Romanow Report Brief

Enhancing Access and Quality

Although health care is probably one of the most frequently debated topics in the country, and universal medicare one of the country’s most dearly-held ideals, the reality is Canadians only have so much time to discuss theories of social justice or the outcomes of certain treatments. What matters most to most people is access — getting the care they need when they need it.

And yet health care simply cannot be all things to all people. Recognizing that, in the report on the Royal Commission on the Future of Health Care in Canada, Roy Romanow has carefully picked among those services Canadians feel present the greatest problems of access, choosing finely-tuned expansions over wholesale — and likely undeliverable — reform.

Romanow’s principal solution to the access problem is five special funds, aimed at fixing some of the worst access problems. They are: a rural and remote access fund of $1.5 billion; a diagnostic services fund of $1.5 billion; a primary health care transfer of $1.5 billion; a home care transfer of $1 billion and a catastrophic drug transfer of $1 billion. The first two should be funded as soon as possible; the others would come on stream later. After two years, all would be blended into the dedicated health transfer.

The health needs of Canadians living in rural and remote areas present special problems and Romanow calls for a national approach, using the special access fund to attract and retain health care providers, increase the time health-care providers spend in rural areas as part of their training and expand telehealth projects.

Romanow says the diagnostic services fund should be used to shorten waiting times by purchasing equipment as well as employing and training people to run it. He would like to see such advanced diagnostic machines as MRIs and CT scanners designated as “medically necessary” under the Canada Health Act, which would end using privately-purchased tests to jump the queue for public treatments.
Changing medical practices and social values have led to far more care being offered at home rather than in hospitals or institutions. But home care is not formally included in medicare, demand far outstrips supply and coverage is uneven across the country. All that led Romanow to recommend expanding the Canada Health Act to include home care coverage for mental-health case management, services for post-acute patients, and palliative services to support people in their last six months of life. Such a move would at least ensure a basic national level of service.

A $1 billion annual home-care transfer, Romanow says, should begin in 2003/04. While it would not cover the largest current area of homecare spending, chronic health problems and physical disabilities, it should free up a substantial amount of money that could address other pressing home-care needs. Romanow also recommended the Employment Insurance program provide direct support for informal caregivers who spend time away from work to provide home care.

Many Canadians cannot afford drugs that are crucially important to their well-being. While he stops short of calling for a full pharmacare program, Romanow recommends a $1 billion “catastrophic drug transfer,” to begin in 2004/05, which would cover 50 per cent of the cost of provincial and territorial drug insurance plans above $1,500 per person per year. The transfer would ease provincial drug plan costs, provide provinces with an incentive to expand their plans and reduce disparities in the plans across the country.

Romanow also calls for a national drug agency to evaluate and approve prescription drugs, control prices, ensure quality, and provide information to health care providers and the public. It would also develop a single list, or formulary, of approved drugs for all provinces, which would greatly increase buying power.

Several other access issues are also addressed in the report, including the difficulty of getting to see a doctor or nurse in many communities; Romanow recommends that a portion of four of the new funds be used to improve the supply and distribution of providers. He also recommends services that recognize the different needs of men and women, visible minorities, people with disabilities, new Canadians and minority language groups.

Waiting lists are the bête noire of Canadian health care and Romanow recommends all provinces take immediate action to manage them by centralizing them and setting standardized criteria for placement on a list. Patients, he says, should be given clear information on how long they can expect to wait.

Romanow envisions a health care system continuously improving through use of data and evidence and recommends the health council work with provinces and territories on a national framework for measuring, assessing and reporting on quality and safety.
It’s clear from the emphasis on reporting and accountability that Romanow views information and research as the foundation of all reform. Better health information, he feels, should guide all public, provider, researcher and policy decisions and adds electronic health records are key to improving access, safety and quality.

However, more research is needed and Romanow recommends the Canadian Institutes of Health Research create four research centres, to address rural and remote health issues, health human resources, health promotion and pharmaceutical policy. The Canadian Health Services Research Foundation would be responsible for improving links between researchers and policy makers to encourage use of research in developing the health care system of the future.