



Madame President, Mr. President-Elect, colleagues, ladies and gentlemen, good evening.

It is certainly my pleasure to come to here to Buffalo and talk with my American colleagues.

Perhaps right off the top I should provide a little bit of a “Canadian context” when it comes to attitudes about you, our southern and closest neighbour.

In 1969 then-Canadian Prime Minister Pierre Elliott Trudeau, speaking at the National Press Club in Washington, quipped:

“Living next to you is like sleeping with an elephant; no matter how friendly and even-tempered the beast, one is affected by every twitch and grunt.”

To say that there has been some twitching — not to mention a great deal of grunting — here in America over health care reform in recent months is a bit of an understatement.

However, on that front I will not claim to be holier than thou. In fact, I guess it would be more accurate to say “I feel your pain.”

In Canada, our health care system is second only to hockey in terms of how we identify ourselves as Canadians.

Of course the big difference is that we still win gold medals in hockey!

I will share with you tonight a bit of an overview of Canada’s health care system. I will touch on the role the medical profession has played — and continues to play — in that, then I will wrap up with a bit of a look ahead in terms of what Canada’s doctors are doing to try and improve how the system treats our patients.

Part One – Association and Presidential Activities

The Canadian Medical Association is the national voice of physicians in Canada. The CMA has 72,000 voluntary members, all of whom are either physicians or physicians-in-training.

The 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. The CMA was formed in Quebec City in October 1867, just three months after the birth of Canada itself – albeit 46 years after the Erie Medical Society!

Our first president, Sir Charles Tupper was also the first — and last — physician to serve as Canada's prime minister. And no, I have no plans on trying to follow Sir Charles' lead.

The CMA is not the national doctor's union. Rather, our work involves providing research, leadership and advocacy on behalf of our members and our patients.

The CMA also takes the lead on numerous public health issues. In 1961, for instance, it told physicians they had a duty to warn patients about the link between tobacco and cancer. We have continued the battle against the harmful effects of tobacco right up to the present day. Just last year, the CMA successfully led an advocacy initiative in Parliament to close a loophole in tobacco legislation that allowed the marketing of flavoured tobacco products to youth and children.

We have also spoken out on issues relating to food safety and the provision of healthy food at reasonable cost, particularly in our northern, remote and inner city urban areas. We advocate on environmental issues such as water quality and safety and clean air. We are also active in the war on obesity, particularly among children, and the so-called epidemic of Type II diabetes.

As you can imagine, the CMA has also been intimately involved with the development over time of our state-funded, universal health care insurance scheme. We call it medicare, but it is not the same as your Medicare.

The CMA first proposed principles and a plan for national health insurance in 1934. Our plan was not adopted. In fact, it was over three decades later that the federal government passed legislation providing for universal, first-dollar coverage for medical services.

In the intervening years, a strong national consensus emerged that Canadians should not be denied access to hospital and medical services because of an inability to pay.

I personally grew up with first-hand experience of the personal dedication of a physician to his patients, as I watched my father, a British immigrant physician, build his new practice and our family's new life in Canada.

We came to Canada in 1958 because my father had seen Britain's National Health Service become mired in bureaucracy. Dad was no longer willing to allow the NHS to dictate to him the care he was allowed to provide to his patients.

Ironically, as the Saskatchewan government moved toward its new provincial health insurance program, he was facing the same issues all over again.

Not long after our arrival in Canada, I witnessed the intense meetings of my father and other physicians who would gather in our house to discuss the provincial government's plan to introduce Medicare in Saskatchewan.

Even as a child I could see the worry, but also the firm resolve, in these physicians. They knew it was their responsibility to do what they felt they must to put the interests of their patients first.

I remember the doctors' gut-wrenching decision to withdraw their services in 1962. I also remember their immense relief when the withdrawal ended with the signing of the "Saskatoon Agreement".

The crux of this agreement was the concession by the government that it would not interpose itself between the patient and the physician in decisions about necessary care.

Physicians have largely been cast as villains in accounts of this critical time in Canada's history. When I assumed the presidency of the CMA in August, I said that if standing up to put the needs of patients first is being a villain, then I'm ready to be fitted for my black hat.

The issue in the 1960s was not about physician opposition to a publicly funded insurance scheme for medical care. The issue was about ensuring patients had the right to appropriate medical care independent of government fiscal policy.

Today, almost half a century later the basic issues behind the “birth of medicare” remain in play. They are also many of the same issues you are grappling with here.

Canada versus the US

But first, the benefits.

The decision by governments to become the payors for physician services and care provided in hospitals — let there be no doubt — did not hurt doctors’ pocketbooks.

With the advent of publicly administered health insurance schemes, physicians no longer had to worry about billing patients, or worse collecting from patients.

Let me be clear: physicians in Canada are not employees of the government. The vast majority of us are private practitioners and are not “under contract” to anyone except individually to each patient.

