

SEIZING THE OPPORTUNITY: ONE TIME FEDERAL INVESTMENTS IN HEALTH

Supplementary Brief to the Standing
Committee on Finance
Pre-Budget Consultations

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ASSOCIATION
MÉDICALE
CANADIENNE



CANADIAN
MEDICAL
ASSOCIATION

*A healthy population...a vibrant medical profession
Une population en santé...une profession médicale dynamique*

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 organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and 43 affiliated medical organizations.

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INTRODUCTION

This year's submission from the Canadian Medical Association (CMA) to the Standing Committee on Finance focused on the need for action in the short and longer terms by identifying strategic investments that will ensure a strong health care *system* supported by a dependable and comprehensive public health infrastructure as its foundation. Specifically, the CMA recommended an initial investment of \$16 billion over five years starting in 2003/04 and an additional \$3.2 billion for shorter-term and public health initiatives.

Following our October 22, 2002 presentation to the Standing Committee on Finance, the CMA has developed four supplementary specific proposals for one-time funding in areas of urgent national need. They represent highly visible initiatives that, taken together, would substantially enhance Canada's capacity in the health care sector in areas of federal jurisdiction. They are:

ACCESS HOME (*Accelerating Community Care through Electronic Services*)

Funding of specific sites across Canada to undertake aggressive, large scale project implementation of remote information and communication technology (ICT) solutions to facilitate care in home and community based settings.

PRO-MISe (*Pro Medical Immigrant Selection*)

Establishment of an international off-shore assessment program to pre-screen potential medical graduates who wish to immigrate to and practice medicine in Canada.

RREAL HEALTH Communication and Coordination Initiative (*Rapid, Reliable, Effective, Accessible and Linked*)

Increased capacity in areas of public health system to ensure communication in real time, both between multiple agencies and with health care providers, especially in times of national emergency or to meet national health needs.

PAN-CANADIAN NETWORKS OF CLINICAL EXCELLENCE

Improved national planning for specialty care across Canada by implementing needs-based planning tools; building synergies around areas of expertise; maximizing the efficiency in the delivery of care;

and creating mechanisms for ensuring timely access to highly specialized quaternary care throughout Canada.

This initial facet of a comprehensive federal reinvestment strategy corresponds with priorities identified in the Speech from the Throne and with the strategic priorities identified in our submission to the Standing Committee on Finance. Together, they constitute an important next step toward implementing the government's Speech from the Throne commitments. However, given the particular urgency of these initiatives, and their ability to stand as independent projects, we feel they would be excellent candidates for modest but meaningful allocations from the federal surplus that may become available towards the end of this fiscal year.

Each of these proposals incorporates a highly visible, targeted approach that not only builds the necessary evidence for transition to a renewed health care system but is also amenable to one-time funding. They reflect priorities that, due to their inter-jurisdictional nature, are highly unlikely to be undertaken by the provinces and territories without federal assistance. They would substantially reduce the uncertainties that Canadians feel and experience in dealing with the health system. Indeed, these initiatives provide an opportunity for the federal government to show immediate leadership in areas that fall clearly under its jurisdiction in ways that are certain to be complementary to the recommendations from the Commission on the Future of Canada (the Romanow Commission).

The Canadian Medical Association believes that the time for targeted action is now as part of a comprehensive strategy for a sustainable health care system. Canadians are counting on governments to turn the corner from debating what needs to be done to implementing necessary changes. We see time-limited, targeted reinvestments as an essential part of this renewal.

ACCESS HOME

*Accelerating Community Care through
Electronic Services*

RATIONALE

In the September 2000 Health Accord, health information and communications technology (ICT) was highlighted as an area where First Ministers agreed to work together to strengthen a Canada-wide health infostructure to improve quality, access and timeliness of health care for Canadians. As part of the funding initiatives announced at that time, Canada Health Infoway Inc. (CHII), received \$500 million in funding to accelerate the adoption of modern ICTs to provide better health care.

Given that implementation of a full health ICT strategy will require significantly more funding, CHII has given priority to the development of the electronic health record. Further, with the sunseting of the two-year \$80 million Canada Health Infostructure Partnerships Program (CHIPPP) there are no other federal programs that provide funding for ITC pilot projects.

Changing demographics in the Canadian population point to emerging pressures to meet increased non-institutional care needs of our aging population. To date, the home care sector has been largely neglected with respect to ICT – the majority of current ICT investments target acute and, to a lesser extent, primary care settings – and is currently ill equipped to cope with growing demand.

Remote healthcare solutions show considerable potential to improve the care provided in home and community settings. Current projects in this area have demonstrated the benefits of using ICTs to facilitate care in non-traditional settings. Larger scale testing of remote ICT solutions should be undertaken to determine how best they can be applied to facilitate the provision of care in home and community based settings, and the implications for provider practice.

