

Response to the Romanow Report

Part 1

Remarks to the
The Canadian Club of Toronto
by

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Standing Senate Committee on
Social Affairs, Science and Technology

December 2, 2002

(Part 2 of the response to the Romanow Report will be given to the Halifax Chamber of Commerce on Wednesday, December 4)

Introduction

With the release of Mr. Romanow's report last week, the badly needed national health care debate is now fully engaged. As you know, the Senate Social Affairs Committee released its final health care report just over a month ago. So we now have on the table two thorough and well-researched proposed national strategies for health care reform. Both are consistent in many respects, although Mr. Romanow's recommendations differ from those of the Senate Committee in several important ways.

Canadians, and in particular opinion leaders in health care and in the community at large, must take a hard look at the proposals that are on the table and make their voices heard in the discussion about what should be done now. The final decisions will rest with our provincial, territorial and federal governments. But make no mistake about two things:

- First, reports and their recommendations are one thing. Now is the time for action! Further delay in reforming the system is *not* an option!
- Second, governments are listening. Your voice will be heard if you make the effort. The outcome of the forthcoming debate, and its translation into action by our federal, provincial and territorial governments depends, very much on people like you in this room making your views known clearly, strongly, and publicly.

I am very pleased to have been asked to speak to you today, and to be able to make my first public comments on the health care issue since Mr. Romanow released his report.

Today I will present the first part of a two-part response to the Romanow Report. There is too much to cover in the time available to me today so I will focus this afternoon on issues relating to the restructuring of Medicare and the provision of timely care. I will complete the picture with the second part of the response on Wednesday, in Halifax. At that time I will address the issues of what should be done to close some of the gaps in the health care safety net, to enhance accountability, how to minimize federal-provincial conflict and how to pay for reform of the health care system.

Let me begin by congratulating Mr. Romanow on the release of his long-awaited report. As I know only too well, recommending change to Canada's most-cherished social program is neither a simple, nor a universally-appreciated task.

The Senate Committee was pleased to see that Mr. Romanow has reached many of the same conclusions as we did in our final report, especially with regard to defining the major goals of health care reform in Canada. He has strongly reaffirmed, as did the Committee, that the single-payer public insurance system must be maintained. He has joined us in pointing to the need to make health care delivery more efficient and more effective, and in stressing the importance of improving patient service.

To this end, he has made a number of recommendations that are the same as the Committee put forward a month ago, such as reducing waiting times and reforming primary care. Moreover, many of his proposals for expanding the areas covered by public insurance in Canada echo those advanced by the Committee. He has called for a program

to protect Canadians against very high prescription drug costs, for a limited national home care program as well as for a palliative care initiative – all areas covered by the Committee's recommendations.

He has also come in with an estimate of the costs for implementing his recommendations that is in the same ballpark as the Committee's figure of \$5 billion new dollars are needed annually.

Nevertheless, between Mr. Romanow's report and that of the Senate Committee there are a number of key differences with regard to the means and the methods to be employed to achieve these shared objectives. We are glad that the debate can now focus on how best to attain a set of goals that we share. The means that are chosen are of no small significance – some means are more efficient than others, some lead to better outcomes for patients and some are more effective at reducing federal-provincial squabbling.

The comments on the Romanow report that follow should not be seen as having a personal dimension. This is not Kirby versus Romanow, as some of the media have occasionally made it out. In the marketplace of public policy ideas, reasonable people can, and indeed often do, have honest differences of opinion. This is what a public policy debate is all about.

Today, I would like to address three topics :

1. The measures proposed in the Senate Committee's report to make the publicly funded hospital and doctor system more efficient;
2. Our recommendations for renewing and strengthening the infrastructure of the system; and
3. Our proposals for dealing with the number one health care issue of concern to Canadians – excessively long waiting times for diagnosis and treatment.

In each case, I will indicate how the proposals and recommendations we put forward in the Senate Committee's report differ from Mr. Romanow's. For example, the last issue I just mentioned illustrates clearly one of the key differences between Mr. Romanow and the Senate Committee. We propose a way to implement a Care Guarantee that will ensure that Canadians receive timely access to services. Mr. Romanow offers no meaningful solution to the waiting time problem.

