

The Cost of Health Care: Is it Sustainable?

Notes for a Speech by Commissioner Roy Romanow Commission on the Future of Health Care in Canada to the Weatherhead Center for International Affairs

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INTRODUCTION

I would like to thank Professor Robert Vipond, the current William Lyon Mackenzie King Visiting Professor of Canadian Studies, for his kind introduction. And I thank you all most sincerely for that warm welcome.

This is my second time at the Weatherhead Center for International Affairs here at Harvard and it is a great pleasure to be back.

I must say, the notion of "Canada Seminars" strikes me, at first blush, as not only utterly appropriate -but essential. I won't repeat the shop-worn justifications of our vast trading relationship and how we share the world's longest undefended border.

Instead, I'll just say that, as much as we know about each other, there's so much more we can learn.

And so, I applaud you for pulling these seminars together - and so frequently, too.

And while I'm at it, I would pay tribute, too, to your eclectic tastes. Indeed, this lectern has been given over not just to politicians, economists and diplomats, but hockey icons and movie directors as well.

In short, these seminars are a clear recognition that Canada and the United States are not just friends and neighbours in the geo-political sense, but in a very richly textured and culturally meaningful way as well.

And so, I thank you for the opportunity to speak to you this evening, and to share with you some thoughts about the single most pressing issue that occupies the national consciousness in Canada: the future of our health care system.

CONTEXT

As explained in the introduction, I have been heading a special commission appointed to examine the ailments - real and perceived - of Canada's health care system.

My mandate has been to listen to Canadians, to consult with experts, and to recommend to the Government of Canada a course of treatment. Ultimately, it will be up to both the federal and provincial governments to implement whatever changes they deem appropriate

My recommendations are due next month and, under the procedures that prevail in Canada, they will be handed first to the Prime Minister and Parliament, and then to the Canadian public at large.

And so, much as I may be tempted to spill the beans from time to time, I am obliged, for the time being, to keep my final conclusions to myself.

Even so, there's no law prohibiting me from describing the current state of Canada's health care system, the factors that will affect it in the years to come, and the main characteristics of the solutions we must pursue.

With your indulgence, that is what I intend to do in the time remaining to me this afternoon.

CURRENT SITUATION

I'd like to begin by clearing up a popular myth.

There is a misconception - not just in the United States but in Canada as well - that Canada has one big public health care system. A few believe it to be an overly-expensive and unwieldy behemoth unable to keep up with the demands of today, and utterly unfit for tomorrow.

To begin with, we don't have one system. We have 13 health care systems, not one: One for each province and territory.

They are, however, bound together by the shared principles enunciated in a federal law called the Canada Health Act. That legislation states that all patients are entitled to medically necessary services, delivered by doctors and hospitals and paid for from the public purse.

More specifically, the act outlines the five pillars of Canada's medicare system: Medically necessary services -- again limited by the current Canada Health Act to doctors and hospitals -- must be universally available, comprehensive in nature, portable between provinces, delivered without direct charge to patients, and publicly administered.

The federal government can enforce the law by withholding cash transfer payments for health service delivery.

But, at the end of the day, each province and territory has a lot of autonomy and latitude to set up its health care system in whatever way it sees fit.

As a result, we don't have a single, uniform health care system. And it's certainly not "socialized medicine" or "state-run medicine" in the common understanding of the term.

It is not "state-run" in the sense that many hospitals and other health care institutions are community-based non-profit bodies. And most doctors are effectively independent contractors paid according to fee schedules.

PUBLIC AND PRIVATE FUNDING

Nor is the whole thing publicly funded. In fact, it's a complex structure with three main categories of financing.

At one level, there are comprehensive tax-funded insurance schemes operated by each province and territory. These so-called medicare plans cover medically necessary services delivered by doctors and hospitals. Individual Canadians contribute indirectly through their taxes, but direct charges are generally discouraged and, in some provinces, prohibited.

These services, paid for wholly by public funds, add up to just over 40 cents on every health care dollar spent in Canada.

The next segment, worth about a quarter of our total health care bill, represents a mixture of public and private spending.

Drug costs are a prime example. Most provinces cover prescription medications only for certain groups, such as seniors and people with low incomes. Other people generally contribute co-payments or turn to private insurance to help defray the cost of medications.

Home care, rehabilitation, continuing care and long-term care, offer similar examples of mixed public and private funding.

A third level of health care services is paid for almost entirely by private funds.

Here, most dental and vision care, for instance, as well as the services provided by psychologists, chiropractors, physiotherapists, osteopaths and naturopaths, are not covered by Canada's public plans. Some people are lucky enough to have work-based insurance programs to cover some of these costs; others pay directly out of their own pockets.

