



**ASSOCIATION OF CANADIAN ACADEMIC HEALTHCARE ORGANIZATIONS  
ASSOCIATION CANADIENNE DES INSTITUTIONS DE SANTÉ UNIVERSITAIRES**

**THE ROLE OF THE FEDERAL GOVERNMENT IN  
ACHIEVING EXCELLENCE AND SUPPORTING INNOVATION  
IN CANADA'S HEALTH CARE SYSTEM**

**A SUBMISSION TO  
THE HOUSE OF COMMONS  
STANDING COMMITTEE ON FINANCE  
NOVEMBER 15, 2002**

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## **THE ASSOCIATION OF CANADIAN ACADEMIC HEALTHCARE ORGANIZATIONS (ACAHO)**

The Association of Canadian Academic Healthcare Organizations (ACAHO) is a member-based association that represents more than 40 teaching centres - which are a combination of teaching hospitals and Regional Health Authorities who have jurisdictional responsibilities for teaching institutions. Members range from single hospital organizations to multi-site, multi-dimensional regional facilities.

The distinguishing characteristic of the members of ACAHO is that they have overall responsibility for the following activities:

- Providing Canadians with timely access to quality specialized health care services.
- They represent all of the principal teaching sites for Canada's health care professionals. This includes all sixteen faculties of medicine (physicians), and other faculties of health (nursing, pharmacy and dentistry), and many colleges with technical and professionals in health including physiotherapy, rehabilitation therapists, laboratory technicians, respiratory therapists, speech therapists and social workers.
- They provide the large majority of infrastructure to support and conduct health research, medical discovery, knowledge creation and innovation.

The mission of ACAHO is to provide national leadership and effective policy representation in the three separate, but related, areas of: (1) the funding, organization, management and delivery of highly specialized tertiary and quaternary, as well a primary health care services; (2) the education and training of the next generation of Canada's health care professionals; and (3) providing the necessary infrastructure to support and conduct basic and applied health research, medical discovery and innovation.

## **L'ASSOCIATION CANADIENNE DES INSTITUTIONS DE SANTÉ UNIVERSITAIRES (ACISU)**

L'Association canadienne des institutions de santé universitaires (ACISU) est une association dont les membres représentent plus de 40 centres d'enseignement, tant des hôpitaux d'enseignement que des régions régionales de la santé dont la sphère de compétence englobe les établissements d'enseignement. Les membres vont d'organisations d'hôpitaux individuels à des installations régionales à sites et dimensions multiples.

La caractéristique distinctive des membres de l'ACISU est qu'ils ont tous la responsabilité globale :

- de fournir aux Canadiens l'accès en temps opportun à des services de santé spécialisés de qualité.
- de représenter tous les principaux lieux d'enseignement destinés aux professionnels de la santé du Canada. Ces lieux comprennent les seize facultés de médecine (médecins) et d'autres facultés de disciplines en santé (sciences infirmières, pharmacie et art dentaire) et nombre de collèges formant des techniciens et des professionnels de la santé, dont physiothérapeutes, thérapeutes de réadaptation, techniciens de laboratoire, inhalothérapeutes, orthophonistes et travailleurs sociaux.
- de fournir la majeure partie de l'infrastructure qui rend possibles la recherche en santé, les découvertes médicales, la création de connaissances et l'innovation et les soutiennent.

L'ACISU a pour mission de fournir un leadership national et une représentation efficace en matière de politiques dans trois domaines distincts, mais liés les uns aux autres : (1) le financement, l'organisation, l'administration et la prestation des services de santé tertiaires et quaternaires hautement spécialisés et aussi des services de santé primaires ; (2) la formation de la prochaine génération des professionnels de la santé du Canada et (3) la fourniture de l'infrastructure nécessaire à la recherche fondamentale et appliquée en santé, la création de connaissances et l'innovation, et à leur soutien.

