The Romanow Commission: Looking Back, Looking Forward

Speaking Notes for

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To

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Check against delivery
1. CONTEXT: LOOKING BACK AT THE GENESIS OF THE COMMISSION

Tom and I have agreed that we would divide our panel presentations in this fashion: I would endeavor to briefly outline the “big picture” political circumstances during this period of the National Forum’s work, and the Romanow Commission work.

In my judgment, common to both enterprises were two connected factors: a national fiscal crisis and the emergence of responses to this crisis which advocated more private funding and delivery as opposed to more public funding.

In the mid-1990’s, Ontario was enforcing the Common Sense Revolution with an emphasis on more private activity in social policy. It was supported, at varying stages and in varying degrees, by Quebec, Alberta and some of the Atlantic provinces. In some ways, the failure of federalism to respond to these challenges and the plea for privatization combined to slow, if not derail, the Forum’s work and that of the Commission.

Permit me to elaborate.

a) FPT Fiscal Pressures

Fiscal imperatives in the mid-1990’s forced severe public spending restraints on health care as evidenced by cutbacks of provincial/federal funding, the latter most markedly with the introduction of the Canada Health and Social Transfer (CHST) in the 1995 federal budget.
The CHST, as will be known to all of you today, saw Ottawa combine all of its cash and transfer point contributions to the provinces by rolling health, social services and post-secondary education into one envelope.

b) **Saskatchewan’s response**

In the early nineties, before the CHST came into being, Saskatchewan had already embarked on a number of initiatives to help bring our fiscal house into order. All governments were similarly experiencing a sharp rise in debt and debt service charges emerging from decisions made in the 1980’s.

One of the ways that Saskatchewan responded to this in the area of health, was to bring about the regionalization of health services, while concurrently closing down 52 hospitals. We argued that fiscal realities had forced us to shift more of our focus to the so-called “Second Stage” of Medicare, namely, a focus on prevention and on getting things right at the beginning.

And while we did have some modest success with these initiatives, the reality is that much of what drove our actions was, as in other provinces, the deficit/debt challenges that were staring us in the face. And the voting public knew it.

c) **Health care satisfaction in Canada plummets**

These measures had a significant toll on how Canadians came to view their health care system. Whereas Canadian satisfaction levels had been near the top of the list in international comparisons prior to the 1990s, the advent of
the kinds of dramatic cost-cutting exercises I just described caused citizen approval to plummet.

In essence, we had a system that was already increasingly under stress, now becoming overwhelmed by cutbacks. Naturally, this deterioration of such a valuable social program was deeply felt—even resented--among Canadians.

d) **Cooperative Federalism – Missing-in-Action**

Throughout all of this, the capacity for cooperative federalism to deal with the emerging challenges was greatly weakened.

During this time, Federal/Provincial/Territorial (FPT) Conferences in the area of health were sporadic, generally ill prepared and always conducted behind closed doors, with little regard to the opinions and mounting concerns of the Canadian citizenry.

Clearly, behind those closed door meetings, disputes over financing were the major cause of friction between the two orders of government.

But there was also something else that helped drive this divisive wedge. The 1990s saw more provincial governments seeking solutions outside the single payer, public model. This gave rise to a fundamental values-based debate about the basis of medicare.

Led by Ontario, and frequently supported in many ways by Alberta and some of the Atlantic provinces, the federation found itself in a two-pronged debate, about what medicare was and what it should be, plus a quarrel over money.
Arguments that framed health care as a commodity as opposed to a public good resurfaced. They clashed with three provinces that argued the contrary. And, tension was high.

An example was a pivotal meeting in Ottawa in September 2000, convened by Prime Minister Chretien to attempt to tackle these emerging financing and philosophical cleavages.

At the outset of this meeting, the First Ministers had every reason to believe that the advanced work of their Health Ministers and officials would be the basis for progress.

But, shortly after gaveling the meeting to order, the Prime Minister and five other Premiers were confronted with an “alternative document”, prepared by Ontario, Quebec, PEI, Nova Scotia and New Brunswick. The rest of the provinces like my own, had no prior knowledge of this paper.

The paper inserted the private pay and delivery option and challenged the role of Ottawa in setting meaningful directions for reform. In effect, the 5-province alternative argued against federal conditionality attached to new dollars, to which Ottawa naturally responded in a negative light.

I’ll spare you the details except to say that the morning session was abruptly adjourned within 40 minutes of having been called to order. I will tell you that on that day the Prime Minister seriously contemplated making this philosophical divide an election issue.
Real or not, this threat undoubtedly was a factor when the First Ministers did, in fact, eventually reach an agreement to spend $23.4 billion in new federal funding over 6 years. The agreement did, however, fall short of attaching more than a few federal conditions to the new spending.

And so, while there was new money, the fundamental philosophical issues and competing points of view remained unresolved.

e) The Commission emerges

A federal election was not far behind, with Chretien returning to office with a 3rd majority. He intended to restore federal-provincial relationships and regain public support for medicare by appealing to citizens and taking the debate to the public. In this context, he appointed me as a one person Commissioner on April 3, 2001 to help set out a future for Medicare in Canada.

Before the actual appointment, however, difficult negotiations about the mandate, funding and status of the Commission took place. Initially, it was suggested that I be a Task Force of one. I rejected this proposal, since I thought that the National Forum had already done this job admirably. Moreover, my view was that if we ever hoped of advancing the lofty goals outlined by the Forum, then an independent Commission was the only possible next step.

