

**Notes for Remarks by**  
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**Commission on the Future of Health Care in Canada**  
**at**  
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**Check against delivery**

## **Introduction**

Thank you for your warm welcome! It is always a pleasure to come to Queen's, a university with a rich history, a bright future, and, perhaps most importantly, a claim to being the home of organized hockey in this country!

In preparation for coming here today, I logged on to the Queen's University website and I was struck by the words of Principal and Vice Chancellor Leggett's welcoming message. He said, and I quote, "Like all great institutions, Queen's University derives its greatness from a series of deliberate, often difficult decisions that have shaped and defined its unique character."

The same may also be said of Medicare, because it too derives its greatness from a series of deliberate, often difficult decisions that have shaped and defined its unique character.

Certainly in the past week or so, since the release of my Report, we have seen the profound concern of Canadians over their health care system reflected in the wall-to-wall media coverage.

And I must say that while the rhetoric has occasionally been a little overheated and, some deliberately mischievous spins have been put on certain of my conclusions and recommendations, I have generally been very heartened by the wishes and response of Canadians.

They see this Report not so much as a statement from me, but as a reflection of their values, their views and their needs. And I have every confidence that as Canadians observe the unfolding intergovernmental debate, they will see past the predictable posturing to what's really at issue and what's really at stake.

Today will be perhaps my final public appearance for some time on the health front, and so I wanted to take this opportunity to set the record straight on a few issues before riding off to the beautiful Saskatoon sunset.

As I am no longer a politician running for office, I feel comfortable ignoring that old political maxim of: "never explain, never complain" only because I don't want to see the reform agenda which Canadians have asked me to articulate for them hijacked by other interests.

My Report is first and foremost about healthcare, how to make it work for Canadians, and how to keep it relevant and sustainable in the future. Of course, it deals with money and inter-governmental relations, but these are only necessary means to a more important end - improving access to better quality health care for all Canadians in the most efficient and effective ways possible.

I am also mindful that I was asked to take on this assignment, not because I am a health expert, but because I have a long and deep commitment to medicare. Because as a former Premier I know what a struggle it is to balance the imperatives quality health care demands against so many other worthy and competing priorities. And also because I believe passionately in Canada and recognize that our healthcare system has been one of the defining aspects of our sense of self.

Frankly, I care more about being faithful to the trust that Canadians placed in me, and to the future of our health care system, than I do about ruffling feathers in Ottawa or elsewhere. Canadians - not politicians and not political turf wars - are what this exercise is all about.

In my remarks today, I would like to focus on those parts of my Report that have implications for federal-provincial relations. I do so for two reasons.

First, in the hope of shedding light on what my Report actually says, versus the interpretations given to it by those who want to use it as a wedge or cudgel to advance their own agenda.

And second, because for too long federal provincial and territorial wrangling has defined the debate and set the agenda. For too long, Canadians have watched as politicians - and I don't exempt myself from this - as politicians fought *over* Medicare instead of fighting *for* Medicare.

Let me begin by repeating what we all already know: Canadians are fed up with the corrosive rhetoric that passes as FPT discourse on health matters. Indeed, one of the key objectives of my Report has been to try and change the dynamics of this increasingly dysfunctional relationship by eliminating, from the FPT battlefield, as many things as possible for governments to fight over.

And so that has led me to propose the following:

## **I. HEALTH COVENANT**

Without exception, every provincial government and opposition party in Canada professes to support the principles of the CHA. And yet, each interprets the CHA differently- to the point where the CHA risks becoming an empty shell.

Moreover, the CHA is a piece of federal legislation; it was designed in Ottawa, by Ottawa, and then - for want of a better word - imposed on the Provinces.

Unlike the federal-only CHA, the proposed Health Covenant would be a consensual document by all levels of government. It would be a declaration by all governments concerning their commitment to working together on the national dimensions of health care. It would be a clear statement of the respective entitlements and responsibilities of individual citizens, health care providers and governments.

As such, this declaration should be built upon the values and expectations of all Canadians, and the Report provides a proposal based on our extensive consultations. To put it another way, the Covenant can serve as a de facto preamble or interpretive clause that keeps the CHA relevant and vital.

## **II. HEALTH COUNCIL OF CANADA**

One of the problems in the intergovernmental relationship is that the different levels of government begin from very different starting points on simple issues of fact. Our Report seeks to reduce such disagreements and misunderstandings through a new Health Council of Canada.

