

**Medicine for a More Competitive
Canadian Economy**

Making Canadians Healthy and Wealthy

addressing Canada's place in a
competitive world

**The Canadian Medical Association's brief to the
Standing Committee on Finance
concerning the 2007 budget**

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ASSOCIATION
MÉDICALE
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CANADIAN
MEDICAL
ASSOCIATION

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

“The first wealth is health.”
- Emerson

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 63,000 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 44 affiliated medical organizations.



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Preface

Making Canadians healthy and wealthy

In the face of an increasingly competitive global economy, Canada must create incentives for its citizens and businesses to invest so that greater investment will increase productivity and our standard of living. The first place to invest is in the health of the workforce. The CMA recognizes the benefits of aligning tax policy with health policy in order to create the right incentives for citizens to realize their potential.

Global competitiveness is about getting Canada beyond commodities

The latest Canadian economic outlook is mixed. Our economy is forecast to grow by 3 per cent in 2007 which is the fastest growing economy among the G7 countries, according to the International Monetary Fund's semi-annual World Economic Outlook. While this may seem impressive, this growth is fuelled by commodity prices. "The Canadian economy continues to perform robustly, benefiting from...the boom in global commodity prices," the IMF said. In fact this is one of the key concerns included in the latest outlook from TD Economics, namely that, "Weakening U.S. demand will lead to a pullback in commodity prices, including a drop in the price of oil to \$50 US a barrel in 2007"¹. What can the federal government do to mitigate these bumps in the global economy?

Investing in "specialized factors" is the key to global competitiveness

Canada's place in a competitive world cannot be sustained by commodities or what the godfather of competitive advantage theory, world-renowned Harvard Professor Michael Porter, calls "non-key" factors. Instead, Porter suggests that sustainable competitive advantage is based on "specialized factors" such as skilled labour, capital and infrastructure. These specialized factors are created, not inherited. Moreover, Porter makes the important distinction that the crafting of "social" policies must make them reinforcing to the true sources of sustainable prosperity.² The demand for highly skilled labour forces does not fluctuate as commodity prices do.

This submission follows Porter's line of thinking in suggesting that Canada should build on these specialized factors, emphasizing the health of our skilled labour force, enhancing the skills of our health care providers and making key investment in our electronic health infrastructure.

Why the CMA is addressing Canada's place in competitive world

The 63,000 members of the Canadian Medical Association are best known for taking care of Canadians — 32.3 million of them — individually and collectively. Through prevention, treatment and research, physicians are also vital in supporting business by ensuring that our work force is as healthy as can be. But our members are also an important economic force in their own right as they own and operate over 30,000 small businesses employing 142,000 people across the country.³ What's more, small businesses, like the ones physicians run, invest in research and

¹ "U.S. Slowdown Underway Canada in for a Bumpy Ride" See www.td.com/economics/ (accessed Sept. 19, 2006)

² www.worldbank.org/mdf/mdf1/advantge.htm (accessed Sept. 19, 2006)

³ Source: Statistics Canada, Business Register 2005.

development proportionally on a far larger scale than big corporations.⁴ In addition to the clinical services they provide, physicians are vitally engaged in advancing medical knowledge through teaching and research, leading to greater innovation.

Health as an investment –“the greatest benefit to mankind”

According to distinguished Yale economist, William Nordhaus, “The medical revolution over the last century appears to qualify, at least from an economic point of view, for Samuel Johnson’s accolade as “the greatest benefit to mankind.”⁵ People demand and spend more money on health because it is useful. The goal of a competitive economy is to produce more wealth. The wealthier our citizens become, the more health care they demand. In other words health care is in economic terms a “superior good”.

Short, medium and long-run incentives for increased productivity

The pursuit of productivity to ensure Canada’s competitiveness in the world is not and cannot be a short-term goal. Productivity is apolitical. Setting the foundation for productivity requires dedication to long-term goals in education, physical infrastructure and health. However, there are recommendations that can create immediate incentives for citizens and businesses to kick start more productive activity sooner than later.

