

**PRESENTATION TO THE STANDING  
COMMITTEE ON FINANCE  
PRE-BUDGET CONSULTATIONS**

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Securing Our Future . . .  
Balancing Urgent Health Care Needs of Today  
With The Important Challenges of Tomorrow

November 1, 2001

HENRY HADDAD, MD, FRCPC  
PRESIDENT

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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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## I. INTRODUCTION

The Canadian Medical Association (CMA) values the open, constructive and ongoing dialogue afforded by the Standing Committee on Finance's Pre-Budget Consultations process. As a society, it is essential that we make every effort to work together to find lasting solutions to what are a series of complex and interdependent policy issues, especially during these turbulent times.

Last August, the Committee set out objectives for this year's consultations. You asked for advice on how to ensure that Canada remains a major player in the New Economy while providing Canadians with equal opportunities to succeed and create a socio-economic environment where they can enjoy the best quality of life and standard of living. However, world events have intervened and the urgent has crowded out the important. The CMA has suspended, for the most part, what we consider important longer term issues in an effort to do our part in helping guide the government's deliberations in this time of national need.

We support the government's commitments, to date, in response to the events of September 11 and their aftermath. We are cognizant of the economic forecasts that show a slowing economy as a result and the need to re-focus our national attention on security issues. The overriding challenge for this Committee therefore, will be to develop recommendations for the next budget that address the current and future situation with respect to national security without losing sight of internal needs such as pursuing the innovations necessary to ensure the long-term sustainability of our health care system. Indeed, we see the latter as supporting the former.

The CMA is committed to working closely with the federal government to ensure that Canada's health care system can respond to immediate health security challenges. Our members are committed to continuing to ensure that Canadians' confidence is restored by developing and implementing policy initiatives that serve to strengthen Canadians' access to quality health care when they need it.

To this end and building on our efforts since September 11, the CMA has put together a to meet these objectives. Specifically, the CMA has examined and developed recommendations that address national preparedness in terms of security, health and capacity; the capacity of our health human workforce in addressing current and future demands; and a look beyond the urgent to the necessary, in the form of a proposed process to review tax policy in support of health policy.

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## II. PREPAREDNESS

### Health and Security

The events of September 11, 2001 have had a profound impact on the lives of Canadians. Anxiety over the openness of our borders, the safety of our airlines and our vulnerability to attacks filled the media and our conversations in the days following the tragedies in the United States. A Canadian Ipsos Reid Express survey taken for the Canadian Medical Association October 23-25, 2001 indicated that 31% of respondents report ongoing sadness, anger, disturbed sleep, or are overprotective of their children.<sup>1</sup> This confirms what our members are telling us, based on everyday practice.

A GPC International survey indicates that three-quarters of Canadians have a moderate to strong fear that the US-led anti-terrorist campaign will lead to Canada being a possible terrorist target.<sup>2</sup> An earlier Canadian Ipsos Reid Express survey taken October 1, 2001 shows that the attacks have risen to the top of the list of issues (73%) that should receive the greatest attention among our leaders.<sup>3</sup> Social issues, including health, are the second rated (49%) concern among Canadians.

The Canadian Medical Association's response following the terrorist attack was immediate and is ongoing. Working through and with our provincial/territorial Divisions and Affiliates, the Association began collecting names of those physicians willing to offer assistance to US agencies dealing with the tragedy should it have been requested. As well, we spearheaded the development of the Canadian Mental Health Support Network ([www.cma.ca/cmhsn](http://www.cma.ca/cmhsn)), which includes Health Canada and twelve other national health associations, to help Canadians and Canada's health professionals cope with the mental health aftermath of the attack. The work of this network continues in terms of a series of public security announcements to be released very soon and in terms of ensuring that the information available through health professionals is clear, concise and consistent. We also provided continuous updated advice to Canadian doctors about bioterrorist threats. In the early days of the anthrax scare, before Health Canada had materials available for the public, hundreds of calls for information to 1-800-OCanada were referred daily by Health Canada to the CMA.

However, there is an aspect of this issue requiring urgent attention given the current environment. It is the ability of our health system to respond to a disaster, be it a terrorist attack, a natural disaster or a large scale accident. As the Canadian Medical Association and others have documented, the people and the infrastructure of our system is already stretched in its capacity to deal with everyday demands. We have seen that emergency rooms across this country can barely cope with the increased demands brought on by the annual flu season. The system is already operating at or beyond capacity. Devastation approaching the scale of September 11 has not been seen in Canada since December 6, 1917 with the Halifax explosion. While no health system can ever be fully prepared to meet such a staggering level of destruction, it must have the confidence, the resources and, the disaster planning and referral systems to rise to the challenge if Canadians are to be reassured that help will be there if and when they need it.

