

ROMANOW SPEECH
To the Truro Chamber of Commerce
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Thank you very much for your kind introduction and good evening to all of you.

I want to thank the organizers of this evening's event for the kind invitation to meet with you.

As you may be aware, my hearing tomorrow in Halifax coincides with my Commission reaching the mid-point of its national dialogue with Canadians on the future of their health care system.

We've completed 11 days of public hearings to date and have another 10 to go before moving on to the next phase of our activities: making sense of all we've heard.

So I welcome this opportunity- early though it may be- to step back a bit from the fray, to gather my thoughts and to reflect on what I've learned to date.

Suffice it to say, as anyone who has been monitoring our progress could attest, we have been overwhelmed by the public's response to our call for participation.

Indeed, to those critics who say that there is little new our Commission can learn, that health care has been studied to death, that our national obsession with health care is on the wane, or that Canadians want someone- anyone- to start making the hard decisions for them, I'd simply say: think again.

Canadians have very strong views about how to fix our national health care system and a deep commitment to its preservation.

I want to begin by making a few observations about what I am sensing to be common concerns and themes emerging from my meetings with Canadians. I also want to speak briefly about the role of the private sector in health care.

A Focus on Values

Let me begin by explaining to you why it is that whenever you see a clip of me on television these days, I appear to be nattering on and on that the health care debate is really a values debate.

Early in my mandate, I made a firm commitment that whatever recommendations my Commission might eventually bring forward, these would be compatible with the values Canadians want reflected in the policies and programs that constitute Medicare.

I believed then, and I continue to believe, that before offering prescriptive solutions to the problems that are eroding public confidence in the future of our publicly funded health care system, we must come to terms with what it is people want and expect from the system.

How can I - or indeed any of the health care reform bodies that have proliferated in recent months- possibly provide meaningful advice to decision-makers without listening to Canadians and without focusing on values?

How can we decide what components of our health care system should be expanded- or contracted- without an insight into what matters to Canadians?

How can we reconcile competing and equally compelling demands for investments in prevention, hospitals, home care, primary care or palliation- let alone the myriad of issues relating to accessibility on a geographic, linguistic or cultural basis- unless we have a good idea of how Canadians expect the \$100 billion health care pie to be divided?

And how can we hope to resolve such issues as how much public money to commit to health care relative to other priorities, or who should pay and through what means- without a clear understanding of what Canadians believe to be acceptable boundaries for such discussions?

More to the point, how can we decide how far to go with a reform agenda without a sense of what public tolerance there is for change?

These are not simple matters and I have devoted a significant portion of my time, and of my Commission's resources, to trying to get at the underlying values Canadians share.

Because, if I am correct that the Medicare house needs remodeling, not demolishing, I need to have a pretty good blue-print in mind before the renovations can begin.

What Canadians are Saying

So how do you get to dig down into the collective psyche of Canadians to get at these values? Is it just hit and miss? Float a few policy trial balloons and see what happens or which get shot down?

I don't believe this approach makes for sound public policy; especially not in a field of endeavour so fraught with symbolism and so vital to Canadians' sense of self and sense of personal security. And I certainly don't believe in the trial-balloon-model of public policy-making for this Commission. I won't go into any great detail at this time on the various instruments my Commission has deployed to gauge the tolerance of Canadians' for reform and change- other than to say that the results have been both heartening and eye-opening.

Heartening because I can detect from our hearings, from our research, from the letters, e-mails and phone calls we have received and from the public's response to our survey instruments, that there is indeed a significant consensus among Canadians about what Medicare can and should be. And eye opening, because the degree of sophistication of the views I am hearing- of what I would characterize as "health policy literacy" among ordinary Canadians- is far beyond what I had expected, and what I believe policy makers- both elected and un-elected- fully recognize.

Those proposing a radical overhaul of Medicare should make no mistake: Canadians understand, substantively, practically and politically, the issues at stake in this debate.

They understand the issues in practical, dollars and cents, front-line delivery terms.
They understand the issues in inter-governmental relations, power-politics terms.
And they understand the issues in symbolic, nation-building and nation-sustaining terms.

They understand the trade-offs, what they would mean and more significantly, they are prepared to make them. Indeed, while Canadians want and expect leadership from their elected representatives, they also want a clear say on how that leadership is to be exercised.

If there is one lesson that I will heed, it is to have faith in the judgment, maturity and instincts of Canadians. My message to all governments is if you ignore Canadians on this issue, you do so at your own peril.

Let me give you just a small flavour of what we have been uncovering.

Four Models for Reform

In my Interim Report, and in my public statements and hearings, I have asked Canadians to express their views on four different models or scenarios for addressing the sustainability challenge. Let me quickly summarize them for you...

The first scenario goes like this. The health care system needs more money, and equity dictates that it should come from the public sector, either through tax increases or through a re-allocation of current spending.