Executive Summary

The CMA’s pre-budget submission presents the facts on how investments in citizens, businesses and health infrastructure make our economy more competitive. Improvements in the quality of care, and especially timely access to care, enable the Canadian labour force to increase its performance and fully reach its potential. Our submission is also sensitive to the constraints facing the federal government and so we have considered the return on investment for these recommendations.

The CMA recognizes the benefits of aligning tax policy with health policy in order to create the right incentives for citizens to realize their potential. Accordingly, our proposals include tax incentives for healthy living and a recommendation to encourage savings for long-term health care.

The time horizon for our 10 recommendations ranges from short-term wins such as getting Canadian doctors working in the U.S. back to Canada sooner than later to turning the tide of rising obesity in Canada. We hope that the Standing Committee on Finance considers these short-term returns on investment as well as the longer returns on investment. A Greek proverb said it best, “A society grows great when old men plant trees whose shade they know they shall never sit in”. This can be a great legacy of the Committee.

On behalf of the members of the Canadian Medical Association, I wish you all the best in your deliberations.

⁴ Source: Statistics Canada, *Industrial Research and Development –2004 intentions*, No. 88-202-XIB, January 2005.

⁵ Nordhaus notes that over the 1990-1995 period the value of improved health or health income grew at between 2.2 and 3.0 per cent per year in the United States, compared to only 2.1 per cent for consumption.

See *The Health of Nations: The Contribution of Improved Health to Living Standards* William D. Nordhaus, Yale University www.laskerfoundation.org/reports/pdf/economic.pdf (accessed Sept. 18, 2006)

Recommendations for Committee consideration

Medicine for a More Competitive Canadian Economy⁶ -10 recommendations with investment estimates

A. CITIZENS – healthy living

Recommendation 1: *That the government consider the use of taxes on sales of high-calorie, nutrient-poor foods as part of an overall strategy of using tax incentives and disincentives to help promote healthy eating in Canada.*

Recommendation 2: *That the government assess the feasibility of an individual, tax-sheltered, long-term health care savings plan.*

B. BUSINESS – healthy workforce

Recommendation 3: *That the government advances the remaining \$1-billion from the 2004 First Ministers Accord that was originally intended to augment the Wait Times Reduction Fund (2010-2014) to support the establishment of a Patient Wait Times Guarantee and deliver on the speech from the throne commitment.*

Recommendation 4: *That the federal government provide the Canadian Institute for Health Information with additional funding for the purpose of enhancing its information gathering efforts for measuring, monitoring and managing waiting lists and extending the development and collection of health human resource data to additional health professions.*

Recommendation 5: *That the government launch a direct advertising campaign in the United States to encourage expatriate Canadian physicians and other health professionals to return to practice in Canada. Investment: A one-time investment of \$10-million.*

Recommendation 6: *That the government provide a rebate to physicians for the GST/HST on costs relating to health care services provided by a medical practitioner and reimbursed by a province or provincial health plan. Investment: \$52.7-million per year or 0.2 % of total \$31.5-billion GST revenues.*

C. INFRASTRUCTURE – healthy systems

Recommendation 7: *That the government follow through on the recommendation by the Federal Advisor on Wait Times to provide Canada Health Infoway with an additional \$2.4-billion to secure an interoperable pan-Canadian electronic medical record with a targeted investment toward physician office automation. Investment: \$2.4-billion over 5 years.*

Recommendation 8: *That the government establish a Public Health Infrastructure Renewal Fund (\$350-million annually) to build partnerships between federal, provincial and municipal governments, build capacity at the local level, and advance pandemic planning.*

Recommendation 9: *That the government recommit to the \$100-million per year for immunization programs under the National Immunization Strategy.*

Recommendation 10: *That the government Increase the base budget of the Canadian Institutes of Health Research to enhance research efforts in the area of population health and public health, as well as significantly accelerate the pace of knowledge transfer. Investment: \$600-million over 3 years.*

