

Canadian Medical Association

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For: Commissioner Romanow

# R *A Prescription for Sustainability*

- Canadian Health Charter supported by a Canadian Health Commission*
- Real say in the decision-making process*
- Legislative Reform to modernize the Canada Health Act*
- A national action plan to invest in health care resources & health care services delivery*

On behalf of the Canadian Medical Association and our more than 53,000 physician members

Signature:



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

On behalf of its more than 53,000 members and the Canadian public, the CMA performs a wide variety of functions, such as advocating health promotion and disease/accident prevention policies and strategies, advocating 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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# Acknowledgements

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# Executive Summary

Medicare emerged from the 1990s bent, but not broken — in large measure due to the tireless efforts of health professionals whose commitment has always been, first and foremost, to their patients. However, this level of effort cannot continue. Canadian health providers and the facilities they work in are stretched to the limit.

Over the past decade there have been countless studies on what is wrong with Canada’s health care system. However, very little action has been taken to solve the problems identified in the reports because very few of these reports provided a roadmap with concrete recommendations on how to achieve change. Furthermore, many decisions regarding the health care system have been made by governments without meaningful input from health professionals. As we indicated in our first submission, there is clearly a need for a collaborative approach to “change management” that is based on early, ongoing and meaningful involvement of all key stakeholders.

However, before consideration is given to how to solve the woes of the health care system, it is essential to establish a shared vision of Canada’s health care system. Several attempts have been made to this end; however, few have included health care providers or the public in the process. The CMA has established its own vision for a sustainable health care system, upon which the recommendations we have presented in this submission are based.

To ensure that our health care system in Canada is sustainable in the future, longer-term structural and procedural reforms are required. The CMA proposes 5 recommendations involving the implementation of three integrated “pillars of sustainability” that together will improve accountability and transparency in the system. These pillars would also serve as the basis for addressing the many short- to medium-term issues facing Medicare today and into the future. To this end, we put forward 25 recommendations suggesting specific “hows” for solving these critical problems.

The three “pillars” are: a Canadian Health Charter, a Canadian Health Commission, and a renewal of the federal legislative framework.

A Canadian Health Charter would underline governments’ shared commitment to ensuring that Canadians will have access to quality health care within an acceptable time frame. It would also clearly articulate a national health policy that sets out our collective understanding of Medicare and the rights and mutual obligations of individual Canadians, health care providers, and governments. The existence of such a Charter would ensure that a rational, evidence-based, and collaborative approach to managing and modernizing Canada’s health system is being followed.

In conjunction with the Canadian Health Charter, a permanent, independent Canadian Health Commission would be created to promote accountability and transparency within the system. It would have a mandate to monitor compliance with and measure progress towards Charter provisions, report to Canadians on the performance of the health care system, and provide ongoing advice and guidance to the Conference on Federal-Provincial-Territorial ministers on key national health care issues.

Recognizing the shared federal and provincial/territorial obligations to the health care system, one of the main purposes of the Canadian Health Charter is to reinforce the national character of the health system. The federal government would be expected to make significant commitments in a number of areas, including a review of the Canada Health Act, changes to the federal transfers to provinces and territories, and a review of federal tax legislation.

While these three “pillars” will address the broader structural and procedural problems facing Canada’s health care system, there are many other changes required to meet specific needs within the system in the short to medium term. The CMA has provided specific recommendations in the following key areas:

- Meaningful stakeholder input and accountability
- Defining the public health system (e.g. core services, a “safety valve”, Public Health, Aboriginal health)
- Investing in the health care system (e.g. human resources, capital infrastructure, surge capacity, information technology, and research and innovation)
- Health system financing
- Organization and delivery of services (e.g. consideration of the full continuum of care, physician compensation, rural health, the private sector, the voluntary sector and informal caregivers)

The following is a summary of the key recommendations set out in *A Prescription for Sustainability*. While we have put an emphasis on having the recommendations as self-contained as possible, readers are encouraged to consult the corresponding section of this paper as appropriate for further details. The first five recommendations refer specifically to the three pillars. The remaining recommendations address the more specific and immediate needs of the health care system.

### **Recommendation 1**

That the governments of Canada adopt a Canadian Health Charter that

- reaffirms the social contract that is Medicare
- acknowledges the ongoing roles of governments in terms of overall coordination and health planning
- sets out the accessibility and portability rights and responsibilities of residents of Canada
- sets out the rights and responsibilities of the governments, providers and patients in Canada
- provides for a “Canadian Health Commission.”

### **Recommendation 2**

That a permanent Canadian Health Commission be established and operate at arm’s length from governments. The Commission’s mandate would include

- monitoring compliance with the Canadian Health Charter
- reporting annually to Canadians on the performance of the health care system and the health status of the population
- advising the Conference of Federal-Provincial-Territorial Ministers of Health on critical issues.

### **Recommendation 3**

That the federal government undertake a review of the *Canada Health Act* with the view to amending it

- to embody the Canadian Health Charter within it
- to provide for the Canadian Health Commission and
- to allow for a broader definition of core services and for certain service charges under certain terms and conditions.

**Recommendation 4**

- (a) That the federal government's contribution to the publicly funded health care system
- be harmonized with the five-year review of the federal equalization program
  - be locked-in for a period of five years, with an escalator tied to a three-year moving average of per capita GDP
  - rise to a target of 50% of provincial/territorial per capita health spending for core services
  - provide for notional earmarking of funds for health.
- (b) That the federal government create special purpose, one-time funds totalling \$2.5 billion over five years (or build on existing funds) to address pressing issues in the following areas
- health human resources planning
  - capital infrastructure
  - information technology
  - accessibility fund.

**Recommendation 5**

That a blue ribbon panel of Parliament be established to work with the Canadian Health Commission to review the current provisions of federal tax legislation with a view to identifying ways of enhancing support for health policy objectives through tax policy.

**Recommendation 6**

That governments and regional health authorities initiate or enhance significant efforts to secure the participation of and input from practicing physicians at all levels of health care decision-making.

**Recommendation 7**

That all Canadians be provided coverage for a basket of core services under uniform terms and conditions.

**Recommendation 8**

- (a) That the scope of the basket of core services be determined and be updated regularly to reflect and accommodate the realities of health care delivery and the needs of Canadians.
- (b) That the scope of core services should not be limited by its current application to hospital and physician services, provided that access to medically necessary hospital and physician services is not compromised.

**Recommendation 9**

- (a) That the scope of the basket of core services be determined and regularly updated by a federal-provincial-territorial process that has legitimacy in the eyes of Canadians – patients, taxpayers and health care professionals.
- (b) That the values of transparency, accountability, evidence-based, inclusivity and procedural fairness should characterize the process used to determine the basket of core services to include under Medicare.

**Recommendation 10**

- (a) That governments develop a new framework to govern the funding of a basket of core services with a view to ensuring that
- Canadians have reasonable access to core services on uniform terms and conditions in all provinces and territories
  - governments, providers and patients are accountable for the use of health care resources
  - no Canadian is denied essential care because of her or his personal financial situation.

- (b) That legislation be amended to permit at least some core services to be cost-shared under uniform terms and conditions in all provinces and territories.
- (c) That once the basket of core services is defined, minimum levels of public funding for these services be uniformly applied across provinces and territories, with flexibility for individual governments to increase the share of public funding beyond these levels.

### **Recommendation 11**

- (a) That Canada's health system develop and apply agreed upon standards for timely access to care, as well as provide for alternative care choices – a “safety valve” – in Canada or elsewhere, if the publicly funded system fails to meet these standards.
- (b) That the following approach be implemented to ensure that governments are held accountable for providing timely access to quality care.
  - First, governments must establish clear guidelines and standards around quality and waiting times that are evidence-based and that patients, providers and governments consider reasonable. An independent third-party mechanism must be put in place to measure and report on waiting times and other dimensions of health care quality.
  - Second, governments must develop a clear policy which states that if the publicly funded health care system fails to meet the specified agreed-upon standards for timely access to core services, then patients must have other options available to them that will allow them to obtain this required care through other means. Public funding at the home province rate would follow the patient in this circumstance, and patients would have the opportunity to purchase insurance on a prospective basis to cover any difference in cost.

### **Recommendation 12**

- (a) That governments demonstrate healthy public policy by making health impact the first consideration in the development of all legislation, policy and directives.
- (b) That the federal government provide core funding to assist provincial and territorial authorities in improving the coordination of prevention and detection efforts and the response to public health issues among public health officials, educators, community service providers, occupational health providers, and emergency services.
- (c) That governments invest in the human, infrastructure and training resources needed to develop an adequate and effective public health system capable of preventing, detecting and responding to public health issues.
- (d) That governments undertake an immediate review of Canada's self-sufficiency in preventing, detecting and responding to emerging public health problems and furthermore, facilitate an ongoing, inclusive process to establish national public health priorities.

### **Recommendation 13**

That the federal government adopt a comprehensive strategy for improving the health of Aboriginal peoples which involves a partnership among governments, nongovernmental organizations, universities and the Aboriginal communities.

### **Recommendation 14**

- (a) That the federal government establish a \$1 billion, five-year Health Resources Education and Training Fund to (1) further increase enrolment in undergraduate and postgraduate medical education (including re-entry positions), (2) expand the infrastructure (both human and physical resources) of Canada's 16 medical schools in order to accommodate the increased enrolment and (3) enhance continuing medical education programs.
- (b) That the federal government increase funding targeted to institutions of postsecondary education to alleviate some of the pressures driving tuition fee increases.

- (c) That the federal government enhance financial support systems for medical students that are (1) non-coercive, (2) developed concomitantly or in advance of any tuition increase, (3) in direct proportion to any tuition fee increase and (4) provided at levels that meet the needs of the students.
- (d) That incentives be incorporated into medical education programs to ensure adequate numbers of students choose medical fields for which there is greatest need.

### **Recommendation 15**

- (a) That governments and communities make every effort to retain Canadian physicians in Canada through non-coercive measures and optimize the use of existing health human resources to meet the health needs of Canadian communities.
- (b) That the federal government work with other countries to equitably regulate and coordinate international mobility of health human resources.
- (c) That governments adopt a policy statement that acknowledges the value of the health care workforce in the provision of quality care, as well as the need to provide good working conditions, competitive compensation and opportunities for professional development.

### **Recommendation 16**

- (a) That a national multistakeholder body be established with representatives from the health professions and all levels of government to develop integrated health human resource strategies, provide planning tools for use at the local level and monitor supply, mix and distribution on an ongoing basis.
- (b) That scopes of practice should be determined in a manner that serves the interests of patients and the public, safely, efficiently, and competently.

### **Recommendation 17**

- (a) That hospitals and other health care facilities conduct a coordinated inventory of capital infrastructure to provide governments with an accurate assessment of machinery and equipment.
- (b) That the federal government establish a one-time catch-up fund to restore capital infrastructure to an acceptable level. (see Recommendation 4(b).)
- (c) That governments commit to providing adequate, ongoing funding for capital infrastructure.
- (d) That public-private partnerships (P3s) be explored as a viable alternative source of funding for capital infrastructure investment.

### **Recommendation 18**

That the federal government cooperate with provincial and territorial governments and with governments of other countries to ensure that a strong, adequately funded emergency response system is put in place to improve surge capacity.

### **Recommendation 19**

That federal government make an additional, substantial, ongoing national investments in information technology and information systems, with the objective of improving the health of Canadians as well as improving the efficiency and effectiveness of the health care system.

### **Recommendation 20**

That governments adopt national standards that facilitate the collection, use and exchange of electronic health information in a manner which ensures that the protection of patient privacy and confidentiality are paramount.

### **Recommendation 21**

That the federal government's investment in health research be increased to at least 1% of national health expenditures.

### **Recommendation 22**

- (a) That the provincial and territorial governments' commitment to funding core services be locked-in for an initial five-year period with an escalator tied to provincial population demographics and inflation.
- (b) That governments establish a health-specific contingency fund to mitigate the effects of fluctuations in the business cycle and to promote greater stability in health care financing.

### **Recommendation 23**

That any effort to change the organization or delivery of medical care take into account the impact on the whole continuum of care.

