ALIGNING HEALTH AND ECONOMIC POLICY IN THE INTEREST OF CANADIANS

CMA's 2004 Pre-Budget Submission
to the Standing Committee on Finance

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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

ASSOCIATION MÉDICALE CANADIENNE

CANADIAN MEDICAL ASSOCIATION

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

On behalf of its more than 58,000 members and the Canadian public, CMA performs a wide variety of functions, such as advocating health promotion and disease/injury prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and 43 affiliated medical organizations.

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I. EXECUTIVE SUMMARY

For the past several years, the Canadian Medical Association (CMA) has been delivering two overall messages to the Standing Committee on Finance. First, we believe that Canadians' health and their health care system must be recognized as ongoing priorities. Second, we have been making the case that economic policy, including tax policy, must be better aligned with national health policy.

This year's brief provides specific examples of how the federal government can take action to address both of these issues. We begin with an assessment or a "check up" of the health of our health system. We then provide constructive suggestions on how to successfully implement the health agreement reached at the September 13-15, 2004 meeting of First Ministers. Finally, we draw attention to the need for continued investments in public health and healthy public policy.

Canadians remain increasingly concerned about the future state of their health care system, particularly in terms of accessing essential care. While their health status has improved over the past decades, international comparisons suggest there is considerable room for improvement. The significant announcements made over the past year related to reinvestments in health care and public health are a welcomed start to support health stakeholders in facing these challenges. The next steps must build on this progress.

INVESTING IN HEALTH CARE

Build on The First Ministers Meeting Agreement

In terms of health care, we must begin by noting that the First Ministers Meeting Agreement (FMM Agreement) was a significant achievement. It represents a positive policy framework to run with, but it must now receive the necessary fiscal, political and legislative follow-through. Legislation should be enacted that specifies the accountability framework for the Agreement. The Wait Times Reduction Fund should be subject to contribution agreements that specify how provinces and territories will use their share of this fund to reduce wait times. Critical to future success is the need for health care stakeholders to be actively involved with all facets of the Agreement, particularly in developing clinically derived wait time benchmarks.

Make Health Human Resources a Priority

At the same time, the federal government can do more to address accessibility to health care services by making a stronger commitment to increasing Canada's health human resources capacity. Several strategies are outlined in this brief, beginning with the need to ensure that the Wait Times Reduction Fund in the FMM Agreement is used immediately to address the crisis in health human resources rather than in the last four years of the ten-year Agreement as currently projected.

One specific health human resources strategy that the federal government should pursue is providing greater support for the training of students in health care professions as part of an overall health human resources strategy. High student debt is a key health human resource issue. It is estimated that, by the time medical students enter their pre-practice postgraduate training period, many are doing so with a debt of at least $120,000 or more. This high debt load is affecting both the *kind* of specialty that physicians-in-training choose, and ultimately *where* they decide to practice. As a result, the CMA calls upon the federal government to implement a national strategy to extend the Canada Student Loans interest payment benefit to eligible health professional students pursuing postgraduate training. Such action would provide a fairer approach and would alleviate some of the problems associated with our current training system of health professionals.

ALIGNING TAX POLICY WITH HEALTH POLICY

The CMA has highlighted the need to better align tax policy with national health policy goals for some time and we believe this challenge remains a priority. One example of where tax policy and health policy can be better aligned is how the GST is currently applied to the health care sector and to physicians—something the Finance Committee has acknowledged in previous reports.

Hospitals in Canada must still pay a portion of the GST on their purchase of goods and services siphoning away millions of dollars that would otherwise be used for patient care. The federal government recognized in the 2004 budget the need to provide a full GST rebate to municipalities, one of the four sectors covered by the so-called "MUSH" formula (Municipalities, Universities, Schools and Hospitals). We call on the government to apply the same logic and provide a full GST rebate to the health care sector.

Another problem exists with how the GST is applied to independent health professionals, such as physicians, providing care to Canada's publicly funded system. By virtue of being "tax exempt" under *The Excise Act,* physicians cannot claim any input tax credits to offset the GST costs they pay on their purchases of equipment, rent and utilities. Unlike other self-employed people, physicians cannot pass on any of these additional costs. This is a fundamental issue of tax fairness. It can be resolved by zero rating the GST on publicly funded health services provided by independent health providers thereby making them eligible to receive input tax credits.

INVESTING IN HEALTH

This past year saw many positive developments made to Canada's public health system. The CMA was pleased to see the creation of the position of Minister of State, Public Health. We commend the Government of Canada for its establishment of the Public Health Agency of Canada and for its selection of Dr. David Butler-Jones as the new Chief Public Health Officer of Canada.

However, the government must continue to reinvest in public health to ensure that the country has a system that earns the trust of Canadians. Investing in public health also makes good economic policy. We have seen in recent years the incredible economic impact that public health outbreaks can have on a country's economy.

Close the Naylor Gap in Public Health

The National Advisory Committee on SARS and Public Health (the Naylor Report) estimated that approximately $1 billion in annual funding is required to implement and sustain the public health programming that Canada requires. While representing an important reinvestment in this country's public health system, the funding announced in the 2004 Budget falls well short of this basic requirement. Accordingly, the CMA calls on the federal government to address the $450 million "Naylor Gap" as soon as possible.

Establish National Health Goals

Guiding this country's efforts to improve the health of Canadians should be the establishment and monitoring of national health goals. Thus, the CMA fully supports the First Ministers' call to establish a Pan-Canadian Public Health Strategy that includes the setting of health goals that are independently monitored. These goals should also cover environmental health goals given their direct implication on Canadians' health status.

Invest in Health Not Tobacco

Another key area for the CMA where current economic policy is not aligned with national health policy is the Canada Pension Plan's investment in tobacco stocks. Despite the fact that tobacco continues to kill approximately 45,000 Canadians a year and costs Canadian society approximately $11 billion per year in net cost, the Canada Pension Plan continues to invest millions ($94 million) in the tobacco industry. We strongly believe that the CPP Investment Board should be prohibited from investing in the tobacco industry and that it divest its current tobacco holdings. Other major pension and investment plans have successfully executed this policy including the MD Funds held for Canada's physicians at MD Management Ltd. a wholly-owned subsidiary of CMA. Accordingly, we call on the Standing Committee on Finance along with the Standing Committee on Health to jointly review the CPP investment policy as it relates to investments in tobacco.

The FMM Agreement and last year's funding announcements for public health must be seen as for what they are—first steps to sustaining Canada's health care system and its public health infrastructure. Canada's physicians and the CMA are committed to working with governments and other health care stakeholders to ensure that these financial investments lead to positive and enduring change, and ultimately improved health for all Canadians.

RECOMMENDATIONS

Recommendation 1

The federal government move quickly to enact legislation to implement the funding and accountability provisions of the First Ministers' Agreement. The legislation should specify that the $4.5 billion Wait Times Reduction Fund be subject to contribution agreements with the provinces and territories.

Recommendation 2

The federal government work with relevant stakeholders to extend interest free status on Canada Student Loans for all eligible health professional students pursuing postgraduate training.

