

CMA's Annual Check-up of Canada's Health Care System

Presentation to the House of Commons
Standing Committee on Finance
Pre-Budget Consultations

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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 55,000 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 45 affiliated medical organisations.

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EXECUTIVE SUMMARY

The past year has been an historic one for health and health care in Canada. We applaud the federal government for the reinvestments that were made at the time of the February 2003 Health Accord. However, what we as physicians continue to hear in our offices, clinics and hospitals right across the country is continuing concern from our patients that Canada's health care system won't be there for them when they need it. And so while we can understand government's desire to "turn the page" on health care issues, the temptation must be resisted. It is appropriate and prudent that at least once a year, the federal government take the pulse of the health care system – an annual check-up – to take stock of where we've been and identify priorities for the coming year.

This year, the Canadian Medical Association's (CMA's) submission to the Standing Committee on Finance moves largely away from macro funding issues to focus in on strategic initiatives that are national in scope and promise high returns in terms of value for money. Specifically, we identify three areas that require immediate new investments while reminding committee members of work that remains unfinished from years past.

Unfinished Business

While the CMA applauds the federal government for its leadership in achieving the 2003 Health Accord, it is now time to follow through on some outstanding promises that were made. In particular, there are two areas that require special mention. At the time of the First Ministers' Health Accord in February 2003, the federal government agreed to provide up to an additional \$2 billion into Canada's health care system at the end of this fiscal year (2003/04) if a sufficient surplus above the normal Contingency Reserve were available. The federal government must honour their commitment. Health cannot be treated as a residual after other contingencies are addressed.

Equally important is moving forward with establishing the Canada Health Council. Suggestions to water down the mandate of the health council to make it more palatable to some jurisdictions are not the answer. Canada needs a robust mechanism that will provide for enhanced evidence and accountability on how Canada's health care dollars are spent. Canada needs a Health Council that will create a meaningful place at the table for Canadians, health care providers and other stakeholders to provide input on how the system operates and monitor its performance.

Protecting Public Health

The public health system in Canada lies at the very heart of our community values. It is the quintessential “public good” and is central to the continued good health of our population. It is the view of the CMA that our public health system is stretched to capacity in dealing with everyday demands, let alone responding to emerging crises. On June 25, 2003, the CMA submitted a brief to the National Advisory Committee on SARS and Public Health headed by Dr. David Naylor. In it the CMA called upon the federal government to make a minimum investment of \$1.5 billion over five years to achieve legislative reform; capacity enhancement; and enhanced research, surveillance and communications capacities.

In particular, the CMA calls for immediate funding of two specific priorities. The first is the same proposal that the CMA brought to the Standing Committee on Finance last year – the REAL (rapid, effective, accessible and linked) Health Communication and Co-ordination Initiative. The purpose of this initiative is to increase the capacity of the public health system to communicate in real time, between multiple agencies and with health care providers. Had CMA's earlier recommendations been acted upon, perhaps we would have been better prepared to communicate with health care providers when SARS first appeared in Toronto. Improved communications must be a priority this time around – we cannot afford to let this recommendation languish another year.

The second short-term priority for public health is to invest in an emergency supply chain for use in times of crisis. SARS showed us that the Greater Toronto Area, an area with one of Canada's most sophisticated public and acute care health systems, was not able to manage the SARS crisis and maintain its capacity to meet other acute care requirements or important public health services such as suicide prevention programs. The federal government must assure Canadians that plans are in place when the health care system is again tested with another public health emergency.

Ensuring Adequate Supply, Distribution and Mix of Canada's Health Human Resources

Health is primarily a people business. Of all of the critical issues facing Canada's health care system, none is more urgent than the shortages of health providers. Simply put, if people are not available to provide care and treatment to patients everything else is irrelevant.

While we were encouraged with the \$90 million provided in the 2003-04 to “*improve national health human resources planning and co-ordination, including better forecasting of health human resources needs*”, details of how these funds will be allocated and for what purposes remain unclear. The CMA has proposals on how this money could be used to support much needed health human resource planning that are ready to be pulled off the shelf and implemented. For example, the CMA believes that an arm's length Health Institute for Human Resources (HIHuR) should be established to address the human side of health, just as existing institutes address the technological (CCOHTA) and information aspects of health (CIHI).

Addressing the Health Status of Canada's Aboriginal Peoples

Particularly alarming is the health status of Canada's Aboriginal peoples where, despite some improvements over the past few decades, Canada has been largely unable to adequately address the health issues facing this community.

At CMA's annual general meeting in August 2003, Health Minister Anne McLellan noted that despite significant investment Canada's aboriginal people continue to have poor health outcomes. The CMA recommends that the federal government adopt a comprehensive review to look at how the money being spent on health, health care and related areas of investment for Aboriginal people can result in better health outcomes. The current results are not good enough. We must do better.

Conclusion

For those involved in the health care community, and indeed for all Canadians, this has truly been a remarkable year for Canada in terms of health and health policy. In many ways, the events of February marked a turn toward significant reinvestment in the health care system. However, with the outbreak of SARS in Ontario and the emergence of other significant public health concerns such as West Nile virus, health continued to be a top-of-mind concern for many Canadians.

We also know that despite investments made in the 2003 federal budget, there continue to be areas for targeted, strategic initiatives that promise high payoff in terms of value for money. Public health, health human resources and the health status of Canada's aboriginal people are the three areas that we have highlighted where additional attention and funding can make a real impact at the national level. When considering these investments, however, we must remember that we cannot afford to rob Peter to pay Paul. Both the public health and the acute care systems must simultaneously benefit from increased investment in order not to download one problem onto the other.

To return to the analogy of an annual health check-up, let us conclude with this prognosis. Many actions taken in the past year should help over time address the acute symptoms of the patient. However, we must not be complacent. Long term health requires follow-through on last year's initiatives, targeted new investments and ongoing vigilance. We look forward to the year ahead.

INTRODUCTION

When historians look back on 2003, they may very well call it the year of health. Since the Canadian Medical Association's (CMA's) presentation to the Standing Committee on Finance on October 22, 2002, several key events have highlighted health and health care issues in the minds of Canadians. Senator Michael Kirby and the Standing Committee on Social Affairs, Science and Technology kicked off the year by releasing its final report of the review of the federal health care system in October 2002. This report was followed closely by the release of the final report of the Commission on the Future of Health Care in Canada (the Romanow Commission) in November.

In February 2003, Canada's First Ministers agreed to their second Health Accord in just over two years. February also brought the federal government's 2003 federal budget, which featured health as a key element. Emerging threats to the health of Canadians such as SARS and West Nile virus, coupled with ongoing concern that the health care system is not meeting patient needs in a timely way, clearly illustrate the prominence health care has played as an issue over the past year.