GOAL

Through funding of specific sites across Canada (mini centres of excellence), engage in aggressive, large scale project implementations of remote ICT solutions to facilitate care in home and community based settings. This would involve working through how best to apply ICTs in these settings, determining what works best and developing practice procedures for the provider community.

GUIDING PRINCIPLES

The *ACCESS-HOME* proposal is based on the underlying principle of a collaborative model and the following potential key partners have been identified: provinces and territories, regional health authorities, and the private sector (e.g., March Networks).

DELIVERABLES

Undertake, over a three year period, a variety of home and community care projects to learn how best to apply remote ICT solutions to facilitate provision of care in these settings. These could include projects to link primary care physicians to elderly frail patients in their home; to link patients with severe chronic conditions to specialists for remote monitoring of their conditions; to link home care nurses to patients to carry out preventive and promotion related activities on line; and to link physicians with recently discharged patients to monitor their rate of recovery.

Part of the project funding proposal would include an evaluation component to build a knowledge base of what works and why. The assessments then would be placed on the Health Canada web site to promote knowledge transfer.

FUNDING & ACCOUNTABILITY MECHANISMS

A one-time, lump sum endowment of \$50 million in this fiscal year to Canada Health Infoway Inc. (CHII) to manage the program and funds.

Over a three-year period, CHII would operate under a very clear mandate set out by Health Canada to fund projects (\$1-2 million each) across the country, in urban, rural and isolated settings, to more aggressively apply ICTs to facilitate provision of care in home and community based settings and to explore the implications for practice management. Accountability for the funds and the program implementation would be set out in a Memorandum of Understanding between Health Canada and CHII.

Funds would be allocated on a cost-shared basis with a threshold of 70% federal funding. The remaining 30% would come from partnership contributions (in-kind costs, human resources, etc.). It is anticipated that it would take one year to get the projects operational and a second year to implement their mandates. The third year would be dedicated to completing the projects and undertaking evaluations in a format that would contribute to the overall knowledge base in this area.

PRO-MIS_e
*Pro Medical Immigrant
Selection*

PURPOSE

The establishment of an assessment program to pre-screen international medical graduates wanting to immigrate to Canada and practice medicine in this country.

RATIONALE

International medical graduates have always been, and continue to be, a valuable addition to the Canadian medical workforce. Recently, the federal government passed new immigration legislation, changing the focus of immigration requirements away from an occupation basis toward a concentration on skills, training, and potential for successful integration into the Canadian workforce and society.

In light of the implementation of these provisions, the Canadian Medical Association (CMA) and the Medical Council of Canada (MCC) propose the establishment of a *Pro Medical Immigrant Selection (PRO-MIS_e)* program for foreign-trained physicians seeking to immigrate to Canada. The purpose of this program would be to ensure that the anticipated increased numbers of foreign-trained medical graduates applying to immigrate to Canada receive fair treatment.

The CMA and MCC have already had a preliminary meeting with a senior advisor to the Honourable Minister Denis Coderre, Minister of Citizenship and Immigration in follow-up to a meeting with his predecessor, the Honourable Elinor Caplan in May 2001.

GOAL

The goal of the project is to expedite the remote processing of applications by highly qualified international medical graduates who wish to immigrate to, and practice medicine in, Canada. This could be facilitated by creating an off-shore electronic assessment system for pre-screening in their country of origin.

GUIDING PRINCIPLES

In these times of physician workforce shortages, Canadian jurisdictions must be cautioned against “poaching” physicians from under-serviced parts of the world to meet their own health care needs (particularly in under-serviced areas or disciplines). Ethical recruitment practices must be established and maintained.

In the longer term, the Canadian medical community strongly believes that Canada must strive for reasonable self-sufficiency in the production of physicians, while continuing to offer opportunities to qualified international medical graduates.

Even in times of physician shortages, it remains imperative that foreign applicants who wish to practise medicine in Canada undergo a comprehensive assessment of knowledge and skills, on par with the assessment of graduates of Canadian medical schools.

The process for assessing international medical graduates must be, and be seen to be, fair, transparent, and accountable to all stakeholders, expedient and cost-effective (for both the applicant and the government).

DELIVERABLES

The project would be comprised of a three-phased approach. Phase I would set up five pilots sites over 4-6 months in varied geo-political areas (e.g., London, Paris, Tokyo, Hong Kong and Port-of-Spain) that would test an Internet-based assessment system providing:

1. Updated and comprehensive information on the Canadian health care system and the Canadian medical education system, with a view to managing expectations regarding opportunities to practise medicine in Canada;
2. Electronic self-assessment tools for international medical graduates, containing questions comparable to those in the official Medical Council of Canada Evaluating Exam (MCCEE);
3. An electronic assessment system for the official MCCEE; and
4. Electronic forms, including the waiver currently used by CIC (Citizenship and Immigration Canada) indicating that the applicant understands there is no guarantee of an opportunity to practise medicine in Canada.

