

*Response to the
Romanow Report*

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Introduction

With the release of Mr. Romanow's report at the end of November, the badly needed national health care debate is now fully engaged. The Senate Social Affairs Committee released its final health care report a month earlier, so we now have on the table two thorough and well-researched proposed national strategies for health care reform. Both are consistent in many respects, although Mr. Romanow's recommendations differ from those of the Senate Committee in several important ways.

Canadians must take a hard look at the proposals that are on the table and make their voices heard in the discussion about what should be done now. The final decisions will rest with our provincial, territorial and federal governments. But two things are crystal clear:

- ?? First, reports and their recommendations are one thing. *Now* is the time for action. Further delay in reforming the system is *not* an option.
- ?? Second, governments are listening. Canadians' voices will be heard if they make the effort. The outcome of the forthcoming debate, and its translation into action by our federal, provincial and territorial governments depends, very much on people making their views known clearly, strongly, and publicly.

In this paper, I will present a response to the Romanow Report. Let me begin, however, by congratulating Mr. Romanow on the release of his long-awaited report. As I know

only too well, recommending change to Canada's most-cherished social program is neither a simple, nor a universally-appreciated task.

The Senate Committee was pleased to see that Mr. Romanow has reached many of the same conclusions as we did in our report, especially with regard to defining the major goals of health care reform in Canada. He has strongly reaffirmed, as did the Committee, that the single-payer public insurance system must be maintained. He has joined us in pointing to the need to make health care delivery more efficient and more effective, and in stressing the importance of improving patient service.

To this end, he has made a number of recommendations that are the same as the Committee put forward a month ago, such as reducing waiting times and reforming primary care. Moreover, many of his proposals for expanding the areas covered by public insurance in Canada echo those advanced by the Committee. He has called for a program to protect Canadians against very high prescription drug costs, for a limited national home care program as well as for a palliative care initiative – all areas covered by the Committee's recommendations.

He has also come in with an estimate of the costs for implementing his recommendations that is in the same ballpark as the Committee's calculation that \$5 billion new dollars are needed annually.

Nevertheless, between Mr. Romanow's report and that of the Senate Committee there are a number of key differences with regard to the means and the methods to be employed to

achieve these shared objectives. We are glad that the debate can now focus on how best to attain a set of goals that we share. The means that are chosen are of no small significance – some means are more efficient than others, some lead to better outcomes for patients and some are more effective at reducing federal-provincial squabbling.

The comments on the Romanow report that follow should not be seen as having a personal dimension. This is not Kirby versus Romanow, as some of the media have occasionally made it out. In the marketplace of public policy ideas, reasonable people can, and indeed often do, have honest differences of opinion. This is what a public policy debate is all about.

In this paper, I will address seven topics :

1. The measures proposed in the Senate Committee's report to make the publicly funded hospital and doctor system more efficient;
2. Our recommendations for renewing and strengthening the infrastructure of the system;
3. Our proposals for dealing with the number one health care issue of concern to Canadians – excessively long waiting times for diagnosis and treatment.
4. What the Committee believes should be done to close some of the gaps in the health care safety net;
5. How the Committee proposes to enhance government accountability to the Canadian public with respect to health care;

6. The measures the Committee proposes to minimize federal-provincial conflict;
7. And, finally, how the Committee envisages paying for the reform and renewal of the health care system.

In each case, I will indicate how the proposals and recommendations we put forward in the Senate Committee's report differ from Mr. Romanow's.

Hospital-Doctor Efficiency Measures: Incentives Instead of Top-Down Micro-Management

Relatively early in its deliberations, the Committee recognized that it had to make a fundamental choice with regard to its approach to health care reform. Were our recommendations to be based on maintaining the current system in which provincial governments, in order to save money, try to micro-manage hospitals and, in some cases, even regulate how people should do their jobs? Or was there an alternative approach that would see government set the ground rules, but leave people the freedom to figure out the best way to get the job done? That is, should government row, or should it simply steer?

The Committee felt strongly that the first approach, top-down command and control, was not the right one. It was painfully apparent to us that attempts by governments over the past many years to achieve increasingly close regulation of the health care delivery system are not working. We concluded that government micro-management of a system

as complex as health care was simply impossible, and that continued efforts to impose such control would lead not only to more failure but also result in stifling, rather than fostering, the kinds of reform that are needed.

The Committee therefore opted in favour of the creation of a set of *incentives* – incentives that would lead people to behave in a way that we believe is in the public interest while making decisions based on their own self-interest. We recognized that the incentives for each of the players in the health care system (doctors, hospital management, and government), would have to be structured in such a way that they would lead to the kind of behavioural changes that are needed to make the system both more efficient and more effective in delivering, in a timely fashion, the services people need. Therefore our recommended incentives were chosen after the Committee first decided on the behavioural changes we wanted to encourage.

Let me give you two examples of how our incentive-based approach is reflected in the Committee's recommendations.

First, our report proposes that the way in which hospitals are funded be transformed. We believe we must move away from the current practice of giving hospitals global budgets based largely on historical spending patterns. Instead, we propose to fund hospitals on the basis of the services that they actually deliver. We call this *service-based funding*. It means simply that fixed prices are established for different procedures, and hospital funding is based on how many of each kind of procedure a hospital actually performs. In

other words, hospitals would be paid for what they do, provided, of course, they do it well. Service-based funding is not a novel concept. It is used throughout the economy.

