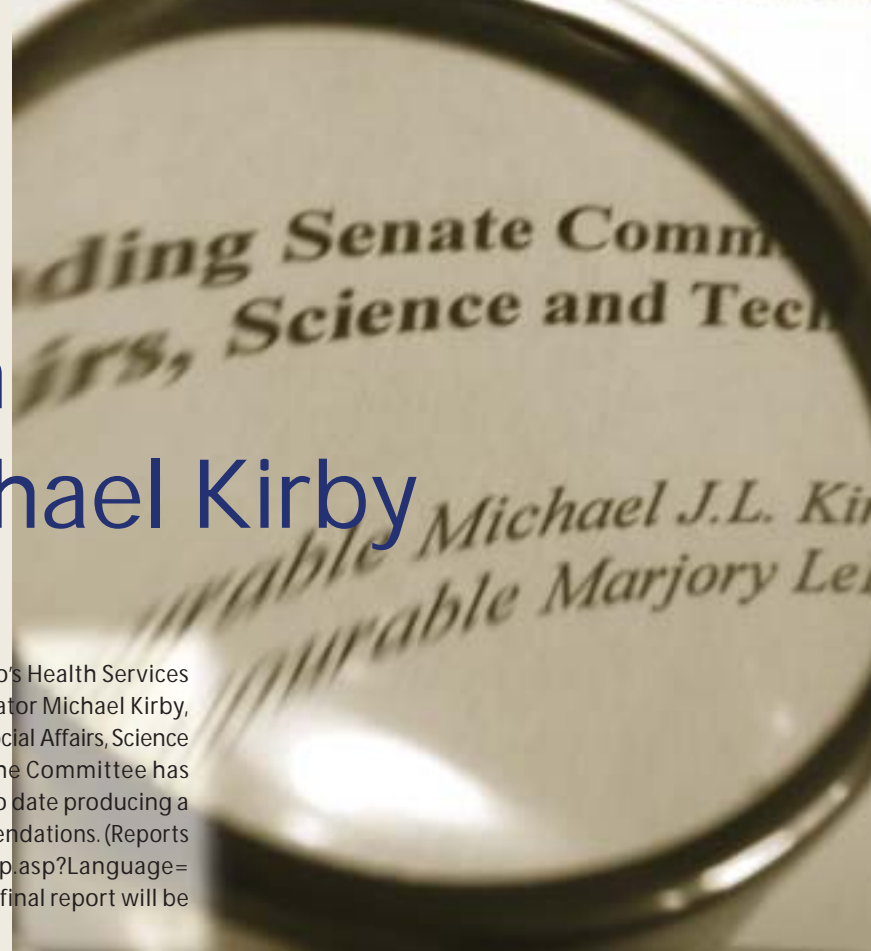


THE HEALTH OF CANADIANS – THE FEDERAL ROLE



Speaking with Michael Kirby

Recently, Duncan Sinclair, who chaired Ontario's Health Services Restructuring Commission, interviewed Senator Michael Kirby, Chair of the Senate Standing Committee on Social Affairs, Science and Technology. Since December of 1999, the Committee has examined and reviewed healthcare services in Canada, to date producing a series of five reports with detailed findings and recommendations. (Reports available at: www.parl.gc.ca/common/Committee_SenRep.asp?Language=E&Parl=37&Ses=1&comm_id=47.) The much-anticipated final report will be released in October 2002.

Sinclair: First of all, Senator Kirby, what does your committee hope to achieve? Let me put this in context. Health is primarily a provincial responsibility, and the federal/provincial conflict is well known – advice from anything associated with the federal government is not likely to be well received by the provinces. The argument could also be made that advice from the Senate might not even have much effect on the federal government.

Kirby: When we got into this, it was clear that many of these issues are so emotional that it's very hard to have a rational debate. One only needs to notice the attacks on the committee when we even suggested, for example, that the corporate ownership of a hospital doesn't matter – that it doesn't matter if it's public or private. The emotional reaction was enormous. When you get into some of the funding issues, a lot of people argue that all you need to do to make the system more efficient is take the inefficiencies out of the system and there will be enough money. Well, we don't believe that. And



Dr. Duncan Sinclair

Dr. Michael Kirby

finally, it's such an ideological issue among various political parties, between the NDP on one extreme and the Alliance on the other, that it's pretty well impossible for members of Parliament or the House of Commons

health committee to do what we've done because work would be so bogged down in (a) ideology and (b) parties trying to score points off each other.

