

Turning the Corner: From Debate to Action

Presentation to the
Standing Committee on Finance
Pre-Budget Consultations

October 22, 2002

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A healthy population...a vibrant medical profession
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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 54,000 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 organisation representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and 43 affiliated medical organisations.

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EXECUTIVE SUMMARY

Canadians are deeply concerned about their health care system. They worry about situations such as whether they will have access to diagnostic testing when they need it or whether they can get a family physician if they move to a new community. This is not what was envisioned when Canada embarked upon a universal public health care system in 1966. Over the past two years an unprecedented number of reports and commissions have been examining what can and must be done to ensure the long-term sustainability of the system. But Canadians are growing impatient. The time for studying the issues is quickly passing. They are counting on governments, to listen to the reports and then act upon them quickly – turning the corner from debate to action.

This year's submission from the CMA to the Standing Committee on Finance focuses on the need for action in the short and longer terms by identifying strategic investments that will ensure a strong health care *system* that is securely supported by a dependable and comprehensive public health infrastructure as its foundation. Hand in hand with new financing, the CMA firmly believes that additional financing must be accompanied by updated governance structures, including a Canadian Health Charter and a Canadian Health Commission that can inject real accountability into the system.

The CMA believes that the federal government has responsibility, alongside the provinces and territories, to increase its financial support of Canada's health care system. Only by increasing funding and identifying clearly the amount allocated to health will the federal government be able to regain its position as an equal player with the provinces.

In our submission to the Commission on the Future of Health Care in Canada, the CMA recommended that the federal contribution to the public health care system be locked in for a 5-year period. We indicated that the longer-term goal would be for the federal contribution to rise to 50% of total spending for core services over time as new and improved services and technologies products became available. We also said that it should be tied to a built-in GDP-growth escalator once that target is reached. To be specific, in order to raise funding to the 50% target level the CMA recommends that funding for new services and technologies be introduced on a 50/50 cost-sharing basis. This would encourage provinces and territories to become early adopters of new technology and help to update the basket of core services available to Canadians.

For illustration purposes the CMA recommends an initial investment of \$16 billion over the first five years starting in 2003/04 with the majority of that funding weighted towards the back-end of the five-year period. This investment would take us partway (45 federal/55 provincial cost sharing) towards reaching our goal of 50/50 cost sharing.

To further support funding for health care across the country, a buffer is needed to protect provincial and territorial health care budgets from the ebbs and flows of the economic cycle. This could be done, for example, by renewing the Fiscal Stabilisation Program or removing the cap on the current Equalisation program.

In conjunction with the longer-term financing needs of Canada's health care system, there are some urgent objectives that cannot wait for governments to finalise and implement their plan. The pressing nature of these issues warrants the use of one-time, targeted, special-purpose transfers in the areas of health human resources supply and training; capital infrastructure; and health information technology.

Finally, last year, our submission reflected Canadians' concerns following the September 11, 2001 events in the United States. It highlighted people's anxiety about security in our country, the safety of our airlines and the vulnerability of our public health infrastructure and health care systems to potential threats. We believe that this work has not been completed and there is ongoing need to support public health as a priority for Canada's health care system particularly in the areas of emergency preparedness, childhood immunisation and a national drug strategy.

Reform of Canada's health care system is a formidable task. It involves the participation and agreement of all levels of government as well as providers, other stakeholders and ultimately the acceptance of the end-users, Canadians. The CMA looks forward eagerly to the Romanow Commission's recommendations and those of the Senate Committee. We will be watching carefully over the coming months on behalf of Canadian physicians, and our patients, to ensure that these discussions result in a timely, action-oriented response and that involvement of the community of providers is early, ongoing and meaningful. Canadian physicians are ready to do our part, all we ask is for the opportunity.

INTRODUCTION

The Canadian Medical Association (CMA) values participating once again in the Standing Committee on Finance’s Pre-Budget Consultations process. We see these consultations as an essential part of Canada’s democratic process, allowing non-government organisations and individuals the opportunity to provide input into the government’s fiscal agenda.