Recommendation 3

As part of an effort to ensure that its tax policy is consistent with the goals of its health policy and the sustainability of Canada's health care system, the federal government should:

- **increase the GST rebate for publicly funded health care institutions and clinics to 100% ($90 million annually for hospitals)**
- **zero rate GST on publicly funded health services provided by independent health care providers ($75 million annually for medical services).**

Recommendation 4

The Standing Committees on Finance and Health hold a joint review of the CPP policy as it relates to investments in tobacco (both current and potential) by the CPP Investment Board.

II. CMA'S ANNUAL CHECKUP

Much has happened over the past year in regards to Canada's health and health care systems. First, we witnessed the creation of the Health Council of Canada, an institution that can play a significant role in improving the accountability of Canada's health system. Second, we saw several announcements aimed at rebuilding Canada's public health system including the establishment of the Public Health Agency of Canada and the subsequent appointment of Canada's first Chief Public Health Officer. And in September, federal, provincial and territorial First Ministers reached a historic agreement on a 10-year plan to strengthen health care.

Canadians no doubt welcome these developments. They have made it known to governments and health care providers alike that access to health care has become their top public policy issue. Not surprisingly, health was the top issue during the recent federal election campaign.

For four years, the CMA has been tracking Canadians' assessment of our health care system through our National Report Card on the Sustainability of Health Care. We are sad to report that the number of Canadians giving the nation's health care system a grade of C or F this year increased by a dramatic 9% over last year. While Canadians still give the system an overall B grade, the percentage of C and F grades was the highest since Ipsos-Reid began conducting the survey on behalf of the CMA in 2001. Moreover, our survey results found that 97% agreed that any discussion to make the system more sustainable needs to guarantee timely access for essential health services.

As our fact sheet on Canadians' health and their health care system illustrates (see Appendix A), improving access remains a major challenge for our health care system. Canada has one of the poorest physician-to-population ratios among all OECD countries. It is therefore not surprising that in 2003, 14% of Canadians reported not having a regular family physician (25% in Quebec). A recent Statistics Canada survey on wait times found that the proportion of patients who considered their wait time unacceptable was 17% for non-emergency surgery, 21% for diagnostic tests and 29% for specialist visits.[1]

Over the past year, CMA has been very active in bringing attention to the issue of access and wait times. The CMA co-sponsored a colloquium on managing wait times last April that culminated in the recently released report, *The Taming of the Queue: Toward a Cure for Health Care Wait Times.*[2]

But what about the state of Canadians' health itself? Certainly our health status has improved greatly over the past decades. However, while Canadians are among the healthiest people in the world, citizens in several industrialized countries are enjoying better health status. For example, disability-free life expectancy, that is quality of life years lived, for Canadian males is 18th among the 30 OECD countries and 16th for Canadian females. Canada's rate of infant mortality—deaths during the first year of life—is among the highest in the OECD.

But we need not compare ourselves to other countries to find differences in levels of health status. Significant discrepancies in health status also exist among Canadians, be it between provinces, between regions, between communities or between neighbourhoods. For example, there remain significant inequities in health status between Aboriginal Canadians and non-Aboriginal Canadians—the incidence of hepatitis and tuberculosis among Aboriginal Canadians are five and ten times higher respectively than for other Canadians.

It has now been over a year since the Report of the National Advisory Committee on SARS and Public Health or the "Naylor Report" was released. The report has lead to some positive developments in rebuilding Canada's public health system. It will be needed as some serious public health issues continue to face the country including:

- the spread of infectious diseases (e.g., C. difficile bacterium);
- the rise in the number of Canadians with unhealthy body weights including rising levels of obesity;
- high levels of physical inactivity;
- smoking, particularly among youth;
- relatively low rates of immunization; and
- threats to environmental health including those that threaten our clean air, and safe food and drinking water.

In summary, notwithstanding all that has transpired this year, Canadians' health and their health care system remain high public priorities. While their health status has improved over the past decades, there is considerable room for improvement, some of which can be addressed through public health measures and better access to care. The significant announcements made over the past year related to health system and public health financing are a welcomed start to support health stakeholders in facing these challenges.

III. THE FIRST MINISTERS' MEETING AGREEMENT

The CMA closely followed the September 13-15, 2004 First Ministers Meeting on the Future of Health Care. In fact, we worked with our health care colleagues leading up to the meeting to identify possible strategies for improving the system.[3] For instance, we recommended the development and adoption of pan-Canadian benchmarks for wait times based on clinical evidence and the creation of a special Canada Health Access Fund to support Canadians' access to medically necessary care in other regions.

While not all of our proposals were accepted, the September First Ministers' Meeting Agreement (herein referred to as the FMM Agreement) features many aspects that the CMA has been championing for some time and is certainly a positive achievement. In particular, we are happy to see a desire "to make timely access to quality care a reality for all Canadians." We applaud the leadership shown by the government in this regard.

We also believe that the Agreement provides an opportunity for a new era of cooperative medicare by engaging physicians and other providers meaningfully. Contrary to belief, health care providers have not been offered many opportunities to participate at federal, provincial and territorial planning tables. We therefore welcome the opportunity to work collaboratively on identifying clinically derived wait time benchmarks. Canada's physicians can and desire to play a significant role in this regard.

We therefore believe the FMM Agreement is a necessary first step or "a framework to go with" towards strengthening our health care system. But as we said in September following the release of the Agreement, "the real heavy lifting begins now." Accordingly, we believe that a number of requirements are necessary to ensure this Agreement fulfills its objectives. We see these requirements as putting words to actions for realizing the full potential of the FMM Agreement.

Enact Legislation to Confirm Financial Support and Accountability Provisions

The CMA supports enacting federal legislation to confirm the budgetary allocations in the Agreement ($18 billion over 6 years and $41 billion over 10 years). This includes a 6% escalator to the Canada Health Transfer (CHT) that will provide predictable funding for provincial and territorial health care systems. This is a provision that we have been recommending for many years.

While $41 billion is a lot of money, we must remind ourselves that this amounts to little more than a 3% increase over 10 years of provincial government health expenditures based on projections of current government spending. Moreover, we estimate that the Agreement will add only .2% to Canada's spending levels per GDP during this period. In other words, the FMM Agreement, while necessary and appreciated, will not propel Canada into the top echelon of health care spenders among the leading industrialized countries. As health care has become a dominant public policy issue, we expect to see future high level discussions in coming years on both future funding levels and on the direction of health care reform efforts.

We are also pleased to see a new Equalization agreement that will complement the FMM Agreement. The Equalization program plays a key role in ensuring that all provinces have adequate and comparable levels of health care and other social services. The issue of Equalization payments to the provinces was identified in discussions leading up to the September First Ministers Meeting over concern that increased federal transfers to health care could be offset by decreases in Equalization payments. The subsequent agreement on Equalization will therefore serve to support the FMM Agreement given that increases in health care transfers to provinces will not be offset by decreases in equalization payments while providing predictable multi-year funding.

A strong accountability framework also needs to be included in the legislation. The FMM Agreement specifies several process accountabilities such as a commitment by governments to report on access indicators and establish wait time benchmarks by December 31, 2005. The CMA believes that the Wait Times Reduction Fund should be subject to contribution agreements that specify how provinces and territories will use their share of this fund to reduce wait times.

For the Agreement to mean something commitments have to backed up—financial and/or political consequences must follow if commitments are not met.

