



The Royal College of Physicians and Surgeons of Canada
Le Collège royal des médecins et chirurgiens du Canada



Cutting through the health system information fog: Royal College environmental scan

August 2009

Introduction

The amount of information about and influencing Canada's healthcare system can be overwhelming. It is forever changing and often conflicting. This collection of data and information provides a snapshot in time, in an attempt to help *cut through the health system information fog*.

It is understood that some of the information reported in this summary may be outdated at the time of reading given the constant flux of the system and reporting on it. It is for this reason that data and information sources are listed in detail so that their currency can be verified.

While some of the content may be the object of constant renewal, other aspects are rarely updated. Hence, although some of the information may appear not current, it is nonetheless the latest available at the time of writing (late winter 2009).

It is hoped that this summary, which will be updated twice yearly, will prove to be a useful source of information or, at least, help disentangle the complex weave of information concerning one of this country's most defining features, our healthcare system.

Readers are encouraged to contact the Office of Health Policy and Governance Support at 1-800-668-3740 ext. 195 if they have any comments or questions, or to suggest new content areas.

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Political environment

2008 Canadian federal election and its aftermath

On September 7, 2008, Prime Minister Stephen Harper called a federal election for October 14, 2008. This campaign was the country's fifth in 11 years and the third since June 2004. The Conservatives had previously passed legislation calling for a fixed election date of October 19, 2009,¹ however, Mr. Harper stated in the period leading up to the election call that Parliament had become increasingly dysfunctional.²

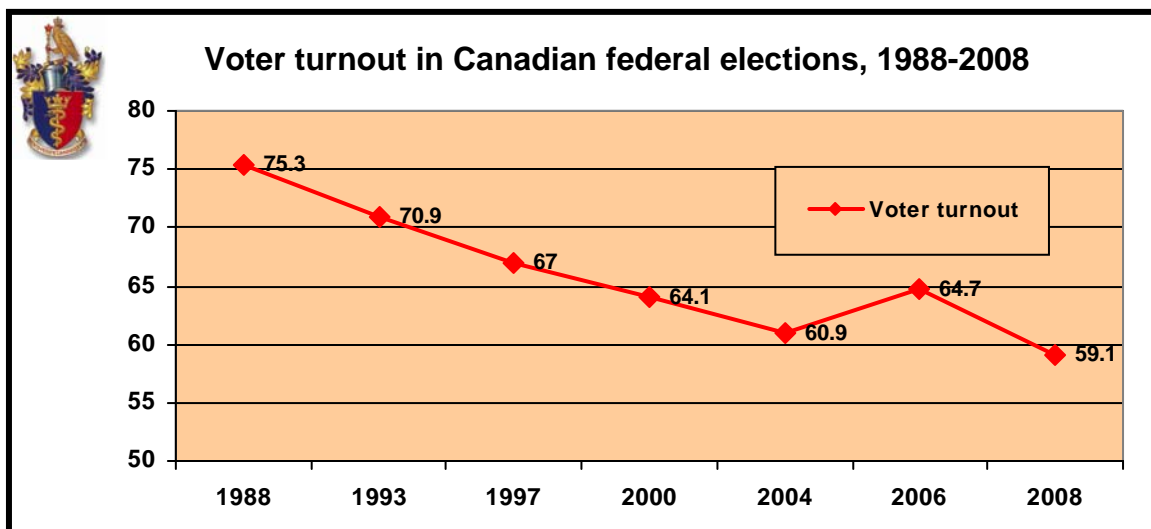
The chart below outlines changes in the Canadian political landscape from the 2006 to 2008 federal elections in terms of seats within Parliament and the popular vote. The 2008 election produced the country's third minority government in just over three years.

 Changes in federal party standings: House of Commons seat totals and popular vote, 2006 and 2008^{3,4,5}					
Political Party	2006 election: seats	2006 election: pop. vote (%)	39 th Parl.: seats at dissolution	2008 election: seats	2008 election: pop. vote (%)
Conservative	124	36.3	127	143 (+16)	37.6 (+1.3)
Liberal	103	30.2	95	77 (-18)	26.2 (-4.0)
Bloc Québécois	51	10.5	48	49 (+1)	10.0 (-0.5)
New Democrat	29	17.5	30	37 (+7)	18.2 (+0.7)
Independent	1	1.0	3	2 (-1)	0.7 (-0.3)
Green	0	4.5	1	0 (no change)	6.8 (+2.3)
Vacant	N/A	N/A	4	N/A	N/A
Total	308	N/A	308	N/A	N/A

Sources: Parliament of Canada, <http://www.parl.gc.ca/information/about/process/house/partystandings/standings-E.htm>,
<http://www.nodice.ca/elections/canada/>
<http://www.nodice.ca/elections/canada/popularvote.php>.

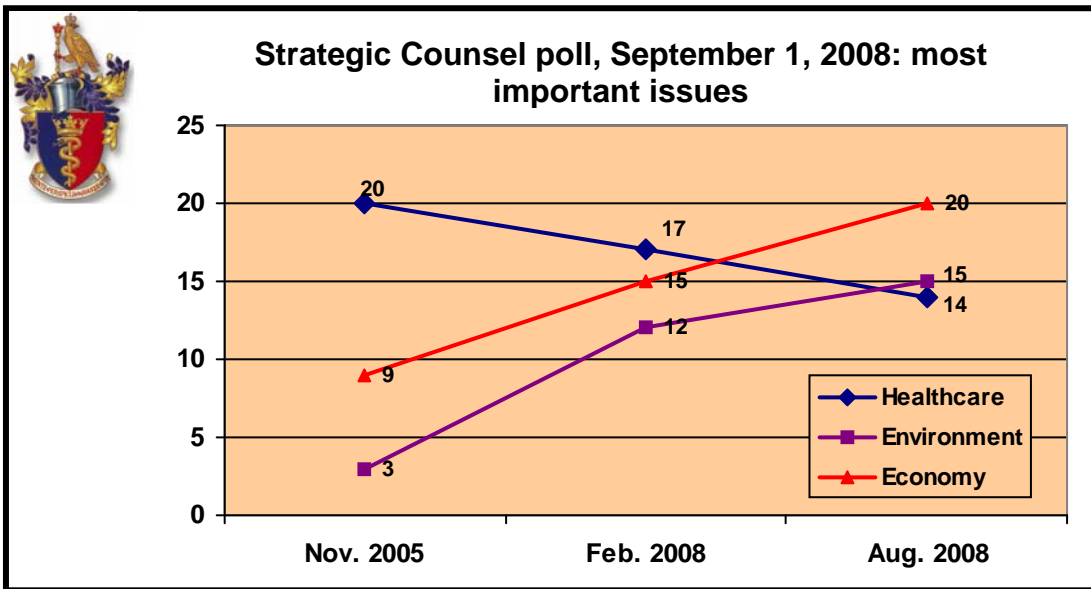
The 2008 federal election marked an historic low in terms of voter turnout. With the exception of the 2006 campaign, voter turnout in federal elections has been declining for the past 20 years since the 1988 federal election, when over 75% of Canadians cast their ballots. In 2008, less than 60% of eligible voters cast ballots—a decline of over 16%.⁶

With the increasing frequency of minority Parliaments, federal elections and declining voter turnout, how may these trends influence the development of health policy in Canada?



Source: <http://www.nodice.ca/elections/canada/popularvote.php>

Public opinion polls conducted near the beginning of the election showed the continuing importance of healthcare as a public policy issue for Canadians. For example, the CBC reported on an Environics poll on September 7 that showed healthcare and the health system as the top issue for Canadians in the 2008 federal election at 19%, followed by the environment at 13% and the economy at 12%. However, the poll noted that “the overall trend of concern about healthcare has declined in recent years and continues to do as other issues arise.”⁷ Evidence of this is apparent in a September 1 Strategic Counsel poll conducted for the *Globe and Mail* and CTV which showed healthcare as the third most important issue for Canadians at 14%, with the environment slightly higher at 15% and the economy as the most important issue at 20%.⁸



Source: Strategic Counsel, 2008, [http://www.thestrategiccounsel.com/our_news/polls/Pre-Election%20Baseline%20-%20Sep%201%20\(with%20second%20choice\).pdf](http://www.thestrategiccounsel.com/our_news/polls/Pre-Election%20Baseline%20-%20Sep%201%20(with%20second%20choice).pdf)

There were a number of health-related promises made by each of the federal parties during the campaign, including:

- a \$165 million commitment by the Conservatives over four years for “ensuring health and environmental well-being”, including “additional steps to ensure that Canada’s communities and hospitals have more doctors and nurses where they are most needed;”⁹
- a \$900 million commitment by the Liberals for catastrophic drug coverage and \$420 million for a Doctors and Nurses fund “to help ensure all Canadians have access to a medical professional;”^{10,11} and
- a \$200 million per year commitment by the New Democrats to enable a 50% increase in training the number of doctors and nurses, forgiveness of student loans for these practitioners, work with provinces on Canada’s foreign credentialing system¹² and an initial commitment of \$1 billion to begin to implement catastrophic drug coverage.¹³

Although healthcare has recently been superseded as the primary public priority issue, it remained among the top priorities for Canadians during the 2008 federal election. However, as the campaign progressed, relatively little attention was paid to healthcare in comparison to other public policy concerns, in particular, the decline in the Canadian economy in the wake of the significant fiscal and economic crisis in the United States.

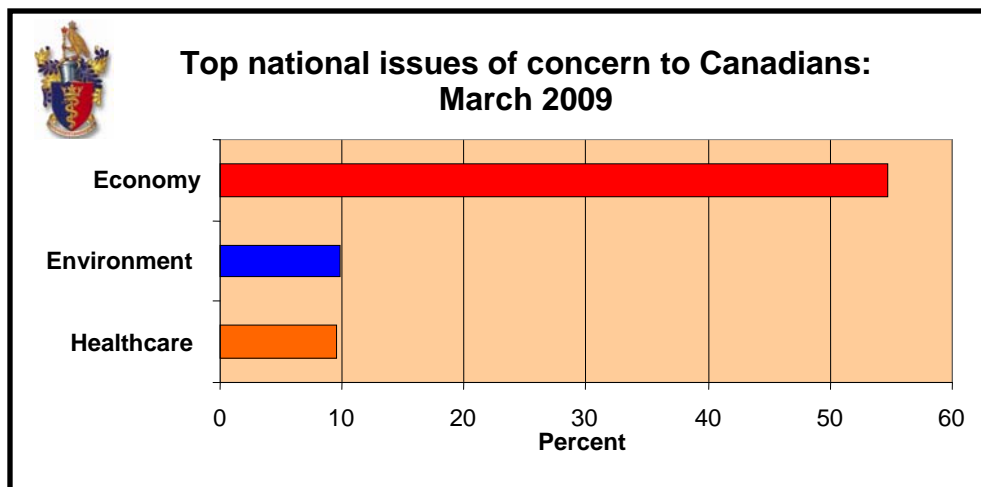
This lack of visibility for healthcare provoked frustration among healthcare advocates, including the Canadian Medical Association (CMA), which conducted a poll during the campaign showing that while 31% of Canadians identified healthcare as one of the most important issues in the campaign (second only to the economy at 32%), 71% of Canadians believe politicians avoided discussing healthcare in depth during the campaign because “they lack the vision and courage to tackle the tough issues.”¹⁴ According to this poll, 74% of Canadians

want political parties to have a comprehensive healthcare policy that “includes a plan to address the doctor shortage.”¹⁵

Health policy analyst and professor Dr. Michael Rachlis attributed the lack of visibility concerning healthcare during the campaign to widespread voter confusion about federal-provincial responsibilities concerning medicare, and around privatization of publicly funded services as opposed to private practice and delivery of healthcare. He adds that voter confusion was exacerbated by the lack of clarity from all parties. As Dr. Rachlis noted, “Canadians are justly proud of their healthcare system, but this election campaign does not mirror their concerns.”¹⁶

With the ascendancy in importance for Canadians of other public policy issues such as the economy and the environment, it will be important to maintain a watch on future public policy decisions relating to the healthcare system. Recent enhancements in the health and healthcare systems must not be lost or seen as the end point. Much work remains to be done to ensure a responsive and sustainable system that meets the needs of Canadians. Does the decline of healthcare relative to other public policy concerns indicate a fatigue on the part of Canadians with healthcare as a public policy and election concern?

By the end of March 2009, healthcare was a distant third among national issues for Canadians, as reported in a Nanos poll for the *Toronto Star* and *La Presse*.¹⁷



Source: Health Edition Online, April 3, 2009, Volume 13 Issue 13), <http://www.healthedition.com/viewarticle.cfm?id=7016>

2009 Canadian federal budget

Following the return of Parliament after prorogation, the Conservative government delivered its budget on January 27. The budget acknowledged the significant economic downturn occurring in Canada, including:

- a decline into recession in the fourth quarter of 2008, with private sector forecasts of the recession continuing for three fiscal quarters;¹⁸ and
- projected deficits of \$1.1 billion in 2008–09, \$33.7 billion in 2009–10, \$29.8 billion in 2010–11, \$13.0 billion in 2011–12, \$7.3 billion in 2012–13, ameliorating to a small surplus of \$0.7 billion in 2013–14 when accounting for the cost of the measures proposed in *Budget 2009* to support the economy.¹⁹

The budget promised several measures to address the worsening economic situation, including spending on infrastructure, housing and tax cuts.²⁰ Health-specific commitments included \$500 million in new funding for the Canada Health Infoway (CHI) to encourage greater use of electronic health records (EHR)²¹ and \$305 million over two years to improve health outcomes for First Nations and Inuit peoples.²² However, there was no mention of the healthcare commitments noted in the Conservative platform to address health human resource challenges.