## Public Health and Safety

The challenge – if and when it comes – will require a local response that is supported nationally. To appreciate the scope of the work necessary to prepare the health system for the threats brought by terrorism it will be useful to understand the challenges currently facing public health in Canada. We have long enjoyed the benefits of a solid public health system through the various health protections, health promotion, and disease prevention and control programs created to maintain and improve the health of the population.

The essential role of the medical officer of health in the public health system must be acknowledged, supported, and respected. Their credibility provides the community and health care professionals, particularly physicians, with balance and specialized medical expertise on public health matters. When the board of health is performing its mandated duties successfully, few are even aware that it is at work. Yet when a public health crisis strikes, the community expects rapid, knowledgeable, expert and quality attention to matters. But it can only do that if there is a strong infrastructure in place to meet the challenge.

A clear and present danger is the emergence of new diseases or the re-appearance of old ones. An editorial in the April 27, 2000 issue of the *New England Journal of Medicine* expresses concern about the ability of public health infrastructures to cope with this problem without the resources needed to respond.<sup>4</sup> Increased trade, rising migration rates, and changes in the environment have led to worries over the revival of diseases thought to be under control or near extinction (e.g., human plague, tuberculosis and malaria) and even the recognition of some new “bugs”.

The need to be vigilant about the re-emergence of infectious diseases was brought home to governments with a large outbreak of human plague in India in 1994.<sup>5</sup> Out of 876 cases reported, characterized as presumptive plague, 56 were fatal. A large outbreak of Ebola in Zaire in 1995 led to as many as 233 people dying from the disease and further strengthened the case for devoting resources to this problem.<sup>6</sup>

### West Nile Virus

The New York City area got a first-hand look at this problem in 1999 with the appearance of the West Nile virus in North America. As the *New York Times* reported, it may have come in the blood of a traveler returning from Africa or Europe.<sup>7</sup> It may have arrived in an infected bird smuggled in baggage or even in a mosquito that got onto a jet. In spite of efforts to contain the disease, it has now begun to spread through the eastern portion of the continent, as far north as southern Ontario and as deep as Florida.

### Tuberculosis

Tuberculosis remains one of the world’s two deadliest infections and it is feared to be on the verge of a major comeback. The disease kills 1.5 million to 2 million people a year, almost as many as AIDS.

Experts say that toll could increase in the coming years because TB bacteria are evolving dangerous new strains that are increasingly drug-resistant.<sup>8</sup> Health Canada reports that there have been some cases (and deaths) in Canada of multiple drug-resistant TB (MDR-TB) strains.<sup>9</sup> Only Newfoundland, PEI and the territories have not had cases of drug-resistant TB. Latvia and Russia are considered “hot spots” in the world for MDR-TB. However, one in three reported isolates in New York City in recent years was MDR-TB. As well, highly resistant strains spread from New York to Florida, Nevada, Georgia and Colorado in less than two years.

## **Malaria**

The World Health Organization estimates that one million die from malaria a year and 90% of those deaths are Africans (2500 African children under five die from malaria each day).<sup>10</sup> The disease seems to be dying back in other continents but growing stronger across Africa. The WHO report on infectious diseases describes malaria as having the power to “overwhelm a young child causing high fever, convulsions and breathing difficulties. With the onset of cerebral malaria the child lapses into a coma and may die within 24 hours.”<sup>11</sup>

## **AIDS**

According to the WHO, there are over 33 million people worldwide living with HIV/AIDS.<sup>12</sup> The hardest hit area is sub-Saharan Africa where one in four of the adult population has HIV/AIDS. In South Africa, 10% of the population is now infected with HIV.<sup>13</sup> The problem among pregnant women is worse, with 22% infected with HIV.

In May, 2000, the US National Security Council declared that the spread of AIDS across the world is a threat to national security.<sup>14</sup> The concern, like many of the infectious diseases, is that eventually it will overwhelm the ability of governments to cope with the disease. The US government has sought to double to \$254 million to combat AIDS overseas.

