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# HEALTH CARE AT THE CROSSROADS

Thank you - Good Afternoon, Ladies & Gentlemen,

I really appreciate this opportunity to speak about the Canadian Health Care System because healthcare is at the top of the national agenda and I believe that we are, in fact, at a crossroads.

I am here today with some trepidation because I am not a physician or healthcare expert, so I speak as a lay person, whose knowledge is based on practical experience gained on the Board of a major hospital.

Before I became involved with Princess Margaret Hospital my only contact with healthcare was through Dr. Kildare, ER and Chicago Hope.

I should also say I am here today as a Trustee of a hospital, not as part of RBC Financial Group. In addition, as we have 38 Trustees I am sure not all of them will agree with all of my comments.

One thing about healthcare is there is no shortage of advice or counsel. Everyone has an opinion.

The national debate on healthcare has reached a new level of intensity.

Government and private sector think tank studies abound and you can find a paper to support any viewpoint you want. There have been three or four major reports over the last few years.

Just last December, the Premier's Advisory Council Report On Healthcare for Alberta which was chaired by the Right Honourable Don Mazankowski, is an excellent piece of work.

Within the next few weeks a report will be tabled by a Senate Committee chaired by the Honourable Michael Kirby which, I am sure, will also make an excellent contribution.

In addition, of course, we await the final report of the Commission on the Future of Healthcare in Canada chaired by Roy Romanow.

Following the Romanow report this fall, it seems to me that the time for talk, analysis and more commissions is over, and the time for making some major decisions and charting a new course, is at hand.

Is our present healthcare system in crisis? I guess that depends on your definition of a crisis. Is our system as good as it could be or should be? Absolutely not.

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A word about the University Health Network which is one of the largest academic health sciences centre in the country and fully affiliated with the University of Toronto.

The UHN represents the merger of three hospitals. The Toronto General on University Avenue and the Western Hospital on Bathurst Street merged in 1987. The Princess Margaret Cancer Hospital joined in 1998.

We have one Board of Trustees, one Chief Executive Officer and an integrated management structure, many shared facilities, a co-ordinated research effort, and the three hospitals continue to function under their own name.

Like all the hospitals affiliated with the U of T, our three hospitals have a proud tradition of serving the community and a colourful history.

The Toronto General, for example, was an outgrowth of The Garrison Hospital which served in the war of 1812. The first hospital building was put up in 1820 at the corner of King & John Streets. The population of the Town of York was 20,000 at the time.

The Toronto Western Hospital, at Dundas and Bathurst, was incorporated in 1896, serving the western end of the city.

The Princess Margaret Hospital was incorporated in 1954 on its Sherbourne Street site and moved to its new $275 million building on University Avenue in 1994.

At the University Health Network we have a number of major clinical and research programs. The four largest are heart and organ transplant at the Toronto General, all aspects of cancer care centered primarily at Princess Margaret, and neurosciences, diseases of the brain and nervous system, at the Toronto Western.

The University Health Network now has:

- Assets – over $1 billion
- Annual revenues of $860 million
- Almost 10,000 employees including 3,000 nurses and 600 physicians and surgeons
- Two emergency departments accepting 70,000 cases per year or 200 per day
- 65,000 inpatient and day surgery cases per year
- Spends $100 million per year on medical research.

All of our medical staff have academic appointments at the University of Toronto and we train approximately 40% of the medical students at the U of T.

All of us at the UHN are proud of our association with the University of Toronto and its medical school and we are proud of our association with the other eight hospitals affiliated with the U of T.

Now, from the vantage point of the Board of Trustees of the University Health Network, what are some of the issues we are facing?

Before commenting on some of the challenges let me say that a lot of things are going well, as funding of the healthcare system has increased from the dark days of the mid 1990s.

At the University Health Network, we are about 40% through a $350 million redevelopment of the Toronto General and Toronto Western Hospital sites, financed primarily by an innovative $280 million public bond issue – the first of its kind in Canada.

The redevelopment includes two brand new state of the art emergency departments – one at the Toronto General and one at the Toronto Western.

We have enlarged and totally rebuilt the Neurosciences Centre at the Western Hospital.

At the Toronto General, the very large Bell Wing on University Avenue was demolished last year and a magnificent new 12-floor clinical services building is now under construction.