Hospital-Doctor Efficiency Measures: Incentives Instead of Top-Down Micro-Management

Relatively early in its deliberations, the Committee recognized that it had to make a fundamental choice with regard to its approach to health care reform. Were our recommendations to be based on maintaining the current system in which provincial

governments, in order to save money, try to micro-manage hospitals and, in some cases, even regulate how people should do their jobs? Or was there an alternative approach that would see government set the ground rules, but leave people the freedom to figure out the best way to get the job done? That is, should government row, or should it simply steer?

The Committee felt strongly that the first approach, command and control, was not the right one. It was painfully apparent to us that attempts by governments over the past many years to achieve increasingly close regulation of the health care delivery system are not working. We concluded that government micro-management of a system as complex as health care was simply impossible, and that continued efforts to impose such control would lead not only to more failure but also result in stifling, rather than fostering, the kinds of reform that are needed.

The Committee therefore opted in favour of the creation of a set of *incentives* – incentives that would lead people to behave in a way that we believe is in the public interest while making decisions based on their own self-interest. We recognized that the incentives for each of the players in the health care system would have to be structured in such a way that they would lead to the kind of behavioural changes that are needed to make the system both more efficient and more effective in delivering, in a timely fashion, the services people need. Therefore our recommended incentives were chosen after the Committee first decided on the behavioural changes we wanted to encourage.

Let me give you two examples of how this approach is reflected in the Committee's recommendations.

First, our report proposes that the way in which hospitals are funded be transformed. We believe we must move away from the current practice of giving hospitals global budgets based largely on historical spending patterns. Instead, we propose to fund hospitals on the basis of the services that they actually deliver. We call this *service-based funding*. It means simply that fixed prices are established for different procedures, and hospital funding is based on how many of each kind of procedure a hospital actually performs. In other words, hospitals would be paid for what they do, provided, of course, they do it well. Service-based funding is not a novel concept. It is used throughout the economy.

The evidence we heard made it clear to our Committee that the incentives built into this kind of funding would generate a number of significant benefits. They would:

- encourage institutions to improve their operating efficiencies, since they get to keep any money saved;
- enhance the ability of managers to manage, because it becomes necessary to know how efficiently the institution is performing each and every procedure;
- make the costs of various procedures more transparent and improve accountability;
- create competition between institutions, encourage specialization and stimulate the development of centres of excellence.

- encourage institutions to improve patient service, since revenue depends on numbers of patients treated (subject, of course, to the proviso that all services provided meet a high standard of quality and satisfactory outcomes);

Given the significant advantages that come with service based funding, it came as no surprise to the Committee that the vast majority of CEOs of major health care institutions with whom we consulted were in favour of this change in funding method. One of the things that most major hospital CEOs told us was that they currently spend in the neighbourhood of 30% of their time haggling with provincial bureaucrats. What a colossal waste of senior management time! Moving toward service-based funding will eliminate much, if not all, of this wrangling since the government will no longer be involved in the micro-management of hospital budgets.

There is also an important synergy between this method of funding and improving the quality of health care services that patients receive. Every research study indicates that if there is one correlation that holds throughout the health care sector it is the link between increasing volume and improved quality. The more frequently a particular procedure is performed, the better the patient outcomes. By encouraging hospitals to specialize and by linking remuneration to the number and type of procedures, we not only drive efficiency, we also enhance quality.

Finally, the shift to service based funding would have the effect of lowering the volume on another peculiarly Canadian debate – whether services should be delivered by the

public or private sector. With service based funding, the government as insurer or funder, would become neutral, or indifferent, with respect to who actually delivers the service.

This is already the case in many areas of the health care sector, although many people are reluctant to recognize it. The principle of public administration in the *Canada Health Act*, one of the famous five, refers *only* to how health care is paid for, not by whom it is provided.