It will be important to have an independent, third party organization assess progress in an open and transparent manner. The Health Council of Canada, identified in the FMM Agreement, could be the body to undertake an annual independent assessment, providing it receives the necessary resources to do so. The Canadian Institute for health Information also has an important role to play in ensuring comparable indicators are used to measure progress.

It is essential to involve practicing physicians throughout the implementation of the FMM Agreement, particularly in the development of clinically derived wait time benchmarks. The determination of clinically derived wait time benchmarks means just that—they must be clinically derived and must not be based on political or financial considerations. To this end, the CMA will play a leadership role in developing consensus with physicians and other expert organizations on acceptable wait-time standards and protocols based on the best available clinical evidence.

RECOMMENDATION 1

The federal government move quickly to enact legislation to implement the funding and accountability provisions of the First Ministers' Agreement. The legislation should specify that the $4.5 billion Wait Times Reduction Fund be subject to contribution agreements with the provinces and territories.

Improve Access by Addressing Health Human Resources

The CMA is pleased to see the First Ministers acknowledge for the first time the current and worsening shortage of health human resources (HHR) in this country. However, the FMM Agreement does not adequately provide a strategy for addressing this crisis beyond the development of health human resources action plans and support for an Aboriginal Health Human Resources Initiative.

The CMA believes that the lack of immediate action on HHR is one area where the Agreement falls short. As noted in our fact sheet, Canada is currently experiencing a shortage in health human resources. Canada's ratio of 2.1 physicians per 1,000 population remains one of the lowest among OECD countries and below the OECD average of 2.9. Initial results from the 2004 National Physician Survey—the largest census survey of physicians ever conducted in Canada—find that up to 3,800 physicians will retire in the next two years, more than double the existing rate. Furthermore, 26% of physicians intend to reduce the number of hours they work.[4] One must remember that timely access to health care services is first and foremost about the people who provide quality care and the tools and infrastructure they need to meet the growing demand for medical services in Canada.

In order for the FMM Agreement to be successful in improving access to care, governments must make health human resources a major priority beginning by ensuring that the Wait Times Reduction Fund is used immediately to address the crisis in health human resources rather than

in the last four years of the ten-year Agreement as currently projected.[5] Given the current shortages in health human resources, action on HHR must begin now—not in 2010.

In addition, the CMA calls upon the federal government to play a key role in improving the availability of health human resources by developing a pan-Canadian HHR strategy that includes the involvement of health care providers. Specifically, we need a three pronged pan-Canadian HHR strategy that would address: (1) HHR planning; (2) increasing the supply of health professionals; and, (3) retention issues.

Planning

Despite the large sum of funding that governments invest in health care, they do so without having the benefit of a national long-term health human resources strategy. Canada has 14 provincial/territorial and federal health care systems in operation. Yet, our immigration policies are largely conducted on a national basis and there is a high degree of labour mobility between provinces.

Presently, there is no overall national coordinating committee to assist provinces and territories in the planning of health human resources, particularly one that includes all pertinent stakeholders including physicians and other health care professionals. We believe a National Coordinating Committee for Health Human Resources involving representation from health care professions should be established for such purposes—something both the Romanow and Senator Kirby reports recommended.

Research is required to support long-term planning in HHR. The CMA has previously proposed the creation of an arm's length Health Institute for Human Resources (HIHuR) that would promote collaboration and the sharing of HHR research among the well-known university-based centres of excellence as well as research communities within professional associations and governments.

Supply

Canada's HHR policy goal should be to ensure Canada is self-sufficient in the supply of physicians and other health care professionals. Several strategies are required to fulfill this goal. They include:

- Dedicating a specific fund to increase enrollment in undergraduate and postgraduate medical education (especially re-entry positions). Medical school enrollment should be increased to a minimum of 2,500 positions by 2007.

- Expanding the post-MD system to accommodate the increase in graduates for training including the several hundred international medical graduates (IMGs) in Canada who have been deemed eligible for post-MD training here. The goal should be to increase the number of first-year residency training positions to a level of 120% of the graduates produced annually by Canadian medical schools. See Appendix B for how this can be implemented. The estimated cost of adding 500 positions is $75 million over five years. In fact, this government's election platform included a commitment to provide funding to top-up training for 1,000 foreign trained medical professionals.

- Expediting the integration of international medical graduates by funding a fast-track on-line assessment program administered by the Medical Council of Canada. It would determine the suitability and eligibility of IMGs for completion of post-MD training (estimated cost $20 million over 5 years).

- Implementing a national strategy to extend the Canada Student Loans interest payment benefit to postgraduate trainees in medicine. High student debt impacts both the *kind* of specialty that physicians-in-training choose, and ultimately *where* they decide to practice—making it a key health human resource issue (see box below). The Canadian Medical Association commends the federal government for its commitment to reduce the financial burden on students in health care professions, as announced in the FMM Agreement.

Did you know?

Becoming a full-fledged, practicing physician is an arduous and expensive endeavor. It requires a minimum of 9 years[6] of post-secondary education and training that is often financed through sizeable government and private loan debt, such as lines of credit. It is estimated that, by the time medical students enter their pre-practice postgraduate training period, many are doing so with a debt of at least $120,000[7] or more.

RECOMMENDATION 2

The federal government work with relevant stakeholders to extend interest free status on Canada Student Loans for all eligible health professional students pursuing postgraduate training.

Retention

Retention remains a major concern for the health care workforce including physicians. We speak not only in terms of losing physicians to other countries but to other professional pursuits as well (i.e., opportunities away from the front line delivery of care). There is little point in recruiting new physicians at the front end if we lose sight of how to keep them once they are highly skilled and are in their most productive years.

Retention issues are crosscutting. Indeed, a major frustration for physicians today are the difficulties faced trying to access other types of care for their patients such as diagnostic testing, specialty care or community services. Thus, improving access to a comprehensive range of health care providers and services and reducing wait times—as previously addressed—can help.

We also believe that investments in information technologies (IT) can help improve the coordination of health care and allow physicians to spend more time with their patients to provide quality care. There is currently limited connectivity among community-based physicians, community based services, specialists, hospitals and diagnostic facilities. IT investments can improve the integration of care, improve patient safety and improve the management of wait times. They can link regional and provincial wait time management systems while supporting more comprehensive scheduling systems. Prescriptions can be sent electronically to the local pharmacist while public health warnings can be sent electronically to physicians' offices.

We recognize that investments in IT are already occurring and systems will be put in place over the next decade. However, we believe that by accelerating IT investments today, system efficiencies and savings can be achieved sooner along with improvements to health care delivery and coordination.

The application of tax policy to the health care sector is another retention issue that greatly frustrates physicians. This issue is discussed in the next section.

Align Tax Policy With Health Policy

The CMA continues to advocate for a review of the relationship between federal tax policy and health care policy in Canada. Taxation is a powerful instrument of public policy. Good tax policy should reinforce and support good health care policy. Yet, it has been 40 years since the federal government last undertook an overarching review of Canada's tax system (the 1962-1966 Royal Commission on Taxation -the Carter Commission).

Standard public finance theory suggests that two objectives of effective tax policy are distributive equity and correcting inefficiencies in the private sector.[8] For some time, the CMA has expressed concern over inequities in tax policy and inconsistencies between national health policy goals and tax policy.