These "third level" services, purchased directly by Canadians, amount to about 30 per cent of the total health care tab.

Clearly, the Canadian system is hardly a monolith of socialized medicine.

RISING COSTS

Is today's health care system, in fact, sustainable?

Is it sufficiently flexible to adapt to growing pressures? Pressures like an aging population, the boom in costly high-tech innovations, and rising public expectations.

My mandate, as head of the Royal Commission on the Future of Health Care in Canada, is to recommend how the government might - and I quote - "ensure the long-term sustainability of a universally accessible, publicly funded health system."

I'll address the second part of that sentence in a moment, the part that refers to a "universally accessible, publicly funded health care system."

But first, permit me to explore the concept of sustainability.

"Sustainable," at least to me, means "ensuring sufficient resources are available over the long-term to provide timely access to quality services that address our evolving health needs."

I deliberately used the word resources rather than money. In addition to cash, a properly functioning health delivery system also depends on the right type of health care providers, buildings, equipment and information systems.

MEETING EVOLVING NEEDS

Figuring out how to apply those resources to our "evolving health needs" is admittedly challenging. Needs tend to evolve, while our service delivery mechanisms are burdened by history, habit and general inertia.

For instance, we continue to emphasize care by physicians rather than teams of health care providers with a broad range of skills.

We also have to be clear on whose needs we are meeting. Ailing individuals, of course, need the attention of our health care system. But we mustn't overlook the needs of populations, such as our Aboriginal people, who suffer disproportionately poorer health.

In a perfect world, our health services would exactly meet the needs of our citizens - individually or on a population basis. And the resources necessary to deliver those services would not only be sufficient, but also stable and predictable.

Unfortunately, there is no magical way -- or invisible hand -- to keep needs, services and resources in balance.

That's why governments that permit free markets in health care also subject them to regulation. That is why professional organizations in our two countries are asked to co-operate by policing their own behaviour.

Where governments are more directly involved -- whether through your Medicare and Medicaid programs or the provincial health plans in Canada -- keeping needs, services, and resources in balance remains a continuing challenge.

RISING COSTS

Let's go back now to the mandate of my commission, and in particular the part that focuses on the "sustainability of a universally accessible, publicly funded health system."

We all know that health care costs have been soaring in recent years. But here's an interesting - and little reported - fact:

If we were to compare cost increases in the publicly funded, privately funded, and mixed groups of services I described earlier, it is the publicly funded group - hospital and physician services - that wins, hands down.

Indeed, per-capita spending on these publicly funded hospital and physician services is the same today as it was in 1991. By comparison, drug costs - which we put in the mixed public-private category - doubled in the past 25 years.

There are two principal reasons why hospital and physician service costs have not grown as fast as other sectors.

One explanation is that a lot of care has shifted out of hospitals. Some of it is being moved to home-based and ambulatory care, and many interventions are being handled now by prescription drugs. As a result, more costs are being borne by individual Canadians.

ADMINISTRATIVE COSTS

The second reason that is that single-payer insurance systems have lower administrative costs.

More than a decade ago, Harvard University professors Woolhandler and Himmelstein estimated that Canadians spent two-thirds less than Americans on health care administration.

Their recent work, using 1999 data, concludes that each Canadian pays \$325 per year in U.S. funds, compared to the \$1,150 paid by each American. Why?

Private insurance systems spend a lot of money on the extensive infrastructure required to deal with multiple insurance companies, assess risk, set premiums, design benefit packages, review claims and reimburse beneficiaries.

By contrast, a single insurer is spared a lot of these administrative outlays.

However, more than half of all health care activity remains outside the single-payer system.

And so, while our overall health care spending is considerably lower than America's, it is in the higher ranks when compared to other OECD countries. At 9.1 percent of GDP, we spend less than the U.S., Germany and France, but more than the UK, Sweden and Australia.

OUTLINES OF THE SOLUTION

While I have to keep my detailed recommendations close to my vest until I submit my report to the Prime Minister, I will at least share with you some of the outlines of my thinking.

1. Universal single-payer

First, for reasons I just outlined, a "universal single-payer" is a feature of our health care system well worth preserving.

There is a broad consensus about this in Canada. Most polls have told me this, as did my own research and extensive public consultations.

People believe not only that this structure is efficient, but also that it is fair. And Canadians value equity.

Indeed, I would go farther.

I think the universal, single-payer system should actually be expanded beyond the basket of services offered in hospitals or by doctors. I can't say now which ones ought to be included; that is grist for more public discussion.