⁶ See Appendix 1 for 3-year investment details as well as short, medium and long-term returns on investment

Introduction

It is well known that Canada's place in a competitive world cannot be sustained by commodities or what the godfather of competitive advantage theory, Michael Porter calls "non-key" factors. Instead Porter suggests that sustainable competitive advantage is based on "specialized factors" such as skilled labour, capital and infrastructure. These specialized factors are created, not inherited. Moreover, Porter makes the important distinction that the crafting of "social" policies must make them reinforcing to the true sources of sustainable prosperity.⁷ The demand for highly skilled labour forces does not fluctuate as commodity prices do.

This submission follows that line of thinking in suggesting that Canada should build on these specialized factors, emphasizing the health of our skilled labour force, enhancing the skills of our health care providers as well as making key investment in our health infrastructure – electronic and otherwise.

Outline: healthy citizens, businesses, infrastructure and affordable government

The Canadian Medical Association (CMA) brief submitted to the Standing Committee on Finance will make 10 recommendations on how the federal government can make our economy more competitive by investing in three priorities: health, health care and health infrastructure. The brief will address these topics, aligning them with support for our (A) citizens, (B) businesses and (C) infrastructure. The CMA also recognizes that the federal government does not have unlimited resources and suggests actions to be taken in order to ensure that these recommendations are both affordable and sustainable. Accordingly, we will also provide a "balance sheet" of investments, return on investments, as well as revenue raising possibilities that could help create incentives for healthy living and, in turn, a more competitive economy.

A. Citizens – healthy living

Canadians must become fitter and healthier. Almost 60% of all Canadian adults and 26% of our children and adolescents are overweight or obese.⁸ Dr. Ruth Collins-Nakai, the immediate past-president of the CMA and a cardiac-care specialist, recently said "I have a very real fear we are killing our children with kindness by setting them up for a lifetime of inactivity and poor health,". Canada should follow the lead of European countries, which have recently recommended a minimum of 90 minutes a day of moderate activity for children. Kicking a soccer ball or riding a skateboard for 15 to 30 minutes two or three times a week is not good enough, she said.

Obesity costs Canada \$9.6 billion per year.⁹ These costs continue to climb. The federal government must use every policy lever possible at its disposal in order to empower Canadians to make healthy choices, help to reduce the incidence of obesity and encourage exercise as well as a proper diet.

⁷ www.worldbank.org/mdf/mdf1/advantge.htm Accessed September 20, 2006.

⁸ Source: ww2.heartandstroke.ca/Page.asp?PageID=1366&ArticleID=4321&Src=blank&From=SubCategory Accessed August 14, 2006.

⁹ P.Katzmarzyk, I. Janssen "The Economic costs associated with physical inactivity and obesity in Canada: An Update" Can J Applied Physiology 2004 Apr; 29(2):90-115. www.phe.queensu.ca/epi/ABSTRACTS/abst81.htm Accessed August 14, 2006.

Obesity and absenteeism affect the bottom line

Obesity not only hurts our citizens it is also a drag on Canadian competitiveness. There is a direct correlation between increasing weights and increasing absenteeism. The costs associated with employee absenteeism are staggering. Employee illness and disability cost employers over \$16-billion each year.¹⁰ For instance, the average rate of absence due to illness or disability for full-time Canadian workers was 9.2 days in 2004, a 26% increase over the last 8 years, according to Statistics Canada's latest labour force survey. While there is a growing awareness of the costs due to obesity are well known. The programs and incentives in place now are clearly not working as the incidence of obesity continues to grow. The benefits of turning the tide of obesity are also clear. In his remarks to the CMA in August 2006, Minister Tony Clement made the following statement:

“And you know and I know that health promotion, disease and injury prevention not only contribute to better health outcomes, they help reduce wait times as well.”

