# THE REPORT OF THE COMMISSION ON THE FUTURE OF HEALTH CARE IN CANADA (THE ROMANOW COMMISSION): A SUMMARY AND ASSESSMENT

Expectations were high as Roy Romanow, the sole Commissioner on The Commission on the Future of Health Care in Canada, tabled his weighty 356-page report with 47 recommendations. Overall the report is a good one, one that sends the right message to the Liberal government. Canadians want a strong public health care system and they are expecting Romanow's recommendations to guide the way.

There is no question that Romanow's report is the most important report on health care in Canada since the Royal Commission headed by Emmett Hall. We need to claim some victory that Romanow's report contains as many positive recommendations as it does. However, we also need to be aware that the positive recommendations are primarily focused on strengthening public insurance and expanding coverage, rather than on strengthening public delivery and prohibiting for-profit delivery of care.

While the text of the report is considerable, there are many details still to be worked out in the implementation of the recommendations. It is here where we must be diligent in our efforts to understand the content and intent of the recommendations and to interpret them from our own perspective. The process of formulation of social and fiscal policy is important and we cannot take it for granted, nor can we cede it to others. Progressive voices must continue to be heard in order that the detail of implementation is not lost among the generalities of the recommendations. In simple terms, we need to be certain that we end up with what we thought we were going to get.

Now, it is time to step back a little and take a sober second look at the report and its recommendations. What does it really say when all the excitement and anticipation is stripped away? Does the report meet our expectations? Just what do we think?

## 1. Public Medicare is Sustainable

Romanow left no doubt that a publicly funded, single payer system of health care is sustainable and should be sustained in an expanded form. He has heard the voices of millions of Canadians who have told him loudly and clearly that they do not want medicare to "go back to the future" – to pre-medicare days where proper health care was for those who could afford it and those who couldn't would suffer the consequences.

The foundation for the entire report is the core Canadian values that underpin a public health care system, and he is asking Canadians and governments to establish a "Canadian Health Covenant" – a commitment to universally accessible publicly funded health care.

***What do we think?***

We agree absolutely with Romanow that public health care is sustainable if governments are prepared to make political decisions to fund public health care. We also agree that the federal, provincial and territorial governments must make that commitment formally and publicly beginning with the First Ministers' meeting in January 2003. The onus is on them to enact social and fiscal policy to lead the way.

## 2. Privatization

a) Health Support Services

In the very first chapter of his report, Romanow concludes that the health care system can be divided into two segments (direct health care and ancillary support services) that seemingly have no bearing on each other. He makes the case that direct patient care should be delivered by public or not-for-profit providers and that support services (dietary, laundry, housekeeping) is a service that employers can feel free to contract out without causing any damage to the health care system. Indeed, he cites competition in the marketplace as an advantage to lower costs.

***What do we think?***

Romanow speaks convincingly about the importance of public and not-for-profit versus private, for-profit delivery of care. For example, he says "Rather than subsidize private facilities with public dollars, governments should choose to ensure that the public system has sufficient capacity and is universally accessible". (p. 9)

It would be nice to say that we have put the public versus private debate to bed once and for all, but while Romanow has closed some doors he has unfortunately left some

ajar. None of the 47 recommendations in the report proscribe a ban on for-profit health services and in his text he allows that ancillary services can be privatized. This is a serious error.

The Commission went out its way to base its recommendations in evidence provided through systematic study of the health care system. They commissioned papers on many topics. They examined the existing already extensive literature and met with and interviewed hundreds of organizations and individuals. However, in the case of health support work the evidence-based system seems to have broken down and pre-dispositions based on something other than hard evidence seems to have come into play without reviewing the evidence. Romanow recommends the privatization of ancillary services.

By allowing that privatization and contracting out has a legitimate role in health support services, Romanow permits employers to attack the lowest paid workers within the system. Employers are encouraged to save money by shifting work to contractors who will pay their employees less, provide fewer benefits and likely no pension benefits. Women, visible minorities and immigrant workers will be the hardest hit. Sadly, savings reached here will likely be diverted to the highest paid workers in the system (see section on health information below.)

