

February 23, 2008

Mr. James Rajotte
Chair, Standing Committee on
Industry, Science and Technology
House of Commons
Ottawa, ON K1A 0A6

Dear Mr. Rajotte:

On behalf of the Canadian Medical Association (CMA), I want to thank you for the opportunity to provide the following information to the House of Commons Standing Committee on Industry, Science and Technology during its review of the service sector in Canada. The committee's study of the strengths and challenges facing this sector, overall employment percentage, overall average of salaries across the sector its impact on Canada's overall economy and the role of the Government of Canada in strengthening this sector comes at an opportune time.

CANADA'S HEALTH SERVICES SECTOR

Canada's health services sector is facing a critical shortage of physicians and other health care professionals and the CMA and our over 67,000 physician members are pleased to have the opportunity to present practical solutions within the jurisdiction of the federal government — working collaboratively with provincial/territorial governments and other health system stakeholders.

Health care delivery in Canada is a \$160 billion industry, representing over 10% of our country's gross domestic product (GDP).¹ The 30,120 physicians' offices across Canada make important contributions to our economy. In 2003, the latest year for which data are available, offices of physicians employed 142,000 Canadians and contributed \$11.6 billion to the Canadian economy.² This represents almost 39 per cent of all Health Service Delivery establishments, and almost 11% of all HSD employees. As a standard measure of economic productivity, physician offices report the highest levels of GDP per employee within the Health Service Delivery sector. On this measure, they are approximately twice as productive as other components of Health Service Delivery.

¹ National Health Expenditure Trends, 1975-2007. Canadian Institute for Health Information. 2007

² Source: Business Register (STC 2003) and TIM (Informetrica Limited)

THE CHALLENGE

There are simply not enough physicians to continue providing the quality health care that Canadians expect and deserve. Here are the facts:

- Almost 5 million Canadians do not have access to a family physician;
- By 2018 an additional 4.5 million Canadians could be without a doctor;
- Canada ranks 24th in Organisation for Economic Co-operation and Development (OECD) nations in terms of physicians-per-population ratio. Canada would need 26,000 more doctors right now to meet the OECD average;
- Canada spends only a third of the OECD average on information technology (IT) and diagnostic equipment in our hospitals; and
- Canada has the highest hospital occupancy rate of all OECD countries and among the highest waits for access to specialty care services.

The lack of physicians and other health care providers has resulted in restricted access to health care services and the growth of wait times for necessary medical procedures. In January 2008, CMA released new research by the Centre for Spatial Economics that proved that, in addition to the human health cost, waiting for care results in dramatic and excessive costs to our economy. Researchers addressed just four priority areas targeted in the 2004 First Ministers Health Accord. They used government and other data to determine how many Canadians were waiting longer than the maximum medical consensus established by the Wait Time Alliance.

Selected for analysis were: joint replacement, cataract surgery, heart bypass grafts, and MRI scans. Costs, as calculated for all provinces varied from \$2,900 to over \$26,000 per patient. The cumulative cost of waiting in 2007, for treatment in just 4 areas, was \$14.8 billion.

This reduced economic activity lowered government revenues in 2007 by \$4.4 billion. That is equivalent to over 1/3rd of the total Ontario health budget. The reduction in economic activity included the impact of the patient's inability to work while waiting, and direct losses from decreased production of goods and services, reduced income, and lowered discretionary spending.

It is important to note that the figure of 14.8 billion dollars is based only on patients that exceed designated maximum waiting times in just 4 clinical areas. In the example of hip replacements, the research only factored in costs for waits that exceed 6 months. Of those waiting longer than the maximum recommended time, average waits were 1 year for hip and knee replacement surgery, 7 months for cataract surgery, and twice maximum for heart bypass surgery. Those who didn't make the MRI target waited an average of 12 weeks.

Reduced economic activity included informal caregiver costs. These costs are generated when caregivers reduce work hours to care for family members on wait lists, or attend

appointments with family members. Patients languishing on wait lists also incur additional costs for drug and other treatments that timely care would eliminate.

Estimates in this study are extremely conservative. They address only the wait time to treatment after a specialist's consultation and recommendation. And exclude the growing, and significant costs of waiting to see the GP or specialist. They do not include anyone who is not working. They do not include the costs, short and long term, of the deterioration that occurs while waiting.