The second scenario also begins with the proposition that the health care system needs more money. However, it suggests that the appropriate policy response is that the additional money should come in the form of user-fees or co-payments that have the added benefit of providing an incentive for people to use the system judiciously.

The third scenario suggests that to relieve pressure on the public system, governments should allow for the creation of a parallel, private system of care. This would empower Canadians by giving them more choice as to where to obtain the care they need and bring the genius of the competitive market to the fore.

The fourth scenario is to fundamentally restructure the current system, especially in regard to primary care, to improve its quality and efficiency and to place greater emphasis on wellness and prevention.

Four scenarios, each resting on a rational and arguably compelling premise... And each enjoying --if public opinion is to be believed-- a community of support among Canadians.

Understand, though, that the primary objective of this exercise is not to see which of the four options best reflects what Canadians want, but to enable us to understand what values take precedence over others when Canadians are obliged to choose between competing visions for health care renewal.

For example, public opinion research tells us that a majority of Canadians agree with the proposition that our health care system should be premised on the principle that need should be the main determinate of access.

But public opinion research also suggests that a significant number of Canadians agree with the proposition that they should have greater choice in terms of where and from whom they can access care- as illusory a concept as this is in many parts of the country. It further suggests that many Canadians feel that, if they have the resources to do so, they should be able to expedite access to the care they need (or the care they want).

And finally, public opinion research indicates that Canadians want people whose lifestyle choices make them heavier users of the health care system to somehow have to pay more for the care they receive (if indeed we can even call them choices in light of the growing body of evidence on the social and economic determinates of health).

But if choice means fast-track for those who can pay, or unequal access to care based on geography, or if the desire for individual accountability means something other than need will determine access to care, does it imply Canadians are prepared to water-down the proposition that need should define access?

So what have Canadians said to date? What have they opted for when the four options are laid out before them and the pros and cons of each carefully enumerated? We have partial results in from a series of 12 intense, full-day focus group sessions that we organized across the country, and that involved some 40 Canadians at each session. And we have partial results from the 15-minute on-line survey that over 12,000 Canadians to date have taken the time to complete. 12,000!

While I will not scoop myself by presenting conclusions of an ongoing research project, I will say the following:

First, *Canadians know far more about the risks to the system and the consequences of different policy options, than they are given credit for. They are neither naïve nor are they prepared to tolerate being treated as such. They want a say in how health care decisions will be made and they want to be listened to. More to the point, Canadians believe the system belongs to them- not to governments, not to politicians and not to physicians.*

Second, *the public does not at this time appear inclined to support tax increases or to support the imposition of user-fees of any sort. They do want more choice, but not at the expense of jeopardizing or compromising the basic social contract at the heart of Medicare.*

Third, *and perhaps more significantly, although they are not inclined to support tax increases or user-fees, they do not necessarily rule them out.*

Fourth, *what they do support- in large numbers- is reforming the system. NOT because this is the easy route, but because they do not accept or are unsure whether the current system is deriving maximum benefit from the resources it already has. And because they do not have the information they feel they need to make an informed decision on whether user-fees or tax increases are warranted --let alone what form or what level-- they are withholding judgment and parking their votes. I would argue that this is a mature, rational and completely understandable position.*

Fifth, *and directly related to the previous point, Canadians want greater accountability and transparency throughout the health care system. They want to know how much money is being spent by all levels of government, on what, and with what results. Again, this appears to be linked to their surprising ambivalence regarding tax increases versus user-fees. In plain language, until and unless they know for certain that any additional revenues raised will be directly and explicitly earmarked for health care and nothing else -- they simply do not want to know about it.*

Indeed, my overall impressions- and I stress that these are my own and that I am at the mid-point in my public hearings- is that Canadians do not accept that simply working harder or smarter will solve health care problems.

They believe we must reform the current system, but that additional monies will eventually be required. And as to where that money should come from, well, it will depend on the actual diagnostic that emerges.

But having said that, I want to emphasize that Canadians' attachment to the current social contract at the heart of Medicare remains exceedingly strong.

Which leads me to the second part of my presentation: the business of healthcare and the role of the private sector in health care.

The Business of Healthcare

You may have read that over \$100 billion is spent annually in Canada on health related services. The full economic picture, when you consider ancillary businesses, is probably higher. About one third of that amount is spent by individuals, either out of their own pockets or through their private insurance schemes.

Despite our commitment to a "public health system" in fact, only about 70% of total health care spending in Canada is publicly administered.

People tend to think of private sector involvement in health care as the direct delivery of services – such as "for-profit" nursing homes. The debate also focuses on direct providers of care, such as eye or hernia clinics. But, there are also "private-for-profit" businesses whose revenues derive largely from the public system by providing important and expensive "second-line" items like medical supplies, lab and food services, laundry, IT, data processing, maintenance, security and so on.