The new Council would certainly not be a "watchdog agency". I find the term pejorative and provocative and it is one I deliberately avoided in my Report. More to the point, the notion is contrary to the spirit of my report, which focuses on collaboration, not policing, and on accountability to the citizens of this country as the users and owners of the system, not accountability between one level of government to another.

Indeed, if you read my Report, you will notice that the Council I propose is built by combining EXISTING agencies - the Canadian Institute for Health Information (CIHI) and the Canadian Office for Health Technology Assessment. (COHTA)

As you may know, CIHI is an independent, arms-length agency that:

1. Serves, and is funded by, both levels of government;
2. Already reports annually to Canadians on health system performance.
3. Is directed by a board whose members are appointed by both levels of governments.

For many years, CIHI has served as a focal point for gathering health information, for setting common health data and informatics standards, and for interpreting and reporting on health outcomes.

The changes I propose would :

1. Bring the COHTA and CIHI together under a single roof; and
2. Make the Council's (ie. CIHI's) governance structure more inclusive by giving a seat on the Board to providers and citizens.

**Why is making more inclusive the governance structure of an existing FPT mechanism, that is based on collaboration and that already reports annually to Canadians on health spending and outcomes, so provocative?**

**And if it is so divisive, why has CIHI been as successful as it has, and why has it become so influential in such a short time?**

I think that is a fair and rational question to ask those who see the Health Council of Canada as an intrusive mechanism.

Finally, the Council, far from imposing a new layer of administration, should actually simplify the current web of FPT committees, while at the same time opening the process to the bright light of public scrutiny.

Maybe it's the transparency that has some people nervous!

### **III. MONEY AND FUNDING**

As we all know, the ongoing battles between the federal and provincial governments over the issue of funding are unpleasant and divisive.

They leave governments wrangling over funding formulas instead of discussing ways of delivering better health care to Canadians.

My Report acknowledges that in recent years, the federal government has not lived up to its part of the Medicare bargain, and that its share of CHA-related health spending has fallen well below historic levels.

(Note that I said the federal share of CHA-insured health services, not overall provincial spending on health. This is a key point. Medicare was built on an agreement between the federal and provincial governments relating to cost-sharing for the specific health services covered in the Act, that is, for doctors and hospital care. It does not cover costs for things outside that core basket.

Costs for non-CHA health spending - for such things as homecare or diagnostic services performed outside of hospitals or pharmacare - are not covered by the CHA.)

My Report notes that 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.

Also at that time, health was mixed with transfers to the provinces for post-secondary education.

By the mid-1990's, the nature of the transfer again changed, but this time without negotiation with the provinces. Social assistance and social services (the old Canada Assistance Plan) were added to health and post-secondary education to form a single transfer called the Canada Health and Social Transfer, or the CHST.

At the same time, the automatic escalator, which had been part of previous transfer arrangements, was dropped, creating an environment in which the federal and provincial governments were constantly bargaining over the annual increases to the CHST.

The thought here was that transferring a lump-sum of money to the provinces would provide them with additional flexibility to allocate funding to where it would have the most effect.

A laudable goal to be sure, but the practical result, as the Auditor General has noted, is that it is almost impossible to track where health spending has gone and whether it is providing value-for-money.

And without a built-in escalator, the constant demands for money by the provinces and territories and the stop/go manner of response by Ottawa, has so dominated the health care debate in this country that we have begun to lose sight of the purpose of Medicare.

My Report recommends that by 2005/06, the federal government should cover at least 25% of provincial health spending for CHA expenditures and that this be in the form of a dedicated cash-only transfer.

Now, provinces might be disappointed that I have not called for the federal government to cover 25% of ALL provincial health expenditures, but that was never the Medicare bargain. The federal government's commitment has always - and only - been to doctors and hospitals.

But with respect to the Medicare-covered services, I recommend that the federal transfer include an escalator provision to enable the federal share of health spending to track inflation and adapt to changing patterns of provincial health care spending.

What does this new funding mechanism achieve? I believe it removes yet another possible irritant from the already volatile inter-governmental relations mix, while simultaneously improving accountability.

If accepted, my proposals will make it clear to Canadians who is spending what on health care and with what results.

It will also mean an end to the nasty “name, blame, shame” game being played out by governments as well as the continual efforts to shift the financial risks by one level of government to the other. Both should be shareholders in the system, accepting their fair share of the risks.

