

September 6, 2000

Honourable Allan Rock, PC, MP
Minister of Health
16th Floor, Brooke Claxton Building,
Postal Locator: 0916-A
Tunney's Pasture
Ottawa, Ontario
K1A 0K9

Dear Minister:

The Canadian Medical Association (CMA) values the open, constructive and ongoing dialogue that has developed over the past year with you and your ministry in seeking solutions to the critical issues and challenges that face Canada's health system. As an open society, it is essential to the future of the health care system that every effort is made to work together to find lasting solutions to what is a series of complex and interdependent social policy issues.

With many policy challenges placed squarely on the table, it is timely that we move beyond issue identification and strive to develop a comprehensive plan for health care that incorporates a set of solutions that are strategic, targeted, long-term, and sustainable. Given the evolving nature of the health care system, the plan must also be flexible, adaptive and innovative.

To assist you as you enter into extensive policy discussions with your provincial and territorial colleagues, CMA believes it is crucial that there is a clear sense of where the medical profession stands on a number of issues.

The purpose of the letter is to outline an action plan to revitalize Canada's health care system. The plan is a series of constructive proposals in which the sum is greater than the individual components. The proposals are grouped under the categories of sustainable and accountable federal funding, national health system innovation and physician resource strategy. This information will likely form the basis of the CMA's presentation to the House of Commons Standing Committee on Finance later this Fall.

By their very nature, the proposals are strategically targeted and align policy solutions to a number of key policy challenges that face the health care system today, tomorrow and into the future. The proposals are designed to complement one another. They should be considered as a series of investments that address a spectrum of policy issues in the health care system.

Our proposals are designed in such a manner that they are sufficiently flexible in meeting provincial and territorial health care priorities, while ensuring that the federal government is fully recognized for its essential investment.

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Furthermore, to promote a higher degree of accountability, transparency and legitimacy, each proposal sets out its own rationale and includes, where possible, an order-of-magnitude cost estimate. In specific terms, the total cost of the recommendations that the CMA is putting forward is a minimum of \$10.15 billion. Each investment is accounted for as follows:

• Health-specific Federal Cash Restoration	\$3.81 billion
• National Health Technology Fund	\$1.74 billion
• National Health Connectivity Investment	\$4.10 billion
• <u>National Physician Resource Strategy</u>	<u>\$0.50 billion</u>
Total	\$10.15 billion

The attached documents summarize our recommendations and provide detailed information each proposal.

The CMA has offered a powerful and strategic combination of policy initiatives designed to revitalize Canada's health care system. The proposals are realistic, practical and serve to focus on making the health care system one that is innovative, responsive and accessible by all Canadians.

Finally, it must also be made clear that no one group can address all of the policy issues and challenges facing the health care system. Thus, the CMA's commitment to working with the federal government and others to ensure that our health care system will be there for all Canadians in need is once again offered.

The CMA looks forward to discussing with you how these specific proposals can be implemented.

Sincerely yours,

Original signed by Peter Barrett

Peter Barrett, MD, FRCSC
President

enclosures

c.c. Prime Minister and Provincial and Territorial Premiers
Provincial and Territorial Ministers of Health
Federal Minister of Finance
CMA Board of Directors
CMA Provincial and Territorial Divisions and Affiliated Societies



SUMMARY OF RECOMMENDATIONS

September 6, 2000

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

In the spirit of placing Canada's health care system on the road to recovery, 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, in consultation with the provinces and territories, and stakeholders, introduce a health-specific cash transfer mechanism to promote greater public accountability, transparency and linkage of sources to their respective uses.
3. That the federal government, at a minimum, increase federal cash for health care by an additional \$3.8 billion, effective immediately.
4. That beginning April 1, 2001, the federal government introduce an escalator mechanism that will grow the real value of health-specific cash over time.
5. That the federal government must allocate new monies, over and above the \$3.8 billion increase to the health-specific cash floor to facilitate the development of a comprehensive and seamless system of care.
6. That the federal government commit a minimum of \$1.74 billion over three years to *A National Health Technology Fund*, to increase country-wide access to needed health technologies.
7. That the federal government make a minimum investment of \$4.1 billion in *National Health Connectivity*.
8. That the federal government immediately establish a *Physician Education and Training Fund* in the amount of \$500 million to fund: (1) increased enrolment in undergraduate and postgraduate medical education; and (2) the expanded infrastructure (both human and physical resources) of Canada's 16 medical schools needed to accommodate the increased enrolment.
9. That the federal government increase funding targeted to institutes of postsecondary education to alleviate some of the pressures driving tuition fee increases.
10. That the federal government enhance financial support systems for medical students, provided that they are: (a) non-coercive; (b) developed concomitantly or in advance of any tuition increase; (c) in direct proportion to any tuition fee increase; and (d) provided at levels that meet the needs of the students.