Indeed, Canadians continue to show unwavering interest in health and the health care system. According to an EKOS Poll, *Private Voices, Public Choices*, health care was consistently identified as Canadians' highest priority for the federal government as compared to other significant public policy issues (debt, level of taxation and unemployment) between August 1995 and January 2002.ⁱ Despite ongoing consensus on the need to make progress in the area of health, polling done for the CMA by Ipsos Reid found that the public remains unsatisfied with the federal government's response to the health issue. In the CMA's recently released Third Annual National Report Card on Health Care, 64% of respondents gave the federal government either a "C" or "F" rating in their performance in dealing with health care in Canada.ⁱⁱ

Notwithstanding, the CMA acknowledges that the flurry of activity and the amount of public attention that health and health care has garnered over the past year can lead to *policy fatigue*. However, practitioners working in the health care system continue to see the concern of Canadians about being able to access health care services when and where they need them. Add to that their heightened sense of vulnerability in the face of new infectious diseases and ongoing reports about the poor state of our public health care infrastructure, and anxiety regarding health and the health care system over the past year has become almost palpable.

Health care is also a huge sector of our economy. At over \$112 billion dollars,ⁱⁱⁱ Canada's health care system represents 9.7% of our Gross Domestic Product^{iv}. At the federal level, major transfers to other levels of government (a large proportion of which goes to support health care in the provinces and territories) represents almost a quarter (22%) of total program spending by the federal government.^v And so, while the physicians of Canada can understand the desire to "turn the page" on health care issues, the temptation must be resisted. It is appropriate and prudent that at least once a year, the federal government take the pulse of the health care system – an annual check-up if you like – to take stock of where we've been and identify priorities for the coming year.

The CMA recognizes that great strides were made last year in terms of reinvestment in Canada's health care system. As such, this submission to the Standing Committee on Finance will move largely away from macro funding issues to focus in on targeted, initiatives that are national in scope and promise high returns in terms of value for money. Specifically, we have identified three areas that require immediate new investment.

1. Protecting public health;
2. Ensuring adequate supply, distribution and mix of Canada's health human resources; and
3. Addressing the health status of Canada's Aboriginal peoples.

Will any of these initiatives alone improve the overall health of Canadians and increase their access to health care? The answer is no. But by improving the public health infrastructure; ensuring better supply of health human resources; and addressing the particularly urgent health care needs of Canada's Aboriginal peoples, the proposed initiatives represent significant steps that can be taken toward eliminating many of the access issues that are top of mind concerns for so many Canadians.

However, before discussing these priorities for new investment, there are a couple of areas of unfinished business that need to be brought to the attention of members of the Standing Committee.

Unfinished Business – delivering on the health accord promise

Federal Reinvestments in Health Care Financing

In February 2003, the federal government announced new funding of \$24.9 billion over 5 years¹ for the provinces and territories. This was a significant investment and we applaud the federal government for making health a priority, while noting that a gap persists between the reinvestments made and the CMA's recommendations for new funding to shore up Canada's core health care system. (Appendix A provides further details of this gap in funding).

At the time of the First Ministers' Health Accord in February 2003, the federal government agreed to provide up to an additional \$2 billion into Canada's health care system at the end of this fiscal year (2003/04) if a sufficient surplus above the normal Contingency Reserve were available.^{vi} Over the past summer however reports in the media have suggested that this money may not be forthcoming, a concern that has impacted negatively on the federal/provincial/territorial (F/P/T) relationship and created a barrier for advancing the business of health care reform.

¹ \$24.9 billion includes all new federal transfers to the provinces and territories (targeted and non-targeted) announced at the time of the First Ministers' meeting on February 4/5, 2003 and confirmed in the February 18, 2003 Federal Budget. It includes the \$2 billion in funding to be made available at the end of fiscal year 2002/03. It does not include previously announced CHST funding, nor investments in federal health programs.

It is exactly this unpredictability that fosters provincial/territorial distrust of the federal government's role in health care. While the CMA firmly believes that the federal government has a critical role to play in supporting health care across the country, it must fulfil this role in a manner that reassures provinces and territories that promises made are promises kept. This must be the modus operandi of federal health investments.

Let us state in the strongest words possible that the CMA and Canada's physicians expect the Government of Canada to ensure its fiscal house is in order so that this commitment can be fulfilled. Canada's health care system must not be treated as a residual after other contingencies are addressed.

Canada Health Transfer

The CMA was pleased to see the 2003 budget announce the creation of a separate Canada Health Transfer effective April 1, 2004. It is the CMA's view that this measure is a significant step toward greater accountability and transparency of funds and we applaud the federal government for this bold initiative. However, in creating the Canada Health Transfer the government has neglected to build-in the key feature of how to ensure the ongoing sustainability of federal support for health care in the provinces and the territories.

Without a built-in escalator, claims by the federal government that its investments have introduced sustainability into the system ring hollow. As it stands now, the Canada Health Transfer does not provide for increases in funding to grow in step with increases in health care expenditures or our ability to pay as a country. In the longer term this will result in a return to the imbalance between federal funding of provincial and territorial health expenditures. The CMA reiterates its recommendation made last year to the Standing Committee on Finance and to the Commission on the Future of Health Care in Canada, that a built-in escalator tied to increases in GDP is a fundamental component of the Canada Health Transfer.

Canada Health Council

One of the biggest piece of unfinished business arising from the February 2003 Health Accord is the continued lack of progress in the area of the Canada Health Council. Canadians are demanding greater accountability for their health care system. Canadians are also fed-up with inter-jurisdictional bickering on health care financing. A Council would provide a forum to allow for non-political assessment of health care issues divorced from the political wrangling that has defined health care in Canada for more than a decade. It would also enhance F/P/T accountability on how health care dollars in Canada are being spent in order to ensure that Canada's health care dollars are being used wisely.

In February, governments promised Canadians that the Health Council would be set up in May. Throughout the summer of 2003, federal government officials indicated that it would be just a matter of time. Most recently, at their Annual Conference on September 4, 2003, F/P/T Ministers of Health agreed to take another seven weeks to "expedite work on the Health Council".^{vii}

Prior to that meeting, the CMA challenged Health Ministers to ratify an implementation plan for a Canada Health Council that would have a council in place no later than November 28, 2003, one year after the release of the final report of the Romanow Commission.^{viii}

Suggestions to water down the mandate of the Health Council to make it more palatable to some jurisdictions are not the answer. Canada needs a robust mechanism that will provide for enhanced evidence and accountability on how Canada's health care dollars are spent.

Canadians need an independent, empowered Council. Senator Kirby said it when he called for a National Health Care Council.^{ix} Commissioner Romanow said it when he recommended a Health Council of Canada.^x Canadians are demanding greater accountability. Enough is enough. Get on with it.

Health Research

Another area for continued reinvestment is health research. In our submission to the Romanow Commission, the CMA called for federal government support of health research equal to at least 1% of national health expenditures. For 2002 this would equal approximately \$1.1 billion. Actual budgeted expenditure by the federal government for the Canadian Institutes of Health Research for 2002/03 was only \$727.2 million.^{xi}

Canada must move beyond viewing health care expenditures as a drain on government budgets and start treating them the same as in any other sector – investments. Today's research provides tomorrow's treatments. For example, the benefits of increased investment in research extend far beyond the scientist's lab. Rather, the return on investment is potentially many times the initial investment through increased trade potential, increased innovation and increased productivity. For this reason, the CMA supports, in principle, that idea proposed by Dr. Henry Friesen for the creation of a Health Innovation Council to encourage greater innovation and investment in Canada's health care system.

Key Recommendations

Keep your word. Direct the Minister of Finance to honour his promise to put \$2 billion back into Canada's health care system in this fiscal year.