The evidence we heard made it clear to our Committee that the incentives built into this kind of funding would generate a number of significant benefits. They would:

- ~~we~~ encourage institutions to improve their operating efficiencies, since they get to keep any money saved;
- ~~we~~ enhance the ability of managers to manage, because it becomes necessary to know how efficiently the institution is performing each and every procedure;
- ~~we~~ make the costs of various procedures more transparent and improve accountability;
- ~~we~~ create competition between institutions, encourage specialization and stimulate the development of centres of excellence.
- ~~we~~ encourage institutions to improve patient service, since revenue depends on numbers of patients treated (subject, of course, to the proviso that all services provided meet a high standard of quality and satisfactory outcomes);

Given the significant advantages that come with service based funding, it came as no surprise to the Committee that the vast majority of CEOs of major health care institutions with whom we consulted were in favour of this change in funding method. One of the things that most major hospital CEOs told us was that they currently spend in the neighbourhood of 30% of their time haggling with provincial bureaucrats. What a

colossal waste of senior management time! Moving toward service-based funding will eliminate much, if not all, of this wrangling since the government will no longer be involved in the micro-management of hospital budgets.

There is also an important synergy between this method of funding and improving the quality of health care services that patients receive. Every research study indicates that if there is one correlation that holds throughout the health care sector it is the link between increasing volume and improved quality. The more frequently a particular procedure is performed by the same institution, the better the patient outcomes. By encouraging hospitals to specialize and by linking remuneration to the number and type of procedures, we not only drive efficiency, we also enhance quality.

Finally, the shift to service based funding would have the effect of lowering the volume on another peculiarly Canadian debate – whether services should be delivered by the public or private sector. With service based funding, the government as insurer or funder, would become neutral, or indifferent, with respect to who actually delivers the service.

This is already the case in many areas of the health care sector, although many people are reluctant to recognize it. The principle of public administration in the *Canada Health Act*, one of the famous five, refers *only* to how health care is paid for, not by whom it is provided.

For example, any hospital that contracts out its laundry, housekeeping or cafeteria services is channelling public funds into private sector service delivery. As long as service quality is maintained at a competitive price, government, as funder of the system, as well as the managers of institutions and patients themselves should be indifferent to the contracting out of services. If service based funding were to be implemented, this same logic would apply throughout the hospital sector – it would not matter who delivered the service, as long as they did so at an agreed, competitive price and with appropriate guarantees of access and quality.

Not only is such private delivery of publicly funded services *not* outlawed under the *Canada Health Act*, it is an integral part of health care delivery in Canada and has been since the inception of Medicare some 40 years ago. Just think of the private labs, x-ray clinics and other such institutions that exist across the country. Think of hospitals, for that matter, almost none of which are government-owned. Think of physicians, almost all of whom are self-employed professionals operating what amounts to independent small businesses.

The Committee is not proposing to change the *Canada Health Act* to allow greater private sector involvement, nor is the Committee advocating in favour of expanding private delivery. What we are saying is that with the set of incentives we propose, it will not be government that decides who actually delivers each and every service. Patients, or regional health authorities acting on their behalf, will seek services from those institutions that can provide them most quickly and conveniently.

Let me be very clear that the comments I have just made apply only to the *delivery* of health care services. The Committee believes strongly that Canada's single public funder model must be maintained for hospital and doctor services. Not only does a single public insurer/funder mean that everyone gets treated equally, but it is also enormously more efficient than the often-advocated funding model that mixes public pay and private pay patients, that is, the "two-tier" model we hear so much about.

The second example of the use of incentives to achieve behavioural change that I want to highlight is in the area of primary care reform. Primary health care constitutes a patient's first point of contact with the health care system, and includes many things, ranging from the diagnosis, treatment and management of health problems to illness prevention and health promotion.

At present, primary care delivery in Canada revolves mainly around family physicians and general practitioners working solo or in small group practices. Approximately one-third of primary care physicians work alone; fewer than 10 percent work in multidisciplinary practices. The vast majority of primary care practices are owned and managed by physicians. Fee-for-service payment is the dominant form of general practitioner remuneration.

There are a number of major weaknesses and problems with the way in which primary care is generally delivered in Canada:

- ~~✍~~ Care and services are fragmented;
- ~~✍~~ Inefficient use is made of many health care providers, such as nurses and nurse practitioners, who have very limited opportunity to use the knowledge and skills learned during their publicly-financed training;
- ~~✍~~ Care is often not available after hours and on weekends (when most people need it); and
- ~~✍~~ There is a lack of emphasis on health promotion and illness prevention;

Many of these difficulties can be traced to a misalignment of incentives with desired behaviour. Fee-for-service remuneration rewards episodic more than continuing care, fast “through-put” of patients, and dealing with simple procedures more than challenging ones. Moreover, it discourages family practitioners from having nurses, nurse-practitioners, psychologists, and other health professionals do all the things they are fully qualified to do. This should not be taken as a criticism of family physicians. Far from it! They are merely responding, as any rational person would, to the incentives now present in the fee-for-service system.

The Committee has proposed that primary care delivery be reorganized by changing the way family practitioners are remunerated. We think that fee-for-service should be replaced by a system based mainly on capitation. Under this system, patients enrol with a group practice and the group receives an annual payment based on the number of patients on its list, weighted for such factors as age and gender. This annual payment is made regardless of whether each patient is seen once or twenty times during the year.

Creating these primary care groups will generate significant benefits:

- ✍ Patients will be guaranteed access on a 24/7 basis to their *own team* of doctors and other providers;
- ✍ It will be possible to utilize better the full spectrum of health care providers, and to coordinate better patient services through interdisciplinary teamwork – primary care groups would, in effect, provide “one-stop shopping” for all the health care needs of the people they serve;
- ✍ There are potential cost savings in the longer term by reducing demand on expensive emergency rooms and specialists’ services and by making sure that the most appropriately qualified professional handles each task;
- ✍ It becomes easier to integrate the provision of health promotion and illness prevention measures into patient care.

