On November 12, 2012 I attended a one-day retrospective/prospective on the Romanow Commission, which was organized by the Canadian Association for Health Services and Policy Research (CAHSPR), and funded by the Health Council of Canada (HCC) (the creation of which was a key Romanow recommendation). There were upwards of 300 people physically present and at least 130 online from various points across the country. I think this was an excellent initiative to have pursued.

I think the main takeaway from the meeting was the repeated call for federal leadership. The most controversial remarks came from Senator Ogilvie, who after warning that he would be speaking for himself described the Canada Health Act as a barrier and concluded essentially with a call for private pay options. I do not recall that there was much discussion about the prospects for the Council of the Federation Health Care Innovation Working Group.

I would also observe that one should also consider that most provinces have gone through at least one in some cases (e.g. Quebec) several rounds of reform studies, and I would add that I think the National Forum on Health (1997) has had a lasting legacy that should be considered (e.g. formation of CHSRF, HTF, PHCTF).

The presentations are highlighted below.

Introduction
Lillian Bayne (ED CAHSPR and AED Romanow Commission) outlined the objectives of the conference as: what was the ground like at the time?; where are we now?; and what of the future?. What do we need to do to transform the system and what are the roles and responsibilities of players including RHAs and clinicians? Adalsteinn Brown (President CAHSPR) noted that all health systems are turning to evidence and noted that the Romanow report was anchored in values and evidence. He noted the current trend toward access to a whole bundle of care as opposed to new programs.

Session 1 – Canadians’ Views
Stuart Soroka (McGill) introduced a 4-fold typology of the structure of opinion that can apply to health care as it does to the economy

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He noted that the retrospective view of the system is shaped by inter-personal experience and the egotropic view is shaped by personal experience. He noted that the media has an influence on the future. He showed a graph taken from the analysis of Globe/Toronto Star stories that showed that concern about waiting lists peaked in 2006 and has declined since then. In terms of drivers of public opinion he showed that experiences such as waiting longer than a day for a doctor’s appointment and waiting longer than 1 hour in emerg have a lasting effect on confidence. Assessments of acute care are more positive than chronic care. He suggested that the health policy mood had hit a low in 2003 and that there has been gradual improvement over the last 10 years. Using data from the CMA’s annual health report cards he showed that retrospective assessments of the quality of care have been improving since 2001, while prospective assessments of the future quality of care have been
diminishing. He also showed comparative data between the US and Canada – which showed an identical overall assessment of the quality of care, however Canadians were more concerned than Americans about waiting times, and the converse was observed about the cost of care.

He concluded by saying that Canadians are only moderately pleased with the existing system and that their ongoing support will depend on:

- Continuing improvements in quality and access; and
- A revised model of health care that is sustainable over the long-term.

Greg Marchildon (U Regina and ED Roman Commission) provided an interesting commentary on the historical context of the Romanow Commission and an assessment of what has changed and what the unfinished business is. He noted that over the 1990-2001 period we went through a famine to feast debt crisis that resulted in public dissatisfaction with service delivery. This was compounded by the federal cuts to transfers that began in 1996. While the feds began to put money back in in 1999 there were issues not only of catch-up but damage repair. Hence there was a negative policy mood in 2001. At the federal level the feds were not sure about the transfer and there was division in Cabinet, as well as a struggle over succession in the Liberal Party. Prime Minister Chretien did not like Royal Commissions as they took too long and went over-budget. It took 2-3 weeks to negotiate the mandate of the Romanow Commission. The feds wanted a narrow mandate and Mr. Romanow wanted a broad mandate. They settled somewhere in the middle. The Romanow Commission was given an 18-month mandate and a budget ceiling of $15 million. Marchildon stressed that it is not valid to make comparison to the cost of studies such as those done by the Senate (infer Kirby!) because the Senate covers a lot of infrastructure. He noted that the PM trusted Mr. Romanow to do this on account of his long experience in politics and his understanding of trade-offs and his deep understanding of federalism. Mr. Romanow accepted because he saw a window of opportunity and a desire for change.