The experts agree, “The economic drive towards eating more and exercising less represents a failure of the free market that governments must act to reverse it.”¹¹

***Recommendation 1:** That the government consider the use of taxes on sales of high-calorie, nutrient-poor foods as part of an overall strategy of using tax incentives and disincentives to help promote healthy eating in Canada.*

Tax-sheltered savings for long-term care — aligning tax policy and health policy

Canada is entering an unprecedented period of accelerated population aging that will see the share of seniors aged 65 and over increase from 13% in 2005 to 23% in 2031. At the same time, the cost of privately funded health services such as drugs and long-term care are projected to increase at double-digit rates as new technologies are developed and as governments continue to reduce coverage for non-Medicare services in order to curb fiscal pressures¹². Since seniors tend to use the health system more intensively than non-seniors, the rising cost of privately funded health services will have a disproportionately high impact on seniors.

Canadians are not well equipped to deal with this new reality. Private long-term care insurance exists in Canada, but is relatively on the Canadian scene and has not achieved a high degree of market penetration. New savings vehicles may be needed to help seniors offset the growing costs of privately funded health services. One approach would be extend the very successful model of RRSPs to enable individuals save for their long-term care needs via a tax-sheltered savings plan.

***Recommendation 2:** That the government assess the feasibility of an individual tax-sheltered long-term health care savings plan.*

B. Business – healthy workforce

In spite of the fact that health as an economic investment has proven returns, governments have been letting up in their support of their citizens' health. The impact is felt not only in terms of poorer health but it also affects businesses through increased absenteeism, as well as

¹⁰ Staying@Work 2002/2003 Building on Disability Management, Watson Wyatt Worldwide www.watsonwyatt.com/canada-english/pubs/stayingatwork/ Accessed July 31, 2006.

¹¹ Swinburn, et al. International Journal of Pediatric Obesity (vol 1, p 133) (accessed Sept. 19, 2006)

¹² Canada's Public Health Care System Through to 2020, the Conference Board of Canada, November 2003.

governments through lower tax revenues. According to the Center for Spatial Economics, "...the cumulative economic cost of waiting for treatment across Ontario, Saskatchewan, Alberta and BC in 2006 is estimated to be just over \$1.8-billion. This reduction in economic activity lowers federal government revenues by \$300-million."¹³ The total costs to the federal government are even higher if all 10 provinces were included. The estimate is based on four of the five priority areas identified in the 2004 First Ministers Health Accord: total joint replacement surgery, cataract surgery, coronary artery bypass graft, and MRI scans.

If you wonder what all this has to do with Canadian business, ask yourself how many person/hours employers lose due to illness? How much productive time is lost due to the stress of an employee forced to help an elderly parent who cannot find a doctor? This challenging situation is going to get worse, as the population ages, and as our health professionals age and retire.

Supporting the Patient Wait Time Guarantee

The establishment of pan-Canadian wait time benchmarks and a Patient Wait Times Guarantee are key to reducing wait times and improving access to health services. The 2004 First Ministers' health care agreement set aside \$5.5-billion for the Wait Time Reduction Fund, of which \$1-billion is scheduled to flow to provinces between 2010 and 2014. To assist provinces with the implementation of the wait time guarantee while remaining within the financial parameters of the health care agreement, the federal government could advance the remaining \$1-billion and flow these funds to provinces immediately.

***Recommendation 3:** That the government advances the remaining \$1-billion from the 2004 First Ministers Accord that was originally intended to augment the Wait Times Reduction Fund (2010-2014) to support the establishment of a Patient Wait Times Guarantee and deliver on the speech from the throne commitment.*

Making investments count and counting our investments

It would be irresponsible for government to make investments if the results were not being measured. As management guru Tom Peters suggests, "What you do not measure, you cannot control." And, "What gets measured gets done." As billion dollar federal funding of health care reaches new heights, the value of measuring these investment increases. That is where the Canadian Institute for Health Information (CIHI) comes in.