For example, any hospital that contracts out its laundry, housekeeping or cafeteria services is channelling public funds into private sector service delivery. As long as service quality is maintained at a competitive price, government, as funder of the system, as well as the managers of institutions and patients themselves should be indifferent to the contracting out of services. If service based funding were to be implemented, this same logic would apply throughout the hospital sector – it would not matter who delivered the service, as long as they did so at an agreed, competitive price and with appropriate guarantees of access and quality.

Not only is such private delivery of publicly funded services *not* outlawed under the Canada Health Act, it is an integral part of health care delivery in Canada and has been since the inception of Medicare some 40 years ago. Just think of the private labs, x-ray clinics and other such institutions that exist across the country. Think of hospitals, for that matter, almost none of which are government-owned. Think of physicians, almost all of

whom are self-employed professionals operating what amounts to independent small businesses.

The Committee is not proposing to change the *Canada Health Act* to allow greater private sector involvement, nor is the Committee advocating in favour of expanding private delivery. What we are saying is that with the set of incentives we propose, it will not be government that decides who actually delivers each and every service. Patients, or regional health authorities acting on their behalf, will seek services from those institutes that can provide them most quickly and conveniently.

Let me be very clear that the comments I have just made apply only to the *delivery* of health care services. The Committee believes strongly that Canada's single public funder model must be maintained for hospital and doctor services. Not only does a single public insurer/funder mean that everyone gets treated equally, but it is also enormously more efficient than the often-advocated funding model that mixes public pay and private pay patients, that is, the "two-tier" model we hear so much about.

The second example of the use of incentives to achieve behavioural change that I want to highlight is in the area of primary care reform. Primary health care constitutes a patient's first point of contact with the health care system, and includes many things, ranging from the diagnosis, treatment and management of health problems to illness prevention and health promotion.

At present, primary care delivery in Canada revolves mainly around family physicians and general practitioners working solo or in small group practices. Approximately one-third of primary care physicians work alone; fewer than 10 percent work in multidisciplinary practices. The vast majority of primary care practices are owned and managed by physicians. Fee-for-service payment is the dominant form of general practitioner remuneration.

There are a number of major weaknesses and problems with the way in which primary care is generally delivered in Canada:

- Care and services are fragmented;
- Inefficient use is made of many health care providers, such as nurses and nurse practitioners, who have very limited opportunity to use the knowledge and skills learned during their publicly-financed training;
- Care is often not available after hours and on weekends (when most people need it); and
- There is a lack of emphasis on health promotion and illness prevention;

Many of these difficulties can be traced to a misalignment of incentives with desired behaviour. Fee-for-service remuneration rewards episodic more than continuing care, fast “through-put” of patients, and dealing with simple procedures more than challenging ones. Moreover, it discourages family practitioners from having nurses, nurse-practitioners, psychologists, and other health professionals do all the things they are fully qualified to do. This should not be taken as a criticism of family physicians. Far from it!

They are merely responding, as any rational person would, to the incentives now present in the fee-for-service system.

The Committee has proposed that primary care delivery be reorganized by changing the way family practitioners are remunerated. We think that fee-for-service should be replaced by a system based mainly on capitation. Under this system, patients enrol with a group practice and the group receives an annual payment based on the number of patients on its list, weighted for such factors as age and gender. This annual payment is made regardless of whether each patient is seen once or twenty times during the year.

Creating these primary care groups will generate significant benefits:

- Patients will be guaranteed access on a 24/7 basis to their *own team* of doctors and other providers;
- It will be possible to utilize better the full spectrum of health care providers, and to coordinate better patient services through interdisciplinary teamwork – primary care groups would, in effect, provide “one-stop shopping” for all the health care needs of the people they serve;
- There are potential cost savings in the longer term by reducing demand on expensive emergency rooms and specialists’ services and by making sure that the most appropriately qualified professional handles each task;
- It becomes easier to integrate the provision of health promotion and illness prevention measures into patient care.

But perceptive listeners might be asking themselves: “Is the Senate Committee not being contradictory?” If fee-for service is bad for primary care why is it good for hospitals? If global budgets are bad for hospitals why would their equivalent, capitation based funding, be good for primary care?

The answer to this apparent contradiction lies in understanding the different impact that the same payment system can have under differing circumstances. Both fee-for-service and service based funding encourage providers (doctors or hospitals) to increase the volume of services that they deliver.