In Mr. Marchildon’s assessment the federal dividend was spent in 2004. Medicare remains frozen in time to the 1905s and 60s. We are left at a point of decision/direction as to whether to go forward to build on universality or to go backward and reduce taxes and pay more out of pocket.

In terms of what has changed since the Romanow report, Marchildon highlighted 3 things:

1. The Romanow Commission provided the broader Canadian public with the opportunity to express their preferences on changes to the health system. He cited the Citizen’s Dialogue which explored deeper tradeoffs and said it had concluded by supporting single-payer, tax-based, single-tier universality.
2. The recognition of the importance of inter-governmental mechanisms and institutions. Health care is not the exclusive jurisdiction of the PTs and the feds have a role as does civil society. He noted the role of arm’s length agencies such as CIHI and CADTH as well as the HCC.
3. He noted that the time of Romanow there had been no activity on primary care reform and that this is underway now. In my opinion primary care reform got its start with the Health Transition Fund that was set in the 1997 budget right after the NFH report and got a bigger boost with the $800 million PHCTF that was part of the 2000 Health Accord.

In terms of what has not changed, Marchildon also highlighted 3 things:

1. There has been no major Canadian effort in focusing on rural/remote health care
2. There has been no major initiative on the part of the FPT governments and Aboriginal organizations to work together to address Aboriginal health care.
3. Medicare remains frozen in time and there has been no decision on whether to expand or retract. – this results on lost opportunity in the area of administrative costs and in the area of home care a lost opportunity to integrate services.

In conclusion Marchildon said that we still need to make a major directional decision – from the point of view of finance/principles it is clear where Canadians want to go. We need leadership at the FPT levels and civil society – and no one player can do it alone. Comment – polling research has shown that pharmacare is not a top priority for Canadians and research conducted for CMA/CHSRF/IHE by Ipsos in 2012 showed a lot of ambivalence towards a public drug program – even among those Canadians without benefits. This remains a conundrum!

Discussion

Several points were brought out in discussion of the two presentations:

- We need more patient engagement especially with morbidity shifting towards long-term chronic conditions
- Concern about out-sourcing of social services (recent announcement by HRSDC)
- Primary health care has not changed from the medical model
- The debate about private delivery is false – e.g. most docs are private professionals
- Why don’t health scorecards get more attention (counter-point they do)
- Civil society organizations have had their funding reduced
- Regarding sustainability – we have cut back the tax base
- It is a good thing Medicare is frozen because that makes it tough to go backward
- Quebec has done a good job on damage control post-Chaoulli

Session 2 – Key Challenges

Steve Morgan (UBC) focused on the issue of pharmacare. He suggested that there is the potential for Canada to save $40 billion over 10 years while improving coverage. Canada is the only country with a universal system that excludes drugs. The closest comparator would be the U.S. and Morgan suggested that once Obama’s health reform legislation comes into force that they could even move ahead of us. He showed some colour coded charts that ranging from Blue(1st dollar coverage) to Red (no coverage).

For Canada, those persons on social assistance come the closest to full coverage. Among seniors there has been a shift more towards the pink direction with greater deductibles/co-payments. Among the non-elderly there has been progress in Atlantic Canada is expanding coverage but there is no jurisdiction with first dollar coverage for this population. He cited Commonwealth Fund research showing that 10% of Canadians have experienced income-related access issues, and that 13% of Canadians with chronic disease were paying $1,000 or more out-of-pocket for drugs. The U.S. and Canada are the two highest spending countries on prescription drugs. If Canada were to spend at the same per capita level as the UK we would spend $10 billion less per year. He concluded by saying that UBC’s winter 2013 CHSPR conference will be entitled Pharmacare 2020.

Matthew Mendelsohn (Mowat Centre) focused on the need for Innovation primarily with reference to a study that the Mowat Centre published on health care sustainability in 2011 (http://mowatcentre.ca/pdfs/mowatResearch/59.pdf). He suggested that reform is possible in a public system and that there is in general plenty of money in the system. He also noted that there has already been success in reducing the growth of health spending, adding that we haven’t really tried too hard yet! He emphasized the importance of doing four things to sustain health care:

- Use disruptive innovation to understand changes in technology and service delivery
• Recognize Moore’s law (declining costs over time) and capture productivity gains as they emerge for the public purse
• Focus on improving quality and access as costs decline
• Treat health care as a high-tech industry

He reviewed a number of strategies that can be pursued (see the Shifting Gears report) and suggested that a number of developments are proceeding organically. In conclusion he noted that AB, SK and NL have sufficient fiscal capacity to deliver services at high levels but noted that fiscal capacity varies across Canada.