Indeed, how much longer must Canadians endure the sorry and depressing spectacle of seeing their provincial governments use **their** tax dollars to buy advertisements accusing the federal government of not paying its share, and then to see the federal government use **their** tax-dollars to take out advertisements of their own trying to prove they are.

I cannot think of a more compelling example of why my proposals on funding should be implemented.

At the same time, these measures will also have the effect of constraining - not forbidding, constraining - the ability of the federal government to act unilaterally in this area of primary provincial jurisdiction.

Too often in the past, the federal government has brought forward, with little or no notification, ambitious new initiatives in areas where the provinces have primary or lead jurisdiction. While invariably laudable in their intent, these initiatives often fail in their implementation. Why?

Because in the absence of collaborative planning, these unilateral federal actions can distort existing or planned provincial policies or spending priorities.

As a former Premier, I know how seductive it is when the federal government is dangling millions or billions of 50-cent dollars in front of you to subsidize the cost of creating new programs in an area deserving of policy attention.

But it is frankly not a good way to build consensus or to build a country. And that money belongs not to one level of government or to the other, but to taxpayers. They must work together.

#### **IV. Targeting Spending**

So why, then, does my own Report propose establishing 5 targeted funds? Isn't it contradictory to what I've just said?

Let me explain. Thus far, there has been much sound, but little light shed, on my proposals to create these special funds over the next 2 years as a bridge to the 25% federal spending floor that I hope will come on stream in 2005/06 or as soon as is reasonable.

These new funds amount to additional federal funding above current forecasts of approximately \$3.5 billion in 2003-/04, \$5 billion in 2004/05, and, once the 25% funding floor is achieved, \$6.5 billion in 2005/2006. The new funds reflect what governments have told us represent their priorities for change and include:

- A Rural and Remote Access Fund (\$1.5B total over 2 years): to improve timely access to care in rural and remote areas
- A Diagnostic Services Fund (\$1.5B total over 2 years): to improve wait times for diagnostic services
- A Primary Health Care Transfer (\$2.5B total over 2 years): to support efforts to remove obstacles to renewing primary care delivery
- A Home Care Transfer (\$2B total over 2 years): to provide a foundation for an eventual national homecare strategy; and

- A Catastrophic Drug Transfer (\$1B beginning in FY 2004/5): to protect Canadians in instances where they require expensive drug therapies to remain healthy

These funds are designed to “kick-start” the process of transforming our health care system in order to make it more sustainable and to address priority issues that are eroding public confidence in Medicare’s future.

It is fair to ask if these proposed funds are in any way inconsistent or incompatible with the current health spending priorities that provinces have themselves articulated. And the answer is NO!

All provinces are working to improve timely access to quality care for their citizens in rural and remote areas.

All have recognized the need to play catch-up by reinvesting in health infrastructure, like advanced diagnostic services, in order to reduce bottlenecks across the system.

All have identified primary health care reform as a priority, so that 24/7 health services become a reality for more Canadians and relieve pressure on hospital emergency rooms and leverage the current supply of health professions.

All are struggling to contain rising drug costs and to improve coverage.

And all recognize that getting people out of \$1,400 dollar-a-day hospital beds, to be treated at home at a fraction of the cost, makes economic sense and social sense and will also relieve pressure on our hospitals.

So these aren't priorities that I just dreamed up. They are the very ones that the provinces themselves have identified.

Do my proposals represent an assault on provincial jurisdiction, contrary to the constitution? No.

In a wide range of fields, from transportation infrastructure to economic development, federal-provincial agreements are the norm. Both levels of government reach a consensus on what needs to be addressed, how best to address it, and how the dollars will flow. This is nothing new.

In the \$23.4 billion Health Accord, which I signed as Premier, along with Mike Harris, Lucien Bouchard, Ralph Klein and others, we agreed to work cooperatively in numerous separate fields of action, and linked the receipt of additional health funding to meeting specific policy objectives in those areas.

Was any province's constitutional rights compromised by that Accord?

Was a constitutional amendment required? Will my proposals require a constitutional amendment or impose onerous new obligations on any

Province? NO!

Will my proposals limit a province's freedom to manoeuvre or impose on them a specific type of program or initiative? NO! Subject to agreement on goals and objectives, provinces remain free to use these transfers to design and implement their programs as they see fit.