Introduce a built-in escalator into the Canada Health Transfer to ensure the federal contribution to the health system keeps pace and remains sustainable.

Enough is enough! Establish the Canada Health Council.

Identify support for health research equal to at least 1% of national health expenditures.

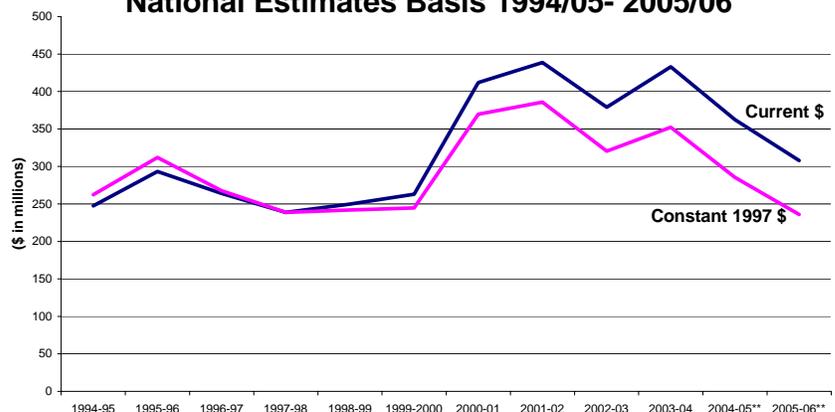
Protecting public health

The public health system in Canada lies at the very heart of our community values. It is the quintessential “public good” and is central to the continued good health of our population. It includes the systematic response to infectious disease, but also much more. It ensures access to clean drinking water, good sanitation and the control of pests and other disease vectors. It provides immunization clinics, and programs promoting healthy lifestyles as well as being there to protect Canadians when they face a public health crisis like SARS.

Our public health system is the first — and often only — line of defence against emerging and ongoing infectious and noninfectious threats to the health of Canadians. But we are only as strong as the weakest link in the emergency response chain of survival. Most health threats know no boundaries, so our public health armaments must be in a constant state of “battle readiness.”

It is the view of the CMA that our public health system is stretched to capacity in dealing with everyday demands, let alone responding to emerging crises. At no time was this more apparent than following the tragic events of September 2001. As a result, the CMA dedicated our 2001 submission to the Standing Committee on Finance to issues related to emergency preparedness in terms of security, health and capacity.

Chart 1: Federal Investments in Public Health*
National Estimates Basis 1994/05- 2005/06



Source: Government of Canada Estimates

* Public Health includes expenditures from the health promotion and prevention strategic outcomes

** Planned Spending

Constant 1997 \$ calculated using the Health Price Index (Conference Board of Canada & Statistics Canada - draft 2003)

In light of SARS and other public health threats those recommendations continue to ring true today.^{xii} It is our contention that had these actions been taken, Canada would have been better prepared to face the recent public health challenges. Unfortunately, the opposite road was taken. Rather than making reinvestments in public health, the federal government has scheduled declines in departmental spending in this area. In fact, according to Government of Canada estimates, by 2005/06 public health expenditures are planned to decrease in current dollars to their lowest level in over a decade (Chart 1).

And while we were encouraged by recent investments made in the health care system, we question the lack of investment and forecast reductions in funding for public health. We cannot continue to rob Peter to pay Paul. Both the public health and acute care systems require ongoing investments and attention.

On June 25, 2003, the CMA submitted a brief to the National Advisory Committee on SARS and Public Health headed by Dr. David Naylor. In it we identified the need to establish a clearer alignment of authority and accountability in times of extraordinary health emergencies. We also highlighted the need to enhance the system's capacity to respond to public health threats across the country. To achieve this, we call on the federal government to make a minimum investment of \$1.5 billion over five years to achieve legislative reform; capacity enhancement; and enhanced research, surveillance and communications capacities. (For additional detail, please refer to CMA's submission to the National Advisory Committee on SARS and Public Health, June 2003.^{xiii} A copy of our recommendations and associated costs are attached as Appendix B.)

While significant, this level of funding represents only a small investment relative to the massive potential cost of, for example, another SARS crisis. \$1.5 billion over five years should be treated as the minimum that could be allocated to these initiatives in order to operationalize each of the recommendations. Estimates do not include existing expenditures on public health that would be reallocated within the public health system. While all of our recommendations for the public health care system are important, there are two components that the CMA believes need immediate action by the federal government.

The first refers to the particular urgency to improve communications between health professionals and address immediate shortages in supplies and equipment. Last year we came to the Standing Committee on Finance with a proposal for the REAL (rapid, effective, accessible and linked) Health Communication and Co-ordination Initiative. The purpose of this plan was to increase the capacity of the public health system to communicate in real time, between multiple agencies and with health care providers. (A copy of the REAL proposal is attached as Appendix C.) This followed the call in our 2001 submission for increased communications between public health officials, police, fire and ambulance services, hospitals and other services.^{xiv} The effectiveness of the public health system depends, largely, on its capacity to disseminate authoritative information in a timely way. Information is key to be able to respond to patient needs effectively during times of emergency.

Information in real time is also essential for effective day-to-day health care to provide, for example, information on adverse drug reactions.

Had the CMA's 2001 and 2002 recommendations been acted upon, perhaps we would have been better prepared to communicate with health care providers when SARS first appeared in Toronto. As it was, the CMA mobilized its own communication networks to provide physicians with the critical information that they needed to manage SARS. And while this worked to get the word out in a pinch – it also underlined the fact that Canada does not have information systems in place to facilitate real-time communication with health professionals. How many SARS-type events must we have? This must be a priority. With a one-time infusion of \$100 million, and an additional \$2 million a year, the REAL proposal would provide the technical capacity to communicate with front-line public health providers in real time during health emergencies. We cannot afford to let this recommendation languish another year.

The second short-term priority for public health is to invest in emergency supply chain for use in times of crisis. SARS showed us that the Greater Toronto Area, an area with one of Canada's most sophisticated public and acute care health systems, was not able to manage the SARS crisis and maintain its capacity to meet other acute care requirements or important public health services such as suicide prevention programs.

Most hospitals work on a just-in-time inventory basis for the purchase of drugs. Without some sort of plan to quickly re-supply their pharmacies and expand their capacity, patient care suffers. Emergency bed space is also lacking. The federal government must assure Canadians that plans are in place when the health care system is again tested with another public health emergency. That is where the federal government can ensure the health system's readiness and reassure Canadians that help will be there when they need it. (Additional information is provided in Appendix D.)

Key Recommendation

Immediately allocate \$1.5 billion over 5 years to reinforce Canada's public health care system in order to respond to public health threats and acute events, such as SARS starting with a Rapid Effective Accessible Linked (REAL) Health Communications and Co-ordination Initiative; and an emergency medical supplies and equipment supply chain.

Health human resources

Health is primarily a people business. Of all of the critical issues facing Canada's health care system, none is more urgent than the shortages of health providers. Bluntly put, if the people are not available to provide care and treatment to patients everything else is irrelevant. The CMA has been encouraged by significant movement toward the implementation of the 1999 Canadian Medical Forum recommendations calling for an increase in undergraduate medical training positions and the subsequent 30% increase in the number of first-year, first-time medical students. Despite these efforts, there continues to be growing concern over the shortage of physicians.