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**ON THE ROAD TO RECOVERY...
AN ACTION PLAN FOR THE FEDERAL GOVERNMENT
TO REVITALIZE CANADA'S HEALTH CARE SYSTEM**

September 2000

SUSTAINABLE AND ACCOUNTABLE FEDERAL FUNDING

Since the introduction of the Canada Health and Social Transfer (CHST) on April 1, 1996, the CMA has taken the strong position that the federal government must restore the level of federal cash notionally allocated to health care that was in place in 1995.

Since that time, the federal government has introduced a series of important first steps towards stabilizing Canada's health care system. Specifically, in 1999, the government announced a five-year fiscal framework that reinvested \$11.5 billion, on a *cumulative basis*, in the health care system. In the budget papers, it was clear that this money was to be earmarked for the health care system only. In 2000, an additional one-time investment of \$2.5 billion, unearmarked through the CHST over four years, was announced.

While seen as a series of important first steps, the figures, however, must be placed in context. Specifically, it is important to note that the CHST monies that have been announced are a combination of increases to the CHST cash floor and "one-time" injections (i.e., "supplements"). Table 1 accounts for the increases via the CHST and its supplement.

TABLE 1 ¹						
CANADA HEALTH AND SOCIAL TRANSFER						
BUDGET IMPACTS (1999 AND 2000)						
1999/00 TO 2003/04						
(\$ BILLIONS)						
Year	1999/00	2000/01*	2001/02	2002/03	2003/04	5 Years
Budget 2000 Increase <i>CHST Supplement</i> **	--	1.0	0.5	0.5	0.5	2.5
Budget 1999 Increase <i>CHST Supplement</i> ***	2.0	1.0	0.5	--	--	3.5
CHST Cash Floor	--	1.0	2.0	2.5	2.5	8.0
Budget 1998 Cash	12.5	12.5	12.5	12.5	12.5	62.5
Total CHST Cash	14.5	15.5	15.5	15.5	15.5	76.5
CHST Tax Transfers	14.9	15.3	15.8	16.5	17.2	79.7
Total CHST	29.4	30.8	31.3	32.0	32.7	156.2

* All figures for 2000/01 onward, with the exception of CHST cash, are projections.

** The \$2.5 billion cash supplement will be paid to a third party trust and accounted for in 1999/00 by the federal government. Payments will be made in a manner that treats all jurisdictions equitably, regardless of when they draw down funds over four years.

*** The \$3.5 billion cash supplement was paid into a third party trust and accounted for by the federal government in 1998/99.

In the latter case, these “CHST supplements,” totaling \$3.5 billion over three years in 1999 and \$2.5 billion over four years in 2000 are specifically designed not to be included as part of the CHST cash floor. Nor is it intended to grow over time through an escalator. In fact the supplement, which is framed as a multi-year investment is charged to the preceding year’s budget. Thus, once allocated and spent, the money is gone.

While the CHST supplements were important first steps, the CMA views them as “tentative half-measures” and by no means a substitute for fostering short-, medium- and/or long-term planning of the health care system. A long-term commitment by the federal government is required to increase its health-specific cash allocation.

Recognizing the limitations of the CHST supplement, on an annual basis, this means that CHST cash for health care increased by \$2.0 billion in 1999/00; 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 2002/03 and 2003/04.

In other words, only in 2002/03 will the CHST cash floor return 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.

¹ Source: Backgrounder on Federal Support for Health in Canada. March 29, 2000. Department of Finance.

The budget announcements by the federal government in 1998/99 and 1999/00 are presented in Table 2. Please note that the amounts applied to the CHST cash floor and the cash supplements have been separated.

TABLE 2 TOTAL CHST CASH, HEALTH-SPECIFIC CHST CASH, CHST SUPPLEMENT 1995/96 TO 2003/04 (\$ BILLION)				
Year	Total CHST Cash	CHST Cash for Health Care*	CHST Supplement	Total CHST Cash for Health Care
1995/96	18.5	7.59	N/A	7.59
1996/97	14.7	6.03	N/A	6.03
1997/98	12.5	5.13	N/A	5.13
1998/99	12.5	5.13	N/A	5.13
1999/00	12.5 + 2.0 = 14.5	5.13	3.5	8.63
2000/01	13.5 + 2.0 = 15.5	6.13	2.5	8.63**
2001/02	14.5 + 1.0 = 15.5	7.13	N/A	7.13
2002/03	15.0 + 0.5 = 15.5	7.63	N/A	7.63
2003/04	15.0 + 0.5 = 15.5	7.63	N/A	7.63

* It is assumed that in 1995/96 the notional allocation to health care is 41% of CHST. Prior to the introduction of the CHST, Established Programs Financing (EPF) and the Canada Assistance Plan (CAP) were in place. In addition, federal cash that has been "earmarked" allocated for health care and added to the CHST base, as outlined in the past two federal budgets, are included

** Assumes that the \$2.5 billion supplement was allocated to health care only.

It is important to pay careful attention with regard to how the figures have been derived and on what basis. Close attention has been paid to the distinction between the increase to the CHST cash floor and the introduction of a "CHST supplement," which has been applied by the federal government over the last two years. In the latter case, the supplement has not been factored into the CHST cash floor analysis since it is a one time expenditure, charged to the previous fiscal year, that can never grow over time. Simply put, once allocated it is gone in perpetuity and does not have any further application in terms of facilitating future growth of the CHST cash floor.