In the case of doctors, this can lead to placing greater emphasis on “through-put”, the numbers of patients seen. This can sometimes occur at the expense of patients with complex problems, those requiring continuing care, and, as is all-too-often the case, by neglecting to provide help to those seeking to prevent illness. This is why our Committee believes that alternative forms of funding must be introduced for primary care physicians.

In the case of hospitals, however, an incentive to provide more services is precisely what is needed, given the current waiting lists. Measures to compare the quality and outcomes of hospital care are available now and therefore a shift towards service based funding would prove beneficial. In other words, incentives must be tailored to encourage the kind of behaviour that is required in different parts of a reformed health care system.

In contrast to the Senate Committee, Mr. Romanow is silent about the method by which hospitals are funded. Some have argued that global funding promotes greater stability and also that the accounting procedures necessary to introduce and sustain service-based funding will divert funds unnecessarily from patient care. These are important points in favour, but the Senate Committee thought them outweighed by the “downside” of global funding – that it will maintain the inefficient and ineffective, top-down micro-management of hospitals by government. The Committee is therefore convinced that the method of funding hospitals must be changed.

Moreover, recognizing the importance of not diverting money from patient care, the Senate Committee also recommended that the federal government fund one hundred per cent of the cost of building the management information system required to make service-based funding possible.

Mr. Romanow’s report is completely silent on issues relating to teaching hospitals and hospitals in urban areas. Unlike the Senate Committee, Mr. Romanow is also adamantly opposed to any expansion of the role of the private sector in health care delivery. In fact, he also implicitly questions the role that is currently allowed the private sector under the *Canada Health Act*. As I said previously, it is the Senate Committee’s view that who provides care is essentially immaterial provided the quality of care is assured and its cost is competitive.

As has the Senate Committee and every provincial commission over the past few years, Mr. Romanow has come out strongly in favour of primary care reform, and has proposed a significant short-term investment by the federal government to make reform happen. We all share the same goals and understanding of the significant benefits that reform in this area will produce.

Rebuild and Expand Infrastructure: Teaching Hospitals, Information Systems, Human Resources and Research

I now turn to my second topic: rebuilding and expanding the infrastructure of the health care system.

Health care infrastructure has been woefully under-funded in this country. Canada can't have a sustainable health care system over the long term without a significant reinvestment in infrastructure. We now rank near the bottom of OECD countries in terms of the availability of many important pieces of diagnostic equipment. We have allowed our capital stock to deteriorate and we are facing shortages of health care personnel across the board. Short-term savings were made in the 90s by deferring investment in health care infrastructure, but we will be long-term losers unless this accumulated shortfall is addressed, starting immediately.

The Committee has taken a broad view of what falls under the category of health care infrastructure. I want to speak briefly about the need for significant *federal* investment in four areas of infrastructure: the physical plant and equipment of Canada's teaching hospitals, information systems including the patient Electronic Health Record, health research and health human resources.

First, the federal government should invest in the renewal of physical plant and equipment urgently needed in Canada's teaching hospitals.

Two facts, out of many I could give you, illustrate the urgency of this need:

- Between 1982 and 1998, real public per capita spending on new hospital construction declined by 5.3% annually; in dollar terms investment dropped from \$50 to \$2 per person over those 16 years.
- Since 1998, real public per capita expenditures on new hospital machinery and equipment has also *fallen* by 1.8% annually.

In addition to being the primary site of training for Canada's health care professionals, teaching hospitals offer the newest and most highly sophisticated services and treat the most difficult, complex cases. They are truly a *national* resource, and as such must be supported by the federal government. It is only by providing adequate funding to our teaching hospitals that it will be possible for Canada to develop genuine centres of excellence, and to be at the forefront of the scientific advances that are continually transforming the practice of medicine. As well, it is only by being at the leading edge that

we will be able to derive the potentially significant economic benefits which are likely to result from the commercialization of the next generation of medical research results.