We had a very unique advantage. We had a group of people in the Senate who'd had long experience with the healthcare system, who crossed two major party lines and who were prepared to come together to see if we could seek a common viewpoint. So to that extent, our primary objective was to do two things – lay out a roadmap to a strategic plan and start at

the beginning. We understand that it's going to take ages to get things implemented, and that the final plan as it emerges certainly won't be identical to ours and may only have some vague similarities. But we think a lot of the ideas we've put forward, because they resonate with a lot of people as being common sense as opposed to being driven by a particular political viewpoint or ideology, are likely to contribute substantially. Also, we got started before Premier Romanow, and we simply decided when Premier Romanow started that we would go ahead and continue our work.

We will do one thing that I'm not sure he will do – and this is just speculation because I don't know what he's going to do. We have said that in order to crystallize the debate among Canadians, basically you have to say, "If this is what you want, then this is what you've got to be prepared to pay for." And rather than say, for example, pick a number – \$4 billion, \$5 billion, \$6 billion a year – which doesn't mean anything to anybody, we will lay out three or four or five ways of raising what we believe will be the required amount of money by specific federal revenue generation measures so that any individual will be able to say, "This is my income, and this is how much it would cost me, and am I prepared to do that?" We think that you've got to get away from this notion of healthcare as being a "free good." I don't mean you have to have user fees, but people perceive it as a free good – because they pay taxes, they don't perceive themselves as paying anything for healthcare. We think a range of specific taxing proposals down to the level of the individual will help crystallize the debate because we will also say that if you're not prepared to pay for this system, then you have to allow a parallel private system. In our view, the one option that is not on the table or that is simply unacceptable is the notion that timely service will not be provided – that is, just continuing to ration by lengthening waiting lines.

It was very interesting, by the way. I guess it was in our fourth volume that we asked whether or not it was even constitutional to have waiting lines, and we got pilloried for asking the question. Significant segments of the left wing and academia in Canada attacked us. But it's very interesting to notice that a month ago or so, Patrick Monahan, the associate Dean of Law at the University of Toronto, along with Stanley Hartt, the former Deputy Minister of Finance, published an article in a law journal, which not only says that we raised the right question but also that they agree with our answer – namely, that the failure to provide timely service is a violation of the Charter, and so if Canadians reject paying for timely service then the only option is a parallel system.

Sinclair: Just let me follow that. When Canadians decide whether they are or are not willing to pay taxes, they make that decision in a political sense, and basically that's a platform

issue. And as you know, the conversion of platforms into legislative action is always a little less than one to one. So if Canadians are being asked at some point to decide how much they are prepared to pay for medicare, how do you anticipate that to be done?

Kirby: Well, that's a good question. I don't think it will be decided in an election actually. I think it will be decided in a budget. We're going to report before the end of October; Roy Romanow is going to report before the end of November. I could easily see a scenario in which in January and February all the news media are essentially doing public opinion polls that say to people, "Are you prepared to pay the following amounts?" We're going to put in a whole bunch of conditions on that money because the answer will be "no" if people think that Ministers of Finance and other department heads can get their hands on it. The money has got to be put in an arm's length fund, it's got to be controlled by a process, and we're working on it now, but a process that would ensure it could never get drawn back into the consolidated revenue fund. It's got to be accountable, it's got to be transparent, and if the money goes to the provinces we've got to know what it's spent on. So Canadians would have the option of saying, "Yes, I'll pay the extra money because I know that it's really going to be spent on healthcare."

I was in the market research business for a long time. I can tell you that it's an easy issue to research, and I would think that most news organizations would be out doing that. The interesting question is what the polls will say. Because there are really three things Canadians could say. They could say, "No I'm not prepared to pay any more money, but I'm also not prepared to allow a private parallel system" – that is, continue to believe it's a free good. Or they could say, "Yes, I'm prepared to pay money because I don't want a parallel system" or "No, I'm not prepared to pay more money and I will not object to a parallel private system." My instinct, knowing Canadians, is that they will decide to pay for it. I'm not talking about a huge amount of money here. The total amount will be fairly high, it'll be in the billions, but that may not require a huge amount of money from each individual. We've got some very good people working on what financial structure would work.