Romanow could not be more wrong about the segmentation of health care into direct health services and ancillary services. Dietary, laundry, housekeeping and maintenance workers are central to infection control, good nutrition and clean facilities.

Romanow has made our work to stop the contracting out of support services that much tougher. We must once again go on the offensive to protect the jobs of CUPE members by raising the awareness of our members, of our employers and the general public to the integral connection between support services such as laundry, dietary and housekeeping, and health.

b) Public Private Partnerships

Romanow reflects CUPE's critical analysis of public private partnerships and says that they are "not a panacea." Romanow correctly questions whether P3s are cost-effective and whether they actually enhance services. However, he fails to rule them out absolutely as a viable alternative in some areas of health care including health information systems (see section on health information below.)

***What do we think?***

In the end Romanow leaves the door wide open by not offering a complete rejection of P3s. While his criticisms may slow some P3 projects down a little it will not stop the massive lobbying campaign being conducted by the Canadian Council on Public Private Partnerships and the corporations that favour private sector involvement in health care. CUPE must continue an active campaign to oppose P3s.

c) <u>For-Profit Diagnostic Clinics</u>

Romanow attempts to deal with the issue of private for-profit clinics by recommending that diagnostic services be clarified and incorporated into the *Canada Health Act*.

***What do we think?***

This recommendation is welcome to the extent that it should be clear to everyone that such services are indeed insured *CHA* services, but it is our contention that they have been covered under the *CHA* all along.

Romanow's recommendation does not, in itself, ban for-profit clinics. What it does is ensure that medically necessary diagnostic services are covered by the CHA and paid for publicly. For-profit clinics could still exist if the province or health region decides to contract diagnostic services to them – publicly paid for services delivered by a for-profit contractor.

The Ontario government has responded publicly to this recommendation by announcing that they still plan to go ahead with a Request for Proposals for 20 for-profit MRI clinics and 5 for-profit CT clinics saying that their plan meets the criteria established by Romanow. Ontario proposes to pay for physician requisitioned, medically necessary scans and to establish a central waiting list.

In a related recommendation, Romanow says that the diagnosis and treatment of injuries covered by worker's compensation should be brought into the public health care system. By doing so, private clinics would be deprived of one very important and lucrative source of revenue. Consequently, for-profit clinics may be curbed.

Romanow reinforces the prevailing view that for-profit clinics are not the way to provide diagnostic services and sends the signal that these services should be CHA insured services free from extra-billing and user fees. However, he provides no policy instrument to effectively ban for-profit clinics.

## 3. Funding

"Based on the evidence both in Canada and internationally, progressive taxation continues to be the most effective way to fund health care in Canada." (p. 31) The remainder of the report reflects this finding.

a) <u>Alternative Funding Sources</u>

Alternative funding sources and mechanism such as user fees, out-of-pocket payments or co-payments, tax-based co-payments and medical savings accounts are soundly rejected They are dismissed for good reason – there is no evidence that they control

health spending or that they benefit individuals to access health services. Indeed, in some cases they undoubtedly will cause hardship.

The Commission also examined a “hypothecated tax” i.e., a tax that is for a single purpose (health care) and is held in a separate distinct fund. It is rejected because the fund would limit the flexibility of the government to shift resources in an urgent situation should it have the need to do so.

Romanow did not reject outright the idea of a “dedicated tax” or a “notionally earmarked tax” - one that would be used to fund specific health services or a portion of the health care system. The Senate Standing Committee on Social Affairs, Science and Technology (the Kirby Committee) identified the dedicated tax as the preferred method to raise $5 billion. Romanow says that governments might want to consider such a tax in the future to fund certain health care needs.

***What do we think?***

We are in full agreement that alternative funding sources are nor an option and that the primary source of revenue for health care funding should come from progressive income and corporate taxes. We are concerned that Romanow has left the door open to a dedicated tax as recommended by the Kirby Committee. Such a tax will not raise the necessary funds in a progressive way.

b) Canada Health Transfer (CHT)

Romanow recommends a cash-only Canada Health Transfer with an escalator provision to ensure on-going stable funding, finally separating health transfers from the Canada Health and Social Transfer (CHST) and incorporating it into the *Canada Health Act.* By 2005/06 the transfer should amount to 25% of total provincial/territorial health expenditures

The “tax points” portion of the funding (which only added confusion to the entire funding formula) would be eliminated.

