

# **“Medicare: Now is the time for Action”**

Notes for the remarks of Hon. Roy Romanow, P.C., Q.C.

On the occasion of the

National Primary Healthcare Conference

Winnipeg, May 2004

## 1. Opening remarks

Thank you for inviting me to be with you today, as you begin your extremely important deliberations on the advancement of primary healthcare reforms in Canada.

When I tabled my Report to Parliament on the Future of Healthcare in Canada, I said this about primary healthcare – “... *in fact, no other initiative holds as much potential for improving health and sustaining our healthcare system.*” In fact, however, the concept and the models of which held the same hope for primary healthcare as a major transformative program have been in existence for quite a few decades before my Report. Back in 1972, describing the concept of community health centres, Dr. John Hastings stated, quote, “CHC’s should be established and linked with hospitals and other health services in a fully integrated health services system,” end quote.

Quote, “a fully integrated health services system,” end quote, recognizes the desire of Canadian citizens to have a medicare plan based on our single-payer and publicly funded model, so as to ensure efficient and timely access to quality healthcare when they need it.

Around this, a strong Canadian consensus exists, even today. And, most people would agree that one of the keys is the implementation of primary healthcare, with its potential to improve health outcomes and guarantee the future viability of one of our most cherished social programs.

That’s why this conference is so timely and so extremely important. I hope the outcome of this meeting will boost the momentum of primary healthcare. I eagerly look forward to the results of your deliberations.

## 2. Primary healthcare and some of its challenges

I don’t presume, especially in the presence of hundreds of experts in health policy and primary healthcare, to have any special expertise beyond what I learned as Royal Commissioner, knowledge that is based on our extensive studies and from listening to the Canadian public. So, after making four observations that I hope are more specifically directed toward primary healthcare, I will move on to discuss the general political climate in which we find ourselves. Suffice to say, I believe that *now is the time for action.*

As I see it, there are four main characteristics of primary healthcare reform that deserve the attention of our caregivers, the policy community, the public, and governments.

1. As Dr. Hastings pointed out, any model must be structured around the **principle of integration and the delivery of a continuum of care** wherein everyone is part of a team. This demands the incorporation of professionals like nurse practitioners, pharmacists, electronic records and telehealth experts, community workers, and of course, physicians. The key to a more seamless system of delivery is the acceptance of new definitions of the scopes of practice of all who are members of the team, which scopes of practice reflect integration of services, maximize each caregiver's greatest potential, and relate to a community. We must also examine the issue of payment, especially fee for service, to determine the logical method that is consistent with the philosophy of primary healthcare. Progress has been made, but strong leadership is still needed to break down the "silos" that impair the realization of this characteristic.

2. **Direct involvement with the community** is also a crucial feature. The primary healthcare team must be a responsive outreach vehicle that is connected to the community it serves. No one model will apply to the wide variety of needs that exist in our country, and innovation, as Dr. Michael Rachlis points out, must be encouraged. To state the obvious, the needs of the South Riverdale Health Centre in Toronto vary from the community needs in rural Saskatchewan, which vary from the needs of people in Nunavut. On a visit to Pangerton, Nunavut, I had the pleasant experience of meeting with both the community elders who served on a community board of directors to guide their primary healthcare service, and the caregivers themselves, who were made up of only six nurse practitioners, one or two lab people, and the necessary maintenance staff. Everyone clearly understood that the needs of that community demanded innovative practices to deal with health concerns like alcoholism, drug abuse, suicides, and poor housing. Telehealth became extremely important when specialized medical advice was necessary. As with all of the models that I visited, people in Pangerton had access to competent, quality healthcare, and as such, pressure was relieved on emergency services, and everyone played an active role in changing attitudes in the community toward health in general.

3. There must be a clearing house or some similar such forum to **exchange ideas about the various best practices that exist**. The logic for this must be obviously clear. Perhaps the newly established Health Council of Canada might eventually develop into a vehicle for the promotion of information, exchange for determining best practices, and as importantly, a mechanism whereby results and progress are directly reported to Canadians.

4. Finally, **there must be a true and real commitment to achieve all of this**, and more, by the caregivers, the policy makers, and the government decision makers. I'll say a few more words about the government and political aspect of this in just a moment, but, Canadians told me loudly and clearly that, with respect to primary healthcare reform, *now* is the time for action.

That's why your daily work and the work of this conference is so important. Canadians eagerly support your daily work, and are hopeful that this major conference will provide a much-needed boost to this transformative initiative.

