's 47 recommendations.

Atkinson Letter (AL): Let's begin with the most basic question. Are you satisfied that your report has made a difference?



Roy Romanow: It's a hard question to answer because these are still early days. After all, it took close to a decade for many of Emmett Hall's prescient and historical universal health care recommendations to be realized, and it's still only a year since my report was tabled.

On the positive side, I think it is fair to say that my report was a catalyst for what eventually became the 2003 Health Accord which was an important milestone in the journey toward strengthening health care in Canada. But I have some serious reservations about how much of what has been agreed to will see the light of day, and I have many questions about the adequacy of the dollars on the table and where and how they will be spent.

AL: What are your concerns about the money?

Romanow: There is less money than what I concluded was needed to buy transformative change, and the bulk of the new money that has been committed is back-loaded, which means progress will be slow. There is also less money than is needed for the federal government to return to paying its historical share of the Medicare bargain. That means the health system still lacks the stable and predictable transfers it requires for long-term planning and that we are still stuck with the annual cycle of grief associated with federal-provincial bickering over health care dollars.

Second, while First Ministers accepted allocating some $16 billion over the next 5 years to a Health Reform Fund, we are still in the dark as to what this investment will actually achieve, what conditions, if any, will apply, or what criteria will be used to evaluate its effectiveness. Deadlines have come and gone, and we are still no closer to knowing. And trust me, this matters! We already know that some provinces have budgeted to use the immediate $2.5 billion top-up that the Health Accord called for—ostensibly to address urgent priorities like reducing waitlists and improving access to care—for purposes other than health care.

AL: And beyond the money?

Romanow: Well, I also believe we need to modernize the Canada Health Act to include a new principle of Accountability and to reflect the reality of how health care is delivered in Canada today. This would involve extending the CHA to include some aspects of prescription drug coverage and home care and to clarify the scope of its application in relation to medically necessary diagnostic services. These are the fastest growth areas of health care spending. This would both reduce the "privatization creep" currently afflicting the system and make the federal government

responsible for paying its share of the system's expansion. Last, we absolutely need to establish an effective Health Council of Canada to make the health system more accountable to taxpayers and to give patients and providers a stronger voice and a greater say in shaping its future directions.

AL: Even after the commitment to reinvest over $34 billion into health, provinces are saying that it is still not enough. Is the health care system really sustainable?

Romanow: It is as sustainable as Canadians want it to be. That's not a glib statement; it is a reflection of reality and it ultimately is a matter of choice.

Despite the significant reinvestment in health care over the past few years by both orders of government, we are spending slightly less today on health care as a percentage of our GDP than we did a decade ago. Moreover, even after posting 6 consecutive budgetary surpluses, the federal government has yet to fully restore its traditional share of health funding to the provinces.

While no rational person would conclude that recent health spending trajectories are sustainable, we should also recognize that these increases are a reflection of governments playing catch-up after several years of spending restraint whose effects we are still feeling today. More to the point, the health care system is not an immutable force of nature, impervious to sound decision-making or change: it is not on autopilot. There is much we can do to reverse these spending trajectories if we have the will to do so.

AL: Can you give some examples of how these spending trajectories can be changed?

Romanow: The fastest growth areas of health care spending in recent years are in areas that fall outside the parameters of the Canada Health Act—things like home care and prescription drug coverage. In fact, spending for CHA-insured physician and hospital services has remained essentially constant over the past decade. I believe that applying the same principles on which Medicare is premised to these fast-growth areas of health spending—pooling risk, reducing costs through standardization and by consolidating purchasing power—we can help rein in these costs. That is one of the reasons why my report proposed expanding the scope of CHA coverage in these areas.

The Honourable Roy J. Romanow

I also believe that there are ways to leverage the existing resources we have more effectively. Such as:

- re-examining scopes of practice for physicians and the role of nurse practitioners;
- providing incentives for people to opt to receive care at home rather than in expensive hospital rooms;
- investing in 24/7 primary care networks that reduce pressure on emergency wards;
- expanding tele-health and tele-medicine applications; and,
- investing more in the upstream—in prevention and wellness, through a national immunization strategy, via targeted public health initiatives focused on those predisposed by virtue of genetics, income or lifestyle, to health problems like obesity, cancer and diabetes.

