

Disability Tax Credit Program

CMA Submission to the Sub-Committee on the Status of Persons with Disabilities (House of Commons)

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The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, CMA's mission is to serve and unite the physicians of Canada and be the national advocate, in partnership with the people of Canada, for the highest standards of health and health care.

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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DISABILITY TAX CREDIT

Introduction

The Canadian Medical Association (CMA) welcomes the opportunity to appear before the Sub-Committee on the Status of Persons with Disabilities to discuss issues related to the Disability Tax Credit (DTC). This tax measure, which is recognition by the federal government that persons with a severe disability may be affected by having reduced incomes, increased expenses or both, compared to those who are not disabled¹, helps to account for the intangible costs associated with a severe and prolonged impairment. It also takes into account disability-related expenses that are not listed in the medical expense deduction or which are excluded by the 3% threshold in the Medical Expense Tax Credit.

Physicians are a key point of contact for applicants of the DTC and, given the way the program is structured, a vital participant in its administration. It is for these reasons that we come before you today to address specific concerns related to the program's performance. In addition, we would like to discuss the broader issue of developing a coherent set of tax policies in support of health and social policy.

The Integration of Tax Policy with Health Policy and Social Policy

The federal government, through a variety of policy levers such as taxation, spending, regulation and information, has played a key role in the development of our health care and social systems. To date however, discussion about the federal role in these areas has centered largely on federal transfers to the provinces and territories and the *Canada Health Act*.

However, in looking at how to renew Canada's health and social programs, we should not limit ourselves to these traditional instruments. Today we have a health system that is facing a number of pressures that will challenge its sustainability. These pressures range from 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. These are only some of the more immediate reasons alternative avenues of funding health care, and thus ensuring the health and well-being of our citizens, must be explored.

In our pre-budget consultation document to the Standing Committee on Financeⁱⁱ, the CMA recommended that the federal government establish a blue ribbon National Task Force to study the development of innovative tax-based mechanisms to synchronize tax policy with health policy. Such a review has not been undertaken in over 25 years since the Royal Commission on Taxation in 1966 (Carter Commission).

The CMA is echoing its call for a National Task Force to develop new and innovative ways to synchronize tax policy with health policy and social policy. A study of this nature would look at all aspects of the taxation system, including the personal income tax system, in which the DTC is a component.

The remainder of our brief addresses issues specific to the DTC.

Physician Involvement in the DTC Program

The CMA has in the past provided input with respect to the DTC program. Our working relationship on the DTC program with the Canada Customs and Revenue Agency (CCRA) has been issue-specific, time-limited and constructive.

Our first substantive contact in regard to the DTC program was in 1993 when the CMA provided Revenue Canada with a brief review of the program and the T2201 form. It is interesting to note what our observations were in 1993 with regard to this program because many of them still hold true today.

Here are just some of the issues raised by the CMA in 1993 during our initial review of the program:

- The tax credit program may not address the needs of the disabled, it is too hit and miss. The DTC program should be evaluated in a comprehensive way to measure its overall effectiveness in meeting the needs of persons with disabilities.
- The program should be called the "Severe Disability Tax Credit Program" – or something equivalent to indicate that not everyone with a disability is eligible.
- The program puts physicians in a potential conflict with patients—the responsibility of the physician to advocate for the patient vs. gate-keeper need for Revenue Canada. The physician role should be to attest to legitimate claims on the patients' behalf.

- Revenue Canada should clarify the multiplicity of programs. There are numerous different federal programs and all appear to have varying processes and forms. These overlapping efforts are difficult for patients and professionals.
- A major education effort for potential claimants, tax advisers and physicians should be introduced.
- A suitable evaluation of claimant and medical components of the process should be undertaken.

The CMA does not have a standardized consultative relationship with the CCRA in regard to this program. An example of this spotty relationship is the recent letter sent by the CCRA Minister asking current DTC recipients to re-qualify for the credit. The CMA was not advised or consulted about this letter. If we had been advised we would have highlighted the financial and time implications of sending 75 to 100 thousand individuals to their family physician for re-certification. We also would have worked with the CCRA on alternative options for updating DTC records. Unfortunately, we cannot change what has happened, but we can learn from it. This clearly speaks to the need to establish open and ongoing dialogue between our two organizations.

Policy Measure: The CMA would like established a senior level advisory group to continually monitor and appraise the performance of the DTC program to ensure it is meeting its stated purpose and objectives. Representation on this advisory group would include, at a minimum, senior program officials preferably at the ADM level; those professional groups qualified to complete the T2201 Certificate; various disability organizations; and patients' advocacy groups.