That is not to deny the need for reinvestment in the capital structures and equipment of community hospitals. That has to be done too. But, in our Committee's opinion, reinvestment should begin first in teaching hospitals for all the reasons I have mentioned.

Second, the federal government should fund the development of a national health information system, which can be used in hospitals and doctors offices across the country.

Despite the importance of information management to good outcomes in health care delivery, Canada's health care system has little capacity for health information management and does not make use of management information technology to anywhere near the same extent as other information-intensive industries. In fact, what we have in this country was described to the Committee as a "patchwork of unconnected information technology projects." Surely, if I can withdraw money from my bank account from just about any ATM anywhere in the world and securely access my account record via the internet, then Canada should be able to put in place a single system that allows one hospital, or one physician, for that matter, to exchange patient information with another within the same country.

Although much good work has been undertaken, a truly national system of patient Electronic Health Records is still far from a reality. That such a system would help make real the portability clause of the *Canada Health Act* is obvious. It would also lay the foundation for meaningful comparisons of the efficiency of different health care institutions, and of health outcomes at various institutions across the country. The creation of a truly national system of Electronic Health Records is one of the cornerstones of our Committee's strategy to bring the health care industry first into the late 20th century and then fully into the 21st century. We consider it a national priority and believe that it should be entirely funded by the federal government.

Third, a dynamic and innovative health research sector is a vital necessity, not only for ensuring the sustainability and the quality of the health care system itself, but also as a major contributor to economic growth in this country.

The creation of the Canadian Institutes of Health Research by the federal government in 2000 represented a major step forward in consolidating and strengthening the country's efforts in health research. But more needs to be done to ensure adequate long-term funding for health research. The Committee has recommended that the federal government move as quickly as possible to bring funding for health research to one per cent of total health care spending. In our view, this represents the minimum required to keep Canada internationally competitive. To meet this target will require almost doubling the current budget of the CIHR.

Finally, our Committee has defined infrastructure of the health care system to include the education and training of the people who do the job of providing health care to Canadians.

A national strategy is needed in order to make Canada self-sufficient in health human resources. The Committee has therefore recommended the creation of a National Coordinating Committee that would bring together the different levels of government and the key stakeholders to develop and guide the implementation of such a strategy.

In the short term, more money is needed to boost enrolment in educational and training programs for all health care professions. The Committee recommended that the federal government do its share by buying places at educational institutions so that more doctors, nurses, and other health care professionals can be educated and trained. By focussing its efforts on funding places at medical, nursing and other faculties, the federal government can lend much-needed assistance to the provinces without interfering directly in their area of jurisdiction.

Mr. Romanow has not addressed the health infrastructure issue directly in the way that the Senate Committee has. Nonetheless, the general thrust of his proposals with respect to information systems and Electronic Health Records are similar to those proposed by the Committee. However, our two reports differ quite significantly on the methods by which the federal government should fund these investments.

Mr. Romanow echoed the Committee's call to boost funding for research, but unlike the Committee he does not recommend a specific amount of money or address the issue of where the money should come from.

In other infrastructure areas his report is regrettably short on detail, especially in terms of estimating the cost of implementing the general objectives he has endorsed. Thus, he does not propose any special investment be made in teaching hospitals or provide any additional funding for the creation of a national system of Electronic Health Records.

Perhaps most surprisingly, he sets no specific targets for increasing the supply of either doctors or nurses in this country, and consequently does not target any specific funding towards the education and training of health care professionals. In reading through Mr. Romanow's report, one is left wondering to what extent he truly believes that there is really a shortage of doctors and nurses in Canada. Moreover, as I previously observed, there is scarcely a word about hospitals to be found anywhere in Mr. Romanow's report. This strikes me as a particularly grave oversight, especially with respect to the urgent needs of Canada's teaching hospitals.

In contrast to Mr. Romanow, the Committee has carefully laid out a plan that contains precise objectives to be met in all critical infrastructure areas, and provides the funding required to meet them. This reflects the Committee's belief that a broad range of investments in the infrastructure of the Canadian health care system is absolutely essential to its renewal and long-term sustainability.

