"Towards a Sustainable Health Care System in the New Millennium"

Submission to the House of Commons Standing Committee on Finance

2000 Pre-Budget Consultation Process

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For further information, contact
CMA's Public Affairs Directorate : 1 800 267-9703

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 43 affiliated medical organizations.

Leadership for Physicians…Health for Canadians
Leadership pour les médecins…Santé pour les Canadiens

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Executive Summary

On the cusp of the new millennium, it is appropriate to reflect with pride on our nation's past and to plan with compassion, innovation and creativity for our nation's future. The new century will present us with many challenges–an ageing population, increased knowledge with corresponding advances in technology and research, competitiveness at home and abroad– to meet the needs of Canadians.

CMA recognizes that we live in a world that is increasingly interdependent. A world where globalization has meant that we, as a country, must look forward and beyond our borders when it comes to determining how we can reach our collective potential.

The mission of the CMA is to advocate, on behalf of Canadians, for the highest standards of health and health care for the country, and to provide leadership on behalf of physicians.

I believe in that mission. I believe that the medical profession must take a leadership role, both individually and collectively. And indeed has a responsibility to speak up for quality health care.

Dr. Hugh Scully, President, CMA
Presidential Inauguration Speech,
August 25, 1999

As we plan for the future it is vital to recognize the importance of the social programs that must remain essential features of our society. Our health care system is an important and defining feature of what it is to be Canadian.

CMA believes a well funded, sustainable, quality health care system must be at the forefront of the federal government's strategic priorities.

The haste to reduce health care costs over the past several years has left a destabilized and demoralized health system in its wake. Diminished access to critical health care services and insufficient human resources are only part of the legacy. Rebuilding Canadians' confidence in the health care system will not be easy.

Sustainable (adjective*);*
… using a resource so that the resource is not depleted or permanently damaged…

Webster's II New Riverside
University Dictionary

CMA noted the important first step that was taken by the federal government in its 1999 budget. A reinvestment of $11.5 billion earmarked for health care was an important signal to Canadians. However, with the complete restoration of funds in 2003/04 the health care system will only be back to its 1995 nominal spending levels, some seven years after the fact – with no adjustment for the increasing health care needs of an increased number of more aged Canadians, inflation or economic growth.

CMA is encouraged with federal government's recent initiatives to increase health research funding. This is of direct benefit to the health of Canadians; to the health care system; to foster the development of health care as an industry and to ensure our best and brightest medical scientists and health researchers are educated and remain in Canada. However, we know that more needs to be done to ensure innovation and competitiveness.

We would like to echo the words of the Prime Minister who said *we consider Medicare to be the best example of how good social policy can be good economic policy, too. While reflecting the desire of Canadians to show compassion for their fellow citizens, Medicare also serves as one of our key competitive advantages*. A sustained health care system will ensure a healthy population, and a healthy labour force that contributes to the productivity of the nation.

In seeking to place the health care system on the road to long-term sustainability, the CMA is committed to working in close partnerships with the federal government and others in identifying, developing and implementing policy initiatives that serve to strengthen Canadians' access to quality health care

The CMA looks forward to contributing to the search for solutions. To work with the federal government and others in building a responsive, flexible and sustainable health care system for all Canadians. In this spirit of co-operation the CMA offers the following recommendations:

1. **That the federal government fund Canada's publicly financed health care system on a long-term, sustainable basis to ensure quality health care for all Canadians.**

2. **That the federal government introduce a health-specific portion of federal cash transfers to the provinces and territories to promote greater public accountability, transparency and visibility.**

3. **That the federal government, at a minimum, increase federal cash for health care by an additional $1.5 billion, effective April 1, 2000.**

4. **That beginning, April 1, 2001, 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, ageing, epidemiology, current knowledge and new technologies, and economic growth.**

5. **That the federal, provincial and territorial governments adopt the guiding principle of national self-sufficiency in the production and retention of physicians to meet the medical needs of the population, including primary to highly specialized medical care, and the requirements for a critical mass for teaching and research.**

6. **That the federal government establish and fund a national pool of re-entry positions in postgraduate medical education.**

7. **That the federal government establish a National Centre for Health Workforce Research.**

8. **That the federal government enhance financial support systems, such as the Canada Student Loans Program, for medical students in advance of any future tuition increase, and ensure that these support systems are set at levels that meet the financial needs of students.**

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

10. **That the federal government establish a National Health Technology Fund to increase country-wide access to needed health technologies.**

11. **That the federal government continue to increase funding for health research on a long-term, sustainable basis.**

12. **That the federal government commit stable funding for a comprehensive tobacco control strategy; this strategy should ensure that the funds are invested in evidence-based tobacco control projects and programs, which would include programs aimed at prevention and cessation of tobacco use and protection of the public from tobacco's harmful effects.**

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

14. **That the federal government place a high priority for funding tobacco prevention and evidence-based cessation programs for young Canadians as early as primary school age.**

15. **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, raising Canadian tobacco price levels in line with or near the US border states, in order to minimize international smuggling.

16. That the dollar limit of RRSPs at $13,500, increase to $15,500 for the year 2000/01.

17. That the federal government explore mechanisms to increase RRSP contribution limits in the future given the delay in achieving pension parity, since 1988.

18. 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 the year 2000.

19. That the federal government explores the regulatory changes necessary to allow easier access to RRSP funds for investment in small and medium-size businesses.

20. That the federal government undertake the necessary steps to creditor-proof RRSPs and RRIFs.

I. INTRODUCTION

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

The Government of Canada wants to work in partnership in that effort with Canada's physicians. We ask for your advice when we seek it, your help when we need it, your support when we deserve it. Together, let's make better health and quality health care much more than just a motto. Let's make it a national mission and eventually a national achievement.

Honourable Allan Rock, Minister of Health
Speech to CMA General Council,
August 23, 1999

As part of the 2000 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

Over the past few years, there has been a significant amount of attention placed on the fact that Canada is living in a world that is increasingly interdependent. A world where globalization has meant that we, as a country, must look forward, outward and with others when it comes to determining how we can reach our collective potential.

While further political and economic change is likely to continue, it is important to recognize that there are important social programs that must remain essential features of our society.

One such program is our health care system - an important and defining feature of what it is to be Canadian. The CMA believes that when it comes to maintaining and enhancing the health of Canadians, a well-funded, sustainable health care system must be at the forefront of the federal government's strategic priorities.