Very, very few physicians practice under employment contracts. Our fees are paid from the public purse, either through fee-for-service payments or through other “alternate” or “blended” formulae.

Fees for physician services to patients, a few of our expenses and a few other “perqs” became a matter of negotiations between provincial medical associations and their governments.

Negotiating with government always presents its own challenges, as I’m sure you will agree.

However, it does help avoid being paid in chickens, or worse, not all.

Another significant benefit to physicians of Canada’s system is in the area of medical malpractice insurance.

North of the border medical litigation continues to trail the explosive situation seen here in the US, but it is nevertheless still a growing cost.

Yet every provincial and territorial medical association negotiates rebates from government to offset these costs. For instance, in my case the Saskatchewan Medical Association has negotiated 100% reimbursement for my medical malpractice dues.

As a full-service family physician who provides full obstetrical services, that is a significant offset for my expenses, although I pay much less than you would pay here in the US.

Similarly, provincial medical associations can negotiate for funding for CME, their IT expenses, their extra costs for providing on-call coverage ... in fact, many of the expenses physicians incur except for their actual office overhead expenses.

So, from the narrow perspective of physician remuneration, the system — for the most part — works. There is of course always room for improvement on the amounts, but that is another story.

Where the challenges come in for physicians is that since its birth in the 1960s, Canada's public health insurance program has not kept up with the times.

Several key issues plague our system.

First, Canada now has some of the longest wait times for care among peer countries. Many factors are responsible for the lengthy wait times, one of which is the shortage of physicians and other health care professionals.

Second, there is a growing problem with patients not having access to the full continuum of care they need.

The 1984 federal *Canada Health Act (CHA)* — which sets out the principles provincial health care insurance plans must meet in order to get federal funding — narrowly defines insured health services as “hospital services, physician services and surgical dental services provided to insured persons.”

Over time, as the amount of health care services delivered outside of institutions has increased, the share of health spending covered by the *CHA* has decreased.

When the *CHA* was passed, physician and hospital services represented 57% of total health spending. This now stands at 41%.

Third, serious concerns remain about the future financial sustainability of publicly funded health care in Canada.

Over the past few decades health care has taken an increasing share of government program spending.

In 1975, health accounted for just under 30% of provincial/territorial government program spending. In 2007, it had increased to 39% and is expected to top 50% soon in some provinces and territories.

Fourth, despite having one of the richest health care programs in the industrialized world, international studies consistently report that the Canadian program is not performing as well as it should.

While there is strong public support for change, they want to see this change occur while safeguarding core principles such as universality, accessibility and comprehensiveness.

Even with these challenges, physicians strongly support the universal access to care for patients in Canada. However, we feel change must be undertaken to put the patient's interests at the centre.

For Canada's physicians, the issue is care, not Medicare. That is why we are pressing forward with what we call our Health Care Transformation Project that aims to address the challenges and make health care in Canada more patient-focused.

The Next Chapter

Whether you are a specialist here in Buffalo, or a family doc in Saskatchewan like me, we share the constant that, as physicians, we cover an enormous spectrum of human experience in our relationships with patients and their families. We are the frontline for a high quality 'patients first' health care system.

To me, this is where our choices begin and end: with the impact on patients and patient care. This may seem like common sense, but common sense is not so common in some of our health care debates north of the border, what about yours?

The question we need to ask ourselves continually in Canada as we struggle with capped budgets and increasing demand is this: "How will this decision affect the quality of patient care?" And if there is another option that will better ensure the quality of care, then that is the option we must choose.

The CMA has been pressing for a transformation in our system that can deliver quality care within a sustainable funding model. We have framed the principles that we believe must be the foundation of these changes: a blueprint for health care transformation.

While we have serious problems with health care in Canada, huge injections of cash would not solve many of them. In any event, that is not coming any time soon.

What we are looking for is an evolutionary transformation of our system that protects the sound principle of universality but carves out a more prominent place for quality throughout the system.

For too long Canadians have felt resigned to the fact that delayed access — lower quality care really — was the price they had to pay for our universal system.

The CMA believes that we can and must get better at managing the system with resources that will only grow slowly in the decades to come. We need to find the path to this new system with an aging population, and spiraling costs of new medical technologies.

The CMA believes our system can become more effective and sustainable while still preserving core values such as universality and accessibility. Above all, our goal is to ensure patient-focused, high quality care for all Canadians.

I know here in the US there is still a great deal of uncertainty about how well the new Federal Health System Reform Legislation will address the challenges facing the health care system.

What is clear, however, is that both Canada and the United States stand on the cusp of a new era for health care. Yet as we embark on a new course, it will be our professionalism and enduring commitment to our patients that provide the steady hand and guidance that will be so critical to success.

Patients will be looking to us, as they always have. We will be there to answer the call, as we always have.

Thank you.