CIHI has been involved in developing wait time indicators and tracking Canada's progress on wait times. It is essential that we have an arm's length body responsible for collecting data on wait times as part of Canada's effort to improve timely access to care for Canadians. CIHI has also played an active role in health human resource data collection and research. Their financial support for the 2004 National Physician Survey resulted in a one-of-a-kind research file with input from over 20,000 Canadian physicians.

***Recommendation 4:** That the federal government provide the Canadian Institute for Health Information with additional funding for the purpose of enhancing its information gathering efforts for measuring, monitoring and managing waiting lists and extending the*

¹³ The Economic Cost of Wait Times in Canada, by the Center for Spatial Economics, June 2006.
www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/CMA_This_Week/BCMA-CMA-waittimes.pdf

development and collection of health human resource data to additional health professions.

Direct advertising in the U.S. to bolster health human resources deficit

The primary barrier affecting timely access to quality health care is the shortage of health care professionals. Canada currently ranks 26th in the OECD in terms of physicians per capita, at 2.1 MDs per 1,000 people. More than three million Canadians do not have a family physician. This situation will get worse as the population ages and as our health professionals age and retire.

Fortunately, another short-term source of health professionals exists that Canada should pursue. Thousands of health care professionals are currently working in the United States including approximately 9,000 Canadian trained physicians. We know that many of the physicians who do come back to Canada are of relatively young age meaning that they have significant practice life left. While a minority of these physicians do come back on their own, many more can be repatriated in the short-term through a relatively small but focussed effort by the federal government led by a secretariat within Health Canada.

Recommendation 5: *That the government launch a direct advertising campaign in the United States to encourage expatriate Canadian physicians and other health professionals to return to practice in Canada. Investment: A one-time investment of \$10-million.*

Re-investing the GST for 30,000 small businesses

The continued application of the GST on physician practices is an unfair tax on health. Because physicians cannot recapture the GST paid on goods and services for their practices in the same way most other businesses can, the GST distorts resource allocation for the provision of medical care. As a result, physicians end up investing less than they otherwise could on goods and services that could improve patient care and enhance health care productivity such as information management and information technology systems.

The introduction of the GST was never intended to fall onto the human and physical capital used to produce goods and services. The GST is a value-added tax on consumption that was put into place to remove the distorting impact that the federal manufacturers sales tax was having on business decisions. However, the GST was applied to physician practices in a way that does exactly the opposite. The federal government must rectify the situation once and for all. Based on estimates by KPMG, physicians have paid \$1.1-billion in GST related to their medical practice since 1991. This is \$1.1-billion that could have been invested in better technology to increase care and productivity.

Recommendation 6: *That the government provide a rebate to physicians for the GST/HST on costs relating to health care services provided by a medical practitioner and reimbursed by a province or provincial health plan. Investment: \$52.7-million per year or 0.2 % of total \$31.5-billion GST revenues.*

C. Infrastructure –healthy system

Recovery of health information technology investments is almost immediate

A Booz, Allen, Hamilton study on the Canadian health care system estimates that the benefits of an EHR could provide annual system-wide savings of \$6.1 billion, due to a reduction in

duplicate testing, transcription savings, fewer chart pulls and filing time, reduction in office supplies and reduced expenditures due to fewer adverse drug reactions. The study went on to state that the benefits to health care outcomes would equal or surpass these annual savings. Evidence shows that the sooner we have a pan-Canadian EHR in place, the sooner the quality of, and access to health care will improve.¹⁴

Mobilizing physicians to operationalize a pan-Canadian Electronic Health Record

The physician community can play a pivotal role in helping the federal governments make a connected health care system a realizable goal in the years to come. Through a multi-stakeholder process encompassing the entire health care team, the CMA will work toward achieving cooperation and buy-in. This will require a true partnership between provincial medical associations, provincial and territorial governments and Canada Health Infoway (CHI).