## **Readiness Post-September 11**

The tragic events of September 11 provided a grim reminder of the necessity of having a strong public health infrastructure in place at all times. As was demonstrated quite vividly that day, we do not have the luxury of time to prepare for these events. While it is not possible to plan for every contingency, certain scenarios can be sketched out and prepared for. To succeed, all communities must maintain a certain consistent level of public health infrastructure to ensure that all Canadian residents are protected from threats to their health.

These are only some of the external threats. The Canadian public health system must also cope with domestic issues such as diseases created by environmental problems (e.g., asthma), sexually transmitted diseases, and influenza, among many others. Even before the spectre of bioterrorism this country’s public health experts were concerned about the infrastructure’s ability to deal with multiple crises. There are many vacancies among the public health physician and nursing staffs, particularly in rural and northern Canada as well as the First Nations units. This workforce is also aging and efforts to attract and retain staff have been lagging.

The announcement of October 18, 2001 by the federal government of a \$11.59 million investment was welcome news to Canadians in the aftermath of September 11. It provided for the “basics” in terms of stockpiling of necessary antibiotics, the purchase of sensor and detection equipment to help respond to radio-nuclear incidents, enhancing a laboratory network to better equip them to detect biological agents, and provide training to front-line health care professionals to help them recognize, diagnose and treat suspicious illnesses. However, far more needs to be done to improve our ability to respond to health and security contingencies of all kinds.

The Walkerton water crisis is an example of the difficulties often faced by public health officials. Without the full resources (legislative, physical, financial, human) to do the job properly, the health of Canadians is potentially jeopardized. The Ontario Medical Association emphasized this point in its brief to the Walkerton Inquiry:

*“Unstable and insufficient resources hamper the Ontario public health system. Steps must be taken by the provincial government to enhance the ability of boards of health to deliver public health programs and services that promote and protect health and prevent disease and injury. Sufficient and reliable public health funding is critical.”<sup>15</sup>*

The CMA reinforced that message in a resolution passed at its 2001 Annual General Meeting:

*“That CMA recommend all levels of government across Canada urgently review legislation governing all aspects of drinking water from source to consumption to ensure that comprehensive programs are in place and being properly implemented, with effective linkages to local, provincial and territorial public health officials and Ministries of Health.”*

In a recent broadcast in the United States, Dr. Jeffrey Koplan, Director of the US Centers for Disease Control and Prevention laid out seven priority areas for building capacity and preparedness within a public health system:<sup>16</sup>

- A well trained, well staffed public health workforce
- Laboratory capacity to produce timely and accurate results for diagnosis and investigation
- Epidemiology and surveillance to rapidly detect health threats
- Secure, accessible information systems to help analyze and interpret health data
- Solid communication to ensure a secure two-way flow of information
- Effective policy evaluation capability
- A preparedness and response capability which includes a response plan and testing and maintaining a high state of preparedness

These points apply whether the threat is a natural disaster or a terrorist attack. Public health must be ready for all such threats. And, at present, we are told, that responding to a crisis like Walkerton or North Battleford, not to mention the possibility of co-ordinated bioterrorism, effectively results in public health units shutting down many core programs that are the building blocks of the health care system.

As the long shadow of bioterrorism rises over Canada and menaces our health and wellbeing, these issues take on even more significance to Canadians. This Committee must do its part to provide for an “act locally by thinking nationally” with regard to public health support systems.

### **The Current Context**

As noted above, prior planning and preparation is one of the keys to ameliorating the effects of such sudden and calamitous occurrences. It must be remembered that a catastrophic event of the nature that occurred on September 11 is a local event in that it happens within the jurisdiction of a specific municipality. The quality and level of the response depends on how well prepared the local authorities are for such actions. The local capacity to respond varies across Canada with some area health services (e.g., the larger urban centres) better prepared and equipped than others (there may be jurisdictions that do not have plans).

Regardless of how well prepared any municipality is there is always the very strong possibility that public health officials will be overwhelmed and need to turn to the province or territory for help. It is also possible that the event is so massive that even the provincial or territorial resources are besieged and it must call on the federal government with their stockpiles of medical supplies and access to epidemiologists and laboratory services. That assumes good planning before hand between the federal and provincial/territorial governments and that is not necessarily the case.

There is an important role for the federal government to urgently improve the coordination among authorities and reduce the variability among the various response plans in cooperation with provincial authorities (and assist those in preparing plans where none exist). Health Canada must help facilitate efforts to rationalize preparations and make it easier for jurisdictions to assist one another in a time of disaster. This could include measures such as transferring patients quickly to facilities outside the affected area when the immediate hospitals are full or even to transferring them to other provinces or territories if necessary.