Based on Table 2, it is estimated that the CHST cash floor in support of health care currently stands at \$6.13 billion in 2000/01. This is roughly \$1.5 billion below the 1995/96 level without adjusting the cash floor in support of health care to reflect a number of factors including, a growing and aging population, the depreciation of the system's physical infrastructure, the cost of pharmaceuticals, or inflation, to name a few.

At a minimum, the federal government must put back what it has taken out of the system. Specifically, the CMA believes that the federal government must re-establish the level of CHST cash allocated to health care at the 1995 level, adjusted to reflect the changing health care needs of Canadians in the coming year of 2001.

The question then becomes on what basis can one arrive at a reasonable estimate? Based on a recent study prepared by the Provincial and Territorial Ministers of Health, the CMA believes that this is an important point of departure in considering orders of magnitude.²

Therefore, if one applies the growth factor that was recently calculated by the Provinces and Territories in its "cost driver" study (at 4.6% per annum), the health portion of CHST cash in 1995 at \$7.59 billion is adjusted upwards to \$9.94 billion in 2001 dollars (see Table 3).

YEAR	CURRENT CHST CASH FLOOR FOR HEALTH CARE	ESCALATOR APPLIED TO BASE YEAR OF 1995/96 (% INCREASE)	EXPECTED HEALTH- SPECIFIC CASH FLOOR
1995/96	7.59	4.6	
1996/97	6.03	4.6	7.94
1997/98	5.13	4.6	8.30
1998/99	5.13	4.6	8.69
1999/00	5.13	4.6	9.09
2000/01	6.13	4.6	9.50
2001/02	7.13	4.6	9.94

Based on the recent combination of announcements by the federal government to increase the CHST cash floor and the supplements, it is estimated that the 2000/2001 health-specific cash floor stands at \$6.13 billion. Therefore, to bring the health-specific cash that flows through the CHST in line with the changing health care needs of Canadians, it should, at a minimum, increase by \$3.81 billion effective immediately.

In reviewing the approach taken by the CMA, it is important to understand that the \$3.81 billion figure is a health-specific cash calculation only. As the CHST is currently configured, it flows federal cash for health, post-secondary education and income support programs.

Currently, the Provinces and Territories are adamant that the federal government return the CHST cash floor to its 1993-94 level of \$18.7 billion by adding \$4.2 billion immediately. However, the \$4.2 billion that is being requested is in "1993/94 dollars"; it is not adjusted to account for the changing needs of Canadians between 1993/94 and 2000/2001 for health, post-secondary education or income support programs.

While raising the health-specific cash floor will serve to stabilize the system, it is likely that there will be future debate about what is the appropriate share of federal cash. While there are those who factor in the value of the tax point transfer, it is only federal cash that can be

² Understanding Canada's Health Care Costs – Interim Report. Provincial and Territorial Ministers of Health, June 2000.

used to sanction the provinces and territories that are in violation of the *Canada Health Act*.³ As the Minister of Health was recently quoted “*For the Canadian government to continue to have the moral authority to influence reform, we have to be a more robust contributor.*”⁴ In this context, the adage “no cash, no clout applies” in its strictest sense.

Therefore, while federal cash must be reinfused into the health care system, there must also be substantive policy discussion about what the federal government's contribution should be in the future, and through what mechanism. For example, should it be a fixed amount only; should it be tied to provincial/territorial public expenditures on health; and/or how should it grow over time?

The Need for Financial Accountability

In making a critical investment in the health care system, the CMA strongly supports the principle of financial accountability. This is consistent with the federal government's call for increased accountability in the health care system. After all, if the federal government is calling on provincial and territorial governments, and providers to be more accountable for what they do, then the federal government should be prepared to be measured by the very same principle when it comes to funding Canada's health care system. Therefore, every effort should be made to ensure that health-specific federal monies are visible and transparent.

The CMA view is also consistent with the underpinnings of the recently negotiated Social Union Framework Agreement which calls for greater public accountability on all levels of government.

These issues have been recently noted by the Auditor-General of Canada “*Under the CHST, the federal government does not know its exact total contribution to provinces and territories for health care as distinct from social assistance and services and post-secondary education.*”⁵ The report goes on to recommend that the federal government explore options to improve information on its total contribution to health care, and work with the provinces and territories to develop requirements for information and reporting purposes with respect to CHST additional funds.

The Canadian Institute for Health Information also observed that “*following the introduction of the Canada Health and Social Transfer (CHST) in April 1996, total federal contributions to health care cannot be clearly defined.*”⁶

Furthermore a recent policy document released by Mr. Tom Kent, one of the policy architects of Medicare in the 1960s, refers to the CHST as “*jelly...It can be varied as we*

³ One must keep in mind that once the tax point transfer occurred, they are part of the provinces own-source revenue structure. The tax points cannot be repatriated to the federal government. Furthermore, with the creation of the CHST cash floor, the relationship between the level of federal cash and tax points has been formally severed.

