

## **Roy Romanow's Odyssey**

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**By Dr. Gordon Guyatt**

Spectator headline: The evidence is in, and public health care gets the decision

Doctors used to turn to authority figures to guide their practice. Nowadays, wise physicians look for the best evidence, and make sure their decisions are consistent with the their patients' preferences and values.

Roy Romanow's job was to diagnose the problems in Canadian health care, and to prescribe treatment. Doing it right for Romanow would mean taking the modern approach, and ensuring that his recommendations were consistent both with Canadians' values, and with the best available evidence.

The health care debate boils down to who should pay – public or private – and who should deliver – for-profit or not-for-profit providers. On the "who pays?" side, Romanow's prescription endorses public funding. On the "who delivers?" side he recommends not-for-profit health care delivery.

Had Romanow made up his mind from the beginning? Were his 18 months of consultation with the public, and dozens of expert reports, a waste of money?

Romanow was no health care expert when he started. Clearly, he was very interested in the issue. Otherwise, he wouldn't have offered Jean Chretien a pivotal Health Care Commission.

At the beginning, though, Romanow had many questions, but no answers.

On the funding side, Romanow began by laying out the options. One was introducing user fees to pay for physician and hospital services. He called this option "shared costs and responsibilities." Others might call it, "make the poor and sick pay".

A second option was a full, separate, system of superior care for wealthier Canadians, funded by private insurance. He called this alternative "increased choice". An alternative label would be "two-tier health care".

A third option, the one he ultimately endorsed, was greater public – that is, government – investment.

The way Romanow presented the private pay options reflects his initial openness. "Shared costs and responsibilities" and "increased choice" both sound appealing.

On the delivery side, a speech Romanow gave early this year describes his position. If for-profit delivery was less expensive, and resulted in higher quality care, he would recommend its expansion. What was it, during Romanow's 18 months of consultation and study, that made up his mind?

First, he learned a great deal about Canadians' values. Romanow held a total of 21 days of public meetings, open to all Canadians. Wherever these hearings went, audiences proclaimed their support for universal, equal-access health care.

When Ontario health minister Tony Clement, in one such hearing, suggested for-profit health care provision, the audience booed loudly. When Mr. Romanow chided the audience for rudeness, they quietly turned their backs on Mr. Clement.

Romanow could see that ordinary citizens who cared enough to show up to his meetings offered strong support for publicly funded health care. Furthermore, rank-and-file Canadians who participated in a dozen daylong focus groups uniformly said they were willing to pay more in taxes to protect equal access to high quality health services.

The demonstration of Canadian values was compelling to Mr. Romanow, but so was the evidence about funding and delivery.

On the "who should fund" side of the issue, Mr. Romanow found that health spending isn't out of control. Canada spent 10% of its GDP on health a decade ago. We now spend 9.4%.

Looking at the numbers, Romanow discovered that there is plenty of

money available for health care. If we had spent only a portion of money allocated to tax cuts and deficit reduction in the last five years, we would have had plenty to sustain publicly funded health care.

Romanow learned that single-payer systems are less expensive than private-pay models, in part because of reductions in administrative costs. Canadians pay an average of \$325 on health care administration each year. The American private pay model costs US citizens \$1,150 in health care administration.

On the "who should deliver" side, Romanow found that the for-profit delivery advocates could offer no compelling evidence that the for-profit sector reduced expenditures, or improved quality.

In contrast, Romanow learned of new evidence published in the leading Canadian and American medical journals. Health researchers from McMaster systematically summarized the high quality studies comparing private for-profit versus private not-for-profit hospital care.

They found that for-profit care resulted in higher death rates in hospitals. The increased death rates were even greater in a comparison of for-profit dialysis facilities to not-for-profit alternatives. The explanation? For-profit providers have to allocate funds for shareholder profits and paying taxes, money that not-for-profit organization can devote to patient care.

At the end of 18 months of consultation and study, Mr. Romanow has a deep understanding of health care funding and delivery issues. Romanow now argues that governments have fallen into the trap of confusing what they spend with what Canadians overall spend on health. Governments think that if they cut their health budgets, their voters will be better off.

In reality, the cost is shifted from governments to individuals. Instead of paying for efficient health care through taxes, Canadians end up paying more out of pocket, and getting a poorer, less equitable product.

Mr. Romanow's recommendations are driven by an understanding of Canadian's values, and of the evidence that tells us that publicly funded health care delivered by not-for-profit providers gives us more efficient, higher quality health care.

