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BRIEF

MÉMOIRE

# Canadians' Access to Quality Health Care: A System in Crisis

## Submitted to the House of Commons Standing Committee on Finance

## 1999 PRE-BUDGET CONSULTATIONS

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Ottawa, Ontario

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HEALTH CARE BUDGET 1999 SOINS DE SANTÉ

ASSOCIATION MÉDICALE CANADIENNE

CANADIAN MEDICAL ASSOCIATION

The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, CMA's mission is to provide leadership for physicians and to promote the highest standard of health and health care for Canadians.

On behalf of its members and the Canadian public, CMA performs a wide variety of functions, such as advocating health promotion and disease/accident prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

The CMA is a voluntary professional organization representing the majority of Canada=s physicians and comprising 12 provincial and territorial divisions and 42 affiliated medical organizations.

*Leadership for Physicians...Health for Canadians*
*Leadership pour les médecins...Santé pour les Canadiens*

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# I. INTRODUCTION

The Canadian Medical Association (CMA) commends the federal government, in its second mandate, for continuing the public pre-budget consultation process. This visible and accountable process encourages public dialogue in the development of finance and economic policies of the country.

As part of the 1999 pre-budget consultation process, the CMA welcomes the opportunity to submit its views to the House of Commons Standing Committee on Finance, and looks forward to meeting with the Committee at a later date to discuss our recommendations and their rationale in greater detail.

# II. POLICY CONTEXT

While the current and future status of our health care system is a top priority for all Canadians, it is evident that their faith in the system's ability to ensure access to quality care is eroding. In May 1991, 61% of Canadians rated the system as excellent/very good. By February 1998 that rating had slipped to 29% - a dramatic decrease in the confidence level of Canadians in the health care system.[1] Unfortunately, their outlook on the future of the health care system is not much better. Some 51% of Canadians believe that their health care will be in worse condition in 10 years than it is today.[2]

It is not surprising that Canadians are losing confidence in the future sustainability of the health care system. They have experienced firsthand the decline in access to a range of health care services (see Table 1):

- 73% reported that waiting times hospital emergency departments had worsened, up from 65% in 1997, and 54% in 1996
- 72% reported that waiting times for surgery had lengthened, up from 63% in 1997, and 53% in 1996
- 70% reported that availability of nurses in hospitals had worsened, up from 64% in 1997, and 58% in 1996
- 61% reported that waiting times for tests had increased, up from 50% in 1997, and 43% in 1996
- 60% reported that access to specialist physicians has worsened, up from 49% in 1997, and 40% in 1996

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[1] Angus Reid, February, 1998.

[2] Angus Reid, February, 1998.

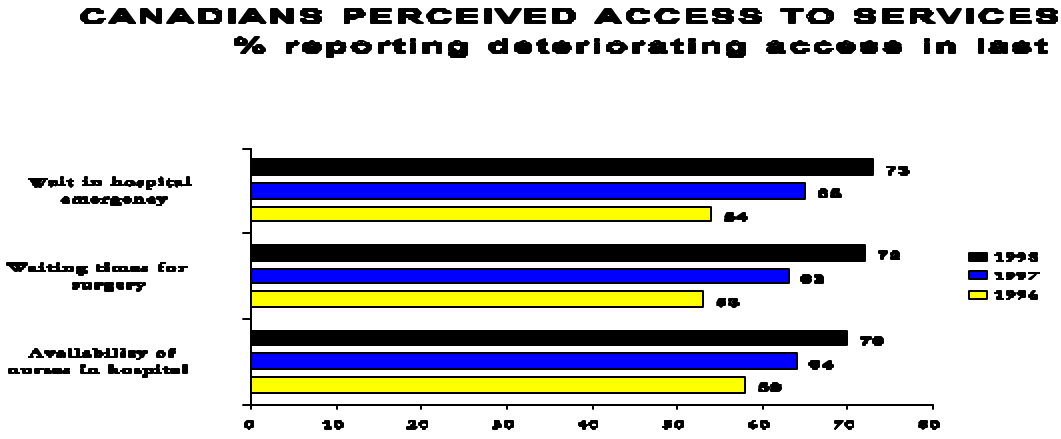


**Table 1 (a)**

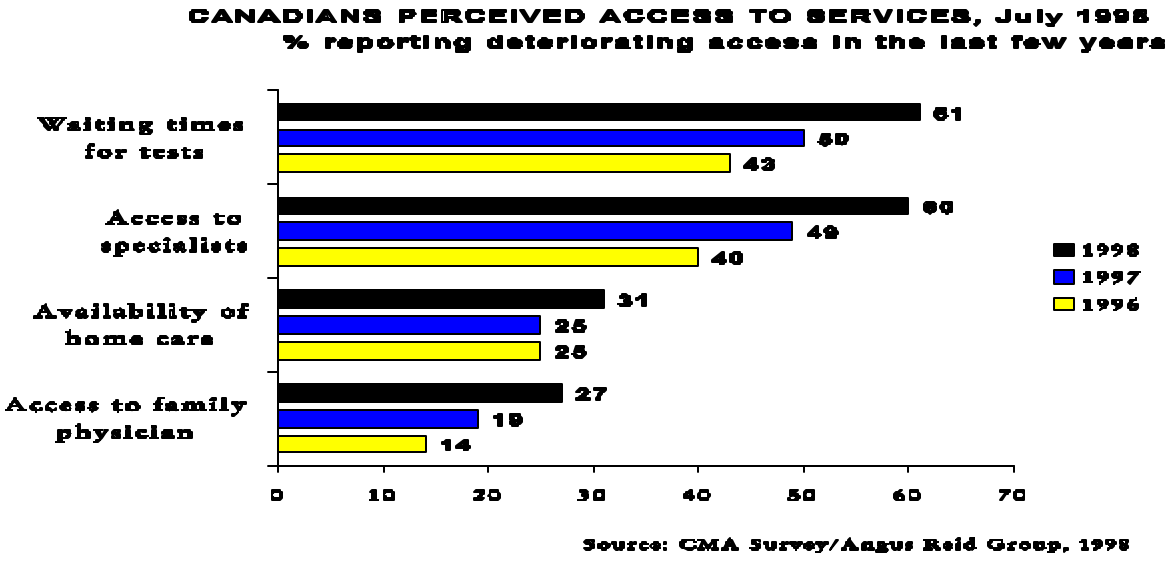


**Table 1 (b)**

Clearly, these findings are significant, and demonstrate the public's increasing concerns regarding current access to quality health care, as well as the future sustainability of our health care system. Canadians have made it clear that it is not, nor can it be, Abusiness as usual in attempting to meet their health care needs as we move into the next millennium. Medicare, Canada's crowning social policy achievement, is in crisis. It is time for the federal government to re-establish its leadership role in this strategic priority area.

