

**Transforming Health Care, Securing Canada's
Competitive Advantage**

**The Canadian Medical Association's brief to the Standing
Committee on Finance's pre-budget consultation**

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

The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, CMA'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 70,000 members and the Canadian public, CMA performs a wide variety of functions. Key functions include advocating for 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 45 national medical organizations.



EXECUTIVE SUMMARY

As signs of economic recovery begin to emerge, both in Canada and globally, the Canadian Medical Association is pleased to put forward three recommendations that will initiate a needed transformation of our health care system so that it is truly patient focused and sustainable. Additionally, these measures will create 17,000 jobs and solidify Canada's health care competitive advantage. Although related to the health care sector, these recommendations are within the context of ensuring a prosperous and sustainable economic, social and environmental future for Canada in the short, medium and long term. Each of these three recommendations also takes into account the finance committee's questions:

1. What federal tax and program spending measures are needed to ensure prosperity and a sustainable future for Canadians from an economic, social and/or environmental perspective?
2. What federal stimulus measures have been effective and how might relatively ineffective measures be changed to ensure that they have the intended effects?

CMA research demonstrates that it is possible to maintain a universally accessible health care system without long waits for care. In 2007 alone, waiting for care in just four clinical areas cost the Canadian economy \$14.8 billion. In particular, two areas require federal attention:

1. ENHANCING PATIENT ACCESS ACROSS THE CONTINUUM OF CARE

Continuing care (i.e., long-term care and home care) and prescription drug coverage need urgent attention. Many Canadians do not have access to as wide a range of insured care as citizens in other highly industrialized countries.

Recommendation 1: The federal government should expand the *Building Canada Plan* to include 'shovel-ready' health facility construction projects including ambulatory, acute and continuing care facilities. Cost: \$1.5 billion over two years

2. HELPING PROVIDERS HELP PATIENTS

a. Accelerating physician EMR adoption: Both national and international studies confirm that Canada lags behind nearly every major industrialized country when it comes to health information technology. Accelerating physician EMR adoption will reduce wait times, improve quality, and improve financial accountability especially of federal dollars. Budget 2009 proposed \$500 million in additional funding to Canada Health Infoway (Infoway) and a temporary, accelerated capital cost allowance for computer hardware. Transfer of these funds to Infoway is imperative. Together, transferring the funding to Infoway and further improving of the capital cost allowance will ensure these initiatives have the intended effects of improving EMR adoption and stimulating the economy.

b. Boosting Health Human Resources: Canada does not have enough physicians, nurses, technicians or other health care professionals to provide the care patients need. Addressing HHR shortages is critical to ensuring sustainable, accessible, responsive and high-quality health care.

Recommendation 2: The federal government should expand the 2-year time-limited accelerated Capital Cost Allowance for hardware costs related to health information technologies by extending it to five years; removing the 50% half-year rule on related software; and including electronic tools involved in connecting patient records from physician offices to laboratories and hospitals. Cost: \$50 million over four years.

Recommendation 3: The federal government should fulfill its 2008 election promise, beginning in 2010, of investing \$65 million in health human resources over four years to fund 50 new residencies per year; repatriate Canadian physicians living abroad; and launch pilot projects with nursing organizations to promote recruitment and retention.

1. INTRODUCTION — HEALTHY ECONOMICS: THE FOUNDATION OF FUTURE PROSPERITY

The CMA believes that by being innovative in its actions Canada can sustain a publicly funded, universal health care system. In fact, doing so provides Canadian industry with a significant competitive advantage in the global marketplace. Despite having one of the richest health care programs in the industrialized world (eighth among 28 Organization for Economic Co-operation and Development [OECD] countries), international benchmarking studies consistently report that the Canadian program is not performing as well as it should. The Euro-Canada Health Consumer Index ranked Canada 30th out of 30 countries in terms of value for money spent on health care in both 2008 and 2009. The CMA's recent review of several European health systems illustrates that a sustainable, patient-centred approach to health care is possible on a system-wide level without compromising founding principles such as universality, and without causing financial difficulty for the country or its citizens. However, getting there will require transformational change to refocus our system.