AL: But is there really enough money for Health relative to other priorities?

Romanow: Yes, if that's what we choose. Consider these facts: Overall, federal program spending, in relation to GDP, now rests at 11.5%, its lowest since 1949, and overall program spending by all governments in Canada—exclusive of debt charges—is now around 27% of GDP, down from just over 33% a decade ago. And over the past several years—both in times of deficit and of surplus—governments in Canada have opted to make

tax reductions their overarching priority.

Indeed, together the federal and provincial governments will be giving up $61 billion in revenue in 2004/05 alone due to tax cuts they have initiated since 1996. That amount increases every year, as the economy grows, and as governments enhance their tax cut packages. Some of these resources, arguably, might have been invested in health care.

I am not making a value judgment about the wisdom of these choices; as Premier of Saskatchewan, I also reduced health spending and cut taxes. Rather, I am simply pointing out that as a society, there are choices we can make as to where to spend or invest our tax dollars. The argument that our system is unsustainable is simply disingenuous.

AL. Why are you so adamant about the need for a National Health Council?

Romanow: Let me try and enumerate the reasons as succinctly as possible.

First, during our public hearings, Canadians from absolutely every region in the country said they wanted greater accountability across the health care system, but especially as regards to how their health dollars were being spent and with what results.

Second, throughout our hearings we heard from ordinary Canadians and health providers that they are fed up with being left out in the corridors when decisions about health care are being made that will affect them. They want a seat at the table, a chance to be heard and an opportunity to shape the decisions. An effective Health Council would let them play that role.

Third, at no point during our massive citizen engagement efforts did a single participant rise to express a particular affinity for their provincial or territorial health care system; they always viewed health care for what it is—a national endeavour and a defining aspect of our citizenship. A national Health Council that brings together Canadians, stakeholders and health professionals from across the country to discuss common priorities, to set national objectives and to assess overall system performance, can help mitigate the inevitable pressures that risk fragmenting the system and ensure we have a viable, integrated and dynamic national system, rather than 13 separate systems of uneven quality.

Fourth, I can think of no more eloquent, and no more depressing an example of why we need a Health Council of Canada than the series of competing advertisements that both levels of government ran following the signing of the Health Accord—using taxpayer dollars! On one hand, you had the federal government touting its "historic" reinvestment in health care; on the other, you had provincial and territorial governments claiming they were being short-changed! Canadians need an objective, neutral arbiter to give them the facts, and to stop the cynical blame-shifting that currently passes as inter-governmental discourse on health care.

> ***"My report does not rule out private sector participation if it clearly meets key conditions such as strict compatibility with the Canada Health Act, clear and transparent evidence regarding standards and outcomes, prevention of queue-jumping and preservation of Canada's ability to protect our health care policies in international trade negotiations and agreements."***

Last, in my report, I noted that over the years, a staggering number of permanent and ad hoc health advisory groups, task forces and committees had evolved, each with their own separate mandates, research agendas, infrastructures and reporting relationships. In my vision of things, the Health Council would integrate the functions of many of these entities in order to bring a greater degree of coherence to decision-making processes and to reduce the number of competing bureaucracies. Mr. Martin's recent advocacy for the Council is encouraging as are the promising messages coming from Mr. McGuinty's Ontario Throne speech last week.

AL: Despite all governments having agreed to abide by the Health Accord, we have yet to see the creation of a National Health Council and deadlines included in the Health Accord for establishing such things as national standards for home care have come and gone, and still the Accord money flows. Has the federal government abdicated its leadership?

