



EXECUTIVE SUMMARY

The past year has been an historic one for health and health care in Canada. We applaud the federal government for the reinvestments that were made at the time of the February 2003 Health Accord. However, what we as physicians continue to hear in our offices, clinics and hospitals right across the country is continuing concern from our patients that Canada's health care system won't be there for them when they need it. And so while we can understand government's desire to "turn the page" on health care issues, the temptation must be resisted. It is appropriate and prudent that at least once a year, the federal government take the pulse of the health care system – an annual check-up – to take stock of where we've been and identify priorities for the coming year.

This year, the Canadian Medical Association's (CMA's) submission to the Standing Committee on Finance moves largely away from macro funding issues to focus in on strategic initiatives that are national in scope and promise high returns in terms of value for money. Specifically, we identify three areas that require immediate new investments while reminding committee members of work that remains unfinished from years past.

Unfinished Business

While the CMA applauds the federal government for its leadership in achieving the 2003 Health Accord, it is now time to follow through on some outstanding promises that were made. In particular, there are two areas that require special mention. At the time of the First Ministers' Health Accord in February 2003, the federal government agreed to provide up to an additional \$2 billion into Canada's health care system at the end of this fiscal year (2003/04) if a sufficient surplus above the normal Contingency Reserve were available. The federal government must honour their commitment. Health cannot be treated as a residual after other contingencies are addressed.

Equally important is moving forward with establishing the Canada Health Council. Suggestions to water down the mandate of the health council to make it more palatable to some jurisdictions are not the answer. Canada needs a robust mechanism that will provide for enhanced evidence and accountability on how Canada's health care dollars are spent. Canada needs a Health Council that will create a meaningful place at the table for Canadians, health care providers and other stakeholders to provide input on how the system operates and monitor its performance.

Protecting Public Health

The public health system in Canada lies at the very heart of our community values. It is the quintessential “public good” and is central to the continued good health of our population. It is the view of the CMA that our public health system is stretched to capacity in dealing with everyday demands, let alone responding to emerging crises. On June 25, 2003, the CMA submitted a brief to the National Advisory Committee on SARS and Public Health headed by

Dr. David Naylor. In it the CMA called upon the federal government to make a minimum investment of \$1.5 billion over five years to achieve legislative reform; capacity enhancement; and enhanced research, surveillance and communications capacities.

In particular, the CMA calls for immediate funding of two specific priorities. The first is the same proposal that the CMA brought to the Standing Committee on Finance last year – the REAL (rapid, effective, accessible and linked) Health Communication and Co-ordination Initiative. The purpose of this initiative is to increase the capacity of the public health system to communicate in real time, between multiple agencies and with health care providers. Had CMA’s earlier recommendations been acted upon, perhaps we would have been better prepared to communicate with health care providers when SARS first appeared in Toronto. Improved communications must be a priority this time around – we cannot afford to let this recommendation languish another year.

The second short-term priority for public health is to invest in an emergency supply chain for use in times of crisis. SARS showed us that the Greater Toronto Area, an area with one of Canada’s most sophisticated public and acute care health systems, was not able to manage the SARS crisis and maintain its capacity to meet other acute care requirements or important public health services such as suicide prevention programs. The federal government must assure Canadians that plans are in place when the health care system is again tested with another public health emergency.

Ensuring Adequate Supply, Distribution and Mix of Canada’s Health Human Resources

Health is primarily a people business. Of all of the critical issues facing Canada’s health care system, none is more urgent than the shortages of health providers. Simply put, if people are not available to provide care and treatment to patients everything else is irrelevant.

While we were encouraged with the \$90 million provided in the 2003-04 to “*improve national health human resources planning and co-ordination, including better forecasting of health human resources needs*”, details of how these funds will be allocated and for what purposes remain unclear. The CMA has proposals on how this money could be used to support much needed health human resource planning that are ready to be pulled off the shelf and implemented. For example, the CMA believes that an

arm's length Health Institute for Human Resources (HIHuR) should be established to address the human side of health, just as existing institutes address the technological (CCOHTA) and information aspects of health (CIHI).

Addressing the Health Status of Canada's Aboriginal Peoples

Particularly alarming is the health status of Canada's Aboriginal peoples where, despite some improvements over the past few decades, Canada has been largely unable to adequately address the health issues facing this community.

At CMA's annual general meeting in August 2003, Health Minister Anne McLellan noted that despite significant investment Canada's aboriginal people continue to have poor health outcomes. The CMA recommends that the federal government adopt a comprehensive review to look at how the money being spent on health, health care and related areas of investment for Aboriginal people can result in better health outcomes. The current results are not good enough. We must do better.

Conclusion

For those involved in the health care community, and indeed for all Canadians, this has truly been a remarkable year for Canada in terms of health and health policy. In many ways, the events of February marked a turn toward significant reinvestment in the health care system. However, with the outbreak of SARS in Ontario and the emergence of other significant public health concerns such as West Nile virus, health continued to be a top-of-mind concern for many Canadians.

We also know that despite investments made in the 2003 federal budget, there continue to be areas for targeted, strategic initiatives that promise high payoff in terms of value for money. Public health, health human resources and the health status of Canada's aboriginal people are the three areas that we have highlighted where additional attention and funding can make a real impact at the national level. When considering these investments, however, we must remember that we cannot afford to rob Peter to pay Paul. Both the public health and the acute care systems must simultaneously benefit from increased investment in order not to download one problem onto the other.

To return to the analogy of an annual health check-up, let us conclude with this prognosis. Many actions taken in the past year should help over time address the acute symptoms of the patient. However, we must not be complacent. Long term health requires follow-through on last year's initiatives, targeted new investments and ongoing vigilance. We look forward to the year ahead.