The Canadian Medical Association's 2010 pre-budget submission puts forward three recommendations in the areas of health care infrastructure, health human resources (HHR) and electronic medical records (EMRs).¹ These three affordable, strategic initiatives fall within the jurisdiction of the federal government and recognize both the ongoing and promising economic recovery and the current fiscal capacity of the federal government. CMA's recommendations help to chart a course toward a prosperous, and sustainable economic, social and environmental future for Canada in the short, medium and long terms. These proposals will kickstart a transformation of the health care system and create over 17,000 jobs that will ensure a competitive economic foundation for the future.

Based on CMA's research, transforming Canada's health care system to better meet the needs of Canadians hinges on five directions for a reorientation of the system:

1. Building a culture of patient-centred care;
2. Incentives for enhancing access and improving quality of care;
3. Enhancing patient access across the continuum of care;
4. Helping providers help patients;
5. Building accountability/responsibility at all levels.

While each of the five directions is important to reorienting the system, points 3 and 4 are directly relevant to the Finance Committee's deliberations.

2. ENHANCING PATIENT ACCESS ACROSS THE CONTINUUM OF CARE

While all elements of the continuum of care are important, the CMA believes that continuing care (long-term care and home care) and prescription drug coverage need urgent attention. Many Canadians do not have access to as wide a range of insured care as citizens in other highly industrialized countries. In fact, many of these other industrialized countries count access to prescription drugs and home care/long-term care among their basic insured services.

a. Continuing care: Augmenting the *Building Canada Plan* to include health care infrastructure

Recommendation 1: The federal government should expand the *Building Canada Plan* to include 'shovel-ready' health facility construction projects including ambulatory, acute and continuing care facilities. Cost: \$1.5 billion over 2 years

Continuing care in Canada faces three key challenges: capacity and access; informal caregiver support and long-term care funding. At 91%, Canada has the highest hospital occupancy rate in the OECD.ⁱⁱ Roughly 25-30% of hospital acute care beds are occupied by patients who do not require hospital or medical care but rather need 24-hour supervised care. Scarce long-term care

¹ A full schedule of the recommended federal investments as well as their job creation potential is included at the end of the document in the Appendix, Table 1.

facilities and home-care services dictate that patients remain in hospital, delaying hospitals from performing elective surgeries and restricting the movement of other patients from the emergency room to acute care wards. Much of the burden of continuing care falls on informal (unpaid) caregivers who need to be better supported. Statistics Canada reported that in 2007 about 2.7 million Canadians aged 45 and over, or approximately one-fifth of the total in this age group, provided some form of unpaid care to seniors (people 65 years of age or older) who had long-term health problems.ⁱⁱⁱ It seems unlikely that future requirements for long-term care can be funded on the same “pay-as-you-go” basis as other health expenditures.

The seven-year, \$33-billion *Building Canada Plan* announced in Budget 2007, and augmented in Budget 2009, could better support a smart economic recovery and the health needs of Canadians if it were to be expanded to include health facility construction.^{iv} Federal investment in hospital and health facility construction will create 16,500 jobs over a two-year period and 11,000 jobs in 2010 alone. (Appendix: Table 1).

Although CMA’s \$1.5 billion recommendation does not eliminate the entire health-facility infrastructure gap in Canada, estimated at over \$20 billion,^v it does provide additional stimulus aimed at shovel-ready projects. It also better prepares our health system to deal with the needs of an aging population. Federal government investment in health infrastructure has two important precedents — the first in 1948 (Hospital Construction Grants Program) and the second in 1966 (*Health Resources Fund Act*). Infrastructure funding should be directed toward projects that deliver long-term value and enhance Canadians’ lives.

b. Prescription drugs: 3.5 million Canadians underinsured

Prescription drugs represent the fastest growing item in the health budget, and the second largest category of health expenditure. More than 3.5 million Canadians have no prescription drug coverage or are underinsured against high prescription drug costs. In 2006 almost one in 10 (8%) of Canadian households spent more than 3% of their after-tax income on prescription drugs; and almost one in 25 (3.8%) spent more than 5%. It is estimated that less than one-half of prescription drug costs were publicly paid for in 2008. Canada must strive for a program of comprehensive pharmaceutical coverage that is universal and effectively pools risks across individuals and public and private plans throughout Canada.

3. HELPING PROVIDERS HELP PATIENTS

Canada’s health care workforce needs more people and more tools to care for Canadians.