We know Canadians value their health care system and the high-quality treatment they receive. What concerns them is whether they’ll be able to access the care they need when and where they need it. The past two years have seen the most significant public concern over Canada’s health care system in a generation. Governments have responded by examining the system through an unprecedented number of reports and commissions. In addition to the Commission on the Future of Health Care in Canada (the Romanow Commission) and the Standing Senate Committee on Social Affairs, Science and Technology’s work on the state of the health care system (the Kirby Commission), since 2000 there have been four other major provincial reviews of health care systems in Canada.ⁱ

Canadians are now looking to governments to turn the corner from studying what needs to be done to acting upon this work. This year’s submission from the CMA to the Standing Committee on Finance focuses on this need for action in the short and longer terms by identifying strategic investments that will ensure a strong health care *system* that is securely supported by a dependable and comprehensive public health infrastructure as its foundation. In this way, it is the belief of the CMA that health and health care go hand in hand.

The CMA believes that to achieve real reform, more than “tweaking” of our current system is required. We see change as requiring a fundamental rethinking of the system including its governance and accountability structures in order to move forward and turn the corner towards a sustainable health care system. The momentum created with the release of the Romanow Commission’s report provides a unique opportunity for the federal government, in partnership with the provinces and territories, to capitalise on that energy by responding in a substantive way to the report within 100 days of its release with an implementation plan.

We were very encouraged by the commitment made in the September 30, 2002 Speech from the Throne to hold a First Ministers’ Meeting early in 2003 to put in place a comprehensive plan for reform. We were also encouraged by the commitment to an action plan in the areas of health policy under direct federal jurisdiction such as addressing emerging health risks and the adoption of modern technology.

The Prime Minister will convene a First Ministers’ Meeting early in 2003 to put in place a comprehensive plan for reform, including enhanced accountability to Canadians and the necessary federal long-term investments, which will be included in the next budget.

Speech from the Throne,
September 30, 2002

We will be watching carefully over the coming months on behalf of Canadian physicians, and our patients, to ensure that these discussions result in a timely, action-oriented response and that involvement of the community of providers is early, ongoing and meaningful.

ACCOUNTABILITY

On June 6, 2002, the CMA released its final submission to the Romanow Commission, *A Prescription for Sustainability*. In this submission, we outlined what the Commissioner called “bold and intriguing” changes to reaffirm and realign our health care system. Specifically, the CMA report laid out an approach for the renewal of Canada’s health care system comprised of three essential interrelated components: a Canadian Health Charter; a Canadian Health Commission; and renewal of the federal legislative framework (including federal-provincial fiscal transfers).

Canada’s health care system does not have the governance structures in place to provide for real accountability or transparency. Often governments meet behind closed doors and make decisions with little or no input from those who ultimately have to implement change and use the system. Rather, full accountability requires the involvement of all key players – federal and provincial/territorial governments, health care providers and patients.

Fundamentally, the current lack of accountability in Canada’s health care system comes down to an inherent conflict of interest between public accountability, which Canadians are demanding, and governments’ desire to retain maximum fiscal control and flexibility. Even with increased cash transfers identified in the September 2000 First Ministers Accord, the federal government has fallen well short of providing the necessary funding to ensure compliance with national principles today and for the future. Clearly, the financial means must be equal to the desired health outcomes. The CMA believes that with appropriate financial reinvestment and updated governance structures the federal government will be on the path towards putting *national* back into national health care insurance system.

Canadian Health Charter

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.ⁱⁱ Increasingly, this has resulted in an unacceptable degree of uncertainty not only for patients but also for health care providers and ultimately for those (both private and public) who contribute to the financing of the health care system.

A Canadian Health Charter would underline governments’ shared commitment to ensuring that Canadians have access to quality health care within an acceptable time frame. It would 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.

Canadian Health Commission

Creating a permanent, independent Canadian Health Commission, would help address the lack of transparency and accountability at the national level. It would create an institution, the very purpose of which would be to report annually to Canadians on the performance of the health care system and the health status of the population. It would put health on the same level as other national priorities such as the environment, transportation and research. Its legitimacy would be strengthened by not having to report to any one government or governments. Rather it would forge a direct reporting relationship with Canadians and not leave Canadians hostage to ongoing inter-governmental disputes.

A Canadian Health Commission would also be uniquely situated to provide ongoing advice and guidance on other key national health care issues. Issues 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; and developing national goals and targets to improve the health of Canadians.

ENHANCED ACCOUNTABILITY

- Implement a Canadian Health Charter and provide federal funding for a permanent Canadian Health Commission to reaffirm Medicare's social contract and to promote accountability and transparency within the health care system.

FINANCING REQUIREMENTS

Long-Term Investments

Improved accountability is an essential, but not complete, answer with respect to reforming Canada's health care system. The CMA believes that the federal government has a responsibility, alongside the provinces and territories, to increase its financial support of Canada's health care system. At the same time, the CMA also believes that governments must provide financing in an accountable and transparent manner that links the funding sources with the use of those funds.