⁴ Iglehart J. *Restoring the Status of An Icon: A Talk With Canada's Minister of Health*. Health Affairs, Volume 19, Number 3, page 133.

⁵ Report of the Auditor-General of Canada. Chapter 29 Federal Support of Health Care Delivery, November, 1999.

⁶ Canadian Institute for Health Information. *Health Care in Canada – A First Annual Report*. 2000.

choose, spent however each province chooses.”⁷ He also says “Ensure that the federal financial contribution to the medicare partnership is made continually clear. This transparency is required not only for the credit of the present government but, equally, to protect the provinces against any future federal government thinking that it could cut its funding with little political penalty...In short, the federal need for recognition of funding and the provincial need for security of funding are not in conflict.”⁸

In many ways, the announcement of the \$11.5 billion, cumulatively, in 1999 was a *de facto* recognition of the need for a health-specific allocation in support of health care. The recent calculations released by the Federal Department of Finance only serve to reinforce this point.⁹

At a time of increased societal awareness and 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.

Therefore, the CHST cash transfer mechanism should be restructured to ensure that there is a higher degree of transparency and explicit linkage between the sources of federal funding and their respective uses at the provincial and territorial level. This can be achieved such that the provinces and territories have the flexibility to allocate resources on the basis of agreed-upon priorities, while ensuring that the federal government is fully recognized for its investment. It would also underscore the relationship between financial “inputs” and health “outputs.”

A Mechanism to Grow the Real Value of Health-Specific Federal Cash Over Time

In addition to increasing the federal cash floor in support of health care, there is also the need to ensure that the cash can grow over time to meet the future needs of Canadians. With this in mind, the CMA recommends the re-introduction of an escalator mechanism to grow the real value of health-specific federal cash. If left as is, federal cash will continue to erode over time with increasing demands from an ageing and growing population, epidemiological trends, new technologies, to name a few.

In previous years, the CMA has proposed an escalator formula which recognizes that future health care costs 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.

The concept of an escalator is not new. In fact, at the time of Established Programs Financing, a three-year moving average of nominal Gross Domestic Product per capita was in place. This policy was regrettably tinkered with and then eliminated in the mid-1990s.¹⁰ Thus, the CMA believes that now is the time to reintroduce a policy measure that served federal-provincial/territorial fiscal relations well.

⁷ Kent T. What Should Be Done About Medicare. Caledon Institute of Social Policy, August 1, 2000. pp 3-4

⁸ Ibid, page 2.

⁹ Backgrounder on Federal Support for Health in Canada. Department of Finance, March 29, 2000.

¹⁰ Thomson A. Diminishing Expectations – Implications of the CHST. May, 1996.

Such a policy measure would be a clear signal to the provinces and territories that the federal government is prepared to be there over the long-term, and is prepared to move away from the annual finger-pointing that plagues federal/provincial/territorial collaboration when it comes to the future of the health care system.

To illustrate the financial impact of an escalator, if the federal government's health-specific cash floor is \$9.94 billion, assuming an escalator of 4.6% would yield an additional \$457 million to the provinces and territories in year 1, and \$547 million in year 5. This is not prohibitive when one considers the current revenues of the federal government, and its anticipated series of surpluses.¹¹

It should also be noted that these recommendations are consistent with the direction set out by the National Liberal Caucus Task Force on Health Care Sustainability.¹²

Combined, the issues of the level of health-specific federal cash for health care and the need for an escalator mechanism speak not only to the fundamental principles of the necessity of stabilizing the health care system, but also in terms of the federal government taking the necessary concrete leadership steps to ensure that adequate and long-term funding is available to meet the health care needs of all Canadians. Their rationale is reasoned and strategic; they give the federal government full recognition for its investment and the provinces and territories flexibility in allocating monies to meet their respective priorities. It also serves to build on and strengthen the core foundation of Canada's 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 within that system, on a more secure and sustainable financial footing.

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, in consultation with the provinces and territories, and stakeholders, introduce a health-specific cash transfer mechanism to promote greater public accountability, transparency and linkage of sources to their respective uses.**
- 3. That the federal government, at a minimum, increase federal cash for health care by an additional \$3.8 billion, effective immediately.**
- 4. That beginning April 1, 2001, the federal government introduce an escalator mechanism that will grow the real value of health-specific cash over time.**

¹¹Beauchesne. Federal Surplus Soars. *Ottawa Citizen*, August 18, 2000. Through the first three months of the current fiscal year, the surplus stands at \$8.2 billion – 42% higher than last year at the same time. Extrapolated over the full year, the surplus would be \$32.8 billion. . McCarthy S. *Ottawa May Have \$74 Billion to Allocate*. *Globe and Mail*, August 29, 2000. The article reports that the Ottawa should have a \$44 billion surplus over the next five years even after allowing spending to rise by more than \$3 billion a year to cover population growth and inflation and setting aside \$3 billion annually for debt reduction.

¹²Investing in New Approaches to Health Care. National Liberal Caucus Task Force on Health Care Sustainability. June 14, 2000. pp 3.