### **Recommendation 24**

- (a) That governments work with the provincial and territorial medical associations and other stakeholders to draw on the successes of evaluated primary care projects to develop a variety of templates of primary care models that would
  - suit the full range of geographical contexts and
  - incorporate criteria for moving from pilot projects to wider implementation, such as cost-effectiveness, quality of care and patient and provider satisfaction.
- (b) That family physicians remain as the central provider and coordinator of timely access to publicly funded medical services, to ensure comprehensive and integrated care, and that there are sufficient resources available to permit this.

### **Recommendation 25**

- (a) That governments develop a national plan to coordinate the most efficient access to highly specialized treatment and diagnostic services.
  - This plan should include the creation of defined regional centres of excellence to optimize the availability of scarce specialist services.
  - Any realignment of services must accommodate and compensate for the relocation of providers.
  - That the federal government create an accessibility fund that would support interprovincial centres of excellence for highly specialized services.

### **Recommendation 26**

That governments respect the principles contained in the CMA's policy on physician compensation and the terms of duly negotiated agreements.

### **Recommendation 27**

That governments work with universities, colleges, professional associations and communities to develop a national rural and remote health strategy for Canada.

### **Recommendation 28**

That Canada's health care system make optimal use of the private sector in the delivery of publicly financed health care provided that it meets the same standards of quality as the public system.

### **Recommendation 29**

That governments examine ways to recognize and support the role of the voluntary sector in the funding and delivery of health care, including enhanced tax credits.

### **Recommendation 30**

That governments support the contributions of informal caregivers through the tax system.

# 1. Introduction

Medicare emerged from the 1990s bent, but not broken — in large measure, due to the tireless efforts of professionals whose commitment has always been, first and foremost, to their patients. But this level of effort cannot continue. Canadian health care providers and the facilities they work in are stretched to the limit.

Our system is truly at a crossroads. The Commission on the Future of Health Care in Canada has a unique opportunity to sculpt a health care system that will meet the needs and expectations of Canadians for the 21st century. Fundamentals and principles of change management must be satisfied for change to be of lasting value. Decision-making processes must become more accessible, accountable and transparent to those most affected. Canadians are tired of the “blame game,” and physicians and other health providers are tired of being marginalized. Why is it that those who have the most at stake and those who have the most invested in the health system — namely patients, physicians and other providers — have the least say in system change? All parties need to be at the table. Health professionals have not been involved in an early, ongoing or meaningful way in discussions about the future of their health and health care systems. This must change.

Another prerequisite for effective change is to reaffirm that there is more to health than health care. Although Canada has led the world in thinking about the overall determinants of health, the same cannot always be said when it comes to action. Canada needs broad consensus around a multi-year, national health action plan — one that is developed in collaboration with all the key players in the system and one that has clear goals, objectives and milestones.

At the same time, sustainability must be seen as ensuring that Canadians have access to required services at the time and to the extent of their need. Canadians have lost confidence that the system will be there for them and for their children. Sustainability is about the legacy of Medicare.

These are some of the key issues and challenges that the CMA stressed in earlier submissions to the Commission. In our first report, entitled *Getting the Diagnosis Right* (November 2001; see Appendix A), we described the signs and symptoms of a system in distress. Earlier this year, in our interim submission, entitled *Getting It Right* (Appendix B), we outlined some of the broad choices that we have to make as a society to help stabilize the Medicare “patient” and transport it into a sustainable future. As part of this future, the interim report proposed a Canadian Health Charter, which has received considerable attention.

In this, our final submission to the Commission, we have built on the earlier work and ask the Commission to consider our *Prescription for Sustainability*. It is important to note that the recommendations we present to the Commission are integrated; and therefore we ask that they not be “cherry-picked”. This document also refers to a number of appendices that will be available as a separate volume.

A great deal of policy research has been done on what changes are needed to make progress. The weak link has been in dealing with the “how.” The CMA believes that if we get the structures and processes right in terms of accountabilities, positive health outcomes will follow for our patients and for the future sustainability of the system.

## 2. Vision

Several attempts have been made over the years to articulate a national vision for Medicare, but they have all proven inadequate. However laudable these attempts may be, they all suffer the fatal flaw of isolationism: they were all developed by governments — federal, provincial or territorial — in isolation from health care providers and the public. Goodwill, collaboration and partnership cannot be legislated or dictated from on high.

In planning for the future, we have consistently argued for a values-based approach centred on a shared vision. The CMA has established a vision for Medicare that forms the basis of our recommendations for improving the design and functioning of the health care system.

### **CMA's Vision for a Sustainable Health System**

The goal of Canada's health system is to preserve, protect and improve the health and well-being of each Canadian. This will be achieved through timely access to services that not only keep people well or restore health, but also enhance their quality of life and add longevity. Health care is an investment in both economic and social terms, providing benefits of value to both individuals and society.

The objective of publicly funded health care is timely access to quality care through a defined set of core services that — as the principal building blocks of Canada's overall health care system — must be provided on a sustainable basis. These core services must be determined and regularly reviewed in an inclusive and transparent manner. This will result in clear choices as to which services will be fully publicly funded, partly publicly funded and fully privately funded.

The special nature of care related to illness — the original focus of Medicare — must continue to be recognized. Core services must reflect the immediacy with which such care is required, the potential to place a financial burden on individuals and families, and the unpredictability as to when such care will be required by an individual.

Canadians should be able to choose who will provide their care, what the treatment(s) will be and where it will be provided. Every Canadian should have access to a physician of their choice and, in particular, should be encouraged to select a primary care physician who provides continuity of care.

Physicians play key roles as agents and advocates for their own patients and for the public at large; they seek a health care system that respects the integrity and primacy of the patient-physician relationship. Payment and delivery mechanisms should be structured to foster and support these roles and to protect clinical and professional autonomy.

Evidence-based care with explicit standards and benchmarks (e.g., maximum, acceptable waiting times) is a prerequisite to achieving high-quality health care — a primary objective of the public system. Individuals should have the opportunity to purchase health services where they are not publicly funded and where the public system does not meet agreed-upon standards.

Effective short- and long-term health care will be achieved through a collaborative model involving public, providers and government. With this joint responsibility comes a corresponding requirement to be held collectively accountable for choices and directions chosen. Government, providers and the public are accountable to each other for all aspects of the effective provision and use of health services.

## 3. Three Pillars of Sustainability

The CMA believes that the current health policy decision-making system is fundamentally flawed and that three steps must be taken to help put the health of Canadians first. The three inextricably linked “pillars of sustainability” presented here are long-term structural and procedural reforms needed to improve accountability and transparency and, thus, enhance the overall sustainability of the system.

In *Getting the Diagnosis Right*, we contended that Canadians had lost confidence that the system would be there for them and their families at the time and to the extent of their need. In our interim report, we also indicated that Canadian health care providers have never felt more demoralized or disenfranchised. The shortages of providers, poor access, resource constraints and passive privatization that occurred through most of the 1990s have combined to create uncertainties around the scope of coverage and the standard of care Canadians can expect from their health care system. The CMA believes that these uncertainties that accompany unplanned changes have also had a deleterious effect on the Canadian economy and a demoralizing effect on the health care community. On both counts, a clarification of the social contract for health is required at the highest level.

### 3.1 Canadian Health Charter

The need to renew the social contract underlying Medicare raises a number of fundamental questions. What will this new social contract look like? Where will it be vested? Who will oversee its development and implementation? And what difference will it make for Canadians? The answers to these questions are set out below in the CMA’s proposal for a Canadian Health Charter.

#### 3.1.1 What is it?

The concept of a Canadian Health Charter is not new. The 1964 report of the Royal Commission on Health Services chaired by Justice Emmett Hall recommended a charter that set out a vision for a universally accessible system of prepaid health care, including the roles and responsibilities for individual Canadians, providers and governments.

Currently, neither the *Canada Health Act* nor the *Charter of Rights and Freedoms* offers Canadians an explicit right of access to quality health care delivered within an acceptable time-frame.<sup>1</sup> Moreover, Canadians do not have the benefit of a clearly articulated national health policy that sets out our shared understanding of Medicare and the rights and mutual obligations of individual Canadians, health care providers and governments. Without such a national policy statement to set the broad parameters around which Canada’s health system can be managed and modernized, the Medicare debate will continue to be characterized by rhetoric, hidden agendas and fruitless finger-pointing.

To be certain, the notion of a Canadian Health Charter raises many issues in a decentralized federation such as Canada, where the constitutional responsibility for health care delivery lies with provinces and territories. Having examined the relevant legal, political and health policy considerations, the CMA is

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<sup>1</sup> A recent article by Patrick Monahan and Stanley Hartt published by the C.D. Howe Institute argues that Canadians have a constitutional right to access privately funded health care if the publicly funded system does not provide access to care in a timely way.

proposing the development and formal approval of a Canadian Health Charter based on a renewed partnership between levels of government and with the agreement of patients and providers.<sup>2</sup>

### 3.1.2 What would it look like?

The CMA envisions a charter with three main parts: a vision statement, a section on national planning and coordination and a section on roles, rights and responsibilities. The CMA has developed an illustrative example of a charter in a separately released paper, *Charter at a Glance*.

#### **Vision**

Although there is no shortage of vision statements for Medicare, there is no single shared vision. The federal government, provinces and territories and individual stakeholders have all developed their own visions for various purposes and at various times. In some cases, such as the September 2000 Health Accord, governments have gone as far as issuing jointly approved vision statements.

What is needed is for all parties to come together and achieve consensus on a shared vision that will lay out a modern view of Canada's health system. The CMA has articulated its own vision in section 2, above.

#### **National planning and coordination**

The Canadian Health Charter would set out the requirement for national planning and coordination based on such principles as collaboration, evidence-based decision-making, stable and predictable funding, regional and local flexibility, and accountability. It could also specify areas where national planning and coordination are required, particularly with respect to the determination and regular review of core health care services; the development of national benchmarks for timeliness, accessibility and quality of health care; health system resources including health human resources and information technology; and the development of national goals and targets to improve the health of Canadians.

The charter would also provide for the creation of a Canadian Health Commission to monitor compliance with and measure progress towards charter provisions, report to Canadians on the performance of the health care system, and provide ongoing advice and guidance to the Conference of Federal–Provincial–Territorial Ministers on key national issues.

#### **Roles, rights and responsibilities**

One of the key aims of the charter would be to develop a common understanding of the roles, rights and responsibilities of the key players in the renewal of Medicare. Key aspects of understanding would include

- Acknowledgement of the ongoing role of governments in terms of overall coordination and health planning
- Reinforcement of the accessibility and portability rights of the residents of Canada by a clear and unequivocal statement that governments must do everything in their power to provide reasonably comparable access to timely, high-quality health care<sup>3</sup>
- Establishment of the rights and responsibilities of patients, providers and governments in Canada.

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<sup>2</sup> Although the word “charter” has a legal connotation, it has been used in other contexts. An example is the 1986 Ottawa Charter for Health Promotion, an international call for action on health promotion that has received worldwide acclaim.

<sup>3</sup> This could be linked to the equalization provision in Section 36(2) of the *Constitution Act (1982)*.

### 3.1.3 Development and implementation of a charter

Key features of our proposed Canadian Health Charter are as follows.

- *National mandate*: It will be an inclusive document — one that is truly national as opposed to federal or interprovincial or interterritorial.
- *Values-based*: It will be consistent with publicly accepted values and principles.
- *Enforceable*: It will achieve compliance to its provisions through administrative mechanisms rather than through the courts.
- *Non-derogational*: It will respect federal, provincial and territorial jurisdictional boundaries.

The Canadian Health Charter will only be as good as the process put in place to develop it and to oversee its implementation. Although it may be too early to speculate on how this would be orchestrated, we make the following observations.

- The development of the Canadian Health Charter will require a broad consultative process. Although this process could be led by governments, it should be developed in an inclusive manner with all stakeholders, including organizations representing health care providers and consumers.
- Once consensus is reached on a proposed Canadian Health Charter, it will be important for the federal, provincial and territorial governments to give it formal approval. This could be accomplished in a number of ways, including approval at a first ministers meeting, through the elected assemblies or by way of a royal proclamation.<sup>4</sup>

#### **Recommendation 1**

That the governments of Canada adopt a Canadian Health Charter that

- reaffirms the social contract that is Medicare
- acknowledges the ongoing roles of governments in terms of overall coordination and health planning
- sets out the accessibility and portability rights and responsibilities of residents of Canada
- sets out the rights and responsibilities of the governments, providers and patients in Canada
- provides for a “Canadian Health Commission” (see next section).

