

Healthy Canadians lead to a Productive Economy

Canadian Medical Association: 2011 pre-budget consultation submission to the Standing Committee on Finance

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A healthy population and a vibrant medical profession
Une population en santé et 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 more than 72,000 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 51 national medical organizations.



Overview

Healthy Canadians lead to a Productive Economy

The Canadian Medical Association's (CMA) pre-budget submission is based on the premise that healthier Canadians are more productive Canadians. It also recognizes that the delivery of quality health care, in a timely manner, is paramount and is not mutually exclusive of any productivity agenda. With the recent release of its *Health Care Transformation in Canada: Change That Works. Care That Lasts.* policy document, the CMA declared its readiness to take a leadership position in confronting the hard choices required to make health care work better for Canadians. Physicians are reaching out to the Canadian public, opinion and business leaders, governments, interested parties and stakeholders to find ways to improve our health care system and to make sure that the upcoming reforms will focus on better serving patients.

Canada's health care system cannot continue on its current path, especially as pressure grows from an aging population. The system needs to be massively transformed, a task that demands political courage and leadership, flexibility from within the health care professions and far-sightedness on the part of the public. It is a lot to demand, but one of Canada's most cherished national institutions is at stake. We must work together toward a common vision of what we aspire for our health care system.

The CMA commends the federal government for publicly stating it will honour its previous commitment of a 6% annual increase to the Canada Health Transfer through to 2014. This sustained predictable funding has brought some long-term stability to the publicly financed health care sector. However, the CMA believes that the health care system must be capable of withstanding or accommodating demand surges and fiscal pressure. Capacity and innovation strategies need to be developed and implemented to meet emerging health necessities.

In this brief, the CMA identifies a number of key issues related to health human resources and infrastructure that require immediate attention if the Canadian economy is to retain its competitive position in the global economy. Pressure is mounting on the system and there is a need to move beyond data collection to interdisciplinary collaboration. Including health care providers in the decision-making process would lead to better health public policy decisions, and result in much needed pan-Canadian health human resource planning. By making strategic direct investments in health human resources, public health and retirement savings, the federal government would retain its leadership role and contribute to the sustainability of a patient-centred health care system.

Health care's contribution: A more productive and innovative economy

The health care system in Canada employs over a million people, or 7.5% of the labour force. In 2009, Canada invested \$183 billion in health care, representing 11.9% of our GDP. The benefits of health care investments not only contribute to a higher quality of life for all Canadians, but the economic multiplier effect of the initial investment is estimated to create an additional \$92 billion in economic activity, such as in the high technology sector, financial services and R&D jobs.ⁱ Further federal investments in the health care system contribute to ensuring a more productive and innovative economy.

The health care sector employs over a million people. In 2009, health care investments of \$183 billion raised billions in taxes and generated an additional \$92 billion in economic activity.

Better Health, Improved Productivity

The Conference Board of Canadaⁱⁱ, the Organization for Economic Co-operation and Development (OECD)ⁱⁱⁱ, the World Health Organization^{iv}, the Commonwealth Fund^v, and the Frontier Centre for Public Policy^{vi} all rate Canada's health care system poorly in terms of "value for money" as well as efficiency. In both 2008 and 2009, the Euro-Canada Health Consumer Index ranked Canada 30th of 30 countries (the U.S. was not included in the sample) in terms of value for money spent on health care. Canadians deserve better. We know that investments in quality today will pay off in improved health that will reduce health care demand and expenditures down the road. The resultant improved productivity from the reduction of illness in the population will generate economic dividends for the country.

Our proposals are informed by regular consultations with our 72,000 physician members and reflect what they believe are the most pressing gaps that exist in our health care system today. These recommendations will also start the process of fostering transformation of the health care system that not only serves the health needs of Canadians, but makes our health care system more effective, accountable and sustainable now and for generations to come.

- **Please note that the sum of the following recommendations would add less than 0.5% to the current \$25 billion Canada Health Transfer that is committed to the provinces.**

Recommendations for the 2011 Federal Budget:

A. Investing in Health Human Resources: \$53.1 million over 4 years

1. The federal government should fulfill the balance of its 2008 election promise^{vii} of investing \$33.1 million over 4 years to fund 35 new residencies per year; and invest \$20 million over 4 years in the repatriation of Canadian physicians working abroad.