By 2002, it is estimated that there will be 2.3 million more Canadians and 444,000 more Canadians over the age of 65. As a consequence, Canada's health care system will continue to face significant challenges in the near future. The pan-Canadian haste of governments across the country to reduce health care costs as quickly as possible over the past several years left a destabilized and demoralized health system in its wake. Diminished access to critical health care services and insufficient human resources are only part of the legacy. The initial federal reinvestment will help ease some of the

pressures but it will not be much more than a short-term solution given that expectations and demands on the system will continue to rise.

Rebuilding Canadians' confidence in the health care system will not be easy. Reports of overcrowded emergency rooms, physician and nursing shortages, and of patients being sent to the United States for treatment to reduce waiting times will not help restore their faith.

The CMA fully recognises the importance of the first step taken by the federal government. However, fundamental questions remain about future steps needed to sustain our cherished health care system over the short-, medium- and long-term - ensuring that all Canadians will have ready access when they or their families are in need.

Given this first step, the CMA believes that we must shift our focus to the vision and overarching strategic framework the federal government must develop to ensure that the health care system will be funded on a sustainable basis.

In seeking to place the health care system on the road to long-term sustainability, the CMA is committed to working closely with the federal government in identifying, developing and implementing policy initiatives that serve to strengthen Canadians' access to quality health care.

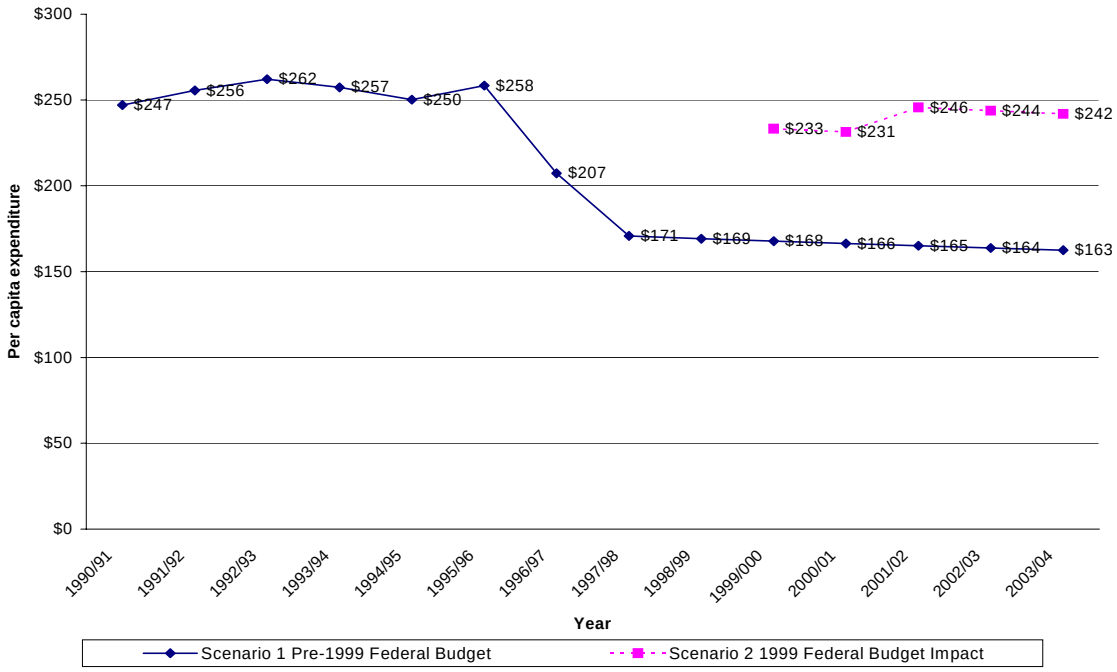
III. TOWARDS A SUSTAINABLE HEALTH CARE SYSTEM

In its 1999 budget, the federal government took an important first step forward toward stabilizing Canada's health care system. The government announced a five-year fiscal framework, effective April 1, 1999 that reinvested $11.5 billion, on a cumulative basis, in the health care system. While this is an important first step, it must be placed in perspective.

The $11.5 billion is a *cumulative* figure over five consecutive years. On an annual basis, this means that federal cash for health care is scheduled to increase by $2.0 billion for 1999/2000; it will remain at the same level for 2000/01 and then increase by $500 million (to $2.5 billion) in 2001/02, and remain at that level for the years 2002/03 and 2003/04. Only in year 4 does the CHST cash floor increase by a total of $2.5 billion.[1]

Restoring $2.5 billion to the Canada Health and Social Transfer (CHST) cash floor in 2002/03, the fourth year of the government's five-year timetable, means that the health system will only be back to its 1995 nominal spending levels, 7 years after the fact - with no adjustment for the increasing health care needs of Canadians, inflation or economic growth.[2]

Figure 1: Federal Government Commitment to Health Care
Nominal per Capita Federal Cash Transfers



In current dollars, it is estimated that the federal government allocates approximately 41% of CHST cash for health care. Based on a cash floor of $12.5 billion this amounts to $5.13 billion. The CMA recognizes that the federal amount has increased cash by a minimum of $2.0 billion in 1999/00 to $7.13 billion, however, once again this figure must be placed in context; $7.13 billion represents only 9 cents of each dollar spent on health care in Canada.

Another way to express the $11.5 billion is to adjust the figure by the number of Canadians (i.e., a per capita basis - see Figure 1).[3] Scenario 1 illustrates nominal per capita federal CHST cash for health care prior to the 1999 budget with projections to 2003/04. In absence of a five-year fiscal framework introduced by the government, federal CHST cash (formerly Established Programs Financing and the Canada Assistance Plan) would have gone from $247 in 1990/01 to $163 per Canadian in 2003/04 - a decrease of 34%. Adjusting for inflation, federal CHST cash for health care would have dropped from $247 to $131 per Canadian - a decrease of 47%.

With the introduction of the $11.5 billion in 1999 (Scenario 2), nominal per capita CHST cash for health care increases from $168 to $233 in 1999/00. This, however, falls short of the $258 per capita in 1995/96. With an estimated population of 30.6 million Canadians, the CHST shortfall is estimated to be $765 million (i.e., $258 - $233 x 30.6 million). Recognizing that inflation since 1995 has eroded the value of the federal CHST cash in 1999, the figure is estimated to be closer to $1.5 billion than $1.0 billion.