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<sup>4</sup> Proclamations are issued by the Queen’s representative in the particular jurisdiction. An example of a proclamation that has been issued this way is the “Proclamation Recognizing the Outstanding Service to Canadians by Employees in the Public Service of Canada in Times of Natural Disaster” (13 May, 1998).

## 3.2 Canadian Health Commission

What is clear from the past decade — through numerous provincial Commissions, a three-year National Health Forum, a Senate study and now the Commission on the Future of Health Care in Canada — is that strategic health planning is a never-ending challenge. This is why we need a permanent, depoliticized forum at the national level for ongoing dialogue and debate — a Canadian Health Commission.

### 3.2.1 Structure, composition and mandate

Our thinking on the development of a Canadian Health Commission has been guided by a number of precedents and models that have been used in the Canadian context, beginning with the Dominion Council of Health, which was provided for in the Act constituting the Department of Health in 1919. It was formed to facilitate coordination with the provinces and territories and various private organizations on health matters and was the principal advisory agency to the Minister of National Health and Welfare. Membership comprised the federal deputy minister (chair), provincial deputy ministers and external members representing women's organizations, labour, agriculture and medical science.

We also examined more recent models of national advisory and oversight bodies. More details on the structures and basic mandates of these bodies are provided in Appendix C. Our assessment of these Commissions, roundtables and councils leads us to a number of conclusions about the structure and composition of the Canadian Health Commission:

- *Independence:* The Commission should be at arm's length from governments and have the freedom to conduct research and advise governments on a broad range of health and health care issues. However, it should have close links with government agencies such as the Canadian Institute for Health Information and the Canadian Institutes for Health Research to facilitate its work.
- *Transparency:* The Commission should be open and transparent. We do not want to recreate the black box of executive federalism. Government representatives would be welcome as observers, and the Commission's deliberations would be made public.
- *Credibility:* The composition of the Commission should reflect a broad range of perspectives and expertise necessary to fulfill its mandate. Appointments should not be constituency-based, to ensure that constituency politics do not interfere with the Commission's deliberations.
- *Legitimacy:* Although the Commission would be established by the federal government, its structure, composition and mandate will have to be legitimate in the eyes of provincial and territorial governments.
- *Permanence:* The Commission should be permanent and it should be afforded adequate resources to do its job, subject to a regular review of its mandate and effectiveness.
- *Stakeholder engagement:* The Commission should include representation from the general public and should seek to engage Canadians at large through research, consultation and public education activities.
- *Authoritative leadership:* The Commission should be chaired by a Canadian Health Commissioner, who would be an officer of Parliament (similar to the Auditor General) appointed for a five-year term by consensus among the federal, provincial and territorial governments. The Health Commissioner

would not be a substitute for the federal minister of health. The minister of health would continue to be responsible to Parliament for federal health policies and programs, as well as for promoting intergovernmental collaboration on a range of health and health care issues. The Commissioner would be afforded the powers necessary to conduct the affairs of the Commission, such as the power to call witnesses before hearings of the Commission.

The Commission's mandate would include the following responsibilities:

- Monitor compliance with the Canadian Health Charter
- Report annually to Canadians on the performance of the health care system and the health status of the population
- Advise the Conference of Federal–Provincial–Territorial Ministers of Health on critical questions such as:
  - defining the basket of core services that would be publicly financed
  - establishing national benchmarks for timeliness, accessibility and quality of health care
  - planning and coordinating health system resources at the national level, including health human resources, information technology, and capital infrastructure
  - developing national goals and targets to improve the health of Canadians.

### **Recommendation 2**

That a permanent Canadian Health Commission be established and operate at arm's length from governments. The Commission's mandate would include

- monitoring compliance with the Canadian Health Charter
- reporting annually to Canadians on the performance of the health care system and the health status of the population
- advising the Conference of Federal–Provincial–Territorial Ministers of Health on critical issues.

## **3.3 Renewing the Federal Legislative Framework**

Flowing from the Canadian Health Charter will be a number of moral and political obligations directed at the federal, provincial, and territorial governments, providers and patients. Recognizing the shared federal, provincial and territorial obligations to the health care system, one of the main purposes of the Charter is to reinforce the national character of Canada's health system. The federal government would be expected to make significant commitments in a number of areas.

### **3.3.1 The Canada Health Act**

The *Canada Health Act* (CHA) was adopted by Parliament in 1984 as the successor to federal legislation governing cost-sharing agreements for hospital and medical insurance. Its principles have become the cornerstone of Medicare. The CHA articulates the underlying vision and values of Medicare and sets out the five conditions with which provincial and territorial health insurance plans must comply — universality, accessibility, comprehensiveness, portability and public administration — to receive the full

federal financial contribution that they are entitled to under the Canada Health and Social Transfer (CHST). Thus, the *Canada Health Act* is the linchpin that holds together 13 separate provincial and territorial health systems.

Although the CHA has been a lightning rod for several federal–provincial–territorial disputes over the years, the reasons for these disagreements have had more to do with politics than with the substance of the act. In fact, if there is one public policy issue in Canada over which there is near unanimity across provinces and territories and across political parties, it is that the principles of the CHA are sound. Recently, federal, provincial and territorial governments agreed to establish a formal dispute avoidance and resolution mechanism to deal more openly and transparently with issues arising from the interpretation of the *Canada Health Act*. The CMA applauds this development.

In section 5.1.3 of this report, the CMA calls for the establishment of a process at the national level to determine and review regularly the basket of core services in an open, transparent and evidence-based manner. The CHA should be amended to provide for such a process.

Finally, and perhaps most importantly, the CHA should be amended to reflect the Canadian Health Charter. This would include changing the preamble to ensure that it reflects a modern vision and values of Medicare, provides for a Canadian Health Commission, recognizes the federal role and reflects the accessibility and portability rights of Canadians.

### **Recommendation 3**

That the federal government undertake a review of the *Canada Health Act* with a view to amending it

- to embody the Canadian Health Charter within it
- to provide for the Canadian Health Commission and
- to allow for a broader definition of core services and for certain service charges under certain terms and conditions. (See section 5 for more details.)

### **3.3.2 Transfers to provinces and territories**

The nature of Canada’s publicly funded health care system creates unique challenges and opportunities regarding accountability and sustainability. Provinces and territories have the constitutional responsibility for health care and provide most of the funding; the federal government’s role includes funding and is based on the desire of Canadians to have the semblance of a national health care program.

The CMA has been a strong advocate of stable, predictable and adequate federal funding for health care. The federal government has responded by introducing a cash floor for the CHST and by restoring some of the cuts made during the 1990s. However, the federal government still has a long way to go. Cash transfers must be increased if the federal government is to be considered a credible partner in Medicare. A larger and continuing federal role in health care financing is required, and the allocation of funds must be done more transparently and in support of a longer planning horizon.

Transparency in federal funding for health care means that the federal government can no longer claim to be spending its CHST contribution three ways. Canadians have a right to know how much of their federal tax dollars is being transferred to provinces and territories to support Medicare. The same should hold for

transfers related to postsecondary education and social services. Although this may be at odds with the prevailing doctrine in the ministries of finance and intergovernmental affairs, it is the least that Canadians can expect from their governments in terms of accountability. It also serves to underscore the fact that the underlying purpose of fiscal federalism is to support Medicare and other important social programs, not the reverse.

In addition to the transfer of block funds to provinces and territories, the sheer magnitude and pressing nature of many issues facing Medicare warrant the use of one-time only, targeted, special-purpose transfers. Precedents for these types of transfers include the National Health Grants Program created in 1948 to develop hospital infrastructure across the country, as well as the more recent funds created to support early child development, medical equipment, the health infoway and primary care renewal. This type of approach, coupled with more stringent accountability provisions to ensure that the funds are spent as intended, should be used to address serious system shortcomings in the areas of health human resources, capital infrastructure and information technology.

#### **Recommendation 4**

- (a) That the federal government's contribution to the publicly funded health care system
- be harmonized with the five-year review of the federal equalization program
  - be locked-in for a period of five years, with an escalator tied to a three-year moving average of per capita GDP
  - rise to a target of 50% of provincial-territorial per capita health spending for core services
  - provide for notional earmarking of funds for health.
- (b) That the federal government create special-purpose, one-time funds totaling \$2.5 billion over five years (or build on existing funds) to address pressing issues in the following areas (see relevant sections for more detail)
- health human resources planning (section 6.1.1)
  - capital infrastructure (section 6.2)
  - information technology (section 6.4)
  - accessibility fund (section 8.1.2).

### **3.3.3 Tax policy in support of health**

In the past, the Government of Canada has relied heavily on its spending power and legislation to influence the development of Medicare across Canada. However, increasing concern associated with Canada's health care system has obliged the federal government to maximize all its available policy levers, including taking another look at how the tax system can be used to support renewal of the health sector.

Although taxes are widely used as a public policy tool, to date the role of taxation in the area of health has been relatively small. In total, personal income tax assistance (i.e., foregone government revenue) for health was estimated at \$3.8 billion in 2001, equal to only a little more than 3.7% of total health expenditures for that year.

The tax system interfaces with the health sector at three levels — health care financing, health care inputs and lifestyle choices. Key questions of reform that could be addressed through a review of the tax system at these levels include the following.

### *Health care financing*

- Could tax incentives be used to improve access to private supplemental insurance?
- How could increased tax relief be provided to people with high out-of-pocket medical expenses?
- Should the tax system be used to encourage personal savings for long-term care?

### *Health care inputs*

- How could tax incentives be used to address health human resource issues (e.g., attracting physicians and nurses to rural and remote areas, off-setting high costs of medical education, promoting continuing education)?
- How can the federal government proceed with changes to the tax system to ensure equitable treatment of all health providers (e.g., GST)?
- Could enhanced tax credits be developed to support informal caregivers?
- Could tax incentives be used to promote research and innovation in health care beyond the pharmaceutical sector?

### *Lifestyle choices*

- How could the tax system be used to encourage healthy lifestyles (e.g., incentives to eat well and exercise; disincentives for unhealthy choices)?

The level of support provided by the tax system for people facing high out-of-pocket expenses is a particularly pressing question. Currently, the medical expenses tax credit provides limited relief to those whose expenses exceed \$1,637 or 3% of net income. The 3% threshold was established before Medicare was introduced. Does it still make sense in 2002? Are there ways to enhance this provision to reduce financial disincentives facing many Canadians when they have to pay for health services that may not be medically necessary, but are beneficial and worthy of government support?

The CMA encourages the federal government to undertake a comprehensive review of these and other tax questions pertaining to health. Clearly, we do not believe tax policy will, by itself, solve all of the challenges facing Canada's health care system. Nevertheless, the CMA believes that the tax system can play a key role in helping the system adapt to changing circumstances, thereby complementing the other two components of our renewal strategy.

### **Recommendation 5**

That a blue ribbon panel of Parliament be established to work with the Canadian Health Commission to review the current provisions of federal tax legislation with a view to identifying ways of enhancing support for health policy objectives through tax policy.

## 4. Meaningful Stakeholder Input and Accountability

In the Commission’s interim report, the question was posed: why are those who have the most to contribute, who are the most committed — Canada’s health professionals — not at the table when the future of health and health care is being discussed by this country’s leaders?

Physicians individually and collectively feel disempowered and disengaged. They feel frustrated, marginalized and left out at all levels of decision-making. Nowhere is this more evident than at the national level, where physicians and other health care providers have tried in vain to gain access to the “black box” of executive federalism. Physicians and other providers have been systematically excluded from participating in decisions about the future of health and health care.

During the past decade, with the exception of successful joint management ventures at the provincial, territorial or regional levels, physicians have been increasingly marginalized in terms of policy decisions. At the federal–provincial–territorial level, physicians have been frozen out since the late 1980s. At the federal level, organized medicine had no opportunity for formal input to the National Forum on Health. Physicians were specifically excluded from many regional boards when they were established in the early 1990s. Finally, the consolidation of many local governance structures (e.g., hospital boards) into regional boards has reduced opportunities for local decision-making.

