Report of

The National Leadership Roundtable on Health Reform

University of Toronto • June 28, 2000

Sponsored by:

Dialogue on Health Reform

Department of Health Administration
University of Toronto

Canadian Healthcare Association

Foreword

The Dialogue on Health Reform is a group of concerned Canadians who are worried that confidence in Canada's unique, exemplary health care system is eroding. We believe our publicly funded health insurance system must be strengthened, not taken apart. So far, very few credible voices have been raised to speak on behalf of the merits of our unique system. While we are supportive champions of it, we are nonetheless far from complacent about the status quo. Reforms are clearly needed. We believe, however, that the evidence clearly demonstrates that reforms will be accomplished most effectively within the principles of a single payer, publicly financed system.

With support from the Atkinson Charitable Foundation, the Dialogue seeks to act as a catalyst for positive interaction, and positive change based on evidence. Through a number of activities, it provides a voice of measured critique and constructive rebuilding to balance the voices of panic and doom and wholesale dismantling that are being heard. Six papers were commissioned from prominent practitioners and scholars in the fields of health care policy, management and administration. These papers discuss the commonly held myths about our health care system and the sometimes appealing but misconceived private financing solutions, which are often proposed. In particular, the papers document the growth of private spending and of two-tiered approaches that have already occurred through passive privatization, and the disorganized province-to-province fragmentation and variation that is developing. As well, they promote sensible reforms in concrete areas, such as home care, pharmaceuticals, and waiting list management.

On June 28, 2000, the Dialogue on Health Reform with the Department of Health Administration, University of Toronto, and the Canadian Healthcare Association, hosted a National Leadership Roundtable on Health Reform at the University of Toronto. The Department of Health Administration at the University of Toronto (www.utoronto.ca/hlthadmn) has been providing education in health administration since 1948. Its faculty is renowned across Canada and throughout the world for their contributions to the advancement of health services, managerial and policy thought. The Canadian Healthcare Association (www.canadian-healthcare.org) is the federation of provincial and territorial hospital and health organizations, representing regional health authorities, hospitals, long-term care facilities, home and community care agencies, community health services, public health, mental health, addiction services, housing services, and professional and licensing bodies.

The Roundtable brought together a balanced collection of community leaders and policy actors to discuss four commonly broached problems in our health care system and their oft-proposed solutions, and to engage in discussion about evidence-based reforms for Canada's health care system. Participants included practice leaders, policy makers, consumer and business representatives, academics and health care system analysts from both Canada and the United States, alongside former politicians and invited media. Steve Paikin, the well-known co-host of *Studio 2*, a nightly current affairs program, was the moderator/facilitator for the day. A list of participants and the full agenda are attached to this report of the day's discussion.

At this time, when our First Ministers are grappling with the challenge of revitalizing our health care system, all Canadians need to become informed and involved. We hope this report, a distillation of the day's discussion, and its key reform directions will stimulate and inform broader engagement and debate in the public and among a range of interested groups.

Terrence Sullivan
Chair, Steering Committee
Email: tsullivan@iwh.on.ca

Patricia Baranek
Project Director
Email: pat.baranek@utoronto.ca

The Dialogue on Health Reform
www.utoronto.ca/hlthadmn/dhr
tel: 416 921-5973
fax: 416 921-7899

"FROM RIGIDITY TO RESILIENCE"

KEY THEMES AND SUGGESTED ACTIONS ARISING FROM THE ROUNDTABLE

1. *Confidence in Canadian Health Care Financing*

While much of the public concern about health care in Canada has focussed on funding issues, there was a clear consensus at the Roundtable that our system of public *financing* is, in fact, extremely sound. Canada's financing mechanism for insured services (i.e., tax-based, and administered through a single payer) was roundly endorsed and supported by everyone in attendance. The issues that drew most attention as targets for reform were the way in which we deliver services and the way we make payment for them. These issues are tied to the *allocation* and *delivery* dimensions of the system, rather than the *financing* dimension.

These matters are of concern to government funders, regional boards, district councils, and others who make decisions about how care will be delivered and how money for it will be allocated. These organizations need to:

- spend their resources focussing on reform of delivery and allocation, not reform of financing, where few problems actually exist;
- seek constructive solutions focussed on issues of access, quality, continuity of care and inefficiencies in the way care is organized and providers are paid, where many problems do exist; and
- focus on restoring public confidence in the health care system's financing basis, while reassuring the public that the true problems are being addressed.

2. *The Shifting Public-Private Balance in Financing*

The focus on cost constraints, private financing options, and hospital reform over recent years has distracted attention from the massive changes in the nature and site of care. The extent of services covered by public insurance has been shrinking relative to those services for which patients share costs or pay entirely through private insurance. This silent shift has come about due to changing sites of service provision over the last 20 years, from hospital services (publicly paid) to community services (cost-shared and privately paid), and the changing health care provider associated with it. Hospital restructuring, and advances in technology and pharmaceuticals have moved care to the family home, where it is no longer protected by the principles of universality, portability, comprehensiveness, and accessibility. The rising private costs and associated insecurities of both home care and pharmaceuticals are immediate concerns. The protection afforded by the *Canada Health Act* against the financial burden of illness needs to be updated to reflect the changing realities of care provision (both site of care and provider of care).

These matters are of concern to all consumers (patients and their informal caregivers) and to all planners. To deal with them:

- the federal government must play an active role in extending national funding mechanisms to cover changing sites of care, beginning with home care and "pharmacare" at this time; and
- mechanisms must be established, with the input of consumers as well as public decisionmakers, for ongoing review of changing delivery realities. While home care and pharmaceuticals are of primary concern right now, they may be replaced by unforeseeable concerns in the future, and a means of anticipating this is necessary. This could take the form of periodic review of the services insured under the *Canada Health Act*.

3. *The Definition of Medical Necessity*

The changing sites of delivery over the past 20 years have raised challenges associated with defining what is medically necessary, since the core of our publicly-funded services in Canada turns on services provided by physicians and in hospitals. The tremendous shift to community services and the revolution in pharmaceuticals that eliminates institutional care has made traditional notions of medical necessity, which has been our chief way of determining access to services, less helpful now than they were in the past. And defining access on a procedure-by-procedure basis has been tried and found limited in other jurisdictions, such as Oregon. Roundtable participants thought that Canadians should not seek new black-and-white definitions of medical necessity, but

should implement new processes and mechanisms that will serve them into the future. These should be characterized by:

- a principle that takes a systems perspective, which recognizes continuity of care for the public and advances a seamless system;
- flexibility in allocating resources independent of the site of care provision and of health care provider for a reasonably comprehensive range of health needs, e.g., through global funding for a range of *types* of service; and
- the capacity to adapt over time, which reinforces the need for a mechanism of ongoing review of coverage described above.