Disease surveillance is another component of these measures. To be effective there must be, at the provincial and territorial level, linked electronic surveillance mechanisms that are standardized and the staff available to analyze and report the data. At the federal level, the government must be ready to provide data in a timely fashion, especially in an emergency. However, very few of Canada’s doctors will have seen the disease entities that threaten Canadians at the moment (e.g., anthrax, smallpox). The CMA has expressed its willingness to assist Health Canada in bringing together stakeholders to develop quickly a curriculum that would train health care professionals to recognize, diagnose and treat the new threats we face as a society.

The government must also aid in the development of volunteer teams of health professionals and other experts that can be mobilized rapidly in response to disasters wherever and whenever they occur. The concept would be similar to the military's Disaster Assistance Response Team (DART).<sup>17</sup> DART consists of medical, engineering, logistics, communications and security personnel ready to deploy at short notice to anywhere in the world from their support base at Canadian Forces Base Trenton.

It is crucial, that the federal government build and maintain its supplies for emergency use, its public health laboratories for early detection, its capacity to rapidly train and inform frontline health workers of emerging threats, its ability to assist the provinces and territories, and co-ordinate provincial responses in the event of overwhelming or multiple simultaneous threats.

**In this area, the CMA recommends that:**

- 1. The federal government immediately provide a minimum of \$15 million for an assistance fund to municipal and provincial authorities to improve the co-ordination of their emergency responses among public health officials, police, fire and ambulance services, hospitals and other services.**

This fund should be over and above a similar sized investment to ensure that Health Canada's Centre for Emergency Preparedness can function even only at a minimal level of effectiveness.

The announcement of October 18 by the Minister of Health that \$11.59 million would be spent to enhance our response to a potential attack is an important step toward reassuring Canadians that help will be there when they need it. However, far more must be done to further expand the federal government's ability to assist municipalities, provinces and territories in dealing with disasters.

The vital role played by disease surveillance cannot be stressed enough. In the event of an unusual or particularly feared illness, or an outbreak of a preventable disease, the public's attention can quickly focus on the public health unit's response. The medical officer of health communicates with physicians (specialists and, general and family practices physicians) in the community. Physicians, especially general and family practice physicians, depend upon their medical officers of health and the health units as an important resource. This includes information on contact tracing, interpretation of unusual clinical symptomatology, vaccination, communicable disease control, outbreak control, environmental health, cluster investigation, epidemiology, travel medicine etc. An effective and efficient surveillance system must be in place in order to provide this data quickly to stop the spread of a disease as fast as possible.

Unfortunately, a weak link in the existing surveillance system is communications. This has had an impact on health professionals' ability to receive timely information regarding changes in disease incidence in their community. Regional, provincial/territorial and federal authorities must work to improve the coordination of communications at all levels to protect the health and wellbeing of Canadians in times of crisis.

**The CMA recommends that:**

- 2. The federal government continue to invest, at a minimum, \$25 million in the coming year in the resources and infrastructure (i.e., medical supplies, equipment, laboratory facilities, and training for health care professionals), needed to anticipate and respond to disasters.**

The sale of Connaught Laboratories meant that Canada lost much its residual capacity to manufacture vaccines. If this were a “normal” war, Canadians would be looking to divert our manufacturing capacity toward meeting the threat. Given the biological threat, the Government of Canada should be negotiating with the pharmaceutical industry to increase our capacity to produce a secure supply of vaccine on Canadian soil. This would include the need for more than one supplier and the capacity to increase quickly the production of the vaccine.

**The CMA recommends that:**

- 3. That the federal government undertake an immediate review of Canada’s self-sufficiency in terms of critical medical supplies (e.g., vaccines) required in the event of disasters with a view to short term self sufficiency.**

**Surge Capacity**

Among the first points of contact with the health system for Canadians in the event of a significant attack on our population it will be the doctors offices and the emergency rooms of our hospitals. As noted earlier, we have witnessed in recent years the enormous strain these facilities can be placed under when even something quite routine like influenza strikes a community hard. The media abounded with stories of patients waiting hours to be examined, of stretchers lining corridors and of ambulances being redirected from hospital to hospital. Canadians themselves experienced first-hand how the resources of the hospitals, particularly the human resources, were stretched to the breaking point.