But perceptive readers might be asking themselves: “Is the Senate Committee not being contradictory?” If fee-for service is bad for primary care why is it good for hospitals? If global budgets are bad for hospitals why would their equivalent, capitation based funding, be good for primary care?

The answer to this apparent contradiction lies in understanding the different impact that the same payment system can have under differing circumstances. Both fee-for-service and service based funding encourage providers (doctors or hospitals) to increase the volume of services that they deliver.

In the case of doctors, this can lead to placing greater emphasis on “through-put”, the numbers of patients seen. This can sometimes occur at the expense of patients with complex problems, those requiring continuing care, and, as is all-too-often the case, by neglecting to provide help to those seeking to prevent illness. This is why our Committee believes that alternative forms of funding must be introduced for primary care physicians.

In the case of hospitals, however, an incentive to provide more services is precisely what is needed, given the current waiting lists. Measures to compare the quality and outcomes of hospital care are available now and therefore a shift towards service based funding would prove beneficial. In other words, incentives must be tailored to encourage the kind of behaviour that is required in different parts of a reformed health care system.

Some have argued that global funding promotes greater stability and also that the accounting procedures necessary to introduce and sustain service-based funding will divert funds unnecessarily from patient care. These are important points in favour, but the Senate Committee thought them outweighed by the “downside” of global funding – that it will maintain the inefficient and ineffective, top-down micro-management of hospitals by government. The Committee is therefore convinced that the method of funding hospitals must be changed.

Moreover, recognizing the importance of not diverting money from patient care, the Senate Committee also recommended that the federal government fund one hundred per

cent of the cost of building the management information system required to make service-based funding possible.

In contrast to the Senate Committee, Mr. Romanow is silent about the method by which hospitals are funded. His report is also completely silent on issues relating to teaching hospitals and hospitals in urban areas. In addition, unlike the Senate Committee, Mr. Romanow is also adamantly opposed to any expansion of the role of the private sector in health care delivery. In fact, he also implicitly questions the role that the private sector is currently allowed under the *Canada Health Act*. As I noted previously, it is the Senate Committee's view that who provides care is essentially immaterial provided the quality of care is assured and its cost is competitive.

As has the Senate Committee and every provincial commission over the past few years, Mr. Romanow has come out strongly in favour of primary care reform, and has proposed a significant short-term investment by the federal government to make reform happen. We all share the same goals and understanding of the significant benefits that reform in this area will produce.

Rebuild and Expand Infrastructure: Teaching Hospitals, Information Systems, Human Resources and Research

I now turn to my second topic: rebuilding and expanding the infrastructure of the health care system.

Health care infrastructure has been woefully under-funded in this country. Canada can't have a sustainable health care system over the long term without a significant reinvestment in infrastructure. We now rank near the bottom of OECD countries in terms of the availability of many important pieces of diagnostic equipment. We have allowed our capital stock to deteriorate and we are facing shortages of health care personnel across the board. Short-term savings were made in the 90s by deferring investment in health care infrastructure, but we will be long-term losers unless this accumulated shortfall is addressed, starting immediately.

The Committee has taken a broad view of what falls under the category of health care infrastructure. I want to discuss briefly the need for significant *federal* investment in four areas of infrastructure: the physical plant and equipment of Canada's teaching hospitals, information systems including the patient Electronic Health Record, health research and health human resources.

First, the federal government should invest in the renewal of physical plant and equipment urgently needed in Canada's teaching hospitals.

Two facts, out of many I could cite, illustrate the urgency of this need:

~~✍~~ Between 1982 and 1998, real public per capita spending on new hospital construction declined by 5.3% annually; in dollar terms investment dropped from \$50 to \$2 per person over those 16 years.

~~✍~~ Since 1998, real public per capita expenditures on new hospital machinery and equipment has also *fallen* by 1.8% annually.

In addition to being the primary site of training for Canada's health care professionals, teaching hospitals offer the newest and most highly sophisticated services and treat the most difficult, complex cases. They are truly a *national* resource, and as such must be supported by the federal government. It is only by providing adequate funding to our teaching hospitals that it will be possible for Canada to develop genuine centres of excellence, and to be at the forefront of the scientific advances that are continually transforming the practice of medicine. As well, it is only by being at the leading edge that we will be able to derive the potentially significant economic benefits which are likely to result from the commercialization of the next generation of medical research results.

That is not to deny the need for reinvestment in the capital structures and equipment of community hospitals. That has to be done too. But, in our Committee's opinion, reinvestment should begin first in teaching hospitals for all the reasons I have mentioned.

Second, the federal government should fund the development of a national health information system, which can be used in hospitals and doctors offices across the country.

Despite the importance of information management to good outcomes in health care delivery, Canada's health care system has little capacity for health information management and does not make use of management information technology to anywhere near the same extent as other information-intensive industries. In fact, what we have in this country was described to the Committee as a "patchwork of unconnected information technology projects." Surely, if I can withdraw money from my bank account from just about any ATM anywhere in the world and securely access my account record via the internet, then Canada should be able to put in place a single system that allows one hospital, or one physician, for that matter, to exchange patient information with another within the same country.

Although much good work has been undertaken, a truly national system of patient Electronic Health Records is still far from a reality. That such a system would help make real the portability clause of the *Canada Health Act* is obvious. It would also lay the foundation for meaningful comparisons of the efficiency of different health care institutions, and of health outcomes at various institutions across the country. The creation of a truly national system of Electronic Health Records is one of the cornerstones of our Committee's strategy to bring the health care industry first into the late 20th

century and then fully into the 21st century. We consider it a national priority and believe that it should be entirely funded by the federal government.

Third, a dynamic and innovative health research sector is a vital necessity, not only for ensuring the sustainability and the quality of the health care system itself, but also as a major contributor to economic growth in this country.