THE SOLUTIONS

To solve Canada's doctor shortage, the CMA believes governments must:

- Adopt a long-term policy of self-sufficiency to provide Canadians with the health care professionals they need when and where they need them;
- Establish a dedicated health human resource renewal fund to educate, retain and enhance the lives of health care professionals; and
- Invest in health technology, infrastructure and innovation to make our health care system more responsive and efficient.

SELF-SUFFICIENCY

Over the past decade, there have been increasing concerns that Canada is not producing an adequate number of health providers to meet the growing demand for health services – now and into the future. These concerns have been consistently registered by physicians, nurses, pharmacists, technicians, in addition to other groups that represent other providers and the institutional and health facilities community.

Furthermore, the policy challenges related to health human resources (HHR) have been identified in several seminal reports – including the Royal Commission on the Future of Health Care in Canada, the Standing Senate Committee on Social Affairs, Science & Technology, and the Health Council of Canada.³

A growing number of health providers are looking to retire over the next decade (or leave the health system all together) relative to the number of trainees who are entering the health system, and at a time where a growing number of Canadians will be turning to the health system for diagnosis and treatment. Over 6% of physicians who responded to the National Physician Survey 2007⁴ said they plan to retire from clinical practice and 1% plan to

³ The Royal Commission on the Future of Health Care in Canada, November 2002. Senate Standing Committee on Social Affairs, Science & Technology, October 2002. The Health Council of Canada "Modernizing the Management of Health Human Resources in Canada: Identifying Areas for Accelerated Change: November 2005.

⁴ The National Physician Survey is a major ongoing research project conducted by the College of Family Physicians of Canada, Canadian Medical Association and Royal College of Physicians and Surgeons of

permanently leave practice for other reasons in the next 2 years. The effect of these changes could mean that, as the baby boom generation gets older, over 4,000 physicians will cease their medical practice within the next 2 years, making it even more difficult for Canadians to find a family physician.

At the same time, the HHR challenges facing Canada's health care system are not unique to our country – over the next decade all western developed countries can expect intensified global competition for talent when it comes to health providers.⁵

While there are, no doubt, other provider groups who are also concerned about the future supply of health providers, there is a growing national consensus that, in addition to the primary role that the provinces and territories play in supporting the training of health providers across the country, there is a significant, catalytic and strong complementary role for the federal government in the area of health human resources.

CMA, like many health care organizations, is of the view that there is a legitimate role for the federal government to strengthen its working relationship with the provinces and territories, and health providers through the creation of a time-limited, issue-specific and strategically-targeted fund to accelerate training capacity in the health system.

The World Medical Association's ethical guidelines for international recruitment of physicians¹⁶ (2003), fully supported by the CMA, recommend that every country "should do its utmost to educate an adequate number of physicians, taking into account its needs and resources. A country should not rely on immigration from other countries to meet its need for physicians."⁷ However, in reality Canada continues to rely heavily on recruitment of internationally educated health professionals. Approximately one-third of the increase in physician supply each year is due to International Medical Graduates (IMGs) who are either recruited directly to practice or who have taken significant postgraduate medical training in Canada. In nursing, the number of internationally educated nurses applying for licensure is increasing rapidly, almost tripling from 1999 to 2003.

Previous recommendations of the CMA to the House of Commons included improved medium- to longer-term supply projection models; sufficient opportunities for Canadians to train for health professional careers in Canada; and integration of international graduates, who are permanent residents or citizens of Canada, into practice. The CMA recognizes that

Canada that gathers the opinions of all physicians, 2nd year medical residents and medical students from across the country. It is the largest census survey of its kind and is an important barometer of where the country's present and future doctors are on a wide range of critical issues.

⁵ The Economist, *The Battle for BrainPower – A Survey of Talent*, October 7, 2006.

⁷ World Medical Association. *The World Medical Association Statement on Ethical Guidelines for the International Recruitment of Physicians*. Geneva: The World Medical Association; 2003. Available: www.wma.net/e/policy/e14.htm

professionals are working in an increasingly global world in terms of the exchange of scientific information, mutual recognition of qualifications between countries and the movement of people.