I did not wish to be an advisor to a Minister. I wished to be independent from government.

And, as a small symbolic gesture, I insisted that the headquarters of the Commission be established in Saskatchewan, the home of Tommy Douglas and
Emmett Hall. To the Prime minister’s credit, he eventually agreed and thus the Commission was established.

All the foregoing, to briefly describe the turbulent political climate at the time of the Royal Commission’s establishment, and the trickiness of trying to navigate the Royal Commission’s work.

2. THE ROMANOW PRESCRIPTIONS

The scope of the Commission’s work and its efforts to engage various wide audiences were, in my view, a success in building an evidence-based set of recommendations. The Commission undertook an innovative deliberative dialogue process, held major public hearings, commissioned over 40 research papers by experts, and maintained a website which garnered over 33 million hits over a short 18-month period.

But what was clear to me that was that we first had to determine where Canadians stood on the values debate over medicare.

It was my hope that if Canadians had a strong consensus on the values-base of Medicare, they would force governments to choose the correct path and in the consequence lessen interprovincial, jurisdictional battles.

Thus, my report recommended the enactment of a “Health Covenant” involving governments, caregivers and the public.

The idea here was to have a televised meeting where each of these players would reaffirm their rights and responsibilities to each other and to Medicare, in a way that was reflective of Canadian values.
From there, I reasoned that we could try to build an architecture for the reforms.

So, the next step of this process was to deal with the question of funding. Funding from Ottawa to the provinces had diminished below the traditional 50/50 levels. In order to regain the clout to influence change, Ottawa had to re-instate its funding role.

The key to new funding relationships, was to break up the CHST into the CHT and the CST, thereby identifying the health care and social components to Ottawa’s funding in order to achieve greater transparency and accountability.

The single-payer system was affirmed by all the evidence I had received. So, I emphasized the need to implement reforms by bringing into the single payer system such things as drug coverage.

Other areas were: catastrophic pharmacare; homecare, including palliative care and mental health services; and, a national drug formulary.

In addition to these specific reforms, I also called for a sixth principle to be added to the Canada Health Act, dealing with the issue of accountability.

Accountability was repeatedly demanded by the public to ensure that the decisions of governments would be more open and transparent.

Tied to this recommendation, I called for a Health Council of Canada to provide overall leadership, establish indicators of progress and report publicly to Canadians.

The Council would draw upon CIHI and COHTA.
The Commission called for an increase in diagnostic services with respect to the C.H.A.; steps to strengthen health records and activate the Canada Health INFOWAY.

On HHR, we called for a portion of new funds to be directed to integrated training programs as one way to facilitate primary health care innovation.

Primary health care reform was a major goal of the recommendations, and I called for a transfer of $1.5 billion over 2 years of federal funding to drive primary health care initiatives.

Finally, the Commission recommended action on the following critical issues in health:

- Rural/remote health which included a recommendation for an outreach fund;
- Aboriginal health which set out a new way to approach the coordination of programs and funding that we hoped would have the effect of giving Aboriginal people an effective voice over their health care;
- And, the Commission wrote a chapter on globalization and identified the potential dangers of international agreements to medicare’s future, calling on Ottawa's vigilance.
3. POST ROMANOW

In February 2003, fed/prov/terr governments came together and acted on the recommendations in the Romanow report by making the following commitments:

- A “covenant” committing them to a high quality, sustainable and affordable system with timely access to services – kind of a “covenant light”.
- Total new spending of $34.8 billion over 5 years, of which an estimated $13.4 billion was new money during the first 3 years.
- $2.5 billion in immediate unconditional funding for the provinces for FY 2002-03.
- $1.5 billion Diagnostic and Medical Equipment Fund for capital and training.
- A $16 billion, 5-year Health Reform Fund to be spent on initiatives in primary health care reform, catastrophic drug coverage, or home care, with funding escalating toward the end of the period.
- $1.3 billion for aboriginal health initiatives, but largely for federal government programs.
- $600 million in new money for Canada Health Infoway Inc.
- $500 million for research hospitals.
- Unspecified financial support for caregivers.
- Creation of a Health Council, mandate and composition to be negotiated by May 2003.
In February 2004, Prime Minister Martin held a televised, second conference which followed up with $40.1 billion in health care investments over 10 years.

However, with new funding also came an emphasis on wait time guarantees in 5 specific areas alongside with loosened conditionality from Ottawa to the provinces. Specifically, Quebec negotiated an asymmetrical deal, to which other provinces could also subscribe.

The overall effect of this Conference was two-fold:

First, with the traditional 50/50 funding formula restored, the provinces could no longer argue that there was a lack of federal funds for health care investments.

But, secondly, the new funds were not dedicated to buying change, since the provincial demand for unconditionally won the day.

4. CONCLUSION

It is this sad tale of a dysfunctional federalism and a divisive emotional debate over ideology that has confused some Canadians and permitted provinces to act on their own without Ottawa's leadership. As I've said, this continues until this day.

Tom Noseworthy, I believe, has drafted a chart which tries to measure the outcomes of the National Forum on Health (with his assessments thereto) and those of the Romanow report (with my assessments).
I look forward to hearing Tom’s more detailed and analytical description of the issues and, if we get around to it, giving you my personal rankings of the success in implementing the Commission’s recommendations to date.

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