The Saskatchewan Institute of Public Policy and the University of Regina are pleased to present:

The Future of Health Care in Canada

A Public Lecture with Mr. Roy Romanow Q.C.

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Introduction

Thank you for having me here today.

It's been just over a week now that Canada's First Ministers came together to reach consensus on the terms of a new national Health Accord.

Coming on the heels of an extensive period of consultation and reflection on the health system's future-- not just by my Commission, but also by no less than 8 separate provincial review processes and that of the Senate Standing Committee-- the momentum for change was unmistakable. Moreover, these various efforts had produced a broad consensus on what I would term the "Big Issues"- namely:

- Recognition of publicly funded medicare as a valuable national asset in need of modernization but absolutely worth preserving and certainly sustainable if the commitment to making it so was there;

- Acknowledgement that the federal government had both a moral and financial obligation to restore its traditional share of funding to the system; and

- Acceptance that the status quo is no longer an option, and that new monies invested in the system facilitate "transformative" change to improve the availability, quality and effectiveness of health services. .

Occurring at this unique juncture in Medicare's evolution the meeting was landmark one. It offered Canada's First Ministers an opportunity to demonstrate collective leadership, to move forward together to restore Canadians' confidence in their most cherished social program.

In large measure, I believe they succeeded. To be sure, we are still in the early days of the reform process- after all, my final report was tabled less than 75 days ago. And I am mindful that it is only over the long-term that we can properly evaluate what progress was achieved. Yet it seems clear that while the Accord remains a work in progress, Canada's First Ministers are on the right track. Let me explain why…

What Canadians Were Seeking

Having had the privilege of leading arguably the most comprehensive and exhaustive effort to engage Canadians in a national dialogue on the future of their health care system, my sense is that, beyond the obvious issues of timely access to quality care on the basis of need, Canadians wanted several results from the First Ministers' meeting.

First, Canadians wanted closure on the increasingly divisive debate about Medicare's sustainability and future. They wanted to know that the system would be there for them when they needed it, what it would cost, what insured services they could count on regardless of where they were in Canada, and whether user-fees or two-tier health care were inevitable. In other words, Canadians wanted their elected leaders to stop fighting *over* Medicare and to start working *for* Medicare.

Second, Canadians wanted the policies and programs that define Medicare to reflect collective values and for the system to be more accountable to them as its shareholders. They wanted a window into the decision-making process and the ability to monitor results across the system.

Third, Canadians wanted decisive action to stabilize Medicare and to address the immediate concerns that were eroding their confidence in its future- especially timely access to quality care, health professionals and advanced diagnostic services.

Last, Canadians wanted the system modernized to better reflect the realities of today's health care needs and challenges. They wanted 24-7 access, within their own communities and preferably under a single roof, to an integrated basket of primary care services. They wanted more emphasis on prevention and on wellness. As well, with one in five Canadian families now caring for someone at home, with advanced diagnostic services like MRIs increasingly available from private providers, and with prescription drug costs the fastest growing component of overall health spending, they wanted progress on these fronts.

Commission Recommendations/Health Accord Response

So how well does the 2003 Health Accord address these issues? Overall, quite well! Let me deal with each one in turn, beginning with the desire of Canadians for closure on the debate over Medicare's sustainability and an end to inter-governmental bickering.

Building FPT Consensus on Medicare

One of the key objectives of my recommendations was to try and change the dynamics of the increasingly dysfunctional federal-provincial relationship by eliminating from the inter-governmental battlefield as many things as possible for governments to fight over.

As a first step, I proposed a Health Covenant, a consensual, non-legislated document by all levels of government. With ongoing disputes between governments over how to interpret and enforce the terms of the Canada Health Act, the Covenant had a number of purposes. One was to allow governments to publicly reaffirm their commitment to Medicare and to work together on its national dimensions. The goal was to make progress toward a cohesive and viable national health care system, not 14 separate systems of uneven quality and capacity. The Covenant would also have defined the respective entitlements and responsibilities of individual citizens, health care providers and governments in regard to the health care system. My hope was that the Covenant might come to serve as a de facto preamble or interpretive clause for the Canada Health Act.

The good news is that the 2003 Health Accord reaffirms the commitment of First Ministers to the five principles of the Canada Health Act, to the values of Canadians and to enhancing transparency and accountability. It also includes more general statements of intent in regard to ensuring all Canadians have timely access to high quality, effective health services based on need. More significantly, it states, and I quote:

> *"Our health system is sustainable and affordable and will be here for Canadians and their children in the future."*

While additional precision would have been welcome, this is nonetheless an extremely important statement. More importantly, there is a golden opportunity for First Ministers to give real expression to the spirit and intent of the Covenant through the Health Council of Canada they have agreed to create. I'll have more to say on this front shortly.