### **3. Recently, progress has been stalled**

However, as with many of the other reforms advocated for our publicly funded medicare plan, the reform of primary healthcare has proceeded slowly across the board. Overall, on all the key issues of reform, we seem to be stalled. Yes, in 1997 Ottawa established the health transition fund, in which primary care was one of its four priorities, and much good work flowed from that initiative. Yes, rural and community health initiatives by Ottawa and the Canada health infrastructure program, both made important contributions to primary care. Yes, the September 2000 First Minister's Accord on Health saw large amounts of new federal money injected into the healthcare system. And, yes, the February 2003 First Minister's Meeting, acting upon the Romanow Report, saw even more substantial federal dollars advanced, ostensibly to effect reform. So, why do I say that progress seems to have stalled, or, at the very least, slowed down considerably? And why do some of you, perhaps, have the same feeling?

Let me cite the results of the February 2003 post-Romanow First Minister's Meeting. Remember, this meeting was intended to quickly act upon the transformative changes that were advocated in my report. I called for five funds to direct the changes in the areas of advanced diagnostics, homecare, catastrophic drug coverage, rural and remote care and primary healthcare reform. Each fund had its own discreet guidelines upon which the funding to the provinces would be based. In other words, new money had to buy change. New money from Ottawa to replenish the monies it had withdrawn in 1995 from healthcare would be coupled with change. In the result, the rural and remote fund was deleted, and homecare, catastrophic drug care, and primary care, were melded into one new fund called the medical reform fund.

Simply stated, the guidelines that direct the spending of this money are too general, too porous, and not targeted. Primary healthcare reform is mentioned, there seems to be a general commitment to it, and there is a call for a 24/7 service. But what does "24/7" mean? A 24-hour answering machine? A hotline? This lack of direction makes fundamentally different interpretations possible, some of which will invariably depart from sound principles of primary healthcare, and other characteristics not contemplated by my Report. Moreover, the February 2003 Accord made none of the recommended changes to the Canada Health Act, such as adding the principle of "accountability," or enhancing the ensured services at the core of our publicly funded system. And, after much delay and intergovernmental wrangling, we finally have established a health council of Canada whose mandate and budget remain unclear.

The result is that Canadians have witnessed very little meaningful progress toward their desired goal of timely access to quality healthcare. This leads to the growing perception in the minds of the public that maybe – just maybe – primary healthcare reform, stable funding, and all of the other transformative changes are beyond the political will of our society to attain. So, should we be surprised that the voices of private delivery have now, again, risen across the land?

Friends, we know what needs to be done to protect our most cherished social program. What we need now is action - but, the period ahead is fraught with challenges.

#### **4. Myths and sustainability**

The myths about our healthcare system remain. A minority - powerful as it may be, but still a minority - speaks of Canada's medicare system as "one large, monolithic, publicly financed and publicly delivered system," when the truth is that it is a mixed system of public and private delivery, with an increasing proportion of private costs and delivery being the fact. They argue that it is not 'sustainable,' their illegitimate arguments aided by the legitimate worry of Canadians that have thus far not been able to affect meaningful change.

The old buzzword is 'sustainability.' The rhetoric surrounding Premier's conference after premier's conference is that medicare will no longer be sustainable within six to ten years, unless Ottawa provides even more money to the provinces without guidelines or conditions for change. I say to Canadians, be careful of the word "sustainability." It is a Trojan horse. For some, to attain sustainability means to attain reforms like primary healthcare, so that we may continue to respect the principles of the CHA and medicare, but for others, "sustainability" is a move toward private delivery, with a distinct lack of innovative or transformative change.

"Sustainable," as my Commission defined it, 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 and correct organization of health care providers, buildings, equipment and information systems to deliver the best quality care in a timely fashion.

Determining the best manner in which to apply those resources to our "*evolving health needs*" is admittedly challenging. *Needs* tend to evolve – and some would argue, they have recently exploded in the field of health - while our service delivery mechanisms are burdened by history, habit and general inertia.

For instance, in Canada, we continue to emphasize care by physicians rather than teams of health care providers with a broad range of skills with the objective of providing a continuum of care.

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 those of Aboriginal peoples in Canada, 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, we do not live in a perfect world. There is no magical way - or invisible hand - to keep *resources, needs* and *services* in balance. That's why societies like America's that rely predominantly on free markets in health continually struggle to subject them to appropriate regulation. But, how well can the market accomplish this daunting task? By all the evidence – not well. And where governments are more directly involved, the task is also difficult. Perhaps the difference is that governments are obliged to respond to the needs of society as a whole. We balance competing social needs and do it in a more equitable fashion with better health outcomes and more efficiency.