Take our Catastrophic Drug Transfer, for example. Some provinces provide quite robust and comprehensive drug programs for their citizens; others provide coverage that is far more limited. The same situation exists with respect to homecare.

As stated in The Social Union Framework Agreement of 1999, and I quote,

“The use of the federal spending power under the Constitution has been essential to the development of Canada’s social union... (by supporting) the delivery of social programs and services by provinces and territories in order to promote equality of opportunity and mobility for all Canadians... (Conditional transfers in particular) ..... have enabled governments to introduce new and innovative social programs, such as Medicare, and to ensure that they are available to all Canadians.”

The Social Union Framework Agreement also states that when the government “uses such conditional transfers, whether cost-shared or block-funded, it should proceed in a cooperative manner that is respectful of the provincial and territorial governments and their priorities.”

Under our proposal, provinces that already have pharmacare or homecare programs or initiatives that meet agreed upon criteria can use these funds to expand their existing efforts or to improve access to them. Those whose programs are rudimentary can use their funds to play catch-up to some eventual agree-upon baseline.

Let me again quote from the Social Union Framework Agreement, because it succinctly captures the intent of my Report:

“A provincial/territorial government which, because of its existing programming, does not require the total transfer to fulfill the agreed objective would be able to reinvest any funds not required for those objectives in the same or a related priority area.”

Naturally, both levels of government should agree in advance on the “accountability framework for such new social initiatives and investments” but all governments that “meet or commit to meet” these objectives AND “respect the accountability framework will receive their share of the funding”. End quote.

So to those who say that the money should simply be provided without an accountability framework and without an agreement on objectives, I respectfully disagree.

We have tried that route and found it wanting. What happened to the \$23.4 we added to the system just 2 years ago? Most of it went through a block fund without an accountability framework and without basic agreement on priorities beyond a general intent to increase health care expenditures.

And where has it gone? What has been achieved from it? How have waitlists improved, or access been enhanced, or quality gotten better?

We don't know, because as the Auditor General notes, we have no way of knowing.

This isn't gratuitous criticism of Ottawa or the provinces; it is simply a statement of fact. And Canadians deserve better.

Indeed, time and again, everywhere I went across Canada, Canadians said to me they wanted greater accountability in how their health dollars are spent. I share that view - indeed, I feel so strongly about it that I have recommended that accountability be added as a sixth principle of the Canada Health Act.

Some of the criticism coming from provincial capitals suggest that my Report opens the door to federal intrusion into their jurisdiction.

In fact, I say clearly that the need for pan-Canadian thinking on health care is far from an invitation for the federal government to insinuate itself into areas of provincial jurisdiction. It is simply an acknowledgement that we need more collaboration across the health care system.

## **Conclusion**

Let me summarize the main points of my presentation here today. One of the goals of my Report is to eliminate or mitigate some of the irritants that have plagued federal-provincial discourse on health care.

I have proposed that provincial and territorial governments, providers and citizens, come together to approve a Health Covenant that defines the values and principles that should guide our health care system and that speaks to the responsibilities and entitlements of each to the system and to one another. This can serve as a de facto preamble or interpretive clause that keeps the CHA relevant and vital.

I have proposed a new Health Council of Canada whose backbone is the Canadian Institute for Health Information, an agency that ALREADY exists, an agency whose Board Members are ALREADY nominated by FPT Health Ministers, and an agency that ALREADY reports annually to Canadians on the performance of the health care system.

The Council we've proposed will have an even more inclusive board that will enable it to become the focal point for objective advice, information and collaboration among governments on health matters.

I have proposed new funding arrangements that establish a permanent cash floor for federal health transfers, that have a built-in escalator so that these transfers track provincial health spending. This will produce the predictable, stable funding policy makers crave and restore much needed civility to the FPT discourse on health.

Finally, until the new cash floor is in place, in order to begin transforming our health care system, I have proposed 5 new interim transfers in areas that the provinces themselves have indicated are priorities. The criteria for how these funds flow will not be imposed by one government on the other, they will be determined collaboratively by the two levels of government.

If governments move quickly to establish the Health Council of Canada, the Council itself could take the lead in advising Ministers on relevant criteria for how these funds should flow.

The common thread in each of these measures? Respect for jurisdiction, an emphasis on collaboration and a focus on making our health care system better for all.

That is what Canadians want to see. That is what our Report attempts to do. And that's what all of us must dedicate ourselves to achieving in the days ahead.

Thank you.