

Directions in Canadian Healthcare

Notes for a Speech by

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Commission on the Future of Health Care in Canada

for

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Introduction

Thank you for your kind invitation and for that warm welcome.

As you know, I have had the unique privilege of heading a Royal Commission appointed to examine the issues – both real and perceived – surrounding Canada’s health care system. Appointed under Part II of the Inquiries Act of Canada, I was independent of all governments and empowered to subpoena witnesses and documents, if necessary, to complete my task. But above all, my 18-month mandate was to listen to Canadians, to consult with experts, and to recommend a course of action.

Objectivity, transparency, and breadth of perspective were the hallmarks of my Commission’s processes.

At every stage, my team and I worked hard to ensure that we were as thorough and inclusive in our research and citizen engagement efforts, as we were transparent in sharing the results of our deliberations with the Canadian public.

I truly believe we set a new standard for facilitating informed and productive policy debate and at the same time, for engaging Canadians in the policy-making process. This may be one of the yet-to-be-told stories of how this Commission differed from previous ones, but that’s for another day.

Today, I’d like to begin by providing, for the sake of context, a broad overview of Canada’s health care system, and while doing so, I will try and de-bunk some of the myths that still exist regarding its nature.

I’ll then outline some of the broad directions of our final report which speak to addressing the system’s most immediate challenges;

I will describe the work yet to be completed by our governments;

And I will conclude with a few remarks on the central importance of values, and of active citizen engagement, in defining the type of health care system envisaged in our report.

Broad Overview

Let me start by clearing up a couple of popular myths.

First, there is a misconception – or myth - that Canada has one big, public health-care system. A few even believe it to be an overly-expensive and unwieldy behemoth unable to keep up with the demands of today, and utterly unfit for tomorrow.

Well, to begin with, we don’t have one system. We have 13 health care systems - not one - one for each province and territory. One might even say 14, if the federal

government's delivery of healthcare to its constituencies like the military, the RCMP, northern territories and aboriginal people are counted.

Constitutionally, the provinces are primarily responsible for the delivery of healthcare in Canada. Some provinces, notably Quebec, argue that they have the exclusive jurisdiction over healthcare, but the preponderance of constitutional writing on this topic points to a shared responsibility between the federal government and the provinces, with the greater share falling to the provinces. This points to the need for cooperation rather than confrontation.

In any event, all systems are 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 core values of Canada's medicare system: "Medically necessary services – but, as I have said, 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 the cash transfer payments it makes to the provinces for health service delivery if there is a violation of the act. In actual fact, this power has rarely been exercised.

Thus, 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. It is not solely "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 – another popular myth. 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 the CHA "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 "medically necessary services," paid for wholly by public funds through a 2

progressive taxation system, 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. It basically falls outside of the core CHA services I've just described.

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. Or, just pay directly out of their own pockets.

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; again, 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. Overall, about 70 per cent of the yearly healthcare costs are covered by public funds, and 30 percent are covered by direct private payment.

Clearly, then, the Canadian system is hardly a monolith of public funding.

Sustainability

But, perhaps, the more pressing question is whether the system of health care we have in place today is, in fact, "sustainable?"

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

Part of my mandate was to recommend how governments 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,” as we 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 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 – and some would argue, they have even 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.

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 Aboriginal people, who suffer disproportionately poorer health. It is a shame that, in a country as rich as ours, the health outcomes of aboriginal people are so much poorer than those of the rest of society.

Now, 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 resources, needs and services in balance.

That's why governments that rely predominantly on free markets in health attempt to subject them to regulation. That is why professional organizations are asked to co-operate by policing their own behaviour.

And, where governments are more directly involved, keeping resources needs and services in balance remains a continuing challenge for them as they juggle competing political, economic and social demands.

Rising costs

Let's go back now to the mandate of my commission, and in particular the part 4

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 three categories of funding I described, namely, publicly funded, privately funded, and mixed groups of services, it is within the publicly funded, CHA-insured group – hospital and physician services – that costs have risen the least!