We are aware that the committee is looking for ideas on tax changes that can lead to a more productive economy. At the same time, we recognize that the government is committed to improving Canadians' access to health care. Ensuring this country's tax policy is supporting our health care system is a good way to achieve both objectives.

Specifically, the CMA calls on the federal government to remove the application of the Goods and Services Tax (GST) to the health care sector. Currently, not-for-profit hospital services receive an 83% rebate on the GST they pay on goods and services, while not-for-profit health organizations receive a rebate of 50%. Health care professionals working in free-standing clinics do not qualify for any GST relief (discussed below). The estimated portion of funding paid by hospitals alone back to the federal government in the form of GST revenue is estimated to be $90 million per year. That is the equivalent of the purchase cost of almost 40 MRI machines! The CMA believes that all publicly funded health care services should be spared from having to use scarce health care resources to remit GST and should receive the full GST rebate.

Would this be setting a precedent? The answer is "no". Prescription drugs, a significant proportion of total health care costs, have been zero-rated since 1996. Furthermore, the 2004 federal budget confirmed that municipalities would be able to recover 100% of the GST and the federal component of the harmonized sales tax (HST) immediately. As part of the "MUSH" sector (municipalities, universities, schools and hospitals), we believe the time has come to extend the full rebate to the health care sector. The federal government must stop taxing publicly funded health care.

The uneven application of the GST rebate to different health services is also impeding efforts to renew and reorient the delivery of health services. Currently, community-based services such as clinics and nursing homes receive a GST rebate of only 50% while hospitals receive a rebate of 83%. Does it make sense that a nursing home or a home care service should pay more for GST than a hospital, particularly when trying to move to a more accessible community-based system? The variability of GST rebates makes no sense for organizations such as regional health authorities that oversee a range of health services but which pay differing rates. The government acknowledged in its 2003 Budget that there was a need to review how the GST is applied to care settings outside of hospitals. We await this review. Such inconsistencies distort the efficiency of the health care sector yet are relatively simple to address.[9]

Physician services, on the other hand, are deemed "tax exempt" under *The Excise Act*. This means that physicians cannot claim any input tax credits despite the fact they must pay GST on their purchases of equipment, rent and utilities. And unlike other self-employed individuals or small businesses, physicians cannot pass on any of these additional costs as approximately 98% of physician compensation is from government health insurance plans. To date, provincial governments have been unwilling to provide funding to reflect the additional costs associated with the GST (insisting that it is a federal matter).

Physicians are not asking for special treatment. They are looking for fairness within the tax system. If physicians, as self-employed individuals, are considered small businesses for tax purposes, then it only seems reasonable that they should have the same tax rules extended to them that apply to other small businesses (i.e., eligibility to receive input tax credits). This is a fundamental issue of tax fairness. In fact, this committee has twice before acknowledged the need to reassess the application of the GST on physician services. [10]

The unfair manner in which the GST is applied to the health care sector has been an on-going source of major frustration to the physician community and remains unresolved. We believe that addressing this matter would be helpful in the country's efforts to retain its physicians. Other self-employed health care providers that provide publicly funded services face a similar problem.

RECOMMENDATION 3

As part of an effort to ensure that its tax policy is consistent with the goals of its health policy and the sustainability of Canada's health care system, the federal government should:

- **increase the GST rebate for publicly funded health care institutions and clinics to 100% ($90 million annually for hospitals)**
- **zero rate GST on publicly funded health services provided by independent health care providers ($75 million annually for medical services).**

IV PUBLIC HEALTH: HEALTHY PUBLIC

As previously noted, much has happened over the past year with respect to Canada's public health system. The CMA was pleased to see the creation of the position of Minister of State, Public Health.

We commend the Government of Canada for its establishment of the Public Health Agency of Canada and for its selection of Dr. David Butler-Jones as the new Chief Public Health Officer of Canada. The 2004 Budget's commitment to approximately $665 million for investments for public health over the next 3 years was also a welcomed announcement.

The CMA will provide its full support to work with Dr. Butler-Jones and the Public Health Agency of Canada, Ministers Bennett and Dosanjh to develop a coordinated and integrated plan to manage and improve public health in Canada. These developments certainly represent a good step towards rebuilding the country's public health system.

Address the "Naylor Gap"

In spite of these initiatives, it remains essential to remind this government and Canadians that further attention to public health is necessary. As a member of the Canadian Coalition for Public Health in the 21st Century (CCPH21), the CMA calls on the federal government to enhance its financial commitment to the renewal of Canada's public health system

The public health system is a vital component of a sustainable health system by reducing pressures on the health care system and providing a net benefit to society.[11]
Two thirds of total deaths in Canada are due to chronic diseases such as cardiovascular disease, cancer, lung disease and diabetes (Type II melitus)—many of which are preventable.

Investing in public health also makes good economic policy. We have seen in recent years the incredible economic impact that public health outbreaks can have on a country's economy. For instance, it has been estimated that the SARS outbreak cost the Canadian economy over $1.5 billion in 2003 alone with its impact still being felt.[12] As stated in the Report of the National Advisory Committee on SARS and Public Health (the Naylor Report), "we are constantly a short flight away from serious epidemics."[13]

Accordingly, we were pleased to hear the government's Speech from the Throne state that the government will proceed with the development of the Pan-Canadian Public Health Network.

But we have to overcome several years of inattention to public health issues and the public health infrastructure—something that cannot be rectified in a year. Spending levels on public health in Canada are meager. International comparisons are difficult to find and to compare, but it appears that this is one instance where Canada could learn from its neighbour to the south with its higher level of spending on public health (see Box comparing public health spending between Canada and the United States).[14] While the role of public health was referred to in the FMM Agreement, no additional funding for public health was included.

Comparing Levels of Public Health Spending: Canada vs. the United States

Using data from CIHI and the US Centers for Medicare and Medicaid Services, the CMA has developed the following comparative estimates of spending on public health in Canada versus the United States in 2002.

	Canada	**United States**
1. Per capita spending on public health services ($CDN, PPP adjusted)	$138	$207
2. Share of spending on public health as a % of public health care spending	5.5%	7.2%
3. Share of spending on public health as a % of total health care spending	3.9%	3.3%

The United States spends approximately 50% more on public health than Canada when comparing per capita payments. The United States also spends more on public health when considering public health spending as a percentage of all publicly funded services (due in part to a proportionately smaller publicly funded sector). Conversely, Canada spends more on public health if looking at the percentage of spending on public health as a percentage of total health care spending. This is due in part to a proportionately larger privately funded sector in the United States. Since public health is predominately a public good paid by governments, we believe it is most appropriate to compare the results from the first two indicators.

The Naylor Report estimated that public health in Canada accounted for 2.6% to 3.5% of total publicly funded health expenditures in Canada and 1.8% to 2.5% of total health expenditures. While these estimates are lower than those provided above, they still support our observation that public health spending in Canada is lower than in the United States.