4. *The Issue of Waiting Lists*

In the public's mind, waiting lists are akin to the canary in the mineshaft. While the waits for some forms of care in Canada have increased, others have improved. However, the public perception that waiting lists on the whole are growing creates individual anxiety and is a source of erosion in confidence in our health care system. As a result, both the reality, and the often-misplaced perception of increased waiting lists are equally problematic. More often solutions have to do with better management than with the injection of more resources. Solutions must address a number of fronts: public perception; inadequate resources; and poor management of access and delivery.

Participants agreed that:

- better access and shorter waiting lists are necessary to strengthen public confidence in our system;
- increased funding for certain problematic areas of care was important;
- but, in cases where the core problem was management rather than resources, simply increasing funds was not sufficient, and could be counter-productive;
- in some specialty care, investment needs to be made in building the human resource base and the technological capacity of the system;
- without exception, comprehensive information systems must be developed with coordination mechanisms built in across sectors of care;
- aggressive management with continuous monitoring and audits of wait list information are necessary; and
- government funders have a critical role to play. They need to be involved not only to fund list reduction (e.g., by human resource and technology development), but also to fund development of management mechanisms that can span activities within and across health care sectors.

5. *An Investment in Information*

Participants at the Roundtable agreed that better and more timely health information must be the bedrock of our system, not only for an accurate picture of its performance, but in order to separate fact from fiction, and reduce the time wasted in debates fuelled by misinformation or out-of-date information. Moreover, information systems are the tools for efficient and effective planning and reform. Valid and reliable information is necessary to support policy decisionmaking as well as clinical practice, and to improve the confidence and informed involvement of the consumer. To achieve this:

- non-partisan, "honest brokers," such as the Canadian Institute for Health Information, are essential; and
- information networks need to be broad-based, linking decisionmakers (at the policy and practice levels) and the consumer.

6. *Home Care and National Standards*

There was a clear consensus that home care is a new frontier in health care. It was agreed that there is a need for some form of national standard to promote a basic range of services in the home that is comparable for all Canadians, and that is based on an understanding of where home care is effective and where it is not. The mechanisms for federal/provincial engagement range from:

- new federal legislation to create common goals, as well as the regulatory mechanisms of achieving them, for community services, to

- a common statement of First Ministers to indicate their commitment to a base of home care coverage. (The latter would be a relatively weak mechanism of engagement, and therefore probably less viable into the future. The former is stronger, and could still leave room for provincial and local decisionmaking around actual delivery and allocation.)

Funding for such an expansion of insured services poses challenges. Options might include:

- a national standard for home care, supported by either a cash floor or a basket-of-services approach.

Whatever the approach used, Roundtable participants agreed it was essential that

- the federal government play an active role in shaping a national program in home care.

This view echoes that of the National Forum on Health, but additional suggestions for financing and governance were considered.

7. *Pharmacare and a National Insurance Program*

The increasing costs of drugs and the increased burden on provincial governments, employers and consumers gave rise to suggestions for a national Pharmacare program. Currently, standards and regulations for the pharmaceuticals industry fall within federal jurisdiction. The chief role of the provinces has been in the setting of drug formularies for payment by provincial plans. Thus, given the nature of the industry and of the product itself:

- this is an area where it would make sense for the federal government to take a lead role, not only in setting standards and providing funds, but in assuming the role of national insurer for pharmaceuticals.

This would have many benefits, including:

- standard availability of pharmaceuticals across the country, which is appropriate to the nature of the service; and
- the elimination of inefficiencies associated with the creation, negotiation and administration of different, parallel formularies from province to province.

The National Forum on Health similarly called for a national Pharmacare program. The complexities of such an undertaking are considerable. Rather than ignoring it and doing nothing, however, the federal government should begin now to:

- establish linked federal-provincial organizations or institutions for identifying the contours of such a program and the means of implementing it.

SESSION ONE

PERCEIVED PROBLEM: THERE IS NOT ENOUGH FUNDING IN THE HEALTH CARE SYSTEM.

PERCEIVED SOLUTION: WE SHOULD INJECT PRIVATE FINANCING.

For many Canadians, the health of their health care system is the single most important policy issue of the day. Concern has been growing – and given vivid expression in our newspapers and on our televisions -- that there simply is not enough funding in the health care system. Spending is rising and putting huge strains on our provincial economies, these reports say, and we can only expect it to keep rising. One of the most widely trumpeted solutions has been the injection of new private financing, which would, it is suggested, relieve strains on the public system.

The background paper by Raisa Deber demonstrated that, far from continuing to rise uncontrollably, Canadian health care spending has been falling in recent years. What expenditure growth has occurred has been in the area of private spending on services not publicly insured. Far from having a broadly nationalized system, Canada has one of the lowest proportions of public expenditure on total health spending anywhere in the industrialized world, with a hearty role for the private sector in financing virtually everything but physician services. Hospitals are 90% publicly funded, but private expenditures on capital and other institutional costs are rising. As for spending on drugs and non-physician professionals, private payments account for, respectively, 70% (including non-prescription drugs) and 90%.

Even though the means of financing our health care system has been the point of greatest debate, there is good reason to be most confident about our single-payer system. There was consensus on this amongst all Roundtable participants, cutting across industry, consumers, government, providers, and academia. The real problems lie not in financing, but in the areas of whether and how to extend publicly insured coverage, and how to organize and manage delivery of services.

Background paper: Raisa B. Deber, *Getting What We Pay For: Myths and Realities About Financing Canada's Health Care System.* Full text available: www.utoronto.ca/hlthadmn/dhr

> Canadians have no idea what they actually have or don't have until they have to access the services.
>
> William Davis, Ontario Premier, 1971 to 1985

THEMES AND IDEAS EMERGING IN DISCUSSION ONE: WHAT FUNDING CHANGES ARE NECESSARY TO SUSTAIN OUR HEALTH CARE SYSTEM?

❶ *Funding for health care no longer reflects delivery realities.*

- Currently, public funding is focussed on physician and hospital services, which reflects how most health care was delivered at the time that the *Canada Health Act* (CHA) was put in place in 1984. At the time, many additional services, such as drugs, rehabilitation, recuperation, and palliative care, were provided in hospitals. But this is no longer the case. Increasingly, these services are being delivered in the community, so public funding no longer covers them.
- In 1984, some 57% per cent of health expenditures were covered under the principles of the CHA; now, some 45.5% are. The hospitalization rate for Canadians has dropped by 25%. And, when we are hospitalized, we spend 35% fewer days there. Far from being supplements to "core" physician and hospital services, community-based services are substituting for what was once provided in hospitals. Canadians have been left with a piecemeal patchwork of health care rather than a smoothly operating system.
- There was general agreement at the Roundtable that drugs and home care are the areas where changing delivery trends have created the most immediate problems.
- Even within hospitals, the organization and funding of delivery is changing. For example, some provinces, such as Alberta, have established a "focussed factory" approach to some former hospital services, such as cataract surgery. Alberta's Bill 11 creates conditions under which focussed-factory delivery will be further encouraged. Other provinces, too, are looking at whether such settings might enhance the ability to deliver certain hospital-type services. The development of this approach

will have implications for general hospitals, such as leaving them with the more complicated, costly cases. Because there is mostly strong evidence against focussed hospitals, it is critical that decisionmakers ask practical questions now, in the early stages of their development, about how best to ensure that such changes continue to serve the overall goals of a Canadian health care system.