Romanow calculates that the existing health transfer (including new transfers allocated in Sept. 2000) is $8.14 billion or 43% of the existing CHST and 18.7% of current provincial/territorial health expenditures. By 2005/06 the transfer would be $8.82 billion or 16.7% of provincial/territorial spending on *Canada Health Act* services. So in order to reach 25% funding by 2005/06, $6.5 billion must be added to the CHT bringing the cash base to $15.3 billion.

In the interim, $8.5 billion of short term funding must be designated for specific programs over the next two fiscal years. These transfers will stop once the Canada Health Transfer is established. Only $6.5 billion will be added to the base CHT that would be fully operational in 2005/06.

c) Short-term targeted funds

In the short term, while the new Canada Health Transfer is being established, priority areas need to be funded. The recommendation is to fund the following areas through interim transfers.

| Services | 2003/2004 ($ billions) | 2004/2005 ($ billions) |
|---|---|---|
| Diagnostic Services | 1.5 | |
| Rural and Remote Access | 1.5 | |
| Primary Health Care | 1.0 | 1.5 |
| Home Care | 1.0 | 1.0 |
| Catastrophic Drugs | -- | 1.0 |

***Diagnostic Services Fund*** - federal money transferred to the provinces for purchase of equipment and operational funding (staff and training).

***Rural and Remote Access Fund*** – to be spent on issues related to the supply and distribution of health care personnel, to support telehealth and other projects.

***Primary Health Care*** – to spearhead change in the way Canadians access health care in the first instance e.g., community health centers, family doctors.

***Home Health Care*** – to expand the CHA to include post-acute care, palliative care and home mental health care.

***Catastrophic Drug Transfer*** – to provide an incentive to the provinces to expand drug plans to cover catastrophic drug expenses for those who need it.

***What do we think?***

We have long argued that the 25% floor should be the starting point for a renewed federal commitment to adequately fund health care. Elimination of the tax points as part

of the federal transfer will simplify the calculation of the federal contribution and provide for greater accountability from the federal government as well as the provinces.

There is no question that the Canadian health system needs a significant infusion of cash. After decades of cumulative cuts to the CHST the system has been starved and under funded for long enough. We are fully supportive of Romanow's view that it will take $15 million over the next two fiscal years to return it to some form of initial stability with much needed new services covered under the CHA.

The $8.5 billion in special funds should provide significant incentive to introduce change in the required areas.

We are in agreement with the formation of a separate health transfer. [Note: if this is implemented we will also have to lobby for new funding arrangements to be dedicated to social assistance and post-secondary education as they are currently part of the CHST.]

## 4. Long Term Care and Chronic Care

Romanow makes no recommendations for long term care and chronic care.

***What do we think?***

Long term care – nursing homes and homes for the aged – are an integral part of Canada's health care system. Even though this sub-sector of health care consumes 10% of total health expenditures and is a major concern for Canadians, Romanow chose not to examine the evidence in this area and chose to make no recommendations. Long term care is vitally important for women. Women form the majority of the workforce in this area and are the majority of those receiving care. This is a major omission in Romanow's report.

## 5. Workers' Compensation

Treatment of injuries through workers' compensation is currently outside of the CHA. Consequently, many workers are diagnosed and treated in private, for-profit clinics and facilities and have preferred access to public facilities for treatment. Romanow recommends that diagnosis and treatment of WCB injuries be incorporated into the CHA to prevent "queue jumping" for these individuals. In order to do this, the public system needs to be expanded and strengthened with additional equipment and personnel in order to accommodate the influx of these individuals.

***What do we think?***

This proposal will eliminate one of the anomalies of the Canadian system. However, the devil is in the detail on this one. How exactly will it be funded? Will employers still face penalties when their workplaces are unsafe and unhealthy? Will those penalties be diverted into the public health care system to assist in its funding? This should be the case.