Looking to the Future...

While the federal government must make a series of investments to stabilize the health care system, it must also consider the broader spectrum of health care services needed to ensure that Canadians do not fall through the cracks.

In the past, the CMA has proposed a *Health System Renewal Fund*. The purpose of the multi-year fund was to recognize the changing nature of our health care system and to facilitate the development of a more comprehensive and seamless system of care.

The *Fund* proposed that as the system continues to evolve additional transitional funding is required to ensure that it remains accessible, and can do so with minimal interruption to Canadians. That being said, over the longer-term, the CMA recognizes that the federal government will have to move from transitional funding to investing significant new federal dollars that will not jeopardize access to quality acute care services.

The CMA recommends:

- 5. That the federal government must allocate new monies, over and above the \$3.8 billion increase to the health-specific cash floor to facilitate the development of a comprehensive and seamless system of care.**

HEALTH SYSTEM INNOVATION

In reviewing the current state of Canada's health care system and the need to carefully consider its future, there are at least two fundamental issues that require our collective wisdom and action.

First, there is the need for long-term sustainable funding. The second concerns the overall structure of the health care system, and the degree to which it must be revitalized. Often portrayed as a separate set of strategic policy issues, *system funding* and *system structure* are linked inextricably in a practical sense when it comes to ensuring timely access to quality health care.

When it comes to structure, the CMA is of the view that renewal and innovation is essential if we, as a society, are to ensure that our health system remains sustainable and responsive over the short-, medium- and longer-term. While we must ensure that the health care system of tomorrow is structurally sound, it must also be sufficiently flexible, adaptive and focused on excellence.

The CMA, therefore, proposes that the federal government invest in two areas that are strategically targeted, and serve to facilitate future innovation, adaptability and flexibility in the health care system. At the same time, they also give the provinces and territories full flexibility in determining their priorities within the mandate of the funds while giving the federal government full recognition for its investment.

National Health Technology Fund

As part of the CMA's submission to the 2000 House of Commons Standing Committee on Finance pre-budget consultations, it was recommended that the government establish a National Health Technology Fund. The purpose of the Fund is to address the significant concerns that have been raised about the lack of access to needed diagnostic and treatment technologies in Canada.

Based on the most recent OECD information, Canada ranks poorly when it comes to the availability of technologies, ranking 12th (out of 15) for CT Scanners; 11th (out of 13) for MRIs; and 10th (out of 11) for Lithotripters. Canada ranks favorably only in the availability of radiation equipment 5th (out of 13) OECD countries.

Given the very real concerns that have been raised with regard to waiting times 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 do more to 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.

In the absence of ready access to current and emerging health technologies, Canadians face the prospect of continued and untreated progression of disease, increased anxiety over their health status, and possibly premature death, while the health care system and society bears the direct and indirect costs associated with delayed access.

If Canada were to provide a level of access to these medical technologies that was comparable to other countries with similar standards of living, a minimum expenditure of \$1.0 billion would be required for capital costs alone. Our proposal, however, recommends that targeted resources be provided to the provinces and territories to operate the equipment for a three-year period at an overall cost of \$1.74 billion. This would give the provinces and territories the opportunity to factor in these additional resources into their respective health budgets.

The CMA recommends:

- 6. That the federal government commit a minimum of \$1.74 billion over three years to *A National Health Technology Fund*, to increase country-wide access to needed health technologies.**

For your information, a copy of the detailed proposal is enclosed.

National Health Connectivity Investment

In addition to a national health technologies fund there is a need for significant attention to be paid to ensure access to both hardware and software in order to develop a health information infrastructure that will create "connectivity" throughout the health care system.

The health care system operates within an information intensive environment. However, to date, a substantial amount of the data being collected is gleaned as a derivative of administrative or billing/financial systems. Although this provides useful information for arriving at a “high level” view of the operation of the health care system, it is generally of limited value to health care providers at the interface with their patients.

Much of the recent debate about the future of the health care system has focused on the need to improve its adaptability and overall integration. One critical ingredient in re-vitalizing the system has to do with the necessary information technologies that physicians and other health care professionals must have at their disposal.

Specifically, health care providers require access to a secure electronic health record (EHR) that provides details of all health services provided to the patient in front of them. An EHR that meets the clinical needs of health care providers when interacting with their patients will serve to benefit not only the health of Canadians, but the overall efficiency and effectiveness of the health care system.

Introduction of new technology, such as an EHR, should be viewed as a “social investment” in the acquisition of knowledge. This benefits patients through the potential reduction in mortality/morbidity rates due to misdiagnosis and improper treatment as well as the reduction in medication errors through access to online drug reference databases and by largely eliminating handwritten prescriptions. Health promotion and disease prevention is enhanced through improved monitoring and patient education as well as improved decision-making by providers and patients. These benefits represent only a sub-set of the potential benefits to Canadians.