The way we see it, much of the current tension between the two levels of government on health care issues can be traced back to unilateral federal changes to the funding formula. It started with the first changes to the Established Programs Financing (EPF) in 1982, and culminated with the introduction of the Canada Health and Social Transfer (CHST – 1995) when the federal government unilaterally announced substantially reduced funding for health, social services and post-secondary education. By claiming to spend the same taxpayers dollar three times – once for health, again for post secondary education and again for social services – the federal government's moral authority to uphold national principles for health is undermined.

Together, these initiatives weaken the federal government's legitimacy in health care and encumber its ability to stand-up for Canadians, as was highlighted in the most recent Auditor General's report.

In order to regain this authority the federal government must be willing to clearly identify a discrete contribution to health care that is large enough so as to be relevant in all jurisdictions. In our submission to the Commission on the Future of Health Care in Canada, we recommended that the federal contribution to the public health care system be locked in for a 5-year period. We indicated that the longer-term goal would be for the federal contribution to rise to 50% of total spending for core services over time as new and improved services and technologies became available. We also said that it should be tied to a built-in GDP-growth escalator once that target is reached.

This submission provides more detailed financial projections and recommendations on the federal contribution to the health care system. To be specific, in order to raise funding to the 50% target level the CMA recommends that financing of new services and technologies be introduced on a 50/50 cost-sharing basis. This would encourage provinces and territories to become early adopters of new technology and help to update the basket of core services available to Canadians. How quickly 50% cost-sharing of all core services were realised would depend on the rate of uptake of new technologies. However, for illustration purposes the CMA recommends an initial investment of \$16 billion over the first five years starting in 2003/04 with the majority of that funding weighted towards the back-end of the five-year period. This investment would take us partway (45 federal/55 provincial cost sharing) towards reaching our goal of 50/50 cost sharing. The expectation would also be that expansion beyond the current basket of services would be funded on a 50/50 cost-sharing basis.

The key message is that the federal government must be an equal partner with the provinces and territories in providing funding for new pressures. This includes taking measures to meet the needs of Canadians living in rural and remote areas where there are unique considerations with respect to ensuring access to, and support of, physicians and other health care services.

To further support funding for health care across the country, a buffer is needed to protect provincial and territorial health care budgets from the ebbs and flows of the economic cycle. As well, varying fiscal capacities of individual provinces and territories has made it increasingly difficult to ensure the provision of reasonably comparable health services across Canada.

Currently, the federal Fiscal Stabilisation 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%. The federal Equalisation program also provides some protection for have-not provinces. However, its effectiveness is limited by virtue of the "ceiling provision" that places a cap on increases in payments to the rate of national GDP growth. This provision was temporarily lifted for fiscal year 1999/2000 in conjunction with the September 2000 health accord, generating an additional \$700 million in Equalisation payments to the have-not provinces.

It is the CMA's belief that this ceiling is one of the contributing factors to the disparity that exists between provinces in their capacity to provide funding for health care services and as such, should be permanently removed.

Making improvements to either or both of these programs would help address the concern raised in the CMA's submission to the Romanow Commission on the need to provide provinces with ways to curb the impact on the health care system from the ebbs and flows of the business cycle.

LONG-TERM FINANCING REQUIREMENTS (\$16 Billion over 5 years)

- Provide funding for new core services and technologies on a 50/50 cost-shared basis with the ultimate goal of reaching 50% of provincial/territorial spending on core services over time.
- Provide greater protection against provincial/territorial revenue shortfalls for example by removing the ceiling on the federal Equalisation program or enhancing the federal Fiscal Stabilisation Program.

Short-Term Bridge Financing of Health Infrastructure

In conjunction with the longer-term financing needs of Canada's health care system, there are some urgent objectives that cannot wait for governments to finalise and implement their plan. We think of these shorter-term objectives as requiring "bridge financing" in areas of health infrastructure that are necessary to support health care innovation.

As roads and highways are the backbone to the production and delivery of products, so too is Canada's health infrastructure the foundation on which the health care system delivers care to Canadians. We applaud the Canadian Foundation for Innovation and other similar programs for their important contributions in this area. Increasingly, however, "infrastructure" incorporates more than bricks and mortar – it can also mean providing improving health information capacity in hospitals; providing human resource infrastructure or the latest diagnostic equipment. Experience has taught us that investments of this type lead to increased innovation, productivity and efficiency.