## 6. Modernizing the *Canada Health Act (CHA)*

The Commission recommends:

- Establishing a new principle of accountability within the *CHA.* This principle would require that all levels of government be accountable for health care spending and for their adherence to the principles of the *CHA.* It will also require governments to report to the Canadian public through annual reports of the new Health Council of Canada.
- Opening the comprehensiveness provision of the Canada Health Act to include home care (mental health, post-acute and palliative care).
- Including prescription drugs in the longer term.
- Clarifying that diagnostic services are indeed a *CHA* insured service.
- Including a dispute settlement mechanism within the *CHA*.
- Establishing the Canada Health Transfer as part of the *CHA.*

***What do we think?***

All of these recommendations are ultimately reasonable and workable. It is a little unclear how the dispute settlement recommendation would work considering that there already is a mechanism in place within the *CHA* and an agreement reached in April 2002 among the First Ministers for a dispute settlement mechanism within the Social Union Framework.

Accountability will be an element of the new *CHA.* For it to be effective the accountability must extend to all levels of government and they should be held accountable for respecting and implementing all of the principles of the *CHA.* At present, accountability seems only to extend to only to the user fees and extra-billing provisions of the *Act.* Provinces should be required to report on the measures they are taking to uphold the principles of the *Act i.e.,* universality, comprehensiveness, portability, public administration, accessibility and now, accountability. The federal government in turn should be required to report on these measures to the appropriate body – parliament or the new Canada Health Council.

## 7. Health Council of Canada

One of the major recommendations is to establish a Health Council of Canada to collect information, establish common indicators and benchmarks, to measure the performance of the health care system, to coordinate health technology assessment and to provide advice on a number of national strategies including primary care reform, health human resources issues and the resolution of disputes.

The Canadian Institute for Health Information (CIHI) and the Canadian Coordinating Office for Health Technology Assessment (CCOHTA) would form the basic infrastructure around which the rest of the Council would be formed.

The Council would be appointed by the federal, provincial and territorial health ministers and would report to them as well. The proposal is that the membership of the Council would be comprised of members of the public, provider groups, health experts, and government appointees.

***What do we think?***

The Health Council is undoubtedly one of the cornerstones in Romanow's platform. It has some appeal as an agency that should have considerable power and resources to draw some of the disparate parts of an already fragmented health care system together. It should also have the expertise and information to make informed recommendations for change.

However, there is no proposal for a democratic governance structure that would ensure that all segments of society are represented on the Council and that the Council would be accountable to the Canadian public. If it is appointed by a consensus of the F/P/T Ministers of Health and reports to them, does that make the Council accountable to the Ministers? Likely.

The idea of a Health Council needs considerable examination and probably some modification before we could accept it as the model for structural decision-making.

## 8. Home Care

Romanow's proposal is bring home mental health, post-acute care and palliative care into the Canada Health Act. A targeted fund of $1 billion per year is proposed as the funding mechanism to begin this process.

***What do we think?***

This inclusion is welcome but it does leave an entire area of preventative home care and community care outside of the *CHA*. It is this type of home care that contributes to the sustainability of the public system by allowing individuals to continue living at home

and not having to access more expensive care in hospitals and nursing homes. Seniors, in particular, will be the most negatively affected by this omission.

## 9. Prescription Drugs

The recommendations are:

- Establish an independent National Drug Agency “to control costs, evaluate new and existing drugs and ensure quality, safety and cost-effectiveness of all prescription drugs.” It would be responsible for leading negotiations on bulk purchasing agreements with the pharmaceutical companies to ensure prices of prescription drugs are contained.

- Establish a national formulary essential to controlling costs.

- Use the new catastrophic drug fund to ameliorate inequity and disparities across the country. The federal government would reimburse 50% of the cost beyond $1,500 per person per year.

- Review patent legislation to address issues of “evergreening” where drug companies make variations of existing drugs to extend patent protections, and to change “notice of compliance” regulations such that patent companies have the onus to prove patent infringement rather than generic companies having to demonstrate that their product is not infringing upon a patent. Both measures would result in cheaper generic drugs getting onto the market more quickly.

***What do we think?***

This bundle of recommendations is very significant. It seems that Romanow has grasped that drug costs (and prices) are at the center of rising health care expenditures and is prepared to recommend some measures to deal with it.