The Naylor report provided a blue print for action and reinvestment in the public health system for the 21st century. It estimated that approximately $1 billion in annual funding would be required to implement and sustain the public health programs that Canada requires. In its submission to the National Advisory Committee on SARS and Public Health, the CMA also identified an essential range of comprehensive public health programming and initiatives totaling an estimated $1.5 billion over 5 years.[15]

The federal government has thus far committed approximately $665 million in new programming (one-time funding, over 2 years, and over 3 years), well short of Dr. Naylor's $1 billion per year. This "Naylor Gap" of approximately $450 million per year is identified below in Table A.

Table A: Estimating "The Naylor Gap"

Naylor Funding Recommendations (by 2006-07)	Budget 2004	Naylor Gap
Public Health Agency of Canada Related Funding		
- $300 million per year core budget of PPHB and other related federal services to be transferred to new agency	- $404 million transferred from Health Canada to Agency	
- core functions to be expanded by $200 million per year within 3-5 years	- $165 million over 2 years to assist in setting up new agency, increase emergency response capacity, enhance surveillance, establish regional centres of excellence, expand laboratory capacity, strengthen international coordination and collaboration	$117.5 million per year ($200 million by Naylor minus $82.5 million per year committed by the federal government averaged out). Moreover, nothing earmarked beyond 2005-06.
System Funding		

3 programs of transfers at a cost of $500 million per year:
- $300 million for Public Health Partnerships Program to build capacity at local level
- $100 million for communicable disease surveillance
- $100 million to bolster national immunization strategy
	- $100 million (one-time) to Canada Health Infoway to pay for real-time public health surveillance system
	- $400 million over three years for:
	  - $300 million for national immunization strategy
	  - $100 million for provinces to address immediate gaps in capacity
		Approximately $333 million per year
		
		($500 million per year request by Naylor less Budget 2004 commitments of $500 million over 3 years or $167 million per year averaged out.)

Total: $1 billion per year	**$404 million annually plus $665 million in new programming (one-time funding, over 2 years, or over 3 years)**	**Total "Naylor Gap": $450.5 million per year**

We acknowledge that the Public Health Agency of Canada is just being created. We also recognize that Budget 2004 noted that: "The Government of Canada expects to make further investments once the new Canada Public Health Agency is operational, the Chief Public Health Officer has developed a comprehensive public health plan, and the Government has had the opportunity to evaluate the need for additional resources."[16] Nevertheless, it is critical that reinvestment in Canada's public health system continue as soon as possible to protect and promote the health of Canadians.

These additional investments are needed to fully implement Dr. Naylor's recommendations. This includes operating costs for a real time communication system for front line public health providers during health emergencies. It would 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 Public Health Agency of Canada. The CMA has recently submitted a proposal to Canada Health Infoway to develop a system (the Health Emergency Communication and Co-ordination Initiative) that would link Canada's physicians with governmental authorities. The additional investments should also be used to help address the recruitment and retention of public health practitioners.[17]

In contrast with other areas of health expenditures, we know very little about how public health dollars are allocated and with what results. Presently, public health expenditures are lumped together with some health system administration costs. We believe there is a need for a better tracking and public reporting of public health expenditures.

Set and Meet National Health Goals

The CMA was pleased to see support by First Ministers in the FMM Agreement to establish a Pan-Canadian Public Health Strategy and health goals that are independently monitored. We believe health goals are a key component in addressing the serious public health challenges that lie ahead. Goals stimulate action and improve system accountability. Unlike Canada, many other countries—including the United States, the UK and Australia—have set health goals for their populations at the national level.

At the CMA's August 2004 General Council meeting, physicians agreed on health goals for physical activity, healthy body weights and obesity (see box below). These goals are already having an effect. Recently, the BC Minister of Health, Colin Hansen, accepted the challenge from the President of the British Columbia Medical Association, Dr. Jack Burak, to increase fitness levels by 10 per cent by 2010.

We also need to be more preoccupied with setting, meeting and monitoring environmental health goals. Let us look at drinking water for example. As hard as it may be for Canadians to believe, a safe supply of water is a key health concern for Canadians today just as it was at the turn of the 20th century. The polluting of our water supply—including the presence of antibiotic-resistant bacteria through the use of antibiotics in human and animal health—and a lack of adequate water treatment infrastructure systems have contributed to the problem. Above all, we as Canadians need to recognize that a large natural supply of water and other natural resources do not eliminate the need for strong environmental governance. Public health officials play an important role in this respect.

But it is pointless to set goals without any intention of meeting them. Resources will be necessary to meet the selected health goals such as the training and hiring of public health workers, as well as funding to support public advertising and marketing campaigns.

Physical Activity and Healthy Body Weight Goals for Canada
(Endorsed at CMA General Council, August 2004, Toronto)

The Canadian Medical Association urges all levels of government to commit to a comprehensive, integrated and collaborative national strategy for increasing the physical activity levels of all Canadians, with a target of a 10% increase in each province and territory by the year 2010.

The Canadian Medical Association calls on all stakeholders to develop, as an urgent priority, an action plan to address the obesity epidemic in Canada, with a goal of increasing by 15% within ten years the proportion of Canadians who are at a healthy weight.

Invest in Health Not in Tobacco

Improving health status is more than promoting healthy lifestyle behaviour. A healthy society also requires public policy that supports health (e.g. adequate income and education, proper housing, adequate nutrition, a clean and safe environment.)

Tobacco use is a good example of a health risk that has been significantly reduced with the help of public policy measures, such as higher tobacco taxes, continued restrictions on tobacco advertising and promotion, and restrictions on smoking in public places. But there remains inconsistency in Canada's public policies—in this case between the investment policies of the CPP Investment Board and Canada's health policy goals.

Canadians are very proud of their public pension plan, the Canada Pension Plan (CPP). It is a well-supported social program that has been viewed as a best practice model by several countries. Yet, despite the fact that tobacco continues to kill approximately 45,000 Canadians a year and costs Canadian society approximately $11 billion per year in net cost,[18] the Canada Pension Plan holds $94 million worth of tobacco investments.

Canada's physicians see the toll that tobacco consumption creates. We see the physical and mental suffering that tobacco-caused diseases bring to patients and their families. Accordingly, the CMA has consistently recommended a wide range of measures to control tobacco use such as higher tobacco taxes, continued restrictions on tobacco advertising and promotion, restrictions on smoking in public places, enforcement of bans on sales to minors, reduction of the level of toxic ingredients in tobacco and the provision of smoking cessation programs. We are pleased with the efforts to date but we are by no means finished in our battle. As our fact sheet shows, there are still segments of the population, particularly among our youth, that have high rates of smoking.

The federal government in recent years has spent hundreds of millions of dollars on a tobacco reduction strategy that, when combined with efforts being taken by the provinces and municipalities, is making a difference for Canadians. However, the CPP Investment Board is investing and voting as shareholders in a pattern that is inconsistent with both public health policy, and the tobacco reduction measures being implemented across Canada. It is inconsistent and illogical for one arm of government to expend many millions of dollars of public money in an effort to reduce tobacco use, while another arm invests many millions of dollars of money in tobacco companies and supports these companies in their drive to be profitable.

Resolution of the Canadian Medical Association General Council, August 2004:

> *…the government amend the Canada Pension Plan Investment Board Act so that CPP investments in the tobacco industry are prohibited and the CPP Investment Board divests itself of existing tobacco holdings.*

The CMA is prepared to back up what it is prescribing—MD Management Ltd's "MD Funds" which are managed for Canada's physicians has followed this policy for almost ten years. Other major pension and investment plans have successfully followed this policy as well including several US State retirement and pension funds and the American Medical Association Pension Fund.