Health organizations had mixed reaction to the budget:

- While the Canadian Medical Association was pleased with the funding commitment to support the expanded use of EHRs, it stated that the government had missed an opportunity for Canada to achieve self-sufficiency in physicians by not announcing additional funding for post-graduate residency positions, while “still hoping the government will act on that promise.”²³
- The Canadian Healthcare Association (CHA) also noted positively the added funding to facilitate uptake of EHRs, but expressed concern over the lack of commitment to health human resources (HHR) and the uncertainty over whether infrastructure funds promised within the budget will be available to the health sector, pointing out the impact of aging health infrastructure on patient safety, overcrowding and wait times.^{24,25}
- The Association of Canadian Academic Healthcare Organizations congratulated the government on its investments in the CHI and the Canada Foundation for Innovation (CFI) of \$750 million, but also expressed concern over the lack of additional base funding for the Canadian Institutes of Health Research (CIHR) and Genome Canada, and funding to cover the indirect costs of research.²⁶
- The Association of Faculties of Medicine also expressed support for the investments in the CHI and the CFI as well as concern over the lack of investments in health and medical research, as well as HHR.²⁷
- Genome Canada President Martin Godbout referred to the lack of new funding as leaving the organization “devastated.”²⁸ While the longer-term future of the organization is unknown, a message from Genome Canada’s Board of Directors posted on the organization’s website stated that “although Genome Canada did not receive funding in the 2009 federal budget to fund new genomics research projects, this will not impact Genome Canada’s current projects that received a full commitment of funding from previous federal government investments in 2007 and 2008.”²⁹

It is also unclear how the government expects to realize \$87.2 million worth of savings over the next three years from the Canadian Institutes of Health Research, the Natural Sciences and Engineering Research Council of Canada and the Social Sciences and Humanities Research Council of Canada’s “streamlining operations.” However, a representative for the Minister of Science and Technology stated “researchers will not get less money.”³⁰

In addition to providing patient care, specialists fill other roles, as embodied in the CanMEDS Roles Framework. This includes an important commitment to research, as reported in the 2007 National Physician Survey. For example,

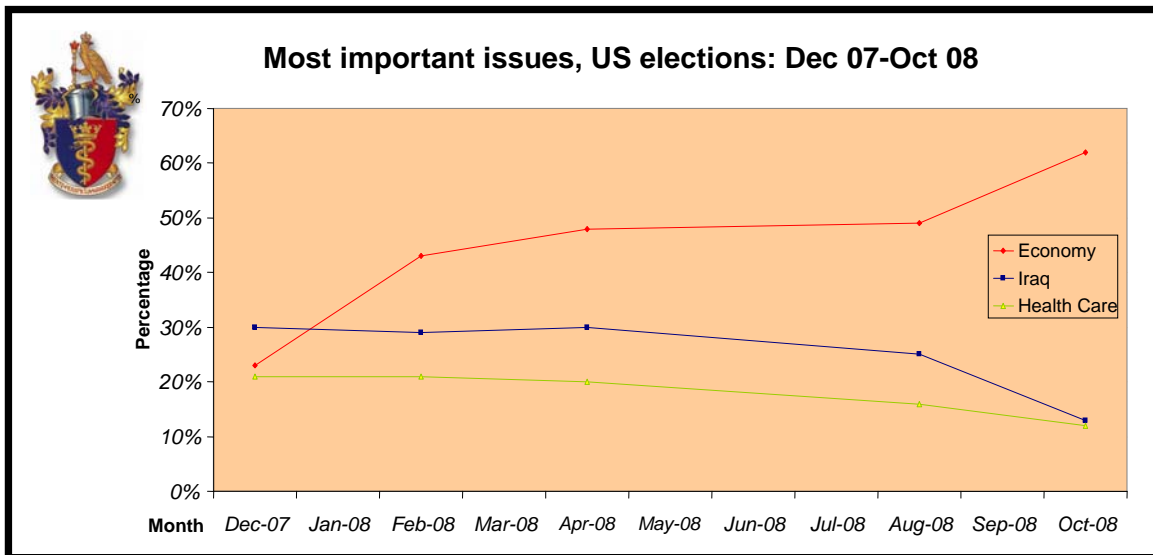
- neurosurgeons reported 3.5 mean hours per week spent on research out of 62 hours or 5.7% of their time;³¹
- endocrinologists and metabolism specialists reported 6.7 mean hours spent on research per week out of 51.2 hours, or 13% of their time;^{32,33} and
- microbiologists and infectious disease specialists reported 6.8 mean hours spent on research per week out of 54 hours, or 12.7% of their time.³⁴

Given the importance of all forms of medical and health system research to specialty medicine and advances in specialty care, how will cost savings be realized from CIHR while ensuring stable and reliable funding for researchers?

Furthermore, concerns are rising about the loss of researchers to other countries offering greater research funding.

2008 US election

In the US 2008 election, similar developments concerning public policy issues occurred in terms of how healthcare compared to other issues. Whereas in December 2007, the war in Iraq was the most important issue for Americans (30%), with healthcare placing second (23%) and the economy placing third (23%), by October 2008, healthcare had declined to third place (12%) and the war in Iraq had declined to second (13%). Concerns regarding the economy had soared in the wake of the fiscal and economic crisis in the US, making the economy the top issue for a significant number of Americans (61%).³⁵ (See graph below.)



Source: Henry J. Kaiser Foundation, 2008, <http://www.kff.org/kaiserpolls/upload/7832.pdf>

Although the economy was the most important issue for Americans, almost twice as many respondents stated that “it is more important than ever to take on healthcare reform” than those who agreed that “we cannot take on healthcare reform right now” (62% and 34% respectively).³⁶ According to the Henry J. Kaiser Foundation, which tracked voter interest in healthcare prior to the election, this “resonates with our continued finding that healthcare concerns are a major strand of voters’ economic anxiety.”³⁷ This is hardly surprising given that the number of Americans who state that in the past 12 months they or another family member in their household had difficulty paying medical bills has risen from 21% in March 2002 to 32% in October 2008. In addition, the percentage of those who report changes in their use of healthcare services to reduce costs rose for all indicators.³⁸

During the US campaign, the Democrats under Senator Barack Obama promised a host of measures to improve access to healthcare and other health-related investments, including

- requiring insurance companies to cover pre-existing conditions;
- measures to boost health coverage to employees from employers;
- creating a National Health Insurance Exchange with a range of private and public plans to allow individuals and small businesses to buy affordable health coverage;
- measures to promote the use of generic drugs; and
- requiring hospitals to report on healthcare costs and quality.³⁹

The democratic plan for healthcare was estimated to cost between \$50-65 billion per year when fully phased in.⁴⁰ Obama subsequently won the campaign and became the 44th president of the United States in January 2009. Coincidentally, in November 2008, the Physicians' Foundation published a survey indicating more difficulty in accessing healthcare in the years ahead. The foundation points out that, "At a time when the new Administration and new Congress are talking about ways to expand access to healthcare, the harsh reality is that there might not be enough doctors to handle the increased number of people who might want to see them if they get health insurance."⁴¹

In terms of interjurisdictional physician migration to and from Canada, from 1990–2004, Canada consistently lost more physicians through migration abroad compared with those who moved abroad and then returned; small gains only began to appear in 2005 and have since been sustained. This change from net loss to net gain is partially the result of more physicians returning from abroad than those leaving for each year from 2003–2007; the overall movement to and from Canada decreased during this period (Canadian Institute for Health Information, 2007; see note 143).

If serious physician shortages forecasted for the US occur, these gains may be in jeopardy of being lost.

Economic environment

Canadian economy: Overview

As the world economy has contracted,^{42,43,44} the Canadian economy has “deteriorated significantly” according to the Bank of Canada, and the country entered into a recession in the last economic quarter of 2008.⁴⁵ The chart below illustrates the economic trends reported by the Royal Bank of Canada (RBC) based on the latest data available at the time of writing (February 11, 2009) across several major indicators.⁴⁶

Indicator	% change from			
	Latest month	Previous month	Year ago	3-month trend
Real GDP	Nov.	-0.7	-0.8	↓
Industrial production	Nov.	-1.5	-5.1	↓
Employment	Jan.	-0.8	-0.5	↓
Unemployment rate (%)*	Jan.	7.2	7.2	↑
Manufacturing				
Production	Nov.	-2.1	-7.0	↓
Employment	Jan.	-5.2	-7.4	↓
Shipments	Nov.	-6.4	-4.3	↑
New orders	Nov.	-12.9	-7.6	↑
Inventories	Nov.	-0.6	4.9	↑
Retail sales	Nov.	-2.4	-0.4	↓
Car sales	Nov.	-7.0	-4.4	↓
Housing starts (000s)*	Jan.	153.5	216.9	↓
Exports	Dec.	-9.7	-2.7	↓
Imports	Dec.	-5.8	4.6	↑
Trade balance (\$billions)*	Dec.	-0.5	23.1	↓
Consumer prices	Dec.	-0.7	1.2	↓

Source: Royal Bank of Canada, 2009, <http://www.rbc.com/economics/market/pdf/ecotrend.pdf>

Contributions to average annual growth of CN real GDP				
Percentage points	2007	2008	2009	2010
Consumption	2.5	1.8	0.4	2
Housing	0.2	-0.2	-1	0
Government	0.9	0.9	0.9	2.3
Business fixed investment	0.5	2.9	-0.6	0
Final domestic demand	4.1	2.9	-0.3	3.3
Exports	0.4	-1.8	-2.6	2.1
Imports	-1.8	-0.1	2.4	-2.1
Net Exports	-1.4	-1.9	-0.2	0
Inventories	0	-0.3	-0.7	0.5
Real GDP	2.7	0.7	-1.2	3.8
Real gross domestic income	3.7	2.3	-3.6	4.1

Source: Bank of Canada, 2009
<http://www.bankofcanada.ca/en/mpr/pdf/2009/update220109.pdf>

The decline in most major Canadian economic indicators has been severe:

Gross Domestic Product (GDP)

Canada's GDP declined by 0.1% in October, followed by a more significant drop of 0.7% in November 2008,⁴⁷ a result of widespread weakness in all major sectors, including manufacturing, wholesale and retail trade, construction, energy, the financial and insurance sector, and other industries. This is the largest decline since the Ontario blackout of August 2003.⁴⁸ In contrast to increases in the GDP in recent years, the Bank of Canada forecasts that the country's GDP will shrink by 1.2% in 2009 before posting gains in 2010.⁴⁹

Employment/unemployment

In January 2009, Canada lost 129,000 jobs (0.8%), which pushed the unemployment rate up from 6.6% in December 2008 to 7.2%. According to Statistics Canada, "this drop in employment exceeds any monthly decline during the previous economic downturns of the 1980s and 1990s."⁵⁰ Some 213,000 full-time jobs have been lost since October 2008, driving down employment by -1.2%. Job losses were felt most acutely in Ontario (71,000), British Columbia (35,000) and Quebec (26,000).⁵¹ According to an Ipsos Reid poll taken in February 2009, approximately 24% of Canadians are concerned about losing their jobs.⁵² These concerns appear to have some grounds as the number of lost jobs continued to grow during the remainder of the first quarter of 2009.

While almost all areas of the economy experienced employment declines, the slide was felt most severely in the manufacturing sector, in which employment fell by 101,000, with the largest losses in the same three provinces mentioned above.

In contrast, the only sector that saw notable gains in employment was healthcare and social assistance, where jobs increased by 31,000, with the largest gains in Ontario and Quebec.⁵³ "Since January 2008, healthcare and social assistance has experienced the fastest employment growth of all industries, up 5.1% (+95,000), with gains in social assistance, nursing and residential care facilities as well as hospitals."⁵⁴

While health coverage in Canada is different than in the US through Canada's medicare system, services covered by provincial and territorial health plans beyond hospitals and physicians may be subject to co-payments or completely delisted from public coverage depending on where you live. Given this, it is no surprise that access to health benefits serve as the primary inducement to keeping older workers in the workforce. In 2008, 60% of Canadians over age 55 regard extended healthcare benefits as the most important factor in deciding to stay in the workforce or to retire.⁵⁵

In its reaction to the 2009 federal budget, the Canadian Healthcare Association (see note 24) observed that "the health industry is as much a driver of the economy as many other sectors. Contributing 10% to GDP and one in 10 members of the labour force, health is well positioned to be part of the solution to Canada's economic challenges and deserves to be supported. There is a global and domestic shortage of health providers, and concerns with healthy workplaces. The initiatives announced in Budget 2009 do not address the 'people factor' supporting the health of the nation." Why were investments in HHR not part of the 2009 federal budget given:

- *the contribution of the health sector to GDP;*
- *the strong employment numbers of this sector in the face of a burgeoning recession in Canada;*
- *the need to address shortages of health providers across the continuum of care; and*
- *the HHR campaign promises of the federal Conservatives?*

Bankruptcies

Personal bankruptcies rose a staggering 50.6% from December 2007 to December 2008. In comparison, bankruptcies by businesses rose 2.4% in the same period. Total bankruptcies climbed 46.7% over the same period.⁵⁶

Trade

In December 2008, Canada posted a merchandise trade deficit of \$458 million—its first trade deficit since March 1976—as compared to a trade surplus of \$1.2 billion for November 2008. Both exports and imports declined, falling 9.7% and 5.7% respectively. Canada's trade balance with the United States fell to its lowest level since December 1998, led by a decline in energy exports.⁵⁷

Housing

Housing starts declined to 153,500 units in January 2009 from 172,200 units in December 2008, a drop of 10.76%. Housing starts decreased by an estimated 40.4% compared to January 2008.⁵⁸ Prices for new houses also dropped by 0.1% between November and December 2008, the third consecutive monthly decline.⁵⁹ Figures for sales of new and existing houses using the multiple listing service fell by 3.1% December 2008, and declined by 37.3% compared to January 2008.⁶⁰

Consumer Price Index

Seasonally unadjusted consumer prices fell 0.4% from November to December, after declining 0.3% from October to November. This was the fourth month-to-month contraction posted in the CPI in the past five months. Consumer prices rose 1.2% from December 2007 to December 2008, the smallest increase since January 2007; the modest nature of this increase was due to the decrease in the price of gasoline.⁶¹ RBC has predicted the possibility of deflation for Canada's in mid-2009 and an average rate of just 0.5% for the year.⁶²

