

“No statute remains frozen in time forever”: Romanow

After 9 months of toil, including 17 site visits and fact-finding missions to the United Kingdom, France and Sweden, Canada’s one-man health care commission has reached the self-evident conclusion that Canadians have choices to make.

In an interim report that is breathtakingly descriptive rather than prescriptive, ex-Saskatchewan premier Roy Romanow says Canadians must reach a “consensus” on whether they would like to save medicare by pumping more tax dollars into the system and introducing new charges like user fees. The other options are to achieve economies through systemic reforms like the introduction of community-based health networks as opposed to the traditional fee-for-service method of paying doctors. Alternatively, they can allow parallel, private, for-profit health services to emerge on the supposition that “the discipline of the marketplace would improve the system’s effectiveness, efficiency, productivity and consumer satisfaction.”

Romanow indicated that he personally believes “the Medicare house needs remodelling ... not demolishing” and that “Canadians do not want a 10-tier patchwork quilt” in which the nature of health differs according to the province of residence.

But he stressed repeatedly that he did not want to prejudge the outcome of the 18 “Citizens’ Dialogue Sessions” that he will hold across the country, commencing Mar. 4 in Regina and concluding May 16 in Yellowknife.

“It’s time again for Canadians to debate values and to choose,” Romanow declared at a press conference after yesterday’s tabling of the interim report of the Royal Commission on the Future of Health Care in Canada. Federal health minister Anne McLellan concurred. “It is about making choices and I think Canadians have to be very much engaged in that process of helping make the choices,” she said.

Yet the interim report cautions that there may be no single option on which Canadians can settle. “In reality, it is doubtful that any one perspective, however logical or persuasive, provides a total solution for our health care system.”

Response to the interim report varied. The *Globe and Mail* said it had “all the pizzazz of cold pizza” but did acknowledge that it was “sensible, fair and focused.” CMA President Henry Haddad commended Romanow for seeking input across the country but warned that the upcoming debate about sustainability “is not only about finances. It is [also] about political leadership and public confidence in our health care system.”

Romanow took several shots across the bow of Canada’s 10 premiers, particularly British Columbia’s Gordon Campbell, who said medicare is on life support, and Ontario’s Mike Harris, who has asserted that medicare is headed inexorably toward “10-tier” health, with the end result being vastly varying levels of service across the nation.

“I reject the notion that we are unable to renew medicare through wise and collective decision-making, that somehow the system is now out of control,” Romanow said, while urging less “ideologically motivated” debate.

As for the assertion that the provinces just can’t wait for the Royal Commission’s final recommendations this November before they begin implementing reforms, Romanow argued that it isn’t unreasonable to defer changes until after Canadians have had a chance to provide input.

It would take at least that long to implement medical savings accounts and other reforms proposed by former deputy prime minister Donald Mazankowski in his recent one-man commission into the sustainability of Alberta’s health care system, Romanow said. “Are they going to close the door on national reform? I’m calling on them not to.”

Romanow also urged caregivers like physicians to recognize the impact of wage demands on the system’s sustainability. And he reiterated earlier assertions that the 5 principles of the Canada Health Act (CHA) — public administration, comprehensiveness, universality, portability and accessibility — must be on the table during his dialogue sessions.

He said Canadians must also determine whether they need some form of dispute-settlement mechanism to re-

solve intergovernmental squabbles over interpretations of the CHA. They must also decide whether they need a mechanism to provide more public input into determining which medical procedures should be covered and whether additional services like home care, long-term care and pharmacare should be included.

The CHA has achieved such “iconic status” it is politically difficult to modernize the legislation, Romanow concluded, “but no statute remains frozen in time forever.” — *Wayne Kondro*, Ottawa

Quebec puts smart-card technology on health care back burner

Quebec has backtracked on a proposal that would have made it the first province to use medicare cards that provide instant access to a patient’s medical history. A draft bill proposing adoption of the smart cards, slated for a June vote, would have introduced them in 2003 at a projected cost of \$150 million, but in February the government decided it had other priorities. The cards, which were expected to save about \$45 million a year by combating fraud, would have allowed access to myriad data, including a patient’s clinical and medication histories. Licensed professionals, with consent from the patient, would have been able to connect to the databases containing the information.

Consent would have been inferred when the patient entered a personal identification number, either for one-time use or for extended access by members of a group practice. “The patient [would always be] master of the information,” said Nathalie Pitre, a spokesperson for the Régie de l’assurance maladie du Québec. Patients would have been able to block access to a diagnosis or laboratory result.

According to the draft legislation, access cards would have been given to licensed health professionals, their students and certain government employees. — *Susan Pinker*, Montreal