The acute care occupancy rates of Ontario public hospitals across the Ontario Hospital Association regions in 1999-00 illustrate this point. In three of the five regions (Eastern Ontario, Central and South West) the occupancy rate ranged from 94% to 97%<sup>18</sup>. The highest rate was found in the very heavily populated Central region. A British Medical Journal study suggests that an occupancy rate over 90% indicates that the hospital system is in a regular bed crisis<sup>19</sup>. This problem is not unique to Ontario: “the decrease in the number of acute care beds across Canada over the past decade, coupled with an aging population and our extraordinary success in extending the survival of patients with significant chronic illness, has eliminated any cushion in bed occupancy in the hospital system.”<sup>20</sup>

With this in mind, picture a catastrophe similar in scale to the destruction seen in New York or Washington D.C. occurring in downtown Toronto, Vancouver or Montréal; or perhaps the release of smallpox or botulism over Fredericton or Winnipeg. As noted earlier, the public health system and medical diagnostic and treatment systems in the community and hospitals could become overwhelmed very quickly without the ability to absorb the extra caseload.

Like our hydro system, that is why surge capacity must be built into the system nationally to enable hospitals to open beds, purchase more supplies, and bring in the health care professionals it requires to meet the need.

An element of surge capacity that is seriously lacking is the federal government’s contribution to emergency bed space. With the closure of most of the Canadian Force’s hospitals and the severe loss of experienced health professionals in the military, the government’s ability to assist local and provincial/territorial civilian authorities should their systems become overwhelmed is limited. Currently the National Emergency Stockpile System can supply up to 40,000 cots, as well as medical supplies and relatively rudimentary hospital equipment. Reports indicate, however, that much of the equipment is decades old, and that protocols for logistical management (e.g., transport and rapid deployment) are outdated. There is an urgent need to reassess and reaffirm capacity in this context. The CMA is in close contact with the American Medical Association as they advise their government on coordinating the use of civilian and federal facilities in an emergency.

Most hospitals work on a just-in-time inventory basis for the purchase of drugs. Without some sort of plan to quickly re-supply their pharmacies and expand their capacity, patient care will suffer. The federal government must assure Canadians that municipal and provincial plans are in place with an overarching national plan to support these jurisdictions if their service capacities are overwhelmed. As mentioned earlier, the announcement by the federal government of the \$11.59 million investment to enhance our response to a potential attack is a good step. But the government must help further by making available an emergency fund that would enable hospitals to plan and organize their surge capacity.

**The CMA recommends:**

- 4. The federal government provide, in the coming year, \$25 million in specific earmarked funding to the provinces and territories to enable health care facilities to plan, build and maintain surge capacity (e.g., open more beds, purchase emergency supplies) into their systems.**

The purpose of having such elaborate response plans and stockpiles of supplies and equipment is to be ready for the possibility that, in spite of all efforts to prevent a catastrophe from occurring, it nevertheless happens. That is when responsibility for dealing with the aftermath of the event falls largely to the public health system where a strong and viable infrastructure must already be in place to meet the challenge.

Without the resources and the preparations, the crisis might well deteriorate and spread beyond “ground-zero.” That notion is often very difficult for non-health sector agencies and organizations to appreciate and can be an impediment to improving our capacity to help Canadians in times of disaster. No one can be completely prepared but you can prepare for certain scenarios. That is where the federal government can facilitate the health system’s readiness and reassure Canadians that help will be there when they need it.

The federal government has taken several steps to reassure Canadians that their physical safety is enhanced. This includes the introduction of the *Anti-Terrorism Act* and the development of an Anti-Terrorism Plan. As well, there is increased funding to the Canadian Security and Intelligence Service and the Communications Security Establishment to help those agencies do their jobs more effectively. The health system must be considered an integral component of any plan to combat terrorism. It too requires assistance, especially the public health infrastructure, in strengthening its ability to counter the effects of an attack, whomever or whatever is responsible.

### III. THE CAPACITY OF OUR HEALTH HUMAN WORKFORCE

Although the right mix of physical infrastructure and sustainable, long-term funding is necessary, in and of itself, it is not sufficient to ensure that all Canadians have timely access to quality medical services. We must also have an adequate supply of physicians and other health personnel or the system will not have the flexibility or adaptability to respond to basic societal needs or a crisis in times of disaster.

We believe that the health workforce in general is facing a major sustainability challenge, and as such, this section of the brief proposes initiatives that are not solely focused on physicians but the entire health human workforce.