Prospects for recovery

Although the 2009 federal budget contained a variety of measures designed to stimulate the economy, opinion differs as to how effective these measures will be. The budget document states that "Budget 2009 will help Canada to meet the challenges of our times. It aims to protect our country from an immediate economic threat while providing the solutions we need to secure our long-term growth and prosperity."⁶³ However, in his February 5 appearance before the House of Commons Finance Committee, Kevin Page, Parliamentary Budget Officer observed that

In general, the Budget 2009 economic assumptions based on the average private sector outlook appear reasonable; however, the adjustment for risk made in the budget may be insufficient for budget planning over the medium term, particularly if the recession turns out to be deeper and/or more prolonged than is currently expected by private sector forecasters.⁶⁴


In his appearance before the committee, Bank of Canada Governor Mark Carney stated that while the Bank had forecast an increase in Canada's GDP of 3.8% in 2010, if "national and multilateral measures are not timely, bold, and well-executed, Canada's economic recovery will be both attenuated and delayed."⁶⁵

Social environment

United Nations Human Development Index (HDI): Overall ranking

Canada ranked third on the United Nations Human Development Index (HDI) in 2008. The HDI “provides a composite measure of three dimensions of human development: living a long and healthy life (measured by life expectancy), being educated (measured by adult literacy and enrolment at the primary, secondary and tertiary level) and having a decent standard of living (measured by purchasing power parity, PPP, income).”⁶⁶

While Canada scored third overall out of 179 countries, it ranked lower in a number of categories used to derive its overall ranking as illustrated in the table below.⁶⁷

 Canada's human development index 2006* and underlying indicators in comparison with selected countries			
HDI value, 2006	Life expectancy at birth (years), 2006	Combined primary, secondary and tertiary gross enrolment ratio (%), 2006	GDP per capita (PPP US\$), 2006
1. Iceland (0.968)	1. Japan (82.4)	1. Australia (114.2)	1. Luxembourg (77,089)
2. Norway (0.968)	7. Sweden (80.7)	4. Finland (101.4)	10. Hong Kong (39,146)
3. Canada (0.967)	8. Israel (80.5)	5. Denmark (101.3)	11. Switzerland (37,396)
4. Australia (0.965)	9. Canada (80.4)	6. Canada (99.3)	12. Canada (36,687)
5. Ireland (0.960)	10. Italy (80.4)	7. Norway (98.6)	13. Netherlands (36,099)
6. Netherlands (0.958)	11. France (80.4)	8. South Korea (98.5)	14. Iceland (35,814)
179. Sierra Leone (0.329)	179. Swaziland (40.2)	179. Djibouti (25.5)	178. Congo (281)

Source: Human Development Reports 2008, http://hdrstats.undp.org/2008/countries/country_fact_sheets/ctv_fs_CAN.html

*Note: the 2008 ranking was derived and updated from the 2006 ranking. (see note 66).

Measures of equity and inclusion

The HDI also measures considerations involving equity and social inclusion. In this regard, Canada sometimes does not fare as well as it should, given its status as a leading member country of the Organisation for Economic Co-operation and Development (OECD). For example:

- 82 countries score better than Canada on their gender-related development index (GDI), which captures inequalities in achievement between women and men. As well, Canada only ranked 11th out of 108 countries in the gender empowerment measure (GEM) which measures whether women take an active part in economic and political life;⁶⁸
- Canada ranked 8th on the human poverty index measuring human and income poverty among OECD countries, central and eastern Europe, and the Commonwealth of Independent States (former Soviet Republics);⁶⁹ and
- Canada measured 9.4 in terms of inequality measures judging the ratio of the richest 10% of the population to the 10% of the poorest—38 countries had better scores, therefore indicating less disparity between the two groups.⁷⁰

In 2006, in its report card on the Royal Commission on Aboriginal People at 10 Years Report Card, the Assembly of First Nations (AFN) determined that “First Nations communities rank 76th out of 174 nations when using the United Nations Development Index 2001. This is compared to Canadian communities who rank 8th [2003].”⁷¹

The Cost of inequality

Social inequality carries the burden of both a greater vulnerability to chronic disease and conditions as well as concomitant usage of health services:

Aboriginal Peoples

- The AFN has pointed out that “First Nations are more likely to require health services than other Canadians: for example, diabetes is at least three times the national average, and tuberculosis is eight to 10 times more prevalent among First Nations.”⁷²

Low-income people

- According to the Canadian Institute for Health Information, hospitalization is higher for individuals in low socio-economic status (SES) groups than higher SES groups across a range of indicators, including anxiety disorders, affective (mood) disorders, traffic accidents, substance-related disorders (addictions, side effects from medications, and exposure to toxins), diabetes, asthma in children, unintentional falls, chronic obstructive pulmonary disease (COPD), ambulatory care sensitive conditions (those conditions that could be treated in the community), injuries (including those affecting children) and mental health.⁷³
- Both hospital and physician use is higher in poor neighbourhoods than in wealthier neighbourhoods. “About 15% more (\$319 per person per year) is spent providing physician services to those neighbourhoods with low SES, compared with those with high SES (\$275 per person per year). Furthermore, yearly hospital care expenditures are 73% higher in the poorest neighbourhoods (\$474 per person per year) compared with the richest neighbourhoods (\$273 per person per year).”⁷⁴

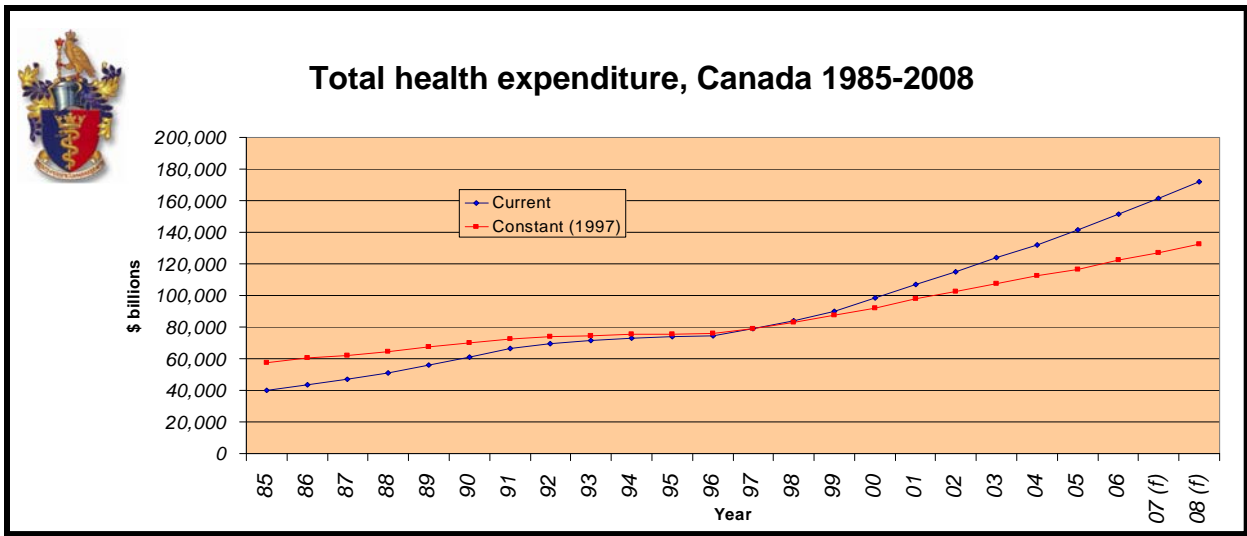
People with low literacy skills

- Not surprisingly, individuals with low literacy skills also display low levels of health literacy, that is, the ability to access and use health information to make appropriate health decisions and maintain basic health⁷⁵ as well as poorer self-reported health status.⁷⁶
- There is research that suggests health literacy generates health, and “policies aimed at increasing levels of health literacy might turn out to be low-cost alternatives to existing practice.”⁷⁷

Health environment

Health expenditures

Total spending. According to CIHI, total spending on healthcare in Canada was \$151.3 billion in 2006 and forecasted to reach \$161.6 billion for 2007 and \$171.9 for 2008 respectively. While this represents annual increases of 6.8% for 2007 and 6.4% for 2008 in current dollars, the rates of increase in constant (1997) dollars, which are adjusted for inflation and population, are more modest at 3.8% for 2007 and 4.3% for 2008.⁷⁸

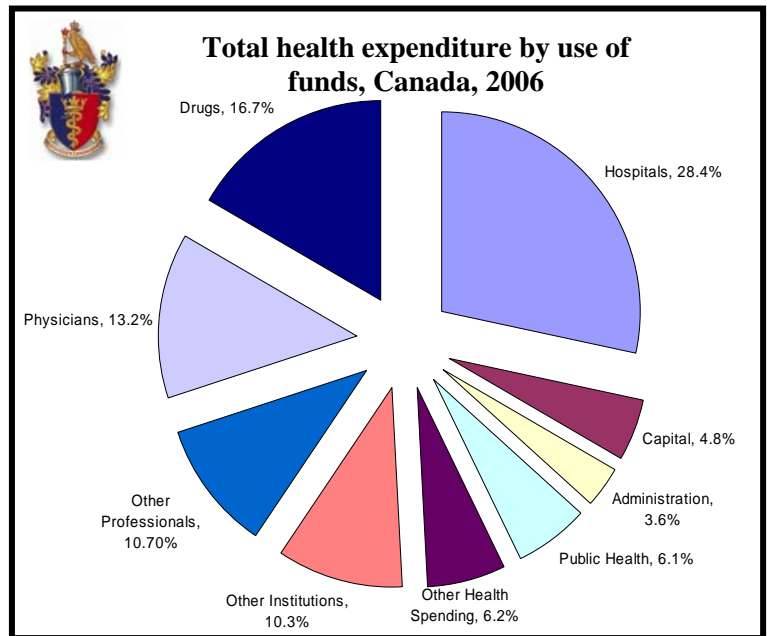


Source: CIHI 2008a, http://secure.cihi.ca/cihiweb/products/nhex_2008_en.pdf

Spending on hospitals. Since the mid-1970s, expenditures for hospitals as a proportion of total spending on healthcare has declined from about 45% to 28.4%.⁷⁹

Spending on physicians. Before 1997, spending on physicians comprised the second largest expenditure on healthcare,⁸⁰ for which public sector spending has accounted for 98% since 1975.⁸¹

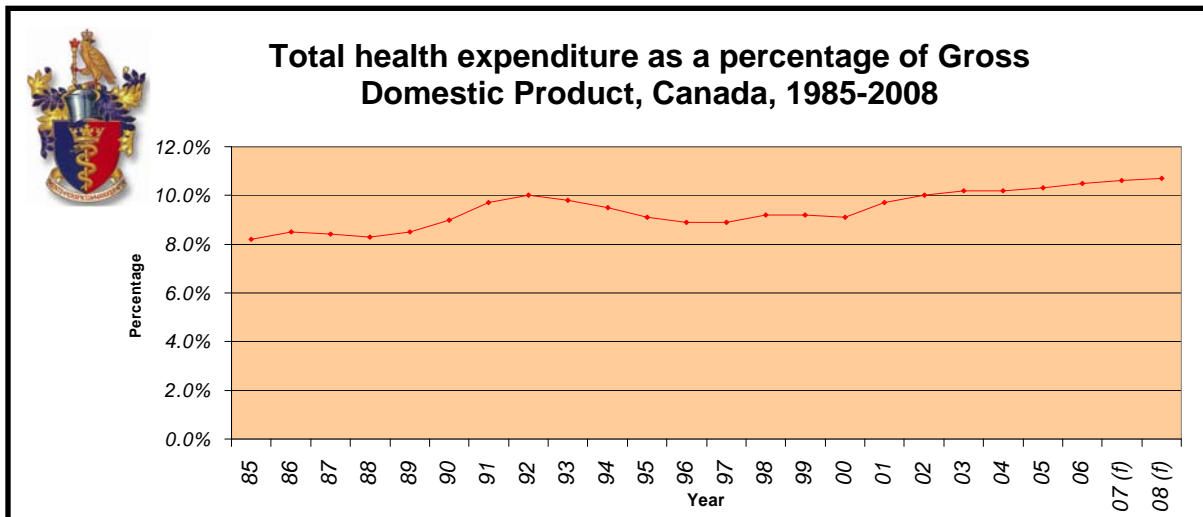
Spending on drugs. Since 1997, spending on drugs has superseded spending on physicians.⁸² In 2008, public sector spending for prescribed drugs accounted for 38.5% of drug expenditures, while private sector spending for prescribed drugs and non-prescribed drugs (which include over-the-counter drugs and personal health supplies) totalled 61.5% of total spending on drugs.⁸³ In 2008, spending on drugs and physicians as proportions of total healthcare spending were 17.4% and 13.4% respectively.⁸⁴



Source: CIHI 2008a, http://secure.cihi.ca/cihiweb/products/nhex_2008_en.pdf

Total healthcare spending as a proportion of GDP

As a proportion of GDP, total healthcare spending has risen from 8.1% in 1985 to 10.0% in 2006, with a further climb to 10.7% forecasted for 2008. Concurrent with government funding constraints, health spending as a proportion of GDP began declining in 1992 from a level of 9.8% for that year down a full point to 8.8% for 1996, 1997 and 2000 before beginning to rise again.