Many hospitals in Ontario are under redevelopment and there are some brand new hospitals under construction as well.

Having said that, extremely serious issues remain.

First, UHN does 65,000 inpatient and day surgeries per year. Despite a lengthy waiting list of patients, we have had to close 15% of our operating rooms since last September due to a shortage of anesthesiologists. (We tried to keep operating rooms open).

Starting last week we began the process of gradually closing another 5% of our operating rooms.

These closures have resulted in thousands of patients being denied surgery on a timely basis.

For those of us on the Board of Trustees, this is hard to believe. Waiting lists for all types of surgery are growing and we are closing operating rooms!?

The shortage of anesthesiologists and other specialists is directly related to a decision that was made by all provincial governments and the federal government ten years ago.

A learned study was done at the time by government health economists that forecast an oversupply of physicians in ten years, i.e., right now.

Governments responded by reducing medical school enrollments by 15% and that's the major reason we have a shortage now.

A second issue our Board focuses on are problems in our emergency departments and the serious shortage of nurses. The emergency department situation has been deteriorating across Canada over the last few years.

Every few weeks we read about patients and ambulances being redirected from one hospital to another.

The problem, however, is not in the emergency department. The doctors and nurses who work in these departments are totally dedicated professionals working extraordinarily hard to care for patients as quickly as possible.

The emergency department situation is a symptom of other problems. In the last ten years, Ontario hospitals have reduced the number of acute care beds by 40%. This pattern is repeated in the other provinces.

The primary reason for these bed closures was the budget constraints in the mid-90s.

As a result, hospital staff, including thousands of nurses across the country, were laid off and many took jobs in the United States.

Nursing schools were downsized because there were fewer employment opportunities for graduates.

Today there are approximately 10% fewer nurses in Ontario per capita than there were five years ago.

Right now, today, UHN has approximately 170 vacant nursing positions.

Approximately 26% of patients arriving at our two emergency departments by ambulance each year, have to wait more than one hour before they can be off-loaded.

Some of our patients remain on stretchers in the emergency departments for up to three days until a bed is available.

In short, we can't get patients out of the ambulances into emergency because we can't get patients out of emergency into rooms, because there are no rooms due to the nursing shortage.

An excellent report done was a year ago by the Registered Nursing Association of Ontario, which examined when and why Ontario registered nurses left Canada and what will bring them back.

Ontario is now short approximately 6,000 nursing positions and there are 3200 RNs living outside Canada who have maintained their Ontario registration.

When you cut through it all, the study indicates the shortage of nurses relates primarily to the issue of job security.

Young people don't enter nursing school to make a lot of money. They go into heath care because they want to help people, they want to make a difference and they want to work with patients one on one.

Imagine going through four years of formal schooling to become a registered nurse, and then after a two or three years of work, you're laid off.

Based on the record it's hard to talk to nurses about job security.

A third subject our Board focuses on is waiting times.

Cancer patients who need surgery are now waiting an average of two months from the time of decision to treat, to surgery.

Less than half of our cancer patients receive radiation within the prescribed four weeks. Many wait 8 to 12 weeks.

The average wait time for a MRI scan in Canada is 12 weeks.

If you need a new hip or knee, the wait time is six to nine months.

I received a letter the other day from one of our eye surgeons at the Western Hospital stating he now has 274 patients on a waiting list for corneal transplant surgery. Therefore, he now books nine months out.

A fourth and important issue for our Board and Hospital Staff is that we have a serious shortage of modern medical diagnostic equipment or even a complete absence of such equipment.

For example, in layman's terms there is a machine called a PET scanner which is extremely helpful in the treatment of cancer .

In the United States there are 250 PET scanners, there are 48 in Japan, 45 in Austria, 20 in Belgium and 2 in Canada, one in Hamilton and one in Vancouver.

How can it be that we do not have one of these at the Princess Margaret Hospital or perhaps at Sunnybrook Cancer Centre.

There is such a thing as a gamma knife which is a highly sophisticated non-invasive neurosurgical instrument permitting surgeons to perform neurosurgery without an incision.