Antonia Maioni (McGill) began by thanking Mr. Romanow for spending all the time he did to create a map for change. She focused on the evolution of fiscal federalism beginning with the National Health Grants of 1948, through HIDS 1957, Medicare 1966, EPF 1977, CHA 1984, CHST 1995, NFH 1907 and the 200 Accord (added $23.4 billion to CHST). Mr. Romanow identified the “Romanow gap” in federal funding (Romanow suggested that a minimum of $6.5 billion should be added into the CHST base by 2005/06). She also noted elements of a non-fiscal gap that Romanow had addressed:
• Research into federalism and health care (number of papers commissioned on this)
• A forum for the exchange of information – HCC
• The need to bring policy-makers to task for their “long-distance hollering” and a reaffirmation of a federal leadership role.

Maioni noted that the latter point has not been resolved – she showed some interesting pictures – the Premiers at the time of the 2003 Accord – all men in suits, the Finance Ministers at the fateful December 19, 2011 meeting – all men in suits and the Premiers at the January CoF meeting several women and flowers on the table – a harbinger? Reflecting on the current context she made several points:
• Health remains salient in the context of elections
• There are haves and have-nots
• There are new actors – e.g. the courts
• We are unlikely to see new (universal?) programs

She concluded with several potential lessons from Obama:
• Health care can be seen as a proxy for the relationship between the state and society
• Institutional contours can be both roadblocks and opportunities
• Don’t ignore regulatory levers
• “Path dependency” is at work but change is not impossible.

Discussion
Several points were brought out in discussion:
• In terms of focusing on performance improvement HCC and CIHI are making efforts
• When we are trying to examine “bending the cost curve” we need to be mindful that we are not simply shifting costs from one line to another (e.g. hospitals to clinics)
• In response to a question about the prospect of a shift of the CHT from cash to tax points Matthew Mendelsohn stated that this will not happen because the feds would have the dilemma of deciding on whether or not to equalize them

Session 3 – Addressing the Future

Senator Kelvin Kenneth Ogilvie (Senate of Canada) gave a provocative presentation of the findings of his Committee’s review of the 2004 Accord. He described the shortcomings of the current situation:
• A collection of siloes – fragmentation of delivery
• Very little innovation
• No accountability for key players
• Payment for services is a major inhibitor of innovation
• Physicians are not responsible to anyone — no one is in charge
• The patient must be the centre of focus
• Specialists are out of control with regard to their work schedules (i.e. it can take months to schedule a sequence of appointments)
• There is a lack of emphasis in illness prevention

He suggested some key changes that should be done. First any incremental funding in health should be directed at innovation. Wait times should be measured from the 1st diagnosis – not the first encounter with the specialist. He then showed several of the OECD stats that demonstrate how Canada under-performs.

On a positive note he indicated that there has been a big shift in how the provinces cooperate between SARS and H1N1.

He concluded with several slides to make the case for mixed public-private funding of health services – citing for example the Supreme Court finding in Chaoulli – and calling for dual (physician) practice – which he claimed was already happening. His final slide contained the question Why in a democratic county should individuals be denied the right to seek medical care for which they are willing to use their own personal funds? He also made the point that provincial governments are best-positioned to run health care. Senator Ogilvie concluded by saying that innovation has to be the basis for moving forward and must be a major driver.

Hon. Deb Matthews (Ontario Minister of Health) focused her remarks on rebutting Senator Ogilvie’s presentation. She stated that we (Ontario) are innovating and that it works better when jurisdictions work collaboratively. She noted the need for the federal government to show national leadership.