The CMA has repeatedly placed its concerns about access to quality health care on the public record. Physicians, as patient advocates, have consistently expressed their frustration with the difficulties faced in accessing medically necessary services - only to fall on the deaf ears of the federal government. In surveying Canadian physicians on the front lines, they know the degree of difficulty in accessing services that their patients need:[3]

& only 27% of physicians surveyed rated as excellent/very good/good their access to advanced diagnostic services (e.g., MRI)
& only 30% of physicians surveyed rated as excellent/very good/good their access to long-term institutional care
& only 45% of physicians surveyed rated as excellent/very good/good their access to psychosocial support services
& only 46% of physicians surveyed rated as excellent/very good/good their access to acute institutional care for elective procedures

These findings are cause for concern. Particularly troublesome is that only 63% of physicians surveyed rated as excellent/very good/good their access to acute institutional on an urgent basis.

The cause for this crisis of confidence is clear - the federal government's unilateral and repeated decreases in the rate of increase in transfer payments beginning with Established Financing Programs (EPF), established in 1977, and continuing for the next decade-and-a-half. It culminated, in April, 1996, with the severe and successive cuts in cash transfers for health, post-secondary education (PSE) and social assistance via the Canada Health and Social Transfer (CHST).

The CMA is not alone in its view. In addition to the public, other health groups and the Provincial and Territorial Premiers have expressed serious concern about the sustainability of the health care system and the urgent need for Federal leadership and reinvestment.

[3] Canadian Medical Association. January 1998 Physician Resource Questionnaire.

Following their meeting in August, 1998, the Premiers "re-affirmed their commitment to maintaining and enhancing a high quality universal health care system for all Canadians and observed that every government in Canada but one - the federal government - has increased its funding to health care - the people's priority".[4] Underscoring the Premiers' view was a detailed proposal submitted to the federal government calling for an immediate increase in CHST cash transfers.

**From Federal Government Acknowledgement to Action**

At the 1997 Annual General Meeting of the CMA in Victoria, the federal minister of health, Allan Rock, stood before delegates and acknowledged "the very real anxiety that's being felt by Canadians" over the future of the health care system.[5] The minister also conceded that cuts to transfer payments have not been insignificant and have had an impact on the system, a point on which the CMA wholeheartedly agrees.

The CMA recognizes that the federal government has made a series of difficult decisions when it comes to its funding priorities in order to restore our country's fiscal health. However, the time has come to consider the fundamental issue of reinvesting in the health of Canadians. The federal government must move beyond the rhetoric in terms of acknowledging the pain and suffering that the cuts have caused, and move to an agenda of action by showing leadership and making the necessary and overdue re-investments in our health care.

At a time when the federal government is beginning to reap the benefits of a fiscal dividend, it must recognize that health care is not simply a consumption good that, once spent, provides no additional benefits. Investments in the health care system provide a substantial and lasting social rate of return in terms of restoring, maintaining and enhancing Canadians health. Furthermore, in an increasingly interdependent and global marketplace, a sustainable health care system must be viewed as a necessary precondition for Canadians to excel, thus strengthening the link between good economic policy and good health care policy in

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4 39th Annual Premiers= Conference, Saskatoon Saskatchewan, August 5-7, 1998. Press Communique.

5 Rock A. *Speech to the Canadian Medical Association=s 130th General Council Victoria*, Aug 20, 1997.

Canada. They should not be viewed as competing against each other or that one must be sacrificed at the expense of the other.

The 1998 federal budget ignored Canadians' number one concern and did nothing to bolster their confidence that the system will be there when they or their family need it.

In responding to the massive reductions in cash transfers to the provinces and territories, in his February 24, 1998, budget speech, federal finance minister Paul Martin announced that he had increased the floor under cash transfers to the provinces in support of health and other programs from the $11.0 billion to $12.5 billion annually and further that it *"will provide provinces with nearly $7 billion more in cash over the 1997/98 to 2002/03 period*. A [6]

While this was announced as an "increase" these statements are misleading. It must be remembered that this is not Anew≅ money; the $12.5 billion represents nothing more than a partial restoration, which falls $6.0 billion (or 32%) short of the cash floor of $18.5 billion prior to the introduction of the CHST in 1996/97.

To date, the cumulative impact of cuts to the Canada Health and Social Transfer (CHST) in 1996 and 1997 amounts to a $15.5 billion withdrawal in federal cash from health and social transfers. Their impact is still working its way through the system and being felt in patients' pain and suffering and unfortunately, even death.

The CMA has consistently stated publicly that the integrity of the health care system is being jeopardized by reductions to federal cash transfer payments for health. The federal government, however, has failed to respond to these concerns. Unless the federal government reinvests in health care, it will only deepen the crisis of confidence Canadians share about the future sustainability of the health care system.

# III. HEALTH CARE FUNDING AND THE FEDERAL ROLE

### The Federal Role

When it comes to the health care system, the federal government's role is aimed at ensuring that Canadians have access to health care services under Auniform terms and conditions.≅ This derives from the government's right to exercise its spending power and has been manifested over the past 40 years through a number of cash-transfer mechanisms to the provinces and territories, framed more precisely by the principles of the *Canada Health Act* (i.e., public administration, comprehensiveness, universality, portability and accessibility).

Since the inception of national health insurance in Canada, the federal government has played a central role in the funding of health care. Until 1977, the government reimbursed each province 50 cents on each dollar spent in the areas of hospital and medical care insurance.
Following a renegotiated formula, government moved from a Acost-sharing≅ to a Ablock funding≅ formula from 1977/78 to 1995/96. Federal-provincial transfers were distributed through a funding mechanism known as Established Programs Financing (EPF). Under EPF, a combination of (basic) cash and tax points

[6] The Budget Plan, 1998. Building Canada for the 21st Century, February 24, 1998.

were transferred to the provinces for health care and post-secondary education (PSE).
While both the tax points and cash components are important in funding health care, there are those who argue that the level of federal cash should be viewed as a true reflection of the government's commitment to health care. This is significant for two reasons. First, it demonstrates the priority the government places on our health care system, and secondly, the cash component (which can be withheld under the *Canada Health Act*) can play an important role in preserving and enhancing national standards.[7]

**The Origins of Federal Cash Withdrawal**

The genesis for the crisis in confidence about the future of Canada's health care system can be traced to 1982, when the federal government introduced a series of unilateral decisions which reduced its cash contributions to the provinces and territories for health and other social programs.