There are many benefits to providers in having access to an EHR, ranging from administrative cost savings to decreased loss of medical records and improved privacy from physical intrusion of a medical record. The healthcare system as a whole benefits from increased efficiencies and effectiveness. In the United States, the Veterans Health Services and Research Administration (VHSRA) in a controlled prospective study found that a computerized patient record to support providers in outpatient geriatric clinics resulted in cost reductions and improvements in the quality and outcomes of patient care. With baby boomers some 10 – 15 years from retirement, cost reductions and improvements in the quality and outcomes of patient care are not an insignificant benefit of an EHR.¹³

With this as an introduction, the CMA recommends to the federal government that a national investment in health connectivity be established with the objective of improving the health of Canadians as well as improving the efficiency and effectiveness of the health care system by funding an information technology infrastructure for the health care system.

¹³Dammond KW, Prather RJ, Date VV, King CA. Computers in Biology and Medicine, Vol. 20, No. 4, pages 267-279, 1990, “A Provider-Interactive Medical Record Can Favorably Influence Costs and Quality of Medical Care.”

The CMA has determined that a preliminary estimate of the total initial cost of such an investment in knowledge acquisition is a point order-of-magnitude estimate of \$4.1 billion. This represents a capital of cost \$1.6 billion with a five year implementation and operating costs of \$2.5 billion, plus or minus 20%. The yearly operating costs after 5 years are estimated to be \$830 million.

Of course, substantial additional work is required to arrive at more precise cost estimates as well as the potential savings of such an endeavour. Such an investment would provide Canadians with a bold vision of the future of health care and the federal government's role in moving the health care system into the future.

The CMA proposal for an investment in National Health Connectivity dovetails with the recent views of the First Ministers at their most recent meeting. The CMA concurs with the views of First Ministers that the broadened application of information and communications technologies to the health care sector will improve the quality, timeliness and integration of health care services.

The CMA, as the representative of Canadian physicians, can play a pivotal partnership role in achieving the buy-in and cooperation of physicians and other health care providers, through a multi-stakeholder process that would encompass the health care team. Our involvement would be a critical success factor in helping the federal government in making a connected health care system a realizable goal in the years to come.

The CMA therefore recommends:

- 7. That the federal government make a minimum investment of \$4.1 billion in *National Health Connectivity*.**

NATIONAL PHYSICIAN RESOURCE STRATEGY

As the federal government is aware, Canada is experiencing a physician shortage that will be significantly exacerbated in the next decade.

In November 1999, when the Canadian Medical Forum (CMF) and Society of Rural Physicians of Canada met with the federal and provincial governments, a detailed report on physician supply, containing five specific recommendations, was submitted. The CMA and the other CMF organizations are encouraged to see that many of the jurisdictions across Canada agreed with the need to increase enrolment in undergraduate medical education programs, although we are still far from the 2,000 by 2000 proposed by the CMF.

These increases in undergraduate enrolment in medicine require funding not only for the positions themselves, but also for the necessary infrastructure (human and physical resources) to ensure high quality training.

The concomitant increases in postgraduate positions that will be required three to four years after entry into medical school must also be resourced appropriately. It is important to note that these positions are independent of the extra positions recommended in the November 1999 CMF report that are needed to increase: (a) flexibility in the postgraduate training system; (b) the capacity to provide training to international medical graduates; and (c) opportunities for reentry for physicians who have been in practice.)

The federal government needs to demonstrate its commitment to the principle of self-sufficiency in the production of physicians to meet the medical needs of the Canadian population. The CMA recommends:

- 8. That the federal government immediately establish a *Physician Education and Training Fund* in the amount of \$500 million to fund: (1) increased enrolment in undergraduate and postgraduate medical education; and (2) the expanded infrastructure (both human and physical resources) of Canada's 16 medical schools needed to accommodate the increased enrolment.**

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, including: (1) creating barriers to application to medical school and threaten the socioeconomic diversity of future health care providers serving the public; and (2) exacerbating the physician 'brain drain' to the United States so that new physicians can pay down their large and growing debts more quickly.

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

- 9. That the federal government increase funding targeted to institutes of postsecondary education to alleviate some of the pressures driving tuition fee increases.**
- 10. That the federal government enhance financial support systems for medical students, provided that they are: (a) non-coercive; (b) developed concomitantly or in advance of any tuition increase; (c) in direct proportion to any tuition fee increase; and (d) provided at levels that meet the needs of the students.**



Proposals for a National Health Technology Fund

Currently, there is a crisis in confidence among Canadians that access to quality health care services will be there when they need it. In addition, there is a crisis of morale among health care providers who are concerned that they are not able to provide the quality care their patients need. One of the areas that your government could show strong and effective leadership is in the development of a national health technologies infrastructure program.

In its 2000 pre-budget submission to the House of Commons Standing Committee on Finance the CMA made the following recommendation:

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

The purpose of this recommendation recognizes that there are country-wide concerns with the availability of current health technologies in Canada and the speed with which the distribution of new technologies is taking place. In both instances, they have a direct impact on the ability of Canadians to access, within a reasonable time, needed health technologies.