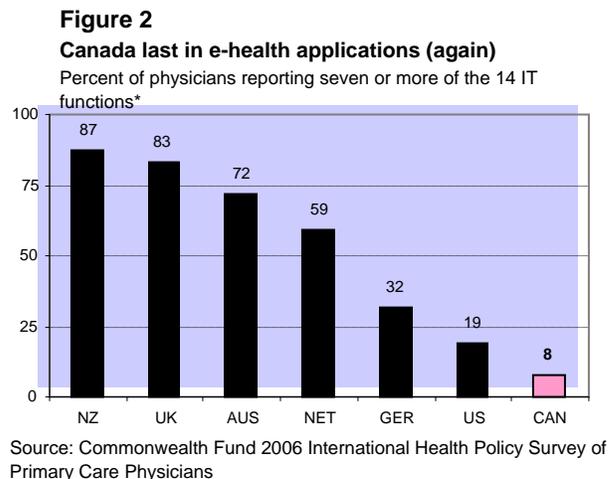
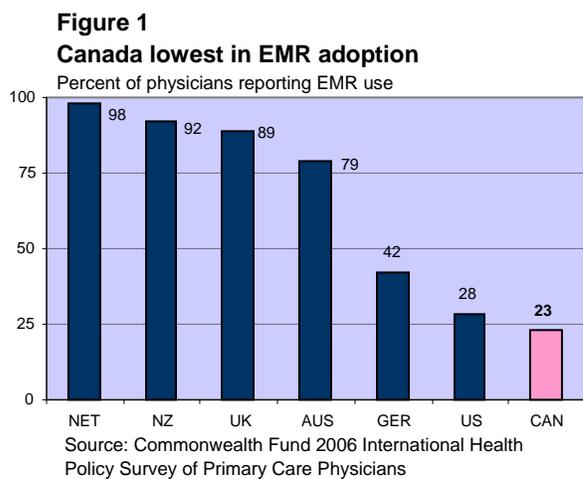
a. Accelerating physician EMR adoption

Recommendation 2: The federal government should expand the two-year, time-limited accelerated Capital Cost Allowance for hardware costs related to health information technologies by extending it to 5-years; removing the 50% half-year rule on related software; and including electronic tools involved in connecting patient records from physician offices to laboratories and hospitals. Cost: \$50 million over four years.

Both national and international studies confirm that Canada lags behind nearly every major industrialized country when it comes to health information technology (see Figure 1 and Figure 2²). The impact of this underinvestment is longer wait times, reduced quality, and a severe lack of financial accountability, especially of federal dollars. The Conference Board of Canada,^{vi} the Organization for Economic Co-operation and Development (OECD),^{vii} the World Health Organization,^{viii} the Commonwealth Fund,^{ix} and

² 14 functions are: EMR, EMR access, access other doctors, outside office, patient: routine use, electronic ordering tests, prescriptions, access test results, access hospital records, computer for reminders, Rx alerts, prompt test results; easy to list diagnosis, medications, patients due for care.

the Frontier Centre for Public Policy^x all rate Canada's health care system poorly in terms of "value for money" as well as efficiency.



The CMA applauds the temporary 100% Capital Cost Allowance (CCA) rate for computer hardware and systems software acquired after January 27, 2009 and before February 1, 2011 that was proposed in Budget 2009. The measure will provide stimulus by helping businesses to increase or accelerate investment in computers. It will also help boost Canada's productivity through the faster adoption of newer technology. However, for this initiative to provide the greatest benefit, the 100% CCA rate should be extended to five years and expanded to include related EMR software. The benefits of EMR investments are clear. International strategy and technology consulting firm Booz Allen Hamilton found the benefits of an interconnected Electronic Health Record (EHR) in Canada could save the health system \$6.1 billion^{xi} a year.

The CMA's recommendation of delivering incentives through the tax system to adopt EMRs is a bottom-up approach that has gained widespread support. John Halamka, the chief information officer at Harvard Medical School, thinks that reformers need to take a bottom-up approach and listen to both doctors and patients. Studies show^{xii} that most of the benefits of EMRs flow to the payer. Incentives for hardware, software and as importantly the time that it takes to implement these e-systems must be taken into account and incented. The urgency for e-health is being recognized in the United States and needs to be in Canada.

"...our medical system has to move into the information age in the same way that all other sectors of our society have. We have a faster more accurate way of communicating medical information and there is no reason not to embrace it".