Furthermore, there is no escalator attached to the federal CHST cash to account for inflation, a growing and ageing population, epidemiological trends or the diffusion of new technologies. This is a departure from previous formulae under Established Programs Financing (EPF) and the CHST which included an escalator (i.e., a three-year moving average of nominal Gross Domestic Product) to grow the value of the cash transfer.[4]

In summary, the context placed around $11.5 billion is important, for it underscores the importance of the initial step that has been taken by the federal government when it comes to shoring up funding for health care in Canada. However, the critical issue now becomes what immediate and successive steps will be taken by the government to place the funding of our health care system on a longer-term and sustainable basis.

The CMA is not alone in its view that there must be a full restoration of CHST cash. The Communiqué issued by the First Ministers at the recent 40th Annual Premiers Conference in Quebec City was clear in the interpretation of sustainability.

Funding is the key for health sustainability. Premiers and Territorial Leaders therefore request that the federal government fully restore Canada Health and Social Transfer funding to 1994/95 levels with an appropriate escalator for the CHST cash transfer that keeps pace with cost and particular demand pressures.

News Release. 40th Annual Premiers' Conference Québec City, Québec, August 9-11, 1999.

While we consider how to ensure that the health care system will be here for all Canadians over the short, medium and long-term, we know that our society is growing and ageing. It is projected that individuals over the age of 65 will increase from just over one in ten (12.2%) in 1996 to one in five (21.7%) in 2031.[5]

…if we don't develop and pursue now long-range multi-faceted strategies to correct the ills of the current health care system and to prepare for the day that is around the corner – when Canada's population will be older than at any point in our history – we will have made a grave error.

Charles Baillie, Chairman and CEO, Toronto-Dominion Bank Speech to the Vancouver Board of Trade, April 1999

The combination of population growth and ageing will place additional pressure on health expenditures. Estimated per capita health expenditures by age for 1994 (see Table 1), shows that per capita expenditures for the 65 and over age group were $8,068, in comparison to $2,478 for the population as a whole-just over a three-to-one ratio.[6] Of interest, while the 65 and over population represented less than 12% of the population in 1994, it is estimated to have accounted for almost 40% of total health expenditures. The Auditor General of Canada, using age-specific per capita health spending, has projected that government health expenditures may reach 12% of GDP.[7] This is a large estimated increase given that the 1998 total health expenditures, which includes both government and private sources, is approximately 9% of GDP.

Table 1 Per Capita Health Expenditures By Age Group, 1994	
Age Group	Expenditures per capita
0-14	$1,156
15-44	$1,663
45-64	$2,432
65+	$8,068

Source: National Health Expenditures, CIHI, 1996.

While it may be argued that those are only estimates, the OECD study on population shows that they are not at all atypical of the international experience.[8] This information alone will present the health care system with a number of challenges when it comes to meeting the future needs of the population.

Given the current and impending pressures on the health care system, it is incumbent on the federal government - the guardian of Medicare - to think how we, as a society, will be able to maintain our health care system well beyond the new millennium.

…the foundation of a productive and prosperous society in the new millennium will be a healthy, well-educated and innovative population. That is what the effort of all governments must be about.

Prime Minister Jean Chrétien
Address to Michigan State University,
May 7, 1999

The CMA therefore recommends:

1. **That the federal government fund Canada's publicly financed health care system on a long-term, sustainable basis to ensure quality health care for all Canadians.**

2. **That the federal government introduce a health-specific portion of federal cash transfers to the provinces and territories to promote greater public accountability, transparency and visibility.**

3. **That the federal government, at a minimum, increase federal cash for health care by an additional $1.5 billion, effective April 1, 2000.**

4. **That beginning April 1, 2001, 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, ageing, epidemiology, current knowledge and new technologies, and economic growth.**

Recommendation 1 is principle-based and speaks to the importance of moving away from managing Canada's health care system on a crisis-to-crisis basis. While the balance between affordability and sustainability of our system should be at the forefront of our thinking, it must not deny Canadians reasonable access to quality health care. It also recognizes that although the federal government has an essential role to play, it cannot do it alone; it must work in close partnership with the provinces and

territories.

Consistent with the Minister of Health's call for increased accountability and transparency in our health care system, Recommendation 2 calls on the federal government to be measured by the very same principle when it comes to funding Canada's health care system. It is also consistent with the Social Union Agreement calling for greater public accountability on all levels of government.

While last year's allocation under the CHST for health care sends an important message, consideration must be given as to how the CHST can be restructured to promote greater transparency and linkage between the sources of federal funding for health care and their intended uses at the provincial/territorial level. This is particularly important when one considers the need to better understand the relationship between defined health care expenditures and their relationship to health outcomes.

In fact, it could be argued that last year's federal budget implicitly re-introduced the concept of earmarking CHST cash to health care. At a time of increased demand for accountability, the CHST mechanism appears to be anachronistic by having one indivisible cash transfer that does not recognize explicitly the federal government's contribution to health in a post-Social Union Agreement world.

Last year, the CMA recommended to the federal government that it reinvest a total of $3.5 billion effective April 1, 1999 into the health care system with the principal objectives of: stabilizing the health care system; and assisting in the transitional process of expanding the continuum of care. As part of the $3.5 billion, the CMA recommended the creation of a *Health System Renewal Fund* which focused on four discrete areas of need: (1) acute care infrastructure; (2) community care infrastructure; (3) support Canadians at risk; and (4) health information technology.

Given that the government reinvested $2.0 billion in 1999/2000, the CMA recommends that the federal government move immediately to reinvest an additional $1.5 billion for health care to facilitate continued system stabilization as well as further development toward an expanded continuum of care.

These additional and necessary resources would be welcomed in addressing strategic policy challenges related to health human resource requirements – particularly those associated with the need for an adequate and stable supply of physicians and nurses; the cornerstone of our health care system.

Furthermore, these resources would assist in the development of necessary capital infrastructure required to assist in the transition from institutional to community-based models of care, within a more integrated framework.

While more specific and substantial funding announcements would be expected with any new shared programs announced by the federal and provincial/territorial governments (e.g., home care and pharmacare), there is a need now, while the system is in flux to ensure that no one falls through the cracks. This transitional funding will assist in the stabilization of the system and will also serve to ensure that as the system evolves toward an expanding continuum of care, it will remain accessible, with minimal interruption of service to Canadians.