While the CMA clearly believes that the CPP Investment Board should not invest in the tobacco industry and that existing tobacco holdings should be divested, we recognize that this committee might want to look at the matter in greater context to assess its full impact. We suggest that this be done in conjunction with the Standing Committee on Health.

RECOMMENDATION 4

The Standing Committees on Finance and Health hold a joint review of the CPP policy as it relates to investments in tobacco (both current and potential) by the CPP Investment Board.

IV. CONCLUSION

The Finance Committee's last report on the pre-budget hearings noted that the CMA's submission identified relatively small, one-time investments that can support the health care system.[19] This year's submission once again puts forward strategic investments that we believe support Canada's health policy goals and which serve to effectively implement the FMM Agreement. Our recommendations are also directed at improving the alignment of Canada's economic policy with its health policy.

It is natural to think of an agreement as an end point. But in reality, the FMM Agreement and last year's funding announcements for public health must be seen as for what they are—first steps to sustaining Canada's health care system and its public health system. Canada's physicians and the CMA are committed to working with governments and other health care stakeholders to ensure the financial investments announced over the past year lead to positive and enduring change, and ultimately improved health for all Canadians.

END NOTES

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[6] Average duration. Only 2/16 medical schools have a 3 (versus 4) year program.
[7] This estimate is based on federal government actual and estimated costs as well as current actual national average tuition fees in undergraduate programs in medicine. Data sources: (1) Statistics Canada, The Daily, April 26, 2004, National Graduates Survey: Student Debt, p. 3. (2) Government of Canada, Canlearn. Saving for your child's education, The projected cost of your child's education. University Tuition. Typical 1996 university cost living away from home: $13,000 - $3,500 tuition = $9,500 x 24% (8 years x 3% inflation cited in reference above) = $11 780. see: http://www.canlearn.ca/financing/saving/guaranteefuture/clcos.cfm?langcanlearn=en (3) Association of Canadian Medical Colleges for tuition
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[18] Adapted from estimates provided by Murray J. Kaiserman, "The Cost of Smoking in Canada, 1991", *Chronic Diseases in Canada*, Vol. 18, No. 1, 1997. Available at http://www.phac-aspc.gc.ca/publicat/cdic-mcc/18-1/c_e.html.
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Straight facts about Canadians' health and their health care system

The recent signing of the "10-Year Plan to Strengthen Health Care" has lead many Canadians to ask how spending in Canada compares to other leading industrialized countries as well as how we are doing in terms of our health status and the performance of our health care system. So, how is Canada doing?

Health spending indicators

Health care spending: Total health care spending in Canada is expected to have been 10% of GDP in 2003. Based on latest available OECD figures (2001–2002), Canada's level of total health care spending was the sixth highest among the 30 industrialized countries, following the United States, Switzerland, Germany, Iceland and France. It is estimated that the planned federal funding increases announced in the 2004 Health Accord will lead to only a .2% increase in total health care spending as a percentage of GDP over the next several years.

Public/private spending: *Canada continues to record one of the lowest public shares of total health care spending, ranking 22 out of 28 reporting OECD countries.* Furthermore, Canadians are the fifth highest out-of-pocket spenders (health care expenditures paid directly by individuals as opposed to private insurers) for health care among 24 reporting OECD countries. Only residents of Switzerland, the United States, Australia and Iceland had higher out-of-pocket payments.

Health status

Life expectancy: Canadian males have the sixth highest life-expectancy rate (77.1 years) among the 30 OECD countries and females the eighth highest rate (82.2). The bad news is that when adjusted in terms of healthy years of living (HALEs) or quality of life years, Canadian males slip to 18th (68.2 years) while Canadian females slip to 16th (71.6 years). *There also remains significant variation in life-expectancy across the country.* Residents of Nunavut born today can expect to live approximately 12 fewer years than residents born in BC. There is also a difference of over 2 years in life expectancy between residents of BC (80.6) and Newfoundland and Labrador (78.3).

Infant mortality: Despite major improvements over the past several decades, Canada's rate of infant mortality actually rose in 2002. Infant mortality refers to the number of deaths during the first year of life for every 1,000 live births. Canada's rate in 2002 was 5.4 up from 5.2 in 2001. *This rate puts Canada 22nd out of 28 reporting OECD countries.*

Smoking: *Canada has the second lowest rate of daily smokers (18.2%) among OECD countries* following Sweden (17.8%). While the number of daily smokers has dropped dramatically since 1970 (40%), there is still cause for concern. The rate of smoking for girls aged 15–19 was 20% in 2003 and 17% for boys. And the smoking rate among those aged 20 to 24 remains consistently high at 30%.

Obesity: Obesity is recognized as a health priority for Canadians. According to OECD figures,

Canadians report much higher levels of obesity (14.9%) than citizens of most other OECD countries (BMI >30kg/m2). Moreover, 47% of Canadians were overweight in 2000–2001, while 56% of Canadians were physically inactive.

Health Human Resources and Access — Canadians' number one concern

Number of physicians: Canada's physician to 1,000 population ratio is 2.1 placing Canada 24th out of 30 OECD countries and well below the OECD average of 2.9. Canada's rate of practicing specialists per 1,000 population (1.1) puts it 21 out of 25 reporting OECD countries.

Physician access: In 2003, 3.6 million or 14% of Canadians reported not having a regular family physician. Almost one in six individuals requiring routine care reported experiencing difficulties accessing care. Access to physician services varies among the provinces. While approximately 5% of Nova Scotians have not looked for or cannot find a regular family physician, the rate increased to over 25% for Quebec residents.

Wait times: According to a recent Statistics Canada survey, *the proportion of patients who considered their wait time unacceptable was 17% for non-emergency surgery, 21% for diagnostic tests and 29% for specialist visits*, with large inter-provincial variations in all three areas. For example, 19% of residents in PEI reported unacceptable waits for specialists compared to 34% in Newfoundland and Labrador.

Access to advanced health technologies: the latest OECD figures place Canada 14th out of 25 reporting OECD countries for MRI units per million population. Canada had 4.2 MRIs per million population in 2001 compared to 8.2 in the United States and 35.3 in Japan.

Public health

Immunization: Canada is one of the leading countries with respect to immunization for influenza for seniors, and has a high rate of immunization of children for measles (94.5%). However, it does poorly (76.8% of children) when it comes to immunizing for DTP (diphtheria, tetanus and pertusis) placing Canada *26th out of 27 reporting OECD countries.*

Environmental quality — Canada's record needs considerable improvement

Air quality: Canada produces the fourth highest levels of carbon dioxide emissions per capita and the second highest levels of sulphur oxides emissions per capita among OECD countries.

Water quality: Only 57% of the Canadian population relies on secondary or advanced water treatment systems. This is below the OECD average (60%) and far below many other countries such as Sweden (93%) and Germany (89%).

Sources

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CMA's Plan for International Medical Graduates (IMGs)

Canada's health workforce policy might be described as one of "beggar thy neighbour," both within Canada—between provinces/territories and communities—and internationally. In terms of how IMGs might be factored into such a plan, the CMA would recommend short, medium and longer-term approaches.