The Care Guarantee: Ensuring the *Timely* Treatment of Patients

I turn now to the health care issue of greatest concern to Canadians – excessively long waiting times for diagnosis and treatment.

There is little doubt that long waiting times for access to diagnostic services and for treatment are the principal worry that Canadians have about their publicly funded health care system. “Will the system be there when I need it?” is a question one hears all the time. Although hard data on the full extent of the waiting time problem is impossible to obtain, there is sufficient polling and anecdotal evidence to indicate that, to the average Canadian, fixing the system means reducing waiting times. Canadians *deserve* to feel secure in the knowledge that they will receive timely treatment.

The Committee thought long and hard about how to achieve this objective. In a system that strives to treat everyone equally, waiting times increase when there are insufficient resources available to meet demand. The rules of supply and demand apply to health care as elsewhere. We know that there is not enough equipment, and that there are too few health care professionals available to provide care where it is wanted and needed. We know that more money is needed.

But the most important question is: how do we prevent future investments from simply getting swallowed up without improving the situation for those who count the most – patients? After all, patients are the people who should be at the centre of it all – the people our health care system is there to serve. Too often in recent years this patient focus has been neglected!

For too long, governments have seen cost cutting as their preferred, and easiest, policy option. The brunt of these cuts, particularly during the 90s, has been borne by front-line workers who experienced increased workloads, and by patients who were forced to wait longer for service. Those in government who made the decisions to cut resources and avoid disciplined waiting lists were not directly affected. They suffered no consequences as a result of their decisions.

Moreover, the health care system has been very slow to make use of the lessons learned from best practices in waiting list management, such as the Cardiac Care Network in Ontario, and has not yet applied the same waiting list management techniques elsewhere in the system. To be fair, a structured, needs-based waiting list for a wide range of surgical procedures is on the point of being implemented in the Province of Saskatchewan. But that merely brings the total of such lists in Canada to two – a pitifully small number!

The blame for the waiting list problem should be placed where it belongs – jointly on the shoulders of governments for not funding the system adequately, and on the providers of

health services, for not developing and implementing clinical, needs-based waiting list management systems.

With government's responsibility for funding the hospital and doctor system through our publicly funded and administered health insurance program, comes the obligation to ensure that reasonable standards of patient service are met. Timely service is the essence of a patient-focused system and of the health care "contract" between Canadians and their governments.

In keeping with its philosophy that the best way to reform a complex system, and the provision of health care certainly qualifies, is to introduce appropriate incentives for the players involved, the Committee is firmly convinced that governments and managers of the health care system must be made to bear the responsibility for the consequences of their decisions. The Committee's proposal to put in place a maximum waiting time *guarantee* for all major procedures gives concrete form to this obligation.

The idea is that when this maximum waiting time is reached, government would have to pay for the patient to receive treatment in another jurisdiction, including in another country such as the U.S. The point at which this health care guarantee would apply for each procedure would be based on an assessment of when a patient's health is at risk of deteriorating as a result of further waiting. Safe waiting times would be established by scientific bodies using clinical, evidence-based criteria.

Were it to be implemented, such a health care guarantee would mean that government and the managers of the health care system would have to shoulder the responsibility of needed care not being delivered in a timely fashion.

The Committee's Care Guarantee would ensure that allowing waiting times to increase would no longer represent a cost-free option for governments, or for hospitals and doctors. They would have to sort out amongst themselves who was responsible in each case where maximum waiting targets were exceeded, much as car insurance companies work out who was at fault in an accident. But in the meantime, the patient would be treated, just as the car gets fixed while the insurance companies figure out who was to blame for the accident and who pays.

Mr. Romanow agrees that patients should be told how long they should expect to wait for each procedure, but has not recommended going the extra step the Senate Committee has recommended - making the commitment that these targets will be met and that someone other than the patient will bear the consequences if they are not. Mr. Romanow believes that it would be enough simply to inform people of how long they should expect to wait for the procedure or service they required.