Based on recent estimates of the government's surplus in 1999 (standing at $4.8 billion through the first three months of fiscal 1999) and beyond,[9] it would appear that the government has an opportunity to make good on its commitment to make health care a key priority for future action.

Furthermore, while this is a substantial investment it is by no means the end of the story. As our financial flexibility increases in the years ahead, health care will continue to be very much one of the key priorities for further action.

The Honourable Paul Martin, Minister of Finance, Financial Statement, 1999 Federal Budget, February 17, 1999

Recommendation 4 addresses the need for a fully indexed escalator to ensure that the federal cash contribution will continue to grow to meet the future health needs of Canadians. The escalator formula recognizes that health care needs are not always synchronized with economic growth. In fact, in times of economic hardship (e.g., unemployment, stress, and familial discord), a greater burden is placed on the health care system. If left as is, the current federal cash value will continue to erode over time with increasing demands from an ageing and growing population, and inflation.

Combined, these recommendations speak not only to the fundamental principles of the necessity of having a sustainable health care system, but also in terms of the federal government continuing to take the necessary concrete leadership steps to ensure that adequate and long-term funding is available to meet the health care needs of all Canadians. The recommendations are strategic and targeted, and serve to build on and strengthen the core foundation of our health care system.

If Canada's health care system is not only to survive, but thrive in the new millennium, we must give serious consideration to a range of possible solutions that place our system, and the federal role in that system, on a more secure and sustainable financial foundation. The CMA is prepared to continue to work with governments and others in developing innovative and lasting solutions to the challenges that face the health care system.

IV. SUSTAINABLE HEALTH CARE AND PRODUCTIVITY

In last year's report tabled in the House of Commons, the Standing Committee on Finance proposed the development of a productivity covenant. The Covenant "*should subject all existing government initiatives (spending, taxation, regulation) to an assessment which evaluates their expected effects on productivity and hence the standard of living of Canadians. Every new budgetary initiative should be judged according to this productivity benchmark.*"[10]

There is another sector that I mentioned earlier that I want to talk about, it's the health of Canadians. We had decided that we're to invest in that and I think we have done it because we believe that our standard of living and our productivity will depend very much on the quality of the health care system …

Prime Minister Jean Chrétien,
Speaking in Montreal, May 3, 1999

In the context of reinvesting in health care, the Standing Committee's Covenant asks that a "business case" be made. The CMA is of the view that there exists an important relationship between a well-funded, sustainable, public health care system and economic productivity.

Just as strong economic fundamentals are generally viewed as an essential requirement for Canada's prosperous future, stable, adequate and where required, increased resources for health and health care funding should also be considered as an investment in the future well-being of Canadians, and by extension, our economic ability to compete. Framed in this context, these "investments" strengthen the capacity of Canadians to live rewarding and productive lives.

From a structural perspective, studies have recognized the link between a well-funded, sustainable health care system as an important contributor to Canada's economic performance.[11]

The studies suggest that the nature in which Canada largely finances its health care system through general taxes is more efficient compared to the United States which finances its system predominantly through employer-sponsored programs.

In Canada, we consider Medicare to be the best example of how good social policy can be good economic policy, too. While reflecting the desire of Canadians to show compassion for their fellow citizens, Medicare also serves as one of our key competitive advantages.

Prime Minister Jean Chrétien
Address to Michigan State University,
May 7, 1999

Compared to the United States, Canada finances its health care system more equitably by spreading the financial risk across all taxpayers. As well, issues related to job mobility and the portability of health care benefits are not in question in the Canadian system. However, recent federal underfunding in health care has significantly contributed to impaired access to care by injured and sick workers delaying their return to work, decreasing productivity and increasing the cost of doing business and the cost to society.[12]

A well-funded, sustainable health care system can be viewed as an important component in the decision-making process of businesses to locate in Canada.[13]

In this context, there are a number of benefits that may accrue to Canadians at the individual and societal level, for example:

- it can attract medium- and long-term business investment;
- lead to the development of new infrastructure (e.g., facilities, equipment);
- nurture the development of new long-term (value-added) jobs;
- generate real and growing incomes;
- increase individual and societal economic activity/consumption, wealth and investment capital;
- reduce overall dependence on publicly funded social programs (e.g., employment insurance, income support programs); and
- contribute to a growing and sustainable tax base.

Underscoring the important linkages between the quality of life of Canadians and productivity is the important role of an efficient and well-funded public health care system and sustained economic growth. Given that policy decisions impact on the economy, health and health care should not necessarily be considered in isolation. In fact, wherever possible, good economic policy and good health and health care policy should be mutually reinforcing, or at a minimum, better synchronized.

In an increasingly global, interdependent and competitive marketplace, businesses are not looking to assume greater costs. When it comes to health care, they are not looking to absorb high risk and high cost cases that are currently funded through the public sector. Instead, it would appear that they prefer a well-funded, sustainable health care system that is responsive to the health and health care needs of Canadians.[14] As well, a sustainable publicly funded health care system affords Canadians full mobility (i.e., portability) when it comes to pursuing job opportunities, which in turn, improves productivity.

Good economic policy and good health care policy are compatible Canadian societal priorities. One need not be sacrificed to achieve the other nor should they be considered to be in competition with each other. Access to quality health and health care services is an important contributor towards Canada's ability to remain competitive in an increasingly complex global economic environment. Governments at all levels, must take responsibility to ensure that the health system remains on a long-term sustainable financial footing to the extent that it continues to benefit Canadians at the individual and societal level, and in terms of maximizing our quality of life and our ability to be productive.

V. PHYSICIAN WORKFORCE ISSUES

Canada is now beginning to experience a physician shortage that will be significantly exacerbated in the early decades of the next century. One of the chief contributing factors to the emerging shortage of

physicians has been the almost singular focus of governments in their efforts to contain health care costs in the 1990s.

A key policy approach introduced by governments to reduce cost growth in health has been to decrease the supply of physicians. A 12-point accord on physician resource management reached by Health Ministers in Banff, Alberta in 1992 included a recommendation for a 10% reduction in undergraduate enrolment in medical schools, which was implemented in the fall of 1993, and a recommendation for a similar percentage reduction in the number of postgraduate training positions.

In addition, the introduction in 1992 of the requirement for a minimum of 2 years of prelicensure training removed most of the flexibility that used to exist in the number of postgraduate training slots. For instance, the opportunity for re-entry was no longer available to practising physicians; these re-entry opportunities ensured that young graduates (in general and family medicine) who had opted to go out and do locums or rural placements could then come back into the system at a later date for skills enhancement or speciality training.