Statistics Canada figures suggest that the number of Canadians who do not have a family physician is greater than three million. Indeed, in order for Canada to meet the OECD average with respect to physician numbers, Canada must increase the number of physicians by an alarming 38%. Given that Canada continues to average a net *loss* of approximately 200 physicians per year due to emigration, action must come without delay to address this growing concern. Similarly, research published last year by CNA predicts that Canada will have a shortage of 78,000 registered nurses by 2011 and up to 113,000 by 2016.^{xv}

While we were encouraged with the \$90 million provided in the 2003-04 to “*improve national health human resources planning and co-ordination, including better forecasting of health human resources needs*”^{xvi}, details of how these funds will be allocated and for what purposes remain unclear. Indeed, it appears to be somewhat of a shell game with various federal departments vying for funding but no one department coming forward to provide leadership with clear proposals.

The CMA has proposals on how this money could be used to support much needed health human resource planning that are ready to be pulled off the shelf and implemented. For example, the CMA believes that an arm's length Health Institute for Human Resources (HIHuR) should be established to address the human side of health, just as existing institutes address the technological (CCOHTA) and information aspects of health (CIHI). It would be a virtual institute, in the same sense as the Canadian Institutes for Health Research (CIHR). The Institute should promote collaboration and the sharing of research among the well-known university-based centres of excellence (e.g., MCHP and CHSPR) as well as research communities within professional associations and governments. It would enable and focus on needs-based long-term planning.

HIHuR would have the ability to embark upon large scale research studies such as needs-based planning that is beyond the purview or financial ability of any single jurisdiction. Standard methodologies could be established for data collection and analysis to estimate health human resource requirements based on the disease-specific health needs and demands of the population (e.g., Aboriginal peoples, the elderly, etc.). The institute would work in close collaboration with primary data providers such as Statistics Canada and CIHI. It would complement the work of the new Canada Health Council.

Possible deliverables of the model could include such cross-disciplinary issues as measuring effective supply, functional specialization, regulatory restrictions, and assessing new and existing models of delivery. The institute could build on and maintain the initiatives of the various health sector studies. The institute would advise on medium and long-term research agendas that could be adopted and implemented by such funding bodies as CHSRF and CIHR.

The CMA recommends that base funding be provided by the federal government (with other members also financially supporting the HIHuR) and that the annual budget for the institute be \$2.5 million with an initial institute development grant from the federal government of \$1 million. (Further details of the HIHuR funding proposal are attached in Appendix E).

High tuition fees also have the potential to have a serious, negative impact on the supply, mix and distribution of health human resources. The CMA is very concerned that high tuition fees in undergraduate programs in medicine are creating barriers to access to a medical education and threatening the diversity of future physicians who later serve the needs of Canadians.

High tuition fees have made a medical education unaffordable to many Canadians and may create an imbalance in admissions to medical school by favouring those who represent the affluent segment of society and not the variety of groups reflected in the Canadian population. High student debt loads, as a consequence of high tuition fees and insufficient financial support, can also influence students' decisions about practice specialty and practice location. Ultimately, these factors could threaten the availability of services provided to Canadians, particularly in rural and remote communities.

For these reasons, the CMA is an active participant on the National Professional Association Coalition on Tuition (NPACT) and supports its recommendations concerning professional tuition and access to post-secondary education.

Key Recommendation

Instruct federal departments to work together on key health human resource initiatives and fund a new Health Institute for Human Resources (HIHuR).

Health status of Aboriginal peoples

Throughout the 1980s, Canada either just maintained or lost ground in the international rankings on key health indicators with other leading industrialized countries. In 1990, Canada ranked fifth on the United Nations Human Development Index measuring average achievement on three basic dimensions of human development – a long and healthy life; knowledge; and a decent standard of living. In 1991, Canada moved to second place behind Japan and in 1992 Canada topped the list. In 2001, however, Canada dropped back to third place as a result of new figures for life expectancy and educational enrolment.^{xvii}

Since the 1980s, Canada has continued to improve in key indicators such as infant mortality and life expectancy. However, other industrialized countries have also made improvements either equalling and in many cases, quite dramatically surpassing gains made in Canada. As a result, Canada's ranking has either stayed the same or dropped. For example, although Canada's infant mortality rate dropped by 22% between 1990 and 1999, its rank dropped from 5th to 17th among the 31 industrialized countries included in the Organization for Economic Cooperation and Development (OECD). Similarly, Canada's ranking for life expectancy at birth decreased over the same period from 3rd to 5th. (Additional information on how Canada compares to other countries in terms of health status indicators is attached as Appendix F.)

Particularly alarming is the health status of Canada's Aboriginal peoples where, despite some improvements over the past few decades, Canada has been largely unable to adequately address the health issues facing this community. The facts speak for themselves:

- The incidence and prevalence of chronic and degenerative diseases (diabetes, cardiovascular disease, cancer and arthritis) is higher among Aboriginal Canadians than for the rest of the population (e.g., the rate of Type II diabetes among First Nations is three to five times that of Canadians in general and is considered a growing problem);
- Certain infectious diseases are more prevalent among Aboriginal Canadians (e.g., the incidence of hepatitis and tuberculosis are five and ten times higher, respectively, than for other Canadians); and
- Manifestations of mental health problems such as violence, suicide and sexual abuse are widespread (e.g., the rate of death from suicide is four times higher among the Inuit than Canadians in general.)

These problems are compounded by the remoteness of many Aboriginal communities, which makes access to health services and infrastructure costly and difficult. Other issues include the distinct health needs of different Aboriginal communities (First Nations, Metis, Inuit and urban Natives) and jurisdictional problems such as the separation of health and social services and conflicting or overlapping F/P/T areas of responsibility. As well, it is broadly accepted that the health status of Canada's Aboriginal peoples is a result of a broad range of factors and is unlikely to be improved significantly by merely increasing the quantity of health services. Instead, inequities within a wide range of social and economic factors must also be addressed, for example: income and education; environmental hazards, water quality, housing quality and infrastructure; and maintenance of cultural identity.

At CMA's annual general meeting in August 2003, Health Minister Anne McLellan noted that despite significant investment Canada's aboriginal people continue to have poor health outcomes. Simply put, these results are unacceptable.

The CMA recommends that the federal government adopt a comprehensive review to look at how the money being spent on health, health care and related areas of investment for Aboriginal people can result in better health outcomes. The current results are not good enough. We must do better.

Key Recommendation

The federal government should adopt a comprehensive review to look at how the money being spent on health, health care and related areas of investment can result in better health outcomes.

CONCLUSION

For those involved in the health care community, and indeed for all Canadians, this has truly been a remarkable year for Canada in terms of health and health policy. In many ways, the events of February marked a turn toward significant reinvestment in the health care system. However, with the outbreak of SARS in Ontario and the emergence of other significant public health concerns such as West Nile virus, health continued to be a top-of-mind concern for many Canadians.