The greatest barrier to enhancing Canada's ability to become more self-sufficient, in terms of physician resources, is the capacity of our medical schools. Despite recent increases in enrolment, Canada continues to turn away approximately 3 equally qualified students for every 1 that is accepted into an undergraduate medical program. This has resulted in over 1500 Canadian students, with the financial means to do so, who are training in medical schools outside of Canada.

INTERNATIONAL MEDICAL GRADUATES

In the larger context, Canada's current fertility rate is not sufficient to support self-sufficiency in general in relation to any professions. And, while self-sufficiency in the production of physicians is a desirable goal, it is also important to promote the international exchange of teaching and research, particularly in an increasingly global society. In this regard, IMGs should be considered as a planning component for a sustainable Canadian physician workforce. Historically IMGs have entered the practice of medicine through a variety of routes, which most typically include a recognized period of post-MD training in Canada.

CMA's best estimate is that there are about 400 IMGs newly licensed to practice in Canada each year who have not completed postgraduate training in Canada. In addition, there are another 300 or so who are exiting Canadian postgraduate training programs and heading into practice. In fact, for the past few years, the College of Physicians and Surgeons of Ontario has licensed more IMGs than new Ontario medical graduates.

In recent years, there have been an increasing number of opportunities for IMGs already living in Canada to achieve the required credentials for licensure. The number of ministry-funded IMG postgraduate residents has more than tripled in the past seven years from 294 to 1065 trainees. In 2007, there were almost 1500 IMGs who were qualified to compete in the Canadian Resident Matching Service (CaRMS) match. By the end of the second round, close to 300 had matched and about 60 were placed through other provincial programs.

Recommendation

The federal government should make a clear policy commitment to increasing self-sufficiency in the education and training of health professionals in Canada that would incorporate the following.

- **Short term** — increase number of community preceptors to train Canadian graduates and assess internationally educated health professionals already living in Canada. Recognition of the time and value of community teaching is needed.
- **Medium term** — support increased capacity for academic health science centres and other institutions that train health professionals.
- **Long term** — creation of new academic health science centres to increase capacity for self-sufficiency.

REPATRIATING CANADIAN DOCTORS WORKING ABROAD

It is known that there are thousands of Canadian-trained health professionals practising in the United States and abroad. Between 1991 and 2004, almost 8,000 physicians left Canada (although some 4,000 returned for a net loss of 4,000).⁸ Of this number, roughly 80% went to the US.⁹ During the 1990s, approximately 27,000 nurses migrated from Canada to the US.^{10,11} A more recent indicator of nursing outmigration is that in 2006, 943 Canadian-trained Registered Nurses and Licensed Practical Nurses wrote the US licensing board examination for the first time.¹² Data for other health professional disciplines are not readily available.

In 2007, with the assistance of the American Medical Association, the Canadian Medical Association (CMA) surveyed all (n=5,156) Canadian-trained physicians practicing in the US who were age 55 or under, with regard to the likelihood of their return to Canada and the importance of various factors that might be incentives to return. A 32% response rate was achieved with a single mailing with no follow-up – this is considered exceptionally high.

While only 13% of respondents indicated that they were likely or very likely to return to Canada, a further 25% were neutral in their opinion. What is more telling is that more than one-half of respondents indicated that they would be willing to be contacted by CMA to explore practice opportunities and provided their contact information for this purpose. When asked about a range of potential incentives to return to Canada, 57% agreed that a

⁸ Canadian Institute for Health Information.

² Canadian Institute for Health Information.

¹⁰ Zaho J, Drew D, Murray T. Brain drain and brain gain: the migration of knowledge workers from and to Canada. *Education Quarterly Review* 2000;6(3):8-35.

¹² Little L, Canadian Nurses Association, personal communication, January 8, 2008.

relocation allowance would be somewhat or very important.¹³ It must be stressed, however, that it is clear from the results that a number of factors would need to be taken into consideration, such as practice opportunities. This would also be true of other disciplines; in the case of nursing, nurses will only come back for full-time jobs and healthy work environments.¹⁴

Nonetheless, expatriate Canadian medical graduates should be good candidates for recruitment on the basis of the greater likelihood that they will meet Canadian standards for full medical licensure, and it is expected that this would also apply to nursing and other disciplines.