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 are in the second mixed public-private category – have doubled in the past 25 years.

Why is it, then, that the costs for insured services have remained steady? One obvious answer is that, increasingly, care is shifting out of hospitals and into home-based and ambulatory care. In the result, individual Canadians bear more of the costs directly.

Administrative costs

But the second reason is the most important one. The single-payer 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.

Relatively recently, they updated their study using 1999 data, 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. These studies were reviewed by the General Accounting Office of Congress, and to my knowledge, have not been contradicted by any other review.

So, 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 and reimburse beneficiaries.

By contrast, a single insurer is spared a lot of these administrative outlays. So, the evidence shows that the single payer system is significantly more cost efficient.

However, more than half of all health care activity in Canada still remains

outside the single-payer system.

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, about 15% of GDP is spent on health, and nearly 100 million Americans either have no health insurance, or are under-insured.

Finally, on this issue of cost and sustainability, let me say the following:

Throughout the 1950's and well into the 1960's, our system was just like America's, and health spending as a percentage of GDP in our two countries was and grew, in lock-step.

But, following the introduction of Medicare in Canada, health spending in both countries has continued to grow - but at a markedly different pace.

As I've said, today, our health spending in Canada amounts to just over 9% of our GDP, while in the United States, it amounts to about 15% of GDP.

And there is a deep irony about the American situation. Professors Woolhandler and Himmelstein also have observed that if one were to add up the costs of Medicare and Medicaid in the United States - both of which are public programs - and couple that with the value of tax breaks that are provided to offset the costs of purchasing private health insurance, then about 60% of all health care spending in the United States is actually public.

In Canada, the comparable figure is 70%- and the system provides for universal coverage and produces health outcomes that are, on the whole, at least comparable to, and more often than not, better than, those produced by the United States.

No wonder there is such a huge debate emerging in America about the organization and delivery of healthcare.

But is our system sustainable? The short answer is: yes. The evidence demonstrates this, but we must remember that sustainability in the context of healthcare is about more than money. It is also about political sustainability in the sense of having the requisite support of a majority of our citizens in our democratic society. From this perspective, any publicly funded healthcare system is as sustainable as a given society wills it to be.

Outlines of the solution

However, in both countries, the need for more sophisticated value-for-money assessments becomes increasingly obvious, and I made some attempt to address this in my Report.

I shall spare you a detailed description of the 47 specific recommendations of my final report. Instead, I shall now try to outline the broad themes of the report that point to a solution.

1. Universal single-payer

First, for reasons I just outlined, my report concluded that a “universal single-payer” is a feature of our health care system well worth preserving and even enhancing. The evidence is supported by a broad consensus among Canadian in favour of public funding.

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

So, my report recommends that the universal, single-payer system should actually be expanded beyond the current basket of CHA services - namely hospitals and physicians - to include the basic aspects of homecare, access to advanced diagnostic services and to provide catastrophic drug coverage.

My reasoning here is that that unless we lay the groundwork now for including these elements of modern healthcare under the umbrella of public funding, then the private costs for these services will continue to grow with little restraint.

My report also acknowledges that expanding the scope of medicare coverage requires additional public investment in the near-term. But, and I wish to stress this, in the longer-term, this will 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.

2. Total costs

This brings me to my second major theme. We should try to 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-1990s, 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 individual residents. This is false economy.

Because, at the end of the day, the total bill for health care is paid by citizens,

whether it's through a progressive taxation system, or personal the fees they pay directly for health services, such as premiums on insurance policies.

The total bill 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: My report argues that 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 of care or waiting times for services.

Today, however, the situation has changed. Complaints about access to some types of surgery, specialists or advanced diagnostic tests have become 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 my report recommends we have an obligation 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 serious equipment and human resource shortages that have created unnecessary blockages.