As a consequence, Canadians are facing ever-growing waiting lists for access to needed health technology services (including magnetic resonance imagers; computed tomography scanners; lithotripters; radiation therapy, dialysis) which are essential in the early detection of cancers (e.g., breast, prostate, lung), tumours, circulatory complications (e.g., stroke; hardening of the arteries) and treatment of disease. At the same time, physicians are either delayed or denied the ability to use proven state-of-the-art health technologies to assist them as clinicians.

In the absence of ready access to current and emerging health technologies, Canadians face the prospect of continued and untreated progression of disease, increased anxiety over their health status, and possibly premature death, while the health care system and society bears the direct and indirect costs associated with delayed access.

In considering this issue, the consensus view is that there is a lack of sustainable financial (i.e., capital) resources to purchase needed health technologies. As well, there also appears to be a lack of ongoing financial resources to ensure that the technology can be operated and maintained (i.e., operational) allowing for access on an ongoing basis.

Notwithstanding the supply of health technologies, questions have also been raised about the adequate supply of health care professionals that are needed to operate the technology, and associated physical infrastructure to facilitate reasonable access to care.

Currently Provincial and Territorial governments, and other groups have called on the federal government to continue its reinvestment in the health care system via the Canada Health and Social Transfer (CHST). However, one drawback of the transfer mechanism is that it is “blind” with no linkage or accountability between federal cash and its intended uses.

Recognizing that there is an urgent need for additional funds to be invested and allocated for needed health technologies, the question from a policy perspective is how to design an accountable, targeted and visible program that will invest federal cash into a specific area of the health care system without intruding in the jurisdictional responsibilities of the Provinces and Territories.

One approach is for the federal government to announce the creation of a *National Health Technology Fund* (NHTF). It is proposed that the NHTF would have the following features:

- 1) The NHTF would be a time-limited program with the singular focus of assisting the Provinces and Territories in the funding and acquisition of needed health technologies.
- 2) The NHTF would require that all Provinces and Territories apply to the federal government program for funding for needed health technologies. By so doing, it would give the Provinces and Territories full flexibility in determining their technological priorities, how many and what mix of technologies should be allocated in their jurisdiction.
- 3) The NHTF would provide full financing (i.e., capital) for the purchase of the technology, and defined resources to defray the operational costs associated with the health technologies across the country. Available monies to the Provinces and Territories could be allocated on a per capita basis and/or cost-sharing basis.
- 4) Once the program has been sun-setted, the Provinces and Territories would be responsible for the ongoing (operational) funding and maintenance for the technologies.

The CMA believes that the *form* of the fund must be closely aligned with its *function* and would, therefore, make the following specific recommendations:

1. The NHTF would explicitly link the source of federal funding with its intended use at the Provincial and Territorial level - establishing a new level of federal accountability in financing strategic components of the health care system.
2. The federal government’s investment in health care would be visible, with full recognition for the investment.

3. The federal government's investment would directly contribute to the increasing patient access to health technologies and reducing waiting lists across the country.
4. The NHTF would be targeted funding in an area of need.

As designed, the NHTF would not be seen as intruding on the Provincial and Territorial decision-making process.

The NHTF would give the Provinces and Territories full flexibility to apply for federal funding, as well as determining the number and mix of health technologies.

Notwithstanding the immediacy and importance of the federal government making this critical investment in the health care system, there are a series of benefits to the federal government, Canadians and institutions/providers. The following are some of the benefits the CMA would ask you to consider:

The Federal Government

1. The federal government begins the process of re-establishing its leadership role when it comes to preserving and enhancing Canadians' access to needed health technologies, and assisting in the stabilization of the acute care system.
2. The Fund avoids transferring non-earmarked money (such as via the CHST) to the Provinces and Territories, and ensures that it will be invested in a specific area of priority.
3. The NHTF is a visible and accountable Fund for which the federal government can take full credit.

The Public

1. Canadians will benefit directly in terms of having increased access to needed health technologies.
2. Canadians will be fully aware of the federal government's investment into the acute care system.
3. Canadians will benefit in terms of quicker diagnosis and treatment of disease.
4. The public's confidence in its publicly financed health care system will improve.

Improved access will reduce the direct (e.g., time off from work) and indirect costs (i.e., caring for family members) of illness, and accelerate Canadians' return to functional status.

Health Care Institutions and Providers

1. The additional funding will give institutions increased flexibility in purchasing needed health technologies.
2. It will give institutions the ability to provide more readily accessible health care to Canadians.
3. Providers will have state-of-the-art diagnostic and treatment tools to provide quality health care to all Canadians.

The CMA has assessed the cost implications of this national initiative and this information is attached.

In addition to a national health technologies fund there is a need for significant attention to be paid to ensure access to both hardware and software in order to develop a health information infrastructure that will create "connectivity" throughout the health care system. The objective would be to foster the integration of the components of the system across the continuum of care supported by evidence-based decision-making by both clinicians and managers. The CMA would like to work with you and your colleague, the Minister of Industry, to explore opportunities to work in partnership with the profession and Canada's high technology industrial sector to develop this health information infrastructure.

It is our hope that your government will give serious consideration to our recommendation for a national health technologies fund. The CMA believes that such a fund is clearly warranted.