Phase II would evaluate the project's success. Phase III, full implementation on a global scale, would follow.

FUNDING & ACCOUNTABILITY MECHANISMS

\$5 million for Physician Assessment

A one-time, lump sum endowment of a \$5 million sequestered fund in this fiscal year to be made to the Medical Council of Canada, to be managed and administered in keeping with the goals and objectives of the project (disbursement criteria would be set in collaboration with Health Canada and Human Resources Development Canada, as required).

\$15 million for Assessment of Other Health Care Providers

There is a shortage of many health care providers. The CMA has had preliminary discussions with the Canadian Nurses Association (CNA) and the Canadian Pharmacists Association (CPhA). The Federal Government should consider funding the development of similar programs for other professions, in partnership with CNA, CPhA and others.

RREAL HEALTH COMMUNICATION & COORDINATION INITIATIVE

Rapid, Reliable, Effective, Accessible and Linked

RATIONALE

Through its public health initiatives society protects and promotes health and works to prevent illness, injury and disability. In today's world these public health functions require an increasingly specialized and well-trained workforce; sophisticated surveillance, monitoring and information systems; and adequate and continuously available laboratory support. Its ultimate effectiveness, however, is dependent on the ability of the system to communicate crucial information and health advice to the right professional in real time when they need it.

The devastating impact of the failure to effectively communicate essential information is evident in examples as diverse, as the water tragedy in Walkerton, and the untimely death of Vanessa Young who died as the result of a fatal adverse drug reaction¹. In both cases, the information health professionals needed to make optimum treatment decisions was not accessible in a reliable and timely manner.

The public health infrastructure is put to the test whenever there is a disaster, large or small, in Canada and, notwithstanding the best efforts of dedicated public health professionals, it does not always receive a passing grade. The public health system is further challenged by the potential for a disconnect in communications between differing jurisdictions that may be found when, for example, First Nations communities under federal jurisdiction overlap areas of provincial jurisdiction. In the aftermath of 9/11 and the anthrax scare in the United States, Canadians must be assured of a rapid, knowledgeable, expert response to emergency public health challenges.

It is essential that the federal government take a leadership role to ensure that the communication tools and information technology necessary to allow for a more rapid and informed response to situations such as natural disasters, disease out-breaks, newly-discovered adverse drug reactions, man-made disasters, or bio-terrorism is accessible in real time in all regions of the country.

A one time infusion of \$30 million for the creation of a ***RREAL Health Communication and Co-ordination Initiative*** would strengthen Canada's public health infrastructure and enhance co-ordination and communication among all levels of government, public health officials, health care providers and multiple agencies such as police, fire, ambulance and hospitals.

GOAL

The ***RREAL Health Communication and Co-ordination Initiative*** would address current deficiencies, and increase the capacity of the public health system to communicate in real time, both between multiple agencies and with health care providers in order to:

¹ Canadian Medical Association Journal, May 1, 2001, 164(9), page 1269.

- Provide a focal point for inter-jurisdictional communication and co-ordination in order to be better prepared in times of emergency; and
- Disseminate emergency information, health alerts and current best practices in public health to health professionals and targeted public health officials in real time and in an effective and accessible fashion.

GUIDING PRINCIPLES

The ***RREAL Health Communication and Co-ordination Initiative*** would involve such key players in public health service and delivery as the Canadian Public Health Association, the Canadian Paediatrics Society, the Chief Medical Officers of Health, the Canadian Federation of Municipalities, the Canadian Red Cross and Health Canada in a collaborative model to ensure integrated co-ordination and communication.

DELIVERABLES

The initiative would undertake a planned program of demonstration projects over a five-year period.

1. To enable the widespread accessibility of information such as newly discovered adverse drug reactions to physicians and other health providers by rapid, reliable, and effective dissemination.
2. To ensure that rural and remote areas of the country and First Nations, Metis and Inuit communities under federal health jurisdiction are linked to public health information systems.
3. To enhance clinical practice guidelines to make them more user friendly and accessible to health care providers.
4. To improve the interoperability of communication technology between multiple agencies such as public health, police and fire services, disaster relief agencies and hospitals in times of emergency.

FUNDING & ACCOUNTABILITY MECHANISMS

A one-time, lump sum endowment of \$30 million in this fiscal year to a designated organization positioned to manage the administration of these funds over a five-year project duration. One option would be to establish a new Canadian Foundation for Public Health as an arms-length agency associated with the Office for Public Health at the Canadian Medical Association.