The pressing nature of these issues warrants the use of one-time, targeted, special-purpose transfersⁱⁱⁱ specifically in the areas of:

- Health human resources supply and training;
- Capital infrastructure; and
- Health information technology.

Health Human Resources Supply and Training

Consistently, Canadians point to the shortage of physicians as a key health care system concern. 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 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 population.^{iv}

The need is particularly great in rural and remote areas where 30% of Canadians live but where only approximately 10% of Canadian physicians practice.^v This is complicated by the fact that accessing services for patients in rural and remote areas can be difficult. In a survey done by the CMA in 1999, physicians living in rural communities indicated that their level of professional satisfaction – i.e., how they are able to meet the health care needs of their patients – fell significantly since the early 1990s. In a striking example, only 17% reported being very satisfied with the availability of hospital services in 1999 compared to 40% in 1991.

The necessary increases in undergraduate enrolment in medicine needed to address this situation 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. In addition, capacity must be sufficient to provide training to international medical graduates and allow currently practising physicians the opportunity to return to school to obtain postgraduate training in new skill areas.^{vi}

As well, 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), between 1996 and 2001 average first-year medical school tuition fees increased 100%. In Ontario, they went up by 223% over the same period. Student financial support through loans and scholarships has simply not kept pace with this rapid escalation in tuition fees.

Findings from recent research show that high tuition fees and fear of high debt loads create barriers that discourage people to apply to medical school and potentially threaten the socio-economic diversity of future physicians serving the public. They may 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. In addition, high debt loads may influence physicians’ choice of specialty and practice location.

Medical Equipment and other Capital Infrastructure

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

In September 2000, the federal government announced a series of new investments to support agreements by First Ministers on Health Renewal and Early Childhood Development. One of these investments was a two-year \$1 billion fund for the provinces and territories, the Medical Equipment Fund (MEF), to purchase new health technologies and diagnostic equipment. However, analysis done by the CMA suggests that of the \$1 billion allocated through the Medical Equipment Fund, only approximately 60% was used to pay for new (incremental) expenditures on medical equipment. It appears the remaining 40% replaced what provinces and territories would have already spent in this area from their own funding sources.

Additional analysis suggests that there continues to be a significant gap between access in Canada to medical equipment and availability of medical equipment in other OECD countries. Cost estimates suggest that an additional investment of some \$1.15 billion in health technology is still needed to bring Canada up to the level of the 7-country OECD comparator country average. Of that amount \$650 million is required for capital expenditures and \$500 million is required to provide the provinces/territories with 3 years of operating funds.

All governments have the responsibility to be transparent and accountable to taxpayers for health care spending. The conditions of the Medical Equipment Fund did not live up to this responsibility. Provinces and territories provided widely variable and often incomplete information that is largely inaccessible to the public, and at the very least difficult to trace. To this end, one of the responsibilities envisioned for a Canadian Health Commission would be to report on the health of health care in Canada and keep Canadians informed as to how their taxpayer dollars are being spent.

Health Information Technology

While the health sector is as information intensive as other industries, it has lagged behind other sectors in investing in information and communication technologies (ICTs). The benefits that ICT promises to deliver the health care system include better quality care, enhanced access to health services (particularly for those 30% of Canadians living in rural and remote locations), and better utilisation of scarce human health resources.

As part of the September 2000 Health Accord, the federal government invested \$500 million to create Canada Health Infoway Inc. with a mandate to accelerate the development and adoption of modern systems of information technology, such as electronic patient records. The CMA applauds this investment, but notes that the \$500-million needs to be seen as a “down-payment”. It provides only a fraction of the \$4.1 billion the CMA estimates it would cost to fully connect the Canadian health care system with all the health benefits that would flow from this in terms of improved national safety and a reduced number of duplicate tests.

Studies point to two key ingredients for successful uptake of information and communication technology: creating mechanisms to help people adapt to the new environment and testing out solutions in real work situations before moving to full-scale implementation. To date, very little investment has been directed towards helping providers prepare for new investments in infrastructure being made by the provinces, territories and the federal government.

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 multi-stakeholder process.

As well, currently the majority of ICT investments have targeted acute care and primary care settings. Changing demographics in the Canadian population suggest that new pressures are likely to emerge in home care settings – an area that has hitherto been largely neglected with respect to ICT and is currently ill equipped to cope with growing demand. A potential safety valve that could be made available, however, is the application of remote healthcare solutions amenable to care provided in the home.

