NOTES FOR AN ADDRESS BY

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ASSOCIATION MÉDICALE CANADIENNE
CANADIAN MEDICAL ASSOCIATION

Leadership for Physicians… Health for Canadians
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ASSOCIATION MÉDICALE CANADIENNE

CANADIAN MEDICAL ASSOCIATION

Mr. Chairman and Honourable Senators:

Good afternoon, my name is Henry Haddad. I am President of the Canadian Medical Association and a practising gastro-enterologist from Sherbrooke, Québec. I am here today representing our members, more than 50,000 physicians from across Canada. The Association has a two-fold mission - to provide leadership for physicians and to promote the highest standards of health and health care for Canadians.

I am accompanied today by Dr. Bruce Wright, President of the Medical Society of Nova Scotia and Mr. Bill Tholl the CMA's Secretary General and CEO. Also with us today is the CMA's President-Elect, Dr. Dana Hanson.

This is the CMA's fourth appearance before the Committee during its study and our second appearance in regard to your "Issues and Options" report. At our appearance in Vancouver, Dr. Peter Barrett focused on principles and parameters for change. Our presentation today builds upon the discussion in Vancouver, and those held with our colleagues of the Ontario Medical Association last week in Toronto.

In Vancouver we provided the Committee with the CMA's principles for change:

- **Patient-centered focus**
- **Universality**
- **Choice**
- **Physician as Agent of the Patient**
- **Quality**

Dr. Barrett also outlined the CMA's proposed parameters for changes, namely:

- **Inclusivity**
- **Accountability**
- **Evidence-based decision-making**
- **Evolution not revolution**
- **Health care as an investment good**

Originally our intent was to develop a detailed grid assessing and ranking each option proposed by the Committee, but given the time constraints I have to state that we are not there yet. I know you appreciate the challenge of consensus building. Instead, this presentation will focus on issues highlighted by the Committee in terms of managing the health care system and accountability in the health care system.

Managing the Health Care System

Over the past two decades significant shifts in the practice of medicine and basic cost drivers have combined to significantly challenge the sustainability of the health care system.

In terms of patterns of practice, I think it is fair to say that this is a good news/bad news story. From a good news standpoint, patients are no longer being hospitalized for conditions they once were. Innovations in care such as minimally invasive surgery have resulted in shorter hospital stays. From a bad news standpoint, the cost pressures to reduce utilization have resulted in some patients being discharged "sicker and quicker" with the result being an off-loading of responsibility to the community.

Physicians have had direct experience with the shift in the burden of care from the institution to the community, particularly with respect to the cost of drugs and community-based services. It is also clear that the resources in the hospital sector are being used much more intensely, on more acutely ill patients and on older patients with complex problems.

While there are many opinions in regard to the future impact of the changing patterns of medicine and an ageing population on health care system costs, the CMA strongly endorses the opinion of the Committee that efficiencies alone won't address financial sustainability. Working harder and smarter is necessary but it is not nearly sufficient.

The Committee is suggesting a range of options to address financial sustainability from increasing CHST transfers, an option that seems unlikely under the current economic climate, to examining user fees, which have always been controversial. However, the CMA believes that there are other innovative options that the Committee should consider such as the strategic use of Canada's taxation system. A thorough review of tax policy has not been undertaken in Canada since at least 1966. 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 comprehensive tax policy review was that of Benson in 1971.

The CMA believes there is an urgent need to more fully consider the role that the tax system can play in supporting the health care system. Last week, the CMA presented the House of Commons Standing Committee on Finance with a proposal to establish a blue ribbon National Task Force to study the development of innovative tax-based mechanisms to better synchronize tax policy and health policy. The mandate of such a Task Force would be to conduct a thorough policy and costing analysis of all potential tax-based mechanisms 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.

Another area that the Committee has identified under managing the health care system is primary care reform. The CMA's view is that much has been and is being done right in terms of primary care. There exists a very real concern that we will throw the proverbial "baby out with the bath water" and compromise the good things currently happening in primary care across Canada as the governments attempt to reform the system.