We also know that despite investments made in the 2003 federal budget, there continue to be areas for targeted, strategic initiatives that promise high payoff in terms of value for money. Public health, health human resources and the health status of Canada's aboriginal people are the three areas that we have highlighted where additional attention and funding can make a real impact at the national level. When considering these investments, however, we must remember that we cannot afford to rob Peter to pay Paul. Both the public health and the acute care systems must simultaneously benefit from increased investment in order not to download one problem onto the other.

Finally, promises made must be promises kept. The federal government must ensure that the fiscal environment is such so that it can fulfill its commitment to provide an additional \$2 billion in this fiscal year. As well, the CMA intends to hold the federal government and the provinces and territories to their promise to implement a Canada Health Council. Governments must open the political black box of health decision making and let others in. To exclude physicians and other health stakeholders would seriously undermine the Health Council and deprive it of the benefits of first-hand insight into how care is actually delivered. Governments must take advantage of this opportunity to introduce a mechanism that will provide evidence to Canadians that they are getting a good return on their investment in health care.

To return to the analogy of an annual health check-up, let us conclude with this prognosis. Many actions taken in the past year should help over time address the acute symptoms of the patient. However, we must not be complacent. Long term health requires follow through on last year's initiatives, targeted new investments and ongoing vigilance. We look forward to the year ahead.

Appendix A: Federal Reinvestments in Health Care Financing

In the January 2003 document, *From Debate to Action*^{xviii}, the Canadian Medical Association challenged Canada's First Ministers to put the health of Canadians first. With respect to health care financing, we underlined the need for a financial commitment to health care that is adequate, stable, predictable, transparent and sustainable. In February 2003, the federal government announced new funding to the provinces and territories of \$24.9 billion over 5 years.² The CMA and others suggested that these reinvestments were good but insufficient to address the challenges facing Canada's health care system.^{xix}

Specifically, we had called for a minimum commitment by the federal government to “fund 50% of the core health care system with at least half of the federal government's contribution in cash”.^{xx} (Core defined to include non-targeted and targeted investments in infrastructure such as health human resources, information technology, capital infrastructure, and rural and remote access.) Altogether, we called for a minimum cash investment of \$31.5 billion over 5 years to renew the health care system.

**Gap Between 2003 Health Accord and
CMA Recommended Re-Investments in Canada's Health Care System**

(\$ billions)	2003–2004	2004–2005	2005–2006	2006–07	2007–2008	Total
Core Funding	3.5	3.9	4.4	4.6	4.9	\$21.3
<i>Targeted Core</i>	0.5	0.5	0.5	0.5	0.5	\$2.5
<i>Targeted New Programs</i>		1.1	2.1	2.2	2.3	\$7.7
Total	4.0	5.5	7.0	7.3	7.7	\$31.5
<i>Federal Reinvestments</i>	4.8	3.3	4.9	5.2	6.7	\$24.9
<i>Remaining Gap in Funding</i>	(0.8)	2.2	2.1	2.1	1.0	\$ 6.7

There remains a significant gap of almost \$ 7 billion over 5 years between our estimate of the minimum requirement needed for the renewal of the health care system and the new resources dedicated by the federal government. In light of this, the CMA calls upon the federal government to finish its unfinished business and allocate an additional \$7 billion over 5 years in its next budget for the Canada Health Transfer to shore up Canada's health care system.

² \$24.9 billion includes all new federal transfers to the provinces and territories (targeted and non-targeted) announced at the time of the First Ministers' meeting on February 4/5, 2003 and confirmed in the February 18, 2003 Federal Budget. It includes the \$2 billion in funding to be made available at the end of fiscal year 2002/03. It does not include previously announced CHST funding, nor investments in federal health programs.

Appendix B: Recommendations to the National Advisory Committee on SARS and Public Health

Legislative reform (\$20 million / 5 years*)

1. The enactment of a *Canada Emergency Health Measures Act* that would consolidate and enhance existing legislation, allowing for a more rapid national response, in cooperation with the provinces and territories, based on a graduated, systematic approach, to health emergencies that pose an acute and imminent threat to human health and safety across Canada.
2. The creation of a *Canadian Office for Disease Surveillance and Control (CODSC)* as the lead Canadian agency in public health, operating at arm's length from government.
3. The appointment of a Chief Public Health Officer of Canada to act as the lead scientific voice for public health in Canada; to head the Canadian Office for Disease Surveillance and Control; and to work with provinces and territories to develop and implement a pan-Canadian public health action plan.

Capacity enhancement (\$1.2 billion / 5 years*)

4. The creation of a *Canadian Centre of Excellence for Public Health*, under the auspices of the CODSC, to invest in multidisciplinary training programs in public health, establish and disseminate best practices among public health professionals.
5. The establishment of a Canadian Public Health Emergency Response Service, under the auspices of the CODSC, to provide for the rapid deployment of human resources (e.g., emergency pan-Canadian locum programs) during health emergencies.
6. Tracking and public reporting of public health expenditures and capacity (both physical and human resources) by the Canadian Institute for Health Information and Statistics Canada, on behalf of the proposed Canadian Office for Disease Surveillance and Control.
7. Federal government funding in the amount of \$1 Billion over 5 years to build adequate and consistent surge capacity across Canada and improve co-ordination among federal, provincial/territorial and municipal authorities to fulfill essential public health functions.

Research, surveillance and communications (\$310 million / 5 years*)

8. An immediate, sequestered grant of \$200 million over 5 years to the Canadian Institutes of Health Research to initiate an enhanced *conjoint program of research* with the Institute of Population and Public Health and the Institute of Infection and Immunity that will expand capacity for interdisciplinary research on public health, including infectious disease prevention and control measures.
9. The *mandatory reporting* by provinces and territories of identified infectious diseases to the newly established Chief Public Health Officer of Canada to enable appropriate communications, analyses and intervention.
10. The one-time infusion of \$100 million, with an additional \$2 million a year, for a "*REAL*" (*rapid, effective, accessible and linked*) *Health Communication and Co-ordination Initiative* to improve

technical capacity to communicate with front line public health providers in real time during health emergencies.

Appendix B: Estimated Cost of Implementing the Recommendations

RECOMMENDATION	ESTIMATED COST OVER 5 YEARS
Legislative and Institutional Reform	
1. Canada Emergency Health Measures Act	N/A
2. Canadian Office for Disease Surveillance and Control (CODSC) 3. Chief Public Health Officer of Canada	} \$20 million
Capacity Enhancement	
4. Canadian Centre of Excellence for Public Health	\$100 million
5. Canadian Public Health Emergency Response Service	\$35 million
6. Canadian Institute for Health Information and Statistics Canada	\$35 million ^a
7. Surge capacity	\$1 billion ^b
Research, surveillance and communications	
8. Canadian Institutes of Health Research	\$200 million ^c
9. Mandatory reporting	Included under 2 and 3 above
10. Enhanced communications	\$110 million
TOTAL	\$1.5 billion

a. Work is currently underway to break out public health from the current category of “public health and administration.”

b. This is an incremental investment in addition to funding currently available under Health Canada’s *Health Promotion and Prevention Strategic Outcome* area.

c. Funding must be sequestered specifically for new initiatives related to public health. Additional money could also be acquired through funding from the Canadian Foundation for Innovation, which received an additional \$500 million in 2002–2003 (announced in the 2003 federal budget) to enhance the Foundation’s support of public health infrastructure.