Clarifying the Private-Public Debate

While the reaffirmation by First Ministers of the CHA principles has brought closure to the debate over the single-payer system, the Accord does little to clarify the related debate about the role of the private sector in health care delivery. In fairness to First Ministers, this contentious issue was never formally on the agenda. But it will need to be resolved sooner, not later, and in a comprehensive way. First Ministers must keep in mind that in today's era of complex multilateral agreements, decisions taken in one province can have implications across all of the provinces.

As Canadians know, at every stage of my Commission's work, throughout the fact-finding, research and public hearings, I expressly and repeatedly encouraged those advocating a greater private sector role in the delivery of health care services to bring forward the evidence that doing so would help to reduce waitlists, make the system more affordable or improve its quality and outcomes. That evidence remains notable by its absence.

To be sure, my report does not preclude private sector involvement in our health care system in ancillary services. Nor does it propose outlawing private delivery of health services**.** The CHA is silent on this issue, and the delivery of health services falls within the jurisdictional competence of the provinces. More to the point, just because one doesn't like something, it doesn't make it illegal. But for the reasons outlined in Chapter 2 of my report, I remain exceedingly skeptical that evidence can be found to support a direct private sector role in delivering health care services.

Health care is a moral enterprise and not a business venture. I therefore encourage Canadians to remain vigilant in ensuring that these so-called "new approaches" do not take root, for they will ultimately comprise the integrity and viability of our public system. But as it is clear that some will continue to experiment with privatizing some parts of health service delivery, then at a minimum, Canadians should insist that such actions at least in part:

- be compatible with the terms of the Canada Health Act;
- meet or exceed the quality, outcomes and transparency standards that apply to public providers of similar services;
- save the public system money;
- improve the efficiency of the system;
- clearly define provider liability (in the event patients must subsequently obtain emergency or other care from the public system due to failed procedures);
- complement the public system and the objective of system integration ;
- prevent queue-jumping by Canadians within or across jurisdictions; and
- preserve Canada's ability to protect its health care policies and programs in international trade agreements or negotiations.

It would likely be unconstitutional for Ottawa to impose or enforce such tests on the provinces, and this is one of the reasons why I chose not to include them in my report. And these and other conditions are not to be interpreted as indirect approval of private-for-profit delivery, but, rather, as a statement of greater clarity to this debate. It is up to individual Canadians to take the lead, and to work with their governments, to ensure the role of public delivery is protected and that these tests are met where privatizing health services delivery is begin considered.

Accountability & Values

Another of the problems in the existing dynamic of delivering health policy is that the different levels of government, and sometimes different provincial governments, begin from very different starting points on simple issues of fact. Hence, my report suggested the creation of a Health Council of Canada to bring together under a single roof a number of existing advisory structures and agencies. This streamlined entity would resolve such disagreements and misunderstandings, and also to give patients and providers a say in how the system operates and the means to monitor its performance.

Far from being a "watchdog agency", a somewhat pejorative and provocative term, the Council would foster collaboration among governments and improve accountability to the public as the users and owners of the system. My vision was that the Council would serve as a focal point for gathering health information, for setting common health data and informatics standards, and for interpreting and reporting to Canadians on health outcomes. In time, the Council might also assist in fact-finding and in resolving disputes between governments over the interpretation of the Canada Health Act. To reinforce the right of Canadians to monitor the health system's progress, I also proposed that Accountability be included as a new CHA principle.

The language of the 2003 Health Accord gives reason for guarded optimism. I have already mentioned the general commitment by First Ministers' to "…enhancing the transparency and accountability of the health care system…" I note, too, the statement in the Accord that:

> *"First Ministers recognize that Canadians want to be a part of the implementation of this Accord. Accordingly, they agree to establish a Health Council to monitor and make annual public reports on the implementation of the Accord, particularly its accountability and transparency provisions."*

The Accord commits governments to establish such a Council within three-months. Obviously, the Council's eventual terms-of-reference and governance structure, and the autonomy and quality of those selected to serve on it, will determine its effectiveness. At this stage, it is not entirely clear whether the Council is intended to monitor all key aspects of the health care system- as I envisage it should- or merely new spending

referenced in the Accord. I thus encourage First Ministers to seek input from concerned Canadians and health care providers in designing an effective and inclusive Council.