Reports produced by several health professional organizations show that although overall numbers may be increasing, it is not sufficient to meet future demands. In 2000, there was a moderate 1.7% increase in the nurse population<sup>21</sup>; however, a 1997 Canadian Nurses Association report projected that the supply of nurses must grow by 2.1% per year to meet future demand.<sup>22</sup> Similarly, the number of physicians per 100,000 population appears to be increasing slightly each year (187 in 2000), but it remains below the 1993 level of 191 per 100,000 population. The physician to population ratio can be misleading in that it does not necessarily represent full time physicians. CMA figures show that a larger proportion of physicians fall into the older age groups and may not be working full time or indeed may not be providing patient care at all. Also, one needs to factor in the demographics of the current physician workforce. Female physicians, who tend to work fewer hours per week than their male colleagues, now represent 30% of the practising pool. This means that more physicians will be needed to provide the same number of services. But this may not be possible, as approximately two-thirds of all family physicians are no longer routinely accepting new patients.<sup>23</sup>

This is placing considerable pressure on those currently working within the health care system with little hope for relief. For example, data gathered through the CMA's annual Physician Resource Questionnaire (PRQ) substantiates anecdotal evidence that physicians are working harder. Over half the respondents to the 2001 PRQ (53.7%) indicated that their workload had increased over the past year. Looking at specific areas that have caused physicians the greatest degree of stress, 63.7% indicated that their workload is heavier than they would like (up from 62% in 1998), while 58.1% felt that their family and personal life had suffered from choosing medicine as a profession (up from 55% in 1998).

There are a number of short-term and longer term initiatives that can be implemented to reverse the shortage in our health care personnel and alleviate the stress they are feeling from trying to keep the system operating as best it can. What follows is a description of the short-term initiative the CMA is proposing for consideration by the Standing Committee. For a detailed description of the longer term initiatives and recommendations, please refer to Appendix A.

## **What Can be Done Today?**

Given the immediate need for more physicians and other health professionals in Canada and the time lag involved in training, especially for physicians, the CMA proposes that a variation on the strategy adopted by the Canadian Forces (CF)<sup>24</sup> be used to repatriate physicians and other professionals. The CF announced the implementation of a Medical and Dental Direct Entry Officer Recruitment Allowance effective April 1, 1999 to recruit licensed family physicians, general practitioners and dentists. Recruitment incentives involve a lump-sum signing bonus/recruitment allowance of \$80,000 per direct entry medical officer and \$25,000 per direct entry dental officer after a successful completion of 3 months of basic officer training. The commitment is for a duration of 4 years and retention incentives involve an adjustment to medical and dental rates of pay that are competitive with private sector net earnings.

The CMA concurs with the concept of an incentive program as proposed by the CF and suggests that a similar approach be implemented for recruiting and retaining Canadian physicians and other health care professionals currently practising outside of Canada. Presently there are some 10,500 Canadian physicians practicing in the US as well as tens of thousands of Canadian nurses. Of these physicians, close to 1,000 are considered active physicians both in Canada and the US.<sup>25</sup> Some of these physicians are no doubt practising in border towns where dual licensure is common, but many may be expatriates who have maintained their licensure in Canada hopefully with plans to either return or at least leave their future options open.

Rather than proposing a lump sum approach as an incentive the CMA proposes that the incentive come through graduated federal income tax relief by reducing federal income tax payable by 50% for 3 years for Canadian physicians and health care professionals who return to practice in Canada. Such an approach provides direct relief and over a period of 3 years would provide incentives similar in size to those proposed by the CF in their recruitment and retention program. It is estimated that such a program would cost approximately \$45 million over 3 years to repatriate an estimated 5% or 500 physicians back to Canada. If repatriation of other health care providers were included then it is estimated that the total cost of such an initiative could increase to \$85 million over 3 years.

**The CMA therefore recommends:**

- 5. That the federal government seriously consider implementing a 3-year graduated tax relief and re-allocation policy to encourage expatriate physicians and other health professionals to return to Canada.**

## IV. TAX POLICY IN SUPPORT OF HEALTH POLICY

The federal government has played a key role in the development of our health care system, primarily through a variety of measures or policy levers such as: spending; taxation; regulation; and information.

Up until now, Canada's health care system has made extensive use of only two federal policy levers, namely spending, in the form of cost-sharing arrangements between the federal and provincial/territorial governments; and by regulation, through the *Canada Health Act*. However, the degree to which the government can continue to rely on these levers must be examined. In the not-too-distant future, our health care system will face a number of pressures that will challenge its sustainability. Namely, an aging and more demanding population in terms of the specialty care services and technology they will seek; the cry for expanding the scope of medicare coverage to include homecare and pharmacare; and a shortage of health personnel.