What the federal/provincial/territorial Ministers of Health did not take into account, however was that the output of Canada's medical schools peaked in the mid-1980s. Between 1986 and 1989, physician supply increased on average by 1,900 per year. This growth was halved between 1989 and 1993 - dropping to an average increase of 960 physicians per year. After 1993, total physician supply dropped in three successive years. This period of declining growth occurred well before the 1993 reductions have had an opportunity to work through the undergraduate education and post-MD training systems.

Part of the reason for the decrease in supply is fewer Canadian medical graduates, but a significant part is due to increased attrition from the physician population. One factor has been increased retirement of physicians. The annual number of physicians retiring increased by 40% between the 1985-1989 and 1990-1995 periods.

Although there have been up turns in the total supply of physicians in 1997 (285) and 1998 (960), this is unlikely to be sustained, given our lower levels of output from the educational system and higher attrition.

The removal of most of these positions was unfortunate because re-entry can provide for more flexibility in the system and can allow for a more rapid adjustment in the physician workforce to meet the health needs of the public. For the Committee's information, appended to the Brief is the CMA's *Draft Principles for a Re-entry System in Canadian Postgraduate Medical Education.*

According to the CMA's projection via the Physician Resource Evaluation Template (PRET), if the current levels of enrolment and attrition patterns continue, Canada will definitely experience a physician shortage in the first decades of the next century, especially after 2011, when the baby-boomer cohort of physicians will begin to retire.

There is additional evidence that Canada is experiencing a physician shortage. First, it can be demonstrated that physicians are working harder than ever. Data from the CMA Physician Resource Questionnaire survey show that the mean hours per week worked by physicians (excluding on-call) have increased from 46.9 per week in 1993 to 54.1 hours in 1999 - an increase of 15.4%.

I believe that most physicians unconsciously contracted with society to pursue their profession to the utmost of their ability and energy, to keep up their skills and do whatever was needed to promote patient care. In return we expected respect, the equipment to do the job, and freedom from financial anxieties. All three of these expectations have been abrogated, yet we continue to fulfil our side of the contract in confusion, disbelief and a sense of betrayal.

Survey Response,
CMA's 1998 Physician Resource Questionnaire

Second, population-based data suggest that it is becoming more difficult to access physician services. Tracking surveys conducted by the Angus Reid group on behalf of CMA show that in 1998, an estimated 60% of the population believed that access to specialist services has worsened in the past couple of years - up from 41% in 1996. Similarly, in 1998 27% of Canadians reported that access to services from a family physician had worsened - almost double the level of 14% that was reported in 1996.[15]

An August 1999 poll conducted by Angus Reid asked Canadians to assess the availability of physicians in their own communities. Only a little over one half of Canadians (52%) feel there are enough physicians available to meet their community's needs. Furthermore, they expect the situation to worsen over the next five years. Less than one third (29%) feel that five years from now there will be enough physicians to meet the health care needs in their communities.[16]

In summary, there is ample evidence that not only is Canada heading for a severe physician shortage, but that a shortage has been developing over the past few years. At the same time, it must be recognized that it takes on average six years to train a general practitioner and 8-12 years to train a specialist from the time one enters medical school. If we are to avoid what appears to be a significantly worsening crisis, planning for the future must begin immediately.

The CMA therefore recommends:

5. **That the federal, provincial and territorial governments adopt the guiding principle of national self-sufficiency in the production and retention of physicians to meet the medical needs of the population, including primary to highly specialized medical care, and the requirements for a critical mass for teaching and research.**

6. **That the federal government establish and fund a national pool of re-entry positions in postgraduate medical education.**

In close consultation and collaboration with the provinces and territories, the federal government could

play an increasingly vital role when it comes to ensuring that Canada produces an adequate supply of physicians. Furthermore, it could play a role in giving physicians the flexibility they need should they require additional training to meet the emerging needs of Canadians.

Cost containment initiatives have also led to decreased numbers of other health care providers all across the country, particularly nurses. The federal government could play a major role in funding and coordinating research across all jurisdictions in Canada on the appropriate supply, mix and distribution of the entire health workforce. Strategic planning in the short, medium and long-term would be greatly facilitated through the establishment of a national institution that could draw on existing national databases and compile research from all the centres in the jurisdictions across the land.

The CMA therefore recommends:

7. That the federal government establish a National Centre for Health Workforce Research.

RURAL-REMOTE ISSUES

While there are physician shortages across the country, it is particularly acute in rural and remote regions of Canada. For a number of personal and professional reasons, physicians are not finding rural and remote practice as rewarding nor sustainable.

In 1999, CMA conducted a survey of rural physicians who were asked to rate their level of satisfaction with rural medical practice both from a personal and professional perspective; this study was funded by Health Canada. A similar survey was previously done in 1991.[17]

There has been little change in the level of satisfaction for the personal and family factors. However, the level of satisfaction with the professional factors has fallen significantly. In 1991, the proportion indicating they were very satisfied with work hours, professional backup, availability of specialty services and continuing medical education opportunities all decreased by at least 10 percentage points.

Similarly, the percentage who were very satisfied with hospital services fell by more than half from 40% in 1991 to 17% in 1999. Likewise, in 1991 42% were very satisfied with their earning potential compared with 23% in 1999.

ESCALATION AND DEREGULATION OF TUITION FEES

The CMA remains very concerned about high, and rapidly escalating, medical school tuition fee increases across Canada. The CMA is particularly concerned about their subsequent impact on the physician workforce and the Canadian health care system.

In addition to the significant impact of high tuition fees on current and potential medical students, the

CMA believes that high tuition fees will have a number of consequences, they will: (1) create barriers to application to medical school and threaten the socioeconomic diversity of future health care providers serving the public; and (2) exacerbate the physician 'brain drain' to the United States so that new physicians can pay down their large and growing debts more quickly.

In support of this priority matter, the CMA Board has struck a working group to develop a position paper on tuition fee escalation and deregulation; the working group is also planning a national, multiprofession stakeholder conference on this issue. In addition to the recommendation that follows, the CMA believes that governments should increase funding to medical schools to alleviate the pressures driving tuition increases, and that any further tuition increases should be regulated and reasonable.