Cost Estimates:

In support of the Canadian Medical Association's proposal for a National Health Technology Fund, the following cost estimates, based on the best available data, for the acquisition of medical technology has been compiled.

The most recent data available on medical technology comparisons between countries is from the OECD (1997). Equipment costs, in terms of acquisition, siting and operating costs were provided by CMA Affiliates as noted in the cost estimates.

If Canada were to provide a level of access to these medical technologies that was comparable to other countries with similar standards of living a minimum expenditure of \$1 billion would be required for capital costs alone. Our program, however, in keeping with the spirit of the Canada Health Act, recommends that resources be provided to the provinces/territories to operate the equipment for a three year period at an overall cost (capital and three years of operating costs) of \$1.74 billion. This would give the provinces/territories the opportunity to factor in these additional operating costs into their respective health budgets over the three year period.

It should be noted that the CMA's estimates do not address the aging state of Canada's existing medical technologies. Unfortunately, information is not available to provide an estimate of the costs of updating such equipment.

Medical Technology Acquisition Cost Estimates:

Purpose:

To estimate the costs of funding a National Health Technology Program.

Data Sources:

- OECD Health Data 99 – Number of units of technology equipment per million population for countries reporting data for 1997 (most recent year).
- Costing information courtesy of:
 - 1) Canadian Association of Radiologists;
 - 2) Winnipeg Health Region Authority; and
 - 3) Canadian Urology Association

Data:

- Capital cost includes, equipment acquisition cost and siting cost (building space, mechanical, technical, electrical, etc.).
- Operating cost includes, yearly service contract and estimate for technical support staff. It does not include expenditures on medical services.

Methodology:

- 1) Medical technologies included:
 - Computed Tomography scanners (CT scanners)
 - Magnetic Resonance Imaging units (MRI)
 - Radiation therapy equipment (linear accelerators, cobalt-60 units, caesium-137 telepathy units, low to orthovoltage x-ray units, high dose rate brachytherapy units, low dose rate brachytherapy units, conventional brachytherapy)
 - Lithotripters (extracorporeal shock wave lithotripters)
 - Positron Emission Tomography (PET)
- 2) Technologies are expressed in units per million population and are compared only with countries included in the OECD database for 1997 that had a purchasing power parity PPP \$ GDP per capita greater than \$20,000. Canada's PPP GDP per capita in 1997 was \$23,745 while the average for the comparator countries was \$23,749. A GDP criteria for comparator inclusion was used to compare Canada with countries that have similar standards of living and potentially similar demands for access to their health care system and to medical technology.
- 3) The comparator countries are mainly from Europe which have a very high population density. The number of units per million population don't take into account the geographic diversity of Canada.

- 4) PET data were provided by the Canadian Association of Radiologists (CAR) who stated there were 200 PETs in the world in 1998. Europe and the USA each had a 40% share with Canada having a 3% share used mostly for research. CAR estimates that accounting for population size; and growth; and that PETs in Canada are mostly used for research, an additional 10 units are required.
- 5) The equipment highlighted are more readily identifiable given their high acquisition costs but other medical technologies in Canadian hospitals need replacement or upgrading as well. For example, gamma cameras are generally 10 to 15 years old and need to be replaced with gated imaging cameras at a cost of \$650,000 each. Colour doppler ultrasound machines are also required at \$200,000 each. As well brachytherapy equipment, which is used for cancer treatment, is becoming increasingly obsolete and has a replacement cost of \$750,000 per unit.
- 6) An 85% factor has been used to estimate requirements for other medical technologies. That is, CAR estimates that radiological high technology medical equipment represents 85% of the overall cost of radiological medical technology. Therefore overall capital costs (equipment and siting) have been grossed up by a factor of (1/.85) or 17.65% to allow for the purchase of other medical technology equipment that cannot be accounted for with the information available.
- 7) Equipment acquisition cost estimates (excluding siting costs) are based on average estimated costs. Depending upon the sophistication of the equipment the ranges are:

CT scanners:	\$0.50m - \$1.50m	Linear accelerators:	
MRIs:	\$1.25m - \$2.50m	Low energy:	\$1.50m
Lithotripters:	\$1.25m - \$1.50m	High energy:	\$1.80m
- 8) Operating costs have been calculated over a three-year period so that all provinces/territories would be able to make use of the program which is in keeping with the spirit if not the terms of the Canada Health Act. It would also give them the opportunity to factor these additional operating costs into their respective health budgets after the 3 years.

Caveats:

The cost estimates reflect the additional cost of bringing Canada up to a standard of access to medical technology of developed countries with similar \$ PPP GDP per capita.

The cost estimates **do not** take into account any replacement of existing medical technology equipment that may be required.

The acquisition cost of medical technology equipment is only one factor. Associated with such equipment are the costs of a physical site, yearly service contracts and the yearly operating cost of materials and personnel.

Findings

The estimated overall capital cost is \$1 billion. The overall cost of the program, which includes resources to operate the equipment for a three year period, is \$1.74 billion.