Figure 1 highlights the changes made to the EPF formula used to fund health and post-secondary education between 1977 and 1995. **These unilateral changes, resulted in the withholding of approximately $30 billion in federal cash that would have otherwise been transferred to provincial and territorial health insurance plans** (and an additional $12.1 billion for post-secondary education - for a total of $42.1

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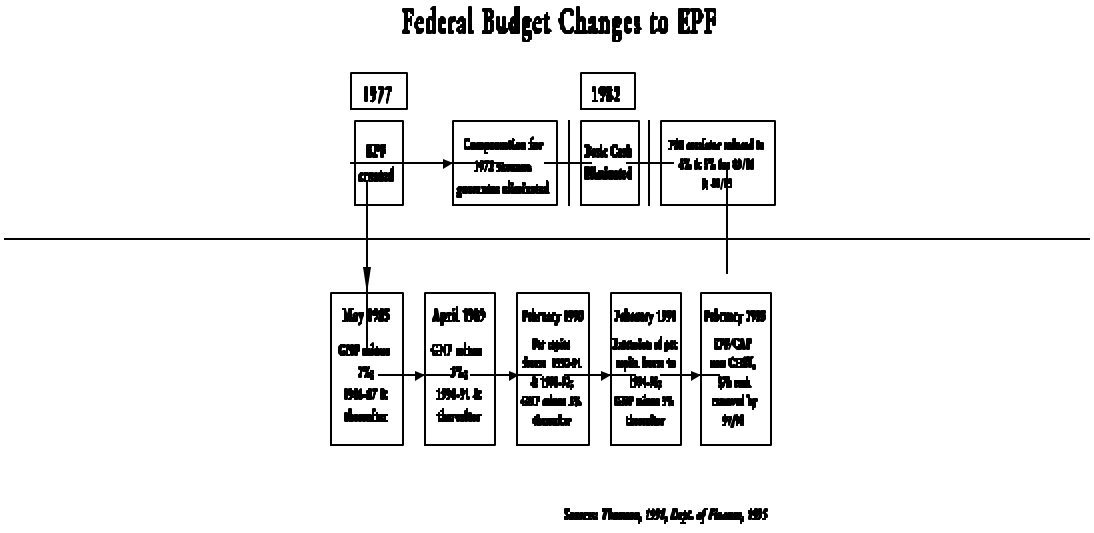
[7] The tax point transfer refers to the dollar value of Atax points≅ that were negotiated with the federal government and the provinces. Specifically, where the federal government reduced personal and corporate income tax rates, the Atax room≅ that was created was then occupied by the provinces. This is an important point because even though the federal government collects taxes on behalf of the provinces (with the exception of Quebec), it is argued that the value of the tax point transfer belongs to the provinces and is not considered as a true Afederal contribution.≅ The last time this issue was negotiated was in 1965.

billion).[8] This dollar amount is of no small consequence when it comes to ensuring that all Canadians have access to quality health care.

Figure 1




Source: Thomson, 1994, Dept. of Finance, 1995

8 Thomson A. Federal Support for Health Care - A Background Paper. Health Action Lobby, Ottawa, 1991.

**Into the Mist...**

Prior to April 1, 1996 the federal government's commitment to insured health services, post-secondary education and social assistance programs could be readily determined since the federal government made separate notional cash contributions to the provinces and territories in each of these areas.[9]

Announced in the 1995 federal budget, the creation of the Canada Health and Social Transfer (CHST), on April 1, 1996, saw EPF merge with the Canada Assistance Plan (CAP). In effect, health, post-secondary education, and social assistance were collapsed into one large cash transfer. At the time, the government claimed that the CHST was Aa new approach to federal-provincial fiscal relations marked by greater flexibility and accountability for provincial governments, and more sustainable financing arrangements for the federal government.≅[10]

In reality, the increased Aflexibility and accountability≅ was accompanied by a $7.0 billion reduction in the cash portion of the new transfer, and introduced a lower level of transparency with respect to where and what proportion the federal government notionally allocated its dollars for health, PSE and the social programs previously funded under CAP.

In its 1998 budget, the federal government moved to partially restore CHST funding by establishing a new cash floor of $12.5 billion (see Table 2) - however, this is still $6.0 billion short of the pre-CHST cash floor. To date, the cumulative impact of previous CHST cash reductions in 1996 and 1997 amounts to a $15.5 billion withdrawal of cash from health and social transfers to 1998/99. By 2002/03, it is estimated that $39.5 billion will have been removed from the CHST. This is in addition to the $30 billion withheld from

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9 Thomson, A., *Diminishing Expectations - Implications of the CHST,* [report] Canadian Medical Association, Ottawa. May, 1996.

10 Federal Department of Finance.

| Canada Health and Social Transfer (in $ billions) | | | | | |
|---|---|---|---|---|---|
| Year | Total Entitlement | Tax Point Value | Cash Entitlement | Additive Cash Reductions (Base year 95-96) | Cumulative Cash Reductions (from 95-96) |
| 1995-96 | 29.7 | 11.2 | 18.5 | - | 0.0 |
| 1996-97 | 26.9 | 11.9 | 15.0 | 3.5 | 3.5 |
| 1997-98 | 25.1 | 12.6 | 12.5 | 6.0 | 9.5 |
| 1998-99 | 25.8 | 13.3 | 12.5 | 6.0 | 15.5 |
| 1999-00 | 26.5 | 14.0 | 12.5 | 6.0 | 21.5 |
| 2000-01 | 27.1 | 14.6 | 12.5 | 6.0 | 27.5 |
| 2001-02 | 27.8 | 15.3 | 12.5 | 6.0 | 33.5 |
| 2002-03 | 28.6 | 16.1 | 12.5 | 6.0 | 39.5 |

Source: Dept. of Finance; CMA Prebudget Brief 1997)

fiscal transfers that would otherwise have gone to the provinces and territories for health between 1982 and 1995.[11]

[11] Thomson A. *Federal Support for Health Care - A Background Paper*. Health Action Lobby, Ottawa, 1991.

Furthermore, in addition to the current cash floor, the cash entitlement will stagnate at $12.5 billion, as adequate provision has not been made to maintain the value of the cash portion of the transfer.[12] This means the spending power of the cash entitlement will continue to erode as the health care system is forced to meet the changing needs of Canadians based on population growth, aging, epidemiology, new technologies and inflation.

