"ISSUES AND OPTIONS" REPORT

PRESENTATION TO THE STANDING SENATE COMMITTEE ON SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY PUBLIC HEARINGS ON HEALTH CARE

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ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

Leadership for Physicians… Health for Canadians
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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.

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Mr. Chairman and Honourable Senators:

My name is Peter Barrett. I'm a practising urologist from Saskatoon, Saskatchewan and Past-President of the Canadian Medical Association. I am here today representing the more than 50,000 CMA physician members from across Canada.

The CMA appreciates the opportunity to offer our comments on the Committee's *Issues and Options* report. Joining me today from the CMA is Dr. Arun Garg, the Chair of our Council on Health Policy and Economics. I am also very pleased to be presenting with my colleagues, Dr. Heidi Otter, President of the British Columbia Medical Association and Mr. Darrell Thomson, BCMA Director of Economics and Policy Analysis.

Our views today are part of the CMA's ongoing work on sustainability and it complements our interaction with the Commission on the Future of Health Care in Canada. A detailed, written submission including a grid assessing and ranking each and every option proposed by the Committee's *Issues and Options* report according to "do-ability" and "desirability" is underway and will be provided to the Committee at our next appearance before the Committee in Toronto on October 30th.

At the outset we agree with your overall assessment that efficiency gains alone will not result in a sustainable system and we applaud your efforts in laying out a comprehensive array of options. We also appreciate your efforts to provoke "new thinking" even if some of the options you present may fail the "do-ability" and/or the "desirability" test.

As for our presentation today, I will focus my remarks essentially in two areas:

- CMA principles and parameters for change
- Assessment of some options: What we like / what we think needs more work

Principles & parameters for change

The CMA believes that it's important to view and assess sometimes contradictory options within a single, values-based framework for change. In turn, the analysis of policy options should be guided by the following parameters:

- **Inclusivity** – To truly achieve buy-in for change all key stakeholders (payers, providers and patients) must be engaged in early, ongoing and meaningful consultation. Too often physicians are seen as the objects of change rather than the agents of change.
- **Accountability** – All stakeholders must assume some level of accountability for the health care system. This must include the practicing community as well as the macro-level policy makers.
- **Evidenced-based decision-making** – This is adapted from the concept of evidence-based medicine, which stresses the examination of evidence from clinical research rather than the individual and unsystematic clinical experience[1]. What's expected of the practitioner "goose" should also apply in equal measure to the legislative "gander."
- **Evolution not revolution** – By this we mean that we should build on the best of what we have in the current Canadian system. We also need to be mindful that good can be an enemy of better.
- **Health care as an investment good** – Contrary to the long held view that health care is only a consumption good, it is the CMA's view that health care is clearly an investment good. Both in terms of the contributions it makes to enhancing individual quality of life and to Canadian socio-economic status as a whole.

The principles of the Canada Health Act, as we all know, include universality, comprehensiveness, accessibility, portability and public administration. However, as physicians we believe there are a series of more fundamental or first principles that underpin Medicare and these must be taken into account explicitly when assessing any new policy direction. They include:

- **Universality** – Health care must be available to all Canadians and health resources should be allocated on the basis of need. We should underscore that Medicare is the best remaining universal program in Canada and this lies at the heart of "political sustainability" of Medicare.
- **Choice** – One of the hallmarks of Medicare is that patients have been able to choose their physician, to switch to another physician and to seek a second opinion. We believe it is essential that the principle of choice between physicians and patients be sustained in order to sustain system integrity.
- **Physician as Agent of the Patient** – Medicare has promoted the concept of the physician, as agent of the patient and this must continue. Any option that puts physicians in the position of being an agent to the payer should be seen as "out of bounds."

- **Quality** – The health care system must continuously strive to provide quality care. By quality care we mean services that are appropriate for patient needs and delivered in a manner that is timely, safe and effective.

The CMA believes that these principles and parameters can serve to guide the "modernization" of our health care system, while at the same time building on the best of our current system.

Assessment of Proposed Options

The CMA's principles and parameters for change provide a policy framework or "screen" for our approach to health care system restructuring. Our framework is not so broad as to cover all of the areas and options contemplated by the Committee, however many of the options would fall within our framework for change.

Using this screen, the CMA is analyzing in detail the various strengths and weaknesses of options in the five areas of federal responsibility identified by the Committee (financing, research and evaluation, infrastructure, population health, service delivery). As mentioned earlier, the CMA will be providing a more detailed analysis of these options at our next appearance before the Committee later this month in Toronto. What follows could be best seen as "first-brush" impressions based on an initial application of the screen.