Source: CIHI, 2008a, http://secure.cihi.ca/cihiweb/products/nhex_2008_en.pdf

While Canada's healthcare spending as a percentage of GDP for 2007 (10.1%) was higher than the OECD average of 8.9%, spending relative to overall GDP was lower than a number of other countries.⁸⁵

Controlling public healthcare spending

The federal government has been instituting measures to contain healthcare spending. This includes the de-indexation (that is, delinking payments from the rate of inflation and economic growth) of federal transfer payments to the provinces to support medicare and other social programs approximately three decades ago.⁸⁶

The federal government was not alone in its efforts to contain healthcare spending; in fact, as the Canadian Healthcare Association has observed, "from 1993-96, in response to deficits, most governments in Canada imposed serious restraint on public sector health expenditures. As a result, total health expenditures (public and private combined) shrank in real terms despite considerable increases in private sector expenditures."⁸⁷

These developments coupled with the "sudden and huge" cuts to federal transfers introduced by the Canada Health and Social Transfer in 1996⁸⁸ have resulted in significant challenges to Canada's health system. Successive FPT Health Accords in 2000, 2002 and finally the 2004 10-year Plan to Strengthen Health Care sought to address these problems using a variety of ameliorative measures, including the addition of an escalator clause of 6% to the Canada Health Transfer applied in 2006—07.⁸⁹

As public funding for healthcare has accounted for an increasing percentage of government spending, various measures are being proposed to "encourage efficiencies, relieve costs pressures and create incentives" such as

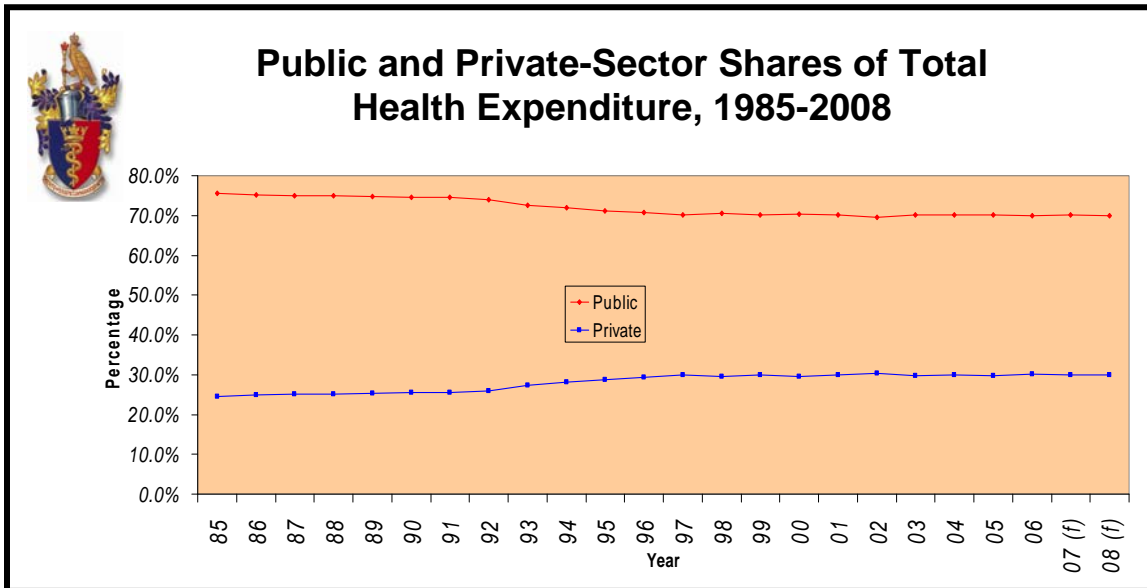
- copayments for any publicly funded medical goods and services;
- legalization of private insurance for all types of medical goods and services, including hospitals and physician services;
- reimbursements to health providers for their services

While governments endeavour to contain public expenditures for healthcare and consider various approaches to that end, voices from many quarters are calling for caution given concerns about potential negative effects on the equitable access to care.

- from any insurer, be it government or private;
- patient user fees; and
- permitting both for-profit and non-profit health providers to compete for the delivery of publicly insured health services.⁹⁰

Public and private expenditures on healthcare

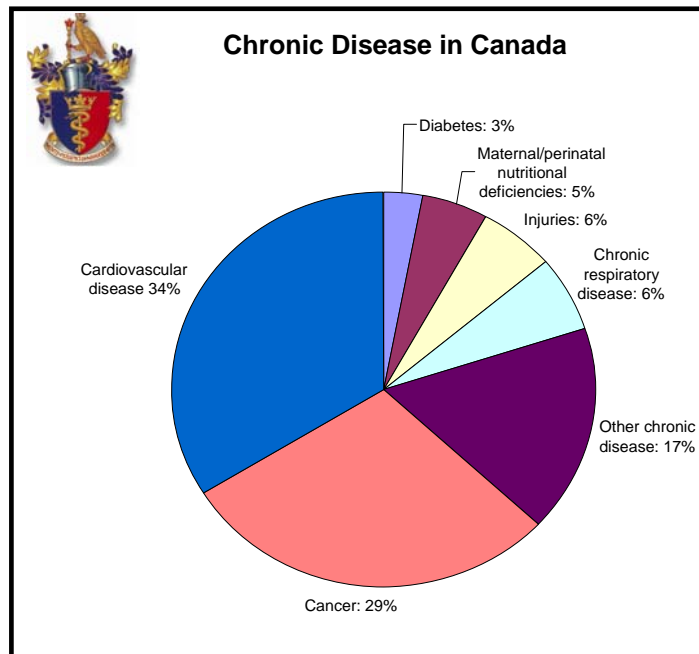
Total expenditure for healthcare is comprised of both public and private spending. *OECD Health Data 2008* shows that Canada's ratio of public to private spending in 1985 was 75.5:24.5, which was more in line with the ratio in other OECD countries (e.g., Austria, Finland, France and Germany).⁹¹ By 1996, public spending had fallen to 70.9%, and by 2002 it was 69.6% before stabilizing in successive years to just above 70%.^{92,93}



Sources: CIHI, 2008a, http://secure.cihi.ca/cihiweb/products/nhex_2008_en.pdf
 OECD, 2008, http://www.oecd.org/document/16/0,3343,en_2649_34631_2085200_1_1_1_1,00.html

Health indicators

Chronic diseases in Canada



Source: WHO [no date] http://www.who.int/chp/chronic_disease_report/

The burden of chronic disease in Canada is significant, both in human and economic terms. The Health Council of Canada estimates that almost one in three Canadians (over nine million people) are afflicted with a chronic disease.⁹⁴

According to projections by the World Health Organization (WHO) for the year 2005, chronic diseases accounted for 89% of all deaths that occurred in Canada that year, or 207,000 of 231,000 people.⁹⁵

- From 2005—2016, the WHO estimates that over two million people in Canada will die from chronic diseases, most particularly diabetes, from which deaths will increase by 44%.⁹⁶ The WHO also notes that “at least 80% of premature heart disease, stroke and type 2 diabetes, and 40% of cancer could be prevented through healthy diet, regular physical activity and avoidance of tobacco products.”⁹⁷
- The federal government estimated that in 2003, chronic disease accounted for 87% of disability in Canada. In terms of economic burden, federal estimates for 2003 indicate that 67% of total direct healthcare costs are spent on chronic diseases.⁹⁸ Assuming that the same is true for 2008, this would mean that of the forecasted \$171.9 billion spent on healthcare in Canada, \$115.17 billion was spent to treat chronic diseases. Chronic diseases were also thought to account for 60% of total indirect costs (\$52 billion at that time) due to lost of productivity, foregone income and other factors.⁹⁹

While the rates of heart disease and stroke have decreased significantly in recent years,¹⁰⁰ the heavy burden imposed by chronic disease in Canada is at risk of worsening in the years ahead:

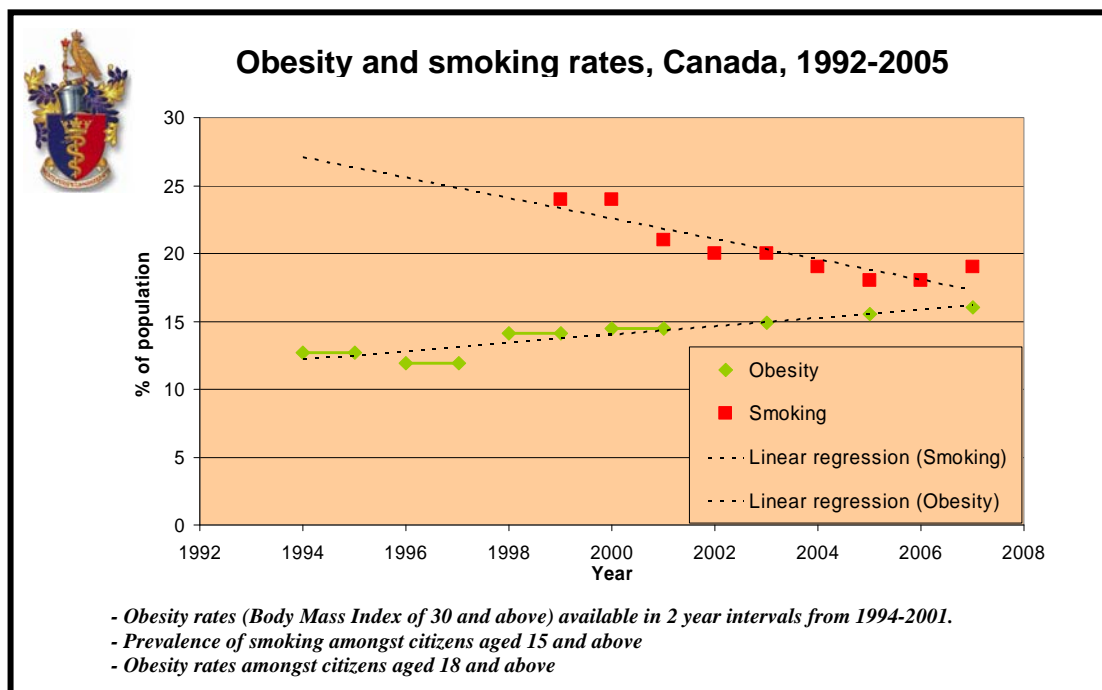
- **Diabetes.** Projections of the growth in the incidence of diabetes are alarming. The Institute for Clinical Evaluative Sciences (ICES) noted in 2007 that the incidence of diabetes in Ontario increased by 69% in Ontario, from 5.2% 1995 to 8.8% in 2005, thus already surpassing the global rate predicted by the WHO for 2030. While mortality from diabetes in Ontario is declining, its incidence is rising,¹⁰¹ which poses significant challenges to Canada’s healthcare system to meet the needs of people with diabetes and associated acute complications such as heart disease, stroke, kidney disease leading to end-stage renal failure, diabetic retinopathy resulting in blindness, and amputations.¹⁰² The Canadian Diabetes Association estimates that by 2010, diabetes will cost the Canadian healthcare system \$15.6 billion a year, rising to \$19.2 billion by 2020.¹⁰³
- **Cancer.** Cancer is currently the second leading cause of death in Canada. The rate of mortality from cancer steadily increased from 1979—2004. If this pattern continues, cancer may soon surpass cardiovascular disease as the primary cause of death in Canada.¹⁰⁴ Based on existing trends for incidence and mortality, the burden of cancer is

expected to double from 2003-2023.¹⁰⁵ According to a 2007 study prepared for the Ontario Chronic Disease Prevention Alliance and the Ontario Public Health Association, cancer was estimated to have accounted for about \$17.9 billion in Canada in 2002: \$4.4 billion total direct healthcare costs (including \$2.1 billion for hospitalization) and \$13.5 billion total indirect costs such as premature death and lost productivity due disability. In fact, cancer is the most costly illness in Canada in terms of premature mortality.¹⁰⁶

- Mental illness. An analysis published in the March 2008 issue of *Chronic Diseases in Canada* using data from the 2003 Canadian Community Health Survey reveals that
 - 7%, or almost 1.9 million persons, of the total adult population in Canada over age 20 has been diagnosed with mental illness;
 - an additional 6% or 1.6 million people are undiagnosed;
 - the total economic burden of mental illness for the adult population is approximately \$51 billion;
 - loss of health utilities (as measured by vision, hearing, speech, mobility, dexterity, emotion, cognition and pain) was by far the largest cost, accounting for more than 50% of the total burden (approximately \$28 billion); and
 - the value of work loss from absenteeism (short-term disability) and unemployment (long-term disability) accounted for about 35% of the burden, while medical expenses accounted for less than 10% of the total burden.¹⁰⁷

The WHO has reported that, in terms of lifetime prevalence, more than 25% of individuals develop one or more mental illnesses throughout their lifetime.¹⁰⁸

- Obesity and smoking rates in Canada. Undoubtedly, Canada has witnessed contrasting trends in obesity and smoking (see graph below). Although the burden of tobacco consumption in Canada is still unacceptably high, the significant reduction of tobacco consumption in Canada is a remarkable public health success story. In contrast, the ascendancy of obesity rates poses significant threats to the health of Canadians.