Sinclair: Let me pursue a little bit more the ambition your committee has in its collective mind. There have been several provincial commissions, committees, task forces – Mazankowski, Clair, Ontario and so on. The degree of consensus among them is pretty high – primary care reform, the need for information systems – and you have fallen in there. Why do you think your report, or indeed Roy Romanow's report, will provoke action whereas these others have not?

Kirby: Oh, because I think each of the individual provincial ones was done from the perspective of the province. For example, in the Fyke Report in Saskatchewan, there was an extensive discussion about how to consolidate 200-odd rural hospitals down to 50 and so on. But you're right, on the broad principles they've been the same. I think there is a difference when a federal task force like Roy Romanow's or ours comes out and then says to the feds you've got to put money behind it, but you've got to put money behind it with strings. Look, our view has been very clear. We would not put more money into the current structure, and this, I guess, is where I part company with people who would argue that this is an area of provincial jurisdiction. It is, and therefore the feds shouldn't have anything to do with delivery, which I understand. But there's absolutely nothing wrong with the federal government saying to a province, "We're prepared to help you on some of your restructuring provided you're prepared to separate the insurer, or the funder, and the provider. If you're not prepared to do that, we're not prepared to help you." Well, I don't regard that as unreasonable. I know for a fact, having worked in a premier's office as well as having run federal-provincial relations for the feds, that some premiers will find that offensive, but I don't think very many are going to find it so. I think most of them will say, "We just need help."

And I'll give you another example – the money for an electronic patient record. I think you can make a case that the funding of the electronic patient record should be done entirely by the federal government, that they should put the money up and give the system to every province and therefore every institution in the country. Why are we going to invest the capital cost of a system development and do it in thirteen different jurisdictions? It doesn't make any sense.

Sinclair: Consistent with the principle of portability.

Kirby: Exactly. I think there's a lot that the feds can do that clearly doesn't relate to delivery ... that even the purist on constitutional grounds would not argue is getting into delivery. And I think there are other things that can be done following exactly the same logic that allowed medicare to be established in the first place. We have to remember what the feds said in the beginning was that they would pay 50% of the costs for any province that wanted to sign on, and we forget that some provinces did not sign on in the first year – Nova Scotia being one. I happened to be living in Nova Scotia. They signed on the next year because the pressure from the public was enormous.

Sinclair: Sure, and the lure of fifty cent dollars ... those two things combined ...

Kirby: After all, our whole restructuring is based on incentives. We've been very clear – governments need incentives too, not just individuals, and that's not unreasonable to say.

Sinclair: You've done a lot of work and a lot of research in what I consider to be very insightful reports, some of them quite provocative. What would you say is the state of the union at present with respect to Canadian healthcare?

Kirby: You mean the state of the union in terms of how well Canadians are taken care of?

Sinclair: Well, yes. There's currently a lot of angst among Canadians – among potential users of the system, actual users, providers of the system, politicians, everybody – that the whole enterprise is failing. Is it failing?

Kirby: No, it is not failing once you're in the system. The quality of service once you get into an institution or the quality of service you get from your local GP and so on, as best as one can tell, is pretty good. That's not where the disaster lies. The disaster lies in failing to meet expectations with respect to timely service.

Sinclair: Now this is waiting time?

Kirby: Yes, it's waiting time, but it's waiting time for all kinds of things. It's waiting time for tests, it's waiting time in many big cities trying to find your own family doctor because you can't get one, so you're going to the walk-in clinic ...

Sinclair: It's worse outside the cities, I can tell you that.

“ We decided to focus on the hospital-doctor system because that's where the big public complaint was, and you couldn't move the public debate or governments beyond that until you got rid of what was seen as the crisis problem. ”

Kirby: Well, that's right. So you have a significant service problem that our proposed structure is designed to deal with. It has always interested me to look at public opinion results when they break the answers down by those who have had an immediate member of the family in a hospital and those who haven't. If you've had a member of the family in the hospital, you're much more positive about the hospital system than people who haven't had experience with the system. So I think that the actual hospital experience is not bad – it's not good,

but it's not bad. I think the danger is if we continue to ration, which is fundamentally what happened by cutting healthcare budgets. Rationing was a "free good" to the government, interestingly enough, because the people who paid the price were those whose quality of life was hurt because they waited in waiting lines, or they were the front-line providers, be they physicians or nurses, and particularly nurses, who became overworked and stressed. One of the advantages of putting in a system that separates the insurer and the provider on the one hand and the care guarantee on the other is that you move the risk or the cost of excessive rationing back on the shoulders of the people who are making the decision to ration, which is governments, and that is where it belongs.