Much has been said in the Committee's report on the need for changes on the part of physicians regarding a "spectrum approach" to health care as well as the need for changing remuneration of physicians away from fee-for-service (FFS) to alternative payment plans such as capitation. We agree with the "spectrum approach" in that the "form of payment" should fit the "functions."

On this and other issues, there is a prevailing myth that physicians are a barrier to change when in fact many of the progressive changes in the health care system have been more often than not physician lead. Canadian physicians are willing to work in teams and the CMA has developed a "Scopes of Practice" policy that clearly supports a collaborative and cooperative approach.

In regard to remuneration and the fee-for-service issue, there has been a preoccupation among policy makers for at least the past decade that fee-for-service is the roots of all problems despite the lack of any rigorous evidence. As Dr. Brian Hutchison and colleagues from McMaster University observed in a recent Health Affairs article, "the impact of primary care funding and remuneration methods on processes and outcomes of care is an area in which high quality evidence is remarkably sparse." In any event, contrary to popular belief, physicians are very open to alternate payment models. Surveys conducted by the CMA clearly indicate a willingness by physicians to look at different payment options. Key to this issue is choice and flexibility in payment models.

In order to help governments assess their proposed delivery models a working group of 12 CMA member organizations (CMA, Divisions, College of Family Physicians of Canada and the Canadian Association of Interns and Residents) established a set of shared policy principles around payment, funding and delivery of primary care services.

The principles, if adopted by provincial/territorial governments in collaboration with physician organizations, will go a long way in helping build a system that meets the needs of governments, providers and their patients.

While we don't question the need for more integrated primary care models, we are concerned with the focus and attention that has been given in comparison to specialty care.

The CMA's 2001 National Health Care Report Card survey results highlighted the dismal state of access to specialized care. These results are also borne out by our direct experience as physicians. Two-thirds of the respondents to the 2001 CMA annual survey of physicians highlighted the difficulty in obtaining appropriate resources on behalf of their patients.

The CMA has recently published a discussion paper entitled "Specialty Care in Canada" that further details the deteriorating state of specialty care. We recognize that in September 2000, $1 billion was set aside for technology acquisitions. However, we are concerned that very little of this money is getting through to the front lines. The medical profession and their patients have been heavily affected but not involved in decisions to cutback the system. The reductions in the system's capacity during the 1990s leave little room for flexibility in that part of the system that deals with the sickest patients.

Most health care organizations, including the CMA and the Canadian public have all identified specialty care to be a priority issue that needs immediate attention. However, governments still seem transfixed on primary care reform.

There are efficiencies in the primary care sector that remain to be reconciled, but we see this as making a good the system better, not fundamental reform. Many primary care models provide for a multi-disciplinary approach to health care and may provide a high level of service but their cost-effectiveness has not been established. As stated in a recent *Health Affairs* article on the subject of primary care reform, "effects of the range and mix of providers, working relationships and division of labor in multidisciplinary teams on health outcomes, patient and provider satisfaction, and cost-effectiveness with differing patient populations remain to be established".

Given this backdrop the CMA concurs with the Committee's view that a prudent approach to public policy requires not only exploring ways of delivering health care more efficiently but that Canadians should be discussing ways on how to raise additional funds.

Accountability

We believe that there is a crisis of accountability due in large measure to a profound problem in the governance of Canada's health system. Why is it that those who have the most expertise in health matters have the least input to important decisions affecting our future system. If governance is defined as the process of effective coordination when knowledge and power are distributed, then there are at least three axes in Canada along which power and knowledge are distributed:

1. between federal/provincial/territorial and regional authority/municipal levels of government/administration;
2. along the east-west array of provinces and territories; and
3. among a range of stakeholders, including government, non-governmental agencies (NGOs) and citizens.