The single-payer, publicly-funded insurance system has clearly demonstrated lower administrative and overhead 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.<sup>1</sup>

Relatively recently, they updated their studies, and it reconfirmed their original findings. Today, in real dollars, each Canadian pays \$325 per year in U.S. funds, compared to the \$1,150 in US funds paid by each American – just for overhead and administrative cost alone.

Why the huge difference in costs between Americans and Canadians? Private insurance systems – the backbone of America's market-based healthcare system - 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, engage in litigation, and reimbursement of beneficiaries. By contrast, a single payer insurer is spared most of these administrative outlays. So, the evidence shows that the single payer system is significantly more cost efficient.

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<sup>1</sup> Woolhandler, S. and D.U. Himmelstein. 2002. Paying for National Health Insurance – And Not Getting It. *Health Affairs* 21(4), 88-98.

Woolhandler, S. and D.U. Himmelstein. 1991. The Deteriorating Efficiency of the US Healthcare System. *New England Journal of Medicine* 324(18), 1253-1258.

Thus, 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 on health than the U.S., Germany and France, but more than the UK, Sweden and Australia. In America, more than 14% of GDP is spent on health, and nearly 100 million Americans either have no health insurance, or are under-insured.

One more point on the sustainability issue. Professor Gordon Guyatt of McMaster University in the province of Ontario, recently wrote the following, referring to Canada' single-payer system:

*“Public funding means that the single payer, the government, can exercise a discipline impossible when private insurance pays for a substantial part of care.”*

*“Between 1992 and 1998, the share of our gross domestic product dedicated to health care dropped from 10 to 9 percent. That extraordinary decrease, without parallel in any industrialized country, occurred because governments could put the brakes – hard – on health care spending. Only a single-payer system allowed that kind of discipline.”*

The combination of administrative savings and spending discipline explains why Canada still spends 10 percent of its GDP on healthcare while health care has consumed more of the U.S. GDP every year, and now stands at an extraordinary 14.9 percent.”<sup>2</sup>

Thus, if we believe in the value of equity as a foundation to our system and its reforms, our healthcare system is as sustainable as our society wills it to be. There is no evidence to the contrary. In fact, the OECD report of May, 2004, the Finance Canada report projecting 40 years out into the future, and a litany of other research makes the best path to the future absolutely clear.

### **Closing – Values really matter; *now* is the time to act**

So my friends, we are now facing a major test of the national will – to transform our national healthcare system in a meaningful way. You are here today to contribute your knowledge and expertise to this duty, adding to everything you've already accomplished in your individual fields. Congratulations, and please keep up your important work.

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<sup>2</sup> Guyatt, Gordon. “Private Payment: the Zombie of Health Care,” Globe and Mail, April 6, 2004, A2.

But in closing, I ask you to keep uppermost in your mind, that as important as primary healthcare reform is, you as citizens of this great country have a duty to raise your voices to ensure that the governments do not stray from the larger task of preserving and enhancing the national treasure of medicare.

On this difficult road, I firmly believe that we will be guided by the central importance of values. I firmly believe that an examination of public values is essential to any thorough review of public policy. Governments that do not have a firm handle on public values and expectations often make decisions that do not reflect the collective will of the people or the public interest, with disastrous results. For this reason, I began my work as Commissioner with the central question: "What are the core principles and values of Medicare and do Canadians remain attached to them?"

Forty-three independent studies were commissioned to try to answer some important questions surrounding healthcare. Some of the most important studies focused on principles and values. Overwhelmingly, Canadians expressed their commitment to a publicly funded system. The reason for this was probably best described by Dr. Arnold Relman, professor emeritus at the Harvard Medical School, who said almost twenty years ago that healthcare should be a "social service", not an "economic commodity sold in the marketplace" only to "those who can afford to pay for it." This is a statement of a value.

The principles of the Canada Health Act were built on basic values like equity and solidarity. To Canadians, these values mean that everyone should have access to our health care system on the same terms and conditions, and that this access is ultimately a right of citizenship.

In closing, permit to invert an old saying: *believing is seeing!* With something as important as healthcare, principles and values come first, and systems architecture and design second... This is an invaluable principle, not only as it applies to healthcare, but also as it applies to all institutions which are a fundamental to civil society, including the rule of law, the systems, and the men and women that support it. 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.

I know that we shall succeed, and I wish you particular success in your deliberations.

**Thank you.**