SHORT-TERM BRIDGE FINANCING (\$2.5B over five years)

- Establish a \$1-billion, five-year Health Resources Education and Training Fund.
- Increase targeted funding to post-secondary institutions to alleviate some of the pressures driving the rise in tuition fees. Provide enhanced direct financial support to students, in particular, through bursaries and scholarships.
- Establish a one-time catch-up fund of \$1.15 billion to restore medical equipment to an acceptable level.
- Assist providers to improve and/or gain skill sets to work to become more ICT enabled and provide for aggressive piloting of remote ICT solutions.

Revenue Sources

The proposals as outlined above for the overall financing of the health care system recommend an incremental approach to increased federal support for health care with the more significant investments not beginning until after 2005/06. We feel that this approach would allow for the majority of funds to come from within existing (or anticipated) fiscal frameworks.

Within the context of broader discussion, the CMA brought together key experts on September 25, 2002 to discuss issues related to the interface between tax and health. One of the issues discussed was the potential for using earmarked taxes as a mechanism for raising revenue, particularly for short-term capital-type investments. With respect to any new funding mechanism, there was agreement on the need to take into account the principles of fairness, progressivity and horizontal and vertical equity in determining any new source of funding for health care services.

While some suggest that efficiencies remain in the system, that if eliminated could provide funding for future health care needs, this is not the view of CMA members working on the front-line of the health care system. CMA's challenge to governments is to not allow the lack of a revenue source to provide an excuse for not proceeding with health care reform in Canada. The CMA is looking forward to the recommendations in the Kirby and Romanow reports to further inform work in this area.

INVESTMENTS IN PUBLIC HEALTH

In essence, public health is the organised response by society to protect and promote health and to prevent illness, injury and disability. These efforts require co-ordination and co-operation between individuals, federal, provincial, territorial, and municipal governments, community organisations and the private sector. A major component of public health is focused on the promotion of healthy living to improve the health status of the population and reduce the burden and impact of chronic and infectious diseases. A recent commitment of \$4.3 billion in the U.S. for the Centers for Disease Control and Prevention challenges us to equally support activities that further strengthen Canada's public health system.^{vii}

The September 30, 2002 Speech from the Throne noted the importance of a strong public health system and promised to “move ahead with an action plan in health policy areas under its direct responsibility” including addressing emerging risks, adapting to modern technology and emphasizing health prevention activities. We see this as an important commitment and will be watching closely as the plan is developed. In the meantime, we have identified three areas of public health that require more immediate federal assistance.

Emergency Preparedness

Last year our submission to the Standing Committee addressed the urgent health security and health care issues arising out of the tragic events of September 11, 2001 in the United States. The CMA raised serious concerns with the ability of Canada's public health care system to respond to disasters and made a number of recommendations to address national preparedness in terms of security, health and capacity of the system. While there has been some movement towards meeting these needs, the CMA firmly believes that there remain significant shortcomings in our capacity to respond to health care emergencies.

At the time of an emergency, among the first points of contact with the health system for Canadians are doctors' offices and hospital emergency rooms. As noted in past CMA submissions to the Standing Committee, we have witnessed in recent years the enormous strain these facilities can face when even something quite routine like influenza strikes a community.

Regardless of how well prepared any municipality is, under certain circumstances public health officials will need to turn to the province, territory and/or the federal government for help. The success of such a multi-jurisdictional approach is contingent upon good planning beforehand between the federal, provincial/territorial and local-level governments. There is an important role for the federal government to urgently improve the co-ordination amongst authorities and reduce the variability between various response plans in co-operation with provincial authorities (including assisting in the preparation of plans where none exist).

Childhood Immunisation

At the beginning of the last century, infectious diseases were the leading cause of death worldwide. In Canada, they are now responsible for less than 5% of all deaths thanks to immunisation programs. Immunisation protects an entire population by preventing the spread of disease from one individual to another: the more people immunised, the less chance of disease. To minimise the spread of vaccine-preventable diseases the maintenance of very high levels of immunisation is required. The National Advisory Committee on Immunisation (NACI) has provided general Canadian recommendations on the use of vaccines, drawing upon the expertise of specialists in public health, infectious diseases and paediatrics from across the country.

Canadian children in all provinces are routinely immunised against nine diseases. For approximately \$150 worth of vaccines, a Canadian child can be vaccinated against these diseases from infancy to adolescence, the impact of which can last a lifetime. Unfortunately, the level of immunisation varies across Canada. This is unacceptable. All children in Canada should and must have the protection that current science has made available against vaccine-preventable diseases according to the recommendations of public health experts.