Appendix C: REAL (Rapid, Effective, Accessible , Linked) Health Communication and Co-ordination Initiative

The effectiveness of the public health system is dependent, in large part, on its capacity to communicate authoritative information in a timely way. A two-way flow of information between experts and the practising community is necessary at all times. It becomes essential during emergency situations. Information, including health advice and alerts, needs to move out to front line health care providers from public health bodies. Information, such as data for surveillance and analysis purposes, needs to move in from these front line providers to the public health authorities.

To detect new emerging diseases or health threats and effectively care for their patients, front-line health professionals must have accurate and timely information. Conversely public health specialists depend on information coming in from the front lines to track disease and institute appropriate public health interventions.

Despite the tremendous developments in information management, there has been scant attention paid to this issue within public health. The SARS outbreak highlighted various weaknesses in our current communication capacity. Gaps in the basic IT infrastructure prevented public health agencies and acute care institutions from communicating with each other in real-time.

There are a number of anecdotal reports of public health units stationing personnel inside hospitals to retrieve information and then telephone it into their units. Case investigators used paper-based files to manage the hundreds of cases reported to public health units, and to investigate and follow up of thousands of contacts. Identification of clusters and links between cases literally depended upon pencil and paper and brainpower. Toronto Public Health did create a database for its SARS cases and could send it electronically to the province. However the province had a different database which raised concerns about the transfer of data files from one system to another.

The deficiency in IT capacity hindered exchanges between public health staff, private clinicians and other sources of information. The potential for a disconnect in communications between different jurisdictions (international, national, provincial/territorial, municipal) and sectors (environment, health, transportation) that are affected by a health emergency is a further challenge to the public health system.

The importance of communicating essential health advice and public health management protocols to front line practitioners and institutions cannot be overstated. During the SARS experience it became evident that government did not have information systems in place to communicate rapidly with physicians across the country. In response to requests from Health Canada the CMA was able to mobilize its communication networks to get information to physicians in real-time. It is interesting to note that in local areas the problem often was not one of not enough information, but of too much information, which was often confusing, conflicting or impractical for a practice setting. Consistent messaging disseminated in a coordinated fashion is essential for a consistent and coordinated response to a health crisis.

The CMA believes that the federal government must take a leadership role to ensure that the communication tools and information technology necessary for a modern efficient public health system, with the capacity to mount a rapid and informed response to public health emergencies, are in place in all regions of the country.

The CMA brought this to the attention of the House of Commons Standing Committee on Finance in October 2001, and again in October 2002 with our recommendation for a REAL (rapid, effective, accessible, linked) Health Communication and Co-ordination Initiative. We called for a one-time infusion of \$100 million, and an additional \$2 million a year, to improve technical capacity to communicate with front-line public health providers in real-time during health emergencies.

This initiative would facilitate seamless communication between local, provincial and federal levels of the public health system and rapid, real-time communication between the public health sector and other components of the health care system. It must also ensure a two-way flow of information between front-line health care providers and public health professionals at the local public health unit, the provincial public health department and the proposed Canadian Office for Disease Surveillance and Control.

The REAL Health Communication and Co-ordination Initiative would improve the ability of the public health system to communicate in a rapid fashion by:

- Providing a focal point for inter-jurisdictional communication and co-ordination in order to improve preparedness in times of emergency;
- Developing a seamless communication system leveraging formal and informal networks and
- Researching the best way to disseminate emergency information and health alerts to targeted health professionals and public health officials in a rapid, effective and accessible fashion.

As well as funding research and demonstration projects, funding should also be allocated to provinces/territories and municipalities to build their connectivity infrastructure. The initiative should build on communication systems currently in place, filling gaps and enhancing capacity.

Communicating with Health Professionals.

One of the key lessons the CMA has drawn from the experience of SARS is that physicians take up information in different ways. Some want it by e-mail, others by fax and still others by mail. Even those with e-mail have expressed a desire to get emergency information in a different format. Other health care associations have also employed various ways to communicate with their membership.

During the SARS crisis, the existing communication networks between health professionals were an important, if informal, avenue to disseminate and in some cases explain public health interventions and information. In fact ten national health care associations³ met via teleconference and in person during the crisis to share information and ensure a consistency of message to health professionals. This sector can play a critical role in bridging the gap between clinicians and the public, as well as in the delivery of credible public education and training to both professionals and the public.

The importance of communicating timely and relevant information directly to those in leadership positions (Chief of Staff, Hospital CEO) should not be overlooked. These individuals can make the information relevant for their particular setting, and ensure that it is widely disseminated within their community.

The uptake of new information is influenced by many qualitative factors and research is needed to determine how best to communicate with individual physicians and other health care providers in emergency situations. Any new communication processes should be based on sound research and build on existing communication networks.

The REAL Health Communication and Co-ordination Initiative would be led by the Canadian Office for Disease Surveillance and Control and would undertake work in three phases.

1. Research Phase

For example:

- Evaluation of communications during the SARS crisis
 - Quantitative research on how health professionals want to receive information
 - Catalogue of existing communication networks
2. Pilot projects in areas such as risk communications and information management in public health.
3. Evaluation and dissemination of best practices in communications and information management.

³ Canadian Association of Emergency Physicians, Canadian Council on Health Services Accreditation, Canadian Dental Association, Canadian Healthcare Association, Canadian Medical Association, Canadian Infectious Disease Society, Canadian Nurses Association, Canadian Pharmacists Association, Canadian Public Health Association, Association of Canadian Academic Healthcare Organizations

Appendix D: Emergency Medical Supplies and Equipment Supply Chain

In the aftermath of the September 11, 2001 terrorist attacks in the United States, the CMA, in its October 2001 pre-budget submission to the Standing Committee on Finance, stressed the fact that in the event of a significant attack on our population among the first points of contact with the health system will be doctors' offices and the emergency rooms of our hospitals. The SARS outbreak has proven that this point is just as valid when faced with a public health emergency.

SARS showed us that the Greater Toronto Area, an area with one of Canada's most sophisticated public and acute care health systems, was not able to manage the SARS crisis and maintain its capacity to meet other acute care requirements or important public health services such as suicide prevention programs.

Most hospitals work on a just-in-time inventory basis for the purchase of drugs. Without some sort of plan to quickly re-supply their pharmacies and expand their capacity, patient care suffers. Emergency bed space is also lacking. The federal government must assure Canadians that plans are in place when the health care system is again tested with another public health emergency. That is where the federal government can ensure the health system's readiness and reassure Canadians that help will be there when they need it.

We have also witnessed in recent years the enormous strain these facilities can be placed under when even something quite routine like influenza strikes a community hard. The acute care occupancy rates of Ontario public hospitals across the Ontario Hospital Association regions in 1999-00 illustrate this point. In three of the five regions (Eastern Ontario, Central and South West) the occupancy rate ranged from 94% to 97%.^{xxi} The highest rate was found in the very heavily populated Central region. A British Medical Journal study suggests that an occupancy rate over 90% indicates that the hospital system is in a regular bed crisis.^{xxii} This problem is not unique to Ontario: *"the decrease in the number of acute care beds across Canada over the past decade, coupled with an aging population and our extraordinary success in extending the survival of patients with significant chronic illness, has eliminated any cushion in bed occupancy in the hospital system."*^{xxiii}

With this in mind, picture the impact of another public health crisis such as an influenza pandemic when hundreds of thousands of individuals could be affected. The public health system and medical diagnostic and treatment systems in the community and hospitals would become overwhelmed very quickly without the ability to absorb the extra caseload. We need no further demonstration of the need to enable hospitals to open beds, purchase more supplies, and bring in the health care professionals it requires to meet the need.