Several national health care studies, namely the Prime Minister's Forum on Health and more recently, the Senate Standing Committee on Social Affairs, Science and Technology's Study of the Health Care System have raised the need to look at alternative health care funding sources. We can not and should not wait any longer to explore and act upon the options available to us.

### Looking at Alternatives

One of the lesser-explored options has been the strategic use of Canada's taxation system. A public discussion of tax policy has not been seen in Canada since at least 1966.<sup>26</sup> Nor have we seen a major assessment of tax policy in relation to social policy since the 1980's Macdonald Commission. In fact, the last major overall tax policy review was that of Benson in 1971.

There is an urgent need to more fully consider the role that the tax system can play in supporting the health care system. Several proposals have been put forward over time in this areas, such as earmarked taxes for health; health-related excise taxes; input tax credits for health care services; medical savings accounts; saving for long-term care; social insurance; and refundable tax credits.

This list is not exhaustive. In fact, the CMA has done some preliminary work in this area by commissioning a discussion paper on taxation and health policy.<sup>27</sup> In the paper, the author puts forth 10 "real world" proposals where the tax system can be used to support health policy. The CMA has initiated detailed discussion with Health Canada, Statistics Canada and others to model some of the possible scenarios. Of course, some of these are more promising than others. It is for this reason that the CMA is recommending the federal government to establish a National Task Force to review the tax system with the purpose of developing innovative tax-based mechanisms that better synchronize tax policy with health policy.

**In this area, the CMA recommends:**

- 6. That the Federal Government establish a blue ribbon National Task Force to study the development of innovative tax-based mechanisms to better synchronize tax policy and health policy. First and foremost this Task Force would study:**
  - a) increasing the reach of the medical expense deduction (i.e., increasing the threshold from the current 3% of taxable expenditures)**
  - b) extending the medical expense deduction from a non-refundable tax credit to a refundable tax credit so that those not having income tax payable are afforded easier access to those services not covered under universal health “programs”**
  - c) dealing with the untoward inequities arising out of the application of the GST.**

The CMA envisions the mandate of the Task Force as being – to conduct a thorough policy and costing analysis of all potential tax-based mechanisms (not limited to those outlined in the above recommendations) that can be developed to assist in the financing and management of the health care system. The Task Force would be comprised of representatives from government, the health care system, private sector, and the public and it would issue its findings and recommendations within 2 years of its conception.

## **V. SUMMARY OF RECOMMENDATIONS**

In closing, the CMA has offered a powerful and strategic combination of policy initiatives designed to re-vitalize Canada’s health care system as well as to restore Canadians’ confidence that they will be taken care of in times of disaster. The proposals are realistic and practical. They give the provinces and territories full flexibility in terms of policy implementation while ensuring full recognition to the federal government for its essential investments.

These proposals emphasize the need for the federal government to continue its leadership to ensure that our health care system, Canada’s most cherished social program, is available to meet the health care needs of all Canadians.

No one group can address all of the issues and challenges facing the health care system. The CMA reiterates its commitment to work with the federal government and others to ensure that our health care system will be there for all Canadians in the future and in times of crisis.

**The Summary of Recommendations is as follows:**

- 1. The federal government immediately provide a minimum of \$15 million for an assistance fund to municipal and provincial authorities to improve the co-ordination of their emergency responses among public health officials, police, fire and ambulance services, hospitals and other services.**

- 2. The federal government continue to invest, at a minimum, \$25 million in the coming year in the resources and infrastructure (i.e., medical supplies, equipment, laboratory facilities, and training for health care professionals), needed to anticipate and respond to disasters.**
- 3. That the federal government undertake an immediate review of Canada’s self-sufficiency in terms of critical medical supplies (e.g., vaccines) required in the event of disasters with a view to short term self sufficiency.**
- 4. The federal government provide, in the coming year, \$25 million in specific earmarked funding to the provinces and territories to enable health care facilities to plan, build and maintain surge capacity (e.g., open more beds, purchase emergency supplies) into their systems.**
- 5. That the federal government seriously consider implementing a 3-year graduated tax relief and re-allocation policy to encourage expatriate physicians and other health professionals to return to Canada.**
- 6. That the Federal Government establish a blue ribbon National Task Force to study the development of innovative tax-based mechanisms to better synchronize tax policy and health policy. First and foremost this Task Force would study:**
  - a) increasing the reach of the medical expense deduction (i.e., increasing the threshold from the current 3% of taxable expenditures)**
  - b) extending the medical expense deduction from a non-refundable tax credit to a refundable tax credit so that those not having income tax payable are afforded easier access to those services not covered under universal health “programs”**
  - c) dealing with the untoward inequities arising out of the application of the GST.**