The CMA decries tuition deregulation in Canadian medical schools and recommends:

8. **That the federal government enhance financial support systems, such as the Canada Student Loans Program, for medical students in advance of any future tuition increase, and ensure that these support systems are set at levels that meet the financial needs of students.**

BRAIN DRAIN

The net loss of physicians from Canada to other countries has doubled since the beginning of the 1990s. Whereas a net loss of 223 physicians due to migration was recorded in 1991, the corresponding figure for 1997 was 432 physicians - which represents roughly the annual output of four to five medical schools. While these physicians leave for a variety of professional and personal reasons, what is particularly telling is that the figure has doubled over the course of the 1990s.

I can assure you that in the health care sector brain drain is not a myth. As the House of Commons Standing Committee on Finance's recent report on productivity noted, "Canada is clearly losing more highly skilled workers to the United States than we are receiving in return," and for health care, that means nine times as many.

Dr. Hugh Scully
Letter to the Prime Minister, June 28, 1999

For several years, the CMA has warned governments and policy makers about the impending crisis of physician shortages and their implications for the health care system. Regrettably, the calls for a more measured, responsible and deliberate approach to physician resource planning has fallen on deaf ears. There are a number of factors that contribute to physicians leaving Canada. While they would appear to be a combination of personal, professional and economic considerations, the bottom line is our brain drain is a *de facto* brain gain for another country - predominantly the United States.

In reviewing the brain drain issue, Statistics Canada concludes that "there is significant net brain drain in the health professions. Brain gain in health is not enough to make up for brain drain to the United States."[18]

This issue is very real for physicians - who are being asked to do more where colleagues are no longer practising; and to the public - who are being asked to be patient as access to the system is delayed or compromised.

In the absence of timely, strategic and lasting policy measures, we are likely to continue to risk losing physicians - many of them our best and brightest - to other countries. In this regard, the CMA is of the view that the federal government has an important role to play when it comes to synchronizing policy in the areas of health care, finance and economics.

One factor that may contribute to a physician's decision to leave or think about leaving Canada is our tax structure. It is important to note that Canada relies more heavily on personal income taxes than any other G-7 country.[19] While this is important, what is more of concern is how Canada's marginal tax structure compares to that of the United States. While it is understood that Canada has taken a fundamentally different approach with regard to the magnitude and role of the tax system in social policy, the gap between the two systems can no longer be ignored in a world of increasing globalization, economic interdependence and labour mobility.

While Canada's personal income tax schedule should be reviewed, it should not come as a surprise to this Committee that other tax policies - such as the Goods and Services Tax (GST)/Harmonized Sales Tax (HST) only serve to remind physicians of the severity and inequity of the problem.

GOODS AND SERVICES TAX (GST)

In its 1997 report to the House of Commons the Standing Committee noted the concerns of the medical profession about the application of the GST and by 1998 indicated that this issue merits further consideration by the government.

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.

Report of the Standing Committee on Finance. December 1997

The CMA believes that it has rigorously documented its concerns and further study is not required[20]- the time has come for concerted action from the federal government to remove this tax impediment.

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'être* of introducing the GST: to be an end-stage consumer-based tax, and not having 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*.

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 is clearly 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.

Having solidified the tax base and eliminated the deficit, the government is now in a position to begin considering the best methods of reducing Canadians' tax burden.

Honourable Paul Martin,
Minister of Finance
Letter to CMA President, August 24, 1999

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. Furthermore, with the introduction of the HST in Atlantic Canada, KPMG has estimated that it will cost physicians an additional $4.686 million per year. By the end of this calendar year, physicians will have been unfairly taxed in excess of $500 million. As it currently applies to medical services, the GST is bad tax policy and the HST will make a bad situation much worse for physicians.

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 or territory 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.

The principles that underpin the fundamental

That the federal sales tax on medical supplies purchased by self-employed physicians in the course of their practices be eliminated.

Chief Justice Emmett Hall,
(Special Commissioner)
Canada's National-Provincial Program
for the 1980s.

issue of tax fairness outlined by Chief Justice Hall are unassailable and should be reflected in federal tax policy. Clearly, it is fairness, not special treatment that the profession is seeking. As it currently stands for medical services, the GST and HST is bad tax policy that does not reinforce good health care policy in Canada.

The CMA strongly recommends:

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

This recommendation would 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:
"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.

The CMA's recommendation fulfils at least two over-arching policy objectives: (1) it strengthens the relationship between good economic policy and good health policy in Canada; and (2) it applies the fundamental principles that underpin our taxation system (fairness, efficiency, effectiveness), in all cases.

In this regard, the CMA is committed to working closely, and on an ongoing basis, with the government to develop collaborative solutions to this tax anomaly.

DIFFUSION OF HEALTH TECHNOLOGIES

Recently, concerns have been raised about the lack of access to necessary diagnostic and treatment technologies in Canada. Many of the technologies are essential in the early detection of cancers (e.g., breast, prostate, lung), tumours, circulatory complications (e.g., stroke, hardening of the arteries) and other illnesses.

A recent study concluded that Canada is generally in the bottom third of OECD countries in availability of technology. Canada ranks 18th (of 29 OECD countries) in making available computed tomography; 19th (of 24 OECD countries) in lithotriptor availability; and 18th (of 27 OECD countries) in availability of magnetic reasonance imagers. Canada ranks favourably only in the availability of radiation

equipment (5th out of 16 OECD countries).[21]

Given the very real concerns that have been raised with regard to waiting lists across the country, Canadians deserve better when it comes to making available needed health technologies that can effectively diagnose and treat disease. Furthermore, it is clear that we must facilitate the diffusion of new cost-effective health technologies that are properly evaluated and meet defined standards of quality. While physicians are trained to provide quality medical care to all Canadians– they must, at the same time, have the "tools" to do so.

Canada has among the fewest advanced radiological machines (computed tomography, magnetic reasonance imaging, positron emission tomography, and bone densitometry devices) on a population basis among the countries in the developed world. It ranks in this respect with the less developed nations.

B. Lentle, Capital Crisis – Fin de Siecle Radiology in Canada (**submitted for publication**)

In this context, the federal government should establish a National Health Technology Fund that would allow the provinces and territories to access funds. While the provinces and territories would be responsible for determining their respective technological priorities, the federal government would very clearly link the sources of funding with their intended uses, with full recognition for an essential investment in the health care of Canadians.

The CMA recommends:

10. That the federal government establish a National Health Technology Fund to increase country-wide access to needed health technologies.