As well, significant progress has been made in restoring and adding capacity to our medical schools but, to achieve self-sufficiency, much more needs to be done. For example, we must try and repatriate Canadian medical students and doctors who are studying and working abroad. There are currently some 1500 Canadian medical students and residents training abroad, we must act now, before things get worse.

During that past few years there have been efforts to enhance national coordination in the health human resources arena. One area of national focus has been the integration of International Medical Graduates, since extended to nursing and other disciplines. There have been several initiatives undertaken in this area such as the establishment of the Canadian Information Centre for International Medical Graduates¹⁵ which provides a clearinghouse of information and links to provincial/territorial jurisdictions.

Relocation grants, from \$10,000 up to \$20,000 could be offered to Canadian-trained physicians practising in the US. It is suggested that advertising be concentrated in and around US cities where Canada maintains a consulate/office (in states with a significant concentration with recruitment candidates) and in major national and selected state health professional journals. The cost of a repatriation secretariat is estimated at \$162,500 per year. Assuming that 1,500 health professionals are recruited back over the 3-year period, the total cost would range from \$21.5 million to \$36.5 million.

This would further translate to a per recruit cost that ranges from \$14,325 to \$24,325. Even at the high end of the range this would be cost-effective as compared to the total cost of training a practice-entry level graduate of any licensed health professional discipline in Canada.

Recommendation

¹³ Buske L. Analysis of the survey of Canadian graduates practicing in the United States. October 2007. http://www.cma.ca/multimedia/CMA/Content/Images/Policy_Advocacy/Policy_Research/US_survey_ver_4.pdf. Accessed 02/04/08.

¹⁴ Little L, Canadian Nurses Association, personal communication, January 28, 2008.

¹⁵ www.img-canada.ca

In light of the foregoing, the CMA has recommended that the federal government should establish a Health Professional Repatriation Program in the amount of \$30 million over 3 years that would include the following:

- secretariat within Health Canada that would include a clearinghouse function on issues associated with returning to Canada such as licensure, citizenship and taxation;
- An advertising campaign in the US to encourage health professionals practicing south of the border to return home; and
- A program of one-time relocation grants for health professionals returning to active practice in Canada.

NATIONAL HEALTH HUMAN RESOURCES INFRASTRUCTURE FUND

The implementation of Medicare in Canada in the 1960s required a major investment in the capacity to train more health professionals. The 1966 *Health Resources Fund Act* played a key role in enabling a significant expansion in training capacity across the provinces for a range of health professionals. Forty years later, Canada faces growing shortages across most health disciplines. Clearly another giant step up is required in the human and physical infrastructure needed to train health professionals if Canadians are to have timely access to care.

During the years of fiscal famine of the 1990s, health professional enrolment was either reduced (e.g., 10% in the case of medicine) or flat-lined. While there have been increases since 2000, we are about to face the double impact of both an aging population as the first of the baby boomers reach 65 in 2011 and aging health professions. For example, more than 1 out of 3 physicians (35%) are aged 55 or older. As mentioned, as many as 4,000 physicians are expected to retire in the next 2 years.

If we are going to have sufficient numbers of health providers to meet the needs of the next few decades, it is imperative to expand the human and physician infrastructure capacity of our health professional education and training system. The federal investments in health human resources over 2003–2005 of some \$200 million have been welcome, but fall far short of what is needed.

It is proposed that the federal government implement a National Health Human Resources Infrastructure Fund in the amount of \$1 billion over 5 years that would be made available to the provinces/territories on an equal per capita basis, and awarded through a competitive process that would include federal/ provincial/territorial representation with consultation/engagement of health professional organizations. The fund would address the following elements:

1. The direct costs of training providers and developing leaders (e.g., cost of recruiting and supporting more community- based teachers/preceptors).

2. The indirect or infrastructure costs associated with the educational enterprise (e.g., physical plant [housekeeping, maintenance]; support for departments [information systems, library resources, occupational health, etc.]; education offices, and the materials and equipment necessary for clinical practice and practical training.
3. Resources that improve the country's overall data management capacity when it comes to health human resources, and in particular, facilitate the ability to model and forecast health human resource requirements in the face of the changing demand for health services.