But I can say that if we don't lay the groundwork now, the private costs for these services will continue to grow with little restraint. As a consequence, more people will turn to acute-care services - which they perceive as free - even though these tend to be more costly and may not be appropriate.

True, expanding the scope of medicare coverage would demand some additional public investment in the near-term. But in the long-term, it would ensure a more rational, cost-effective and sustainable use of all health care services. And it is the long-term we must always keep firmly in mind.

As Dr. Arnold Relman, professor emeritus here at the Harvard Medical School said almost twenty years ago, health care should be a "social service", not an "economic commodity sold in the marketplace" only to "those who can afford to pay for it."

2. Total costs

This brings me to my second point. We should avoid shifting costs between the publicly and privately funded sectors of the health care system. Our concern should be to control total costs.

Until the mid-90s, some provincial governments -- charged as they are with the primary responsibility for the delivery of health -- including my own in Saskatchewan, were successful in restraining the growth in public

health care costs. We rationalized our services and improved efficiencies, while trying (not always successfully) to preserve access to quality services.

It turned out, however, that we pushed some of these costs out of our own budgets, and onto the residents of the provinces. It was, in other words, a false economy.

At the end of the day, the total bill for health care is paid by citizens, whether through their taxes, their premiums on insurance policies, or the fees they pay directly for health services.

The total bill should matter more than the individual portions.

It should represent value for money, and it should be affordable by people who are sick and in need of health care.

3. Equitable access

Which brings me to my third point: We must do everything possible to improve timely access to quality services.

According to a survey of five countries, including the United States, done a decade ago, Canada enjoyed -- by a considerable margin -- the highest satisfaction ratings. At the time, there were few concerns about quality or waiting times for services.

Today, however, the situation has changed. Complaints about access to some types of surgery, specialists or advanced diagnostic tests are becoming commonplace.

And however bad the situation is in our cities, it has long been far worse for people in rural and remote parts of Canada.

Another common fear revolves around "queue-jumping" in the public system. The idea that money or influence -- rather than medical need -- can give some people faster access to publicly funded services is so far more a myth than a reality.

However, MRIs and other diagnostic tests, in great measure due to a withdrawal of public investment here in the 1990s, are now becoming more available on a user-fee basis. It is therefore likely that patients who are tested sooner will also be seen sooner for surgery or follow-up care. This is a growing phenomenon and, in my view, potentially threatening. Why?

Because it is a serious violation of a core value shared by Canadians: The notion that people should have equal access to care, and that medical need should be the only criterion governing who should be tended to first.

And so, we have to do a better job of managing waiting lists. We need to be more open with patients about the criteria for getting on and moving up the lists. We need to apply those criteria in a fair, consistent and open way. And we need to address the equipment and human resource shortages that have created unnecessary blockages.

4. Transformative change

My fourth and final point is that because health care needs are constantly evolving, service delivery has to keep pace. Toward that end, governments must show the will and leadership to achieve what I call transformative change.

One route is to enhance preventative care and to shift the focus from "illness" to "wellness." This can happen among individuals. Governments, often in partnership with community-based organizations, can also promote this shift among specific populations.

Modernizing and transforming the health care system also involves the evolution of primary care - people's first point of contact with the health care system.

We need, for instance, to shift the focus away from hospitals and medical treatments and to break down traditional barriers among health care providers.

The best way to do that is to create a comprehensive primary health care system that is available 24 hours a day, 7 days a week, with providers who have long-standing and trusting relationships with patients.

These are transformative changes because in order to attain their goal of a more seamless continuum of care, they must transform how health care providers and institutions are organized within the system.

More important, though, they must alter the way we perceive and use the health system.

No question it will be difficult to achieve such transformations, because change, especially wholesale change, is always a challenge.

But ultimately, these changes will be essential if we are to preserve and sustain the Canadian health care system.

CONCLUSION

In summary, sustainability is about more than money. It is about ensuring a continuum of health services in a way that is both fiscally responsible and responsive to ever-changing needs.

It is also about political sustainability in the sense of the system having the requisite support of a majority of citizens within a democratic society. This includes sharing the fundamental values that underpin the system. From this perspective, any public health care system is as sustainable as a given society wills it to be.

Indeed, I am acutely aware that the support of Canadians for their health care system is not given freely. It is given in exchange for a commitment that their governments will ensure that high quality care is there for them when they need it. 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.

Once my final report has been submitted, the future of our health care system will be in the hands of Canadians. Their commitment to the values underpinning medicare, and their willingness to fight to preserve and build on the proud legacy they have inherited, will decide its destiny. I have no doubt Canadians- and their governments- will make the right choices.

I thank you for your time and look forward to your questions.

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