❷ *We must rethink the roles of provincial and federal governments in a coherent Canadian health care system.*

- Federal spending power ensures that provincial health care arrangements share common goals and major features, even if they are not identical. Such common goals are being eroded as delivery of services moves outside hospitals. Thus, it is important for the federal government to redefine its role and actions with respect to national features of the health care system. As Monique Begin, Canada's Minister of Health at the time the CHA was enacted, said:

> Some programs of the federal government should deal directly with the daily lives of Canadians. It is a rule of governing a country.
>
> Monique Begin

- One way of deciding which level of government should be involved is on the basis of the local character of the service. For example, the federal government would be the most appropriate insurer (not just funder) of pharmaceutical care precisely because pharmaceutical care is less local in nature and is already highly standardized. There would be pros and cons for manufacturers and extended benefit insurers in such an arrangement, and these would need to be thoroughly worked out. On the other hand, home care *is* local in nature, but in need of consistent standards (see Section Three). Thus, the federal government could establish national standards and funding input, while provinces and municipalities managed and organized delivery.
- All governments fear creating new programs that establish entitlements, because these may create open-ended and unforeseen future costs. Such a concern led the federal government to implement funding changes in 1994 for health care, education and social services. These changes eroded provincial confidence in a federal role in health care, while at the same time enhancing provincial fiscal autonomy (via tax point transfers). It is now time "to get the federal government back into the game" in a meaningful way that will establish national standards in keeping with the realities of today's health care system.

❸ *As delivery realities change, it is vital to start conceptualizing solutions in terms of a system.*

Many Canadians think they have a coherent health care system, but they truly do not, a situation many people discover only when they find themselves needing multiple health-care interventions. It is vital to communicate to the public what in fact is available, across the spectrum of care, in each province. Otherwise, it is not possible for people to plan adequately or to be informed about the issues when they vote.

- Many Roundtable participants felt that long-term solutions ought to be sought at a system level, in ways that create enduring and flexible links amongst various health care service areas. They noted that seeking solutions at each single service area – e.g., drugs, home care, long-term care, rehabilitation, hospice care, etc. – could undermine efforts to create system-wide solutions. Although system-wide solutions would be very challenging to develop or implement, seeking them is important. One example suggested was the direct allocation of a percentage of savings, derived from reduced hospital stays, to community-based care as per the individual patient's requirements.
- Thinking at a system level raises the question of gatekeepers. Under the *Canada Health Act*, decisions about management and delivery of services have been made mostly by physicians. The value of their ongoing contributions is enormous. But as delivery is re-routed to the community, policymakers will need to consider the input of an expanded range of providers, such as nurses, nurse-practitioners, physiotherapists, and occupational therapists. The issue of how such input is to be organized was not resolved, but will require attention.

❹ *The impact of trade agreements and economic policy will be felt strongly in health care.*

- Analysts and decisionmakers must inform themselves, and the broader community, of the potential impact of new trade agreements and economic policies that constrain the options available in the area of health. For example, Industry Canada and provincial economic policies shape the pharmaceuticals industry in ways that make it increasingly difficult to achieve broad goals, such as universal access to necessary drugs

outside hospitals, and cost control. Also, new discussions about proposed trade and service agreements could create conditions under which Canadian public health insurers (i.e., the tax-supported provinces) will be less able to organize and manage delivery. Such new trade and service agreements could impose upon us ways of organizing and delivering health care that would have ramifications across the country. What one province "chose" to do could set a precedent under such agreements for what all provinces must do. The federal government must negotiate international trade agreements in ways that ensure our health care system maintains its integrity and goals, and provinces must act with an eye to the larger whole.

SESSION TWO

PERCEIVED PROBLEM: THE STRICTURES OF THE *CANADA HEALTH ACT* RESTRICT CHOICE AND INNOVATION.

PERCEIVED SOLUTION: ALLOW THE PROVINCES MORE LEEWAY.

There is a popular perception that it is illegal in Canada to pay privately for physician services, thereby greatly limiting patient and provider choices. In fact, however, as the background paper by Colleen Flood and Tom Archibald shows, there is no province where private provision of physician services is illegal. Nor does the *Canada Health Act* make it illegal. Rather, the legislation mostly seeks to prevent cross-subsidization of private services by public funds as much as possible. In every province, physicians are free to opt out of Medicare entirely if they wish. Even so, in no province has a substantial private market for physician services developed.

There is an equally strong popular perception that freedom of choice abounds in the United States. In a companion background paper, Robert Evans demonstrates that only the wealthiest Americans, who constitute a tiny fraction of the population, have such freedom. Some 40% of the population has no health insurance at all. And the vast majority of those who have any coverage, are restricted by their employers in their choice of HMO, which in turn further restricts their choice of provider and then the provider's choice of treatment. Canadians have contained costs and maintained choice by not allowing cross-subsidization of a private sector. Americans only began to contain costs by restricting choice under managed care. In both cases, benefits come from the payer having a greater hand in decisionmaking about what services will be provided and at what price. But only in Canada is the payer held publicly accountable for its decisions and processes. To maximize these benefits, Canada's health care system does require reform – not to liberalize choice, which we all generally have in basic health care, but to gain and use knowledge about effectiveness, and to work through the political and ethical choices implicit in the phrase "medical necessity," which underpins our approach to health care.

Background papers: (1) Colleen M. Flood and Tom Archibald, *Legal Constraints on Privately-Financed Health Care in Canada: A Review of the Ten Provinces.* (2) Robert G. Evans, "Two Systems in Restraint: Contrasting Experiences with Cost Control in the 1990s," in *Canada and the United States: Differences that Count* (DM Thomas, ed.).
Full texts available: www.utoronto.ca/hlthadmn/dhr

The public health care system is about distributive justice issues.
Steven Lewis, Health Policy and Research Consultant

THEMES AND IDEAS EMERGING IN DISCUSSION 2: WHAT INNOVATIONS WOULD BEST ENSURE CHOICE?

❶ *Is "medical necessity" still a useful concept for determining access to health care?*

➢ Currently, medical necessity is an ill-defined concept that, in practice, means whatever physicians or hospitals deliver. That is the "floor" under the *Canada Health Act*, although provinces may set a "ceiling" higher than it, e.g., by insuring other professional services, such as chiropractic or physiotherapy, or allocating funds for uninsured programs, such as assistive devices or long-term care facilities. Fuzzy as the concept is, medical necessity forms the chief dividing line between public and private financing, and is being severely strained as real-life delivery changes. Yet Canadians have no way of

keeping the concept up-to-date with these changes. Thus, "medically necessary" services, if strictly defined as what physicians and hospitals do, will continue to shrink in scope, and access to community-based services will be dependent on policy preferences of individual provinces.