Source: OECD 2008, http://www.irdes.fr/EcoSante/DownLoad/OECDHealthData_FrequentlyRequestedData.xls

- Smoking. OECD statistics indicate that from 1980 to 2005, the rate of daily smoking amongst adults in Canada was reduced by half, from 34.4% to 17.3%.¹⁰⁹ Smoking nonetheless remains a leading cause of morbidity and mortality in Canada. In a 2007

study published in *Chronic Diseases in Canada*, using 2002 data, an estimated 16.6% of all deaths among those aged 0–80 in Canada (21% for men and 12.2% for women) are attributed to smoking, or 37,209 people (23,766 men and 13,443 women).¹¹⁰

- **Obesity.** Unfortunately, while the rate of tobacco consumption has decreased, the rate of obesity has increased significantly in Canada; the rate among adults was 18% in 2005,¹¹¹ an increase from 11.4% in 1996.¹¹² While Canada's rate of obesity for 2005 is lower than in the United States (34.3% in 2006) and the United Kingdom (24.0% in 2006), it is higher than most other OECD countries.¹¹³ When both obese and overweight individuals are counted together, almost half (49.9%) weighed more than they should in 2005.¹¹⁴ The OECD has observed increasing obesity rates in numerous OECD nations and argues such escalation may have an adverse effect on healthcare costs. "Given the time lag between the onset of obesity and related health problems (such as diabetes, cardiovascular diseases and asthma), the growing prevalence of obesity in most OECD countries, including Canada, will mean higher healthcare costs in the future."¹¹⁵
- Particularly disturbing is the increasing rate of childhood obesity in Canada, characterized as an "epidemic" by the House of Commons Standing Committee on Health. As the committee noted in its March 2007 report on this issue, "Canada has one of the highest rates of childhood obesity in the developed world, ranking fifth out of 34 OECD countries. Recent data reveals [sic] that 26% of young Canadians aged two to 17 years are overweight or obese. Even more distressing is the evidence that about 55% of First Nations children on reserve and 41% of Aboriginal children living off reserve are either overweight or obese."¹¹⁶

The committee shares the fears of many experts who predict that today's children will be the first generation for some time to have poorer health outcomes and a shorter life expectancy than their parents.
- House of Commons Standing Committee on Health. *Healthy Weights for Healthy Kids*, March 2007

Access to health services

Progress on wait times in priority areas

Under the September 2004 FPT 10-Year Plan to Strengthen Health Care, the Wait Times Reduction Fund (WTRF) was established, which committed the federal government to invest \$4.5 billion over six years, beginning in 2004–05.¹¹⁷ In return, provinces agreed to:

- establish comparable indicators of access to healthcare professionals, diagnostic and treatment procedures with a report to their citizens to be developed by all jurisdictions by December 31, 2005;¹¹⁸ and
- establish evidence-based benchmarks for medically acceptable wait times beginning with the five priority areas of cancer, heart, diagnostic imaging procedures, joint replacements, and sight restoration by December 31, 2005, as well as the development of multi-year targets to achieve these priority benchmarks by December 31, 2007, and annual reporting to their respective citizenry on progress in meeting these targets.¹¹⁹

In the 10th annual Healthcare in Canada Survey (2007), sponsored by a coalition of health organizations and other stakeholders, 20% of public respondents stated that wait times were the most important healthcare issue facing Canada, the highest response and up from 4% in 1998. The survey can be accessed at:
http://www.hcic-sssc.ca/index_e.asp

In a number of reports, the Health Council of Canada has noted progress on access to the five priority areas across jurisdictions since the adoption of the 10-Year Plan. For example, in June 2007, the Health Council observed that the "First Ministers' commitments in 2004 have clearly led to focused efforts to reduce wait times within—and, in some jurisdictions, beyond—the five priority areas;¹²⁰ indeed, wait times for certain procedures have declined in some areas.¹²¹ However, the Council also noted in this same report that comparable and complete data across jurisdictions must provide the foundation for reporting to citizens, but "because of the lack of comprehensive and comparable data, it is not possible to report whether each

jurisdiction achieved meaningful reductions in wait times for targeted healthcare services by March 31, 2007.”¹²² A year later, in June 2008, the Health Council pointed out that the deadline for provinces to establish multi-year targets to achieve their benchmarks for medically acceptable wait times had passed in December 2007, however, only some provinces had set timetables to reach some of the wait time benchmarks.¹²³

The Wait Times Alliance, a coalition of 12 medical specialty societies and the Canadian Medical Association, stated before the House of Commons Standing Committee on Health in April 2008 during its statutory review of the 10-Year Plan that this lack of comparable data is “undermining efforts” towards progress on this issue.¹²⁴ Several witnesses before the committee made this observation, which was noted in its report.¹²⁵ In her December 2008 report, the Auditor General of Canada also criticized the federal government’s reporting efforts within its biannual reports entitled *Healthy Canadians: A Federal Report on Comparable Health Indicators*, noting that these reports “do not fulfill the broader intent of the agreements—to provide the information Canadians need on the progress of healthcare renewal”¹²⁶ and had not improved over successive iterations and regardless of the feedback they received.¹²⁷

Canada's initial success at shortening wait times will not transform our healthcare system unless it is matched with equal success in the prevention and management of chronic diseases. A growing body of evidence highlights the significant gap between recommended care and actual care received for those at risk for or living with chronic illnesses. This quality gap not only results in significant preventable morbidity and mortality but also lengthens wait times for healthcare services and threatens the sustainability of our healthcare system...A national strategy on chronic disease prevention and management (CDPM) that leverages the federal, provincial and territorial (FPT) response to wait times will not only transform chronic illness care but also help to ensure the sustainability of our healthcare system.

- Matthew W. Morgan, Nicholas E. Zamora, Michael F. Hindmarsh. “An Inconvenient Truth: A Sustainable Healthcare System Requires Chronic Disease Prevention and Management Transformation,” *HealthcarePapers*, 7(4) 2007: 6-23

Access to services and providers across the continuum of care

Under the 10-Year Plan, governments committed to provide first-dollar coverage for short-term (two-week) acute and community mental health home care as well as palliative care by 2006. Governments also directed health ministers to establish a ministerial task force to develop and implement a national pharmaceutical strategy (with Quebec maintaining its own system).¹²⁸

The Health Council noted in its 2008 report on health renewal that, despite strong public support and the initiative some jurisdictions have taken in expanding home care services, the pan-Canadian level access to home care is “piecemeal” and “not the integral part of healthcare that Canadians deserve and expect.”¹²⁹

In January 2009, the Health Council lamented that, despite the fact that a national pharmaceuticals strategy was a key part of the 10-Year Plan, it remains unfulfilled. The Council called on FPT governments to resolve the impasse concerning the strategy, noting the importance of having access to pharmacare, especially in uncertain economic times.¹³⁰

Access to healthcare infrastructure and diagnostic technology

According to the OECD, the number of acute care hospital beds in Canada was 2.8 per 1,000 population in 2005; this is higher than the US (2.7 in 2006), but lower than the OECD average of 3.9 beds per 1,000 population. The number of hospital beds per capita in Canada has fallen over time (as in most OECD countries); this is not surprising given the reduction of average length of stays in hospitals and an increase in the number of surgical procedures performed on an ambulatory basis.¹³¹

In contrast, medical technology has increased over the past decade. In Canada, the number of MRIs also increased over time, reaching 6.2 per million population in 2006, however, this was below the OECD average of 10.2 MRI units per million population. Similarly, the number of CT scanners in Canada was 12.0 per million population in 2006, below the OECD average of 19.2.¹³²

According to CIHI, 2007–2008, 35% of acute care hospitalizations in Canada (excluding Quebec) were for people age 75 and older. Of these, 10% were for patients who had been transferred from a continuing care setting. Only one in 10 patients admitted via continuing care spent time as alternate level of care (ALC)—in other words, the acute care portion of their stay was complete and they were waiting for discharge to a more appropriate setting.

- Patient Pathways: Transfers from Continuing to Acute Care, January 2009, available from http://secure.cihi.ca/cihiweb/products/Patient_Transfers_EN.pdf.

The 2007 NPS reveals approximately 60% physicians rated access to long term beds as fair to poor. 45% rated access to hospital care for elective procedures fair to poor and over one third of all physicians felt access to operating room time was fair to poor.

- Q25a, results available at http://www.nationalphysiciansurvey.ca/nps/2007_Survey/Results/ENG/National/pdf/Q25/Q25aALL_only_NON.CORE.only.pdf

Access issues for people living with chronic conditions

People living with diabetes. Access to medications, services and providers in many instances is already compromised for people with diabetes:

- ICES noted in its 2003 Practice Atlas concerning diabetes in Ontario that “the average number of visits to internal medicine specialists and endocrinologists does vary heavily and is related to the supply of specialists. The healthcare system may not be providing as equitable a level of access to more advanced services across the province.”¹³³
- The Canadian Diabetes Association and Diabète Québec estimated in its 2005 Report Card that people afflicted with Type 1 diabetes may pay from \$0 to over \$3,600 annually in out-of-pocket expenses, and those with Type 2 diabetes may pay anywhere from just over \$40 to almost \$3,900 annually, depending upon where they each live in Canada for diabetes medications (insulin as well as oral medications), supplies and devices (e.g., lancets, syringes, needles, and pump supplies).¹³⁴ Not unlike Americans who change their consumption of healthcare services to reduce costs,¹³⁵ many Canadians with minimal or no coverage curb their utilization of medications and supplies to save money, or simply go without, compromising their care and increasing their risk of serious complications. As Mary Ellen Wright, a widow living in St. John’s, NL, diagnosed with diabetes in 2002 profiled in the report, commented “It happens all the time,” says. “I usually juggle my medication to stretch it out a little farther, and am not testing often enough, so my diabetes is not at all well-regulated.”¹³⁶
- According to the 2007 National Physician Survey, 26% of endocrinologists said their practice is partially closed to new patients. Furthermore, while continuity of care for diabetic patients is crucial to chronic care management, 50% of endocrinologists rated access to family practitioners for their patients as poor.¹³⁷

People living with cancer. According to the 2009 Report Card of the Cancer Advocacy Coalition of Canada, people suffering from cancer are not benefiting from optimal cancer care due to several factors, including

- under-utilization of EHRs, especially affecting patients who live in rural and remote communities and possibly preventing them from attaining better health outcomes. Of those oncology clinics located more than two hours from a regional cancer centre, most are not using electronic health records to record vital information;
- restrictive use of the HPV vaccine program among several provinces with the highest incidence of cervical cancer, with vaccination programs having no relationship to the risk of cervical cancer in each province;
- a rapid shift in funding for oral “take at home” cancer drugs from public to private insurers, leaving employers and individuals to shoulder the increasing cost burden. Given the anticipated significant increase in the rate of cancer, some who incur the disease, especially if they lack private sector drug coverage, may not be able to access the newest drug therapies for a potentially life-threatening disease; and
- the lack of public drug coverage, especially for catastrophic drugs and the requirement for 20% co-payment on pharmaceuticals under private sector employee drug plans. The lack of public coverage is especially troublesome given that many private employee plans terminate coverage at retirement, when employees are older and at greater risk for developing cancer.¹³⁸

Alberta is significantly ahead of other provinces in terms of incorporating electronic records. The 2007 NPS reports that 40% of Alberta physicians are using electronic records compared to the overall Canadian average of 26%. (Specialists questionnaire, question 40a)

According to a 2006 Commonwealth Fund survey, 98% of primary care doctors in the Netherlands use electronic patient medical records compared with 23% in Canada and 28% in the United States (Commonwealth Fund 2006 International Health Policy Survey of Primary Care Physicians in Seven Countries, November 2006, available at:

http://www.commonwealthfund.org/usr_doc/Schoen_2006intlurve_primarycareMDs_chartpack.pdf?section=4039

People living with mental illness. *Out of the Shadows at Last*, the May 2006 final report of the Standing Senate Committee on Social Affairs, Science and Technology on mental health, mental illness and addiction services in Canada, provided exhaustive documentation of the experience of people afflicted with mental illness trying to access the services they need, only to encounter gaps in or a lack of services altogether. Those seeking services also face a lack of knowledge and compassion in healthcare providers, part of the larger experience of stigma and discrimination.¹³⁹ In the shocking and sad words of Helen Forristall, who testified before the committee: “I would do anything to have breast cancer over mental illness. I would do anything because I [would] not have to put up with the stigma.”¹⁴⁰ Indeed, as the interim report of the committee stated,

Although dramatic improvements have been made in the past two decades in the delivery of mental health services and addiction treatment, the Committee concurs with numerous witnesses that neither area has gained sufficient public support or government funding to ensure that Canadians obtain the same quality of services as they do when they receive treatment for physical illnesses, such as cancer or heart disease.¹⁴¹

In 2008, a new Mental Health Commission of Canada (MHCC) was announced with an investment of \$110 million in that year's federal budget. The MHCC is concentrating its efforts around four main themes: 1) a mental health strategy; 2) an anti-stigma campaign; 3) homelessness research demonstration projects; and 4) a knowledge exchange centre.¹⁴²

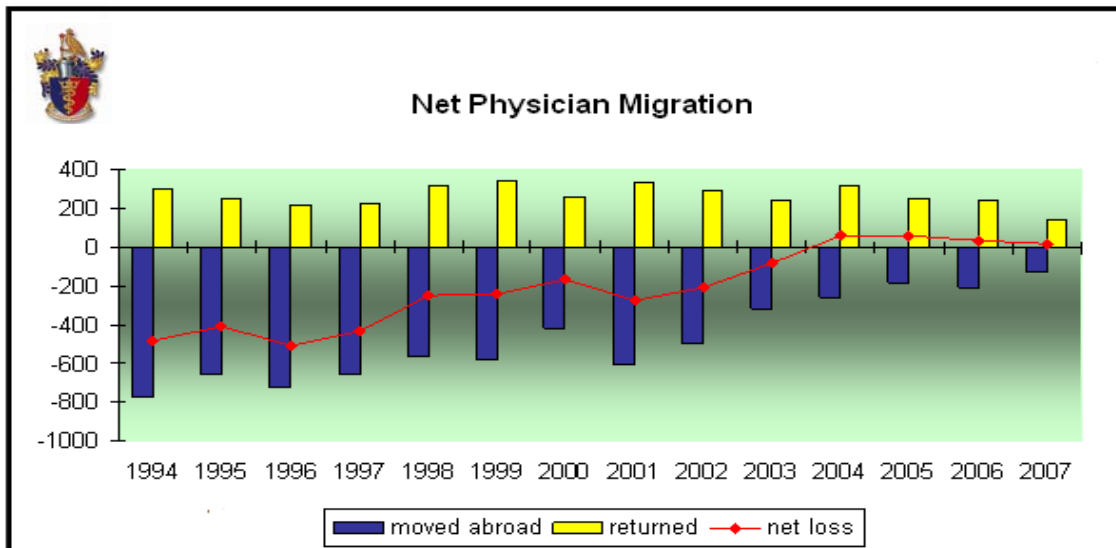
The Royal College is investigating opportunities to collaborate with the MHCC to ensure that all specialists have core competencies in mental health to ensure that all people suffering from mental illness are treated with dignity and respect.