With the introduction of the CHST, the disappearance of health, post-secondary education and social assistance into the *shadowy mist* makes it impossible to hold the federal government accountable with respect to its relative commitment to each of these important policy areas. Using the pre-CHST percentage distribution, the federal government's current cash allocation to health care stands at roughly $5.0 billion, or 7% of total health care expenditures. This is not surprising considering that the AH≅ in CHST was added later, only *after* health organizations protested its absence.

[12] Currently, the CHST cash entitlement has an escalator attached to it, however, it is scheduled to begin in 2000/01, 2001/02, 2002/03, at a rate of GDP- 2% (year 1), GDP-1.5% (year 2), and GDP-1% (year 3).

Based on the reduced federal cash contribution to health care, it would appear that the government has made a conscious decision to abdicate its responsibility and leadership role in funding health care. While claiming to uphold the integrity of our national health care system, the reality of reduced cash transfers has forced all provinces and territories to make do with significantly fewer federal dollars for health.

Federal Aoffloading≅ at its best has allowed the federal government to meet (and exceed) its own financial projections; at its worst it has forced the provinces and territories to consider a series of unattractive options: re-allocate program spending from within current budgets; deficit-financed program spending; or reduced program spending.

To be clear, from a national perspective, the CMA believes that the single most important reason for the deterioration of the health care system is the significant decline in federal financial support for health care. It is critical that the federal government immediately signal its commitment to Canadians that the health care system is a high priority, and to immediately reinvest in a program that will restore the confidence of Canadians' that the system will be there for them when they need it.

Now is the time for the federal government to demonstrate leadership and address the number one concern of Canadians by turning the "vicious cycle" of deficit reduction into a "virtuous cycle" of reinvesting in the health care system. This is not business as usual, and the status quo is not sustainable.

# IV. A TIME TO RE-ESTABLISH FEDERAL LEADERSHIP IN HEALTH CARE

**Stabilize the System**

Canadians, who strongly support a publicly-funded health care system - a conviction shared by the CMA - need to see some leadership from their federal government about how it perceives the future of the health care system unfolding. The failure to re-invest in health care in the last federal budget leaves them confused by the contradiction of seeing the government withdraw funding while at the same time talking about introducing new programs such as home care and pharmacare.

Before the federal government can even contemplate future program expansion, it must move quickly to stabilize our current health care system. Canadians have made it very clear where they believe the federal government's spending priorities lie. Seventy-one percent (Angus Reid, November, 1997) want federal cash transfer restored and 81% (Ottawa Sun/Roper, June 1998) of Canadians want the federal government to dedicate more resources to Medicare.

The CMA believes strongly that there is an immediate need for a measured, deliberate and responsible approach to re-invest in our health care system. Canadians need to be reassured that the system will be there for them and their families when they need it.

To restore access to quality health care for all Canadians, the CMA respectfully recommends:

1. **That in order to ensure greater public accountability and visibility, the federal government introduce a health-specific portion of the cash transfers to the provinces and territories.**

2. **That in addition to the current level of federal cash transferred to the provinces and territories for health care, the federal government restore at a minimum $2.5 billion in cash on an annual basis to be earmarked for health care, effective April 1, 1999.**

3. **That beginning April 1, 2000, the federal government fully index the total cash entitlement allocated to health care through the use of a combination of factors that would take into account the changing needs of Canadians based on population growth, aging, epidemiology, current knowledge and new technologies, and economic growth.**

The principles outlined in the above recommendations are fundamental and underscore the importance of establishing an accountable (i.e., linking sources with their intended uses) and visible transfer for federal cash that is targeted for reinvestment into health care.

While there is ongoing discussion about the mechanism(s) to reinvest in health care, the minimum federal cash restoration of $2.5 billion on an annual basis into the health care system recognizes the high priority of placing health care on a more sustainable financial footing for the future. This figure is separate from the $5 billion notionally allocated to health care via the current CHST, and is calculated on the basis of the recent historical federal cash allocation (approximately 41%) under EPF and CAP (now the CHST) to health care as a proportion of the $6.0 billion dollars required to restore the CHST cash floor to $18.5 billion (1995/96 level).

The recommendations also speak to the necessity of having in place a fully indexed escalator to ensure that the federal cash contribution will continue to grow to meet the future health care needs of Canadians, and with the economy. The escalator formula recognizes that health care needs are not always synchronized with economic growth. In fact, it could be argued that in times of economic hardship (i.e., unemployment, stress, anxiety), a greater burden is placed on the health care system.

Taken together, the above recommendations are a targeted approach to reinvesting in health care, and serve to re-establish the federal government's leadership role when it comes to the current and future sustainability of our health care system. It also signals that the federal government is prepared to address, in a focused and strategic approach, Canadians' number one concern - access to quality health care.

Finally, it is important to note that in principle the above recommendations are consistent with those of other groups such as the provincial and territorial ministers of finance, the Canadian public and other national health organizations, who are not asking for new resources but an immediate restoration of monies that have been taken out of the federal/provincial/territorial transfer envelope over the past three years.

**Looking to the Future**

At the same time that the federal government reinvests to stabilize the health care system, it must also consider the broader spectrum of health care services that must be in place to ensure that Canadians do not fall through the cracks. In addition to the re-investment required to stabilize our Medicare system, there is also an urgent need for investments into other components of the health system. In many ways, this suggests that new transitional funding is required to ensure that as the system evolves, it remains accessible, and can do so with minimal interruption of service to Canadians.

Proposed by the CMA, the *Health System Renewal Fund*, is time limited, sector-specific, and strategically targeted to areas that are in transition. Funding is intended to meet defined need and give the federal government sufficient flexibility in how the funds will be allocated, with full recognition for the investment.

The CMA respectfully recommends:

**4. That the federal government establish a one-time *Health System Renewal Fund* in the amount of $3 billion to be disbursed over the three-year period beginning April 1, 1999, for the following areas of need:**

**a. *Acute care infrastructure support:* assist health institutions to enhance the delivery of a continuum of quality patient care by improving their access to necessary services including new technologies, and modernizing health facilities and upgrading infrastructure.**

**b. *Community care infrastructure support:* to enable communities to develop services to support the delivery of home and community-based care in the wake of the rapid downsizing of the institutional sector.**

**c. *Support Canadians at risk*: to provide access to pharmacotherapy and medical devices to those in need, who are not adequately covered by public or private insurance (pending the development of a long-term solution).**

**d.** ***Health information technology:*** **to allow the provinces and territories to put in place the transparent, clinically driven health information infrastructure necessary to support the adequate and appropriate management of access and delivery of health care. In implementing the health information infrastructure scrupulous attention must be paid to privacy and confidentiality issues.**

The Acute Care Infrastructure Support program is designed to ensure that targeted reinvestments are made in the institutional sector such that it has the necessary physical capacity and infrastructure to deliver quality health care. In a world where downsizing has become the accepted wisdom, health care facilities need to be modernized in terms of new technology and equipment to ensure the full continuum of patient care is available.