A basic principle of justice states that those who are affected directly by decisions ought to be present when such decisions are made. Physicians, nurses and others bring much to the table. The grounds for exclusion are often not clear, but tend to be a result of the misguided notion that self-interest might prevail over the collective interest. In today’s environment, with the rapid turnover of senior health officials, we believe the pendulum must swing toward building a table where enlightened self-interest is promoted.

Whereas elected officials are in the health business for only a short time, physicians and other providers have their careers on the line. We have the most invested, the most to give and, next to our patients, the most to lose. Why is it that we have the least say in decisions about the future of health and health care? Why is it that we learn about decisions after the fact and are then expected to support them?

Canada has paid an enormous price for this policy of exclusion. Ill-informed policy decisions in human health resources planning have had catastrophic results. Recently, the shell game around investments in medical technology has typified how federal, provincial and territorial governments working behind closed doors tend to promote solutions that minimize friction between the two levels of government, but are of little or no concrete benefit to the health care system. We need a more transparent and accountable process.

### **Recommendation 6**

That governments and regional health authorities initiate or enhance significant efforts to secure the participation of and input from practising physicians at all levels of health care decision-making.

## 5. Defining the Public Health Care System

Sustainability and accountability are overarching themes of this submission, and our ultimate goal is timely access to quality care for all Canadians. The time has come to stop making excuses for rationing the publicly funded health care system. Our patients deserve health care that is available to them in a timely fashion in their own country.

Canada's physicians support publicly funded health care, but not if it means patients are denied timely access to quality care and not if it means rationing and denial of necessary care. We strongly believe that all Canadians, regardless of where they live, should have access to high-quality health care.

### 5.1 Core Services

One of the pathways identified in our initial submission was the need to strike a better balance among everything and everyone. No country in the world has been able to provide first-dollar<sup>5</sup> coverage for timely access to all services. In light of the rapidly transforming delivery system with its shift from institutional to community-based care, a re-examination of the Medicare "basket" is overdue.

#### 5.1.1 Uniform coverage for all Canadians

All Canadians should have coverage for basic health care services under uniform terms and conditions, regardless of where they live. A clearly defined basket of core services is an essential requirement for a national program in a decentralized system of health care such as Canada's. This basket would ensure that a minimum level of coverage is applied uniformly across all provinces and territories. However, it is important to acknowledge that variation will occur in health care priorities across provinces and territories; as a result, provinces and territories may choose to add to this basket.

#### **Recommendation 7**

That all Canadians be provided coverage for a basket of core services under uniform terms and conditions.

#### 5.1.2 Redefining core services

Since the inception of Medicare in Canada, core services have generally been understood to be those subject to the five program criteria set out in the *Canada Health Act*. These include medically necessary hospital services, physician services and surgical dental services provided to insured persons.

However, as health care delivery has evolved, more and more services have migrated out of the hospital setting, effectively reducing the relative size of the basket of core services. For example, while hospital and physician expenditures accounted for 56% of total health spending in 1984, by 2000 this had declined to 45%. Many services previously provided in hospitals are now delivered through a combination of community-based services and drug therapy. Services that continue to be provided in hospitals are

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<sup>5</sup> 100% government-funded without patient cost-sharing.

increasingly being provided on a “day surgery” basis (requiring no admission) or during a much shorter stay.

If Medicare is to continue to meet the needs of Canadians, then the notion of core services must be changed to cover an array of services consistent with the realities of health care in the 21st century. Specifically, the definition of core services should be reviewed to determine the extent to which it should go beyond hospital and physician services.

**Recommendation 8**

- (a) That the scope of the basket of core services be determined and be updated regularly to reflect and accommodate the realities of health care delivery and the needs of Canadians.
- (b) That the scope of core services not be limited by its current application to hospital and physician services, provided that access to medically necessary hospital and physician services is not compromised.

*5.1.3 A process for clarifying what is in and what is out*

There is no simple way to decide what the basket of core services should include or exclude. It involves making difficult value judgements and trade-offs and achieving consensus among a broad cross-section of perspectives and interests. For several years, the CMA has advocated a balanced approach to the determination of core services that addresses the issues of ethics, quality (evidence) and economics (Appendix D). The risks of not making these difficult decisions have become all too clear: a health system that is locked into antiquated notions of health care and is increasingly out of touch with the needs of Canadians.

The process used to determine core services should be inclusive and transparent. Decisions should be evidence-based and not biased in favour of any single provider or setting in which care is provided. The special nature of care related to illness should be recognized — emergent vs. non-emergent conditions, the potential financial burden on individuals and families, and the inability to predict when such care will be required. Most important, whoever is assigned the task of defining and updating the basket of core services must have legitimacy in the eyes of the public.

The CMA believes that the values listed below should characterize the process used to determine the basket of core services covered under Medicare.

### Values for Determining Core Services

*Transparency:* The process and principles or rules on which decisions are based should be open to scrutiny and made public.

*Accountability:* Decision makers should have proper authority to make these decisions and provisions should be in place for them to be held accountable for the decisions they make.

*Evidence-based:* The decision-making process should incorporate relevant empirical evidence as available and appropriate.

*Inclusivity:* Parties having an important stake in the decisions, should be identified, consulted and included in decision-making.

*Procedural fairness:* The process used to make the decision should be fair to all those involved in or affected by the decision, including a right of appeal.

### Recommendation 9

- (a) That the scope of the basket of core services be determined and regularly updated by a federal–provincial–territorial process that has legitimacy in the eyes of Canadians — patients, taxpayers and health care professionals.
- (b) That the values of transparency, accountability, evidence-based, inclusivity and procedural fairness should characterize the process used to determine the basket of core services to include under Medicare.

#### 5.1.4 Funding core services — finding a new Canadian compromise

Under the *Canada Health Act*, provinces and territories must ensure that medically necessary physician and hospital services are provided on a first-dollar basis. Beyond these core services, provinces and territories provide varying degrees of coverage for other services, which are funded through a mix of government funding and patient cost-sharing. Some services are completely funded from private sources. Beyond hospital and physician services, there is no uniformity across provinces and territories in the terms and conditions under which services may be partly covered under the public funding umbrella.

If the basket of core services is to be expanded beyond its focus on physician and hospital care, then certain realities must be addressed. First, although first-dollar coverage may be required to maintain access to services for the most vulnerable in society, its universal application creates the illusion that health care services are free when they clearly are not. Second, given limited fiscal resources and political priorities, governments will likely not be able to afford first-dollar coverage for an expanded set of core services. Without additional funding, resources will have to be reallocated from hospital and physician services to finance other services added to the basket.

This argues for a different approach to the funding of core services — one that is more pragmatic and less ideologically driven. Under this approach, health services would be divided into three categories: those that are exclusively publicly funded, those that are partly publicly funded, and those that are exclusively privately funded. The services in the first two categories would be defined as core services. As discussed earlier, the basket of core services would be determined and regularly updated by a legitimate, multistakeholder group using an evidence-based process; it should no longer be defined on the basis of whether the services are 100% publicly financed.

If core services are redefined to include services that are currently financed through a mix of private and public funding, then Canadians must be prepared to review the use of first-dollar coverage to ensure that it is applied where it is most needed to maintain access to core services. Uniform terms and conditions for core services with mixed private–public funding must also be developed, i.e., by defining the minimum level of public funding from all provinces and territories.

The development of uniform terms and conditions around those services that receive a mix of public and private funds has never been addressed in Canada. Even though the criteria of the *Canada Health Act* — universality, accessibility, comprehensiveness, portability and public administration — should be relatively easy to apply in a world of first-dollar coverage, Canada’s health system has not been able to satisfy all of them consistently. It is essential that these criteria be more diligently applied to core services that are funded on the basis of first-dollar coverage. In addition, they must be adapted to provide an effective framework of terms and conditions to govern access to services with mixed private–public funding.

There is a need for a more rational discussion of the role of patient cost-sharing in the Canadian health care system. Many types of mechanisms for cost-sharing are in place today, including premiums, deductibles, co-payments, charges at point of service and taxation of health benefits. Here again, governments should adopt approaches that promote transparency and accountability, while ensuring that no one is denied care because they cannot afford to pay.

Service charges are an acceptable part of the provision of many important health-related products and services such as pharmaceuticals and dental care. Furthermore, the *Canada Health Act* makes an explicit provision for chronic care co-payments. However, other services such as physician and hospital services are currently considered off-limits. Certain services that possess an “amenity” component, such as some pharmaceuticals, prostheses and certain elements of home care could continue to include a service charge to cover a portion of the service.

However service charges are applied, it should be done in a fair and equitable manner that takes into consideration those at a financial disadvantage so that it does not impede access to necessary care, but encourages appropriate use of the health care system. In addition, patient cost-sharing arrangements for core services must be consistent across provinces and territories. Minimum thresholds for the public share of financing could be established for different categories of core services; however, any jurisdiction would be free to increase its share to a level above the minimum.

### Recommendation 10

- (a) That governments develop a new framework to govern the funding of a basket of core services with a view to ensuring that
- Canadians have reasonable access to core services under uniform terms and conditions in all provinces and territories
  - governments, providers and patients are accountable for the use of health care resources
  - no Canadian is denied essential care because of her or his personal financial situation.
- (b) That legislation be amended to permit at least some core services to be cost-shared under uniform terms and conditions in all provinces and territories.
- (c) That once the basket of core services is defined, minimum levels of public funding for these services be uniformly applied across provinces and territories, with flexibility for individual governments to increase the share of public funding beyond these levels.

## 5.2 Care Guarantee and “Safety Valve”

A common frustration in recent years among many physicians and patients has been the lack of any recourse or alternative care in Canada when the publicly funded health system fails to provide timely access to health care. For Canadians, the only alternative since the inception of Medicare has been to turn to the United States or other countries for medical care. This may have been acceptable in the early days of Medicare when public funding was plentiful and the need to seek care outside of Canada was more theoretical than real; however, in 1998, the National Population Health survey estimated that some 17,000 Canadians traveled to the United States to seek medical care. Clearly, this is not an option for most Canadians.

Recent court cases have held provincial governments accountable for providing timely care. An increasing number of Canadians are seeking private care in Canada, such as at private magnetic resonance imaging (MRI) clinics, even though this service is potentially in conflict with the principles of the *Canada Health Act*. The public has, in effect, built its own safety valve. This is a concrete example of what happens when the publicly funded system fails to respond to a legitimate demand. This gap in Canadian health policy must be addressed in a way that compels the system to provide timely care while preserving the right of Canadians to seek alternate care if the public system fails to deliver.

The first step in addressing these issues is to define core services. The second step is to establish guidelines and standards around quality and waiting times that are evidence-based and that patients, providers and governments consider reasonable. To date, the best example of such benchmarking in Canada has been by the Cardiac Care Network in Ontario. The CMA has reviewed progress toward the development of benchmarks in *A Canadian Health Charter: A Background Discussion Paper*, which examines Canadian and international experience with health charters. We have also written a policy on operational principles for the measurement and management of waiting lists (Appendix E).

If the publicly funded health care system fails to meet the specified agreed-upon standards for timely access to core services, then patients must have other options to allow them to obtain this required care

through other means. Step three involves setting up a “safety valve” to address situations where the established time guarantees cannot be met. This safety valve provision would allow patients and their physicians to seek required care wherever it is available. Attempts would be made to find care geographically close to the patient — first within the province or territory, then in another province or territory or even out of country.

The public funds that would have been used to pay for the patient’s care if the time guarantee had been met would be used to pay for the service wherever it is provided. In some cases, the cost of this service will be more than what would have been charged had the service been available in a timely manner from the public system in the patient’s home province or territory. Patients would be able to purchase supplementary private insurance on a prospective basis to cover this difference in cost.

Ideally, Canadians would never have to use this “safety valve.” However, its inclusion in Canadian health policy will provide assurances and help restore public confidence in the health system. It will also remind governments about the repercussions of not living up to mutually agreed-upon commitments to provide timely access to care.