Health human resources environment

Physicians in Canada: A portrait

According to CIHI's 2008 report on the supply, distribution and migration of physicians in Canada

- there were 63,682 physicians (32,598 family physicians and 31,084 other specialists) in Canada in 2007, an increase of 7% from 2003. This outpaced the growth of the Canadian population (4.2%) during the same period and slightly increased the ratio of physicians to the population per 100,000 from 187 in 2003 to 192 in 2007;
- both Canadian-trained and international medical graduates (IMGs) increased in the Canadian workforce from 2003—2007 by 6.6% and 4.5% respectively; and
- Physician mobility decreased during this period. The movement of physicians out of Canada fell by 58.6%, physicians returning from abroad declined by 40.8%, and mobility of physicians between jurisdictions within Canada fell to 0.8%, its lowest rate in five years.¹⁴³

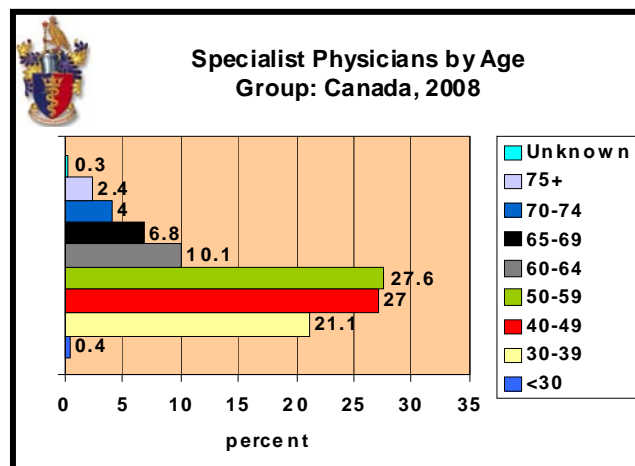


Source: Adapted from CMA, 2007, http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/Statistics/19-Abroad_Returns.pdf

Demographics

Age

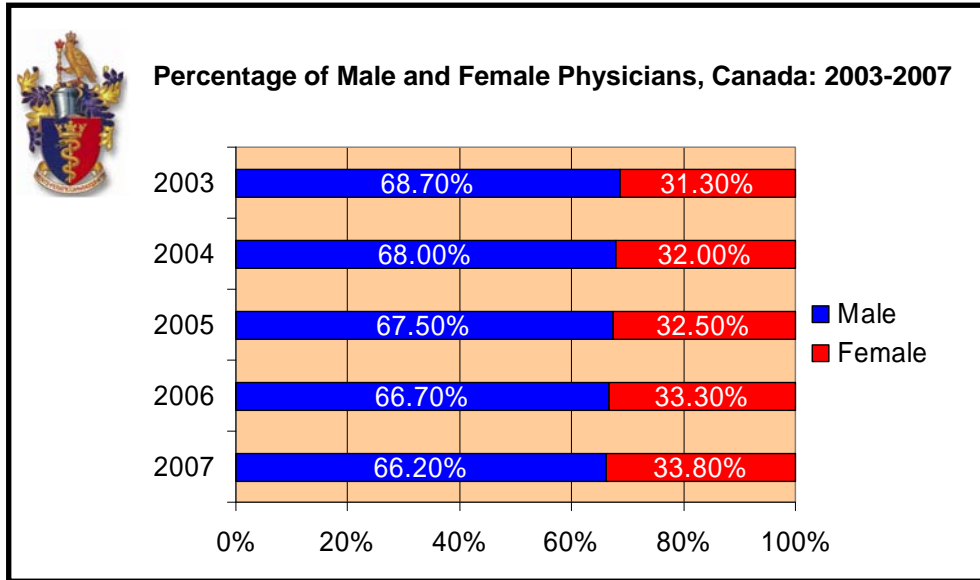
- In 2007, the average age of the physician workforce was 49.6 years. The average family medicine physician was 48.9 years of age and the average specialist was 50.5 years of age.
- Between 2003 and 2007, the average age of the physician workforce increased by 1.3 years.¹⁴⁴



Source: CIHI, 2008b, http://secure.cihi.ca/cihiweb/products/SupDistandMigCanPhysic_2007_e.pdf

Sex

- Between 2003 and 2007, the number of male physicians increased by 2.9%, while the number of female physicians increased by 15.2%. As a consequence, females comprised 33.8% of the physician workforce in 2007 compared to 31.3% in 2003.
- Female physicians are, on average, younger than their male counterparts, representing 49.4% of physicians under the age of 40, 35.1% of physicians aged 40–59, and 14% of physicians aged 60 older.^{145,146}



Source: CIHI, 2008c, http://secure.cihi.ca/cihiweb/en/smdb_2007_fig3_e.html

Results of the 2007 National Physician Survey¹⁴⁷

Impediments to care

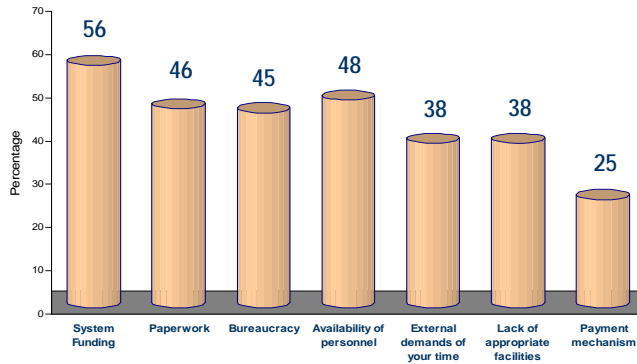
The National Physician Survey is a partnership of the Royal College, the College of Family Physicians of Canada, and the Canadian Medical Association. It is administered every three years to all eligible family physicians, other specialists, medical students and second-year residents.

Respondents to the 2007 NPS identified several impediments to their providing care, including:

- system funding,
- paperwork,
- bureaucracy;
- availability of personnel,
- external demands on the physician's time,
- lack of appropriate facilities, and
- the way they are paid for their work.¹⁴⁸

NPS 2007: Q24 What do you see as major impediments to your delivery of care to your patients? Check all that apply.

The Most Common Impediments to Care Provision Identified by Canadian Physicians
All Physicians (n=18474 N=55570)

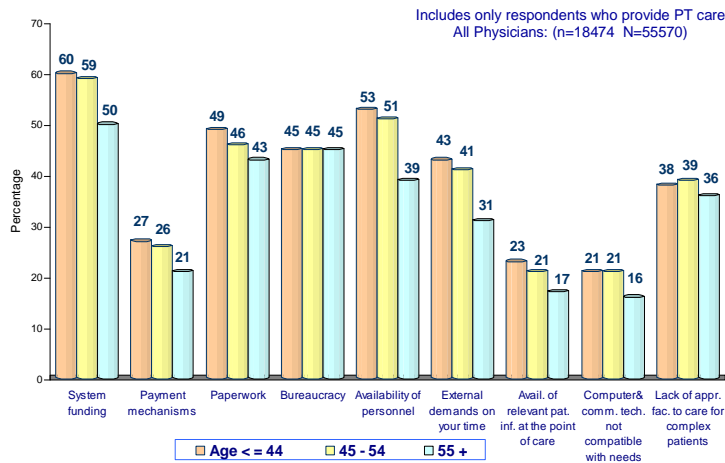


Source: 2007 National Physician Survey, The College of Family Physicians of Canada, Canadian Medical Association, The Royal College of Physicians and Surgeons of Canada.

Understanding barriers to the delivery of care will help planners, among others, to address the impediments that hinder the ability of physicians to care for their patients.

NPS 2007: Major impediments to your delivery of care to yr PTs by Age Group (Q24)

% Distribution: All Physicians



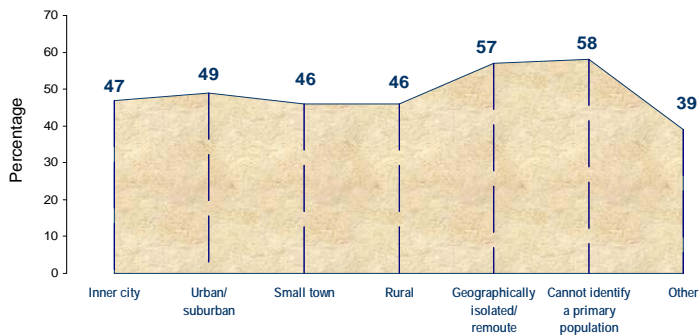
Source: 2007 National Physician Survey, The College of Family Physicians of Canada, Canadian Medical Association, The Royal College of Physicians and Surgeons of Canada.

Younger physicians identified greater barriers to delivery of care than their older counterparts.

NPS 2007: Q 24 What do you see as major impediments to your delivery of care to your patients?

Impediment: "Availability of Personnel" by Geographic Practice Setting

All Physicians (n=18474 N=55570)



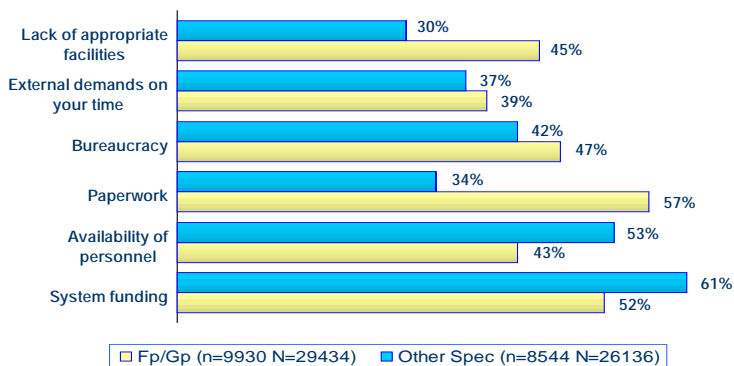
Source: 2007 National Physician Survey, The College of Family Physicians of Canada, Canadian Medical Association, The Royal College of Physicians and Surgeons of Canada.

Surprisingly, availability of personnel is seen as an impediment to a slightly lesser extent for physicians working in small towns and rural settings than in urban settings. However, as would be expected, this is seen as an impediment to care far more by those physicians who practice in geographically isolated and remote regions.

NPS 2007: Q24 What do you see as major impediments to your delivery of care to your patients? Check all that apply.

Variations by Broad Specialty Groups

All Physicians (n=18474 N=55570)



Source: 2007 National Physician Survey, The College of Family Physicians of Canada, Canadian Medical Association, The Royal College of Physicians and Surgeons of Canada.

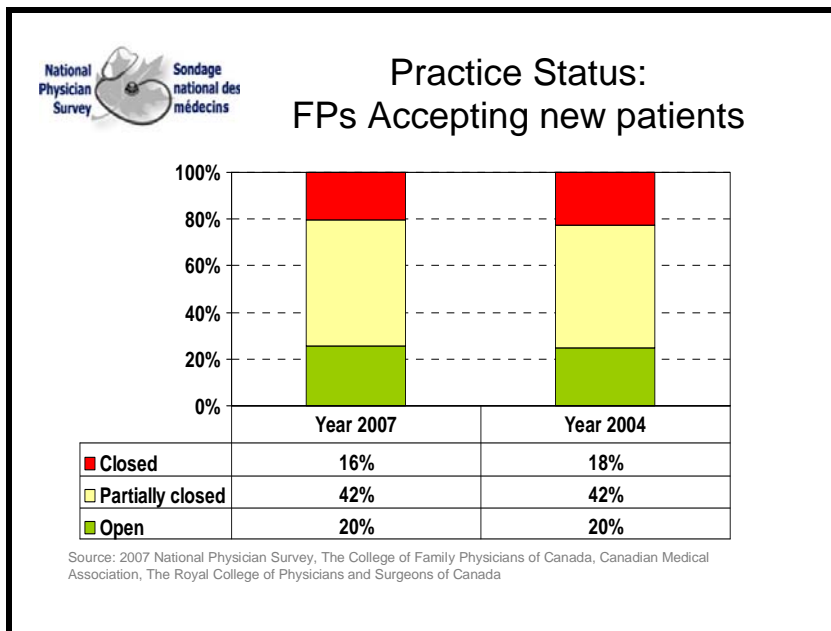
Responses to impediments to care also vary by broad specialty, with more family physicians reporting the above issues as impediments to care than other specialists.

Access to Care

While there have been some modest improvements in access to some forms of care, the 2007 NPS reveals a deterioration in access to several specific areas of care:

- Almost two-thirds (64%) of family physicians rated access to psychiatrists as fair or poor (compared with 66% in 2004).
- Over half (55%) of family physicians rated access to orthopedic surgeons as fair to poor (an increase from the result in 2004 of 48%).
- 66% of family physicians rated availability of long-term care beds as fair or poor (an increase from 60% in 2004).
- 55% of other specialists rated access to family physicians as fair to poor (an increase from 43% in 2004).¹⁴⁹

Even in those areas where access has improved since the 2004 NPS, it is far from ideal. For example, over half (56%) of family physicians rated availability of advanced diagnostic services as fair or poor (a decrease from 64% in 2004).¹⁵⁰



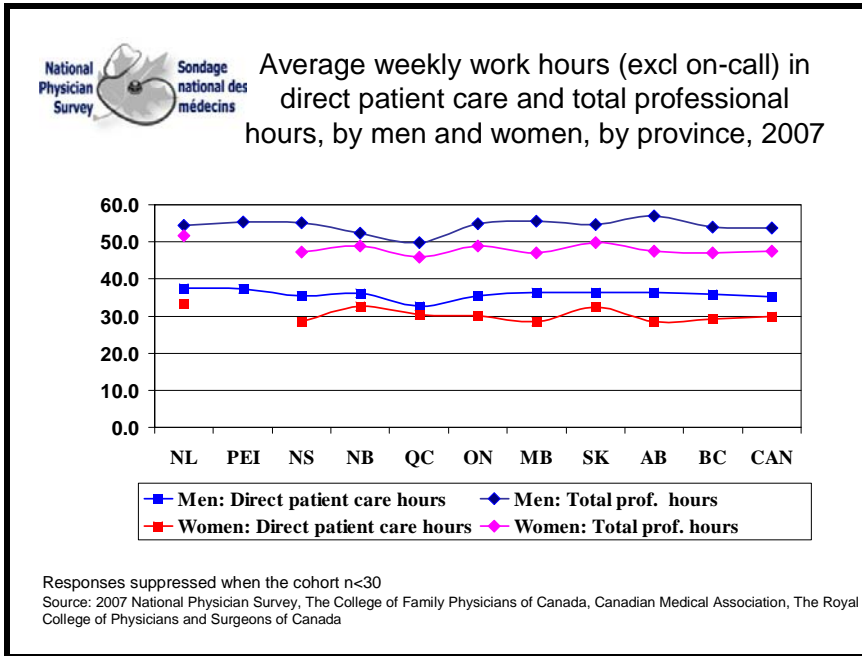
The 2007 NPS reveals remarkably little change in the number for family physicians accepting new patients. Ongoing challenges experienced by patients accessing family physicians will impact other specialists. For example:

- *other specialists are at times called upon to provide needed primary care; and*
- *patients often have no recourse but to seek medical attention in hospital emergency departments.*

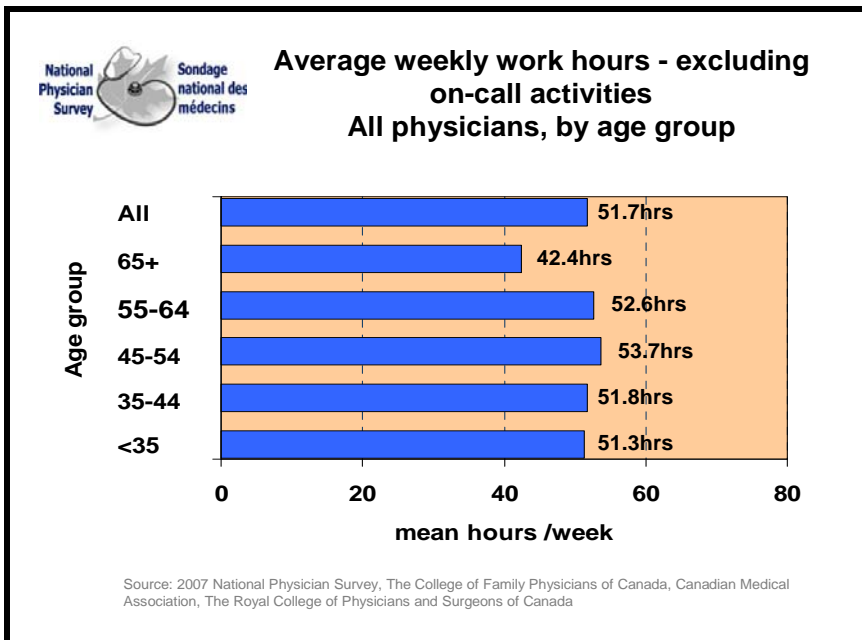
The most frequently cited factors increasing the demand for physicians' time were

- increasing complexity of their patient caseloads (80%);
- management of patients with chronic diseases/conditions (73%);
- increasing patient expectations (70%); and
- the aging patient population (69%), of special importance to 80% of FPs.¹⁵¹

Hours of Work

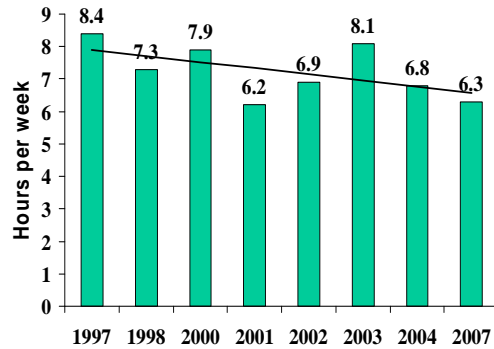


Excluding on-call activities, family physicians reported working almost 50 hours per week while other specialists reported 54 hours per week. Work activities included direct patient care and other professional duties such as managing their practice, research, teaching and other administrative duties.



Typically, young doctors are seeking a different balance in their work and personal lives than previous generations. Physicians under the age of 45 reported working fewer hours per week excluding on-call than their colleagues between the ages of 45 and 65.

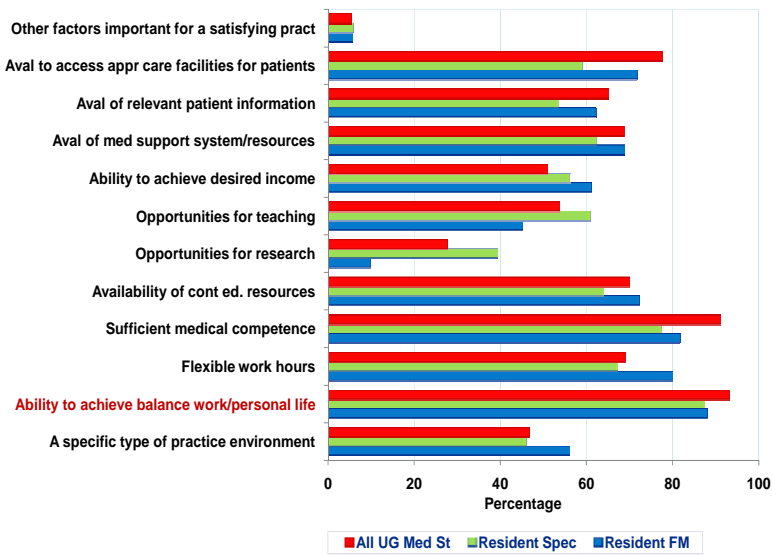
Male/female workload differences – hrs/wk (excl call)



Sources:
 1997 to 2003 CMA Physician Resource Questionnaires
 2004, 2007 National Physician Survey

In addition to generational differences in hours worked, female physicians reported fewer work hours than their male colleagues but the gap appears to be narrowing over time.

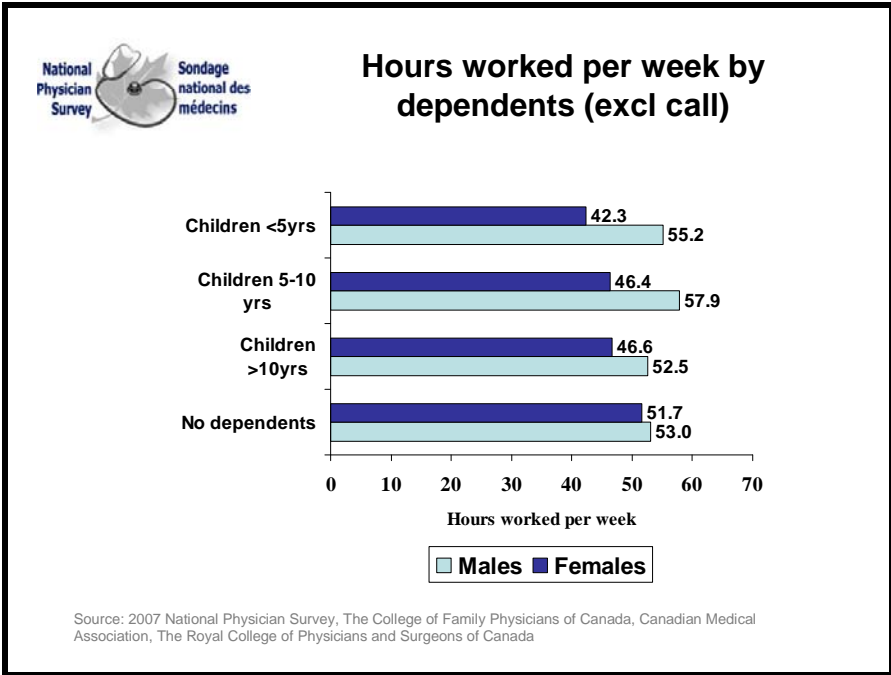
NPS 2007: For you, what factors do you think will be most important in having a satisfying and successful medical practice?



Source: 2007 NPS, The College of Family Physicians of Canada, Canadian Medical Association, The Royal College of Physicians and Surgeons of Canada

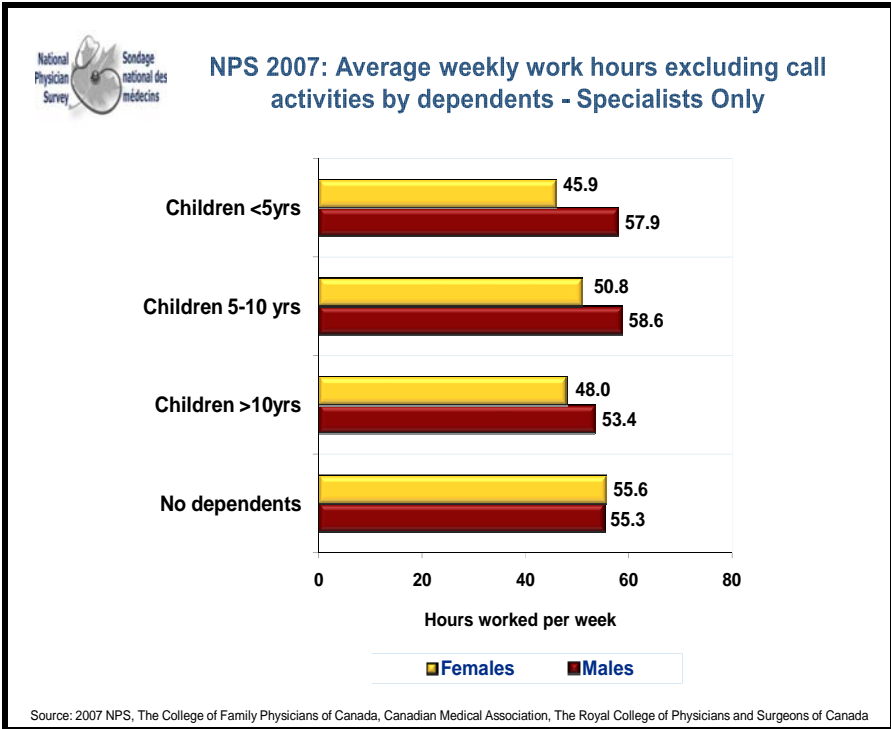
Important generational variations may soon emerge in regard to work hours. Overall, some 9 out of 10 undergraduate medical students and second year residents ranked work life balance as the most important factor underlying their professional satisfaction.

Given the importance placed by younger physicians, including specialists, on work-life balance, it will be important in coming years to keep a watchful eye on these practice patterns.



Caring for dependents appears to influence the number of hours worked by physicians per week (excluding on-call) especially for female practitioners who worked 9.4 fewer hours per week (excluding on-call) while caring for children younger than age 5 compared to other female physicians with no dependents.

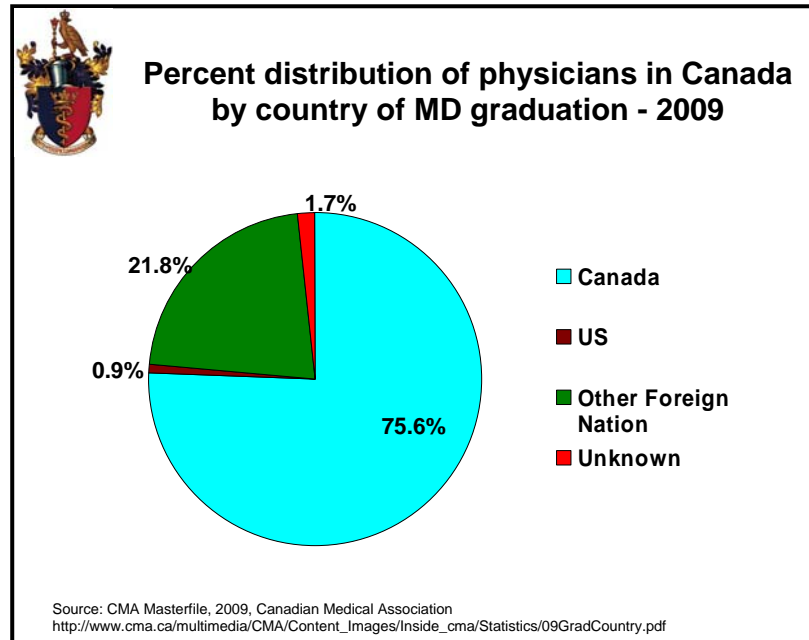
Given the impact child caring has on professional hours of work, planners will have to account for the increasing number of younger female physicians in the practice workforce.



International Medical Graduates: Key issues

IMGs in the Canadian physician workforce

For many years, Canada has relied upon IMGs, who have historically comprised approximately 20–30 per cent of the physician workforce.¹⁵²



While the overall total for Canada in 2007 was 22%, there were considerable variations across jurisdictions in Canada, with Newfoundland and Labrador, Saskatchewan, Manitoba and the Yukon including a greater proportion of IMGs within their respective workforces than other provinces and territories.¹⁵³ There is a heavier reliance on foreign-trained physicians in rural Canada, where IMGs account for 26.9% of family physicians in rural areas, compared with 22.6% in urban areas.¹⁵⁴

Canadian-trained medical graduates and international medical graduates, Canada, 2007*														
P/T	NL	PEI	NS	NB	QC	ON	MB	SK	AB	BC	YT	NWT	NU	CAN
All MDs														
• CN	65%	86%	72%	78%	89%	76%	70%	51%	72%	72%	69%	71%	89%	78%
• IMG	35%	14%	28%	22%	11%	24%	30%	49%	28%	28%	31%	29%	11%	22%
FamMed														
• CN	66%	85%	73%	84%	88%	78%	58%	45%	64%	71%	69%	66%	88%	77%
• IMG	34%	15%	27%	16%	12%	22%	42%	55%	36%	29%	31%	34%	13%	23%
Specialists														
• CN	63%	88%	70%	72%	90%	74%	81%	59%	82%	73%	71%	85%	100%	79%
• IMG	37%	13%	30%	28%	10%	26%	19%	41%	18%	27%	29%	15%	0%	21%

*Note: percentages may not equal 100% due to rounding.