Health Minister Leona Aglukkaq
February 2009

Beyond tax incentives, Budget 2009 also provided Canada Health Infoway (Infoway) with \$500 million to support the goal of having 50% of Canadians with an electronic health record by 2010. As of March 31, 2009, Infoway and its partners had put in place an electronic health record for 17% of the population. Budget 2009 funding will allow Infoway to extend EHRs to 38% of the population by March 31, 2010.^{xiii} This investment will not only enhance the safety, quality and efficiency of the health care system, but will also result in a significant positive contribution to Canada's economy, including the creation of thousands of sustainable, knowledge-based jobs throughout Canada.^{xiv} Infoway has not yet received this funding and the CMA strongly encourages the federal government to transfer the funds promised in Budget 2009 as soon as possible.

b. Boosting Health Human Resources

Recommendation 3: The federal government should fulfill its 2008 election promise^{xv}, beginning in 2010, of investing \$65 million in health human resources over four years to fund 50 new residencies per year; repatriate Canadian physicians living abroad; and launch pilot projects with nursing organizations to promote recruitment and retention.

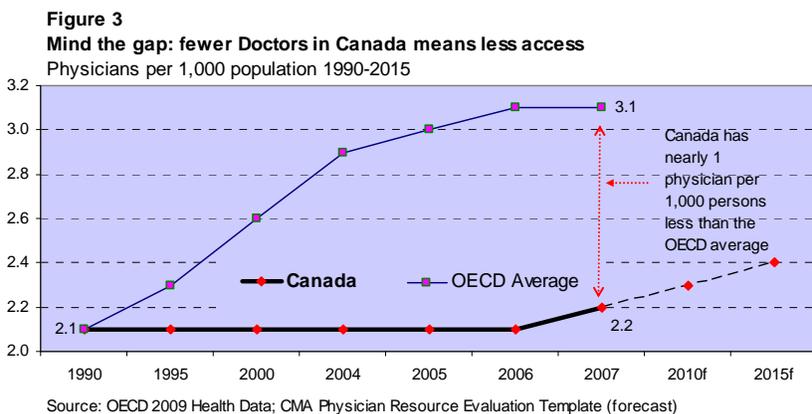
Canada does not have enough physicians, nurses, technicians or other health care professionals to provide the care patients need. Addressing health workforce shortages is critical to ensuring sustainable, accessible, responsive and high-quality health care across the nation. Canada has suffered from a significant physician shortage since the mid-1990s. Nationally, we rank 26th of 30 OECD member countries in

physician-to-population ratio (see Figure 3). The lack of physicians in Canada puts the system under pressure, and the impact of this is being felt by patients across the country. Currently, approximately five million Canadians do not have a family physician. In 2008, a study commissioned by the CMA found that the Canadian economy lost \$14.8 billion as a result of excessive wait times for just four procedures: joint replacements, MRIs, coronary artery bypass surgery and cataract surgery.

As health care reform plans evolve south of our border, Canada should be proactive in order to retain the health professionals we have educated and trained, and make it easier for those who have emigrated to return to practice in Canada. In the 2008 federal election, most parties recognized the urgency of HHR shortages and committed to address the situation. The Conservative Party committed to fund additional medical residency positions, create a repatriation fund for Canadian physicians practising abroad and fund nursing recruitment and retention pilot projects. It is thought this repatriation program could bring back as many as 300 Canadian physicians over four years. The federal government should keep this important commitment. Migration to the United States peaked in the late 1990s when Canada lost between 600 and 700 physicians per year. While some physicians returned to Canada each year, our net losses for this period were over 400 per year. Today we are enjoying small net annual gains but this may not last. With predicted shortages in the U.S. of between 80,000 and 100,000 physicians in the years ahead, we can expect U.S. recruiters to ramp up activities in Canada soon.

4. CONCLUSION

The emerging economic recovery offers an excellent opportunity for the federal government to create a more patient-focused and sustainable health care system. Enhancing patient access across the continuum of care by bolstering the *Building Canada* infrastructure plan and helping providers help patients by enhancing EMR tax incentives and addressing health workforce shortages are important first steps in transforming our health care system. Looking ahead, it will be important to continue to honour the financial transfers of the 2004 Health Care Accord, including the annual 6% escalator, through to 2014. Past cuts to health care funding at all levels have had significant negative effects that continue to be felt to this day. Now is the time to begin thinking ahead to the fiscal needs of the health care system in the post-2014 era.