- It was generally agreed that listing individual health care services as either in or out of the public scheme on the basis of "medical necessity" is too rigid an approach. What is needed is an ongoing process for reviewing services to be publicly covered as delivery realities change. The details of such a process would need to be determined, but its core features should include access to up-to-date information about health care delivery realities, the flexibility to respond to them appropriately, and the capacity to determine best practices.
- In uninsured areas (i.e., those not captured currently by "medical necessity"), managed-care arrangements are fast developing, with restrictions on providers' treatment choices. In addition, these health-care markets have limited means for controlling provider entrants, so it is not possible either to control future volumes (and rising total health expenditures) or to ensure and monitor quality.

❷ *Not just any relationship, but a well-conceived one, to the private sector is vital.*

- Much of the discussion about a role for the private for-profit sector, thus far, has been in the areas of financing and delivering services. Alberta's Bill 11, for example, creates a potential market for for-profit provision of publicly-funded services, with the claim that this will reduce pressure on the public system and spur innovation. But it was stated by private-sector representatives at the Roundtable that the only significant way that business can add value (i.e., make a profit) from health care services is by high volumes (which would most likely involve "cherry picking" the easiest cases, since complicated ones reduce volume) by reducing production costs (by driving down wages), or by selling discretionary services and upgrades.
- As for privately financed focussed factories, there are very few medical procedures that provide the necessary scale, alongside the relatively low risk of performing them in isolation from auxiliary and emergency services, to make them reliably profitable. Their success depends on the back-up of the public system.

  Population density in many areas of Canada would not support competitive for-profit markets in many professional or quasi-professional health care services. In a private, for-profit system, choice hinges on the existence of competition, said one of the Roundtable's American participants. Roughly half the US does not have sufficient population density to foster competitive health care. With a population a tenth that of the US's, Canada is more likely to be absorbed into the US market than it is to develop its own competitive system. Furthermore, the US market is not competitive. Rather it is an oligopoly dominated by a small handful of powerful corporations (i.e., much like the oil industry).
- If the collective principles of the *Canada Health Act* are seen as desirable by Canadians (which polls indicate they overwhelmingly are), then the most beneficial role for for-profit investment in our health care system is in the development and management of health "info-structures." Information about the performance of the national and provincial economies over the last three months is available, yet the most recent aggregate health data are those from 1997. It is virtually impossible to have a coherent, responsive health care system when working with such out of date data. The for-profit sector could help to develop information systems that support practitioners and resource allocation decisionmakers. Very importantly, it also could help to inform public debate, and to enhance public involvement in discussion.
- The private-sector perspective includes that of employers. Canada's health care system has given manufacturers here a tremendous competitive edge because of reduced costs of employee benefits. With costs now shifting onto extended benefits plans as services are delisted from public insurance, employers find themselves having to become experts about health care formularies, a role neither they nor the employee representatives who negotiate workplace benefits are eager to play.

> We (employers) find ourselves now…being health care experts about what should be provided and how it should be provided and to whom. This is not a place we want to be.
>
> Gretchen van Riesen, Employers' Council on Health Care, Ontario

- The private sector might provide valuable insight into issues about division of labour, which creates ongoing debate and conflict in the health care fields. As care moves into the community, this issue will become increasingly pressing. It is important to support MDs, but it will be difficult

to create or sustain a system characterized by continuity of care between institutions and communities if the system is based mainly on physicians and the relation amongst providers lack clarity and consensus.

❸ *Choice is a value that needs to be balanced with other values, and that is not synonymous with wholly individualized actions or private markets*

Rules such as those of the *Canada Health Act* do create some limitations on individual choice. But the private sector in health care also operates by rules, many of which also limit (or even abolish) choice for a great many people, depending on whether they can pay. In Canada, choice is balanced against collective goals and values about fairness of access. In the United States, choice is balanced against individual ability to pay, rooted in values about individual action. Canadians must ask themselves which of these goals they value more highly. Platforms for having these discussions must be developed.

- Canadians may see the US's "private market" in health care as a way of maximizing individual responsibility, liberating citizens from the "nanny state." But this is more rhetoric than reality. There is considerable cross-subsidization of private plans by public funds in the US, particularly in the form of tax write-offs. When this is taken into account, the public share of health expenditures in the US is more than 60%, which belies the perception that the American system is fully private for everyone but the elderly and the poor, who are covered by Medicare and Medicaid. US public subsidy of private health insurance, in the form of tax benefits, contributes approximately $2,357/year for families earning more than $100,000 annually, and $71/year for those earning less than $15,000.

VIEWS FROM OUR NEIGHBOURS TO THE SOUTH ON CHOICE AND NECESSITY

Most people in the US covered by employers have a very narrow choice of coverage; 45% have fewer than three choices of insurer. Your employer largely determines your coverage, and increasingly employers are looking into health status before employing -- some 3% now enquire about genetic background before hiring; and some are doing covert HIV and breast cancer gene testing before hiring.

David Himmelstein, MD, Harvard Medical School

There is simply no rational way that a political process can define (medical necessity). It's a local, circumstantial, judgemental, moving decision that can only be made by well-motivated doctors and informed patients living within a budget. An ideal system would make a political decision at the start regarding how much money to spend for a broadly defined range of benefits, then decide where it'll come from; and then it would have to get (providers) to organize themselves into multispecialty, not-for-profit, community-based local groups in which they work for salary, not fee, because fee for service distorts decisionmaking.

Arnold Relman, MD, Harvard Medical School,
Past Editor, *New England Journal of Medicine*

SESSION THREE

PERCEIVED PROBLEM: WAITING LISTS INDICATE INADEQUATE FUNDING IN THE SYSTEM.

PERCEIVED SOLUTION: INJECT MORE PRIVATE FUNDING TO RELIEVE PRESSURE ON PUBLIC SYSTEM.

Canadians are deeply, and understandably, disturbed by images of patients waiting for care, and by the thought that they may one day have to do the same.

While there are many problems, it is often difficult to understand them fully, as the background papers to this session demonstrate. Waiting lists are largely a phenomenon of public systems. This is not because such systems are less efficient, but because they seek to gain efficiency by minimizing excess capacity; while in private systems, excess capacity is maintained in order to be competitive, but drives overall costs up because of the incentives to maximize its usage and prevent "waste."

Where public systems admit private competition, such as in the United Kingdom, waiting lists are the longest. Also, waiting lists frequently contain individuals who are not only waiting for a procedure, but are voluntarily waiting while they make a decision about proceeding. In addition, waiting list guidelines are not written in stone. For example, of waiting list guidelines for cancer treatment, only some are supported by good-quality randomized trials (the gold standard). Other guidelines for what constitute appropriate waiting times for cancer treatment are based purely on consensus, and consensus has been shown to change for reasons other than scientific evidence (e.g., political pressure). The lack of clarity and consistency contributes greatly to patient anxiety.