**At the Western Hospital, we have a world-class neurosciences centre and not only is there no Gamma Knife, there is not one in Canada.**

**It was announced last week that the Winnipeg Regional Health Authority has ordered Canada's first Gamma Knife. At the Toronto Western we just don't have the money.**

**There are sixty operational Gamma Knives now across the United States – 1 next year in Canada.**

**A Gamma Knife costs $6.6 million to buy, sixteen months to install and costs $1.7 million per year to run.**

**At present, we are sending patients to the U.S. for Gamma Knife treatment at an estimated cost of $37,000 per patient.**

**A fifth issue that occupies our Board is that at UHN we have a budget of $860 Million but we can't plan ahead more than perhaps six months.**

**Hospitals across Canada basically live by quarterly or sporadic funding grants which make it impossible to plan or budget ahead – even for one year.**

**The grant process and our inability to plan ahead, is a budgeting and management nightmare and creates great uncertainty for our staff.**

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So these are some of the issues we are facing. I am sure other hospitals across Canada have similar issues.

I think you will agree that these are serious problems but don't blame the doctors, nurses or other medical staff. They can only work with the resources they are given.

In my opinion, the staff at our three hospitals and health care staff generally across Canada are totally dedicated, overworked, underpaid and, frankly, under appreciated.

Over the past ten years all medical staff, have been relentlessly required to do more and more with less and less as demand for medical services outpaces human and financial resources.

Do these waiting times, professional staff shortages, lack of modern equipment and financial issues mean a crisis in healthcare? As I say, it all depends on your definition of a crisis.

I can tell you if all of this happened at the firm I work for, it would be regarded as a major crisis.

There is no silver bullet or short-term resolution to these problems.

No matter what decisions are made or how much money is allocated, the shortage of nurses and medical specialists is going to get worse over the next few years because it takes four to ten years to train these people.

It takes ten years to train an anesthetist – four years medical school, four years residency and two years fellowship. The shortage of anesthetists will take years to resolve.

Anyone who thinks the United States has all the answers should think again. Many Americans have no healthcare insurance and very limited access to the system. This would be totally unacceptable to us in Canada.

The nursing shortage is worldwide. Teams from U.S. hospitals and Europe comb the world for nursing recruits.

In Australia the shortage of nurses became so acute the government has offered free tuition for anyone entering nursing school.

At the end of the day I'm not sure it's particularly productive to travel the world in search of a better healthcare format.

Far better to focus on our own system, which in many respects has served us well, and figure out how we can do it better.

As a starter, I don't want to read another healthcare report which says we should run our hospitals more efficiently. In my view, that's just a complete cop-out.

The time of lay-offs, cutbacks, reduced capital spending and doing more with less in Canadian hospitals is over.

Hospitals should be run on a financially sound basis but hospitals are not a business, they are healthcare institutions designed to treat and look after patients.

Sometimes we forget that hospitals are not car, television or widget factories which you can press to the limit in the endless pursuit of super efficiency.

You can't treat professionals in healthcare as so many production line workers where you set quotas and productivity targets and you can't, or shouldn't, treat patients like robots.

Hospitals are no different than great private sector companies.

If you don't invest for the future, if you don't have access to capital, if you can't attract bright, young energetic people and convince them there is a long term future in healthcare, your franchise and reputation will go into serious decline.

Based on my experience in business over the last 40 years, and more recently as a hospital board member, I can tell you major hospitals across this country, which are the life blood of our healthcare system are suffering from acute financial paralysis.

If we are not prepared to make some major changes and chart a new course now, we will witness a silent national tragedy as these great institutions decline into mediocrity.

How many times have we heard over the past few years that our present healthcare system is not sustainable?

The real question is -- who would want to sustain our present system at current service levels, with long waiting lists and serious shortages of both professional staff and modern equipment?

We must set our sights a little higher with the objective of restoring our hospitals and healthcare to a more appropriate level.

I would like to table four recommendations which would substantially improve our hospitals and healthcare system over five years.

First, I recommend the Federal government should establish the standards and specifications for a national healthcare information technology system including an electronic healthcare card or electronic medical record – which would also include prescription drugs.