Appendix Table 1

Federal Initiatives (\$ millions)	Healthy Investments: Building a Competitive Economy								2-year Total	4-year Total
	2010				2011					
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
A. Hospitals/ Long-term care facilities										
Hospital/ Long-Term Care Construction	\$ 100.0	\$ 200.0	\$ 400.0	\$ 300.0	\$ 200.0	\$ 100.0	\$ 100.0	\$ 100.0	\$ 1,500	\$ 1,500
B. Health Human Resources										
50 new residency positions	\$ 4.9	\$ 4.9	\$ 4.9	\$ 5.1	\$ 5.1	\$ 5.1	\$ 5.1	\$ 5.1	\$ 40	\$ 65
repatriate Canadian physicians living abroad	\$ 3.1	\$ 3.1	\$ 3.1	\$ 3.1	\$ 3.1	\$ 3.1	\$ 3.1	\$ 3.1	\$ 25	\$ 40
launch pilot projects to promote recruitment and retention	\$ 1.3	\$ 1.3	\$ 1.3	\$ 1.5	\$ 1.5	\$ 1.5	\$ 1.5	\$ 1.5	\$ 11	\$ 20
	\$ 0.5	\$ 0.5	\$ 0.5	\$ 0.5	\$ 0.5	\$ 0.5	\$ 0.5	\$ 0.5	\$ 4	\$ 5
C. Electronic Medical Records										
EMR Accelerating the Capital Cost Allowance for EMR related software*	\$ 3.1	\$ 3.1	\$ 3.1	\$ 3.1	\$ 3.1	\$ 3.1	\$ 3.1	\$ 3.1	\$ 25	\$ 50
Total	\$ 106	\$ 206	\$ 406	\$ 306	\$ 206	\$ 106	\$ 106	\$ 106	\$ 1,550	\$ 1,590

*This takes into account that the Capital Cost Allowance on software is now 100% over two years; we're asking for \$2k (software costs) multiplied by roughly 25,000 offices across Canada. We are estimating 25,000 physician offices (or 71% of 35,000 offices) will take up the incentive assuming that some already have EMR software in place.

Federal jobs created**	Healthy Jobs: Building a Competitive Economy								2-year Total	4-year Total
	2010				2011					
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4		
A. Hospitals/ Long-term care facilities										
Hospital Construction	1,100	2,200	4,400	3,300	2,200	1,100	1,100	1,100	16,500	16,500
B. Health Human Resources										
50 new residency positions	53	53	53	56	56	56	56	56	441	715
repatriate Canadian physicians living abroad	34	34	34	34	34	34	34	34	273	440
launch pilot projects to promote recruitment and retention	14	14	14	17	17	17	17	17	124	220
	6	6	6	6	6	6	6	6	44	55
C. Electronic Medical Records										
EMR Accelerating the Capital Cost Allowance for EMR related software	34	34	34	34	34	34	34	34	273	327
Total	1,168	2,268	4,468	3,368	2,268	1,168	1,168	1,168	17,046	17,267

**For example: A \$1 billion increase in infrastructure spending (at nominal prices and allocated to a representative mix of types of infrastructure in 2010 should increase the size of the real economy by about 0.13 per cent in 2010, or by \$1.3 billion in nominal terms. In 2010, this adds 11,500 jobs to overall employment. The investment to jobs conversion methodology used above was adapted from a paper prepared by Informetrica for the Federation of Canadian Municipalities. See: Macroeconomic Impacts of Spending and Level-of-Government Financing Informetrica Limited, May 31, 2008 see: www.fcm.ca//CMFiles/Final%20Informetrica1LUG-5312008-7682.pdf

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- ^{xii} Although the savings would accrue to different stakeholders, in the long run they should accrue to payers. If we allocate the savings using the current level of spending from the National Health Accounts (kept by the Centers for Medicare and Medicaid Services), Medicare would receive about \$23 billion of the potential savings per year, and private payers would receive \$31 billion per year. Thus, both have a strong incentive to encourage the adoption of EMR systems. Providers face limited incentives to purchase EMRs because their investment typically translates into revenue losses for them and health care spending savings for payers. From: Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, And Costs, by Richard Hillestad, James Bigelow, Anthony Bower, Federico Girosi, Robin Meili, Richard Scoville and Roger Taylor, Health Affairs, 24, no. 5 (2005): 1103-1117
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