PAN-CANADIAN NETWORKS OF CLINICAL EXCELLENCE

RATIONALE

Canada's health care system commits to providing Canadians with reasonably comparable access to medically necessary care. This commitment must be met across the spectrum, from primary care to highly specialized care. However, low volumes associated with highly specialized care often does not warrant the ongoing maintenance of the physical and human resources necessary in all regions of the country to be able to respond to patients' needs.

Recent evidence has found that a critical volume of patients is required to ensure a high quality standard of care. In the Canadian Institute for Health Information's 2002 Health Care in Canada report, they state that "for many types of care and for many different surgeries, research shows that patients treated in hospitals with higher numbers of cases are often less likely to have complications or to die after surgery".²

Although clinical centres of excellence (hospitals/clinics that house the human and physical resources necessary to deliver care that meets or exceeds accepted professional standards) currently exist, in Canada they are generally focussed on serving the patient needs of a single province and, in some cases, the city in which they reside. There are no formal mechanisms at the national level to facilitate needs-based planning and sharing of best practices and pooling of resources for highly specialized care. The resulting capacity "deficit" manifests itself in difficulties in accessing care – an issue that has become central to the debate on the renewal of Canada's health care system.

This proposal is about networking existing centres to achieve improved economies of scale and to accelerate quality improvement. It would build the infrastructure necessary to support and link these centres across the country. It would not aim to further consolidate or centralize the delivery of highly specialized services.

GOAL

Implement a *Pan-Canadian Networks of Clinical Excellence* program as a means to improve the quality and accessibility of highly specialized care in Canada.

GUIDING PRINCIPLES

This proposal is premised on:

- A collaborative/partnership model between health organizations such as the Canadian Stroke Network, the Association of Canadian Academic Health Organizations (ACAHO); and the Canadian Medical Association (CMA);

² Dudley RA, Johansen KL, Brand R, Rennie DJ, Milstein A. (2000). *Selective referral to high-volume hospitals: Estimating potentially avoidable deaths*. Journal of the American Medical Association, 283(9), 1159-1166 as cited in *Health Care in Canada, 2002*, Canadian Institute for Health Information, Ottawa: May 2002, p. 52.

- Support the Provincial/Territorial Premiers' commitment to develop Sites of Excellence in various fields such as paediatric cardiac surgery and gamma knife neurosurgery³;
- Consensus building and consultation;
- Build on, and learn from, existing provincial models (e.g., Cardiac Care Network of Ontario, Ontario Stroke System);
- Reliance on evidence-based practices;
- Improved quality of care;
- Rapid diffusion and adoption of new and emerging technologies;
- Pilots and on-going evaluation leading to additional networks; and
- Adoption of an evidence-based approach to network development.

DELIVERABLES

Building on the experience of earlier network models, activities envisioned for a *Pan-Canadian Networks of Clinical Excellence* program would be to:

- Develop electronic registries to track and connect patients and physicians across the country;
- Support collaborative research extending from the bench to bedside⁴;
- Establish and implement clinical best practices;
- Develop and implement knowledge translation plans; and
- Promote the sharing of human capital and expertise across jurisdictions.

Beyond striving to reach optimum efficiency in the delivery of sub-acute care specialties, a *Pan-Canadian Networks of Clinical Excellence* program would support the development of internationally competitive centres of excellence that would offer attractive employment opportunities for the best and brightest in health human resources thereby helping to attract and retain health human resources in Canada.

FUNDING & ACCOUNTABILITY MECHANISMS

A five year phased approach to the development of the networks is envisaged.

The first phase (two years) would involve piloting and evaluating a small number of networks. Based on detailed evaluation of the pilots, the second phase (year 2) could involve additional networks to be determined through consultation with partners. It is anticipated that by year 5, there would be five networks fully operational. The funding would be ideally delivered through a single year endowment of \$25 million to existing foundations such as the Canadian Stroke Network. The new consortium would allocate funding over a 5-year period based on established criteria with regular reporting to the funding consortium partnership and ultimate accountability to report back to Parliament. A steering committee would be struck with representatives from each of the participating partners to provide direction and guidance on the project's implementation.

³ As agreed to at the January 24-25, 2002 Provincial-Territorial Premiers' Meeting in Vancouver. Information available at: www.scics.gc.ca/cinfo02/850085004_e.html

⁴As discussed in a presentation to the House of Commons Standing Committee on Health regarding Bill C-13: An Act to Establish the Canadian Institutes of Health Research. Dr. Peter Vaughan, Secretary General and CEO, Canadian Medical Association, December 6, 1999, Ottawa, Ontario.