### **Recommendation 11**

- (a) That Canada’s health system develop and apply agreed-upon standards for timely access to care, as well as provide for alternative care choices — a “safety valve” — in Canada or elsewhere, if the publicly funded system fails to meet these standards.
- (b) That the following approach be implemented to ensure that governments are held accountable for providing timely access to quality care.
  - First, governments must establish clear guidelines and standards around quality and waiting times that are evidence-based and that patients, providers and governments consider reasonable. An independent third-party mechanism must be put in place to measure and report on waiting times and other dimensions of health care quality.
  - Second, governments must develop a clear policy stating that if the publicly funded health care system fails to meet the specified agreed-upon standards for timely access to core services, then patients must have other options available to them that will allow them to obtain this required care through other means. Public funding at the home province rate would follow the patient in this circumstance, and patients would have the opportunity to purchase insurance on a prospective basis to cover any difference in cost.

### **5.3 Public Health**

Canada has been a leader in recognizing that there is more to health than health care. The Hon. Marc Lalonde’s 1974 *New Perspective on the Health of Canadians*, which has since become world renowned, introduced the health field concept that emphasized the role of environmental and lifestyle determinants of health.

Public health is often associated with measures to prevent illness, such as safe drinking water, sanitation, waste disposal, immunization programs, well-baby clinics or programs promoting healthy lifestyles. It is the organized response of society to protect and promote health and to prevent illness, injury and

disability. Public health carries out its mission through organized, interdisciplinary efforts that address the physical, mental and environmental health concerns of the population at risk of disease and injury. These efforts require coordination and cooperation among individuals, governments (federal, provincial, territorial and municipal), community organizations and the private sector.

Putting patients first means, among other things, making sure that the health system is capable of stretching to capacity to meet unforeseen circumstances. The need for this “surge capacity” is discussed in more detail in section 6.3.

Canadian physicians have long recognized the value of health promotion and disease prevention and have incorporated these elements into their practices. The CMA and its divisions and affiliates have also been active in the field of public health. For its part, the CMA

- Worked with the CBC on the first series of public health broadcasts
- Was the first organization to call for a ban of smoking on airplanes
- Developed a tool to help physicians determine medical fitness to drive
- Launched a campaign to reduce traffic injuries (seatbelts, breathalyzers, etc)
- Carried out a national Bicycle Helmet Safety Program
- Supported warning labels on tobacco products.

Public health is complex, and the current status of the public health system in Canada requires a full and open review. In 1999, the auditor general found Health Canada unprepared to fulfill its responsibilities in the area of public health: communication among multiple agencies was poor and weaknesses in the key surveillance system impeded the effective monitoring of communicable and noncommunicable diseases and injuries. It is imperative that various departments and sectors coordinate and communicate effectively to synergize efforts and to avoid duplication.

The capacity of the public health care sector to deliver disease prevention and health promotion programs is inadequate, and its ability to respond varies across the country. This situation is due to a lack of trained professionals and a lack of operational funds. Greater commitment is needed from governments at all levels to ensure that adequate human resources and infrastructure are available to respond to public health issues when they arise. This includes the expansion of the public health training programs.

Once a public health issue has been identified, it is the responsibility of professionals within the system to use effective means of control. The public health system must be supported by a strong and viable infrastructure to allow them to meet such challenges. Major public health issues facing Canadians include, but are not limited to, high rates of obesity, tobacco and other substance use, mental health challenges, ensuring a clean and safe environment and prevention of injury and violence.

The ability of the public health system to respond to these issues directly affects the well-being of Canadians, in a manner as important as the ability of the acute care system to respond to medical emergencies. However, investment in public health initiatives must not be made at the expense of acute and long-term care.

Since the 1970s, the World Health Organization and national governments around the world have paid increasing attention and put greater effort into establishing goals for improving public health and into monitoring achievement. Numerous examples can be cited in the United States, England and Australia. In Canada, although the federal government has not attempted to establish goals, several provinces have undertaken such an exercise.

Public health priorities or goals are considered to be an asset to a health care system in that they

- Provide a baseline assessment of a population's health and a tracking system for monitoring change
- Encourage an increase in the breadth and intensity of health improvement activities and improve the efficiency and effectiveness of existing activities
- Facilitate evaluation of the impact of health improvement activities
- Foster unity of purpose, organization, participation and spirit of cooperation through consensus
- Build awareness of and support for health programs among policymakers and the public
- Guide decision-making and funding allocations.

At their meeting in September 2000, the first ministers made several commitments to improve public health

- Promote the public services, programs and policies that extend beyond care and treatment and that make a critical contribution to the health and wellness of Canadians
- Develop strategies and policies that recognize the determinants of health, enhance disease prevention and improve public health
- Further address key priorities for health care renewal and support innovations to meet the current and emerging needs of Canadians
- Report regularly to Canadians on health status, health outcomes and the performance of publicly funded health services, and the actions taken to improve these services.

Unfortunately, there has been little progress to date.

Canada must develop a strategic approach to sustain and strengthen the capacity of the public health system to prevent, detect and respond to public health issues.

### **Recommendation 12**

- (a) That governments demonstrate healthy public policy by making health impact the first consideration in the development of all legislation, policy and directives.
- (b) That the federal government provide core funding to assist provincial and territorial authorities in improving the coordination of prevention and detection efforts and the response to public health issues among public health officials, educators, community service providers, occupational health providers and emergency services.
- (c) That governments invest in the human, infrastructure and training resources needed to develop an adequate and effective public health system capable of preventing, detecting and responding to public health issues.
- (d) That governments undertake an immediate review of Canada's self-sufficiency in preventing, detecting and responding to emerging public health problems and furthermore, facilitate an ongoing, inclusive process to establish national public health priorities.

## 5.4 Aboriginal health

Despite improvements in many areas, First Nations, Métis and Inuit people continue to have a poorer health status than the general Canadian population.

The current health status of Canada's Aboriginal peoples is a result of a broad range of factors. It is generally acknowledged that improving it will take a lot more than simply increasing the quantity of health services. The underlying roots of the problem must be addressed; for example, poverty, low levels of education, unemployment and underemployment, exposure to environmental contaminants, inferior housing, substandard infrastructure and maintenance, low self-esteem and loss of cultural identity.

A problem of this magnitude and complexity must be addressed in a comprehensive way, with all components of health, government and other sectors working in full partnership with the Aboriginal community. In recognition of this need, in February 2002 the CMA signed a letter of intent with the National Aboriginal Health Organization (NAHO) (Appendix F) to collaborate on activities in four areas of mutual interest:

1. *Workforce initiatives*: To increase recruitment and retention of physicians and other health professionals, particularly of Aboriginal descent, who serve Aboriginal communities.
2. *Research and practice enhancement initiatives*: To promote research into Aboriginal health issues and the translation of research into effective clinical practice through means such as dissemination of best-practice information and the development of user-friendly practice tools.
3. *Public and community health programs*: To address and develop initiatives to promote healthy living for Aboriginal communities.
4. *Leadership programs*: To develop and implement leadership development initiatives including mentoring programs for Aboriginal physicians.

The exploration of these and other areas is essential to improve Aboriginal health status so that it is on par with the rest of the Canadian population.

### **Recommendation 13**

That the federal government adopt a comprehensive strategy for improving the health of Aboriginal peoples that involves a partnership among governments, nongovernmental organizations, universities and the Aboriginal communities.

## 6. Investing in the Health Care System

### 6.1 Health Human Resources

*Governments must demonstrate their commitment to the principle of self-sufficiency in the production of physicians to meet the medical needs of the Canadian population.*

Coverage means nothing without access, and access means nothing without availability of health care professionals. Unfortunately, there are shortages of human resources in various health care disciplines, and these shortages will be exacerbated by the demographics of the Canadian population and of each provider group and by changing public expectations.

The population in general is becoming older. Older age groups experience an increased incidence of illness and disability, and thus place higher demands on the health care system. At the same time, significant numbers of health care providers are approaching retirement; in many cases, there are not enough young people entering the professions to replace those who will soon be leaving.

Over the past two decades, one of the most striking changes in the medical workforce in Canada has been the increased proportion of female medical graduates: in 1980, women represented 32% of medical graduates; by 1996, this proportion reached 50%. Women now represent 30% of the practising profession in Canada and this will approach 40% by the end of the decade. Although more research is needed, it is clear that male and female physicians have different practice patterns. The changing gender distribution must be taken into consideration when examining the problem of physician supply.

A more highly educated population and the widespread use of information sources such as the Internet are contributing to a heightened sense of patient empowerment, higher expectations and consumerism. These factors will increase pressure for high-quality health services. Although we encourage patients to be informed, we must be prepared for the added demands on the health system that this enhanced knowledge will create, especially in terms of the supply of health human resources.

The human resources crisis is one of the most important issues facing health care today. Solutions must be found to address the many specific problems that are plaguing all health provider groups. The nursing field is suffering from many of the same challenges as physicians, including attrition and the “brain drain.” The accessibility crisis is compounded by shortages of laboratory technologists and others in the health care field, who directly support the work of physicians. Although these problems must all be addressed to make our health care system sustainable for the future, this document focuses on the professionals about whom the CMA has the greatest knowledge and expertise: physicians.

#### 6.1.1 Supply, training and continuing education

All areas of the health care continuum are experiencing a shortage of physicians. The key factors underlying this shortage include physician demographics (e.g., age and gender distribution), changing lifestyle choices and productivity levels (expectations of younger physicians and women differ from those of older generations) and the insufficient numbers entering certain medical fields.

According to 2001 data from the Organisation for Economic Co-operation and Development (OECD), Canada ranked 21st out of 26 countries in terms of the ratio of practising physicians to the population. In addition to the factors affecting physician supply mentioned above, other drivers of change, such as technological innovation and information technology, are adding further pressure to an already

overworked medical profession. The OECD report further states that empirical evidence shows that lower doctor numbers are closely linked with higher mortality, after taking other health determinants into consideration. Yet, in terms of female and male life expectancy at birth, Canada ranks 7th and 6th, respectively.<sup>6</sup> This is a powerful testament to the efforts of Canadian health professionals in putting patients first.

Increasing numbers of Canadians feel the impact of the widespread physician shortages when they are unable to find a family physician or they experience delays in seeing specialists. Physicians themselves are finding that they must reduce the time they can spend doing research, teaching and pursuing continuing medical education in order to focus on direct patient care.

In November 1999, the Canadian Medical Forum<sup>7</sup> (CMF) and the Society of Rural Physicians of Canada met with the federal, provincial and territorial governments to present a detailed report on physician supply containing five specific recommendations. The CMA and the other CMF organizations were encouraged to see that many jurisdictions across Canada agreed with the need to increase enrolment in undergraduate medical education programs, although we are still far from the 2,000 medical students by year 2000 that was recommended.

The necessary increases in undergraduate enrolment in medicine require funding not only for the positions themselves, but also for the infrastructure (human and physical resources) needed to ensure high-quality training that meets North American accreditation standards. The concomitant increases in postgraduate positions that will be required three to four years later must also be resourced appropriately. This is in addition to the extra positions recommended in the November 1999 CMF report, which are needed to increase flexibility in the postgraduate training system; the capacity to provide training to international medical graduates; and opportunities for re-entry for physicians who have been in practice.

The CMA remains very concerned about high and rapidly escalating increases in medical school tuition fees across Canada. According to data from the Association of Canadian Medical Colleges (ACMC), in just five years (1996 to 2001), average first-year medical school tuition fees increased by 100%. In Ontario, they went up by 223% over the same period. Student financial support through loans and scholarships has not kept pace with this rapid escalation in tuition fees. The CMA is particularly concerned about the impact this will have on the physician workforce and the Canadian health care system.

High tuition fees will have a number of consequences. They create barriers to application to medical school and threaten the socioeconomic diversity of future physicians serving the public. They also exacerbate the “brain drain” of physicians to the United States where newly graduated physicians can pay down their large student debts much more quickly.

Medical education does not end with earning the title MD; in fact, this is just the beginning of a physician’s learning. The continuously evolving nature of medicine requires that physicians remain up-to-date on emerging medical technologies, new treatment modalities and numerous other developments. In the early 1990s, the conventional wisdom was that medical knowledge was doubling every five years. Now, a time of less than two years is more commonly cited. Clearly, there is an increasing role for continuing medical education (CME), underscored by explicit requirements for self-directed activities to

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<sup>6</sup> Organisation for Economic Co-operation and Development. *Health at a glance*. Paris, France: OECD; 2001.