Currently the National Emergency Stockpile System can supply up to 40,000 cots, as well as medical supplies and relatively rudimentary hospital equipment. Reports indicate, however, that much of the equipment is decades old, and that protocols for logistical management (e.g., transport and rapid deployment) are outdated. There is an urgent need to reassess and reaffirm capacity in this context.

The SARS experience also brought to our attention the critical lack of equipment. The Canadian Association of Emergency Physicians (CAEP) has noted that many emergency departments across the country are not adequately equipped for 21st century infection control challenges. They do not have negative pressure rooms with contained toilets, often have only one resuscitation suite for critically ill patients and do not have a safe place to segregate accompanying persons. Nor do they have protective hoods like the PARR device that is needed to safely intubate SARS patients. CAEP concluded that most emergency departments are not physically designed to cope with infection control problems.

The federal government must assure Canadians that municipal and provincial plans are in place with an overarching national plan to support these jurisdictions if their service capacities are overwhelmed. But the government should help further by making available an emergency fund that would enable hospitals to plan and organize their surge capacity.

The purpose of having such elaborate response plans and stockpiles of supplies and equipment is to be ready for the possibility that, in spite of all efforts to prevent a catastrophe from occurring, it nevertheless happens. That is where the federal government can facilitate the health system's readiness and reassure Canadians that help will be there when they need it.

Appendix E: Health Institute for Human Resources (HIHuR)

While the need for more health human resources is apparent, resource planning is difficult and fraught with complexity. Answers must balance affordability, reflect population health needs and consider issues pertaining to the supply, mix and distribution of physicians. Over the last decade, a number of stakeholders including government, associations, and researchers have invested significant resources in health human resource planning.^{xxiv} However, these groups do not systematically communicate with each other and do not always buy into each other's products. The result is silo-based planning, lack of progress on key areas of database development, and an overall failure to address important issues such as professional burnout.

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. At the same time, 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 that take into account the mobility of health care providers nationally and internationally.

Identification of the need for more coordinated research in the area of health human resources has come from many sources. In the Listening for Directions report of 2001^{xxv}, the partner organizations indicated health human resources as the number one priority theme for research funding over the next two to five years. A joint report in 1995 by national organizations representing occupational therapists, physiotherapists, dieticians and nurses established an integrated health human resources development framework with three main components of planning, education and training, and management.^{xxvi}

Similarly, the Canadian Policy Research Networks Inc. (CPRN) commissioned by Mr. Romanow to investigate and summarize health human resource issues, recommended the creation of a national health human resources coordinating agency to provide focus and expertise for health human resource planning. Senator Kirby also identified the need for such a planning body in his final report. He recommended that the federal government work with other concerned parties to create a permanent National Coordinating Committee for Health Human Resources, to be composed of representatives of key stakeholder groups and of the different levels of government.^{xxvii}

Finally, the final report of the Commission of the Future of Health Care in Canada called for a substantial improvement in the base of information on Canada's health workforce and the need to establish a comprehensive plan for addressing supply, distribution, and education issues.^{xxviii}

The CMA believes that an arm's length Health Institute for Human Resources (HIHuR) should be established to address the human side of health, just as existing institutes address the technology (CCOHTA) and information aspects of health (CIHI). It would be a virtual institute, in the same sense as the Canadian Institute for Health Research.

The Institute should promote collaboration and the sharing of research among the well-known university based centres of excellence (e.g., MCHP and CHSPR) as well as research communities within professional associations and governments. It would enable/focus on needs-based long term planning.

HIHuR should have the ability to embark upon large scale research studies such as needs-based planning that is beyond the purview or financial ability of any single jurisdiction. Standard methodologies could be established for data collection and analysis to estimate health human resource requirements based on the disease-specific health needs and/or demands of the population (e.g., Aboriginal peoples, the elderly, etc.). The institute would work in close collaboration with primary data providers such as Statistics Canada and CIHI. It would complement the work of the new Canada Health Council.

Possible deliverables of the model could include such cross-disciplinary issues as measuring effective supply, functional specialization, regulatory restrictions, and assessing new and existing models of delivery. The institute could build on, and maintain, the initiatives of the various health sector studies. The institute would advise on medium and long-term research agendas that could be adopted and implemented by such funding bodies as CHSRF and CIHR.

It is recommended that base funding be provided by the federal government (with other members also financially supporting the HIHuR). It is proposed that the annual budget for the institute would be \$2.5 million with an initial institute development grant from the federal government of \$1 million.

Appendix F : Straight facts about health...Is Canada getting left behind?

Straight facts about health... *Is Canada getting left behind?*

Through the 1980s, Canada has either remained the same or lost ground in the international rankings on key health indicators with other leading industrialized countries surpassing our progress. This worrisome turn of events, the Canadian Medical Association believes, needs attention.

United Nations Human Development Index

In 1990, the United Nations Development Programme (UNDP) began publishing an annual *Human Development Report* (www.undp.org/hdr). The Human Development Index (HDI) is one of the key indicators in this report. It is a composite index that measures average achievement in three basic dimensions of human development: a long and healthy life; knowledge and a decent standard of living.

How has Canada fared? In 1990, Canada ranked fifth. Canada moved to 2nd place behind Japan in 1991 and into 1st place in 1992. It again dropped behind first-place Japan in 1993. Canada then led the world on the HDI between 1994 and 2000. In 2001, Canada dropped back to 3rd place. As the UNDP reported in 2001, “Norway is now ranked first in the world and Australia second. Both moved narrowly ahead of Canada, the leader for the previous six years, as a result of new figures for life expectancy and educational enrolment. Canada fell in the rankings even though its per capita income rose by 3.75 percent.” Canada remained in 3rd place in 2002.

**Leader for 6 years
Now in 3rd place**

World Health Organization health system performance indicators

The World Health Organization (WHO) (www.who.int/whr) ranked the health system performance of 191 member countries for the first time in its 2000 *World Health Report*. The ranks are based on the measurement of population health in relation to what might be expected given the level of input to the production of health.

**Health status:
35th of 191**

WHO presented two rankings. The first, performance on health level, considers health status in disability-adjusted life expectancy relative to a country’s resource use and human capital. Canada ranked 35th among 191 countries with respect to this indicator in 2000.

The second indicator is a measurement of overall performance. This assesses health system attainment relative to what might be expected for five goals of the health system, including health status, health inequality, level and distribution of responsiveness and fairness in financing. In 2000, Canada ranked 30th on the index of overall performance. France led the world on this indicator in 2000.

**Overall system
Performance: 30th of 191**

International health indicators

Since the 1980s, Canada has continued to record improvements on key health indicators such as infant mortality and life expectancy. However, other industrialized countries have also recorded improvements that have either equaled or, in some cases, quite dramatically surpassed the gains made in Canada. As a result, Canada’s ranking has either stayed the same or dropped.