I think it's possible to make a lot of progress relatively quickly by recognizing that the human resource factor is probably the longest-term problem to solve simply because it takes 10 years to produce a physician. But even here there's been roughly a combined 25% increase across the country in medical school enrolment in the last three years. One of the tragedies that shocks me is that there has not been a corresponding increase in nursing schools, and if anything there is a much, much bigger shortage of nurses than doctors.

Sinclair: So if rationing is the major problem – whether it's access to personnel or to services – are you saying that we will not have to ration access under the reforms you are proposing?

Kirby: It depends on what you mean by ration. Let me be very clear. What I mean by rationing, is having to wait, as a friend of mine did, 22 months to get a knee replacement, that's rationing. Having to wait four months – of course you're going to have to wait four months.

Sinclair: So in other words what you really see is that the rationing is too severe, and the relation to supply and demand is not well managed.

Kirby: Right. We've said that the care guarantee or the maximum waiting time would vary by procedure, to be determined by experts, and the test should be at what point the individual's health starts to deteriorate. For instance, some orthopedic surgeons have told us that if people have to wait more than six months, then it's actually a tougher medical problem to fix; but that doesn't mean they have to do it in a week, they can do it in five weeks.

Sinclair: There are two kinds of rationing, or at least two bases on which to ration. One is rationing on the basis of need ...

Kirby: We're never going to do that. This country will not do that ... which is why we should never have user fees.

Sinclair: But rationing on the basis of demand means you have to discriminate between demand and real need, and we don't do that well.

Kirby: We do it in the emergency room and in the Ontario Cardiac Care Network. The Ontario Cancer Care Network is getting better at it also.

Sinclair: ... and the Western Waiting List project. But we don't have very good discipline on our waiting lists, and in order to create that, we need an information system.

Kirby: Which is why we said that you have to begin with the electronic health record because it's the key to an information system. But you also need an information system in terms of costs and various other elements related to the actual administration of the institution.

Sinclair: Yes, but in addition we need to develop criteria that can then be applied against the information system. Are these criteria being met so that the person who needs a knee in fact gets to the front of the line, whereas the person who really demands a knee because of a relatively lesser problem stays in the grid?

Kirby: No system is going to be perfect. But you've got to have more objectivity in it than presently exists because right now lots of people jump the queue – they just jump the queue on the basis of who they know. You have to have a reasonable set of criteria that are out there, that the public understands, that aren't hidden away in somebody's drawer. And so when you're told that you're on the waiting list, and that this is the likely waiting time, it's because this is where you are in terms of the scale of, as you put it, need versus demand.

Sinclair: That's one of the great strengths, for example, of the Cardiac Care Network in Ontario. People understand it and think that it makes sense, so they are happy to be on a longer wait list because their need isn't as great.

Kirby: Correct, and it seems to work well. So we have to do that for other services. There will be a lot of education both of physicians and patients to do that, but the reality is that the Cardiac Care Network in Ontario has shown that it's absolutely doable and the Western Waiting List project has shown that it's doable.

Sinclair: Senator, you've been concentrating on the hospital-doctor system but if you think of the whole object of this enterprise – the need to optimize the health of the population – there are many other things that come into consideration.

Particularly now, hospitals have become much less central to healthcare than they were 40 years ago, and similarly with physicians. Would you like to comment about some of these other elements in the system that are not wrapped up in medicare?