The creation of the Canadian Institutes of Health Research by the federal government in 2000 represented a major step forward in consolidating and strengthening the country's efforts in health research. But more needs to be done to ensure adequate long-term funding for health research. The Committee has recommended that the federal government move as quickly as possible to bring funding for health research to one per cent of total health care spending. In our view, this represents the minimum required to keep Canada internationally competitive. To meet this target will require almost doubling the current budget of the CIHR.

Finally, our Committee has defined infrastructure of the health care system to include the education and training of the people who do the job of providing health care to Canadians.

A national strategy is needed in order to make Canada self-sufficient in health human resources. The Committee has therefore recommended the creation of a National

Coordinating Committee that would bring together the different levels of government and the key stakeholders to develop and guide the implementation of such a strategy.

In the short term, more money is needed to boost enrolment in educational and training programs for all health care professions. The Committee recommended that the federal government do its share by buying places at educational institutions so that more doctors, nurses, and other health care professionals can be educated and trained. By focussing its efforts on funding places at medical, nursing and other faculties, the federal government can lend much-needed assistance to the provinces without interfering directly in their area of jurisdiction.

Mr. Romanow has not addressed the health infrastructure issue directly in the way that the Senate Committee has. Nonetheless, the general thrust of his proposals with respect to information systems and Electronic Health Records are similar to those proposed by the Committee. However, our two reports differ quite significantly on the methods by which the federal government should fund these investments.

Mr. Romanow echoed the Committee's call to boost funding for research, but unlike the Committee has not addressed the issue of where the additional money for research should come from.

In other infrastructure areas his report is regrettably short on detail, especially in terms of estimating the cost of implementing the general objectives he has endorsed. Thus, he

does not propose that any special investment be made in teaching hospitals or provide any additional funding for the creation of the national system of Electronic Health Records that he has endorsed.

Perhaps most surprisingly, Mr. Romanow sets no specific targets for increasing the supply of either doctors or nurses in this country, and consequently does not allocate any specific funding for the education and training of health care professionals. Moreover, as I previously observed, there is scarcely a word about hospitals to be found anywhere in Mr. Romanow's report. This strikes me as a particularly grave oversight, especially with respect to the urgent needs of Canada's teaching hospitals.

In contrast to Mr. Romanow, the Committee has carefully laid out a plan that contains precise objectives to be met in all critical infrastructure areas, and provides the money required to meet its infrastructure objectives in its funding proposals. This reflects the Committee's belief that a broad range of investments in the infrastructure of the Canadian health care system is absolutely essential to its renewal and long-term sustainability.

The Care Guarantee: Ensuring the *Timely* Treatment of Patients

I turn now to the health care issue of greatest concern to Canadians – excessively long waiting times for diagnosis and treatment.

There is little doubt that long waiting times for access to diagnostic services and for treatment are the principal worry that Canadians have about their publicly funded health care system. “Will the system be there when I need it?” is a question one hears all the time. Although hard data on the full extent of the waiting time problem is impossible to obtain, there is sufficient polling and anecdotal evidence to indicate that, to the average Canadian, fixing the system means reducing waiting times. Canadians *deserve* to feel secure in the knowledge that they will receive timely treatment.

The Committee thought long and hard about how to achieve this objective. In a system that strives to treat everyone equally, waiting times increase when there are insufficient resources available to meet demand. The rules of supply and demand apply to health care as elsewhere. We know that there is not enough equipment, and that there are too few health care professionals available to provide care where it is wanted and needed. We know that more money is needed.

But the most important question is: how do we prevent future investments from simply getting swallowed up without improving the situation for those who count the most – patients? After all, patients are the people who should be at the centre of it all – the people our health care system is there to serve. Too often in recent years this patient focus has been neglected!

For too long, governments have seen cost cutting as their preferred, and easiest, policy option. The brunt of these cuts, particularly during the 90s, has been borne by front-line

workers who experienced increased workloads, and by patients who were forced to wait longer for service. Those in government who made the decisions to ration the supply of health care services by cutting resources and to avoid disciplined waiting lists were not directly affected. They suffered no consequences as a result of their decisions.

Moreover, the health care system has been very slow to make use of the lessons learned from best practices in waiting list management, such as the Cardiac Care Network in Ontario, and has not yet applied the same waiting list management techniques elsewhere in the system. To be fair, a structured, needs-based waiting list for a wide range of surgical procedures is on the point of being implemented in the Province of Saskatchewan. But that merely brings the total of such lists in Canada to two – a pitifully small number!

The blame for the waiting list problem should be placed where it belongs – jointly on the shoulders of governments for not funding the system adequately, and on the providers of health services, for not developing and implementing clinical, needs-based waiting list management systems.

With government's responsibility for funding the hospital and doctor system through our publicly funded and administered health insurance program, comes the obligation to ensure that reasonable standards of patient service are met. Timely service is the essence of a patient-focused system and of the health care "contract" between Canadians and their governments.

In keeping with its philosophy that the best way to reform a complex system, and the provision of health care certainly qualifies, is to introduce appropriate incentives for the players involved, the Committee is firmly convinced that governments and managers of the health care system must be made to bear the responsibility for the consequences of their decisions. The Committee's proposal to put in place a maximum waiting time *guarantee* for all major procedures gives concrete form to this obligation.

The idea is that when this maximum waiting time is reached, government would have to pay for the patient to receive treatment in another jurisdiction, including in another country such as the U.S. The point at which this health care guarantee would apply for each procedure would be based on an assessment of when a patient's health is at risk of deteriorating as a result of further waiting. Safe waiting times would be established by scientific bodies using clinical, evidence-based criteria.

Were it to be implemented, such a health care guarantee would mean that government and the managers of the health care system would have to shoulder the responsibility of needed care not being delivered in a timely fashion.