The Council must be an instrument that improves accountability and allows Canadians and providers a say in decisions affecting health care. But to be successful, it must equally be an instrument that fosters collaboration and collective action among governments to improve public health care and promote the public good. I look forward to seeing what form this Council takes and remain optimistic that Health Ministers will respect the wishes of Canadians to be involved in shaping health care policy.

<u>Stabilization and Transformative Change of the Health System</u>

Let me now turn to the question of whether enough additional resources have been invested into the system to make headway on their priority concerns and to facilitate transformation.

I want to begin by applauding the decision of First Ministers to replace the Canada Health and Social Transfer with a dedicated Canada Health Transfer. This is a very important first step toward making the system more transparent.

But the next step must be to go further than that. In addition to replacing the CHST, the need for adequate, stable and predictable funding is essential.

I therefore recommended that by 2005/06, the federal government *cover a minimum of 25% of provincial health spending for CHA expenditures and that this be provided in the form of a dedicated <u>cash-only</u> transfer*.

Why 25 per cent? In 1977, both levels of government agreed to change the way the federal government delivered its share of health spending to the provinces. Henceforth, roughly half of the federal transfer would take the form of tax points (which were permanently transferred to the provinces), while the other half would take the form of cash over time.

In the early 1990's the federal government unilaterally reduced its share of health transfers to the provinces. Recognizing the permanent tax transfer, the cash target of 25% would see the federal government restore its funding to historic levels. And including an escalator provision within the transfer would enable the federal share of health spending to track inflation and adapt to changing patterns of provincial health care spending.

What would this new funding mechanism achieve? First, it would remove yet another possible irritant from the already volatile inter-governmental relations mix, while simultaneously improving transparency and accountability. The federal and provincial governments would be working from the same numbers, and they would not be continually negotiating the size or growth of the federal transfer. In short, funding would be adequate, stable and predictable. The federal share of funding would be fixed at 25% of provincial CHA-related spending.

Second, the recommendation for a 25% federal funding floor by 2005-2006 was linked to targeted funding over the next two years in five specific areas.

- A Rural and Remote Access Fund
- A Diagnostic Services Fund
- A Primary Health Care Transfer
- A Home Care Transfer
- A Catastrophic Drug Transfer

The Rural and Remote Access Fund and the Diagnostic Services Fund were designed to address some of the immediate, short-term challenges that were eroding the public's confidence in the system's future- namely timely access to care and to advanced diagnostic services.

The Primary Health Care, Home Care and Catastrophic Drug transfers, on the other hand, were meant to provide a structural foundation for a necessary reforming of the system and to "kick-start" the transformation process.

To entrench these transformative changes, I also recommended that the Canada Health Act should be amended to include priority home care services and, over time, prescription drug coverage. Why? To acknowledge that health care today is more than just about doctors and hospitals. I also recommended that the CHA be clarified to close the loophole that enables queue jumping by allowing private providers of advanced diagnostic services to operate side-by-side with the public system. Keeping in mind that prescription drug coverage and homecare are the fastest growth areas of health care spending, this would ensure the federal government was financially responsible for paying its share of the system's expansion.

Frankly, I'm surprised the Accord did not include a commitment to a fixed, indexed federal funding share or call for changes to the CHA that would require the federal government to share in the fastest growing areas of health spending. I'm confident that in future meetings, First Ministers will recognize the benefits of these approaches.

Adequacy of Funding

Now let me turn very briefly to the specifics of the Health Accord and try and address the issue of whether sufficient money has been allocated to stabilize the system and bring much needed change.

First, I would note that the Accord provides for an immediate $2.5 billion contribution that provinces have committed to use to shore up the existing system. This will presumably be used to address issues relating to waitlists, to timely access to care, including advanced diagnostic services. To be sure, the absorptive capacity of the health care system can be infinite, but the additional dollars on the table will make a difference.

Second, I am heartened by the willingness of First Ministers to proceed beyond the simple focus on hospitals and physician services and to embrace a reform agenda. Establishing ambitious and explicit targets for primary health care goes beyond my Report's more general recommendations and the precision in regard to 24/7 access to frontline care is exceedingly important and a welcome development. I am also glad to see a collective commitment to set certain national objectives in regard to homecare, especially for community mental health services. Again, this is a praiseworthy step forward, as is the recognition by First Ministers of the need for action to provide catastrophic prescription drug coverage.