Nonetheless, with an aging population, and a rising incidence of treatable diseases, waiting lists have become a genuine problem that requires thoughtful solutions.

Background papers: (1) SED Shortt, *Waiting for Medical Services in Ontario: Clarifying the Issues in a Period of Health Reform.* (2) Morris L. Barer and Steven Lewis, *Waiting for Health Care in Canada: Problems and Prospects.*
Full text available: www.utoronto.ca/hlthadmn/dhr

> We need to … make strategic investments in reducing waiting times where it's sensible to do so, either because there is real patient benefit to be gained, or there is real public confidence to be regained. The public system should be willing to invest in either of those two incentives.
>
> Michael Decter, Chair
> Canadian Institute of Health Information, Board of Directors

IDEAS AND THEMES EMERGING FROM DISCUSSION 3: HOW CAN WE REDUCE WAITING LISTS FOR SPECIALTY AND HIGH-TECH SERVICES?

❶ *It is not appropriate to wait for all the evidence to be in before addressing public concerns.*

- Waiting lists are not just scientific but political and social in nature. Many people experience first-hand, or bear witness to, the anxieties of waiting for care. Both the political and scientific communities have an obligation to respond thoughtfully to these concerns, while at the same time have an obligation not to inflame them.
- Fear attaches to some conditions more than others. No one would argue that waiting a long time for cancer radiation is a good thing. Nonetheless, many concerns arise because people do not know whether they are waiting too long and fear they might be. It would be valuable for all concerned to invest in informing people, as much as knowledge permits, whether they are compromising their outcomes by waiting the length of time typical for a given intervention and condition.
- One means could be to establish ongoing communication, via such mechanisms as websites or dial-in lines, that could provide information about any of the following, as appropriate:
  - what benchmarks have been established for a given intervention in a specific condition;
  - what the basis is for current guidelines for the intervention;
  - whether and to what extent waiting might affect prognosis;

- how the length of the current list compares to the total population receiving or requiring the care;
- current rate of "coming off" the list for the particular intervention; alternatives available (for example, re-referrals); and
- suggestions they could discuss with caregivers for managing the condition while waiting.

❷ *Evidence must continue to be gathered, and applied in a coherent way.*

- Conditions such as cancer, and many others, are not one disease, but many different diseases in different stages of progress. Ongoing research is needed to establish scientific benchmarks for waiting times.
- We need to change how waiting lists are managed. Evidence should be gathered from across the country about management, and best practices determined. In Ontario, waiting list management for cancer care is subject to two different sets of policies. One coherent set of policies is required.
- Where not enough personnel are available to deliver an intervention, waiting lists become (or are perceived to become) problematic. Adequate resources for recruitment, retention and training, or to provide fiscal incentives to existing providers, need to be available. There is also a need for institutions such as universities and colleges, ministries, associations, and organizations, continuously to examine the size of training programs relative to epidemiological evidence about disease trends. This evidence should be from different perspectives, including impact on patients and families, and the perspectives brought together.

❸ *Waiting lists for home care will grow as demographics change.*

- Several years ago, the Organization for Economic Development (OECD) identified a coming crisis: Smaller families, labour mobility, and household income requirements for two or more jobs, will have a profound impact on waiting lists for home care because there will be fewer family members available to provide informal care in the home.
- Patients who are at home waiting for treatment frequently require additional help. The ability of institutions to send people home to wait will be undermined by a lack of both informal and formal caregivers in the home. The issue of home care, beyond its impact on waiting lists, was taken up in detail in Session Four.

❹ *Simply creating a private funding tier will not reduce waiting lists.*

- Making it possible for individuals to "queue jump" by privately purchasing interventions does not reduce public waiting lists. There are ample studies to demonstrate this, from Australia, the United Kingdom, New Zealand, and even the United States. Studies from the UK, where parallel private provision on a competitive basis was introduced, found that public waiting lists increased.
  Cataract surgery in Alberta provides a test case of a parallel public-private market in Canada. For 20 years, since 1980, Albertans have had the option to purchase private cataract surgery from an ophthalmologist, who could perform the surgery either privately or publicly. Not only have public waiting lists not been relieved, but examples have been documented of numerous patients whose physicians did not inform them that they had the option of receiving the surgery from another, equally qualified practitioner whose waiting list for publicly- funded surgery was shorter. Thus, patients think their only options are quick private access with the practitioner, or a long wait on a public list.
- Re-referral lists, and the requirement to inform patients of the availability of re-referral, are possible ways of addressing these problems. In addition, public and professional debate is necessary. Do most Canadians agree that individuals should be able to "queue jump" by using private payment, even if it results in public-system erosion? Most polls indicate they do not. In addition, many physicians and other providers in Canada also do not agree. Again, public information about the impact and uses of waiting lists, and public discussion about how they are managed (e.g., by private purchase, or by re-referral) could prove vital to informed decisionmaking about them.

SESSION FOUR

PERCEIVED PROBLEM: DEMAND FOR PUBLIC HOME CARE IS INCREASING.

PERCEIVED SOLUTION: HOME CARE SHOULD BE AN INDIVIDUAL OR FAMILY RESPONSIBILITY.

The need for home care will become a major issue for all Canadians as the baby boomers age, as average life expectancy rises, as health care delivery becomes both more de-institutionalized and more technologically complex, and as work and social patterns decrease the availability of "informal" caregiving by family members (assuming such patterns continue in their current trends). The background papers to this session described the extent of current home care utilization, needs and costs, and analyzed the likelihood of future trends.

Far from being a peripheral element of health care, home care is becoming central to current modes of delivery, and many of the same concerns that fuelled acute-care insurance now apply to it. Furthermore, through much of the early days of debate about, and development of, Canada's health care system, it was believed that home care should and would become woven into the system's fabric. Hospital and physician services were to be just the first steps of several towards a fully integrated system characterized by continuity of care. Recent studies support that home care is cost-effective in many cases, and it is clear that many people want to be able to receive care in their homes, rather than in institutions, but this does not mean they wish to be at home with no or inadequate care. The time has come to revisit the earlier vision of a seamless arrangement of care, and to tackle the difficult questions of how to finance and govern it.

Background papers: (1) Peter C. Coyte, *Home Care in Canada: Passing the Buck.* (2) Malcolm Anderson and Karen Parent, *Care in the Home: Public Responsibility – Private Roles?*
Full text available: www.utoronto.ca/hlthadmn/dhr

Closer to home should not mean *out of pocket.*
Greg Stoddart, Centre for Health Economics & Policy Analysis, McMaster University

We need to shift our focus, not only from hospitals to home, but also to wherever care and information are needed, in a variety of settings.
Shirlee Sharkey, Pres. St. Elizabeth Health Care; Pres., Reg. Nurses Assoc. of Ontario.