What we like / What we think needs more work

There are a number of areas and options in which we commend the Committee for its work so far and there also are a number of options and areas that we believe need significantly more consideration and study.

Examples of areas and options that we concur with are:

- **Health Technology:** The CMA has developed a detailed proposal that would help bring Canada up to par internationally in acquisition of new technology and a further proposal that would lead to a national policy (i.e. the work with radiologists). Our National Health Technology proposal reflects many of the observation made by the Committee.
- **Spectrum of Care:** The CMA has developed a "Scopes of Practice Policy" that clearly supports a collaborative and cooperative approach. We have copies of this document available for the committee.
- **Aboriginal Health:** The CMA has long been calling for a national strategy to deal with what we view as a national health crisis in our aboriginal communities across Canada.
- **Health Care Report Card:** As you know, the CMA issued its first National Report Card on Health Care this summer. We have copies of this document available for the committee. We believe that this sort of assessment and accountability model is critical to ensure a sustainable and equitable health care system across Canada.

Examples of areas and options that we think needs more work are:

- **Rural & Remote Practice:** The Society of Rural Physicians of Canada has developed a national rural strategy that should be examined in detail by the Committee. Their proposal goes well beyond the limited telehealth solutions proposed by the Committee. The CMA has also developed a rural and remote practice policy that makes 28 recommendations in training, compensation, and work and lifestyle issues.
- **Health Human Resources:** Access to physicians is not uniform in Canada and disparities are likely to grow worse as the population ages. Without the availability of physicians, access to medical care is meaningless. We applaud the HRDC/Health Canada recent announcement concerning a physician labour sector study in partnership with health professionals. At the same time, the federal government needs to demonstrate its leadership and commitment immediately to the principle of reasonable self-sufficiency in the production of physicians to meet the medical needs of Canadians.
- **Mental Health:** The Canadian Psychiatric Association has developed a detailed brief on future directions for mental health care in Canada. It is imperative that the Committee examines this issue and the valuable role that the federal government can play in the mental health system in more detail.

In addition to these areas, I would also suggest another key area under the federal financing role that we believe needs further examination and that is something the CMA refers to as "Tax Policy in Support of Health Policy." The use of the tax system to help individuals pay for a range of health care services should be viewed as a serious option for the federal government. The CMA has undertaken a very ambitious review of available evidence and options and we are working to develop with Statistics Canada and Health Canada to complete a detailed tax and benefits incentive analysis by income class and a cost analysis of various options. A thorough review of tax policy with support of health policy as a goal may yield alternative funding approaches. We believe that this deserves further attention and could result in a major review of Canada's taxation system by the federal government.

While we are not in a position today to comment on the options proposed by the Committee we can say that there appears to be some options that may be inconsistent with our principles and parameters. That being said we are certainly open to reviewing any proposals by the Committee on variations of the following options to determine if they meet our principles and parameters. For example:

- **Medical Savings Accounts:** Are not on option for a global method for funding medically necessary health care. This would be a major shift in policy in Canada; funding for the health care to individuals from which they would fund their health care in form of direct payments to providers and purchase of catastrophic health insurance. However, there may be limited forms of saving account through a registered mechanism for long term care and other services.

- **User Fees:** As they apply on acute hospital and medical care services. User fees are a costly administrative burden and there is ample evidence that user fees in this context are a greater disincentive for the poor and elderly who actually require more medical services than on those who abuse the system.

- **Tax Point Transfers:** The further transfer of federal tax points in lieu of cash is neither "desirable" nor "doable". It would weaken the federal government's already limited powers, both moral and economically, in enforcement of the Canada Health Act. It would also result in an even greater disparity between the "have" and "have-not" areas of the country.

The CMA believes that the Committee and the federal government should clearly establish its first principles and parameters for change before deciding upon options for restructuring the system. We believe our outline of first principles and parameters provides the Committee with a useful tool in determining plausible options for change.

Conclusion

To conclude my remarks, I want to re-emphasize that Canadian physicians see a need for change. To reiterate, we agree with the Committee's assessment that better management alone will not lead to a sustainable system. In fact, without significant change we will very soon lose the underpinning of social and political support for the publicly funded health care system.

The focus of change must be on restoring both public confidence and provider morale. We need to concentrate on patient care and speak to individuals and their needs, rather than on a systems level analysis. We need to focus on the "how's (the process of change) not the "what's." We also need to focus on the health care workers in the system. Without an adequate, renewable health care workforce, access to health and medical care will continue to be on the critical list.

The CMA looks forward to our next appearance before the Committee in Toronto. Thank you.

[1] Evidence-Based Working Group. Evidence-based medicine: a new approach to teaching the practice of medicine. JAMA 1992; 268(4): 2420-2425