Therefore, we need an integrated and comprehensive approach to timely access to care, including specific recommendations to overhaul the primary care system, measures to address mismatches in supply and demand for health professionals and specific investments to improve access to care in rural and remote areas.

4. Transformative change

The fourth and final theme of my report was that service delivery must keep pace with constantly evolving health care needs. To that end, governments must show the will and leadership to achieve what I call transformative change.

One example of transformative change is to enhance preventative care and to shift the focus from “illness” to “wellness.” The evidence is clear that the “determinants” of health, such as lifestyle, environment, education, housing and income, have a great impact on our health throughout our lifetime, and especially in our later years. So it makes sense to direct a portion of our funds and our attention to the “upstream” care as well as the “downstream,” sometimes described as “acute” care.

Another example involves the evolution of primary healthcare – people’s first point of contact with the health care system.

We need, for instance, to shift the focus away from hospitals toward 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, and who can provide a continuum of care across the boundaries of traditional medical specialties.

We need these and other transformative changes in order to attain the goal of a more seamless continuum of care. Everyone must work to transform how healthcare providers and institutions are organized within the system in order to meet today’s needs.

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.

So, how are we making out?

So, how are we making out? So far, I would say that progress based on the report is mixed. On funding, although there is a substantial reinvestment to counter-act the reductions of the 1990s, by all governments at all levels, the cash transfer portion of funds from Ottawa still falls short of the 25 percent which I recommended. Historically, Ottawa has shared 50 percent of insured costs with the provinces. How is the 50 percent federal share arrived at? Giving credit to Ottawa for the transfer of tax points to the provinces made back in 1977 - at a value of 25 percent – a cash portion of 25 percent would restore us to the traditional level of 50/50. I recommended five-year funding commitments with an escalator, and funds to produce transformative change. Some transformative funds have been established, but the five-year, predictable

funding proposal has not. In sum, this funding shortfall will very likely lead to a return to intergovernmental wrangling over the sufficiency of and the responsibilities for funding, thereby further delaying transformative change, and, most importantly, testing the patience of Canadians who desperately seek solutions.

Second, with respect to the CHA, governments have not agreed to expand the publicly insured core basket of services to include home care, catastrophic drug coverage, and advanced diagnostic treatment. Moreover, a sixth principle of accountability – which Canadians repeatedly argued should be added to the CHA, has not been so included. In short, the CHA insured programs remain the same as they did back in 1984, the year the CHA was enacted. It has not been modernized, and with this decision is the likelihood of increasing costs.

Third, I recommended the creation of a Health Council of Canada, an independent and arms-length body which would serve as a focal point – for governments, caregivers, and the public - for establishing objectives, common indicators and benchmarks, criteria for measuring and tracking health expenditures and outcomes, advancing and reporting on progress respecting transformative changes, and – above all – reporting all of this to Canadians in an open and transparent way. The Health Council was designed to foster cooperation and guarantee public accountability. First Ministers mandated their health ministers to establish such a body by May 5, 2003. This has not been accomplished, and Canadians are still waiting.

Overall, the First Ministers accomplished much when they met in February of 2003, but funding, modernizing the CHA, and establishing a collaborative agency to eliminate useless intergovernmental wrangling and long-distance hollering about healthcare all remain to be accomplished.

Values

Let me make a few final comments on the central importance of values in the debate over the future of health care.

I firmly believe that an examination of public values is essential to any thorough examination 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 started my work 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. 10

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.

Access should be based on need, not factors like wealth, province of residence, gender or age. Canadians still feel strongly that these basic values must set the direction upon which the system is governed into the future. They have served us well, and they must guide us still.

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.

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 to accept the wrong answers - 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 a society.

Friends, the Report’s agenda is an ambitious one, but at a time when one of our most cherished national programs is at a crossroads, Canadians expect no less than an ambitious plan, and no less than a determined and cooperative course of action by all our governments. They will not settle for less.

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