B. Investing in pandemic preparedness (post H1N1): \$500 million over 5 years

2. The federal government should increase funding (\$200 million over 5 years) to enhance disease surveillance by linking public health databases with real-time clinical information through patient Electronic Medical Records in order to facilitate data collection and analysis between local public health authorities and primary care practices.
3. The federal government should increase funding (\$200 million over 5 years) for local health emergency preparedness planning to improve collaboration and coordination of clinical care and public health structures at the local level during public health crises and reduce the variation of capacity across the country.
4. The federal government should invest in the creation of a pan-Canadian strategy (\$100 million over 5 years) to build a process for a harmonized national clinical response, including vaccine programs in times of potential health crises.

C. Improving retirement savings options for the self-employed: federal taxes to be deferred over time

5. The federal government should increase RRSP limits and explore opportunities to provide pension vehicles for self-employed Canadians.

D. Encourage Canadians to save for long-term care needs: federal taxes to be deferred over time

6. The federal government should study options for pre-funding long-term care, including private insurance, tax-deferred and tax-prepaid savings approaches, and contribution-based social insurance.

E. Support for informal caregivers

7. The federal government should undertake pilot studies that explore tax credit and/or direct compensation for informal caregivers for their work and expand relief programs for informal caregivers that provide guaranteed access to respite services for people dealing with emergency situations.

A. Investing in Health Human Resources: \$53.1 million over 4 years

Every high-performing health system begins with a strong primary care system. Yet roughly 5 million Canadians do not have a regular family physician, and once Canadians do access primary care, they often face long waits to see consulting specialists and further waits for advanced diagnostics and treatment. Part of the reason for these delays is the shortage of health care professionals in Canada and the lack of long-term pan-Canadian planning to ensure needs are met.

Canada ranks 26th of 30 OECD member countries in physician-to-population ratio. The lack of physicians in Canada puts the system under pressure and the impact of this is being felt by patients across the country. A Centre for Spatial Economics study^{viii} commissioned by the CMA, found that the Canadian economy is expected to lose \$4.7 billion in 2010, as a result of excessive wait times for just four procedures: joint replacements, MRIs, coronary artery bypass surgery and cataract surgery. When people wait too long for care businesses face increased human resource costs to replace lost or affected employees. There is a loss in output and especially productivity. The reduction in output would lower federal and provincial government revenues in 2010 by \$1.8 billion. The econometric model in the report used to calculate these costs also estimates that to cut wait times to government recommended benchmarks would require a \$586 million investment or just 2% of the current Canada Health Transfer. This investment would boost GDP by \$6.2 billion.

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The global shortage of health professionals compounds the problem — while Canadian training programs still lack sufficient seats to produce enough new providers to meet current and future demands, Canadian-educated physicians, nurses, technicians, and other health professionals are being lured away by ample opportunities to train and work outside Canada.

The CMA commends the federal government for recently announcing the Northern and Remote Family Medicine Residency Program in Manitoba, which constitutes an investment of just over \$6.9 million. The program will provide extensive medical training for 15 additional family medicine residents over the next four years. We urge the government to build on this announcement and honour its full commitment. Thousands of health care professionals are currently working abroad, 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 return 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 1: The federal government should fulfill its 2008 election promise^{ix} of investing \$33.1 million over 4 years to fund 35 new residencies per year; and invest \$20 million over 4 years in the repatriation of Canadian physicians working abroad.

B. Investing in pandemic preparedness (post H1N1): \$500 million over 5 years

The absence of a national communicable disease/immunization monitoring system is an ongoing problem. In 2003, the report of the National Advisory Committee on SARS and Public Health recommended that “the Public Health Agency of Canada should facilitate the long term development of a comprehensive and national public health surveillance system that will collect, analyze, and disseminate laboratory and health care facility

data on infectious diseases... to relevant stakeholders.” Seven years later, Canada still does not have a comprehensive national surveillance and epidemiological system.

Clinicians’ practices are highly influenced by illness patterns that develop regionally and locally within their practice populations; thus, surveillance data are useful in determining appropriate treatment. During the H1N1 outbreak, real-time data were not available to most physicians and when data did become available, they were already several weeks old. Greater adoption of electronic medical records (EMRs) in primary care and better public health electronic health records (EHRs), with the ability to link systems, will augment existing surveillance capacity and are essential to a pan-Canadian system. International strategy and technology consulting firm Booz Allen Hamilton found that the benefits of an interconnected Electronic Health Record (EHR) in Canada could provide annual system-wide savings of \$6.1 billion. A pan-Canadian electronic health information system is urgently needed and must become a priority during the inter-pandemic phase, with adequate federal funding and provincial/territorial collaboration.