<sup>7</sup> CMF membership includes: CMA, Association of Canadian Medical Colleges, College of Family Physicians of Canada, Royal College of Physicians and Surgeons of Canada, Canadian Federation of Medical Students, Canadian Association of Internes and Residents, Federation of Medical Licensing Authorities of Canada, Medical Council of Canada, and Association of Canadian Academic Healthcare Organizations.

promote maintenance of certification for both family practitioners and specialists. Historically, this is an area where physicians have largely had to fend for themselves. For its part, the CMA has sponsored the Physician Manager Institute, which provides training for physicians moving into leadership positions. Although many provincial and territorial medical associations have negotiated CME benefits with their governments, it is essential that academic health science centres be supported to expand capacity in the area of CME.

In the early days of Medicare, the federal government played a leadership role in building the infrastructure for health education through the Health Resources Fund, which distributed \$500 million during 1966–1980. The purpose of this fund was to help provinces bear the capital costs of constructing, renovating and acquiring health training facilities and research institutions. More recently, the federal government supported a rebuilding of the university research infrastructure generally through the \$800-million Canada Foundation for Innovation fund, which was announced in the 1997 budget, and the \$900-million Canada Research Chairs program, which was announced in the 2000 budget to support the establishment of 2,000 research chairs by 2000. The health field will be a significant beneficiary of these funds.

However, considering the shortage of health professionals that we face today and that will soon worsen, as well as the prospect of diminished access to professional education as a result of higher tuition, there is an urgent need for targeted federal funds to address this situation immediately.

#### **Recommendation 14**

- (a) That the federal government establish a \$1-billion, five-year Health Resources Education and Training Fund to (1) further increase enrolment in undergraduate and postgraduate medical education (including re-entry positions), (2) expand the infrastructure (both human and physical resources) of Canada's 16 medical schools to accommodate the increased enrolment and (3) enhance continuing medical education programs.
- (b) That the federal government increase funding targeted to institutions of postsecondary education to alleviate some of the pressure driving tuition fee increases.
- (c) That the federal government enhance financial support systems for medical students that are (1) non-coercive, (2) developed concomitantly or in advance of any tuition increase, (3) in direct proportion to any tuition fee increase and (4) provided at levels that meet the needs of the students.
- (d) That incentives be incorporated into medical education programs to ensure that adequate numbers of students choose medical fields in which there is greatest need.

#### **6.1.2 Physician retention and recruitment**

As important as investments in medical education may be, they will only begin to pay off in terms of increased supply of physicians in the medium- to long-term. In the short-term, shortages of family physicians and specialists will persist and possibly worsen. There is no quick fix for this problem; we must manage the best we can. This means making sure that we retain the physicians who are now practising in communities across the country. Physician turnover is a chronic problem in both rural and urban areas. The loss of a physician in a community has a very real impact in terms of continuity of care.

There are unmeasured costs to patients, such as distress and turmoil, as well as to the remaining physician(s) and communities that must cope with the repeated loss of valued physicians.

Canada is both an exporter and an importer of physicians. The two-way flow, mainly between Canada and the United States, is tracked by the Canadian Institute for Health Information. Since tracking began in the 1960s, Canada has been a net exporter of physicians to the United States. During the mid-1990s, the net loss exceeded 400 — roughly equal to 4 graduating medical classes. Since then, it has abated to 164 in 2000, but this is still the equivalent of 1.5 medical classes. Conversely, Canada is a net importer of physicians from the rest of the world. Although the figure is more difficult to quantify, it is estimated that Canada is a net importer of 200–400 international medical graduates, who are most typically recruited to work in rural and remote communities.

Short-term responses to the physician shortage include repatriating Canadian physicians working abroad and integrating qualified international medical graduates and other providers. Canada must recognize that there is a global shortage of physicians — and a global marketplace for our services; a widespread, organized recruitment of physicians from other countries, especially from those that are also experiencing physician shortages, is not the way to solve Canada's health human resources problems.<sup>8</sup>

### **Recommendation 15**

- (a) That governments and communities make every effort to retain Canadian physicians in Canada through non-coercive measures and optimize the use of existing health human resources to meet the health needs of Canadian communities.
- (b) That the federal government work with other countries to equitably regulate and coordinate international mobility of health human resources.
- (c) That governments adopt a policy statement that acknowledges the value of the health care workforce in the provision of quality care, as well as the need to provide good working conditions, competitive compensation and opportunities for professional development.

### *6.1.3 The need for integrated health human resources planning*

Health human resource planning is complex. The CMA seeks to build consensus within the medical profession on major program and policy initiatives concerning the supply, mix and distribution of physicians and to work with major stakeholders in identifying and assessing issues of mutual importance.

Planning for the provision of services by a broad array of providers to meet changing health care needs should focus on having the right providers in the right places doing the right things. This first requires the determination of the needed supply, mix and distribution of physicians, which will assist in the development of a similar assessment for all other providers. Resource planning must be based on the health care needs of Canadians rather than driven by cost.

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<sup>8</sup> See for example the *Melbourne Manifesto: A Code of Practice for the International Recruitment of Health Care Professionals*, which was adopted at the 5th Wonca World Conference on Rural Health in May 2002. It puts the onus on every country to train enough health professionals to meet their own needs ([www.wonca.org](http://www.wonca.org)).

The CMA has developed principles and criteria for the determination of scopes of practice. The primary purpose is to meet health care needs and to serve the interests of patients and the public safely, efficiently and competently. These principles and criteria (listed below) have been endorsed by the Canadian Nurses Association and the Canadian Pharmacists Association. See Appendix G for more details.

<b>Principles and Criteria for the Determination of Scopes of Practice</b>	
<b>Principles:</b>	<b>Criteria:</b>
<ul style="list-style-type: none"> <li>• Focus</li> <li>• Flexibility</li> <li>• Collaboration and cooperation</li> <li>• Coordination</li> <li>• Patient choice</li> </ul>	<ul style="list-style-type: none"> <li>• Accountability</li> <li>• Education</li> <li>• Competencies and practice standards</li> <li>• Quality assurance and improvement</li> <li>• Risk assessment</li> <li>• Evidence-based practices</li> <li>• Setting and culture</li> <li>• Legal liability and insurance</li> <li>• Regulation</li> </ul>

The CMA remains sensitive to Canada's provincial and territorial realities with respect to the fact that health human resource planning requires assessment and implementation at the local or regional level. However, there is a need for a national body to develop and coordinate health human resources planning initiatives.

### **Recommendation 16**

- (a) That a national multistakeholder body be established with representatives from the health professions and all levels of government to develop integrated health human resource strategies, provide planning tools for use at the local level and monitor supply, mix and distribution on an ongoing basis.
- (b) That scopes of practice be determined in a manner that serves the interests of patients and the public, safely, efficiently and competently.

## **6.2 Capital Infrastructure**

The crisis in health human resources is exacerbated by an underdeveloped capital infrastructure — bricks, mortar and tools. This is seriously jeopardizing timely access to quality care within the health care system.

In our 2001 discussion paper, *Specialty Care in Canada*, the CMA indicated there has been inadequate investment in buildings, machinery and equipment and in scientific, professional and medical devices. Provincial and territorial government spending on construction, machinery and equipment for hospitals, clinics, first-aid stations and residential care facilities has remained, on average, 16.5% below its peak in

1989. Specifically, real capital expenditures on new building construction decreased 5.3% annually between 1982 and 1998. Investment in new hospital machinery and equipment declined by 1.8% annually between 1989 and 1998. In 1998, hospital expenditures on scientific, professional and medical devices were nearly 17% below 1994 levels.

While these cutbacks were occurring, significant innovations in medical technology were being introduced worldwide. Although hospitals are still providing most acute care services, whether patients are treated as inpatients or outpatients, the equipment required is not keeping pace with the growth of new technologies, the health needs of the patients and the increase and aging of the population. Equipment and machinery in the hospital sector are overaged due to a lack of replacement capital.

In the absence of timely access to current and emerging health technologies, Canadians face the prospect of unrestrained progression of disease, increased stress and anxiety over their health status and, possibly, premature death. Meanwhile, society bears the direct and indirect costs associated with delayed access.

On September 11, 2000, the federal government announced a new \$1 billion transfer to provinces and territories for the purpose of purchasing new medical equipment. A recent analysis by the CMA found that just over half of this fund can be accounted for as being spent as intended (Appendix H). The question remains as to what has happened to the remainder of the fund.

Governments have been placing a lower priority on capital investment when allocating financial resources for health care. It will not be enough simply to bring Canada's health infrastructure up to par; a commitment to ongoing funding to maintain the equipment must also be made. This, in turn, requires continuous inventory maintenance for regular replacement.

Therefore, it may be necessary for hospitals to develop innovative approaches to financing capital infrastructure. The CMA agrees with other organizations such as the Canadian Healthcare Association on the need to explore the concept of entering into public-private partnerships (P3s) to address capital infrastructure needs as an alternative to relying on government funding. Joint ventures and hospital bonds are but two examples of P3 financing.

### **Recommendation 17**

- (a) That hospitals and other health care facilities conduct a coordinated inventory of capital infrastructure to provide governments with an accurate assessment of machinery and equipment.
- (b) That the federal government establish a one-time catch-up fund to restore capital infrastructure to an acceptable level. (See Recommendation 4(b).)
- (c) That governments commit to providing adequate, ongoing funding for capital infrastructure.
- (d) That public-private partnerships (P3s) be explored as a viable alternative source of funding for capital infrastructure investment.

### 6.3 Surge Capacity

Putting patients first means, among other things, making sure that the health care system is capable of stretching its capacity to meet unforeseen circumstances, that the system is monitored for quality, that compensation is available when unintended harm occurs and that patient privacy and confidentiality are respected.

The tragic events of September 11, 2001, followed closely by the distribution of anthrax through the United States postal service, provided a grim reminder of the necessity of having a strong public health infrastructure in place at all times. As was demonstrated quite vividly, we do not have the luxury of time to prepare for these events. Although it is not possible to plan for every contingency, certain scenarios can be sketched out and anticipated. 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.

In addition to 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.

Like our hydro system, "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 they require to meet the need. The CMA's 2001 pre-budget submission lays out comprehensive recommendations to address this issue (Appendix I).

#### **Recommendation 18**

That the federal government cooperate with provincial and territorial governments and with governments of other countries to ensure that a strong, adequately funded emergency response system is put in place to improve surge capacity.

### 6.4 Information Technology

Much of the recent debate about the future of the health care system has focused on the need to improve its adaptability and overall integration. One critical ingredient in revitalizing the system is establishing the information technology (IT) and information systems (IS) that physicians and other health care professionals must have at their disposal. Effective and efficient networks will facilitate integrated and coordinated care, as well as better management of clinical information.

Although health care is information-intensive, health care systems in Canada and abroad have generally been slow to adopt IT. Other sectors of the economy have invested heavily in IT/IS over the past two decades and have reaped enormous benefits in efficiency and service to clients.

IT should be viewed as a "social investment" in the acquisition of knowledge. Patients will benefit through potential reductions in rates of mortality and morbidity due to misdiagnosis and improper treatment, as well as reductions in medication errors that come with access to online drug reference databases and the virtual elimination of handwritten prescriptions. IT will permit better access to diagnostic services and online databases, such as clinical practice guidelines, that are widely available but underused. Health promotion and disease prevention will be enhanced through superior monitoring and

patient education (e.g., e-libraries), and decision-making by providers and patients will be improved. These represent only a subset of the potential benefits to Canadians.

A great deal of effort is currently being devoted to the development of a secure electronic health record (EHR) that provides details of all health services provided to a patient. An EHR will not generate new information on patients; it will simply make existing information more readily accessible to the physician or appropriate health care provider. We are still at the infant stage of EHRs. Implementation will require a process of continual expansion, beginning with the most basic of patient information and evolving into a comprehensive record of all of the patient's encounters with the health care system — as well legislation protecting personal privacy and unwarranted access.

It is widely accepted in industry that 4 – 5% of financial budgets is a reasonable target for information technology spending. It is equally widely accepted that in Canada the health care sector falls well short of this target. As part of the September 2000 Health Accord, the federal government invested \$500 million to create the Canada Health Infoway with a mandate to accelerate the development and adoption of modern systems of IT, such as electronic patient records. The CMA applauds this investment, but notes that the \$500-million down-payment is only a fraction of the \$4.1 billion that the CMA estimates it would cost to fully connect the Canadian health care system. A number of provincial and territorial governments are also moving ahead with the development of IT in health care, but further financial support is required.

