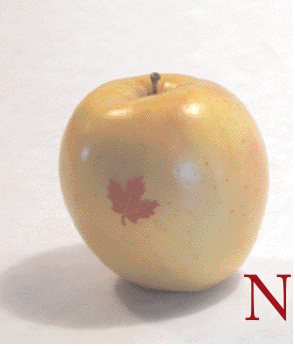

Notes from the Editor

I CAN'T REMEMBER A TIME when public expectations ramped to the heights they reached during the countdown to Commissioner Roy Romanow's presentation late last fall of the report of the Royal Commission on the Future of Healthcare in Canada (*Building on Values: The Future of Healthcare in Canada,* November 2002). For weeks, the media dissected and analyzed the Commissioner's every word for its portent and the responses of every politician for signs his recommendations would be acted upon. The release of *Building on Values* followed closely on the publication in October 2002 of *Volume Six: Recommendations for Reform*, the culmination of an equally comprehensive two-year study of healthcare by the Standing Senate Committee on Social Affairs, Science and Technology, chaired by Senator Michael Kirby. The Canadian public came to expect in these two reports answers to their every question and neat solutions to healthcare's widely publicized problems. Now we are well into the New Year and everybody is waiting for somebody to *do* something!

Although the reports, both well researched and argued, differ somewhat in their approaches to implementation (the how question), there is clear agreement on what to do so that publicly funded healthcare will meet the needs of Canadians into the 21st century:

- Stop intergovernmental bickering and re-create a genuine partnership to provide effective leadership and stable, predictable funding.
- Establish apolitical governance and management structures for healthcare as a system of increasingly coordinated services.
- Make governments, providers and the "system" more accountable to the public.
- Accelerate development of a capacity for health information management.
- Address Canada's self-sufficiency in health professional person-power and its distribution.
- Reform primary healthcare to provide comprehensive care to everyone, 24 hours a day, seven days a week.
- Expand coverage under the Canada Health Act to include, within limits, prescription drugs and home care.
- Do something special to address the health of Aboriginal Canadians.

Agreement on what to do, sadly, is no guarantee that anything will be done. Indeed, over the past decade both of the senior levels of government have had poor records when it comes to translating the recommendations of reports into changes in healthcare. The record of healthcare providers in changing how and where they work to achieve better distribution of services and higher productivity is no better. The question is, post-Kirby, post-Romanow, what now? Will the clear policy directions of these two reports be followed with implementation by our federal and provincial/territorial governments and the embracement of change by the many "players" in healthcare? What actions should be

taken, and by whom? How fast and in what order?

This issue of Healthcare*Papers* contains responses to the question, "Where do we go from here?" Our commentators have extensive hands-on experience in getting things done. They are those who carry now, or have carried in the recent past, major responsibility for the implementation and management of public policy.

We begin with republication of the Executive Summary of Commissioner Roy Romanow's values-driven, evidence-based and consultation-informed report, *Building on Values: The Future of Healthcare in Canada*. It stands as the last, most authoritative word on what to do to reform and renew our most highly cherished and single most expensive social program.

Senator Michael Kirby follows with categorization of the recommendations of the Senate Committee's and other reports. He gives priority to action now on recommendations affecting the delivery of services (e.g., primary care reform, creating the capacity for health information management) over what he calls systemic or process issues (e.g., the public/private question, opening the Canada Health Act). As for approach, Senator Kirby urges pragmatic incrementalism; a few sure-footed steps at a time!

To complete the trio of scene-setters, that wise voice of long experience, Tom Kent, raises our sights from the in-course corrections and "catch-up" recommendations of the Senate Committee and Royal Commission to what's really next – healthy children – after medicare has been fixed: "Once the presently proposed reforms have put medicare back on track, the first priority should be to ensure that fully comprehensive services are universally accessible for children." His focus on the future is as clear today as it was 40 years ago when he and others grasped leadership's nettle to initiate Canada's publicly funded health insurance system.

Following east to west, Thomas F. Ward gives priority to five focuses for action by government, providers of healthcare and by the public. First is a national centre on health human resources to plan, in light of new knowledge and technology, for change in what providers do, their mix, and the ways in which they should work together. Second is infrastructure, health information management, diagnostic and bedside facilities and equipment. Third are National Centres for Health, hubs of research to help the public and governments realistically match service needs with resource availability. Fourth is governance disentangled from political exigencies, coupled with across-the-board devolution of responsibility for service delivery to regional health authorities. Fifth is full public participation in the process of establishing certainty about the boundaries of publicly funded insurance of health and healthcare services.

Dovetailing neatly with Tom Ward's fourth point, David Levine describes the role of Quebec's regional health boards in managing implementation of the recommendations of the Clair Commission and, in particular, those directed to transforming and expanding primary care to encompass fuller responsibility for the health of the population served. Achieving greater integration of the work of the many "players" in healthcare is also high on his agenda. What's next, according to Mr. Levine, is to find the money necessary to

fund the essential reforms that, as has been the case so often in the past, have already been initiated in Quebec.

Peter Glynn identifies three priorities. First Ministers and their officials should reread and "take to heart" the rhetoric of the Social Union Framework Agreement and their communiqué of September, 2000; a genuine partnership of governments is essential. Second is informed, lay-language communication with the public, region by region, province by province, to establish accountability for the productivity, performance and public financing of healthcare. Third is establishment of standardized registers to ensure that waiting lists in every province and territory, based solely on measures of patients' clinical needs, are made transparent and real.