Infant Mortality — Although Canada's infant mortality rate dropped by 22% between 1990 and 1999, its rank dropped from 5th to 17th among the 31 industrialized countries included in the Organization for Economic Cooperation and Development (OECD). Other countries have recorded even greater gains; for example, Sweden and Austria both recorded a drop of 43% in infant mortality over the same time period. Among others, Spain, Italy and the Czech Republic now rank ahead of Canada. However, the United Kingdom, United States and Australia rank behind Canada.

**Infant mortality:
from 5th to 17th in
less than 10 years**

Perinatal Mortality — Between 1990 and 1999, Canada's perinatal mortality rate declined by 18% while its international ranking remained essentially the same — moving from 10th in 1990 to 11th in 1999. In comparison, the perinatal mortality rate for 1st-ranked Japan dropped by 31% during the same period.

Life Expectancy — In 1999, Canada ranked 5th in life expectancy at birth, down from 3rd in 1990. During the 1990–1999 period, total life expectancy increased by 1.8% in Canada, compared to 2.0% in 1st-ranked Japan.

**Life expectancy:
dropped to 5th place**

Healthy Life Expectancy (HALE) — Healthy life expectancy is based on life expectancy but includes an adjustment for time spent in poor health. In its 2002 *World Health Report*, WHO presented HALE estimates for 191 countries during 2001. Among these countries, Canada ranked 20th in 2001, tying with the Netherlands at 69.9 years at birth. Japan and Switzerland headed the list at 73.6 and 72.8 years respectively in 2001.

Health human resources per capita

Canada continues to lag behind other industrialized countries with respect to physicians per 1000 population. The OECD average of 2.8 per 1000 population is one-third higher than Canada's rate of 2.1 (including post-graduate residents), placing us 23rd out of 27th for this indicator. In a comparison of G-8 countries (excluding Russia) between 1990 and 1999, Canada was the only country that did not show any improvement in the physician-to-population ratio.

**Physicians per capita:
23rd of 27
industrialized countries**

The situation for nurses is equally distressing. Canada placed only 12th in 1999 and experienced a 7% drop in the ratio between 1990 and 1999 from 8.1 per 1000 population to 7.5. This puts Canada in the middle of the G-8 group.

Public sector as percent of total health spending

Among the industrialized (OECD) countries, Canada has consistently reported one of the lower public shares of total health spending since the 1980s. In 1985, Canada's public spending on health represented 75.6% of total health spending — placing Canada at 14th among the 22 countries reporting. In 2000, with public spending representing 72% of total health spending, Canada ranked 16th among 26 countries reporting. Canada's 2000 level of public spending was down almost four percentage points from 1985.

**Public sector health
Spending – percent
of total: 16th of 26**

Note: The UNDP contains 173 countries, WHO contains 191 countries and the OECD contains 31 countries. Life expectancy figures represent years at birth. Infant mortality represents the number of deaths of babies less than one year of age that occurred during a year per 1000 live births during the same year expressed as a rate. Perinatal mortality represents the number of deaths under 7 days (early neonatal deaths) plus fetal deaths of 28 weeks of gestation or more per 1000 total live births (live and stillbirths). Health indicators data are from OECD *Health Data*, 2002, 4th ed. www.oecd.org/healthdata. WHO performance indicators for 2002 are based as estimates for 1997.

ENDNOTES

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- ⁱⁱ Canadian Medical Association. *Third Annual National Report Card on Health Care*. August, 2003. (Conducted by Ipsos Reid). p. 17.
- ⁱⁱⁱ Canadian Institute of Health Information. *National Health Expenditure Trends, 1975-2002*. December 2002.
- ^{iv} Organization for Economic Cooperation and Development (OECD), *Health Data 2003*.
- ^v Government of Canada. *The Budget Plan, 2003*. February 18, 2003. p. 211.
- ^{vi} Government of Canada. *The Budget Plan, 2003*. February 18, 2003. p. 69.
- ^{vii} News Release, Annual Conference of Federal-Provincial-Territorial Ministers of Health, Halifax, Nova Scotia, September 4, 2003.
- ^{viii} Canadian Medical Association. Press Release, “*CMA Calls for Council by November 28 – Further Delay Unacceptable*”. September 3, 2003.
- ^{ix} Standing Senate Committee on Social Affairs, Science and Technology. *Final Report on the State of the Health Care System in Canada: The Health of Canadians – The Federal Role Volume Six: Recommendations for Reform*. October 2002. p. 17 - 20.
- ^x Commission on the Future of Health Care in Canada. *Building on Values: The Future of Health Care in Canada – Final Report*. November 2002. p. 52.
- ^{xi} Canadian Institutes of Health Research. *Report on Plans and Priorities for the Fiscal Year, 2003-2004*. p. 29.
- ^{xii} For more information, please refer to CMA’s 2001 report to the Standing Committee on Finance, *Security Our Future ... Balancing Urgent Health Care Needs of Today with the Important Challenges of Tomorrow*. November 1, 2001.
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- ^{xvii} United Nations Human Development Project. *Human Development Report 2001*. Press Release, July 10, 2001, Mexico City (www.undp.org/hdro).
- ^{xviii} Canadian Medical Association. *From debate to action. Message to First Ministers ... It’s time to put the health of Canadians first*. January 2003.

^{xix} Other organizations that reiterated the need for additional investment in health care included the Canadian Healthcare Association (Press Release, February 18, 2003 (www.cha.ca) and the Association of Canadian Academic Healthcare Organizations (Press Release, February 19, 2003 (www.ACAHO.org).

^{xx} Canadian Medical Association. *From debate to action. Message to First Ministers ... It's time to put the health of Canadians first.* January 2003. p. 8.

^{xxi} Ontario Hospital Reporting System, 2001. *Acute Care Occupancy Rates, Ontario Public Hospitals by OHA region, 1999/00.* Ontario Ministry of Health and Long Term Care.

^{xxii} Bagust A, Place M, Posnett J. Dynamics of bed use in accommodating emergency admissions: stochastic simulation model. *BMJ*; 319: 155-158 July 17, 1999.

^{xxiii} Nicolle L. Viruses without borders. *Can J Infect Dis* Vol. 11, Issue 3, May/June 2000 (Downloaded from Web: October 23, 2001: www.pulsus.com/Infdis/11_03/nico_ed.htm)

^{xxiv} At the national level there are a number of bodies that, in some cases, have been involved in health human resource planning issues for literally decades. The long standing Advisory Committee on Health Human Resources reported to the Conference of Deputy Ministers on health human resource issues but it functioned without outside expertise from the provider community and found it difficult to implement an integrated approach to planning. The National Coordinating Committee on Postgraduate Medical Training did include membership from both the medical profession and the government but its mandate was narrow (postgraduate training of physicians) and the committee was de facto sunsetted a couple of years ago.

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^{xxvi} Canadian Association of Occupational Therapists, Canadian Dietetic Association, Canadian Nurses Association, Canadian Physiotherapy Association, *Integrated Health Human Resources Development – Pragmatism or Pie in the Sky*, August 1995.

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