The CMA is prepared to play a pivotal partnership role in achieving the buy-in and cooperation of physicians and other health care providers through a multistakeholder process. Toward this end, the CMA has developed principles for the advancement of EHRs (Appendix J). The CMA's involvement would be a critical success factor in helping the federal government make an electronic health care system a realizable goal in the years to come.

#### **Recommendation 19**

That governments make additional, substantial, ongoing investments in information technology and information systems, with the objective of improving the health of Canadians as well as improving the efficiency and effectiveness of the health care system.

#### **Recommendation 20**

That governments adopt national standards that facilitate the collection, use and exchange of electronic health information in a manner which ensures that the protection of patient privacy and confidentiality are paramount.

### **6.5 Research and Innovation**

Research and innovation in the health sector are producing an expanding array of treatments and therapies that improve quality of life and longevity, e.g., pharmaceuticals, surgery, human genome, etc. Health research provides substantial economic, social and health care benefits to society. It

- Creates high-quality, knowledge-based jobs that drive economic growth
- Supports academic institutions across the country and helps train new health professionals in the latest health care technologies and techniques

- Supports health care delivery and is key to maintaining centres of excellence for highly specialized care
- Leads directly to better ways to treat patients and promote a healthier population.

In Canada, health research is carried out by a mix of public, voluntary and private-sector organizations with the federal government being the main player in publicly funded health research. Several provinces have their own health research funding agencies. Canada's health charities play an important role in funding research on a range of diseases and conditions. The pharmaceutical industry, especially the name-brand companies, invests heavily to develop new drugs.

Recent federal investments have begun to revitalize Canada's health research capacity. With the creation of the Canadian Institutes for Health Research (CIHR), Canada now has a modern funding agency that integrates biomedical, clinical, health services and population health research. New programs have been introduced to attract world-class scientists, modernize research infrastructure and equipment and support research in genomics.

As significant as these investments have been, Canada still ranks second-to-last among G7 countries in terms of support for health research. The United States' National Institutes of Health has a budget that is 50 times that of the CIHR for a population only 10 times bigger than Canada's. Other countries are increasing their investment in health research to keep pace. If Canada is to improve its position vis-à-vis our key competitors, the federal government must map out a plan to increase its investment in health research to internationally competitive levels.

The federal government's investment in health research currently stands at about 0.5% of total health expenditures. There is a broad consensus in the health community that this should be increased to at least 1% of total health expenditures.

### **Recommendation 21**

That the federal government's investment in health research be increased to at least 1% of national health expenditures.

## 7. Health System Financing

*Governments' contributions to funding Canada's health system should support the long-term sustainability of the system and the provision of high-quality health care for all Canadians.*

*Governments' contribution to Medicare should promote greater public accountability, transparency and a linkage of sources with their uses.*

Changes in health system financing have played a central role in the crisis facing Medicare. Significant and unpredictable funding cuts at both federal and provincial–territorial levels have wreaked havoc in the planning and delivery of a very complex array of services. Health care costs that were previously covered by provincial and territorial health insurance plans have been gradually shifted to individuals (“passive privatization”) leaving those without private insurance coverage increasingly vulnerable. Mounting evidence of unacceptably long waits for treatment and poor access to services has underlined the risks attached to having a single-payer system, with insufficient accountability for timeliness and accessibility of care. Growing problems of access and declining provider morale, combined with constant bickering about funding between federal and provincial–territorial governments have led to deterioration of public confidence in the system. **The message from the front lines is clear: restoring the health care system to a sustainable footing cannot be accomplished by simply managing our way out of this crisis.**

As Medicare is renewed, it is essential that its underlying financing framework is modernized, taking into account the multiple policy objectives served by health financing mechanisms.

### 10 Policy Objectives for Health Financing Mechanisms

1. Stable and sustainable funding
2. Risk-pooling
3. Equity (between population subgroups, across regions)
4. Responsible use
5. Administrative simplicity
6. Transparency and accountability
7. Choice
8. Efficiency
9. Meet current needs
10. Fairness between generations (intergenerational equity)

Our recommended changes to the legislation governing federal transfers to provinces and territories are set out in section 3.3.2. To restore the federal–provincial–territorial partnership in health, we recommend that the federal contribution to the public health care system be locked in for a 5-year period, with a built-in escalator tied to increases in GDP, rising to a target of 50% of spending for core services. We also recommend that the federal government establish special purpose, one-time funds to address a number of pressing issues.

Given their constitutional responsibility in the area of health care, provinces and territories will continue to play the lead role in regulating the flow of public funding for health care. Once the basket of core

services is determined according to the process outlined in section 5.1, provinces and territories will have to commit sufficient funding to ensure that these services are available and accessible in a timely way.

The funding commitment of provinces and territories will, therefore, drive the federal government's 50% contribution. In addition to providing half of public funding for core services, provinces and territories will also have the option of funding additional health services beyond the national minimum core basket, much as they do now.

Although adequate and stable funding for health care is imperative at the federal level, it is equally important at the provincial and territorial level. Provincial and territorial commitment to funding core services must also be locked-in for a five-year period with an escalator tied to provincial demographics and inflation.

To ensure stability, a buffer will also be needed to protect provincial and territorial health care budgets from the ebbs and flows of the business cycle. Currently, the federal Fiscal Stabilization Program compensates provinces if their revenues fall substantially from one year to the next due to changes in economic circumstances. However, this program is not health-specific and only takes effect when provincial revenues drop by over 5%. It is also funded from general revenues, which makes it more vulnerable to economic and political factors. A more robust approach to guaranteeing stability of public funding for health care would be to create a stand-alone contingency fund to which all governments would contribute. Excess revenues would be collected into this fund during periods of high economic growth, and could be used during less prosperous periods when governments experience fiscal capacity shortfalls.

**Recommendation 22**

- (a) That provincial and territorial governments' commitment to funding core services be locked-in for an initial five-year period with an escalator tied to population demographics and inflation.
- (b) That governments establish a health-specific contingency fund to mitigate the effects of fluctuations in the business cycle and to promote greater stability in health care financing.

## 8. Organization and Delivery of Services

### 8.1 The Medical Care Continuum

There is a tendency to separate medical care into two areas; primary care and specialty care. However, we must recognize that medical and health care encompass a broad spectrum of services ranging from primary prevention to highly specialized care. Primary and specialty care are so closely interrelated that the renewal of either should not be attempted without considering the impact on the rest of the care continuum.

#### Recommendation 23

That any effort to change the organization or delivery of medical care take into account the impact on the whole continuum of care.

#### 8.1.1 Primary care services

In recent years, several government task force and Commission reports have called for primary care reform. Common themes include improving continuity of care (including 24/7 coverage); establishing alternatives to fee-for-service payment of physicians; placing greater emphasis on health promotion and disease prevention; and adopting team models that involve nurse practitioners and other health care providers working collaboratively with physicians.

Governments have responded by launching pilot projects to evaluate different models of primary care delivery. It is critical to evaluate these projects before moving ahead with them on a broader scale and to consider the implications of their system-wide implementation. Although some jurisdictions have moved forward with ambitious proposals to change the structure of primary care and the remuneration of physicians, the CMA urges the Commission not to view primary care renewal as a panacea for all that ails Medicare. Primary care renewal should not be used as a pretext for changing how doctors are paid nor should it focus on substituting the lowest cost provider. The focus should be on patient need.

*Any changes to the delivery of primary care should respect the following principles:*

- *All Canadians should have access to a family physician.*
- *No single model will meet the primary care needs of all communities in all regions of the country.*

Successful renewal of primary health care delivery cannot be accomplished without also addressing the shortage of family practitioners. Not only is the supply of these physicians affected by an aging physician population and by changes in lifestyle and productivity, but the popularity of primary care as a career choice among medical graduates is also declining. According to the Canadian Resident Matching Service (CaRMS), in 1997, only 10% of positions that were still vacant after the first round of the residency match were in family medicine. By 2000, family medicine's share of vacant positions after the first iteration peaked at 57%; since then it has remained close to 50%. Furthermore, before 1994, more graduates were choosing family medicine than there were positions available. Since then, the situation has reversed with fewer graduates consistently choosing family medicine than there are positions available.<sup>9</sup>

<sup>9</sup> Canadian Resident Matching Service. *PGY-1 Match Report 2002*. History of family medicine as a career choice of Canadian graduates. [[http://www.carms.ca/stats/stats\\_index.htm](http://www.carms.ca/stats/stats_index.htm)]. Ottawa: CaRMS; 2002.

A major factor in this trend may be the 1993 change in the residency program, which removed graduates' ability to do a first-year rotation in family medicine, then have the choice of continuing in the family medicine program or switching into a specialty. Now, any graduate who chooses family medicine is committed to that program. The dramatic shift in the number of graduates choosing family medicine in 1994 is likely due to the assumption that it is easier to switch out of a specialty into family medicine than vice versa.

The uncertainty of the future of primary care caused by these constant reform efforts has also contributed to the decline in popularity of family medicine among medical graduates. Efforts must be made to remove these perceived barriers so that the public's need for primary care services can be met.

Multidisciplinary teams, both formal and informal, are common in primary care today. The reliance on the team approach will likely grow because of the increased complexity of care, the exponential growth of knowledge, the greater emphasis on health promotion and disease prevention, and the choice of patients and providers. Although desirable, primary care teams — physicians, nurses, pharmacists, dieticians and others — will cost the system more, not less, than the traditional fee-for-service physician approach. Funding these initiatives must not come at the expense of the provision of illness care. The add-on costs of primary care teams, including informational technology (IT) and information systems (IS), must be looked upon as an investment in the health of Canadians. (IT and IS opportunities must also be available to all physicians, regardless of how they are paid or their patterns of practice.)

Although multidisciplinary teams may provide a broader array of services, for most Canadians having a family doctor as the central provider of all primary medical care services is a core value. As the College of Family Physicians of Canada (CFPC) indicated in its submission to the Commission on the Future of Health Care in Canada, over 90% of Canadians seek advice from a family physician as their first resource in the health care system. The CPFC also reports that a recent Ontario College of Family Physicians public opinion survey, conducted by Decima, found that 94% of people agree that it is important to have a family physician who provides the majority of primary care and coordinates the care delivered by others.<sup>10</sup>

A family physician as the central coordinator of medical services promotes the efficient and effective use of resources. This facilitates continuity of care because the family physician generally has the benefit of developing an ongoing relationship with his or her patients and their families and, as a result, can advise and direct the patient through the system so that the patient receives the appropriate care from the appropriate provider.

Canada has one of the best primary care systems in the world, but it can be improved through better integration and coordination of care. This requires investment to increase quality and productivity through improved IT and connectivity to support physicians in their expanded roles as information providers, coordinators and integrators of care, and to support the integrated care of primary care teams.

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<sup>10</sup> College of Family Physicians of Canada. *Shaping the Future of Health Care*. Submission to the Commission on the Future of Health Care in Canada. Ottawa: CFPC; 25 Oct. 2001.

### **Recommendation 24**

- (a) That governments work with the provincial and territorial medical associations and other stakeholders to draw on the successes of evaluated primary care projects to develop a variety of templates of primary care models that would
- suit the full range of geographic contexts and
  - incorporate criteria for moving from pilot projects to wider implementation, such as cost-effectiveness, quality of care and patient and provider satisfaction.
- (b) That family physicians remain as the central provider and coordinator of timely access to publicly funded medical services, to ensure comprehensive and integrated care, and that there are sufficient resources available to permit this.

#### *8.1.2 Specialty care services*

Much of the focus in recent years has been on primary care renewal. Countless reports indicating a major crisis in the area of primary care delivery have overshadowed the problems that are plaguing other areas of the health care continuum. For example, a severe physician shortage is occurring in specialty care at the generalist level. The Royal College of Physicians and Surgeons of Canada reports that a third of general surgeons are aged 55 or older and nearly 40% more general surgeons are retiring than are graduating from medical schools.<sup>11</sup>

Canada cannot afford to continue to ignore this key segment of the care continuum. A concerted effort must be made to increase the visibility of secondary care specialists and to encourage medical students to enter general specialties.