Romanow: Everyone would agree that a scant few years ago, our nation was on the verge of a fiscal calamity. Part of the federal government's response was to unilaterally change the rules of the game in relation to how health and social transfers would flow to the provinces, and what the value of those transfers would be. In short, provinces were told they would have less money, but greater flexibility in how to spend it. As a Premier who had to scramble to cope with this unexpected funding shortfall, I can tell you that I certainly put myself in the camp of those who argued that the federal government had lost its moral authority to impose conditions on provinces in relation terms to how to spend their health dollars. That is why I argued in my report, and why I continue to argue, for the federal government to restore its funding for health care to historic levels. The fact that the Health Accord will see a return to a dedicated Health Transfer that will improve transparency in relation to health funding, is a positive step forward. But until the federal government antes up in full, it will be hard pressed to assume the mantle of leadership.

AL: What do you say to those who suggest that your political orientation made it a foregone conclusion your report would dismiss any meaningful role for the private sector in health care?

Romanow: I am proud that objectivity and breadth of perspective were the hallmarks of my Commission's processes. My report does not rule out private sector participation if it clearly meets key conditions such as strict compatibility with the Canada Health Act, clear and transparent evidence regarding standards and outcomes, prevention of queue-jumping and preservation of Canada's ability to protect our health care policies in international trade negotiations and agreements.

At every possible stage in our research and consultations, we made it a point to ensure those espousing market-based approaches to health care reform had a full and fair opportunity to make their case directly to Canadians and to bring forward evidence that their proposals would work.

Not only was that evidence NOT forthcoming, Canadians frankly did not accept the anecdotal evidence being proffered about the virtues of the "new ways" as being sufficiently compelling to jeopardize a system that not so long ago they viewed as the best in the world, and that I firmly believe can again be the best in the world. As well, there is substantial evidence, such as the McMaster Medical research, that suggests the deleterious downside of for-profit medicine. (See note on page 5.)

AL: In recent months, you've spoken at length about the imperative for governments to take a broader "public health" or "wellness" perspective when considering reforms to health care. What do you mean by this?

"I believe governments need to think beyond illness management and place a far greater emphasis on prevention and health promotion than is now the case. And they need to connect the dots! Social justice, economic well-being, personal security and good health are inextricably linked."

Romanow: This is probably the subject for a much longer discussion, but in a nutshell, I believe governments need to think beyond illness management and place a far greater emphasis on prevention and health promotion than is now the case. And they need to connect the dots! Social justice, economic well-being, personal security and good health, are inextricably linked.

AL: What do you mean by "connecting the dots"?

Romanow: Besides good genes and good parents, consider some of the factors that research tells us are linked to a long and healthy life: having a good education and a well paying job, living and working in a clean and healthy environment, living in a community where you can trust your neighbours, and a strong early learning and care system for children.

Healthy lifestyle choices may be important and vital—and they are. A comprehensive, responsive and accountable national health care system may be important and vital—and it is. But the main factors—the main "determinants" as the experts call them—that will likely shape your health and life span are the ones that affect society as a whole. And if we want Canadians to be the healthiest people in the world, we have to deal

with them at that level. In fact, eventually, I would hope the Health Council we proposed would have the resources and independence to comment publicly on other "determinants" policies and programs that affect health outcomes such as the environment, early childhood development and care, and income levels and distribution.

AL: How do you respond to critics who suggest that basing an entire report on something as anodyne as "values" is a dubious proposition?

Romanow: What better basis is there? How could I provide a blue-print for re-modelling the system without the input of those it is intended to serve? Would they have preferred that I not ask Canadians—who are paying for the system and for whom it has been built—what they wanted and expected for the investment?

AL: While many public opinion polls rank long waitlists as the single most important health care issue for Canadians, your report rejects the notion of waitlist guarantees. Why?

Romanow: I am acutely aware that long wait times for medical procedures are eroding the confidence of Canadians in their health care system. We absolutely must make progress in this area—and there are some excellent initiatives underway, like the Western Waitlist Project that is providing us with the research foundation we need to do so. But at this stage of the game, I'm not convinced that guarantees are the right choice. A better alternative would be to systematically gather information about health system performance that allows us to document where and why there are bottlenecks in the system so that we can target our prescriptive efforts. If the problem is a lack of doctors, hospital beds, or MRI capacity, then we should invest accordingly. Or if the problem is that we lack a centralized system for channelling patients to providers or institutions that have the smallest wait times, then let's do that.