The Committee's Care Guarantee would ensure that allowing waiting times to increase would no longer represent a cost-free option for governments, or for hospitals and doctors. They would have to sort out amongst themselves who was responsible in each case where maximum waiting targets were exceeded, much as car insurance companies

work out who was at fault in an accident. But in the meantime, the patient would be treated, just as the car gets fixed while the insurance companies figure out who was to blame for the accident and who pays.

Mr. Romanow agrees that patients should be told how long they should expect to wait for each procedure, but has not recommended going the extra step the Senate Committee has recommended – making the commitment that these targets will be met and that someone other than the patient will bear the consequences if they are not. Mr. Romanow believes that it would be enough simply to inform people of how long they should expect to wait for the procedure or service they required.

Mr. Romanow also believes that the Committee's Care Guarantee could not be implemented in practice. Our Committee believes that it could be made to work, as does Don Mazankowski, whose report has shaped the reform of the health care system underway in Alberta, and the Canadian Medical Association, which also advocates the implementation of a Care Guarantee. As well, the Minister of Health of Quebec recently indicated that he too was in favour of making a commitment that patients will receive timely treatment. The Committee's approach is intended to lift the consequences of underfunding and bad waiting list management from the shoulders of the one player in the system who bears none of the responsibility – the patient. On this issue of greatest concern to Canadians, Mr. Romanow has not offered a solution.

The consequences of not solving the waiting time problem are great. Unless Canadians are guaranteed timely treatment, the future of publicly funded health care is likely to be at risk, most probably as a result of a constitutional challenge based on the right of individual Canadians to have access to timely care and to purchase private health insurance to provide it.

Governments can no longer have it both ways – they cannot continue to fail to ensure that the delivery system provides timely access to medically necessary care in the publicly funded health care system and, at the same time, prevent Canadians from acquiring those services through private means. Thus, one consequence of not implementing the health care guarantee would be to render it highly likely that the current legal prohibition on the creation of a parallel private health care insurance and delivery system would be challenged successfully in the courts. To avoid this outcome, the Committee is convinced that the Care Guarantee must be in place.

I turn now to the Senate Committee’s proposals for closing some of the gaps that now exist in the health care safety net.

Catastrophic Drug Coverage

Four factors motivated the Committee’s approach to expanding public coverage with respect to prescription drugs. First, as everyone knows, drug prices are the fastest

growing component of health care costs. Second, the development of new treatments and new prescription drugs often replace hospital care; they make it possible to treat people out-of-hospital where, of course, Medicare, as originally conceived, does not pay for drugs. Third, new scientific research often leads to new highly effective, but extremely costly, drugs becoming a bigger part of the therapeutic arsenal. Together, these three factors mean that the trend toward prescription drugs consuming an ever-larger portion of the health care budget is not a short term phenomenon.

Fourth and finally, publicly funded coverage for prescription drug costs is very uneven across the country, a situation that is particularly acute in Atlantic Canada.

Throughout its work the Committee sought to uphold two fundamental principles with respect to publicly-funded health care:

- ~~✍~~ Every Canadian should receive timely access to needed medical care
- ~~✍~~ No Canadian should suffer undue financial hardship as a result of having to pay for necessary medical treatment

It quickly became clear to the Committee that these principles were threatened by the absence of a national prescription drug program to protect Canadians against the risk of very high, or as we say in the report, ‘catastrophic’, prescription drug costs. Although Canadians, on average, spend relatively little of their income on prescription drugs, the problem for those who face very high drug expenses can be extremely severe. Let me

illustrate with just two of the examples given to the Committee, both of which involve Atlantic Canadians.

The first case the Committee became aware of involved a professional librarian who was a member of a good quality employer-sponsored drug benefit plan. His wife required prescription drugs costing \$50,000 a year, leaving the individual in question with personal out-of pocket costs of \$17,000 annually. This example clearly illustrates that even people with excellent drug insurance plans are not fully protected against the risk of undue financial hardship arising from catastrophic drug costs.

In the second case, which we recounted in our recent report (and which was also widely featured in news reports on the CBC in the run-up to the release of Mr. Romanow's report), medication for pulmonary hypertension costs a particular patient more than \$100,000 a year. The patient spends over \$4,600 monthly (or \$55,000 annually) for her health insurance premium, and her share of the cost of the drugs and the peripherals needed to administer them. Because in her province patients must exhaust all their savings, including RRSPs, before receiving government aid, she faces destitution as a result of having to take the medication that is keeping her alive.

This, in the Committee's view, is simply wrong. No Canadian should be forced into bankruptcy as a result of having to pay prescription drug costs. It was to achieve the goal of removing the financial barriers between those who need health care services and those who provide it that Medicare was conceived in the first place.

The Committee worked hard to find a feasible remedy to this growing problem. A detailed study done on behalf of the Committee showed that there were 600,000 people, or 2% of the population, with no drug coverage at all. All of them live here in Atlantic Canada. The data also indicated that a further 9% of the population were still at considerable risk of impoverishment despite having some prescription drug coverage under their current private and/or public plans.

This means that, in all, 11% of the Canadian population is at risk of significant financial hardship as a result of having to pay high prescription drug expenses out of their own pockets. Currently, more than 100,000 Canadians experience annual drug expenses exceeding \$5000 per year and there is little doubt that this figure will grow substantially in coming years.

While offering protection to Canadians who risk financial ruin is the main reason the Committee chose to recommend a catastrophic drug insurance program, there are also a number of other good reasons to move in this direction. Patients who face high drug costs may simply decide not to continue their treatment, and as a result doctors may be inclined to keep patients in hospital longer where their drugs are paid for under Medicare. Existing private supplementary plans could also come under severe financial pressure, causing employers to reduce or even eliminate coverage, as is already happening with some small and medium-sized companies.