As highly specialized care and technology have advanced, there has been increasing pressure at the tertiary level of the health care system to provide the highest level of care possible. Delivering tertiary care in the ways to which Canadians are accustomed cannot be sustained into the future; and such tertiary care cannot be available in all areas of the country. Alternative approaches to delivering and receiving high-level specialty care are both required and inevitable. The aging population, the challenges posed by Canada's geography, rapidly expanding high-cost technologies and the lack of a critical mass of highly specialized health care providers necessitate a change in thinking.

The health system has reached the point where certain types of care are neither universally nor readily available. The shortage of specialists and the high cost of technology and pharmaceuticals will exacerbate this situation. The future challenge is to design delivery systems that are built around a series of regional centres of excellence, without abandoning the concept of "reasonable" access. As these highly specialized services are realigned interprovincially, resources must also be realigned to accommodate and compensate for the relocation of providers and to ensure that patients have equitable access to treatment.

At their January 2002 meeting in Vancouver, the premiers recognized that some types of surgery and other medical procedures are performed infrequently and that the necessary expertise cannot be developed and maintained in each province and territory. Building on the experience in Canada's three territories

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<sup>11</sup> Royal College of Physicians and Surgeons of Canada. *Health care renewal through knowledge, collaboration, and commitment*. Ottawa: RCPSC; 31 Oct. 2002.

and Atlantic Canada, they agreed to share human resources and equipment by developing sites of excellence in such fields as pediatric cardiac surgery and gamma knife neurosurgery. This should lead to better care for patients and more efficient use of health care dollars. At the provincial–territorial level, this strategy has led to regional centres and hospitals with responsibilities for province- and territory-wide programs and services.

The concept of centres of excellence can be further supported by the adoption of telemedicine and telehealth technologies which will permit rapid access to or exchange of electronic diagnostic information (e.g., imaging) and enable remote consultation and treatment.

Determining where care is available will become an increasingly relevant policy matter — especially as costs such as travel and lost income could be downloaded onto patients and their families. Efforts will be required to optimize the use of scarce specialist services, improve care and availability, assure continuity and enhance provider morale.

In the interests of quality care, patient safety and the economical use of scarce resources interjurisdictionally, there is a need for a Canadian Accessibility Fund. This fund would be modeled after the Portability Fund established to support the Federal–Provincial–Territorial Eligibility and Portability Agreements under the *Medical Care Act*. The cost of the new fund, like the old, would be 50–50 cost-shared by the federal and provincial–territorial governments. It would require an initial investment of \$100 million. Access to the fund would be determined by a mutually agreed upon set of criteria, and any monies withdrawn would be used to facilitate access to highly specialized health care services that are not available in the patient’s home province.

### **Recommendation 25**

- (a) That governments develop a national plan to coordinate the most efficient access to highly specialized treatments and diagnostic services.
  - This plan should include the creation of defined regional centres of excellence to optimize the availability of scarce specialist services.
  - Any realignment of services must accommodate and compensate for the relocation of providers.
- (b) That the federal government create an accessibility fund that would support interprovincial centres of excellence for highly specialized services.

## **8.2 Physician Remuneration**

It is a common misconception that successful renewal of the health care system involves simply changing how physicians are paid — specifically, abolishing fee-for-service. In their analysis of primary care in Canada, Hutchison and colleagues note that governments’ preoccupation with the “big bang” approach — that typically involves the adoption of inappropriate funding and remuneration methods — is a major contributor to the failure of many primary care projects.<sup>12</sup>

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<sup>12</sup> Hutchison B, Abelson J, Lavis J. Primary care in Canada: so much innovation, so little change. *Health Aff* 2001 May/Jun; 20(3):116-31.

Every system of remuneration has its strengths and weaknesses. Canadians should not be led to think that movement away from fee-for-service remuneration of physicians will provide them with better care. How physicians (and other health care providers) are paid should be a means to an end, not an end unto itself. Nevertheless, physicians are willing to consider other appropriate methods of remuneration in appropriate circumstances.

Physicians must be given a choice about their method of payment. Experience has taught us that a “one size fits all” approach to compensation does not work. Furthermore, any remuneration arrangement must preserve and protect physician autonomy and the ability of the physician to act as an advocate for his or her patients.

In 2001, the CMA developed a policy on physician compensation (Appendix K) that is based on the following principles.

#### **CMA Policy on Physician Compensation: Basic Principles**

- Medical practitioners must receive fair, reasonable and equitable remuneration for the full spectrum of their professional activities.
- Physicians need to receive reasonable consideration and compensation when facilities and programs are discontinued, reduced or transferred.
- Individual medical practitioners have the liberty to choose among payment methods.
- Payment systems must not compromise the ability of physicians to provide high-quality cost-effective medical services.
- Payment mechanisms must allow for a reasonable quality of life.
- Provincial and territorial government resources and funding for physician services must be allocated directly to physicians for services provided.
- All physicians, including those indirectly affected, have the right to representation in negotiations on issues of payment, funding, and the terms and conditions of their work.
- Paying agencies must fulfill the terms of agreement negotiated with legitimate agents of the medical profession and be obliged to honour a mutually agreed-upon and established process of negotiation with those agents.
- In the event of failure of negotiations relating to physician compensation, such disagreement must be resolved by a mutually agreed-upon, timely process of dispute resolution.
- The federal minister of health must enforce the provisions of the *Canada Health Act* relevant to physician compensation (section 12.2).

#### **Recommendation 26**

That governments respect the principles contained in the CMA’s policy on physician compensation and the terms of duly negotiated agreements.

### 8.3 Rural Health Care

Canadian physicians and other health care professionals are greatly frustrated by the impact that health care budget cuts and reorganization have had, and continue to have, on the timely provision of quality care to patients and on general working conditions. For physicians who practise in rural and remote communities, this impact is exacerbated by the breadth of their practice, long working hours, lifestyle restrictions created by on-call responsibilities, geographic isolation and lack of professional backup and access to specialist services.

In 2000, the CMA developed a policy statement on rural and remote practice (Appendix L) to help governments, policymakers, communities and others involved in the retention of physicians understand the various professional and personal factors that must be addressed to retain and recruit physicians to rural and remote areas. The 28 recommendations address training, compensation and work and lifestyle support issues.

Training for rural practice must span the full medical career lifecycle, from recruitment of candidates likely to enter rural practice to special skills training, retraining and continuing professional development. Compensation must reflect the degree of isolation, level of responsibility, frequency of on-call duty, breadth of practice and additional skills.

Consideration must also be given to the broader social issues of the physician and his or her family, as well as the need to facilitate the availability of locum tenens, particularly across jurisdictional boundaries. There is a need to ensure that there is sufficient availability of physicians so that on-call requirements are manageable and that adequate professional backup is provided, e.g., locum services currently offered through provincial and territorial medical associations.

We concur with the observation made by the Society of Rural Physicians of Canada in their August 2001 submission to the Commission that Canada needs a national rural health strategy. The aim of the strategy would be to look at the systemic barriers to meeting the needs of rural Canadians and to provide strategic program funding to catalyze change.

#### **Recommendation 27**

That governments work with universities, colleges, professional associations and communities to develop a national rural and remote health strategy for Canada.

## 8.4 Emerging and Supportive Roles in Health Care Delivery

### 8.4.1 Private sector

Canada has a mixed system of public–private delivery and public–private financing, as illustrated in the following diagram with all four possible combinations.

		Delivery	
		Public	Private
Financing	Public	Public delivery/ public financing  (e.g., public hospital services)	Private delivery/ public financing  (e.g., doctor’s office care)
	Private	Public delivery/ private financing  (e.g., private room in a public hospital)	Private delivery/ private financing  (e.g., cosmetic surgery)

No issue in Canadian health policy has generated more controversy than the role of the private sector. As we move forward with the renewal of Medicare, it will be important for Canadians to understand the distinction between private delivery and private funding. The appropriate mix of public and private should not be based on ideology, but rather on the optimal use of resources.

Health care is delivered mainly by private providers including physicians, pharmacists, private not-for-profit hospitals, private long-term care facilities, private diagnostic and testing facilities, rehabilitation centres. (In addition, supplies from food and laundry to drugs and technology are provided almost exclusively by the private sector.) This significant level of private-sector delivery has served Canada well. Accordingly, the CMA supports a continuing and major role for the private sector in the delivery of health care. However, we are not proposing a parallel private system.

There may be a growing role for private delivery. We would encourage this as long as the services can be provided cost-effectively. As with the public sector, any private-sector involvement in health care must be patient-centred as well as open, transparent and accountable. Furthermore, it must be strictly regulated to ensure that high standards of quality care are being met and monitored.

#### Recommendation 28

That Canada’s health care system make optimal use of the private sector in the delivery of publicly financed health care provided that it meets the same standards of quality as the public system.

### 8.4.2 *Voluntary sector*

The voluntary sector, including many charities and consumer advocacy groups, has played a critical role in the development of the public health system — providing and funding services, programs, equipment and facilities. Much of the capital infrastructure development, especially in hospitals, has been made possible through the fundraising efforts of charity foundations and service organizations. In addition, many patient support services such as “Meals on Wheels” exist only because of the efforts of volunteer groups.

Although the voluntary sector is a major asset for Canada’s health care system, it is critical for governments to fulfill their obligation to support publicly financed health care. Governments must avoid passing off their responsibilities to the voluntary sector, which is already stretched to the limit. Governments should not abuse the voluntary sector, but should properly fund the public health system’s ongoing operating costs and capital expenditures.

The voluntary sector should be formally recognized for the contribution it makes to the health care system. Many of these organizations operate on a shoestring budget with limited capacity to respond to the increasing demands being placed on them.

#### **Recommendation 29**

That governments examine ways to recognize and support the role of the voluntary sector in the funding and delivery of health care, including enhanced tax credits.

### 8.4.3 *Informal caregivers*

Informal caregivers — particularly those who provide care for ailing relatives and friends — play an essential role in the health care system. The massive off-loading onto these caregivers has gone unrecognized. The costs of providing this kind of care go beyond identifiable dollar amounts such as loss of income. Many indirect costs, including emotional strain on the caregivers and their families, must also be acknowledged with support provided by governments and employers.

Patients often prefer to receive their care at home, but it cannot be assumed that care provided at home is better for the patient than that provided within a health care institution. Resources must be made available to ensure that the care patients receive at home is acceptable. Increased financial support should be provided to informal caregivers through the tax system. Refundable tax credits and a program for family leave are two examples of this support.

#### **Recommendation 30**

That governments support the contributions of informal caregivers through the tax system.



# Conclusions

Canada's health care system is at a crossroads. We need to act now to ensure that our health care system will be able to meet the current and future health care needs of Canadians. Canadians are looking for real solutions that will have meaningful results. This means not only addressing the most critical issues such as health human resources, infrastructure and delivery mechanisms, but also implementing system-wide structural and procedural changes. It also means involving all key stakeholders in the decision-making process at all levels.

In this second submission to the Commission on the Future of Health Care in Canada, the CMA has offered solutions that are patient-centred and reflect Canadian values of a publicly funded system that is sustainable and accountable and provides timely access to high-quality care. These recommendations form a complete, integrated package that should be implemented as a whole to be successful.

The CMA would like to thank the Commission for providing this opportunity to submit our *Prescription for Sustainability* and we wish the Commission every success in developing a concrete plan for revitalizing our cherished Canadian health care system.

## **APPENDICES**

- A: Getting the Diagnosis Right...Toward a Sustainable Future for Canadian Health Care Policy
- B: Getting it Right: A values-based approach to a sustainable health system for Canada
- C: A Review of National Advisory and Oversight Bodies
- D: Core and Comprehensive Health Care Services
- E: Operational Principles for the Measurement and Management of Waiting Lists
- F: CMA/NAHO Letter of Intent
- G: Scopes of Practice
- H: Whither the Federal Government's Medical Equipment Fund? (Will be released Summer 2002)
- I: Securing our Future...Balancing Urgent Health Care Needs of Today With The Important Challenges of Tomorrow
- J: Advancing Electronic Health Records: CMA Working Principles and Recommendations
- K: CMA Policy: Physician Compensation (update 2001)
- L: Rural and Remote Practice Issues