The reality is that our health care system is a mixed bag of non-profit and "for-profit"; self-employed practitioners and salaried professionals; unionized and non-unionized workers; and government and private financing mechanisms.

So when we start talking about the "public-private" debate, let's not oversimplify a very complex set of questions, facts and objectives. It is a barrier to reasoned discussion.

Some have said that I have opened the door to user-fees. Others have said that I have rejected user-fees. I am studying them-- and I am paying attention to what Canadians are saying about them. We have user charges in health care now. The current system has defined certain of your body parts as outside the scope of what we publicly fund or manage – your eyes and your teeth, for example. You pay when you need those body parts looked after. You pay for a wide range of uncovered but arguably medically necessary services now.

We applaud the "public" nature of our system but seldom recognize that there is a substantial private investment in health care in Canada today.

We need an open and transparent dialogue, which grasps the simple truth that there is a difference between public funding, public administration and private service provision.

The failure of key public figures to adequately distinguish between “provider” and “payer” issues is inexcusable, given the “passive privatization creep” we are experiencing, through which more and more new services are not insured by the public purse.

Health care is a funny business. Typically, in all but a few locations, managers of our care institutions have few direct incentives to provide a high quality service. Nor are care providers given explicit incentives to focus on health promotion and disease prevention. To be sure, professional and public sector ethics may partially explain the absence of incentives... but it does not have to be that way.

I am told that it is possible – and other countries have done it – to introduce market disciplines into a publicly funded, universally accessible, health care system. Infusing effective accountability into our institutions, and among care providers, also represents one of the most important challenges facing our system. But it must be done to improve the system’s overall quality and to drive efficiencies that will help to ensure its sustainability.

Private Sector Involvement in Public Sector Health Care

Now, I said I wanted to raise some questions about the business of health...

I agree with the World Health Organization’s Gro Harlem Brundtland when she asserts that good public stewardship also means harnessing the energies of the private and voluntary sectors to better achieve the goals of the system.

Indeed, if it can be demonstrated that there are areas where the private sector can deliver certain health care services in a manner consistent with the principles of the Canada Health Act and in a way that:

- a) saves our health care system money;*
- b) improves its quality and effectiveness;*
- c) improves timely access to care;*
- d) facilitates and allows for integration within the continuum of care; and,*
- e) is subject to the same standards of accountability and transparency as publicly administered services;*

We would be devoid of common sense and we would be doing a disservice to Canadians- to ignore that evidence. But we need to see the evidence. And the onus to bring the evidence forward rests with the proponents of an expanded private sector role in the system.

Obviously, there are many features of successful business that could serve to improve our health care system. Management techniques and systems, vision, creativity, cost-control, cross-border partnerships that achieve economies of scale, rewards and incentives, effective communication.

My challenge to you is, what can you do to help accelerate these improvements? How can you apply your expertise?

One way is in raising the voice of business in a constructive and thoughtful way about these very problems and possible solutions. Participate on boards and advise on maximizing productivity and quality; and how to recruit and retain the very best people.

Consider secondments from the private to the public sector, a seldom-used but potentially rich exchange tool that may provide mutual benefit.

Geography is often no longer the basis on which companies organize themselves, but remains the foundation for most of our health care services. Does it make sense for provinces to continue to organize health care services exclusively along geographic lines?

Many smaller provinces- mine included- do not have the population to support, attract or retain specialists or to afford high-tech medicine and new “wonder-drugs” that are being introduced almost daily. Yet despite some successes, collaboration across jurisdictions to pool resources and to coordinate efforts to overcome these hurdles is often a painful, slow and uncertain process. How can the private sector assist in resolving such challenges?

You know what indicators are required in your business for effective management. We have made progress toward collecting procedural, diagnostic and outcome data, but its still slow and inconsistent. We haven't yet begun to collect “system” data on prices paid for goods and services. However, the health sector does not need to reinvent that wheel – you can help.

I know the Canadian Chamber of Commerce is on record in calling for the introduction of market forces into the system. But, can the principles of market forces be introduced in a universally accessible, publicly funded system? If integration and continuity are the priorities - then partnerships, not competition between the public and private sectors, is the better path to follow.

While successful partnership models exist in other areas of public policy, they remain notable by their absence in the health field. But this need not preclude continued experimentation or analysis. How might some of the lessons learned elsewhere be applied within publicly administered health care? Help us answer this.

Conclusion

As I have said before, our current approach – just working a little harder or smarter – will not work in the long run. Nor will blindly pouring more money into the existing system. We must change our policies and our approaches. There are feasible alternative courses of action, and I am counting on us to collectively have the courage to choose one. I trust that we will learn from our experience and let hard solid evidence be our guide.

Thank you.