The Community Care Infrastructure Support program speaks to the important need to develop adequate community-based systems before any reforms are introduced in the acute care sector. It also recognizes that community-based programs should not be implemented at the expense of the acute care sector, but rather, should be designed such that both sectors complement one another and add value to the health care system.

The Support Canadians at Risk program focuses on those who with inadequate coverage and have compromised access to needed pharmacotherapy and medical devices. Currently, drug coverage is not universal nor is it comprehensive. In many cases, the working poor, those that are self-employed or employed by small businesses do not have drug coverage (nor are they eligible for government sponsored plans). In other cases, co-payments/deductibles of some public plans are so high that individuals must pay out-of-pocket (e.g., $850 deductible, semi-annually, in Saskatchewan, then 35% co-payment) for all necessary prescription drugs. As a result, this patchwork coverage may inhibit Canadians access to quality care and may place additional demands on the acute care sector. Similarly, Canadians may not have access to medical devices covered by the public and/or private plans.

The Health Information Technology program speaks to the critical need to develop and implement a transparent and clinically driven information systems that will support better management, measurement and monitoring of the health care system. At the same time, scrupulous attention must be paid to privacy and confidentiality issues. To this end, the CMA has taken a proactive approach in addressing these issues by developing a health information privacy code.

Taken together, our recommendations are a powerful and strategic package. They speak to the need to immediately stabilize the health care system - which is in crisis, and the need to look at the broader spectrum of health care services to ensure that Canadians in need do not fall through the cracks.

# V. REINFORCING GOOD ECONOMIC POLICY WITH GOOD HEALTH CARE POLICY IN CANADA

While the system-wide issues related to the federal role in funding health care is clearly of importance to Canada's physicians, there are also other important issues that the CMA would like to bring to the attention of the Standing Committee on Finance.

As mentioned earlier in the brief, good economic policy and good health care policy should go hand-in-hand. They should serve to reinforce, not neutralize, one another. They should not be viewed as one gaining at the expense of the other. Viewed in their proper context, they can be balanced such that policy decisions produce outcomes that are fair to all parties.

**Tobacco Taxation Policy**

Smoking is the leading preventable cause of premature mortality in Canada. The most recent estimates suggest that more than 45,000 Canadians die each year due to tobacco use.

The estimated economic cost to society from tobacco use in Canada has been estimated between $11 billion to $15 billion[13]. Tobacco use directly costs the Canadian health care system $3 billion to $3.5 billion[14] annually. These estimates do not take into account intangible costs such as pain and suffering.

CMA is concerned that the 1994 reduction in the federal cigarette tax has had a significant effect in slowing the decline in cigarette smoking in the Canadian population, particularly in the youngest age groups - where the number of young smokers (15-19) is in the 22% to 30% range and 14% for those age 10-14[15].

The CMA congratulates the federal government's February 13, 1998 initiative which selectively increased federal excise taxes on cigarettes and tobacco sticks. This is a first step towards an integrated tobacco tax strategy, and speaks to the importance of strengthening the relationship between good tax policy and good health policy in Canada.

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13 Health Canada, *Economic Costs Due to Smoking (Information Sheet)*. Ottawa: Health Canada, November 1996.

14 Health Canada, *Economic Costs Due to Smoking (Information Sheet)*. Ottawa: Health Canada, November 1996.

15 Health Canada, *Youth Smoking Behaviour and Attitudes (Information Sheet)*. Ottawa: Health Canada, November 1996.

The CMA understands that tobacco tax strategies are extremely complex. Strategies need to consider the effects of tax increases on reduced consumption of tobacco products with increases in interprovincial/territorial and international smuggling. In order to tackle this issue, the government could consider a selective tax strategy. This strategy requires continuous stepwise increases to tobacco taxes in those areas with lower tobacco tax (i.e., Ontario, Quebec and Atlantic Canada).
The goal of selective increases in tobacco tax is to increase the price to the tobacco consumer over time (65-70% of tobacco products are sold in Ontario and Quebec). The selective stepwise tax increases will approach but may not achieve parity amongst all provinces; however, the tobacco tax will attain a level such that inter-provincial/territorial smuggling would be unprofitable. The selective stepwise increases would need to be monitored so that the new tax level and US/Canadian exchange rates do not make international smuggling profitable.

The selective stepwise increase in tobacco taxes can be combined with other tax strategies. The federal government should apply the export tax and remove the exemption available on shipments in accordance with each manufacturers historic levels. The objective of implementing the export tax would be to make cross-border smuggling unprofitable.

The federal government should establish a dialogue with the US federal government regarding harmonizing US tobacco taxes with Canadian levels at the factory gate. Alternatively, US tobacco taxes could be raised to a level that when offset with the US/Canada exchange rate differential renders international smuggling unprofitable. The objective of harmonizing US/Canadian tobacco tax levels (at or near the Canadian levels) would be to increase the price of internationally smuggled tobacco products to the Canadian and American consumers.

The CMA's comprehensive tobacco taxation strategy is designed to achieve the following objectives: (1) to reduce tobacco consumption; (2) to minimize interprovincial/territorial smuggling of tobacco products; (3) to minimize international smuggling of tobacco products from both the Canadian and American perspective; (4) to reduce and/or minimize Canadian/American consumption of internationally smuggled tobacco products.

The CMA recommends:

**5. That the federal government follow a comprehensive integrated tobacco tax policy:**

**a. To implement selective stepwise tobacco tax increases to achieve the following objectives: (1) reduce tobacco consumption, (2) minimize interprovincial/territorial smuggling of tobacco products, and (3) minimize international smuggling of tobacco products;**

**b. To apply the export tax on tobacco products and remove the exemption available on tobacco shipments in accordance with each manufacturers historic levels; and**

**c. To enter into discussions with the US federal government to explore options regarding tobacco tax policy, bringing US tobacco tax levels in line with or near Canadian levels, in order to minimize international smuggling.**

The Excise Act Review, *A Proposal for a Revised Framework for the Taxation of Alcohol and Tobacco Products* (1996), proposes that tobacco excise duties and taxes (*Excise Act* and *Excise Tax Act*) for domestically produced tobacco products be combined into a new excise duty and come under the jurisdiction of the *Excise Act*. The new excise duty is levied at the point of packaging where the products are produced. The Excise Act Review also proposes that the tobacco customs duty equivalent and the excise tax (*Customs Tariff* and *Excise Tax Act*) for imported tobacco products be combined into the new excise duty [equivalent tax to domestically produced tobacco products] and come under the jurisdiction of the *Excise Act*. The new excise duty will be levied at the time of importation.