Mr. Romanow also believes that the Committee's Care Guarantee would not work in practice. Our Committee believes that it could be made to work, as do Don Mazankowski and the Canadian Medical Association, who both advocate the implementation of a Care Guarantee. Also, the Minister of Health of Quebec recently indicated that he too was in

favour of making a commitment that patients will receive timely treatment. The Committee's approach is intended to lift the consequences of underfunding and bad waiting list management from the shoulders of the one player in the system who bears none of the responsibility – the patient. On this issue of greatest concern to Canadians, Mr. Romanow has not offered a solution.

The consequences of not solving the waiting time problem are great. Unless Canadians are guaranteed timely treatment, the future of publicly funded health care is likely to be at risk, most probably as a result of a constitutional challenge based on the right of individual Canadians to have access to timely care and to purchase private health insurance to provide it.

Governments can no longer have it both ways – they cannot fail to ensure that the delivery system provides timely access to medically necessary care in the publicly funded health care system and, at the same time, prevent Canadians from acquiring those services through private means. Thus, one consequence of not implementing the health care guarantee would be to render it highly likely that the current legal prohibition on the creation of a parallel private health care insurance and delivery system would be challenged successfully in the courts.

Conclusion

By way of conclusion, let me summarize briefly the four main points of divergence between the Senate Committee and Commissioner Romanow with regard to restructuring the hospital and doctor system and providing timely care to patients. As I noted at the outset of my talk today, these differences are essentially over how to go about achieving health care reform in Canada, not about the need for reform. The Senate Committee and Mr. Romanow also agree on the basic objectives to be pursued and the need to pursue them vigorously and without delay. If I have highlighted some of the differences between Mr. Romanow and the Senate Committee, it is because, having come to many of the same general conclusions, we can now engage in a constructive debate over how to bring about the changes that Medicare needs.

1. The Senate Committee believes that the system is too complex to be micro-managed by government and that reform can only be achieved by putting in place an appropriate set of incentives to motivate behavioural change. Mr. Romanow remains wedded to the old-fashioned, top down, command-and-control model. Hence, the Committee favours service-based funding for hospitals and Mr. Romanow is silent on the issue.
2. The Senate Committee believes that the funding and delivery of health care services are separate issues. Like Mr. Romanow we favour a single payer, publicly funded model. Unlike Mr. Romanow we believe that the funder should

be neutral or indifferent with respect to who owns and operates the organizations responsible for service delivery. This means keeping open the delivery systems to greater competition amongst providers. Mr. Romanow wants to close the door on testing the variety of approaches to service delivery to find the most effective for Canada's very diverse communities and regions.

3. The Senate Committee's proposals with regard to the federal role in rebuilding and developing the infrastructure are vastly more extensive and concrete than Mr. Romanow's. This is particularly true with respect to our emphasis on treating teaching hospitals as a national resource, whose capital needs should be met by the national government. As well, the Senate Committee, unlike Mr. Romanow, has attached great importance to setting precise, carefully costed, targets for increasing the supply of health care professionals across the country.
4. The Senate Committee believes that providing patients with a guarantee that they will be treated within a specified maximum waiting time is essential to the reform of the health care system. Moreover, for the Committee, those who are responsible for the lengthening waiting times in recent years must be held accountable for fixing the problem.

From the outset the Committee's priority has been protecting the health of patients. The Committee recognized that what was needed was not the affirmation of lofty principles and general goals, but to set out in as much detail as possible a plan of action whose cost of implementation would be clear. Canadians must not be given the impression that health care is a free good to be paid for out of someone else's pocket.

We are all responsible for paying for our health care system, and a responsible approach to public policy means letting each and every Canadian know how much it is going to cost them to have the kind of publicly funded health care system they want and deserve. It is, of course, both normal and necessary for reasonable people to disagree over the best means to achieve this shared goal. The Committee truly believes that it has put on the table an action plan that, if implemented, could help make a sustainable health care system a reality.

This returns me to my opening theme. The national health care debate has now been joined. This debate will come to a head at the First Ministers' meeting in late January.

It is critical that between now and then you make your views known to as many federal and provincial political leaders as possible, including your Premier, your provincial Minister of Health, and your provincial Finance Minister. Tell them what reforms you want them to support at the January meeting.

The future of the health care system depends very much on what you do in the next two months.