Kirby: Absolutely. We decided to focus on the hospital-doctor system because that's where the big public complaint was, and you couldn't move the public debate or governments beyond that until you got rid of what was seen as the crisis problem. And that's why we said in our last report that there were a number of other issues we intend to start looking at once we finished the current report in October, and we named three or four. One is Aboriginal health. I'll tell you, you pick up some very interesting insights when you ask the minister of health for Nunavut, a very smart young man, how he would spend the money if out of the blue he had \$100 million to put into his hospital system. He said he'd spend every cent on housing. And I say that only to emphasize the point of how complex the Aboriginal health problem is. So we're going to do one on Aboriginal health. We're also going to do one on public health because we're not doing enough on the wellness side and we've talked explicitly about this.

Sinclair: Mazankowski makes that a very strong point. There are two health services now receiving a lot of attention in other countries as well as in Canada, and it's quite possible Romanow will comment on one or both of them. One is the provision of pharmaceutical prescription drugs and the other is home care, and these were commented on by the National Forum on Health. Any comments?

Kirby: Yes, we will have in this report a specific proposal on what we're basically calling catastrophic drug costs. Let me explain what we mean by that. We are not in favour of going all the way to a national pharmacare program. If we were starting from scratch, if individual Canadians and individual employers didn't have health plans, you might well logically look at a single pharmacare system, but trying to get from where the country is now to there would be extremely difficult. It's not that the money on drugs is not going to be spent, but you'd have to have such a huge reallocation in terms of who pays what that it would be very difficult to do.

Sinclair: Difficult for medicare?

Kirby: Yes, but also difficult economically because suddenly you'd have to have a significant increase in taxes for some people and what would amount to a decrease for others because people are now paying premiums that they wouldn't have to pay. So it would be a reallocation issue more than anything else, and yes, it would be difficult to do politically,

absolutely, and I think hard to sell, frankly.

On the other hand, there clearly are a small number of people in the country for whom drug costs are catastrophic, and they can't pay for them, or if they do pay for them they have to give up other things. We've had testimony from pharmacists who say that someone will come in late in the month, a senior will come in with a prescription and ask how

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much it is, and they'll reply \$80, and the senior will say, “Well, I have to choose between the \$80 for the pills or food for the rest of the week, so I'll take the food.” You know that's wrong in a country like Canada, it's categorically wrong. So we are in the process of having some very good experts help us work out a program that will begin to deal with the issue of catastrophic drug costs.

Sinclair: So in effect, then, you're thinking about going back, with respect to pharmacare, let's call it that, to what medicare was vis-à-vis hospital insurance – catastrophic coverage so people would not be bankrupt as a consequence of pharmaceutical expenditure.

Kirby: That's right. Similarly, if you're going to have a home-care program, it ought to follow the same philosophy as the catastrophic drugs. It ought to deal with the essentials, and not with things that are nice to have but not absolutely essential. How you define that is very, very difficult.

Now, the one place that one would contemplate starting in that direction – and I say contemplate because the committee has not reached any views on this at all – would be to address the problems of people who are now being sent home from hospitals earlier than they used to be, not discharged so early that they are in danger but discharged earlier than they previously would have been, and they clearly need some help in that immediate two-, three- or four-day post-acute-care period. One presumably could draw a pretty good boundary line which would prevent a lot of the spinoff or abuse by saying, for instance, if you're on immediate post acute care, you can

get up to seven days and it would include drugs and a certain element of home care on the grounds that whatever that amounts to is a heck of a lot cheaper than leaving people in hospital, which is the alternative. And if you get back to the principle that this type of home care is really a part of hospital care in the sense that in the old days they would have stayed in hospital, then I think you can argue that that's a legitimate extension of medicare, and I would be more inclined to call that an extension of medicare than I would be to call it home care, even though it's being delivered at home.

To put it another way, the part of medicare that says it has to be provided within the four brick walls of the hospital has struck us as kind of silly anyway, but you still have to re-fence the system so you know what you're paying for and not paying for.

Sinclair: Again the fence ... the ridiculous fence is that drugs that are given within the four brick walls of the hospital are in fact under medicare and those immediately thereafter essentially are not.

Kirby: It's one of the things we're looking at, because New Brunswick got around this a little bit with their concept of the hospital without walls. By the way, interestingly enough, the minister of health who introduced that, Brenda Robertson, is a member of our committee. It was designed exactly to get around this definition. You have to absolutely limit the maximum number of days to prevent it becoming an ongoing program. In other words, at some point you move from post acute to actual home care. In the delivery of service in the home, the one piece we have been looking at is what I would call the immediate post acute care, and we will do a separate piece on more general home care next year.