The CMA recommends a two-step strategy. First we encourage the federal government to work with the provinces and territories to jointly develop goals in the area of vaccination, such as linking record-keeping systems, implementing vaccine safety guidelines and seeking purchasing partnerships. Second, we urge the federal government to work within this framework to ensure that three new vaccines be introduced across the country to prevent children from contracting varicella (chicken pox); meningitis and pneumococcus (the leading cause of invasive bacterial infections, bacterial pneumonia and middle ear infection in children).

National Drug Strategy

The development of a national strategy for addressing issues related to illicit drug use should be a priority for federal leadership and investment. Illicit drug use has adverse effects on the personal health of Canadians and the well-being of society. The CMA believes that the government must take a broad public-health policy approach to address illicit drug use.

A single-handed criminal justice approach to dealing with illicit drug use is inappropriate particularly when there is increasing consensus that it is ineffective and exacerbates harm. Addiction should be regarded as a disease and therefore, individuals suffering with drug dependency should be diverted, whenever possible, from the criminal justice system to treatment and rehabilitation.

We applaud the recent commitment in the September 30, 2002 Speech from the Throne to implement a national drug strategy to address addiction while promoting public safety. In keeping with this, the CMA urges the government to fully implement and evaluate a national drug strategy prior to proceeding with any movement toward changes in the legal status of marijuana.

INVESTMENTS IN PUBLIC HEALTH (\$700 million over three years)

- Create an assistance fund for municipal and provincial authorities to support public health infrastructure renewal at a local level, improve the co-ordination among public health officials, police, fire and ambulance services, hospitals and other services and to support the infrastructure for public health emergency response.
- Continue to invest in the resources and infrastructure (i.e., medical supplies, equipment, laboratory facilities, and training for health care professionals) needed to anticipate and respond to disasters.
- Implement a National Immunisation Strategy to achieve the optimal level of immunisation for all Canadians and ensure coverage of all children with routinely recommended childhood vaccines.
- Develop a comprehensive national drug strategy on the non-medical use of drugs that re-balances the distribution of resources so that a greater proportion is allocated to drug treatment, prevention, cessation and harm reduction.

CONCLUSION

Reform of Canada's health care system is a formidable task. It involves the participation and agreement of all levels of government. It also requires that providers, other stakeholders and ultimately the acceptance of the end-user, Canadians are at the planning table. The Commission on the Future of Health Care in Canada, over the past year and a half, has undertaken a vast review of the issues impacting Canada's health care system including Canadians' values. As providers of care at the front-line of the health care system, Canadian physicians see themselves as key partners in this reform.

The CMA will be looking eagerly at the Romanow Commission's recommendations and those of the Senate Committee. We will be holding the federal, provincial and territorial governments accountable for implementing, in a timely fashion, a response with clear deliverables. Clearly, we see the report's release as offering a short window of opportunity to turn the corner on health care system reform. We need to act now and not just wait for the system to fix itself. Canadian physicians are ready to do our part, all we ask is for the opportunity.

ENDNOTES

ⁱ Since 2000 there have been four major provincial reviews of their health care systems (Caring for Medicare: Sustaining a Quality System (the Fyke Commission), April 2001; la commission d'étude sur les services de santé et les services sociaux (the Clair Commission); Patients First: Renewal and Reform of British Columbia's Health Care System, December 2001; A Framework for Reform: Report of the Premier's Advisory Council on Health (the Mazankowski Report), January, 2002.

ⁱⁱ 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.

ⁱⁱⁱ Precedents for these types of transfers include the National Health Grants Program created in 1948 to develop hospital infrastructure across the country. More recently, several funds were created to support early child development, medical equipment, the health infoway and primary care renewal at the time of the First Ministers' Agreement on Health in September 2000.

^{iv} Organisation for Economic Cooperation and Development. *Health at a Glance*. Paris, France: OECD; 2001.

^v The CMA has developed a policy on Rural and Remote Practice Issues which was released on October 17, 2000 (CMAJ, October 17, 2000, Vol. 163 (8)).

^{vi} Canadian Medical Forum 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 Interns and Residents, Federation of Medical Licensing Authorities of Canada, Medical Council of Canada, and Association of Canadian Academic Healthcare Organizations.

^{vii} As announced on December 20, 2001 by the United States Department of Health and Human Services. Copy available at: <http://www.hhs.gov/news>