The Committee has therefore proposed a plan that builds on, rather than replaces, Canada's extensive current systems of provincial prescription drug coverage and private supplementary drug insurance plans. The Committee's proposal calls for the federal government to take over responsibility for 90% of prescription drug expenses that exceed a certain limit that qualifies them as "catastrophic." This limit has been set at a total of \$5000 per year, no matter whether the \$5000 is paid partly by the individual, partly by a private plan, or partly by a public plan.

The net result of the Committee's plan, which will cost the federal government \$500 million a year to implement, is that no Canadian will ever have to pay more than 3% of his or her family income for prescription drugs.

The Committee's plan shifts the burden of insuring against catastrophic drug expenses to the insurer most able to deal with the risk – the federal government. This will free up money in all provinces and also help to ensure the long-term sustainability of private drug insurance plans by removing the extreme volatility in plan costs due to catastrophic drug expenses. Moreover, potential plan sponsors who have hesitated to adopt supplementary prescription drug benefit plans in the past may now be more inclined to introduce them.

Mr. Romanow has also addressed the catastrophic drug problem. He proposes to have the federal government pay 50% of the cost incurred by provincial drug insurance plans for 'catastrophic' drug coverage. His plan places the threshold of 'catastrophic' at \$1500 per year.

It is impossible to know what the impact of Mr. Romanow's plan would be for Canadians in general, since there are no fixed targets set for the maximum that families could spend out-of-pocket on prescription drug expenses. Everything depends on how the provinces choose to use the new federal contribution. However, if the current levels of individual out-of-pocket contributions within many provincial plans are maintained, Mr. Romanow's plan would cost many lower income Canadians who face catastrophic drug expenses more than would the Committee's plan. Moreover, Mr. Romanow has not addressed in any way the role of the many private employer-sponsored plans that play a major role in insuring Canadians for prescription drug expenses. In short, the Committee's proposal for catastrophic drug insurance is both more feasible and more equitable than Mr. Romanow's plan.

Post Acute Home Care

The design of Medicare has not kept up with the times. The Canadian system has remained a publicly funded hospital and doctor system. Increasingly, however, health care services are being delivered outside of hospital walls, by a wide array of highly-trained professionals, not just by doctors.

Service delivery in the home is a reality now and the need for it will grow as the baby boom generation ages, as average life expectancy rises, as health care delivery is

increasingly de-institutionalized, and as work and social patterns decrease the availability of informal care-giving by family members.

Currently, each province and territory offers financial support for some form of home care program, but it is not defined as a “medically necessary” service under the *Canada Health Act*. Therefore, publicly funded home care programs vary greatly across the country in terms of eligibility, scope of coverage and applicable user charges. Some, like the extra-mural program in New Brunswick, stand out as models of the benefits an integrated home care program can provide.

Recognizing that resources are and will continue to be tight and that only a fiscally responsible program has any chance of being implemented, the Committee focused only on post-acute home care, that is home care that follows an episode of hospitalization.

The Committee’s proposed plan would cover patients for up to three months following their release from hospital. It would be administered by the hospitals themselves, with the federal/provincial/ territorial governments sharing the costs on 50/50 basis. We have estimated that the federal share of a National Post-Acute Home Care Program would cost \$550 million annually.

Just as we recommended with respect to hospital funding, the Committee has recommended that a service-based funding approach be used for its post-acute home care program. Because we have recommended that the funding for post-acute home care go

directly to the hospitals from which the patients concerned are discharged, those hospitals will have a strong incentive to provide the most efficient form of care available, whether delivered inside the hospital walls or in the home.

Similarly, patients will be able to convalesce in the most appropriate setting without worrying whether they will have access to the care they need. By having 'the money follow the patient' a national post-acute home care program will therefore both improve patient care and generate new efficiencies in the health care system. Hospitals will be able to use the money to develop home care services themselves or to contract with the most efficient community-based home care provider.

Despite the 50:50 federal-provincial cost shared structure of the Committee's proposal, there should not be significant federal-provincial conflict. Because the program uses service-based funding, the federal government would never become involved in operational decision-making. Of course, agreement between the two levels of government will be required in order to put in place the service-based funding framework. But once that is done, the federal role will be limited to paying its share of the bill for the services that are actually delivered to patients, and periodically undertaking an audit simply to make sure that billed services were in fact performed.

Mr. Romanow's home care proposal is both broader and less extensive than the Committee's plan. It is broader in that he devotes most of the \$1 billion in funding that he allocates to home care to providing services for home mental health case management

and intervention, whereas the Committee decided to wait to conduct a separate study on mental health issues before making its proposals with respect to mental health.

It is less extensive in that it provides post-acute home care for only 14 days following discharge from acute care and 28 days for rehabilitation, compared to the three months of coverage under the Committee's plan. This difference in scope is reflected in the fact that the total cost of the post-acute home care provisions in the Commission's plan are around \$300 million, compared to the total of \$1.1 billion in the Senate Committee's federal-provincial cost-shared program. It seems to us that Mr. Romanow has considerably underestimated the cost of an adequate, publicly funded, post-acute home care program.

Palliative Care

Palliative care is a special kind of health care for individuals and families who are living with a terminal illness that has reached such an advanced stage that death is close on the horizon. The goal of palliative care is to provide the best possible quality of life for the terminally ill by ensuring their comfort and dignity and relieving pain and other symptoms.

Palliative care can be offered in a variety of places — at home, in hospital, in long-term care facilities, and occasionally in hospices. However, in Canada these services are fragmented and, in many parts of the country, they don't exist. Recent studies have

estimated that while over 80% of Canadians die in hospital, fully 80-90% of Canadians would prefer to die at home, close to their families, living as normally as possible. But the services necessary to enable them to do so are not often available.