For much of the past decade, the tension between the federal/provincial/territorial governments in relation to healthcare has been very pronounced and unproductive. For example, the provinces and territories did not generally participate in the National Forum on Health. Conversely, when the provincial/territorial Health Minister produced their 1997 Renewed Vision for Canada's Health System the report received very little attention at the federal level.

In general, governments have discounted the role that NGOs and citizens might play in on-going policy-making and in promoting policy among their members. This was further exacerbated by the rapid turnover of both Health Ministers and Deputy Ministers.

Recent federal/provincial/territorial agreements such as the Social Union Framework Agreement and the September 2000 Health Accord have been negotiated behind closed doors and are just another example of "Executive Federalism" or what Frank Graves at Ekos Research has dubbed "normative disjunction."

In the past such "Executive Federalism" has caused, in part, the acute shortage of physicians in many places across Canada when a unilateral decision by Health Ministers in 1992 reduced undergraduate enrolment by 10%. In general the Social Union Framework Agreement has been a barrier to strengthening accountability because it only binds one party (the federal government) to the agreement.

Put simply, the profession feels it has been blindsided nationally by initiatives undertaken without real discussion, consultation or even notification. We have been targeted as part of the problem – not as part of the solution.

I can tell you that many physicians are disheartened, frustrated and angry. Physicians have been distanced from the decision-making process and feel disenfranchised. This has contributed to the erosion of physician morale.

One result of the morale problem is that doctors are increasingly disengaging from the health care system. Excellence in health care requires willingness on the part of those who work in the system to "go the extra mile." Many physicians no longer have a sense of ownership of the health care system. Needless to say, this does not bode well for the future of the health care system.

Physicians are expected to work longer hours, take on more administrative and "on call" duties. However, when it is time to discuss changing the system, their views are not always welcomed or even sought out. And it is just not physicians, I suspect nurses and many other health care providers are equally frustrated.

Lets be clear, right now the reason why Canadians are still receiving high quality care is because of the dedication and commitment by all health care providers in the system. But what we're seeing is people starting to burn out. If this problem grows and more professionals choose to do the minimum required of them, the deterioration of the system will accelerate.

What is required is a new attitude, a renewed partnership that goes beyond government to include all health care stakeholders. It is no longer acceptable to the CMA to discuss the future of Canadian health care without the early, ongoing and meaningful involvement of those who are responsible for the delivery of that care.

Governments must begin to more work collaboratively with other stakeholders and with all Canadians. This would take us toward "Cooperative Federalism" and avoid the "Executive Federalism" of the past.

Health Human Resources & Aboriginal Health

Before I conclude, I want to briefly comment on two other priority issues that the CMA identified in your report, Health human resources and aboriginal health.

The federal government needs to demonstrate its leadership and commitment immediately to the principle of self-sufficiency in the workforce supply to meet the medical needs of Canadians. The survey results released last week by the College Family Physicians of Canada are a sobering assessment of the extent of the problem.

Key to resolving the workforce supply is a long-term health human resource strategy that will examine all issues affecting the state of health human resources in Canada. A world-class health system cannot function without highly skilled health professionals – doctors, nurses and other allied health providers.

Turning to 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. A particular concern to the CMA is the lack of aboriginal physicians in Canada. We understand the importance of having aboriginal physicians providing care in aboriginal communities.

In recent years, the CMA itself has been directly involved in the issue. The CMA is assisting in the effort to address the lack of aboriginal physicians by providing up to $42,000 dollars annually in financial assistance programs for aboriginal medical students. Obviously much more needs to be done. We hope increasing the number of aboriginal physicians will be identified as one of the major goals of the Committee's National Aboriginal Health Care Plan.

Conclusion

To conclude, the CMA applauds Committee members for their innovative and long-term thinking. We also want to thank the Committee for the opportunity to present our views. I believe that through our constructive dialogue with the Committee the CMA has shown that Canadian physicians are working towards and would welcome change in the health care system that would ensure Canadians have access to quality health care.

Physicians are not only amenable to change we are leading the way. However, it is our view that the focus of change needs to be on providing better outcomes for our patients.

Thank you.