Preliminary Analysis of the Romanow Report from the Canadian Health Coalition and the Canadian Labour Congress:

Overview and Broad Principles

The Romanow Report on the Future of Health Care concluded that there is a consensus among Canadians that Medicare is a moral enterprise, not a commercial venture. Canadians believe that equal and timely access to medically necessary health services on the basis of need alone is a right of citizenship. The core values which underpin Medicare remain the same - equity, fairness and solidarity. As a result, Canadians reject diluting the principles of Medicare, scrapping national standards, paying privately to get faster care, and treating health care as a business.

In his message to Canadians, Commissioner Romanow said, "I believe it is a far greater perversion of Canadian values to accept a system where money, rather than need, determines who gets access to care." The Report clearly states that Romanow challenged those advocating user fees, medical savings accounts, de-listing public services, greater privatization, and a parallel private system to provide him with evidence that these choices would improve or strengthen the health care system. He clearly said that "The evidence has not been forthcoming." There is no evidence that these solutions will deliver cheaper care or improve access to care. Further, the principles underlying these solutions are directly contradictory to the values of Canadians and the values of Medicare.

For those reasons, the Romanow Report rejects a parallel tier of private, for-profit care for the delivery of what he calls direct health care services such as medical, diagnostic and surgical care. This conclusion is to be applauded. It is based on evidence that for-profit care will harm, not improve, Medicare.

However, the Report mistakenly says that a line can be drawn between health services and ancillary services such as laundry, food preparation, cleaning, and maintenance services. These services are said to be appropriate for delivery in the private sector. The labour movement disagrees with this approach. These services are health services and those who provide them are health care workers, and they see themselves as health care workers. These services are pertinent to the health of patients. Good nutrition is critical to people who are sick, and the cleanliness of hospitals is essential to patients, staff and the public. While the Report has rejected a parallel tier of for-profit care, there does not appear to be a mechanism for ensuring that this does not happen. It does recommend that the Canada Health Act must be clarified to include these services under the Act. The Report needs to be looked at more closely.

Overall, the Romanow Report offers some important steps forward to preserving and expanding Medicare for today's and future generations, but it is just a starting point. It has established some fundamental principles which need to be built and expanded upon.

Public-Private Partnerships

The Report rejects the argument that Public-Private Partnerships to design, build and operate health facilities, such as hospitals, will save the public money. Romanow notes that these agreements have been shown to cost more over the longer term, and can have the effect of hospital bed closures and a reduction in nurses and other health staff. Romanow stops short of recommending no Public-Private Partnerships.

Medical Savings Accounts, User Fees and Co-payments, Tax Credits, and Deductibles

Romanow rejects these alternative measures to raise more funding for Medicare. In the end, all of these measures violate the core principle of equity and equal access to care based on need for care. These measures promote access based on ability to pay.

MRIs and CT Scans

The Report calls all diagnostic services required to assess a patient's need for health services to come under the conditions of the Canada Health Act, including the prohibitions of user fees, facility fees and extra-billing. The CHA should be amended to clarify this.

CHST

The Report calls for federal health funding to be taken out of the CHST and put into a new transfer - The Canada Health Transfer. This transfer would be a cash-only transfer and have an escalator clause so that federal funding would keep pace with economic growth and our ability to pay. The CLC has called for this since the CHST was put in place in 1995.

Expansion of the Public System

The Report recommends that the Canada Health Act should be revised to include home care services in priority areas. This would include post-acute home care, including drugs and rehab services, as well as coverage of palliative care in the home during the last six months of life. Also, it would include a program of support for informal care givers. Home mental health services should immediately come under the CHA. It calls for a Catastrophic Drug Transfer to help provinces with their drug plans. Eventually, the CHA would cover the cost of prescription drugs. It calls for a creation of a National Drug Agency to control costs and insure the safety of drugs and it also calls for the establishment of a National Drug Formulary to help control costs. Finally, it calls for a review of aspects of the Patent Act. There must be an effective dispute mechanism maintained in the CHA. The dedicated Health Transfer would be directly connected to the principle and conditions in the Act. The Report calls for the development of a Rural and Remote Access Fund to attract and retain health care providers, including opportunities for health professionals in training to gain experience for doctors, nurses

and other health providers. The Report states that the current status of injured workers getting preferred access to care violates the principle of equal access to care for all Canadians. The Canada Health Act allows this to take place. This exception needs to be reconsidered.

Accountability

The Report calls for the establishment of a new Canadian Health Covenant which would state Canadian values and would be a guiding force for Medicare. A Health Council of Canada would be established to analyze and assess the national health system as a whole. Membership in the Council would include the public, providers and governments. The Canada Health Act should be revised to include a Sixth Principle of Accountability.

Trade and Health Care

In recognition of the threat to health care from globalization, Romanow sends a clear message to the federal government that current protections for health care in trade agreements must not be weakened. Future expansions and actions must be protected in all future agreements. The right to regulate health care policy should not be subject to claims from foreign companies.

Primary Care Reform

The Primary Care Transfer should drive changes to the primary care system. We need a common national platform for health care reform. Prevention and promotion initiatives would be a part of this. Primary care needs to be delivered in multi-disciplinary teams in a community-based setting. All funding sources for Aboriginal health care should be pooled into a new Aboriginal Health Partnerships Fund. The goal is to improve access to care and provide adequate, stable funding. The system needs to reflect cultural diversity and language barriers to accessing care.

Funding - Making Medicare Sustainable

Civil Society organizations have called for the federal government to increase its share of health funding to 25% of publicly insured health services. The Romanow Report recommends that the federal government move to this standard by 2005-06 with increased funding in each of the next three years. The Report calls for new federal funds to bring the federal share up to 25% of insured health spending provided under current provincial plans. This will require additional investments to be added to the current level of funding. This would mean a new investment of $3.5 billion next year, 2003-04, followed by an additional $5 billion the next year, 2004-05, and a $6.5 billion increase in 2005-06. By 2005-06, these increases will bring the federal cash transfer to $15.3 billion per year. Romanow assumes that this will equal 25% of the public health services insured under provincial health plans. An escalator clause will increase this cash floor according to economic growth. These funding arrangements need to be

stable and predictable. These funds would be targeted to specific spending areas over the next two years.

	2003-04/$ billion	2004-05/$ billion
Diagnostic Services Fund	.75	.75
Rural and Remote Access	.75	.75
Primary Health Care	1.0	1.5
Home Care	1.0	1.0
Drugs	--	1.0
TOTAL	3.5	5.0

In 2005-06, the federal transfer for that year would rise from $5 billion to $6.5 billion, bringing the total federal cash transfer to $15.3 billion that year.