**The Federal government should set out the national standards but the system should be built by the private sector or perhaps by a public/private partnership.**

**Information technology in the healthcare industry across Canada is in the dark ages and the system is drowning in paper.**

**In terms of information technology I would say the healthcare industry is perhaps twenty years behind the Canadian banking system.**

**We will never control the cost of health care without significant new capital investment in information technology. Healthcare must be brought into the new world of web based information systems – and that takes money.**

**Banking and healthcare are similar insofar as both deal with virtually all Canadians coast to coast.**

**Expenses of the Canadian banking industry run about $40 billion annually and health care expenditures are about $100 billion. So the healthcare industry is approximately 2½ times the size of the banking business.**

**Over the last 25 years, Canadian banks have been world leaders in developing new web based systems and technology infrastructure. The result has been a quantum increase in productivity and efficiency.**

**Our highly centralized, state controlled health care industry on the other hand, has not invested in new technology and information systems and we are reaping the consequences.**

**Just consider the record of the banking business.**

The Visa card was introduced by the Canadian banks in 1967 – one year after the Federal Medicare Act.

The first automatic banking machine was introduced in 1975, telephone banking was introduced in 1987, the debit card in 1993, discount brokerage over the telephone in 1993 and banking on the internet in 1997. All of this technology required major upfront capital investment.

Without this technology and the systems that go with it, there is no conceivable way the financial services business in Canada could handle the number and variety of transactions it does today on a manual basis.

At RBC, for example we routinely process in excess of six million transactions per day. Try doing that with hand written manual systems.

Collectively the Canadian banks probably now have at least six million customers banking electronically on the internet despite the fact it only arrived on the scene in 1997. This is the type of quantum change we need in healthcare.

Why is it the banking industry can develop cards where you can access your bank accounts, do transactions from tens of thousands of automatic banking machines, not only across Canada but from just about anywhere in the world yet an Electronic Medical Record has not been developed for the healthcare industry.

Why is it that virtually any Canadian can access a bank account or investment account, 24 hours a day, through the Internet, pay bills, buy and sell securities but to gather up medical records one has to visit two or three hospitals, a couple of clinics and end up with a mountain of paper - much of which is indecipherable scribblings.

Technology and web-based systems can do for healthcare what they have done for banking. Proven technology already exists.

Worse still, the major medical complexes across Canada are developing their own information technology systems of one form or another but they won't be able to talk to one another.

We, and our doctors, should have card and Internet access to our healthcare records so that individual patients can move from hospital to hospital, clinic to clinic or from Toronto to Halifax to Vancouver and be able to access their medical records at any time from any location.

In the United States, a 1999 study by the Institute of Medicine, estimated there were 45,000 deaths annually in the United States due to medical error. A significant number of these deaths resulted from misinterpreted hand written prescriptions or incorrect drug dosage.

In response to this problem, several major have warned they will direct their employees and their families only to hospitals which require the use of Computerized Physician Order Entry.

Currently, only 3% of the 5,500 U.S. hospitals have Computerized Order Entry but there is now a buying spree to implement this new technology.

The Federal government should require a uniform Computerized Physical Order Entry system across Canada.

Things are moving fast. In the U.S., twenty-two states have already mandated that every hospital must implement an electronic health record or they won't get certified.

When, as a country we are spending $100 billion a year on healthcare can we afford say $750 million or a billion a year for five years to develop, in stages, a national web based electronic health record system which would save us billions annually.

I say we can't afford not to.

In my view, the most important single recommendation put out by the Mazankowski report was to "develop and implement an electronic health record for Albertans starting with an electronic healthcare card" and "to provide long term financial funding to develop and implement information technology systems".

My only issue is that I believe it should be a national electronic health record – no need to reinvent the wheel ten times.

The Federal government made an initial step in 2000 by establishing Canada Health Infoway, capitalized at $500 million, an independent "not for profit corporation" to establish an effective electronic health record with compatible standards on a pro-Canadian basis.

That's exactly what we want but the whole initiative is moving far too slowly and it should be implemented by the private sector – not a government bureaucracy.

There are people within a few blocks of this hotel who are totally qualified to draw up the specifications for such a national system. There are companies with proven records who could build and implement the system, it's just a case of getting on with it now.

My second recommendation is that our governments should focus our scarce public healthcare dollars on patient care and not ancillary assets or services.

For example, the provinces have billions of dollars tied up in land and buildings which are just bricks and mortar and have nothing to do with healthcare.

You don't have to own the land, the hospital or even the equipment to provide top flight healthcare.

For example, at Royal Bank, three years ago we decided we were not in the real estate business and we sold our major buildings and the land under them for $827 million and redeployed the capital in our core business of financial services.