If the National Drug Agency can maintain its independence from the powerful pharmaceutical industry who want drugs approved more quickly with less rigorous testing, it will be an agency that may well protect the interests of Canadians. However, if the Liberal government does not provide it with the mandate and tools to do its job, the agency may fall victim to pressures from global capital, far more so than Health Canada does now.
A National Formulary to replace separate provincial and territorial formularies will be a step forward towards a national pharmacare plan.

A catastrophic drug transfer will provide an additional incentive for a truly national pharmacare plan. However, the threshold of $1,500 is too high and should be lowered

and consideration should be given to a federal government reimbursement on a dollar for dollar basis above the threshold.

Progressive organizations have fought long and hard for a review of patent legislation. The very fact that Romanow is suggesting that it actually happen is evidence of a recognition that the current patent legislation has contributed greatly to an inefficient and ineffective prescription drug regime in Canada. This recommendation is an excellent one but one that will require considerable fortitude on the part of the Liberals if they wish to implement it.

## 10. Health Information and Electronic Health Record

Romanow recommends that an individual electronic health record be established in order to facilitate the flow and retention of health information. Romanow mandates Canada Health Infoway, a not-for-profit, arms length agency to establish a pan-Canadian electronic health record framework.

***What do we think?***

Health information is one of those areas that Romanow identified as fertile ground for P3 arrangements. It is more than coincidental that only two days prior to the release of Romanow's report, Canada Health Infoway was at the Annual Conference of the Canadian Council on Public Private Partnerships in Toronto seeking private finance partners to develop a pan-Canadian framework for an electronic health record.

Privatization of health information carries with it considerable risk. The first risk is that the system will cost more than intended – technology development and implementation has a habit of coming in drastically over budget resulting in excess profits to the corporate technology provider. The second risk is that the private sector will have control over sensitive health information

Can both of these risks be controlled such that Canadians benefit from an electronic health record? The risk is much smaller if governments avoid public private partnerships.

## 11. Health Human Resources

Romanow recognizes the vital importance of planning health human resources in an integrated fashion. The proposed Canada Health Council is tasked with the challenge of developing a comprehensive plan for Canada's health workforce. In order to develop the plan the Council will need to examine issues of training and education, scopes of practice, differing regulations in provinces and territories, and continuing tensions within the workforce. It will need to consult with governments, regulatory bodies, professional associations, unions, employers and individuals.

The Rural and Remote Access Fund will contain $1.5 billion over two years to attract health care workers to those communities that are desperately in need of health professionals.

“Poaching” health care professionals from other provinces and from the third world is not acceptable. The Commission says we need to reduce our reliance on recruitment from developing countries.

***What do we think?***

The potential for change in the recruitment and retention of health care workers is positive. Scopes of practice must be examined and changed. Training and education programs need to be modernized and changed accordingly.

Additional money to attract health care professionals to rural and remote areas is a positive attempt to ensure some equity in the delivery of health services to populations that have been deprived to this point.

Any attempt to eliminate “poaching” of health care personnel is a step forward. However, the Commission should have considered a more far reaching recommendation to establish a policy on the migration of health care workers that would respect the rights of individuals to migrate but would prohibit the exploitation of immigrants to Canada by recognizing their credentials or by establishing prior learning assessment tools to measure qualifications.

## 12. Primary Health Care

A proposed primary health care transfer of $2.5 billion over the next two years is to “kick-start the process” of reform beyond the “experiments” already started by the provinces after the September 2000 First Ministers’ agreement.

For Romanow, provinces must address the following in order to receive additional funding from the primary care transfer:

1) Provide training and re-training for health care providers including case managers.
2) Change payment systems for physicians and other health care providers to ensure the best mix of providers.
3) Expand health promotion and prevention programs.
4) Use information effectively to evaluate and assess outcomes while sharing best practices.

The National Health Council would convene a National Summit on Primary Health Care within two years to continue the process of implementing primary care reform.

Preventive programs would include programs designed to address obesity and tobacco use and to promote recreation. A national immunization program should be introduced to ensure that all children are immunized against serious illness.