We would now like to draw the Sub-committee's attention to three areas that, at present, negatively impact on the medical profession participation in the program, namely program integrity, program standardization (e.g., consistency in terminology and out-of-pocket costs faced by persons with disabilities) and tax advisor referrals to health care providers.

Program Integrity

A primary concern and irritation for physicians working with this program is that it puts an undue strain on the patient-physician relationship. This strain may also have another possible side effect, a failure in the integrity of the DTC program process.

Under the current structure of the DTC program, physicians evaluate the patient, provide this evaluation back to the patient and then ask the patient for remuneration. This process is problematic for two reasons. First, since the patient will receive the form back immediately following the evaluation, physicians might receive the blame for denying their patient the tax credit—not the DTC program adjudicators. Second, physicians do not feel comfortable asking for payment when he or she knows the applicant will not qualify for the tax credit.

For the integrity of the DTC program, physicians need to be free to reach independent assessment of the patient's condition. However, due to the pressure placed by this program on the patient-physician relationship, the physician's moral and legal obligation to provide an objective assessment may conflict with the physician's ethical duty to "Consider first the well-being of the patient.

There is a solution to this problem it's a model already in use by government, the Canadian Pension Plan (CPP) Disability Program. Under the CPP Disability Program, the evaluation from the physician is not given to the patient but, it is sent to the government and the cost to have the eligibility form completed by a physician is subsumed under the program itself. Under this system, the integrity of patient-physician relationship is maintained and the integrity of the program is not compromised.

Policy Measure: The CMA recommends that the CCRA take the necessary steps to separate the evaluation process from the determination process. The CMA recommends the CPP Disability Program model to achieve this result.

Fairness and Equity

The federal government has several programs for people with disabilities. Some deal with income security (e.g., Canada Pension Plan Disability Benefits), some with employment issues (e.g., Employability Assistance for People with Disabilities), and some through tax measures (e.g., Disability Tax Credit). These government transfers and tax benefits help to provide the means for persons with disabilities to become active members in Canadian society.

However, these programs are not consistent in terms of their terminology, eligibility criteria, reimbursement protocols, benefits, etc. CMA recommends that standards of fairness and equity be applied across federal disability benefit programs, particularly in two areas: the definition of the concept of “disability”, and standards for remuneration to the physician. These are discussed in greater detail below.

1) Defining “disability”

One of the problems with assessing disability is that the concept itself is difficult to define. In most standard definitions the word “disability” is defined in very general and subjective terms. One widely used definition comes from the World Health Organization’s International Classification of Impairments, Disabilities and Handicaps (ICIDH) which defines *disability* as “any restriction or inability (resulting from an impairment) to perform an activity in the manner or within the range considered normal for a human being.”

The DTC and other disability program application forms do not use a standard definition of “disability”. In addition to the inconsistency in terminology, the criteria for qualification for these programs differ because they are targeted to meet the different needs of those persons with disabilities. To qualify for DTC, a disability must be “prolonged” (over a period of at least 12 months) and “severe” i.e. “markedly (restrict) any of the basic activities of daily living” which are defined. Though CPP criteria use the same words “severe” and “prolonged” they are defined differently (i.e., “severe” means “prevents applicant from working regularly at any job” and “prolonged” means “long term or may result in death”). Other programs, such as the Veterans Affairs Canada, have entirely different criteria.

This is confusing for physicians, patients and others (e.g., tax preparers/advisors) involved in the application process. This can lead to physicians spending more time than is necessary completing the form because of the need to verify terms. As a result if the terms, criteria and the information about the programs are not as clear as possible this could result in errors on the part of physicians when completing the forms. This could then inadvertently disadvantage those who, in fact, qualify for benefits.

Policy Measures: The CMA would like to see some consistency in definitions across the various government programs. This does not mean that eligibility criteria must become uniform.

In addition, the CMA would like to see the development of a comprehensive information package for health care providers that provides a description of each program, its eligibility criteria, the full range of benefits available, copies of sample forms, physical assessment and form completion payment information, etc.

2) Remuneration

The remuneration for assessment and form completion is another area where standardization among the various government programs would eliminate the difficulties that some individuals with disabilities currently face. For example, applicants who present the DTC Certificate Form T2201 to their physicians must bear any costs associated with its completion out of their own pockets. On the other hand, if an individual is applying to the CPP Disability Program, the cost to have the eligibility form completed by a physician is subsumed under the program itself.

Assessing a patient's disabilities is a complex and time-consuming endeavour on the part of any health professional. Our members tell us that the DTC Certificate Form T2201 can take as much time and effort to complete as the information requested for CPP Disability Program forms depending, of course, on the patient and the nature of the disability. In spite of this fact, some programs acknowledge the time and expertise needed to conduct a proper assessment while other programs do not.