Our governments which run the healthcare industry should do the same.

In this regard hats off to Superbuild here in Ontario which is moving aggressively to find new and more efficient ways to finance bricks and mortar through the private sector.

Authorization for the University Health Network to do a $280 million bond issue was a good start.

There are two or three major companies in Britain which specialize in building, equipping and maintaining hospitals and leasing them back to governments under very long term leases. This makes good economic sense.

The simple fact is that private sector companies can build and maintain a hospital more cheaply than the government.

These private companies are not involved in any aspect of patient care, they just do what the private sector does best and it frees up valuable healthcare capital to focus on patient care.

Superbuild is now proceeding to finance a major new $300 million redevelopment of the William Osler Health Centre in Brampton and a $100 million redevelopment of the Royal Ottawa Hospital in this fashion – that 's progress.

Apart from real estate and hospital maintenance, there are many non-direct patient care sectors of the healthcare industry which could outsourced.

Do hospitals have to own their own laundries, boilers and steam systems – the answer is "no".

Lab testing is a big expense item and maybe several hospitals should get together and put their testing labs into a company and take it public or sell out to an existing private sector company that is in the lab testing business.

A third recommendation I would make is that it is absolutely essential our governments move to multi-year funding of our hospitals.

The highly volatile funding of healthcare over the past ten years is directly related to the stop and go policies of the Federal government which itself has no long term healthcare funding policy in place.

The present stop and go approach makes it impossible to plan ahead and injects a high degree of uncertainty into our financial planning.

Erratic funding from governments results in very expensive mistakes.

For example, in 1996 the Vancouver General built a brand new $280 million 18-storey hospital tower right next door.

The building was completed three years ago and now three floors are occupied by offices and fifteen floors are totally vacant because there is no money to equip and operate the hospital.

A long term funding formula could and should be implemented for healthcare in Canada.

Since 1990 Canada's healthcare expense to GDP ratio has fluctuated between 8.9% and 9.9%. The ratio is projected to have declined slightly in the year 2000 to 9.1% and risen to 9.4% in 2001.

The records show that in 1998, Canada and France had the third highest total healthcare expenditure as a percentage of GDP among the G-7 countries and the United States was the highest at 12.9% of GDP. Germany was at 10.3%.

Why can't our governments just agree that we will spend 10% of our GDP on healthcare with an appropriate cap rate just in case inflation gets out of hand or economic growth accelerates to unsustainable levels? Maybe it should be on a rolling three year average of GDP.

In that environment each hospital and sector of the healthcare industry could be given a base funding figure for the start of the next fiscal year and in subsequent years this base would automatically increase by the rate of growth in GNP.

I am sure experts would come up with 125 reasons why we can't have a long term funding formula but if we really worked at it, I am sure we could.

A multi-year funding formula would bring a discipline to the system and would be a huge plus for healthcare planning.

Finally, let me address the delicate subject of the Canada Health Act and Funding.

In my view, the Canada Health Act should be redone. As presently constituted it is a statement of high and well meaning principles expressed with wording so vague as to be subject to a wide variety of interpretations which causes confusion and dissention.

The fundamentals of the Canada Health Act date back thirty-five years to the Medicare Act of 1967. It was updated in 1984 when the Federal Government banned extra billing.

Healthcare has changed a thousand-fold since Medicare was introduced in 1967.

Even now we are not living up to the five major principles of the Canada Health Act.

For example, the Canada Health Act talks about comprehensive coverage – all medically necessary services must be insured.

The problem is there is no definition of what is "comprehensive or medically necessary" and with the huge assortment of new diagnostic tools, medical treatments and drugs developed over the past several decades, many services which most people would deem medically necessary are not covered.

Canadians spent $12.3 billion on prescriptions drugs last year. If you are prescribed drugs in a hospital they are covered, if you take the same drugs at home you pay for them yourself. I imagine paying for something yourself.

What is deemed medically necessary in one province is not covered in another. It is a labyrinthe.

The Canada Health Act talks about accessibility – "reasonable access by insured persons unimpeded by financial or other barriers."

It sounds great. Is two months access for cancer surgery reasonable access? Is waiting three days on a stretcher in emergency for a hospital bed reasonable access? I don't think so!

How do we insure equal access under the Canada Health Act? The answer is the waiting list. A waiting list for almost every service. In effect, the waiting list is "the great leveler" of the Canadian Healthcare system. I think we can do better than that.