Recommendation 2: The federal government should increase funding (\$200 million over 5 years) to enhance disease surveillance by linking public health databases with real-time clinical information through patient Electronic Medical Records in order to facilitate data collection and analysis between local public health authorities and primary care practices.

Recommendation 3: The federal government should increase funding (\$200 million over 5 years) for local health emergency preparedness planning to improve collaboration and coordination of clinical care and public health structures at the local level during public health crises and reduce the variation of capacity across the country.

A key measure to combat pandemic influenza is mass vaccination. On the whole, Canada mounted an effective campaign: 45% of Canadians were vaccinated, and the proportion was even higher in First Nations communities — a first in Canadian history. The outcome was positive, but many public health units were stretched as expectations exceeded their pre-existing constrained resources. Nationally promulgated clinical practice guidelines had great potential to create consistent clinical responses across the country. Instead, the variation and lack of coordination in providing important clinical information during this crises eroded the public’s confidence in the federal, provincial and territorial response.

Recommendation 4: The federal government should invest in the creation of a pan-Canadian strategy (\$100 million over 5 years) to build a process for a harmonized national clinical response, including vaccine programs in times of potential health crisis.

C. Improved retirement savings options for self-employed: federal taxes to be deferred over time

With the aging Canadian population and the decline in the number of Canadians participating in employer-sponsored pension plans, now is the time to explore strengthening the third pillar of Canada’s government-supported retirement income system: tax-assisted savings opportunities and vehicles available to help Canadians save to meet future continuing care needs.

Of keen interest to the medical profession are measures to help self-employed Canadians save for their retirement. Physicians represent an aging demographic — 38% of Canada’s physicians are 55 or older. Self-employed physicians, like many other self-employed professionals, are unable to participate in workplace registered pension plans (RPPs). This makes them more reliant on Registered Retirement Savings Plans (RRSPs) relative to other retirement savings vehicles^x. The recent economic downturn has shown that volatility of global financial markets can have an enormous impact on the value of RRSPs over the short-and medium-term. This variability is felt most acutely when RRSPs reach maturity during a time of declining market returns and RRSP holders are forced to sell at a low price.

The possibility that higher-earning Canadians, such as physicians, may not be saving enough for retirement was raised by Jack Mintz, Research Director for the Research Working Group on Retirement Income Adequacy of Federal-Provincial-Territorial Ministers of Finance. In his *Summary Report*, Mr. Mintz wrote that income replacement rates in retirement fall below 60% of after-tax income for about 35% of Canadians in the top income quintile. This is due to the effect of the maximum RPP/RRSP dollar limits and the government should consider raising these limits.

Recommendation 5: The federal government should increase RRSP limits and explore opportunities to provide pension vehicles for self-employed Canadians.

D. Encourage Canadians to save for long-term care needs: federal taxes to be deferred over time

According to Statistics Canada's most recent population projections, the proportion of seniors in the population (65+) is expected to almost double from its present level of 13% to between 23% and 25% by 2031^{xi}. With Canadians living longer and continuing care falling outside the boundaries of *Canada Health Act (CHA)* first-dollar coverage, there is a growing need to help Canadians save for their home care and long-term care needs. These needs are an important part of the retirement picture as the federal government considers options for ensuring the ongoing strength of Canada's retirement income system.

Additional information is contained in CMA's submission to the House of Commons Standing Committee on Finance during its study on Retirement Income Security of Canadians (May 13, 2010).

Recommendation 6: The federal government should study options for pre-funding long-term care, including private insurance, tax-deferred and tax-prepaid savings approaches, and contribution-based social insurance.

E. Support for informal caregivers

Much of the burden of continuing care falls on informal (unpaid) caregivers. More than a million employed people aged 45-64 provide informal care to seniors with long-term conditions or disabilities, and 80% of home care to seniors is provided by unpaid informal caregivers. Canada lags behind several countries, including the U.K., Australia, Germany, Japan, the Netherlands and the U.S. in terms of supporting informal caregivers.

Recommendation 7: The federal government should undertake pilot studies that explore tax credit and/or direct compensation for informal caregivers for their work and expand relief programs for informal caregivers that provide guaranteed access to respite services for people dealing with emergency situations.

The CMA encourages the federal government to consider the recommendation found in the report entitled; *Raising the Bar: A Roadmap for the Future of Palliative Care in Canada* supported by the Canadian Hospice Palliative Care Association.