Although physicians have the option of approaching the applicant for remuneration for the completion of the DTC form, they are reluctant to do so because these individuals are usually of limited means and in very complex cases, the cost for a physician's time for completing the DTC Form T2201 can reach as much as \$150. In addition, physicians do not feel comfortable asking for payment when he/she knows the applicant will not qualify for the tax credit. Synchronizing funding between all programs would be of substantial benefit to all persons with disabilities, those professionals completing the forms and the programs' administrators.

Policy Measure: We strongly urge the federal government to place disability tax credit programs on the same footing when it comes to reimbursement of the examining health care provider.

Tax Advisor Referrals

With the complexity of the income tax system today, many individuals seek out the assistance of professional tax advisors to ensure the forms are properly completed and they have received all the benefits they are entitled to. Tax advisors will very often refer individuals to health professionals so that they can be assessed for potential eligibility for the DTC. The intention of the tax advisors may be laudable, but often, inappropriate referrals are made to health professionals. This not only wastes the valuable time of health care professionals, already in short supply, but may create unrealistic expectations on the part of the patient seeking the tax credit.

The first principle of the CMA's Code of Ethics is "consider first the well-being of the patient." One of the key roles of the physician is to act as a patient's advocate and support within the health care system. The DTC application form makes the physician a mediator between the patient and a third party with whom the patient is applying for financial support.

This "policing" role can place a strain on the physician-patient relationship – particularly if the patient is denied a disability tax credit as a result a third-party adjudicator's interpretation of the physician's recommendations contained within the medical report. Physicians and other health professionals are not only left with having to tell the patient that they are not eligible but in addition advising the patient that there may be a personal financial cost for the physician providing this assessment.

Policy Measure: Better preparation of tax advisors would be a benefit to both patients and their health care providers. The CMA would like CCRA to develop, in co-operation with the community of health care providers, a detailed guide for tax preparers and their clients outlining program eligibility criteria and preliminary steps towards undertaking a personal assessment of disability. This would provide some guidance as to whether it is worth the time, effort and expense to see a health professional for a professional assessment.

As raised in a previous meeting with CCRA, the CMA is once again making available a physician representative to accompany DTC representatives when they meet the various tax preparation agencies, prior to each tax season, to review the detailed guide on program eligibility criteria and initial assessment, and to highlight the implications of inappropriate referral.

Conclusion

The DTC is a deserving benefit to those Canadians living with a disability. However, there needs to be some standardization among the various programs to ensure that they are effective and meet their stated purpose. Namely, the CMA would like to make the following suggestions:

1. The CMA would like established a senior level advisory group to continually monitor and appraise the performance of the DTC program to ensure it is meeting its stated purpose and objectives. Representation on this advisory group would include, at a minimum, senior program officials preferably at the ADM level; those professional groups qualified to complete the T2201 Certificate; various disability organizations; and patient advocacy groups.

2. The CMA recommends that the CCRA take the necessary steps to separate the evaluation process from the determination process. The CMA recommends the CPP Disability Program model to achieve this result.
3. That there be some consistency in definitions across the various government programs. This does not circumvent differences in eligibility criteria.
4. That a comprehensive information package be developed, for health care providers, that provides a description of each program, its eligibility criteria, the full range of benefits available, copies of sample forms, physical assessment and form completion payment information, etc.
5. That the federal government applies these social programs on the same footing when it comes to their funding and administration.
6. That CCRA develop, in co-operation with the community of health care providers, a detailed guide for tax advisors and their clients outlining program eligibility criteria and preliminary steps towards undertaking a personal assessment of disability.
7. That CCRA employ health care providers to accompany CCRA representatives when they meet the various tax preparation agencies to review the detailed guide on program eligibility criteria and personal assessment of disability, and to highlight the implications of inappropriate referral.

These recommendations would certainly be helpful to all involved - the patient, health care providers and the programs' administrators, in the short term. However what would be truly beneficial in the longer term would be an overall review of the taxation system from a health care perspective. This could provide tangible benefits not only for persons with disabilities but for all Canadians as well as demonstrating the federal government's leadership towards ensuring the health and well being of our population.

ⁱ Health Canada, *The Role for the Tax System in Advancing the Health Agenda*, Applied Research and Analysis Directorate, Analysis and Connectivity Branch, September 21, 2001

ⁱⁱ Canadian Medical Association, *Securing Our Future... Balancing Urgent Health Care Needs of Today With The Important Challenges of Tomorrow*", Presentation to the Standing Committee on Finance Pre-Budget Consultations, November 1, 2001.