We should think carefully about what the Canada Health Act actually says and what are the unintended consequences.

By mandating universal access and equal treatment for all and banning extra billing in any form, the Canada Health Act is actually saying that –

"if we can't afford top level healthcare for everyone on the same terms, then we will reduce the standard of healthcare to a level which we can afford", i.e. reduce everyone to the lowest common denominator and I ask –is that what we want?

A second consequence of this legislation is that if we can't afford top level of healthcare for everyone, then we'll make sure that no one can have access to it because there is no extra billing – again is this what we want?

In terms of additional funding, I am not in favour of "user fees" for basic healthcare services or doctors' visits because they would raise a very modest amount of money and while they might reduce demands on the system, even a low user fee may cause some low income people not to seek treatment.

A more basic issue is the ban on extra billing for more exotic medical services and treatments over and above basic healthcare – a hip or knee replacement to facilitate a better golf game, for example. Should that be covered?

The Canada Health Act basically says to Canadians:
"Here is the base level of healthcare we will provide you and if you want more or faster, too bad". Again, is that what we want?

Would it not be better to say "here is the base level of healthcare we will provide and if you want more, you will have to pay for it directly or through a privately funded insurance program."

Canadians buy life insurance, house insurance, car insurance, travel insurance – why not insurance for incremental medical services over and above the norm?

From the standpoint of a hospital Board of Trustees, we don't really care where increased funding comes from, we just know it's absolutely essential if we want to restore patient care in our hospitals to an acceptable level.

If our governments can provide the additional funding – fine.

If our governments cannot provide additional funding, then they should change the rules and regulations to permit private sector funds to flow into the system.

It's a clear choice - one or the other. We can't stonewall any longer.

Personally, I support universal access and equal treatment for all for a base level of clearly defined medical and healthcare services on a uniform basis across Canada but over and above that, people should have to pay either directly or through a privately funded insurance plan.

Healthcare in Canada has suffered from "benign neglect" and a refusal to make decisions.

We have reached the point in healthcare funding where any decision is better than no decision. I always say "when you come to a fork in the road – take it".

Healthcare workers across Canada as well as hospital management and Boards are tired of the eternal wrangling between the provinces and the Federal government.

The provinces have important responsibilities to deliver healthcare but they have the worst of all worlds – the responsibility for healthcare but not the authority or the taxing power.

Healthcare expenditures are growing more than twice as fast as the economy. Last year Canadians spent $12.3 billion on prescribed drugs – up 64% in just five years – an annul growth rate of 11%.

Last year in the United States, Americans purchased $154 billion of prescription drugs – a 17% year-over-year increase. There are now about 10,000 prescription drugs and the number is increasing exponentially.

Ontario is already spending 44% of its budget on healthcare and within a few years, it will blast through 50% crowding out education and other important priorities. Is that what we want? I don't think so.

The time for action is now.

The Federal government controls the purse strings, the Federal government controls the all important Canada Health Act and the Federal government can implement national standards.

Accordingly, responsibility for charting a new course to restore healthcare in Canada lies squarely and unequivocally with the Federal government.

At this crucial time, Mr. Romanow has an incredible one time opportunity to make a huge contribution to the future of healthcare in Canada.

I urge Mr. Romanow to deliver one clear cut comprehensive plan – not a range of potential solutions to be further debated – been there, done that.

I urge Mr. Romanow to set aside the vocal special interest and activist groups who are trying to block reform and progress at every turn. Let's for once do what is right for the silent majority.

There are many vested interests which benefit from current inefficiencies in healthcare.

I urge Mr. Romanow to be crystal clear on user fees and extra billing and to state specifically how we should fund healthcare reform and provide for increasing health expenditures – is it public money or is it private – because it's one or the other. He himself has stated in his interim report that the "status quo" is not an option.

Extra billing is a key issue. That's when we will find out what happens when an unstoppable force collides with an immobile object.

We can no longer neglect of our healthcare system and hospitals.

If we make the right decisions now, we can effectively deal with these issues over perhaps five years and have a much improved healthcare system for all Canadians.

It can be done, it just takes a little leadership – first to admit we have a serious problem, second to actually make some major decisions about charting a new course and finally to allocate the required resources.

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