Sinclair: Let me pose a hypothetical question. Say a person says to you, well I'm a believer in the principles of the Lalonde Report, I really am. And I can make a case that the provision of home care for people who are not in hospital, have never been in hospital, is in fact a very good investment because if they continue to have access to home care it will keep them out of hospital.

Kirby: I don't dispute that at all. All I'm saying, and the reason we said we would go ahead and do a separate report on it, is precisely that we haven't had time to do it. My own mother was a case. My mother had home care for quite a while. In that case she was supported by the family, but it was there and it absolutely kept her out of the long-term care institution until she became too frail and we had no other alternative. It is actually a terrific investment, but the details are very tricky if you're going to control that program. And we will work on that, but we'll be doing that subsequently.

Sinclair: So to summarize, you're going to concentrate on things that are defined as medicare or can be defined within a broad envelope of medicare and then come at some of the other issues later.

Kirby: Right, and the reason we've used the term hospital and doctor repeatedly is because Canadians believe they have a healthcare system, a national healthcare system, and they don't. They have a national hospital and doctor system, which is now 46% of the total healthcare bill and falling. One of the depressing things in all of this is the number of myths that people have about what they have and don't have and how the system operates and doesn't operate. So one of the politically difficult things – and I don't mean this in the partisan sense, just one of the difficulties in getting Canadians to come along with reform – is to first make sure they understand current reality, and generally they don't.

Sinclair: Well, I agree with that very strongly, and frankly the only way to get people from that state of ignorance into a state of knowledge is if we do develop a capacity to manage health information and to collect it, analyze it, and make it available to people so that some of these myths can be dispelled. I'm moved to my third theme, and that is looking toward October. Would you care to speculate on what you'll be recommending?

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Kirby: Except for numbers, I'd be happy to do that. The only reason I can't do numbers is because I don't know what they are. We've received some terrific testimony on how our 20 principles can actually be implemented, along with things to think about, so we'll enlarge on those in a practical how-to-do-it sense. We will repeat, for the sake of completeness, the firm recommendations we made in the last volume on human resources, on research, on electronic health records, on systems. We'll add a piece on catastrophic drugs and conceivably a piece on post-acute-care delivery in the home – I'm going to call it that rather than home care. And we will get an estimate, and it's going to be a ballpark estimate, of what we think would be a reasonable federal contribution to this program on a yearly basis, but it won't be insignificant – it will clearly be in the billions.

Then we will say, here are three or four different ways of raising that money. One will be some form of a national health-care premium. And there are all kinds of possible premium-based models. You could have a national healthcare premium that is flat, you could have them graded. There will be some form of a consumption-driven model. The most obvious consumption tax is the GST, but you know we have other consumption taxes. We have them on alcohol, we have them on cigarettes. Another model has been proposed, and we will certainly include it in the report, which isn't to say we will necessarily recommend it. This is the so-called taxable benefit model whereby at the end of the year individuals would receive a T5 slip, a taxable benefit slip, for the dollar value of the health services they have received up to some maximum amount, and that would be taxable. It has the advantage that it's progressive, in the sense that if you don't pay income tax you don't pay anything. It has the disadvantage that it's clearly open to the charge that you're taxing the sick. On the other hand, the sick are getting the service.

So there would be at least those three models. There's likely to be a pure income-tax-driven one, so there will probably be four models, and some of the experts are looking at others. But we will try to do them so that each of the models raises an identical amount of money. We're going to say right up, look, our forecast is a ballpark estimate – \$3 billion, \$4 billion, something like that – but it's just interesting for people to see you can raise that amount of money in three or four different ways and they'll all raise the same amount of money. We may or may not specify one particular model. If there are four ways of raising the money, what we really want is a debate on what people are prepared to pay and which model they prefer if they are prepared to pay for it. And some of us think that choosing one alternative would be a mistake because it would focus all the attention on that one and not on the others, and somehow we would like the full range of debate.

Then we will say, look, if people aren't prepared to pay for this, then you've got to allow a parallel private system because

we believe that access to timely care is a right, as we stated earlier, and here are some ways in which a parallel private system would work. We're probably not going to flush that out in too much detail, but we will give essentially an alternative model if people don't want to pay for the public one.