The CMA is urging the federal government to allocate an additional investment of \$2.4-billion to Canada Health Infoway over the next five years¹⁵ to build the necessary information technology infrastructure to address wait times¹⁶ as well as support improved care delivery. Both the *Federal Wait Times Report* and Booz Allen Study concur that this requires automating all community points of care – i.e., getting individual physician offices equipped with electronic medical records (EMRs). This is a necessary, key element to the success of the EHR agenda in Canada and recent assessments place the investment required at \$1.9-billion of the \$ 2.4-billion.

CHI has proven to be an effective vehicle for IT investment in Canadian health care. For example, as a result of CHI initiatives, unit costs for Digital Imaging have been reduced significantly and are already saving the health care system up to 60-million dollars. In fact as a result of joint procurements and negotiated preferred pricing arrangements through existing procurement efforts with jurisdictional partners the estimated current cost avoidance is between \$135-million to \$145-million. Moreover, in the area of a Public Health Surveillance IT solution, a pan Canadian approach to CHI investments with jurisdictional partners has lead to benefits for users, the vendor and Canadians. The negotiation of a pan-Canadian licence enables any jurisdiction to execute a specific licence agreement with the vendor and spawn as many copies as they need to meet their requirements. The vendor still owns the IP and is free to market the solution internationally — clearly a win/win for both industry and the jurisdictions.

***Recommendation 7:** That the government follow through on the recommendation by the Federal Advisor on Wait Times to provide Canada Health Infoway with an additional \$2.4-billion to secure an interoperable pan-Canadian electronic medical record with a targeted investment toward physician office automation. Investment: \$2.4-billion over 5 years.*

Establishing a Public Health Infrastructure Renewal Fund

The CMA remains concerned about the state of Canada’s public health system. Public health, including the professionals providing public health services, constitutes our front line against a wide range of threats to the health of Canadians. While there is much talk about the arrival of

¹⁴ Booz, Allan, Hamilton Study, Pan-Canadian Electronic Health Record, Canada’s Health Infoway’s 10-Year Investment Strategy, March 2005-09-06

¹⁵ See Appendix 1 and Appendix 2 for more investment details and background.

¹⁶ Final Report of the Federal Advisor on Wait Times, June 2006, Dr. Brian Postl

possible pandemics, Canada's public health system must be ready to take on a broad range of public health issues.

The CMA has been supportive of the Naylor report which provides a blue print for action and reinvestment in the public health system for the 21st century. While this will take several years to achieve, there are some immediate steps that can be taken which will lessen the burden of disease on Canadians and our health care system. These steps include establishing a Public Health Partnership Program with provincial and territorial governments to build capacity at the local level and to advance pandemic planning. In addition, we call on the government to continue its funding of immunization programs under its National Immunization Strategy.

Public health must be funded consistently in order to reap the full benefit of the initial investment. Investments in public health will produce healthier Canadians and a more productivity workforce for the Canadian economy. But this takes time. By the same token, neglect of the public health system will cost lives and hit the Canadian economy hard.

***Recommendation 8:** That the government establish a Public Health Infrastructure Renewal Fund (\$350-million annually) to build partnerships between federal, provincial and municipal governments, build capacity at the local level, and advance pandemic planning.*

Supporting the National Immunization Strategy

Dr. Ian Gemmell, Co-Chair of the Canadian Coalition for Immunization Awareness and Promotion, has said, "Vaccines provide the most effective, longest-lasting method of preventing infectious diseases in all ages." strongly urge that immunization programs be supported. Healthy citizens are productive citizens and strong immunization programs across the country pay for themselves over time.

***Recommendation 9:** That the Federal Government recommit to the \$100-million per year for immunization programs under the National Immunization Strategy.*

Making medical research investments count – supporting knowledge transfer

The Canada Institutes of Health Research (CIHR) was created to be Canada's premier health research funding agency. One of the most successful aspects of the CIHR is its promotion of inter-disciplinary research across the four pillars of biomedical, clinical, health systems and services as well as population health. This has made Canada a world leader in new ways of conducting health research. However, with its current level of funding, Canada is significantly lagging other industrialized countries in its commitment to health research. Knowledge transfer is one of the areas where additional resources would be most usefully invested.