IDEAS AND THEMES EMERGING FROM DISCUSSION 4: WHAT SHOULD NATIONAL STANDARDS FOR HOME CARE BE AND WHO SHOULD FUND THEM?

❶ *No one knows the true costs of home care as health care is de-institutionalized, because informal caregivers mostly bear them.*

- The National Population Health Survey found that the majority of those who report needing help in the home due to age, chronic illness or disability, received no formal, publicly-funded care whatsoever. Eighty to 90% of all care for this group is unpaid.
- The survey did not report, and no one can say, to what extent needs not met publicly are met by private payment, by informal caregivers, or simply go unmet. For those without the good fortune of informal caregivers or of money, conditions must be grim.
- It is assumed that those who provide informal, unpaid care do so gladly. Many family members and friends long have considered it a virtue and a blessing, as well as a duty, to provide care. But these are personal choices, and it should not be taken for granted by policymakers that they will be made or even that devoted family and friends are available. In an economy where many households need at least two incomes to get by, it is inappropriate for government and decisionmakers to disregard the immediate and long-term economic impact of time lost from work. Yet little has been done to take this into account.
- In addition, hospital restructuring, and advanced technology and pharmaceuticals have resulted in people with highly complex needs requiring home health care services. Thus, even with the best intentions, informal caregiving is, in many instances, not feasible, appropriate, or safe.

- When economic value is assigned to informal caring it generally takes one of two forms: evaluation of opportunity cost, e.g., lost real and potential wages; or evaluation of replacement cost, i.e., what it would cost to hire someone. The latter may be fairer, since opportunity cost varies greatly depending on how much the informal caregiver is normally paid.
- The long form of the last Canadian census did ask about unpaid work. But it set the highest category for number of weekly hours spent in "elder care" (a vague term that probably would not capture spousal care) at "10 or more," while the maximum for child care was "60 or more." Volunteer work was excluded entirely from the census question, yet public payers rely heavily on volunteers to keep their costs down.
- It is necessary to begin the work of evaluating these real costs, and also to bring the people who bear them to the table.

❷ *No financing option for home care will be entirely attractive to everyone, but inaction is just as unappealing to many. .*

- Like virtually all policy options, none of the several conceivable for financing home care will be politically attractive to all parties. But this cannot paralyze action; or else we will find ourselves in an increasingly worse situation.

  It was generally agreed by Roundtable participants that some basic entitlements in home care need to be established at a national level, much like basic entitlements in acute care. Such entitlement-based legislation could be limited, but at least would decrease current confusion about eligibility amongst consumers, and decrease the considerable inconsistency across the country.
- Any policies in Canada to extend home care services, or to compensate currently unpaid caregivers, must be formulated with an eye to their long-term implications if they are to have political support now and durability into the future.
- Clear and open debate amongst all interested parties is needed on this point, but the judicious use of different types of limitations on entitlements may need to be considered. An example of how it might be achieved is that different financing options could apply to different aspects of home care delivery – tax-based and employer-based financing might provide "core" home care services, with additional services having co-payments, possibly based on means testing, or other forms of limitation on escalation of long-term public exposure. The question of how to balance multiple payment sources so as to achieve goals such as equity and overall cost containment – whether there would be parallel vs. supplementary private service tiers is the most obvious example; whether financing from different sources would be pooled – would need important consideration.
- As one employer representative at the table said, employers have a direct stake in getting home care right, since substantial productivity issues could arise from a work force conflicted by duties to family members on the one hand, and to the workplace on the other.

❸ *Currently, there are large gaps in legislative frameworks across the country.*

- Many Canadians do not know what home care is available to them. Our so-called "national health care system" and "social safety net" are assumptions that have a limited basis in reality, notwithstanding rhetoric at home and elsewhere. Furthermore, standards in home care are highly uneven from province to province.
- Ontario's retirement homes are a case in point: While other provinces require retirement homes to be licensed, Ontario leaves care services in them entirely unregulated, except insofar as professional licensing applies to some providers. Municipalities can inspect for fire safety, sanitation, and building safety. And the provincial Tenant Protection Act applies to costs of accommodation. But costs and quality of residents' care are administered separately, and no one has the power to monitor service standards. In the worst of these places, residents have been assessed as living at risk. Many wind up in hospitals, shifting the costs of their poor for-profit care onto the public purse.
- In Ontario, again, the competitive framework that was created for home care services, in which for-profit and not-for-profit providers bid, has eroded work conditions and wages. There is concern that well-qualified nurses, physiotherapists and occupational therapists will abandon home care and return, if they can, to hospitals; or, alternatively, leave the province, the country, or their professions altogether. Such de-skilling of available home care workers threatens quality and continuity of care.
- Some provinces have handled home care much better than others have, particularly where services were developed not in cost-cutting and downsizing eras, but with different goals in place. Manitoba, for example, makes basic home care an entitlement, and organizes, regulates, and manages it within the public health care system. And New Brunswick combines the home care budget with the hospitals budget. Provinces have done better and worse jobs with home care. These policy practices need to be assessed.

❹ *People are falling through the legislative framework gaps, and system-wide goals and standards are needed.*

- Beyond evaluating policy practices and outcomes, what is the best way to frame national standards for home care? Should home care be brought in under the *Canada Health Act*, or should parallel legislation be created for it? Participants believed that, without an active federal role, national standards are unlikely. A letter of agreement amongst provinces, without any capacity for monitoring and ensuring its terms beyond initial good will, would be a highly unstable framework to support such a major initiative.
- Parallel legislation, even if it shared all or many of the principles of the CHA, would have the benefit of permitting new funding and monitoring rules.
- It will be more of a challenge to establish national standards in home care than it is to establish standards in medical care. Some standards, such as labour organization and personnel payment, can be established relative to local conditions. What needs to concern policymakers at the legislative level the most, at this time, is setting standards for service provision.

We ought not to have a debate about home care alone; it means we will need to debate everything, one thing at a time. Ideally, we would try to conceptualize the whole spectrum as a system.

Mike McCracken, CEO, Informetrica Ltd.

Welcome and Agenda for the Roundtable, 28 June 2000 (Terrence Sullivan, Vivek Goel)

Roundtable Introductions (Steve Paikin, Facilitator)

Session 1

Problem: Many Canadians feel that there are not enough resources to deal with the enormous pressures in the Canadian health care system.
Misconceived Solution: Private financing would relieve the pressure on the public system

Background Paper:
Raisa B. Deber, *Getting What We Pay For: Myths and Realities about Financing Canada's Health Care System.* Report prepared for the Dialogue on Health Reform. 2000.

Rapporteur: Vivek Goel

Presenters: Raisa Deber, Owen Adams, Bob Rae

Participant Discussion Theme: What kind of funding reform is essential to sustain Canada's health care system?