Presumably with reference to the Senator’s remarks about private financing she noted that Canadians had voted Tommy Douglas the number One Canadian. Turning to the need for innovation Ms. Matthews noted that the top 1% of health care users in Ontario consume 1/3 of the health budget – the top 5% 2/3 and the healthiest 50% consume just 1%. She then narrated a story of a woman who broke her hip and subsequently was shunted though the system and as a result went from living independently to ending up in long-term care at a cost of $500K. She followed this by a hypothetical scenario of how this woman could have been treated through proactive care – she would have remained independent and the cost would have been $100K. She said it was a question of making the system wrap around the needs of a person.

Joe Gallagher – CEO First Nations Health Authority – described the creation of the First Nations Health Authority (FNHA) in BC, a process that began in 2005. This brings together the First Nations Peoples of BC, the BC Government and Health Canada (see http://fnbc.info/sites/default/files/documents/FNHC_Health_Governance_Book-web2.pdf). He noted that the First Nations population is the fastest growing, the youngest, and at the same time has the worst health outcomes. He stressed the amount of collaboration and inclusiveness and ongoing discussion in the formation of the FNHA. He noted that the First Nations like to use a wellness approach. Ultimately all of the federal resources for health will be transferred to FNHA. He noted that this will provide an opportunity to address rural/remote issues and social determinants of health.
He concluded by saying that the bad news is that First Nations peoples are even more disappointed that the rest of the population about the performance of their health system but the good news is that we know what to do to fix it.

**Discussion**

Several points came out in discussion:

- The language of “transformation” has been added to the agenda but nobody means it yet
- Transformation can be achieved but it will need significant oversight
- The profit motive in health results in over-servicing healthy people
- While appreciation was expressed for the vision/values contained in the Senate report – displeasure was expressed with the references to private delivery when Health Canada has said that there is no evidence that it is cost-effective.
- Health Canada has a number of roles including food/drug safety
- The federal government has a moral responsibility of ensuring that Canadians have comparable access to health care.

**Session 4 – Hon. Roy Romanow**

Mr. Romanow began by recapping remarks made by Hon. Allan MacEachen in 2003 at a lecture Mr. Romano had given at St. Francis Xavier University. He noted that Mr. MacEachen had paid tribute to the leadership that Lester Pearson had displayed in deciding to proceed with Medicare despite the opposition of the provinces and the divisiveness in Cabinet. The Medicare legislation ultimately passed by a vote of 177 to 2.

Mr. Romanow enumerated five things that matter:

1. Values matter—equity trumps income – we value access based on need
2. Responsibility matters *I didn’t catch the explanation*
3. Evidence matters – the Romanow Commission commissioned 50 peer-reviewed papers, all of which were posted
4. Innovation matters – we need to bring the results of science to the health care system
5. Sustainability matters – financial sustainability results from the decisions that governments make – in this regard he noted the recent work on bulk purchasing – but stressed that Ottawa must be at the table too.

He noted work underway at the University of Waterloo on the Canadian Index of Well-Being. He also emphasized his deep personal belief that Medicare is the key symbol of our uniqueness as Canadians, and suggested that there is a convergence of values. He concluded by acknowledging the existence and importance of new ideas and new voices.

Cheryl Doiron (HCC) gave the closing remarks. She suggested that the day reminded her of the **best of times the worst of times.** She noted 4 pillars that had come out during the day:

- Basic values
- Fundamentals of fiscal sustainability
- Quality and access
- Leadership and collaboration.

She then commented on four themes. First in terms of program directions she noted that there has been some movement in primary care, home care, palliative care and public health. However there has
been much less action on Aboriginal health, rural health, pharmaceuticals and social determinants. Nonetheless we have gained some understanding of the continuum of care. She discussed the importance of leadership and the need for physicians to be involved. She described the challenges of quality and the need to define and measure things. We need the federal government to be involved in the definition of national standards and to support inter-jurisdictional agencies. Fiscal sustainability is a non-issue – we have enough money. The PTs need to get away from competition between governments.

Finally Jeremy Veillard Pres-Elect CAHSPR enumerated next steps – I had to leave before he finished but he did say that he was working for WHO in Europe at the time that the Romanow report came out and that Canada is looked to very favourably – which dates back to the Lalonde report of 1974.

Owen Adams
November 11/12