The Committee is convinced that it is essential for the federal government to make a substantial contribution to make palliative care services available to Canadians in their homes. Try as we might, however, it has proven impossible to obtain the data to permit accurate estimates of the cost of a national palliative home care program. Nonetheless, the Committee believes the federal government should set aside \$250 million in new money to cover the costs of a program to be developed in conjunction with the provinces and territories and paid for on a 50:50 cost-shared basis. The Romanow Commission allocated \$90 million per year to palliative care in the home.

Another measure, allowing people who take time off work to care for dying relatives to draw Employment Insurance benefits, has also been recommended by the Committee.

Financing the Committee's recommendations?

By now readers are probably wondering how the Committee proposes to pay for rebuilding the infrastructure of the Canadian health care system and expanding public coverage to new areas such as 'catastrophic drug' insurance, home care and palliative care. The Committee has calculated that it will require an additional \$5 billion in federal

funding annually to implement its recommendations. This is new money, over and above current funding, and is an essential investment in order to buy the changes that are needed to ensure the long-term sustainability of our health care system.

From the outset, the Committee has insisted that it would be irresponsible for it to ‘duck’ the tough issue of where additional funding should come from. Of course, should the federal government have the money available through a realignment of spending priorities, then the question of raising additional money would not arise. Nonetheless, the Committee felt it both prudent and responsible to propose a plan to raise additional funds, and it has done so by proposing a variable National Health Insurance Premium that would cost Canadians in the lowest income tax bracket 50 cents a day, increasing to \$4 a day for those in the highest income tax bracket.

Mr. Romanow, on the other hand, has chosen not to address the issue of where the money to pay for his proposals should come from. The issue is quite simply not dealt with in his report.

Easing federal-provincial tensions

I would now like to turn my attention briefly to indicating how adoption of the Committee’s approach to health care reform would also help calm the notoriously stormy waters of federal provincial relations.

There is no doubt that Canadians are fed up with what appears to them to be perpetual squabbling between the two levels of government involved in the health care system. Canadians, quite simply, do not care whether one level of government is more at fault than another for the failings of the system. Canadians want the system to work and to be there when they need it. And they expect both levels of government to work together to make sure this happens.

The Committee has made it clear that its approach to health care reform is based on carefully distinguishing between the funding of health care and the actual delivery of services. In our view, the key to minimizing federal-provincial conflict is to avoid having two levels of government involved in the joint management of *operational* decisions relating to the hospital and doctor system.

The Committee has thus proposed two kinds of funding arrangements. First, some programs will be funded entirely by the federal government, and targeted towards specific ends. These include infrastructure funding for teaching hospitals, information systems and their development, the Electronic Health Record, as well as the purchase of additional places for the education and training of health care professionals and an expanded health research program. As these investments are 100% federally funded, there should not be federal-provincial squabbling over who should pay how much.

The second type of funding arrangements proposed by the Committee are 50:50 federal provincial cost-shared programs. But unlike past programs of this kind, the Committee has recommended using service-based funding as the way of distributing the new money. What this means is that the federal government would not be involved in the operational decision-making process. Once the program parameters were in place, all the federal government would have to do is pay its share of the bill once it was known how many of each type of procedure or service were actually performed in each province or territory.

This means that for the federal government the only issue is basically an accounting issue – calculating how many people received home care following a hip operation, and how many needed it after cataract surgery, and so on – and not a question of how these services were delivered or by whom. This gets the federal government out of the operational side of service delivery, and avoids arguments over such questions as the details of how a service should be delivered and what services should be publicly funded; these questions have frequently been the source of federal-provincial conflict. Therefore the service-based funding approach should go a long way towards avoiding the type of problems that used to arise when federal-provincial cost sharing also meant much greater joint management of service delivery.

Mr. Romanow has chosen to recommend that the Canada Health Act be amended in order to include a sixth principle that will hold the provinces accountable for spending federal money targeted to health care.

The Committee decided not to go this route for a number of reasons. In the first place, opening up the CHA in order to incorporate additional principles, no matter how worthy, is a very risky undertaking. Once the icon – the *Canada Health Act* – is taken off its pedestal it is impossible to predict exactly how it will be amended. We don't think it is worth the potential threat to some of its fundamental principles, universality being one.

Moreover, the key aspect of accountability that must be improved does not involve the federal and provincial governments. What needs improvement most is the accountability of all levels of government and the health care system itself in all of its aspects to the Canadian public. This can be achieved without opening up the *Canada Health Act*. In addition, we have little doubt that the provinces are indeed spending the health portion of the CHST on health care, since the federal cash transfers to the provinces represent a small percentage of total provincial health care budgets.

Therefore, the Committee regards Mr. Romanow's proposals to open up the *Canada Health Act* as both unwise and unnecessary. In fact, there is the very real danger that by placing his new programs, such as home care, palliative care and catastrophic drug insurance under the *Canada Health Act* as he proposes to do, Mr. Romanow will end up actually exacerbating the state of federal-provincial relations.

This is because, no matter what the rhetoric about federal-provincial collaboration that surrounds these programs, once they are under the umbrella of the *CHA* the enforcement of their provisions becomes the exclusive responsibility of the federal government. The

Committee has avoided this kind of problem by not opening up the *Canada Health Act* and by utilizing service-based funding for all cost-shared programs.

The recommendations in Mr. Romanow's report and that of the Senate Committee reflect diverging approaches to the role of the federal government in the health care system, and are likely to have quite different impacts on federal-provincial relations.

Mr. Romanow sees the federal government as the guardian of the national health care system, whose role is to set national standards and to enforce them. This approach assigns to the federal government the task of ensuring that the provinces behave in the right way. This is hardly the best way to go about improving federal-provincial cooperation in health care.