A critical first step in moving ahead on such a plan would be to convene a table along the lines of the recent IMG Task Force that would tackle the full breadth of workforce issues with representation from the national medical organizations and the federal, provincial and territorial governments.

Short-Term

At present, IMGs are able to access postgraduate medical (post-MD) training by successfully completing the Medical Council of Canada Evaluating Exam (MCCEE), and then applying to the second iteration of the match conducted each year by the Canadian Resident Matching Service (CaRMS) or by applying to one of the special programs for IMGs that are offered at some Canadian medical schools.

In the short-term, the CMA would recommend that the federal government provide sufficient funding to provide additional training positions for a number of the some 700+ IMGs who would be eligible to begin a post-MD residency training immediately. Such funding could also provide for the comprehensive assessments of IMGs that have been developed in several jurisdictions. The CMA also strongly supports the initiative of the Medical Council of Canada (MCC) in developing a pilot for the off-shore electronic administration of the MCCEE. The March 1, 2004 announcement by Dr. Hedy Fry of $4 million in support of the Task Force recommendations is very welcome, but it is just a first installment on what is required.

Medium-Term

The CMA and other national medical organizations believe that the size of the postgraduate medical training system is a bottleneck, both for Canadian medical graduates and IMGs alike. The number of post-MD training positions funded by provincial governments has been flat-lined since the early 1990s, and is only barely sufficient for the graduating cohort, thus leaving virtually no room for either IMGs or for practising Canadian graduates wishing to retrain.

Over the past few years the number of IMGs applying in the second iteration of the CaRMS match has more than doubled, rising from 294 in 2000 to the forecast 758 who were expected to have competed for the 177 positions in the 2nd round match on April 29, 2004. Among the 625 IMGs in the second round of the match in 2003, just under 11% (67) were matched.

Several medical schools have special programs for IMGs. According to the Canadian post-MD registry, while 67 IMGs were matched to postgraduate year one (PGY-1) positions in 2003 there were a total of 213 IMGs in PGY-1 as of November 2003.

The CMA and other national medical organizations have been advocating for a minimum of 120 PGY-1 training positions for every 100 graduates. Action on this recommendation will become crucial in the next few years when the expanded undergraduate cohort (post-1999) graduates.

More generally, we believe that the following components must be explicitly factored into the planning for the capacity of the post-MD training system:

- all new graduates of Canadian medical schools who are permanent residents (including opportunities to switch training programs);
- re-entry into postgraduate training among physicians in practice in Canada;
- IMGs who are permanent residents or citizens of Canada; and
- non-resident IMGs wishing to pursue postgraduate training in Canada as visa trainees.

Increased efforts and resources will be required to recruit additional community-based teachers to participate in both undergraduate medical education and post-MD training, and to support and retain those who are already doing so. As well, government funding will need to be forthcoming for the infrastructure costs to medical schools to handle the increased training.

Long-Term

Canadians should be served by a uniform standard for medical practice that applies both to Canadian medical graduates and IMGs alike. This national standard must continue to be the cornerstone of a long-term vision and plan for Canada's physician workforce.

In moving toward such a plan, the CMA believes Canada should adopt a policy of increased self-sufficiency in the production of physicians in Canada that includes:

- increased opportunities for Canadians to pursue medical education in Canada;
- enhanced opportunities for practising physicians to return for additional training;
- strategies to retain physicians in practice and in Canada; and
- increased opportunities for IMGs who are permanent residents or citizens of Canada to access post-MD training leading to licensure/certification and the practice of medicine in Canada.

National Physician Survey / Sondage national auprès des médecins

Initial Data Release of the 2004 National Physician Survey

A collaborative project of
The College of Family Physicians of Canada,
the Canadian Medical Association, and
The Royal College of Physicians and Surgeons of Canada

October 2004

The Royal College of Physicians and Surgeons of Canada / Le Collège royal des médecins et chirurgiens du Canada
The College of Family Physicians of Canada / Le Collège des médecins de famille du Canada
Association médicale canadienne / Canadian Medical Association

Access to care

Findings from the National Physician Survey confirm that many Canadians are experiencing problems in obtaining access to both family doctors and medical specialists and provide insight into some of the causes. Results from the poll show more than half (60%) of all family physicians either limit the number of new patients they see or do not take new patients at all. This finding is not confined to more well-established practices. Almost half of all young family physicians (under age 35) report their practices are either partially or completely closed to new patients. “It’s a crying shame that we have gotten to the point where so many Canadians cannot find a GP,” wrote one physician. “I feel guilty each and every time I say no to new requests but I realize for my own health I can’t accept new patients.”

Similar problems were reported in referring patients to see a medical specialist. One third of the specialists who responded to the survey indicated they could not see non-urgent cases referred from family physicians in less than three months. For urgent cases the situation is somewhat better. Even so, only one in four specialists said they could take an urgent referral within 24 hours and almost one third (30%) indicated they would be unable to see even an urgent case within a week of referral.

When it came to actually finding a specialist to see their patients, family doctors said it was especially difficult to access psychiatrists and orthopedic surgeons. In these cases, family doctors rated access as fair/poor in 66% and 48% of cases respectively. Overall, a third of family doctors said that in general access to specialist physicians for referrals was fair/poor. One specialist wrote: “I am not able to see new patients regularly as I have a waiting list in excess of three years.” Interestingly the converse situation also seems to be true, as almost half of specialists (43%) rated access to family physicians as fair/poor.

When asked to rate accessibility to a selection of medical services, more than half of all doctors polled said access to advanced diagnostic services such as magnetic resonance imaging (MRI) scans and long-term beds was either fair or poor. Family doctors tended to rate access to services as being poorer than their specialist colleagues. On the positive side, the vast majority of physicians polled said they did not have problems obtaining access to emergency room services or routine diagnostic services. Even so, some doctors felt obliged to make comments such as “the waiting time in the emergency departments is ridiculous and paramedics wait in line in the corridor to find a stretcher for their patients.”

A closer look at the type of medical procedures performed by family doctors shows an almost universal decline in the number of doctors performing these services compared with results from three years ago. Fewer doctors indicated they were doing procedures ranging from Pap smears to suturing to hearing tests. Further analysis of data is needed to try to determine if this is related to changes in the practice patterns of family physicians e.g. increased emphasis on focused areas of care. It is also not known yet whether those still performing these services are doing more of them - as is the trend from other studies. An ongoing area of special concern is maternal and newborn care. This survey confirms the trend of more than one third (36%) of family doctors indicating that maternity and newborn care are not part of their practice.

Another trend was confirmed in the survey that could impact future access to medical care. While 16% of doctors polled stated they have reduced their weekly work hours in the

past two years and 13% indicated they had reduced the scope of their activities, fully one quarter of them say they plan to reduce their weekly work hours in the coming two years. Reducing the number of hours they worked was identified by the survey respondents as the most significant change in their practices, both over the past two years and for the coming two years. Coupled with demographic changes that will see more physicians retiring and female doctors who tend to work fewer hours making up a greater percentage of the overall physician population in future, these findings show the growing crisis in getting access to a physician is no illusion.