Sinclair: To whom will your report be addressed?

Kirby: Well, like all Senate Committee reports it's really addressed to the public. It gets tabled in Parliament, it gets widespread coverage by the media. It's not a formal report to government, although it's interesting that as I travel across the country I run into people in health departments, both provincial and federal health departments – and I don't mean ministers, I mean senior-level or middle-senior-level bureaucrats – and they are certainly following what we're doing. If part of our role here was to put ideas out that spark a debate, we've certainly accomplished that in the sense that the people involved in the system, whether they be the professions like the CMA or the OMA, and the people involved in health departments and treasury departments seem to be aware of what we're doing. It's not too often a Senate Committee gets the sort of coverage that we get.

Sinclair: This provokes a lot of discussion on virtually everybody's part. It's a good thing.

Kirby: But you know one of the rules of the Senate is that of sober second thought on major issues, and to get a debate going, frankly we're pleased.

Sinclair: Right, although you refer to those words "sober second thought." In this case, from the federal government this is sober first thoughts.

Kirby: It is. It really is. In fact, it was funny, somebody asked me at a press conference, since Mr. Romanow was out there doing his work and we were doing ours, why did the federal government need a second view? And I said, well since we started first, then we're finishing first. I guess we're a first view. But you're right, from the federal government it is a first view. You had the National Forum on Health, but it was broader, it wasn't as targeted, it was more independent in the sense that it didn't involve parliamentarians. The remarkable thing about this is we've collected 12 people, seven Liberals, four Conservatives and an independent, from all parts of the country with a wide range of experience and we've actually reached a consensus in the sense that there's been none of the horse trading – you know, that I'll support this if you support that. It's been very fascinating to watch the group process, how all of us have changed our opinion on a lot of things as we've gone through this collective process.

Sinclair: Including the Chairman, I presume.

Kirby: Oh, absolutely. Well, I began as someone who knew public policy processes. I didn't have any experience with the healthcare system, and I will tell you it was the evidence in talking to people who are running hospitals and people like yourself who has chaired provincial commissions that led us to what I regard as the pivotal thing – which is the separation of payer and provider. And the care guarantee developed with the constant issue of how you deal with the public's concern – and, yes, Sweden has tried a version which wasn't quite right, Denmark has a different version. But all of this sort of emerged from the group process, which in that sense has been wonderful.

Sinclair: A great friend of mine, a mentor at one time, once said to me, "Dunc, if you have priorities more than three, you haven't set them." So to conclude with one question, if you were able to secure implementation of three things in your report, what would they be and in what order?

Kirby: Number one would be the care guarantee because without it I don't think you can get public support to do the rest of it, and public support in monetary terms is crucial. Number two would be to separate the insurer and the provider, and I'm going to sneak in under there that you can't move to service base funding without the information system. And number three would be human resources both in the short term and in the long term, and what I mean by that is that we've got to do something to address the short-term situation.

So that would be my sequence, but let me just comment on the human resources thing. One of the ideas we threw out in the last volume was that in order to get more nurses – a lot of nursing students do not pay fees for a number of reasons – we ought to make it free. Interestingly, the nurses associations said to us, "That doesn't solve our problem. The problem is we need places at universities. So what you really should be doing if you're going to be putting any money into nursing is to put it into opening up places at universities." And I use the example, at one university they had 800 qualified applicants for 70 spots. And by the way the 70 hasn't changed in the last decade.

Okay, so you ask how our opinion changes – that changes our opinion. And do we think that in the end maybe the feds should say for the next five years we will buy – pick the number, I don't know – an extra 5,000 places or something in nursing schools ... I don't know what the number is, but we'll buy them. There's a huge problem there because you have to choose.

Sinclair: There is no point in providing a place unless you've got the assets to make that place a valuable place.

Kirby: It's not that simple, but all I'm saying is that the federal government, and we will say this, clearly needs to deal with the human resources issue. And again you're going to say that gets into an area of provincial jurisdiction, but so did it when we built the medical schools, redid the medical infrastructure ...

Sinclair: Health resources funding ... exactly the same thing.

Kirby: Exactly, that's my point, you'd do it again.

Sinclair: Senator, thank you.

Kirby: Terrific! 🍷

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