Source: CIHI, 2008b, http://secure.cihi.ca/cihiweb/products/SupDistandMigCanPhysic_2007_e.pdf

Due to differences in training and education of some IMGs, not all are eligible for certification, and some provincial alternatives are being developed. For example, HealthForceOntario's Physician Assistant Initiative is aimed at recruiting IMGs as physician assistants, some of whom face challenges to practice without complete retraining.¹⁵⁵

Changes to the physician regulatory landscape

In Canada, governments and regulators are adopting new approaches to address labour and medical workforce shortages, including amendments to the Agreement on Internal Trade (AIT), establishing international agreements, and adopting new ways to achieve medical registration for medical graduates whose education and work experience may differ from the majority of physicians who practice here:

The Royal College has produced a discussion paper analyzing these developments and their potential implications for the quality of care as well as access to and continuity of care. This document is available at

http://rcpsc.medical.org/publicpolicy/Physician%20Mobility%20Paper_e_fe.pdf.

The Royal College has also provided commentary concerning the potential benefits and pitfalls of the amendments to the AIT to federal/provincial/territorial (FPT) Ministers of Health and Labour in a letter sent on December 5, 2008, which is included as an appendix to the above report. On the same day, FPT Ministers of Internal Trade approved the text of a Protocol of Amendment to the AIT to actualize these proposed amendments.

- In July 2008, provincial and territorial premiers announced amendments to the AIT by January 1, 2009, that allow any worker, including physicians, certified for an occupation by a regulatory authority of one province or territory to be recognized as qualified to practice that occupation by all other provinces and territories. By the summer of 2009, mutual recognition of occupational credentials will exist in all provinces and territories and any exceptions to full labour-market mobility will have to be justified as required to meet a legitimate objective such as the protection of public health or safety.¹⁵⁶
- In an effort to reduce barriers to physician mobility, the College of Physicians and Surgeons of Ontario (CPSO) has introduced new alternative pathways to registration. These requirements vary depending on the source of the physician's medical degree, where she or he is currently practicing, and where the applicant received postgraduate training.¹⁵⁷
- In October 2008 Quebec and France announced an agreement to provide mutual recognition of professional qualifications between their jurisdictions, with a subagreement between the Collège des médecins du Québec (CMQ) and the Ordre national des médecins de France to provide mutual recognition of professional qualifications for physicians trained in each jurisdiction by June 30, 2009.¹⁵⁸

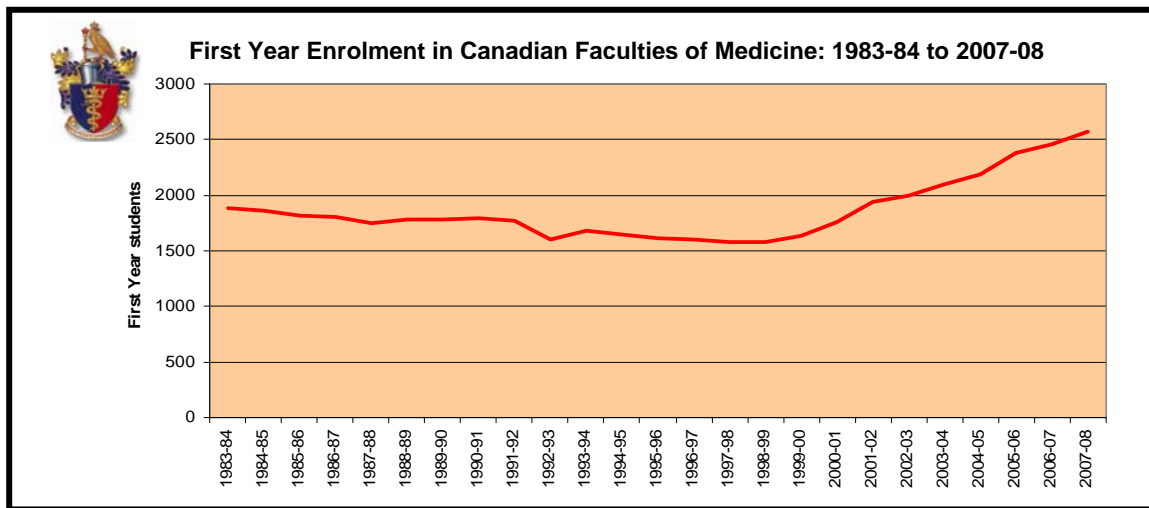
The Royal College will continue to work with our partner health organizations and other stakeholders to make our concerns known to FPT governments regarding the potential unanticipated ill-effects of these proposed changes during the implementation period. We will also help develop measures that will ensure the maintenance of high-quality care for Canadians, including advocating for rigorous evaluation of the results emanating from these changes to the AIT on the provision of timely and safe care in Canada. In addition, the Royal College will also examine our own certification protocols to ensure that the processes by which physicians achieve certification as specialists in Canada keep pace with medical education and training to meet societal health needs.

Medical education

Undergraduate education

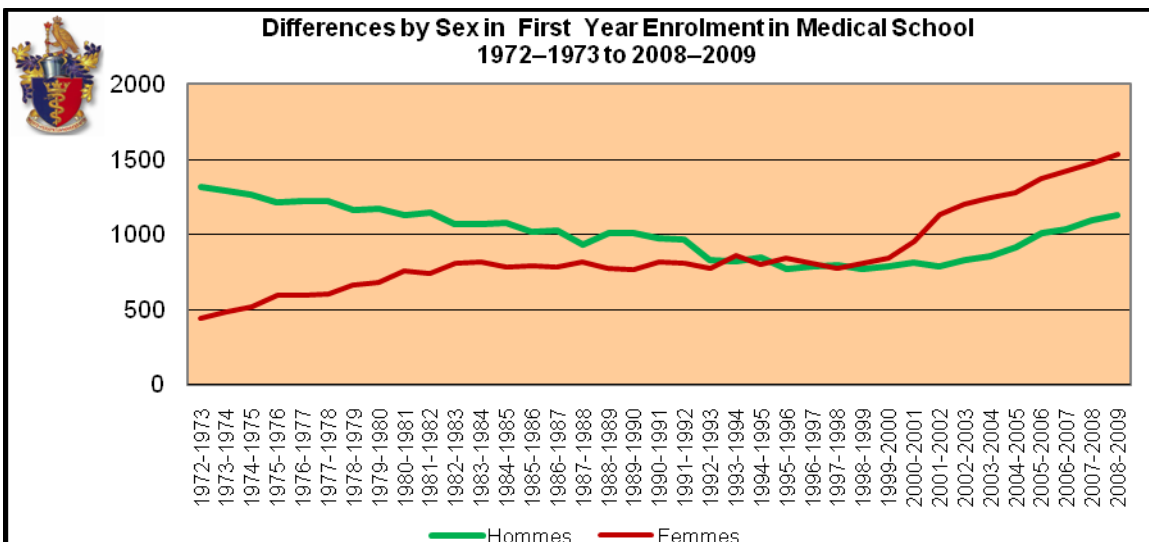
Enrolment in Canadian medical education has undergone significant change over the past few decades, both in terms of the number of positions available within medical schools and the gender balance within these schools.

Following the release in 1991 of the Barer-Stoddart report on medical resource policies for Canada,¹⁵⁹ first year enrolment in Canadian medical schools declined by approximately 10%. (First year enrolment was 1,887 in 1983–84, compared to 1,604 in 1992–93.) Since 1999–2000, enrolment has climbed gradually as the number of spots has increased; figures for 2007-08 show 2,569 students enrolled in first year medical school.¹⁶⁰



Source: Canadian Medical Education Statistics, AFMC <http://www.afmc.ca/publications-statistics-e.php>

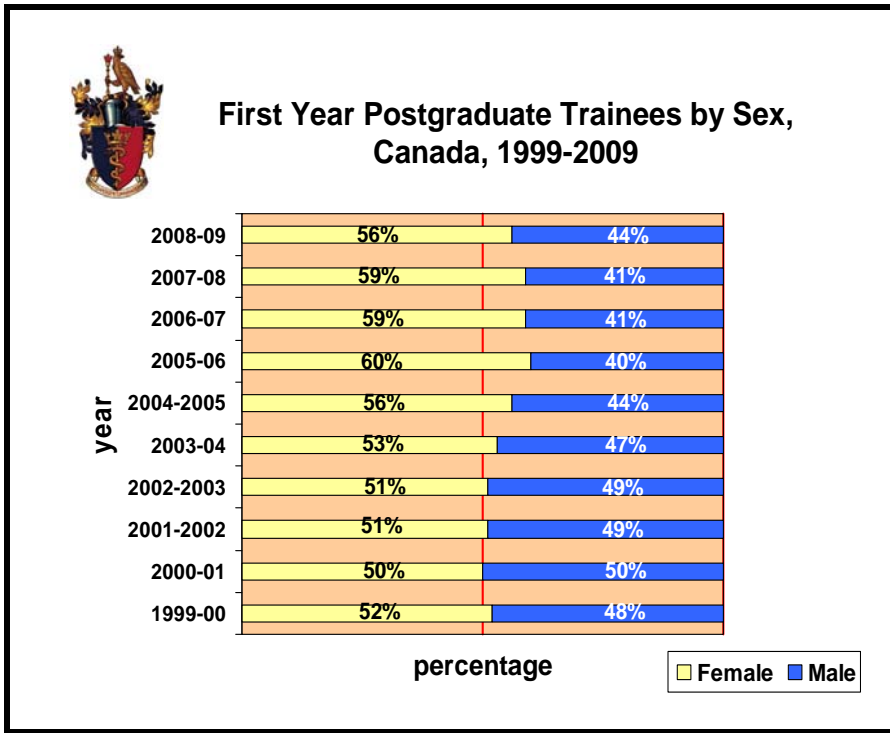
The first year enrolment of women in Canada's medical schools has increased significantly as well. In the 1972-73 academic year, women comprised only 22% of first year medical students. But by 1995-96, this percentage had more than doubled to 50.6%. In fact, since that academic year, women have comprised more than half of all first year student in Canadian medical schools, and since 2003-04, their representation has comprised slightly below 60% of the total first year population.¹⁶¹



Source: Canadian Medical Education Statistics, AFMC <http://www.afmc.ca/publications-statistics-e.php>

Postgraduate education

Based on these figures, it should come as no surprise that females also comprise the majority of students in postgraduate medical training environments.



The ratio of female to male physicians will likely continue to grow in the years ahead, based on trends of first year undergraduate and postgraduate medical school enrolments.

Data source: Canadian Post-M.D. Education Registry, Annual Census of Post-MD Trainees, 2008-09 from http://www.caper.ca/docs/pdf_2008-09_CAPER_Census.pdf

The Canadian Resident Matching Service (CaRMS) reveals several trends among Canadian-trained medical graduates and international medical graduates.¹⁶²

<i>CaRMS Match 2008 : Results of matched Canadian graduates</i>			
Year	# Matched to First Choice Discipline	%	Total matched
2008	1850	91%	2032
2007	1720	90%	1910
2006	1674	91%	1838
2005	1197	90%	1328
2004	1084	89%	1214
2003	999	90%	1116
2002	960	90%	1068

IMGs (including Canadian IMGs) can match in first round of match process (since 2007)

353 of 1299 IMGs (27%) were matched into programs in 2008 vs 87 IMGs (13.2% out of 657 IMGs in total) matched in 2004

50% of international trained graduates selected family medicine as their career stream in 2008

Medical school debt

According to a January 2007 study by the Canadian Association of Internes and Residents (CAIR):

- 86% respondents went into debt to finance their medical education.
- The average debt level for resident physicians is \$158,728, while the median is \$135,000.
- Debt is accumulated during residency training since residents must pay not only the principal but also interest on government student loans throughout training.
- Residents from less well off families accumulate far greater debt levels.
- The implications of this situation include:
 - limiting access to medical education from middle and low-income families;
 - limiting access to medical education from residents from rural areas who are generally much more likely to practice medicine in these areas or with under-served populations, thus exacerbating the physician shortage in under-served areas;
 - deterring students from entering family medicine where the physician shortage is greatest; and
 - levels of extreme stress among resident physicians, thereby negatively affecting their wellbeing and the capacity of physicians to best serve their patients.

CAIR is advocating that the federal government extend the interest free status and deferral of Canadian student loan's interest and repayment until training is complete.¹⁶³

Conclusion

The information and facts about and influencing Canada's healthcare system collected in this issue of *Fog* highlight certain themes and questions:

- It is undeniable that, for many, health and issues surrounding health as a public policy priority are taking a back seat in comparison to other issues such as the economy and the environment. How can the Royal College and partner organizations best advocate for quality specialty medicine and a sound health system in this new policy environment?
- If the new US administration succeeds in improving accessibility to healthcare in that country, what implications does this pose for the self-sufficiency of Canada's medical workforce?
- While Canada enjoys a high mark of human development, we are still weak in certain measures of equality, such as the health of First Nations, Inuit and Métis, and low-income Canadians, who are more vulnerable to chronic conditions. How can we increase equity within Canada when it comes to improved health outcomes for vulnerable populations?
- While healthcare spending has increased in recent years, efforts to contain it must not impinge on equitable access to care. Efforts to unduly contain health spending may also restrict efforts to effectively address chronic diseases, thereby increasing their human and fiscal burden later on. How can we enhance access to care and chronic disease prevention and treatment to those in need?
- Physicians report several impediments to providing care to their patients. What are the best strategies to address these impediments?
- Practice patterns within the physician workforce are changing. What measures need to be in place to anticipate changes in physician practice and plan accordingly?
- The amended Agreement on Internal Trade may pose certain unintended consequences both in terms of access to care and the quality of care. What mechanisms are needed to evaluate the impact of this agreement on the provision of medicine in Canada?

The above issues are top of mind in many quarters. The Office of Health Policy and Governance Support will continue to track these issues to raise awareness and understanding of the many influences and developments shaping our health system. This will assist the Royal College, its Fellows and many partners in achieving excellence in specialty medical care, the highest standards in medical education and lifelong learning, and the promotion of sound health policy for the health of Canadians now and into the future.

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- putting off/postponing getting healthcare you need;
- skipping a recommended medical test or treatment;
- not filling a prescription;
- cutting pills or skipping doses of medicine;
- incurring problems getting mental healthcare; and
- encountering any of the above.

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