Physician supply

There is a changing demographic picture of the Canadian medical profession. Women students have made up more than half of many medical school classes for much of the last decade (the most recent 2003 –2004 enrolment figures in Canadian Faculties of Medicine show approx 58 % women) so it should come as no surprise that the number of female physicians is greater now than it has been at any time in the past. About a third of all physicians (31%) are now women, and in the under 35 age group female doctors make up the majority (52%). Women are also more likely to enter family medicine than specialty medicine. In the youngest age group, two thirds of female physicians practice family medicine while only one third are working in other specialties.

As noted earlier, this trend will have a significant impact on planning to ensure an adequate number of doctors and proper access to medical services in future. The survey showed while younger doctors as a whole report working fewer total hours per week than their older colleagues, this difference is due primarily to the higher percentage of women doctors in the under 45 age group. The survey showed that female physicians average about seven hours less per week than men regardless of whether they are working in family medicine or specialty care. This difference is due to a number of factors such as the additional responsibilities placed on young women doctors who are also caring for their young children. One female physician who is having trouble finding a substitute for a colleague going on maternity leave wrote: “I have come to realize why so many new grads, especially women, don’t settle into full-time family medicine during the childbearing years. I fervently believe this is an issue that needs to be addressed – we are literally discouraging young female family physicians from committing to the job they were trained to do.” Another wrote: “Despite all efforts, the elusive attempt at balance between a rewarding career and a fulfilling family life continues.”

Another finding that impacts on physician supply in Canada is the significant number of physicians planning to retire in certain specialties. The survey indicates that while 6.3% of all physician respondents said they plan to retire in the next two years, this rate is more than doubled for doctors who practice internal medicine (14%). For all physicians, this would translate to a 3.1% annual rate of retirement, significantly higher than the actual average annual retirement rate of 1-2% per year for at least a decade. If this finding can be applied to all physicians in Canada, that means we would see up to 3800 retirements in the next 2 years. Similarly high rates are also reported for pathologists, general surgeons and otolaryngologists where at least one in 10 specialists say they are planning on retiring in the next two years.

In terms of hours worked, physicians overall report working an average of 51 hours per week. Specialists average more hours a week (53 hours) than family physicians (49

hours). However in addition to hours of actual work, the vast majority of Canada's doctors (71%) also report having to spend time on-call – that is, available to provide care if called upon. Of those who reported having on-call responsibilities, more than half had on-call responsibilities of up to 120 hours a month but 12% said they were on-call for more than 240 hours a month. In addition, many doctors surveyed said they were on-call 24 hours a day, seven days a week. For many doctors, these on-call responsibilities are probably the most stressful part of being a physician today because of the degree to which it curtails other aspects of life.

As a snapshot of the medical profession today, the survey findings debunk the stereotype of the individual physician operating a solo private practice and being paid by fee-for-service. The majority of family doctors reported being in a group practice (61%) compared with 48% of specialists. Only a quarter of family doctors said they had a solo practice. Regardless of practice setting, there is much sharing among physicians in terms of office space, staff, or equipment. Although 82% of physicians report receiving some professional income from fee-for-service billings, just over half of those polled said they receive 90% or more of their professional income from fee-for-service. This is a drop from the mid-1990s when two-thirds of physicians said they were paid this way. Interestingly, fee-for-service has also ceased to be the preferred way doctors say they would like to be paid. Given the choice, only one quarter of family doctors said they would choose this manner of payment as did 31% of specialists.

Professional satisfaction

Overall, physicians' satisfaction with the balance in their lives, did not rate as highly as their levels of satisfaction with their relationships with their patients. While over two-thirds rated their current professional life as being somewhat or very satisfying, only half were satisfied with the balance between personal and professional commitments in their lives.

Asked to delineate the most stressful part of the practice of medicine, on-call responsibilities was the item mentioned most frequently. This was followed by concerns about the amount of paperwork and bureaucracy involved in medicine today and problems trying to get access to other types of care for their patients.

More than three-quarters of those who responded to the survey said the intellectual challenge and stimulation of medicine was one of the factors that led them to select their current career. As well, caring for patients is obviously professionally satisfying to most physicians. Despite the concerns expressed about the quality of today's health care system and the stresses doctors face, 86% reported being somewhat or very satisfied with their relationship with patients. The words of one family physician clearly illustrate this sentiment: "Being a family physician has been a wonderful journey. I have met and supported and nurtured so many people, watching them grow … have families, age and die. It has been a privilege and an honour to be such an integral part of the journey of life for so many. I love my work. I love to teach it to others. Sometimes I am overwhelmed by demands or undervalued financially and sometimes overly caught up in administrating change. But if I could live my life again I would do family medicine …"

Methodology

The National Physician Survey (NPS) is a collaborative project of The College of Family Physicians of Canada (CFPC), the Canadian Medical Association (CMA), and The Royal College of Physicians and Surgeons of Canada (RCPSC). Financial support has been contributed by the CFPC, CMA, RCPSC, the Canadian Institute for Health Information (CIHI), and Health Canada. The 2004 NPS questions evolved from questions used on the CFPC's National Family Physician Workforce Survey, the CMA's Physician Resource Questionnaire, and the RCPSC's specialist questionnaire. A working group, including representatives of the CFPC, CMA, RCPSC, other affiliated societies, and CIHI was used to develop the 2004 NPS questions.

Two versions of the physician questionnaire were used, one for family physicians and general practitioners (FPs), and a second for all other specialists. Ninety percent of the questions were identical for FPs and specialists, with differences predominantly in the clinical practice profile questions. The questions were piloted in the fall of 2003 with a variety of physician committees and national specialty societies, and finalized in December 2004. The final 2004 NPS questionnaires were 16 pages long, bound in booklet fashion. The NPS received ethical approval from the University of British Columbia Behavioural Ethics Review Board.

The 2004 National Physician Survey (NPS) was carried out as a self-reported survey, sent to all licensed physicians in Canada. The NPS mail and email list was generated from the CMA Masterfile. The CMA Masterfile includes all physicians in Canada holding a medical license and is compiled and updated on a daily basis with information received from provincial licensing bodies, associations, CFPC and RCPSC membership listings, and individual physicians. Email addresses were verified for 34.0% of all physicians. This group received survey communications by email, including invitations to complete the questionnaire online. The remaining 66.0% of physicians received all NPS communications by mail. In total, 61,751 physicians in all provinces and territories were asked to reply to the 2004 NPS, 31,965 FPs and 29,786 specialists.

Responses from all questionnaires returned by June 30th, 2004 were captured into an electronic database file. The file created by physicians completing the online questionnaire and the file created by the returned paper responses were merged to create a single NPS database.

Unique identification numbers were assigned for the NPS project to ensure that physician responses would remain confidential and anonymous, to enable subsequent mailings of the questionnaire to physicians who had not yet replied, and to apply the same numbers to future NPS surveys for longitudinal analysis.

Of the 61,751 doctors identified on the original mailing/emailing list, 2,362 were eliminated due to retirement, residency, or working abroad. Of the remaining 59,389 physicians, 21,296 replied to the survey for an overall study response rate of 35.9%.

National level estimates based on the 2004 NPS study results are considered accurate within +/- 0.7%, 19 times out of 20.