Session 2

Problem: The Canadian health care system is too rigid and does not allow for individual consumer choice or innovative solutions.
Misconceived Solution: We need to get rid of the CHA and allow provincial governments to redesign health care systems that meet their own needs.

Background Papers:
Colleen M. Flood & Tom Archibald, *Legal Constraints on Privately-Financed Health Care in Canada: A Review of the Ten Provinces.* Report prepared for the Dialogue on Health Reform, April 2000.

Robert G. Evans, "Two Systems in Restraint: Contrasting Experiences with Cost Control in the 1990s." in D.M. Thomas, ed. *Canada and the United States: Differences that Count*, Peterborough, Ont.: Broadview, pp. 21-51.

Rapporteur: Greg Stoddart

Presenters: Colleen Flood, Bill Blundell, David Himmelstein.

Participant Discussion Theme: What innovation in Canada's health care system will best ensure patient and provider choice?

Session 3

Problem: Long waiting lists are an indication of the financial pressures on the system
Misconceived Solution: Private funding would relieve waiting lists and ease the pressures on the public system.

Background Papers:
S.E.D. Shortt, *Waiting for Medical Services in Ontario: Clarifying the Issues In a Period of Health Reform*. Report prepared for the Dialogue on Health Reform, 2000.

Morris L. Barer and Steven Lewis, *Waiting for Health Care in Canada: Problems and Prospects*, Report prepared for the Dialogue on Health Reform, 2000.

Rapporteur: Michael Decter

Presenters: Sam Shortt, Ken Shumak, Bill Gleberzon

Participant Discussion Theme: What steps are required to reduce wait lists for specialty care and high technology services?

Session 4

Problem: More and more people are demanding that governments pay for services in the home.
Misconceived Solution: People should be responsible for their household expenses, so they should pay for their own home care.

Background Papers:
Peter C. Coyte, *Home Care in Canada: Passing the Buck*. Report prepared for the Dialogue on Health Reform, 2000.

Malcolm Anderson and Karen Parent, *Care in the Home: Public Responsibility - Private Roles?* Report prepared for the Dialogue on Health Reform, 2000.

Rapporteur: Steven Lewis

Presenters: Peter Coyte, Shirlee Sharkey, Ethel Meade

Participant Discussion Theme: What should national standards for home care like and how should we pay for them?

Concluding Remarks (Sharon Sholzberg Gray)

Participants at the National Leadership Roundtable on Health Reform

DIALOGUE STEERING COMMITTEE

The Hon. Monique Bégin was Canada's Minister of National Health and Welfare from 1976-1984, and steered in the *Canada Health Act* in 1984. As well, she was Dean of Health Sciences (1990-1997) at the University of Ottawa. A sociologist by training, she is currently Visiting Professor in the Master's of Health Administration Programme at the University of Ottawa.

Peter C. Coyte is a health economist in the Department of Health Administration, University of Toronto. He is also Co-Director of the University's Home Care Evaluation and Research Centre, a collaborative venture amongst academia, industry and policy decision makers.

Michael Decter is Chair of the National Board of the Canadian Institute for Health Information. He is the author of two books on health care: *Healing Medicare* (1994), and *Four Strong Winds* (2000). He has served as Deputy Minister of Health for Ontario, and Secretary to Cabinet in Manitoba.

Doris Grinspun is the Executive Director of the Registered Nurses Association of Ontario. Her research interests are in the areas of the nurse/patient relationship, health services restructuring, professional practice and rehabilitation.

Colleen M. Flood is Assistant Professor in the Faculty of Law, University of Toronto. She specializes in health law, reform and policy and is the author of *International Health Care Reform: A Legal, Economic and Political Analysis* (London: Routledge, 2000). She was the 1999 Labelle Lecturer.

Vivek Goel trained in community medicine, health administration and biostatistics. He is currently Chair of the Department of Health Administration at the University of Toronto, and the Scientific Program Leader of the Health Evidence Applications Linkages Network (HEALNet), a federal Network of Centres of Excellence.

Steven Lewis is currently a health policy and research consultant based in Saskatoon, and Adjunct Professor of Health Policy at the University of Calgary. He has been CEO of the Health Services Utilization and Research Commission in Saskatchewan, and a member of the National Forum on Health.

Tom Noseworthy is Professor and Chair of Public Health Sciences at the University of Alberta in Edmonton. A physician by training, he is Chair of the Western Canada Waiting List Project, and was Vice Chair of the National Forum on Health.

Greg Stoddart is a Professor in the Dept. of Clinical Epidemiology and Biostatistics, and an Associate Member of the Dept. of Economics, at McMaster University. He is also a Fellow and a founding member of the Population Health Program of the Canadian Institute for Advanced Research.

Terrence Sullivan is President of the Institute for Work and Health in Toronto, and a member of the Department of Health Administration. He was formerly Executive Director of the Premier's Council on Health, and Assistant Deputy Minister of Intergovernmental Affairs, in Ontario. He is the editor of two recent volumes, *Health Reform: Public Success/Private Failure* (with D. Drache, Routledge, 1999), and *Injury and the New World of Work* (UBC Press, 2000).

Patricia Baranek is Project Director for the Dialogue on Health Reform. A health policy and research consultant, her research activities include public/private financing and delivery, and home care. She has served in Ontario's ministries of Health, Citizenship, and Intergovernmental Affairs across two administrations.

OTHER ROUNDTABLE PARTICIPANTS

Owen Adams has been Director of Research at the Canadian Medical Association since 1990. Prior to joining the CMA, he spent 12 years in the Health Statistics Division of Statistics Canada, where he conducted analyses of population health survey and vital statistics data.

Malcolm Anderson is a Research Coordinator with the Department of Rehabilitation Medicine, Queen's University. His chief current research focus is on home care services, including their relationship to emergency services, their monitoring by report card, and their provision to people with serious mental illness.

Wendy Armstrong is a well-known consumer rights advocate, author and commentator. Her most recent project, called "Canada's Canary in the Mine Shaft," was an expose of the Alberta experience with private surgery clinics, written on behalf of the Alberta Chapter of the Consumers' Association of Canada.

Bill Blundell was Chairman & CEO of GE Canada. He subsequently served as Chairman of Manulife Financial Corp. He was also a former Chairman of the Board, Wellesley Hospital, and a member of the National Forum on Health. He currently serves on numerous corporate boards in Canada.

Leslie Buckley is a member at large on the executive of the Professional Association of Interns and Residents of Ontario.

The Hon. William Davis entered the Ontario legislature in 1959. He was Minister of Education in 1962 under Premier John Robarts. He served as the Premier of Ontario from 1971-1985.

Raisa Deber is a Professor of Health Policy in the Department of Health Administration, University of Toronto. A political scientist by training, she has taught, written, and consulted widely on Canadian health policy, and is the past president of the Canadian Health Economics Research Association.