The Committee's recommendations are based on the view that it is the responsibility of the federal government to put in place the infrastructure that makes a national health care system possible. This approach makes the federal and provincial government into partners, each having its own role to play – the federal government has the main responsibility for providing the infrastructure and the provinces operate the system.

Accountability to the Canadian Public

As I just suggested, the real area where accountability must be significantly improved is the way in which all levels of government report to the Canadian public on the state of the health care system and the health status of the Canadian population. For this reason, the Committee recommended the creation of a National Health Care Commissioner and a National Health Care Council that would be *national* in scope, rather than being the creation of just one level of government or the other.

The Commissioner and Council would be responsible for reporting to the Canadian public on an annual basis on the state of the system as well as on the health of Canadians, working closely with such established and well-respected institutions as the Canadian Institute for Health Information. They would also advise the federal government on spending priorities for any new money raised for health care.

Mr. Romanow has proposed the creation of a new Health Council of Canada that resembles the Committee's proposal in many ways. He has given his Council a somewhat broader mandate than the Committee assigned to its Commissioner, but it would report to Canadians on many of the same topics.

The one potentially significant difference is over the degree of independence that these organisms would have from government. The Senate Committee thought very carefully about how best to ensure that in its day to day operations the proposed National Health

Care Commissioner would be entirely independent of government. While Mr. Romanow envisages representation on the Health Council of Canada from stakeholders and ordinary citizens, there would also be government representatives on the Council, which would almost certainly make it more difficult for it to act in a truly independent fashion.

Conclusion

By way of conclusion, let me briefly summarize the six main points of divergence between the Senate Committee and Mr. Romanow. As I noted at the beginning of this paper, these differences are essentially over how to go about achieving health care reform in Canada, not about the need for reform. The Senate Committee and Mr. Romanow are agreed on the basic objectives to be pursued and the need to pursue them vigorously and without delay. If I have highlighted some of the differences between Mr. Romanow and the Senate Committee, it is because, having come to many of the same general conclusions, we can now engage in a constructive debate over how to bring about the changes that Medicare needs.

1. The Senate Committee believes that the system is too complex to continue to be micro-managed by government and that reform can only be achieved by putting in place an appropriate set of incentives to motivate behavioural change by people on the ground. Mr. Romanow remains wedded to the old-fashioned, top down,

command-and-control model. Hence, the Committee favours service-based funding for hospitals and Mr. Romanow is silent on the issue.

2. The Senate Committee believes that the funding and delivery of health care services are separate issues. Like Mr. Romanow we favour a single payer, publicly funded model. Unlike Mr. Romanow we believe that the funder should be neutral or indifferent with respect to who owns and operates the organizations responsible for service delivery. This means keeping open the delivery systems to greater competition among providers. In the search for the most effective forms of service delivery for Canada's very diverse communities and regions, Mr. Romanow has closed the door on testing any approaches to service delivery that involve an increased role for the private sector.
3. The Senate Committee's proposals with regard to the federal role in rebuilding and developing health care infrastructure are considerably more extensive and detailed than Mr. Romanow's. This is particularly true with respect to our emphasis on treating teaching hospitals as a national resource the capital needs of which should be met by the national government. As well, the Senate Committee, unlike Mr. Romanow, has attached great importance to setting precise, carefully costed, targets for increasing the supply of health care professionals.
4. The Senate Committee believes that providing patients with a guarantee that they will be treated within a specified maximum waiting time is essential both as a spur to the pace of reform of the health care system and as a direct benefit to patients waiting too long for essential services. Moreover, the Committee believes firmly that those who are responsible for the lengthening waiting times of recent

years must be held accountable for fixing the problem. The consequences of Mr. Romanow's position is that those who fund and manage the health care system are not held accountable.

5. The Committee has provided Canadians with a concrete plan for raising the money that is needed to renew, rebuild and reform Canada's publicly funded health care system. Moreover, the Committee's plan does not rest on the shaky ground of forecasting permanent federal surpluses. Mr. Romanow has chosen not to venture onto this terrain. He is completely silent in his report on how he would pay for implementing his proposals.
6. The Committee's proposals for expanding publicly insured services do not require the opening of the *Canada Health Act*, whereas Mr. Romanow has chosen to place expanded services under the umbrella of the *Act*. Because the federal government solely responsible for enforcing provincial conformity with the *Act*, this could have the opposite effect to the one desired by Mr. Romanow, that is, it could worsen federal-provincial relations.

From the outset the Committee's priority has been protecting the health of patients. The Committee recognized that what was needed was not the affirmation of lofty principles and general goals. What is needed is a detailed plan of action whose cost of implementation is clearly spelled out. With this in hand, Canadians will be able to decide whether they are prepared to pay the cost of preserving the health care system they hold so dear. Canadians must *not* be given the impression that health care is a free good to be paid for out of someone else's pocket.

We are all responsible for paying for our health care system, and a responsible approach to public policy means letting each and every Canadian know how much it is going to cost them out of their own pockets to have the kind of publicly funded health care system they want and deserve. The Committee believes that it has put on the table an *action plan*, and a method of funding that plan, that, if implemented, would help make a fiscally sustainable health care system a reality.

This brings me back to my opening theme. The national health care debate has now been joined. This debate will come to a head at the First Ministers' meeting in late January.

It is critical that between now and then Canadians make their views known to as many federal and provincial leaders as possible, including their Premiers, their provincial Ministers of Health, and their provincial Finance Ministers. They need to tell them what reforms they want them to support at the First Ministers' meeting, and to tell them also what approaches to reform they want them to take.

The future of the health care system depends very much on what Canadians do in the next two months.