The CMA supports the proposal of the Excise Act Review. It is consistent with previous CMA recommendations calling for tobacco taxes at the point of production.

**Support for Tobacco Control Programs**

Taxation should be used in conjunction with other strategies for promoting healthy public policy, such as public education programs to reduce tobacco use. The Liberal party, recognising the importance of this type of strategy , promised: *"...to double the funding for the tobacco control programs from $50 million to $100 million over five years, investing the additional funds in smoking prevention and cessation programs for young people, to be delivered by community organizations that promote the health and well-being of Canadian children and youth."*[16]

The CMA applauds the federal government's efforts in the area of tobacco use prevention and cessation - particularly its intent to commit $50 million to public education through the proposed Tobacco Control Initiative. However, a time limited investment is not enough. Substantial and sustainable funding is required for programs in prevention and cessation of tobacco use.[17] A possible source for this type of program investment could be tobacco tax revenues or the tobacco surtax.

The CMA therefore recommends:

**6. That the federal government commit stable funding for a comprehensive tobacco control strategy; this strategy should include programs aimed at prevention and cessation of tobacco use and protection of the public from tobacco's harmful effects.**

**7. That the federal government clarify its plans for the distribution of the Tobacco Control**

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16 Liberal Party, *Securing Our Future*, Liberal Party of Canada, Ottawa, 1997. p. 77.

17 In California, between 1988 and 1993, when the state was carrying on an aggressive public anti-smoking campaign, tobacco consumption declined by over 25%. Goldman LK, Glantz SA. Evaluation of Antismoking Advertising Campaigns. JAMA 1988; 279: 772-777.

**Initiative funds, and ensure that the funds are invested in evidence-based tobacco control projects and programs.**

**8. That the federal government support the use of tobacco tax revenues for the purpose of developing and implementing tobacco control programs.**

## Fair and Equitable Tax Policy? - The Goods and Services Tax (GST) and Harmonized Sales Tax (HST)

When it comes to tax policy and the tax system in Canada, the CMA is strongly of the view that both should be administered in a fair and equitable manner. This principle-based statement has been made to the Standing Committee on a number of different occasions.

While these principles are rarely in dispute, the CMA has expressed its strong concerns regarding their application - particularly in the case of the goods and services tax (GST) and the recently introduced harmonized sales tax (HST) in Atlantic Canada.

By designating medical services as "tax exempt" under the *Excise Tax Act*, physicians are in the unenviable position of being denied the ability to claim a GST refund (i.e., input tax credits - ITCs) on the medical supplies necessary to deliver quality health care, and on the other, cannot pass the tax onto those who purchase such services.

This is a critical point when one considers the *raison-d'etre* of introducing the GST: to be an end-stage consumer-based tax, and having not a producer of a good or a service bear the full burden of the tax. Yet this tax anomaly does precisely that. As a result, physicians are "hermetically sealed" - they have no ability to claim ITCs due to the *Excise Tax Act*, or pass the costs to consumers due to the *Canada Health Act*.

To be clear, the CMA has never, nor is currently asking for, special treatment for physicians under the *Excise Tax Act*. However, if physicians, as self-employed individuals are considered as small businesses for tax purposes, then it only seems reasonable that they should have the same tax rules extended to them that apply to other small businesses. This is a fundamental issue of tax fairness.

While other self-employed professionals and small businesses claim ITCs, an independent (KPMG) study has estimated that physicians have "overcontributed" in terms of unclaimed ITCs by $57.2 million per year. By the end of this calendar year, physicians will have been unfairly taxed in excess of $480 million. Furthermore, with the introduction of the HST in Atlantic Canada, KPMG has estimated that it will costs physicians an additional $4.686 million per year. As it currently applies to medical services, the GST is bad tax policy and the HST will make a bad situation worse for physicians.

Last year, the Standing Committee, in its report to the House of Commons stated: *"According to the CMA, the GST is fundamentally unfair to physicians and is a deterrent in recruiting and retaining physicians in Canada. This issue merits consideration and further study"*.[18]

The CMA believes that it has rigorously documented its case and further study is not required - the time has come for concerted action from the federal government to alleviate this tax impediment.

There are other health care providers (e.g., dentists, physiotherapists, psychologists, chiropractors, nurses) whose services are categorized as tax exempt. However, there is an important distinction between whether the services are publicly insured or not. Health care providers who deliver services privately have the opportunity to pass along the GST costs through their fee structures. **It must be remembered that physicians are in a fundamentally different position given that 99% of their professional earnings come from the government health insurance plans:** under the GST and HST, "not all health care services are created equal".

There are those who argue that the medical profession should negotiate the GST at the provincial/ territorial level, yet there is no province that is prepared to cover the additional costs that are being downloaded onto physicians as a result of changes to federal tax policy. Nor do these governments feel they should be expected to do so. The current tax anomaly, as it affects the medical profession, was created with the introduction of the GST - and must be resolved at the federal level.

As it currently stands for medical services, the GST and HST is not a tax policy that reinforces good health care policy in Canada.

The CMA view is not unique. The late Honourable Chief Justice Emmett Hall recognized the principles that underpin the fundamental issue of tax fairness by stating: *"That the federal sales tax on medical supplies purchased by self-employed physicians in the course of their practices be eliminated"*.[19] Even though Mr. Hall's recommendation was made prior to the introduction of the GST and HST, the principles outlined above are unassailable and should be reflected in federal tax policy.

Canadian physicians work hard to provide quality health care to their patients within what is a publicly funded health care system. Physicians are no different from Canadians in that they, too, are consumers

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[18] Report of the Standing Committee on Finance. December, 1997.

[19] Hall Emmett (Special Commissioner). Canada=s National-Provincial Program for the 1980s, p. 32.

(purchasers). Why then, they ask, has the medical profession been singled out for such unfair treatment under the GST regime?