## APPENDIX A

## The Capacity of Our Health Human Workforce

### Looking to the Future

There are some signs that governments have begun to acknowledge that we are in a sustained shortage situation. In November 1999, several health ministers met with members of the Canadian Medical Forum Task Force on Physician Supply in Canada which recommended 2000 first year medical school places for 2000. Since then, governments have been very active in committing to increases in both undergraduate and postgraduate medical training. Enrolment of new medical students in 2000/2001 reached 1763 for an increase of 12% since 1997/98. This closely matches the promised increases to undergraduate enrolment made by governments. Approximately 140 more positions have been promised for the school years beginning 2001 and 2002.

**In this area, the CMA recommends that:**

- 7. That the federal government immediately establish a Health Human Resources Education and Training Fund in the amount of \$500 million per year for 5 years to fund: (1) increased enrolment in undergraduate and postgraduate education; and (2) the expanded infrastructure (both human and physical resources) required at Canada's 16 health science centres as a result of increased enrolment.**

While the outlook for the future supply of physicians in Canada seems brighter, it will be quite a few years before we can benefit from the current increases in undergraduate enrolment. These initiatives must not only continue, but be enhanced to ensure that our health care system is sustainable into the future. However, there is one factor that may keep us from attaining the optimal level of medical school enrolment – high and rising medical school tuition fees.

In August 2000, at the Conference of Premiers, Prime Minister Chretien said, "*It is indeed important in the new knowledge-based economy that Canadians ... have access to high quality post-secondary education without excessive debt loads, and that every child get the best possible start in life. This is all part of the Canadian competitive advantage.*"<sup>28</sup> This sounds well and good, but the facts tell us otherwise.

Since 1980, medical school tuition costs have increased by almost 880%, or more than twice as fast as the general cost of living.<sup>29</sup> The average tuition for students entering first year medical school in September 2001 was \$12,840, a 158% increase over the 1997 average fee of \$4,977. This means that over the course of four years, an undergraduate medical student is likely to spend approximately \$110,000 in tuition, academic and living expenses.<sup>30</sup>

Many students have had to resort to bank loans to cover the shortfall from their government-sponsored student loan, but the growing amount of debt accumulating for medical students is starting to worry the banks. The CIBC says that rising medical education costs have resulted in debt loads growing much faster than medical students' potential income and so, it will no longer grant medical students preferred lending rates. The CIBC sets limits on the amount of debt that they feel students can repay in the years following their training. Unfortunately, medical students are now reaching these limits – which are in the \$100,000 - \$130,000 range.<sup>31</sup> Unlike the government-sponsored loans, interest on bank loans begin accruing immediately, up to a decade before a medical student starts earning a full income.

This trend raises serious concerns that access to medical education will be restricted solely on the basis of personal financial resources. High debt loads will discourage capable and qualified students – particularly those from modest financial backgrounds – from applying to medical school. Canada's health care system needs individuals from different socio-economic, cultural, rural and urban backgrounds to serve an equally diverse population of patients.

First and foremost, the government must address the situation concerning the high and rising tuition fees and the insufficient financial support systems available to medical students. It must also consider purchasing additional training positions in Canada's medical schools specifically targeted for groups, such as Aboriginal, Indian and Inuit populations. These measures will foster the education and training of a diverse population of health care givers, and will support the culturally and socially sensitive health care needs of all Canadians.

The CMA sees a strong role for the federal government in ensuring that medicine remains a rewarding and affordable career accessible to students based on their passion and academic performance, not their financial status.

**The CMA therefore recommends:**

- 8. That, in order to alleviate some of the pressures driving tuition fee increases, the federal government increase transfer payments to the provinces/territories with targeted amounts for post-secondary education.**
- 9. That the federal government create and fund a national health services student bursary program to encourage students who have limited financial resources to apply for an education in health care services.**
- 10. That the federal government develop financial support systems for health services students that 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.**
- 11. That the federal government purchase additional training slots in Canadian medical schools for particular segments of our population, such as aboriginals.**

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