***What do we think?***

Romanow has provided the prescription for change in primary health care - teams of health care providers within an integrated system and a revamped payment system. All that remains to be seen is if the provinces will see their way clear to implement such changes. The additional transfer money will be an incentive.

## 13. Health, Globalization and Trade

Romanow sends a clear signal that federal and provincial reforms are to be implemented only when there is absolute assurance such reforms do not alter the definition of "public services" under any trade agreements. Canada's position in trade talks should be that Canada has the right to regulate health care policy and that right should not be subject to claims for compensation from foreign-based companies.

***What do we think?***

The Commission heard the concerns of Canadians about the impact of trade deals on health care policy and vice versa and they heard it from both conservative and more left leaning experts. Romanow has rightfully raised the concern in his report with recommendations that should send the message that all health reforms have to be considered through the filter of the trade agreements prior to implementation.

## 14. Aboriginal Health Care

Romanow accurately identified the many health issues facing Aboriginal people and the deep disparities between aboriginal and non-aboriginal Canadians with respect to health status. He cites a "confusing mix" of federal, provincial, territorial and band run health care as part of the problem.

The Romanow report makes two recommendations that are specific to Aboriginal health. The first is to pool all aboriginal health funding into single, consolidated budgets. The second is to establish Aboriginal Health Partnerships responsible for developing policies, providing services and improving the health of Aboriginal people.

***What do we think?***

It is disappointing that more funding was not allocated directly to Aboriginal health rather than simply relying on a pooling of funds. It is also disappointing that more attention was not given to the social and economic determinants of health e.g., poverty and

education.  A great deal of weight is placed on the aboriginal health partnerships as the vehicle to deal with these issues.  It will take a great deal of cooperation on all sides to facilitate their success.  It is not clear that the proper incentives are in place for this to happen.

Many native groups asked Romanow to recommend more native control over health policy and services.  Some of this may happen through the partnerships initiative but it is not clear how the necessary cooperation between governments and native groups will happen.  If it happens with greater Aboriginal involvement the new approach may work.

The report also fails to provide any solutions to health concerns of Metis people.

## 15. Women and Health Care

Romanow recommends that a “caregiver’s leave” be established through the Employment Insurance Program.

Some primary care reform recommendations (such as multi-disciplinary teams of health care providers) may be beneficial to women if implemented appropriately.

***What do we think?***

The report does not make recommendations that are very beneficial to women in Canada.  The National Coordinating Group on Women and Health Reform and the Canadian Women’s Network applauds the report for its focus on sustainability but says

> “… this report fails to recognize the significant ways in which health care is an issue for women.  Women are 80% of paid health care providers, a similar proportion of those providing unpaid personal care and a majority of those receiving care, especially among the elderly.  The sustainability of the system is not just about finances – it’s about women’s work.”

The distinction that Romanow draws between direct health care services and ancillary services ignores at worst, and diminishes at best, the skills of women health care workers.

The caregiver’s leave under EI will not benefit the many women who are not in the paid workforce.

Women make up approximately 75% of the paid workforce in long term care and chronic care, but the report is silent on these sectors.

No recommendations are directed to improving the deteriorating conditions women face when providing care.

## Conclusion

Romanow's report lays a solid foundation for substantive change within the Canadian health care system – change that should enhance access to needed services and ensure accountability to Canadians. Public, not-for-profit health service delivery is the model of choice.

However, there are many areas where CUPE members need to be active to make it all happen. The myth that health care services can be divided into direct patient care with public delivery and that ancillary support services can be contracted out, needs to be exploded.

The next months are critical for us to influence the implementation phase. The federal/provincial/territorial Ministers of Health met on December 6th in Toronto. The Romanow Report dominated the agenda and will continue to dominate the agenda in future meetings. The First Ministers are meeting in late January 2003 and they will be asked to come to some agreement on Romanow's recommended "covenant" for health care. Finally, the federal budget will come down in February 2003 and the funds will need to flow to health care. Any supporting legislation to implement a health program will need to be introduced shortly thereafter.

All of this is to say that time is still short if we are to convince the federal government that our vision of health is the vision that must be implemented through Romanow's recommendations.

**Research Branch -- December 9th, 2002**

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