Bill Gleberzon is the Associate Executive Director of CARP, Canada's Association for the Fifty-Plus, where he is responsible for the development of policy. He has extensive managerial experience in social service and seniors' agencies.

David Himmelstein is Associate Professor of Medicine, Harvard Medical School. He also practices primary care internal medicine and serves as the Chief of the Division of Social and Community Medicine at Cambridge Hospital, Cambridge, MA. He was a founder of Physicians for a National Health Program, and serves as the Co-Director of the Center for National Health Program Studies at The Cambridge Hospital/Harvard Medical School.

Mel Hurtig is an Officer of the Order of Canada and has been a bookseller, a publisher (*The Canadian Encyclopedia*) and the author of four best-selling books, the most recent being *Pay the Rent or Feed the Kids: The Tragedy and Disgrace of Poverty in Canada*. He is the founder of the Council of Canadians, and a founder and past National Chairman of the Committee for an Independent Canada.

Mike McCracken is Chair and CEO of Informetrica Limited, an economic research and information company in Ottawa. He focuses on long-term strategic planning for organizations and governments. In 1998-99 he was an active member of a group examining approaches to an Integrated Healthcare Delivery System in Ottawa-Carleton.

Ethel Meade is Chair of the Health Issues Committee of the Older Women's Network, an executive member of Care Watch, Toronto, and a member of the steering committee of the Ontario Health Coalition.

The Hon. Keith Norton is Chief Commissioner of the Ontario Human Rights Commission. A lawyer and educator by training, he has served as Minister in a number of Ontario government portfolios, including Health, Community and Social Services, Education, and Colleges and Universities. He was also the former President of the Canadian Human Rights Tribunal.

Jon Oberlander is Assistant Professor of Social Medicine at the University of North Carolina-Chapel Hill, where he teaches health policy in the School of Medicine and political science departments. Dr. Oberlander has written extensively on the effects of market-based reforms on public health insurance systems and vulnerable populations.

Steve Paikin hosts two programs on TVOntario, the largest educational television network in the world: *Studio 2*, a nightly current affairs program now in its 6th season; and *Diplomatic Immunity*, a weekly program on in foreign affairs. He has produced many feature-length documentaries, including "Return to the Warsaw Ghetto," "A Main Street Man" (the life of former Ontario Premier William Davis), "Balkan Madness," and "Teachers, Tories, and Turmoil" (about the current Ontario government's controversial education reforms).

Karen Parent is a Research Coordinator with the Department of Rehabilitation Medicine, Queen's University. Her research initiatives include research examining the interface between home care and the emergency department, LTC waitlists, a report card on home care, the relationship between people with serious mental illness and home care, and the development of a home care resource and research web site.

Charles Pascal is executive director of the Atkinson Foundation, which supports the Dialogue on Health Reform. As former Ontario Deputy Minister, he served in a number of portfolios including the Premier's Council on Education and Training, the Ministry of Community and Social Services, and the Ministry of Education.

The Hon. Bob Rae served as Ontario's 21st Premier from 1990 to 1995, at the end of a 20-year political career. He is a Partner in the Canadian international law firm Goodman Phillips & Vineberg, and is adjunct Professor at the University of Toronto in the faculties of Law and Arts and Sciences. The author of two books, Mr. Rae serves as a member of the Security Intelligence Review Committee for Canada, and in 1999 co-chaired an international conference on federalism. He continues to serve as Chairman of the Forum of Federations.

Arnold Relman is Professor Emeritus of Medicine and of Social Medicine at Harvard Medical School. He was Editor-in-Chief of *The New England Journal of Medicine* from 1977 to 1991. He is currently a member of the Massachusetts State Board of Registration in Medicine in charge of its Quality Assurance program.

Mark Rochon is President and CEO of the multi-site Toronto Rehabilitation Institute. He has held health service management positions at the Clarke Institute of Psychiatry, served as President and CEO of the Georgetown & District Hospital and Humber Memorial Hospital; Assistant Deputy Minister, Institutional Health Services, Ontario; and Chief Executive Officer of the Health Services Restructuring Commission, Ontario.

John Ronson is the Chair of the Advisory Council of the Centre for Health Economics and Policy Analysis at McMaster University and a founding partner of Quantum Solutions. Quantum Solutions produces knowledge products and services to help build the capacity of individuals, organizations and systems for sustainable change.

Graham Scott is Managing Partner, McMillan Binch, Barristers and Solicitors of Toronto. He leads the firm's health group and represents McMillan Binch in a special health consulting arrangement with Maureen Quigley and Associates Limited. He has extensive experience at both the Federal and Provincial levels of government serving as Deputy Minister of Health, and of the Environment in Ontario.

Judith Shamian is Executive Director of Nursing Policy, Policy & Consultation Branch, Health Canada, and Associate Professor at the Faculty of Nursing, University of Toronto. Dr. Shamian is immediate Past President of the Registered Nurses Association of Ontario. She led the World Health Organization Collaborating Centre at Mount Sinai Hospital in Toronto, where she was Vice-President for 10 years.

Shirlee Sharkey is President and CEO of Saint Elizabeth Health Care, a major provider of home and community-based health care in Ontario. Ms. Sharkey is also the President of the Registered Nurses Association of Ontario (RNAO).

Sharon Sholzberg-Gray is President and CEO of the Canadian Healthcare. She is also co-chair of HEAL, a coalition of national health and consumer. A lawyer by profession and association manager by occupation, she speaks and writes extensively about health and social issues and is active in a wide range of community organizations.

Sam Shortt is a family physician who holds post-graduate degrees in Canadian studies, history and public policy. He is a Professor in the Department of Community Health and Epidemiology and the Department of Family Medicine at Queen's University, and is the Director of the Queen's Health Policy Research Unit.

Ken Shumak is the President and CEO of Cancer Care Ontario. He came to this position from the Toronto-Sunnybrook Regional Cancer Centre where he also was CEO. In these positions, he has had responsibility for patients on waiting lists for cancer treatment.

The Hon. Greg Sorbara was a Member of Provincial Parliament for three consecutive terms. He served as Ontario's Minister of Consumer and Commercial Relations, Minister of Labour, Minister Responsible for Women's Issues, Minister of Colleges and Universities, and Minister of Skills Development. He is currently: Partner of the Sorbara Group, an Ontario based land development and property management organization; Chair designate of the Richmond Hill Hydro Electric Commission; and Director of the Business Development Bank of Canada.

Gretchen Van Riesen is Senior Director, Pensions and Benefits Policy, at Canadian Imperial Bank of Commerce. She is a past chair of the Association of Canadian Pension Management, and current chair of its Advocacy and Government Relations Committee. She acts on numerous other committees and boards, including those of the Canadian Bankers Association, the Board of Trade, the Employer Committee on Health Care - Ontario, the Pension Investment Association of Canada, and the Safe Communities Foundation.