Knowledge Translation (KT) is a prominent and innovative feature of the CIHR mandate. Successful knowledge translation significantly increases and accelerates the benefits flowing to Canadians from their investments in health research. Through the CIHR, Canada has the opportunity to establish itself as an innovative and authoritative contributor to health-related knowledge translation.

Population and public health research is another area where increased funding commitments would yield long-term dividends.

Recommendation 10: *That the government Increase the base budget of the Canadian Institutes of Health Research to enhance research efforts in the area of population health and public health, as well as significantly accelerate the pace of knowledge transfer. Investment: \$600-million over 3 years.*

Conclusion

The CMA recognizes the benefits of aligning tax policy with health policy in order to create the right incentives for citizens to realize their potential. Accordingly our proposals include tax incentives for healthy living as well as a recommendation to encourage savings for long-term health care.

The time horizon for our 10 recommendations ranges from short-term wins such as getting Canadian doctors working in the U.S. back to Canada sooner than later to turning the tide of rising obesity in Canada. We hope that the Standing Committee on Finance considers these short-term returns on investment as well as the longer returns on investment. A Greek proverb said it best, “A society grows great when old men plant trees whose shade they know they shall never sit in”. This can be a great legacy of the Committee.

On behalf of the members of the Canadian Medical Association, I wish you all the best in your deliberations.

Appendix 1 - Recommendations for Committee consideration

10 point plan with estimated investments and revenues

Medicine for a more competitive economy - CMA's 10 point plan					
(in millions of dollars)					
	Time Horizon of Return on investment	2007/08	2008/09	2009/10	3-year Total
A. CITIZENS - healthy living					
i. Taxes on high calorie, nutrient poor foods + promoting healthy living*	medium /long-term	-\$300	-\$300	-\$300	-\$900
ii. Tax sheltered long-term health care savings plan**	long-term	\$563	\$844	\$1,125	\$2,531
Citizens total		\$263	\$544	\$825	\$1,631
B. BUSINESSES- healthy workforce					
iii. Patient wait time guarantee***	short-term	\$0	\$0	\$0	\$0
iv. Making investments count and counting our investments -CIHI funding for wait times	medium	n/a	n/a	n/a	n/a
v. Direct ad-campaign "Welcome back mat" + \$5,000 moving expenses tax grant	short-term	\$10	\$2	\$2	\$14
vi. Provide a rebate to physicians for the GST/HST on costs relating to health care services	short-term	\$53	\$54	\$55	\$162
Business total		\$63	\$56	\$57	\$176
C. INFRASTRUCTURE - healthy system					
vii. Investing in e-health infrastructure -physician office automation (CHI transfer)****	short/medium	\$800	\$600	\$500	\$1,900
viii. Making health research investments count -supporting knowledge transfer (CIHR)	medium/long-term	\$100	\$200	\$300	\$600
ix. Public Health Infrastructure Renewal	short/medium	\$350	\$350	\$350	\$1,050
x. National Immunization Strategy	long-term	\$100	\$100	\$100	\$300
Infrastructure total		\$1,350	\$1,250	\$1,250	\$3,850
Total		\$1,675	\$1,850	\$2,132	\$5,657

* Note: This includes \$500 million in revenue as well as \$200 million in expenditure = Net revenue of \$300 m.

** Note: This assumes a \$2,500 tax free savings at 45% rate and that over time more people would subscribe.

*** Note: This \$1 billion has already been committed to in the 10-year 2004 Health Accord, but it is only active in 2013.

**** Note: additional 2 years of funding at \$250 million per year. Total = \$2.4 billion over 5 years.

Canada Health Infoway (CHI) would deliver funding in conjunction with 50:50 tax credited physician contributions.

Estimates are based on information from Canada Health Infoway (September 2006).