To be sure, I would have preferred to see more attention devoted to rural and remote communities. And at least some funding distributed on a population-needs formula. But I hope that governments will sit down again in the not-too-distant future and address these issues. They will go a long way toward bringing our three northern territories into the fold. And we must make the Canadian family whole again –as a priority. And as I have said, we are still at the early stages of a longer-term reform process, and we should not diminish the very positive efforts steps that have been taken.

Third, on the broader issue of the adequacy of the funding, the federal government has provided for less than the provinces were seeking, and somewhat less than what I and the Senate Committee Report recommended- albeit with fewer strings attached. Still, the dollars are significant and we will have to wait and see what will be done with them. But the more the available cash is used to shore up the system, the less targeted money there is for the reforms it so urgently requires. Indeed, it appears the quid pro quo for this

trade-off is a longer time horizon for achieving change in areas like home care, prescription drug coverage and primary care reform. It also appears that the bulk of the additional money within the Accord that is specifically targeted for transformative change- the $16 billion, five-year Health Reform Fund- will be back-loaded.

Once again, this underscores the need for Canadians to remain vigilant in ensuring that the Health Reform Fund money which does eventually flow is carefully directed to specific initiatives, with measurable outcomes, that serve to change the system.

I will not mince words here; the Accord provides for less money than is required to implement all of the changes envisaged in my report. But this is by no means fatal, so long as we have embarked firmly on a path toward reform. We should remind ourselves that it took over seven years before many of Emmett Hall's key recommendations on Medicare came to fruition. A long time, yes! But worth it, because we got it right as a country. And that is why I keep repeating that we should avoid overly hasty judgments of what will or will not eventually come to pass. At the end of the day, or at least 75 days into this, I believe governments are on the right path.

More sobering is that some of the provinces have already indicated that the money that has been accepted- as opposed to agreed to- is inadequate. Inadequate both in terms of the quantum, and inadequate in terms of meeting certain outcome targets to which they have notionally agreed. The parting shot by some Premiers that they will return to the table next year with renewed funding requests underscores for me the importance of changing the basis on which our health care system is funded. We need a CHT that provides for stable, predictable and adequate funding. It also underscores the need for empowering the new Health Council with providing Canadians a clear picture of who is paying for what in our health care system, and with what results.

There are many other laudable elements of the agreements that time, not lack of interest, precludes my commenting upon for now. These include the investments in academic health science centers, for national immunization efforts and to support electronic patient records, among others.

The Path Ahead

And so where to from here?

I am well aware that First Ministers' did not, and realistically could not, give full consideration to all of the issues affecting Medicare. The focus of this session was on money, setting broad policy directions, taking preliminary steps on the path toward

reform and accountability. This in itself was a substantial and ambitious agenda for a 1-day meeting.

But I would be remiss if I did not at the very least mention other important health policy issues will, sooner rather than later, require the attention of policy-makers sooner.

A priority must of course be placed on bringing the territorial governments into the fold and on resolving the murky and confusing jurisdictional issues that are impeding progress on aboriginal health. In that regard, my report recommended experimenting with population needs-based funding formulas. It also proposed a new partnership with aboriginal peoples to leverage existing resources devoted to them and to empower their leadership to take greater responsibility for the health of their communities.

To contain rising prescription drug costs, governments should consider the creation of a new National Drug Agency, a review of some aspects of drug patent legislation and the integration of medication management within the primary care system. It is essential that First Ministers delegate to Ministers of Health responsibility for addressing these issues on a priority basis.

A broader focus on population health issues would also be an integral component of a comprehensive wellness agenda designed to make Canadians the world's healthiest peoples. I firmly believe the strengthened primary care system Health Ministers are envisaging can play a pivotal role in advancing this agenda. There has already been much progress on this front, but more needs to be done, especially in light of the financial commitments and specific targets established by First Ministers to expand primary care delivery.

Again, these are all issues that must not drop by the wayside, and which will require continued vigilance by Canadians to ensure progress.

As I stated when I tabled my Commission's final report, 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.

Canada's First Ministers have made strides toward upholding their part of the bargain, and the 2003 Health Accord is an important milestone on a much longer journey. The Prime Minister and the Premiers deserve credit for acting so quickly.

But this is not the end of the story, only the beginning. In the coming weeks and months, concerned Canadians will need to be vigilant to ensure their elected leaders implement not only the spirit and letter of the Accord, but that they go further wherever necessary to refit the system for the 21st century! The goal must be nothing less than a modern, responsive, affordable and effective heath care system that respects our values and strengthens our collective citizenship.

It is within our reach.

Thank you.