AL: But won't a wait guarantee have the same result?

Romanow: Well, what happens if the guarantee is not met? If the consequence is some sort of financial penalty for the health region or institution—without understanding the underlying causes of the problem—that may make things worse. But if the result is that more money gets invested, or the patient gets to go elsewhere for treatment (assuming that there is no waitlist "elsewhere"), then there is a perverse incentive to keep people waiting. And if the result is that the patient gets sent out of country for treatment, then who pays, and at what rate if the cost of out-of-province treatment exceeds that covered by the provincial fee schedule? And do the same guarantees apply to patients in rural and remote areas? Can a patient who has been waiting for an elective procedure bump one waiting for a life-saving procedure? Will hospitals feel obliged to maintain excess capacity and over-invest scarce resources to cope with infrequent surges in demand that may affect wait guarantees? And on and on…

Comparing Private For-Profit and Private Not-For-Profit Hospitals

Dr. P.J. Devereaux and colleagues at MacMaster University have recently published two systematic reviews in the Canadian Medical Association Journal and the Journal of the American Medical Association that include data on 38 million patients and 500,000 patients in the two studies. The research results show that inpatients being treated at investor owned private for-profit hospitals and outpatients being treated at investor owned private for-profit dialysis centres have a greater risk of dying than patients being treated at not-for-profit hospitals and dialysis centres, respectively.

For further information, the CMAJ article, "A systematic review and meta-analysis of studies comparing mortality rates of private for-profit and private not-for-profit hospitals", can be found at:

http://www.cmaj.ca/cgi/reprint/166/11/1399.pdf.

While the JAMA article, "Comparison of Mortality Between Private For-Profit and Private Not-For-Profit Hemodialysis Centers", can be found at:

http://jama.ama-assn.org/cgi/reprint/288/19/2449.pdf.

AL: What should be the top priorities for the new Prime Minister vis-à-vis the health care file?

Romanow: Over the long-term, I would of course want to see all of my report's recommendations implemented. But over the short term, in addition to the issues I've already raised in regard to system funding, modernizing the CHA, establishing a Health Council of Canada and connecting the dots in relation to population health wellness and prevention, I would emphasize three things.

The first would be to act decisively to ensure the federal government isn't perceived as a bit player in the system whose sole responsibility is for bankrolling it. Canadians want the federal government to be a full partner in the health care system, to provide national interest oversight in regard to the system's integrity and overall direction, and to vigorously enforce the CHA.

The second is to report clearly to Canadians on the changes and improvements they can expect as a result of the new Health Accord dollars. I am pleased the Accord called for, among other things, targeted funding to shore up critical parts of the health care system, like home care, catastrophic drug coverage, primary care and investments in advanced diagnostic services. But Canadians are still in the dark about how that money will be spent, when and with what results.

Finally, I would hope to see significant progress made in regard to the health of our First Nations. The health status of far too many of our aboriginal people is a national disgrace. We have got to stop the buck-passing and start working in a real partnership with our aboriginal stakeholders. As a country, we can and must do better.

AL: Do you have any final words for Canadians?

Romanow: The 18 months I spent as Commissioner were among the most exciting, challenging and rewarding of my public life. The process renewed my faith in Canadians, in their maturity, in their capacity to understand and make tough choices, and in the common values that unite us as a country. I believe absolutely that we can make our health care system the best in the world if we are prepared to heed the advice of Canadians and to respect their wishes.

Would You Like To Know More?

We invite our readers to visit the web site of The Atkinson Charitable Foundation to view copies of speeches given by The Honourable Roy Romanow in 2003. The web address is:

http://atkinsonfoundation.ca

The Atkinson Letter is an occasional publication designed to disseminate research findings and ideas that contribute to full and reasoned public education on factors that may influence economic and social justice.

The opinions expressed are solely the views of those interviewed.

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