Appendix 2 - The Information Technology Agenda in the Canadian Health Care Sector

- The Health Council of Canada, the Presidents and CEOs from the Academic Healthcare Organizations and the federal advisor on wait times all agree on the need to accelerate the building out of the information technology infrastructure for the healthcare sector
- All these groups amongst others argue that there are large gains to be made on improving healthcare delivery and achieving efficiencies in operating the health care system
- Automating health care delivery in Canada will lead to a more efficient healthcare system and will build industry capacity to compete in the international market place
- A \$10-billion investment is estimated to result in a return on investment (ROI) exceeding investment dollars by an 8:1 margin, and a net savings of \$39.8-billion over a 20-year period. It is estimated that a net positive cash flow would occur in Year Seven of implementation, and an investment breakeven by Year 11, resulting in an annual net benefit of \$6.1-billion.¹⁷
- Part of this investment is to automate the over 35,000 physicians who have a clinic in a community setting
- It is estimated that \$1.9-billion is needed to accomplish this task which when complete will facilitate better management of wait times, improved patient safety, helping to address in part the human resource shortage for providers as well as make a contribution to improved First Nation health.
- Our recommendation is that the Federal government provide a further direct investment of \$1-billion into Canada Health Infoway (CHI) that is targeted to the automation of physician offices. This funding would pay for 50% of the costs to automate a physician's clinic.
- The funds would be allocated to provinces and medical associations through CHI once an agreement has been developed. A jointly developed program would ensure complementarity with a provincial health IT strategy and a program that has been designed by physicians such that it does the most to improve health care delivery
- Physicians would be asked to pay the other 50% and through tax policy they would be able to claim a deduction for capital information technology acquisitions
- This arrangement mirrors current programs funded by CHI on a 75%-25% cost sharing model with provinces but with physicians picking up approximately 25% of the costs

¹⁷ Booz Allen Hamilton Study, Pan-Canadian Electronic Health Record, Canada Health Infoway's 10-Year Investment Strategy, March 2005

Appendix 3 Can taxation curb obesity?

A recent article in the New Scientist.com¹ asks, Can taxation curb obesity?

“The economic drive towards eating more and exercising less represents a failure of the free market that governments must act to reverse.”¹⁸ “We have market failure in obesity, because we have social costs greater than the private costs,” according to Lynee Pezullo director of the economic advisory group Access Economics. “The government also bears the health costs, and people don’t take into account costs they bear themselves. If people had to pay for their own dialysis they might bear these things in mind a bit more.”

When two-thirds of the population of countries like Australia or the US are obese or overweight, you can't handle the problem with simple solutions like education," Barry Popkin of the University of North Carolina, Chapel Hill. A Yale University professor is generating support for a "twinkie tax"¹ on high-calorie foods like french fries.

This tax works

In California in 1988, Proposition 99 increased the state tax by 25 cents per cigarette pack and allocated a minimum of 20% of revenue to fund anti-tobacco education. From 1988 to 1993, the state saw tobacco use decline by 27%, three times better than the U.S. average.¹

CMA is not alone in supporting a junk food tax

In December, 2003, the World Health Organization proposed that nations consider taxing junk foods to encourage people to make healthier food choices. According to the WHO report, "Several countries use fiscal measures to promote availability of and access to certain foods; others use taxes to increase or decrease consumption of food; and some use public funds and subsidies to promote access among poor communities to recreational and sporting facilities."

The American Medical Association is planning to demand the government to levy heavy tax on the America's soft drinks industry. Currently, 18 U.S. states have some form of "snack" food tax in place and five states have proposed policy and legislative recommendations.

The economic costs of obesity are estimated at \$238-billion annually, and rising. Along the same lines, the former Surgeon General, C. Everett Koop, believes that after smoking, "obesity is now the number one cause of death in [the U.S.]...we're not doing the same kind of things with obesity that we have done with smoking and alcohol as far as government programs are concerned ... It's got to be like smoking, a constant drum beat."

¹⁸ Can taxation curb obesity? See www.newscientist.com/article/dn9787-can-taxation-curb-obesity.html (accessed September 20, 2006.)