Clearly it would be necessary to develop guidelines around the types of expenditures that would be eligible as was done for the 1966 Health Resources Fund, and more recently for the Medical Equipment Fund II.

Recommendation

The federal government should establish a National Health Human Resources Fund in the amount of \$1 billion over 5 years to expand health professional education and training capacity by providing funding to support the:

- direct costs of training providers
- indirect or infrastructure costs associated with the educational enterprise
- resources that improve Canada's data collection and management capacity in the area of health human resources.

HEALTH INNOVATION

More than 85% of the health care delivered in Canada occurs within the community. This is the most under-invested segment of the health care delivery system in terms of information technology. Dr. Brian Postl in his June 2006 wait-time report¹⁶ to the federal government noted health information technology is essential in improving wait times. He quantified the investment needed at \$2.4 billion with the largest portion of this investment (\$1.9 billion) targeted to automating physician offices, which are located at the front line of care in community settings and are key to managing and resolving the wait time issue in Canada.

Why invest in physician office automation? Because it will lead to improved productivity from the provider community through more efficient resource usage and through improved coordination in the delivery of care; it will enable labour mobility of health care workers through portability of records; it will support the wait time agenda by improving the flow of timely information; it will build an electronic infrastructure platform to enhance patient care and health research and will provide a direct financing vehicle for the federal government to influence and shape the health care sector.

¹⁶ Postl, B. *Final Report of the Federal Advisor on Wait Times*. Ottawa: Minister of Health Canada, Health Council of Canada; 2005.

The federal government has made similar types of infrastructure investment. The CFI Program was established to fund research infrastructure, which consists of the state-of-the-art equipment, buildings, laboratories and databases required to conduct research. Investing in EMR infrastructure will lead to the creation of state of the art clinical environments across Canada, electronic data base of health information and the foundational underpinnings of a health information network to support enhanced population health and health research.

Under this scenario the federal contribution would provide a direct benefit to physicians without any need for provincial or territorial involvement. Second, the federal government could use existing government machinery to manage the program. Third, the federal contribution to infrastructure would only flow after a physician has introduced an EMR into his/her clinic ensuring that the funding is directly tied to building the EMR infrastructure platform.

The recent National Physician Survey notes that some progress is being made across the country to automate community clinics. However without incentives the adoption trend will be incremental and extend over a further 20-year time frame. Financial incentives can shorten the timelines since it addresses one of the main adoption barriers physicians identify.¹⁷

Diffusion theory¹⁸ of new technologies into any sector of the economy demonstrates that without appropriate incentives it will take approximately 25 years the technology to reach the saturation point of integration. It is estimated that a financial incentive can shorten this timeline by 15 years.

Recommendation

The federal government, over a 5-year time frame, should provide a full tax credit to any physician who takes the steps to automate his or her clinical office. The tax credit would only apply to 1-time costs to establish a state of the art clinical environment. It is estimated, on average, 1-time costs would be \$22,000. Total costs of the program if fully subscribed would amount to \$880 million.

¹⁷ Canadian Medical Association/Canada Infoway. Physician Technology Usage and Attitudes Survey. Ottawa: CMA/CanadaInfoway; 2005. Available: www.cma.ca/index.cfm/ci_id/49044/la_id/1.htm (accessed 8 Jan 2008).

¹⁸ Bower, Anthony. *The Diffusion and Value of Healthcare Information Technology*. Santa Monica (CA): RAND Corporation; 2005

CONCLUSION

The health services sector makes significant contributions to the Canadian economy, both in terms of direct stimulus and by keeping Canadians healthy and productive. However, Canada's health services sector is facing a critical shortage of physicians and other health care professionals. By:

- Adopting a long-term policy of self-sufficiency to provide Canadians with the health care professionals they need when and where they need them;
- Establishing a dedicated health human resource renewal fund to educate, retain and enhance the lives of health care professionals;
- Investing in health technology, infrastructure and innovation to make our health care system more responsive and efficient;

the federal government, in partnership with provincial/territorial governments and other health system stakeholders can strengthen this sector. A strong health services sector means healthy Canadians and a vibrant Canadian economy.

Again, on behalf of the Canadian Medical Association, Canada's doctors appreciate the opportunity to provide information to the Committee.

Sincerely,

Brian Day, MD
President, Canadian Medical Association