The CMA is prepared to work closely with the federal government to assist in the development of objectives and deliverables of such a fund within a reasonable period of time. In so doing, the federal government would work in a strategic partnership with the provinces and territories such that monies from the fund to purchase equipment would be supported by ongoing operational resources at the site of delivery.

VI. SYNCHRONIZING FEDERAL GOVERNMENT POLICY: WHERE FINANCE, ECONOMICS AND HEALTH CARE COME TOGETHER

In appearing before the House of Commons Standing Committee on Finance, the CMA is well aware that policy considerations in finance and economics have an important and direct impact on the funding and delivery of health care in Canada.

In the world of public policy, rarely are difficult decisions portrayed as simply being black or white. In most instances, where tough choices are made amongst a series of competing ends, they are often in varying shades of grey.

While this is true when it comes to health care policy in Canada or any other discipline, it is important that it be placed in a broader context in terms of being consistent with, or reinforcing other good policy choices that have been implemented.

This concept is critical to ensure that, if possible, all policy decisions are moving consistently in the same direction. In effect, synchronized in a way that the "policy whole" is greater than the sum of its individual parts. Such an approach also ensures that policy decisions taken in one sector are not countering decisions taken in other sectors.

HEALTH RESEARCH IN CANADA

In previous submissions to the Standing Committee on Finance, the CMA has encouraged the federal government to take the necessary steps to establish a national target and implementation plan for health research in Canada.

If you compare the amount per capita of research money available in the States for health research as compared to hers, we are behind. With the investment we are making now, we are going to catch up, but we are still not going to be equal. So we have to keep going in that direction.

Honourable Allan Rock, Minister of Health
Quoted in Ottawa Citizen, September 2, 1999

The CMA was very encouraged with the federal government's announcement in last year's budget to set aside significant resources to develop the Canadian Institute for Health Research (CIHR). By 2001, funding for the CIHR is expected to increase to $484 million. The CMA was also pleased with the Minister's recent announcement to earmark $147 million to attract and retain health researchers in Canada.

In offering a vision and structure to facilitate health research in Canada, the government should be congratulated. The CMA believes that significantly increasing funding in support of health research is of direct benefit to: (1) the health of Canadians; (2) Canada's health care system; and (3) to foster the development of health care as an industry. This is where good economic policy goes hand-in-hand with good health and health care policy in Canada.

The CMA strongly supports the CIHR model and is prepared to work closely with government and others to do what is necessary to make this become a reality. Recognizing that Canada is moving into a new phase when it comes to funding and undertaking health research, the government is taking an important step to ensure our best and brightest medical scientists and health researchers are developed and remain in Canada.

Good research is at the core of a quality health care system. Better research is about better health for Canadians.

Prime Minister Jean Chrétien,
Prime Minister's Update, spring 1999

As a national organization representing the views of practising physicians across the country, the CMA

strongly believes it has a meaningful contribution to make in moving the CIHR model forward. Specifically, in the areas of:

- knowledge management (the CMA contributed greatly to stimulating clinical and health services research in Canada)
- contributing to the research agenda (the CMA contributes to the research agenda in health services research, for example the Western Waiting List project funded by the Health Transition Fund)
- ensuring quality peer-reviewed research (the CMA publishes the leading peer-reviewed medical journal in Canada)
- research transfer (the CMA plays a leading role in developing tools to transfer research into practice – such as the Clinical Practice Guideline Database)
- ethics (the CMA maintains a standing committee on ethics)
- sustainability (the CMA has advocated for a strong Canadian presence in health research)

While the CIHR will have a broad mandate for health research, physicians will have a key role to play in medical and health services research. The CMA looks forward to playing a more substantive role as the model moves to become reality.

The CMA recommends:

11. That the federal government continue to increase funding for health research on a long-term, sustainable basis.

TOBACCO CONTROL PROGRAMS

Tobacco taxation policy should be used in conjunction with other strategies for promoting health public policy, such as public education programs to reduce tobacco use.

The CMA continues, however, to maintain that a time-limited investment is not enough. Substantial and sustainable funding is required for programs in prevention and cessation of tobacco use.[22]

…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.

Securing Our Future,
Liberal Party of Canada, Ottawa, 1997

A possible source for this type of program investment could be tobacco tax revenues or the tobacco surtax. The CMA believes that that the federal government should designate 0.6 cents per cigarette sold to a fund to defray the costs of tobacco interventions, including those provided by physicians with the expertise in the treatment of nicotine addiction. This would generate approximately $250 million per year to help smokers quit.[23]

The CMA recommends:

12. **That the federal government commit stable funding for a comprehensive tobacco control strategy; this strategy should ensure that the funds are invested in evidence-based tobacco control projects and programs, which would include programs aimed at prevention and cessation of tobacco use and protection of the public from tobacco's harmful effects.**

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

14. **That the federal government place a high priority for funding tobacco prevention and evidence-based cessation programs for young Canadians as early as primary school age.**

TOBACCO TAXATION POLICY

Smoking is the leading preventable cause of premature mortality in Canada. The most recent estimates suggest that more than 45,000 deaths annually in Canada are directly attributable to tobacco use.

The estimated economic cost to society from tobacco use in Canada has been estimated from $11 billion to $15 billion.[24] Tobacco use directly costs the Canadian health care system $3 billion to $3.5 billion[25] annually. These estimates do not consider 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 aged 10-14.[26] A 1997 Canada Health Monitor Survey found that smoking among girls 15-19 is at 42%.[27] A Quebec study found that smoking rates for high school students went from 19% to 38%, between 1991 and 1996.[28]

The CMA congratulates the federal government's initiatives to selectively increase federal excise taxes on cigarettes and tobacco sticks. This represents the first step toward the development of a federal integrated tobacco tax strategy, and speaks to the importance of strengthening the relationship between good health policy and good tax policy in Canada.

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 selective 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 interprovincial/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 be congratulated for reducing the export exemption available on shipments in accordance with each manufacturers' historic levels, from 3% of shipments to 2.5%. However the CMA believes that the federal government should remove the exemption. 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. Canada and the US should hold discussions regarding harmonizing US tobacco taxes with Canadian levels at the factory gate. Alternatively, Canadian tobacco tax policy should raise price levels such that they approach US tobacco prices. The CMA therefore recommends:

15. 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, raising Canadian tobacco price levels in line with or near the US border states, in order to minimize international smuggling.

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 standard of living upon retirement.