Jeffrey C. Lozon and Sarah E. Vernon focus on the need for a clear vision of what "the system" is to be and do for Canadians. They address six points. Federal/provincial relations should be improved by concentrating on information management and selected national strategies – for example, pharmacare and home care. Fiscal sustainability equals more money. Information management is imperative; without it there is no accountability worth talking about. They too see primary healthcare reform as key but believe new as-yet-to-be-defined strategies are needed to bring it about. Catastrophic drug coverage, post-acute home care and palliative care have to be parts of today's healthcare system. Their final point is that people's expectations must be shaped by realism about what that system can deliver.

From her front and centre perspective in Saskatchewan, Glenda Yeates sets out four priorities for what's next. First is health-designated federal cash transfers made predictable by an escalator to restore trust between the two levels of government and permit sensible planning and operation of healthcare delivery. Second is change – beginning with primary care reform, health human resources, quality assurance, and health information management. Extending publicly funded health insurance to incorporate prescription drugs is third. Fourth is a National Quality Council together with a variety of other comparable governance-reinforcing bodies to advise governments and inform Canadians on ways and means to achieve reconciliation between healthcare expectations and their realistic cost.

Out of his varied experience in government and regional management, Jack Davis maintains that a "fix" for healthcare continues to be elusive primarily because of a failure of governance – absence (referred to repeatedly) of a clearly understood consensus on the level of service to be provided and its realistic cost. Governments have to "step up to the plate," forge that consensus and then decide on how to finance both reform and ongoing operation of the system. He points out that conditioning the expectations of the public and providers alike by our dominant southern neighbour, with its commodification and (for those insured) "market" approach to rationing services, makes reconciliation of Canadian expectations with the lower proportion of GDP we spend on healthcare difficult.

Primary healthcare reform is the focus of David Kelly's call for change in the one-sided contractual relationship between physicians and society now represented by billing

numbers. "Is it rational behaviour on the part of governments to leave in place the open-ended contracting system, which enables physicians to continue to make decisions about the location and organization of practice that are contrary to the policy direction governments are trying to pursue, and contrary to the population's health needs as the payers perceive them?" Implementing his "modest proposals" will certainly take courage and create furore among provincial medical associations. But as in the beginning of Saskatchewan's doctors' strike, that may be the price of accelerating the slow, stuttering pace of primary healthcare reform, a key change all our contributors consider essential to the future of publicly funded healthcare in Canada.

I am grateful to Peggy Leatt and her colleagues at Longwoods for the invitation to edit this issue of Healthcare*Papers*, not least because it also provides me the opportunity to express a personal opinion on what's next – where we should go from here. First, we must have effective governance. In healthcare, that is a responsibility of governments. People should understand clearly what to expect from the healthcare delivery system for their tax dollars. Governments have to lead providers and the public to consensus on an overarching vision of what, in the early 21st century, we want our healthcare insurance and delivery systems to achieve within the limits of what we are prepared to pay in taxes (and privately) to support them.

Accountability to patients, their families and taxpayers can be convincingly provided only by relatively local (regional) health organizations with responsibility for delivery of the full range of locally provided services, including physicians' services. Apart from Ontario, all provinces have started down this path of devolved, accountable authority for management of their delivery systems. I would have Ontario join them and all move further along the path more quickly and comprehensively.

Enhanced accountability requires greatly enhanced capacity for health information management locally, regionally, provincially/territorially and nationally. More funding is needed, but even more essential are clear policy directions/governance by both levels of government acting together, and much greater commitment on the part of providers – hospitals, physicians, home-care providers, the lot – to reach consensus on the data and communication standards needed to provide patients with the protection of sharable, comprehensively informative electronic health records. This last is a professional responsibility too long neglected.

Innovation leading to new ways of "doing business" in healthcare must claim high priority if healthcare is to meet the contemporary needs of patients and the population now and in the future. Canadians should expect productivity increases in healthcare comparable to those achieved elsewhere in the economy by the application of new knowledge and technology. This requires redefinition of the roles and responsibilities of physicians, nurses and other providers of healthcare services. Why don't we use nurse-anaesthetists as they do in the United States and other countries to alleviate the current shortage of anaesthetists and operating-room time? The professions and, failing quick response, the federal government should address this issue post-haste.

Increased and more stable funding should be used to "buy change" and not to increase further fees or wage and salary rates. This condition attached to increased federal funding should not be a "string" but the promise of reward for those provinces and territories willing to undertake the challenge of developing successful change templates for application more widely throughout the country. Some may want to accelerate ongoing initiatives in primary health reform; others may prefer to concentrate on devolution of authority and responsibility to regional organizations; yet others may give priority to initiatives in Aboriginal health; others may take the lead in health information management. It makes sense to draw on Canada's diversity to meet them province by territory, and subsequently to apply nationally the most fruitful results.

Finally, I agree with the priority of transforming primary care to encompass multiprofessional practices that provide a comprehensive range of services to enrolled populations, including primary obstetrics, 24 hours a day, seven days a week. How could that be done quickly? Giving regional health authorities the money and authority to develop the contracts suggested by David Kelly to replace billing numbers would be a great way to start. But pursuing the model developed by Ontario's Health Services Restructuring Commission remains, in my opinion, the best way to proceed decisively to provide greatest benefits both to provider-professionals and the people they serve (see *Health Services Restructuring Commission, Primary Healthcare Strategy: Advice and Recommendation to the Honourable Elizabeth Witmer, Minister of Health*, November 1999).

To conclude, we have enough reports. We have well-reasoned consensus on many issues. One thing is clear – without change, and soon, healthcare in Canada as we know it will fragment and be lost. Enough talking. It's time to act!

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Guest editor