Conclusion

The recommendations contained in the CMA's pre-budget submission represent our priority recommendations for federal investments that will contribute to a healthy, more productive and innovative economy. These recommendations will also start the process of fostering transformation of the health care system that not only serves the health needs of Canadians but makes our health care system more effective, accountable and sustainable now and for generations to come. As the federal government's commitment to the provinces through the 2004 Health Care Accord expires in 2014, it is imperative that investments are made that not only provide better care but are also sustainable for our country's economy.

Appendix Table 1

Federal Initiatives (\$'s millions)	Healthy Canadians Productive Economy					
	2011	2012	2013	2014	2015	5-year total
1. Health Human Resources						
35 new medical residency positions*	\$13.3	\$13.3	\$13.3	\$13.3		\$ 33.1
Program to repatriate Canadian physicians living in the US	\$ 5.0	\$ 5.0	\$ 5.0	\$ 5.0		\$ 20.0
Total	\$18.3	\$18.3	\$18.3	\$18.3		\$ 53.1
2. Pandemic preparedness - post H1N1						
Disease surveillance	\$ 40	\$ 40	\$ 40	\$ 40	\$ 40	\$ 200
e-infrastructure for public health coordination	\$ 40	\$ 40	\$ 40	\$ 40	\$ 40	\$ 200
National Immunization Strategy	\$ 20	\$ 20	\$ 20	\$ 20	\$ 20	\$ 100
Total	\$ 100	\$ 100	\$ 100	\$ 100	\$ 100	\$ 500
Total	\$ 118	\$ 118	\$ 118	\$ 118	\$ 100	\$553.1 million

* The original promise of \$40 million for 50 residency spots has been reduced by the recent (May 2010) \$6.9m commitment for 15 spots in Manitoba.

References

- ⁱ The additional economic activity generated by the health care sector is based on a conservative 1.5 multiplier. The CMA is pursuing precise estimates of the benefits of health care investments in Canada. Please see:
Economic Footprint of Health Care Services in Canada Prepared for: Canadian Medical Association by Carl Sonnen with Natalie Rylska Informetrica limited January 2007 In economics, the multiplier effect or spending multiplier is the idea that an initial amount of spending (usually by the government) leads to increased consumption spending and so results in an increase in national income greater than the initial amount of spending. The existence of a multiplier effect was initially proposed by Richard Kahn in 1930 and published in 1931. http://en.wikipedia.org/wiki/Fiscal_multiplier
Snowdon, Brian and Howard R. Vane. Modern macroeconomics: its origins, development and current state. Edward Elgar Publishing, 2005. ISBNs 1845422082, 9781845422080. p. 61.
- ⁱⁱ How Canada Performs 2008: A Report Card on Canada, The Conference Board of Canada see: <http://sso.conferenceboard.ca/HCP/overview/health-overview.aspx>
- ⁱⁱⁱ Organization for Economic Co-operation and Development [OECD] (2007). OECD Health Data 2007. Version 07/18/2007. CD-ROM. Paris: OECD.
- ^{iv} World Health Organization [WHO] (2007). World Health Statistics 2007. see: <http://www.who>.
- ^v Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care May 15, 2007 (updated May 16, 2007) | Volume 59
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see: www.commonwealthfund.org/publications/publications_show.htm?doc_id=482678
- ^{vi} Euro-Canada Health Consumer Index 2008, Health Consumer Powerhouse, Frontier Centre for Public Policy, FC Policy Series No. 38 see: www.fcpp.org/pdf/ECHCI2008finalJanuary202008.pdf
- ^{vii} Health Care Certainty for Canadian Families, the Conservative Party of Canada, backgrounder 10/08/08. See: http://www.conservative.ca/?section_id=1091§ion_copy_id=107023&language_id=0
- ^{viii} The economic cost of wait times in Canada, the Centre for Spatial Economics, July 2010.
- ^{ix} Health Care Certainty for Canadian Families, the Conservative Party of Canada, backgrounder 10/08/08. See: http://www.conservative.ca/?section_id=1091§ion_copy_id=107023&language_id=0
- ^x A more detailed outline of the issues surrounding pension reform can e found in CMA's Submission on Pension Reform Backgrounder for the Standing Committee on Finance, May 13, 2010. www.cma/submissions-to-government
- ^{xi} Statistics Canada. Populations projections. The Daily, Thursday, December 15, 2005.