The CMA respectfully recommends:

**9. That health care services funded by the provinces and territories be zero-rated.**

The above recommendation could be accomplished by amending the *Excise Tax Act* as follows:

*(1). Section 5 part II of Schedule V to the Excise Tax Act is replaced by the following:*

*5. "A supply (other than a zero-rated supply) made by a medical practitioner of a consultative, diagnostic, treatment or other health care service rendered to an individual (other than a surgical or dental service that is performed for cosmetic purposes and not for medical or reconstructive purposes)."*

*(2). Section 9 Part II of Schedule V to the Excise Tax Act is repealed.*

*(3). Part II of Schedule VI to the Excise Tax Act is amended by adding the following after section 40:*

*41. A supply of any property or service but only if, and to the extent that, the consideration for the supply is payable or reimbursed by the government under a plan established under an Act of the legislature of the province to provide for health care services for all insured persons of the province.*

Our recommendation fulfils at least two over-arching policy objectives: (1) strengthening the relationship between good economic policy and good health policy in Canada; and (2) applying the fundamental principles that underpin our taxation system (fairness, efficiency, effectiveness), in all cases.

**Registered Retirement Savings Plans (RRSPs)**

There are (at least) two fundamental goals of retirement savings: (1) to guarantee a basic level of retirement income for all Canadians; and (2) to assist Canadians in avoiding serious disruption of their pre-retirement living standards upon retirement. Reviewing the demographic picture in Canada, we see that an increasing portion of society is not only aging, but is living longer. Assuming that current demographic trends will continue and peak in the first quarter of the next century, it is important to recognize the role that private RRSPs savings will play in ensuring that Canadians may continue to live dignified lives well past their retirement from the labour force.

This becomes even more critical when one considers that Canadians are not setting aside sufficient resources for their retirement. Specifically, according to Statistics Canada, it is estimated that 53% of men and 82% of women starting their career at age 25 will require financial aid at retirement age - only 8% of men and 2% women will be financially secure.

In its 1996 Budget Statement, the federal government announced that it froze the dollar limit of RRSPs at $13,500 through to 2002/03, with increases to $14,500 and $15,500 in 2003/04 and 2004/05, respectively. As well, the maximum pension limit for defined benefit registered pension plans will be frozen at its current level of $1,722 per year of service through 2004/05. This is a *de facto* increase in tax payable.

This change in policy with respect to RRSP contribution limits run counter to the White Paper released in 1983 (The Tax Treatment of Retirement Savings), where the House of Commons Special Committee on Pension Reform recommended that the limits on contributions to tax-assisted retirement savings plans be amended so that the same comprehensive limit would apply regardless of the retirement savings vehicle or combination of vehicles used. In short, the principle of "pension parity" was endorsed.

Furthermore, in three separate papers released by the federal government, the principle of pension parity would have been achieved between money-purchase (MP) plans and defined benefit (DB) plans had RRSP contribution limits risen to $15,500 in 1988. In effect, the federal government postponed the scheduling of the $15,500 limit for seven years - that is, achieving the goal of pension parity was delayed until 1995.

The CMA has been frustrated that ten years of careful and deliberate planning by the federal government around pension reform has not come to fruition, in fact, if the current policy remains in place it will have taken more than 17 years to implement (from 1988 to 2005).

As a consequence, the current policy of freezing RRSP contribution limits and RPP limits without making adjustments to RRSP limits to achieve pension parity serves to maintain inequities between the two plans until 2004/2005. This is patently unfair for self-employed Canadians who rely on RRSPs as their sole vehicle for retirement planning.

The CMA recommends:

**10. That the dollar limit of RRSPs at $13,500 increase to $14,500 and $15,500 in 1999/00 and 2000/01, respectively. Subsequently, dollar limits increase at the growth in the yearly maximum pensionable earnings (YMPE).**

Under current federal tax legislation, 20% of the cost of an RRSP, RRIF or Registered Pension Plan's investments can be made in "foreign property." The rest is invested in "Canadian" investments. If the 20% limit is exceeded at the end of a month, the RRSP pays a penalty of 1% of the amount of the excess.

In its December 1998 pre-budget consultation , the Standing Committee on Finance made the following recommendation (p. 66): *"...that the 20% Foreign Property Rule be increased in 2% increments to 30% over a five year period. This diversification will allow Canadians to achieve higher returns on their retirement savings and reduce their exposure to risk, which will benefit all Canadians."*

A recent study by Ernst & Young, demonstrated that Canadian investors would have experienced substantially better investment returns over the past 20 years with higher foreign content limits. As well, the

Conference Board of Canada concluded that lifting the foreign content limit to 30% would have a neutral effect on Canada's economy.

The CMA and believes there is sufficient evidence to indicate that Canadians would benefit from an increase in the Foreign Property Rule, from 20% to 30%. The CMA therefore recommends:

**11. That the 20% foreign property rule for deferred income plans such as Registered Retirement Savings Plans and Registered Retirement Income Funds be increased in 2% annual increments to 30% over a five year period, effective 1999.**

As part of the process to revitalize the economy, greater expectations are being placed on the private sector to create employment opportunities. While this suggests that there is a need to re-examine the current balance between public and private sector job creation, the government, nonetheless has an important role to play in fostering an environment that will stimulate job creation. In this context, the CMA, strongly believes that current RRSPs should be viewed as an asset rather than a liability.

With proper mechanisms in place, the RRSP pool of capital funds can play an integral role in bringing together venture capital and small and medium-size businesses and entrepreneurs. In this regard, the CMA would encourage the government to explore current regulatory impediments to bring together capital with small and medium-size businesses. The CMA, recommends the following:

**12. That the federal government foster economic development by treating RRSP contributions as assets rather than liabilities and by exploring the regulatory changes necessary to ensure increased access to such funds by small and medium-size businesses.**

**Non-Taxable Health Benefits**

In last year's federal budget, the CMA was encouraged by the federal government's announcement to extend the deductibility of health and dental premiums through private health services plans (PHSP) for the unincorporated self-employed. The CMA believes that this initiative is a step in the right direction when it comes to improving tax fairness.

As well, the federal government is to be commended for its decision to maintain the non-taxable status of supplementary health benefits. This decision is an example of the federal government's serving to strengthen the relationship between good tax policy and good health care policy in Canada.

If supplementary health benefits were to become taxable, it is likely that young healthy people would opt for cash compensation instead of paying taxes on benefits they do not receive. These Canadians would become uninsured for supplementary health services. It follows that employer-paid premiums may increase as a result of this exodus in order to offset the additional costs of maintaining benefit levels due to diminishing ability to achieve risk pooling.