Reviewing the demographic picture in Canada, we know that an increasing portion of society is not only aging, but is living longer. Assuming that current trends will continue and peak in the first quarter of the next century, it is important to recognize the role that private RRSP savings will play in ensuring that

Canadians may continue to live in dignity well past their retirement from the labour force.

In its 1996 budget statement, the federal government announced that the contribution limits of RRSPs was to be frozen 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 contribution 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 policy runs counter to the 1983 federal government White Paper on *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 explicitly recognized and endorsed.

Since that time, in three separate papers released by the federal government (1983, 1984, 1987), the principle of pension parity would have been achieved between money-purchase (MP) plans (i.e., RRSPs) and defined-benefit (DB) plans (i.e., Registered Pension Plans) had RRSP contribution limits risen to $15,500 in 1988.

As a founding member of the RRSP Alliance, the CMA, along with others has been frustrated that eleven 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 needed reforms to achieve parity (from 1988 to 2005). While pension parity will be achieved between RRSP plans and RPP plans in 2004/05, it will have been accomplished on the backs of Canadians whose RRSP contribution levels have been frozen for far too long.

As a consequence, the current policy of freezing RRSP contribution limits and RPP limits without adjusting the RRSP contribution limits to achieve pension parity serves to maintain inequities between the two plans until 2004/05.

This situation is further compounded by the implementation of this policy because the RRSP/RPP plans are frozen and therefore unable to grow at the rate in the yearly maximum pensionable earnings (YMPE) Specifically, if the recommended policy of pension parity had been implemented in 1988, the growth in RRSP and RPP contribution limits could have grown in line with the yearly maximum pensionable earnings - and would be approximately $21,000 today.

TABLE 2 - RRSP Contribution Limits Adjusted by the Yearly Maximum Pensionable Earnings (YMPE

Year	YMPE	% change	RRSP Limits
1988	$27,700		$15,500
1989	$28,500	2.89	$15,948

1990	$28,900	1.40	$16,171
1991	$30,500	5.54	$17,067
1992	$32,200	5.57	$18,018
1993	$33,400	3.73	$18,690
1994	$34,400	2.99	$19,249
1995	$34,900	1.45	$19,529
1996	$35,400	1.43	$19,809
1997	$35,800	1.13	$20,032
1998	$36,900	3.07	$20,648
1999	$37,400	1.36	$20,928

YMPE Source: Revenue Canada, April 1999

Each year the Department of Finance publishes revenue cost to the federal treasury of a number of policy initiatives. For RRSP contributions, the net tax expenditure (i.e., tax revenue not collected) is estimated to be $7.5 billion in 1998. The net tax expenditure associated with registered pension plans is estimated to be $6.2 billion in 1998.

In this context, it is critical to understand the difference between *tax avoidance* and *tax deferral*. RRSPs allow Canadians to set aside necessary resources to provide for their retirement years. In the medium and longer-term, when RRSPs are converted to annuities, they bring increased tax revenues to government. While current contributions exceed withdrawals, this will not continue indefinitely as the baby boom generation retires at an accelerated rate.

In sum, at a time when the government is reviewing the role of public benefits in society, there is a social responsibility placed on government to ensure a stable financial planning environment is in place which encourages greater self-reliance on private savings for retirement.

From the standpoint of synchronizing good tax policy with good social policy, it is essential that the RRSP system be expanded such that it gives Canadians the means and incentive to prepare for retirement, while at the same time, lessening any future burden on public programs.

The CMA recommends:

16. That the dollar limit of RRSPs at $13,500 increase to $15,500 for the year 2000/01.

17. That the federal government explore mechanisms to increase RRSP contribution limits in the future given the delay in achieving pension parity, since 1988.

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% foreign content 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 1999 pre-budget consultation, the Standing Committee on Finance made the following recommendation (p. 58): "*The Committee recommends 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 when they retire.*"

A study by Ernst and Young demonstrated that Canadian investors 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 strongly supports the Standing Committee'**s** position that 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:

18. 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 the year 2000.

As part of the process to revitalize and sustain our economy, greater expectations are being placed on the private sector to create long-term 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 responsibility in fostering an environment that will accelerate 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 business and entrepreneurs. The CMA would encourage the federal government to explore current regulatory impediments to bring together capital with small and medium-size businesses. The CMA recommends:

19. That the federal government explore~~s~~ the regulatory changes necessary to allow easier access to RRSP funds for investment in small and medium-size businesses.

Currently, if an individual declares bankruptcy, creditors are able to launch a claim against their RRSP or RRIF assets. As a consequence, for self-employed Canadians who depend on RRSPs for retirement income, their quality of life in retirement is at risk. In contrast, if employees declare bankruptcy, creditors are unable to lay claim on their pensionable earnings. This is an inequitable situation that would be remedied if RRSPs were creditor-proofed. The CMA recommends:

20. That the federal government undertake the necessary steps to creditor-proof RRSPs and RRIFs.

ENDNOTES:

1. It is important to keep in mind that in addition to the CHST, a separate accounting procedure was established through what is called a CHST Supplement. The Supplement, which totals $3.5 billion, was charged to the 1998 federal government public accounts, but is allocated over a three-year period (i.e., $2.0 billion, $1.0 billion, and $0.5 billion). However, at any point in time, a province or territory can take its portion of the $3.5 billion.

2. The $2.5 billion dollars to be reinvested represents the amount of federal cash that was removed with the introduction of the Canada Health and Social Transfer (CHST) beginning in April 1996 through to 1998. The amount 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 required to restore the CHST cash floor to $18.5 billion (1995/96 level).

3. The data sources for Figure 1 are: (1) CHST: Canadian Medical Association, Looking Toward Tomorrow, September 1998, p. 4.; (2) Historical national cash transfer to health from Established Programs Financing Reports, Federal-Provincial Relations Division, Department of Finance; (3) Population Statistics: Statistics Canada Catalogue no. 91-213; (4) CPI annual % change: Source for 1990-96 is Canadian Economic Observer, cat. No. 11-210-XPB, Historical Statistical Supplement 1996/97, p. 45. For 1996, 1997 and 1998 the source is Canadian Economic Observer, cat. No. 11-010-XPB, April 1999. For 1999 and 2000 the source is Royal Bank of Canada Econoscope, May 1999, p.14. For 2001, 2002 and 2003 CPI % change is assumed to stay constant at the 2000 level of 1.3%.

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