As well, in terms of fairness it would seem unfair to "penalize" 70% of Canadians by taxing supplementary health benefits to put them on an equal basis with the remaining 30%. It would be preferable to develop incentives to allow the remaining 30% of Canadians to achieve similar benefits attributable to the tax status of supplementary health benefits. The CMA therefore recommends:

**13. That the current federal government policy with respect to non-taxable health benefits be maintained.**

**Health Research in Canada**

At the same time that our health care system has been de-stabilized, so too has the role of health research in Canada. In response, the federal government announced in its 1998 budget that it would increase funding levels for the Medical Research Council of Canada (MRC) from $237.5 million (1997/98), to $267 million (1998/99), $270 million (1999/00) and $276 million (2000/01). While this is a step in the right direction, the $134 million over three years represents for the most part a restoration of previously cut funding - only $18 million would be considered new money.

Furthermore, when compared against other countries, Canada does not fare well. Of the G-7 nations for which recent data were available, Canada ranks last in per capita spending for health research. France, Japan, the United States and the United Kingdom spend between 1.5 and 3.5 times more per capita than Canada.[20] In what is increasingly a knowledge-based world, the federal government must be reminded that a sustained and substantial commitment to health research in required. The CMA therefore recommends:

**14. That the federal government establish a national target (either in per capita terms or as a proportion of total health spending), and an implementation plan for health research and development spending including the full spectrum of basic biomedical to applied health services research, with the objective of improving Canada's position relative to other G-7 countries.**

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[20] Organization for Economic Cooperation and Development. OECD Health Data 97. Paris: OECD, 1997.

**Brain Drain and Tuition Deregulation**

In June, 1998, the CMA met with the Standing Committee on Finance to discuss the issue of "brain drain" in Canada. At that time, the CMA expressed its serious concerns over the recent tuition deregulation policy in Ontario and its subsequent impact on the career choices of new medical graduates.

Specifically, the CMA officially decries tuition deregulation in Canadian medical schools and believes that governments should increase funding to medical schools to alleviate the pressures driving tuition increases; that any tuition increase be regulated and reasonable; and that financial support systems be in place in advance of, or concomitantly with, any tuition increase. These measures will foster the education and training of a diverse population of health care givers, and will support culturally and socially sensitive health care for all Canadians.

As new physicians graduate with substantial and growing debt loads, they will be attracted to more lucrative positions in order to repay their debts - particularly positions in the United States. As a consequence, tuition deregulation policies will have a direct and detrimental impact when it comes to retaining our best and brightest young physicians in Canada. The CMA is currently in the process of developing a position paper on this issue.

# VI. SUMMARY OF RECOMMENDATIONS

With the future of access to quality health care for all Canadians at stake, the CMA strongly believes that the federal government must demonstrate that it is prepared to re-establish its leadership role and re-invest in the health care system that all Canadians cherish and closely identify with.

The CMA therefore makes the following recommendations to the Standing Committee on Finance in its deliberations.

**Stabilize the System**

1. **That in order to ensure greater public accountability and visibility, the federal government introduce a health-specific portion of the cash transfers to the provinces and territories.**

2. **That in addition to the current level of federal cash transferred to the provinces and territories for health care, the federal government restore at a minimum $2.5 billion in cash on an annual basis to be earmarked for health care, effective April 1, 1999.**

**3. That beginning April 1, 2000, the federal government fully index the total cash entitlement allocated to health care through the use of a combination of factors that would take into account the changing needs of Canadians based on population growth, aging, epidemiology, current knowledge and new technologies, and economic growth.**

## Looking to the Future

**4. That the federal government establish a one-time *Health System Renewal Fund* in the amount of $3 billion to be disbursed over the three-year period beginning April 1, 1999, for the following areas of need:**

**a. *Acute care infrastructure support:* assist health institutions to enhance the delivery of a continuum of quality patient care by improving their access to necessary services including new technologies, and modernizing health facilities and upgrading infrastructure.**

**b. *Community care infrastructure support:* to enable communities to develop services to support the delivery of home and community-based care in the wake of the rapid downsizing of the institutional sector.**

**c. *Support Canadians at risk*: to provide access to pharmacotherapy and medical devices to those in need, who are not adequately covered by public or private insurance (pending the development of a long-term solution).**

**d. *Health information technology:* to allow the provinces and territories to put in place the transparent, clinically driven health information infrastructure necessary to support the adequate and appropriate management of access and delivery of health care. In implementing the health information infrastructure scrupulous attention must be paid to privacy and confidentiality issues.**

## Tobacco Taxation Policy

**5. That the federal government follow a comprehensive integrated tobacco tax policy:**

**a. To implement selective stepwise tobacco tax increases to achieve the following objectives: (1) reduce tobacco consumption, (2) minimize interprovincial/territorial smuggling of tobacco products, and (3) minimize international smuggling of tobacco products;**

**b. To apply the export tax on tobacco products and remove the exemption available on tobacco shipments in accordance with each manufacturers historic levels; and**

**c. To enter into discussions with the US federal government to explore options regarding tobacco tax policy, bringing US tobacco tax levels in line with or near Canadian**

**levels, in order to minimize international smuggling.**

**Support for Tobacco Control Programs**

**6. That the federal government commit stable funding for a comprehensive tobacco control strategy; this strategy should include programs aimed at prevention and cessation of tobacco use and protection of the public from tobacco's harmful effects.**

**7. That the federal government clarify its plans for the distribution of the Tobacco Control Initiative funds, and ensure that the funds are invested in evidence-based tobacco control projects and programs.**

**8. That the federal government support the use of tobacco tax revenues for the purpose of developing and implementing tobacco control programs.**

**Goods and Services Tax (GST)**

**9. That health care services funded by the provinces and territories be zero-rated.**

**Registered Retirement Savings Plans (RRSPs)**

**10. That the dollar limit of RRSPs at $13,500 increase to $14,500 and $15,500 in 1999/00 and 2000/01, respectively. Subsequently, dollar limits increase at the growth in the yearly maximum pensionable earnings (YMPE).**

**11. That the 20% foreign property rule for deferred income plans such as Registered Retirement Savings Plans and Registered Retirement Income Funds be increased in 2% annual increments to 30% over a five year period, effective 1999.**

**12. That the federal government foster economic development by treating RRSP contributions as assets rather than liabilities and by exploring the regulatory changes necessary to ensure increased access to such funds by small and medium-size businesses.**

**Non-Taxable Health Benefits**

**13. That the current federal government policy with respect to non-taxable health benefits be maintained.**

## Health Research in Canada

**14. That the federal government establish a national target (either in per capita terms or as a proportion of total health spending), and an implementation plan for health research and development spending including the full spectrum of basic biomedical to applied health services research, with the objective of improving Canada's position relative to other G-7 countries.**