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## **EXECUTIVE SUMMARY**

### **INTRODUCTION**

Since its introduction, Medicare has served Canadians well. In addition to providing timely access to quality health care independent of one's ability-to-pay, it has been a defining symbol of what it means to be Canadian.

Canadians take great pride in their health care system and the principles upon which it has been built. At the same time, however, they remain concerned about the future of the system and its ability to provide timely care to their families and friends in times of need.

While the 1970s and 1980s witnessed a significant amount of expansion in the capacity of the health care system to meet the growing health care needs of Canadians, the recent past has not been as kind. As a result, the system has had to react to a series of ongoing pressures - both financial and structural in nature.

Not unexpectedly, Canadians since the late 1990s have consistently ranked the future of health care as their most pressing public policy issue that must be addressed by governments.

At this point in our country's history, ACAHO is of the strong view that the release of the reports of the Standing Senate Committee on Social Affairs, Science and Technology (i.e., Kirby) and The Royal Commission on the Future of Health Care in Canada (i.e., Romanow) presents the federal government with an important, if not historic opportunity to contribute in redefining our collective vision of health and health care, renew our commitment to a health care system that is national in character, and re-build our leadership capacity to place our cherished health system on the road to long-term sustainability.

As a consequence, there is no better time than the present for the federal government to consider a series of pragmatic and collaborative policy options that will renew our collective support for a health care system that is pan-Canadian in design.

The term pan-Canadian is used not because it is clear that all Canadians have placed a high priority on the future of health care from coast-to-coast. Rather, while there have always been a number of different policy approaches that the provinces and/or territories have introduced, ACAHO believes that there are a series of important "national" foundational principles and structural building blocks upon which our health care system must be built on if it is to be adaptable, responsive, innovative, cost-effective and accountable. Simply put, the challenge at hand is to build a system that is sustainable over the short-, medium- and longer-term.

As the number one public policy issue identified by Canadians, they should ask no less of the federal government and those who are the guardians of the public interest when it comes to the future of Medicare. Furthermore, expectations remain high that the federal government will continue to play a significant role in facilitating system renewal and innovation.

To ensure that Canada's health care system is placed on the road to short-, medium- and longer-term sustainability, ACAHO has developed a series of recommendations that focus on the twin public policy objectives of: (1) implementing targeted, strategic federal investments that are required to accelerate system renewal and re-structuring, and embrace new innovative approaches to organize, manage and deliver care; and (2) determining an ongoing level of federal funding that is required to place the health care system on firm financial ground and will facilitate timely access to cost-effective quality health care services.

In many respects, the former can be considered as "*transitional*" funding and the latter as "*fixed*" funding, that when combined, will allow the system to rejuvenate itself and respond to the evolving expectations and needs of Canadians – ultimately transforming the structure of the health care from where it is, to where it needs to be.

The recommendations underscore ACAHO's view that while there is an urgent need to review how we design the system's architecture, we do not have the sole option of reorganizing ourselves out of the current set of policy circumstances; the federal government must be prepared to introduce a combination of strategic investments that will not only stabilize the system in terms of meeting the health care needs of Canadians today, but will give the system the flexibility to adapt to future demands.

#### **INVESTING IN CANADA'S HEALTH CARE SYSTEM OF THE 21<sup>ST</sup> CENTURY – THE ROLE OF THE FEDERAL GOVERNMENT**

By virtue of their mission and mandate, members of ACAHO are "centres of health innovation." As a result, they are leading-edge research-driven organizations that have the capacity to improve the health status of Canadians, revolutionize how health care is delivered, and significantly contribute to our economic potential as a nation. Combined, teaching centres are powerful engines of system-based change. However, in order to fulfill this mandate now and into the future, there is an important need to invest in the infrastructure of teaching centres/hospitals.

In this context, ACAHO is of the view that the federal government has an essential role to play not only in terms of working collaboratively with the provinces and territories to ensure that our health care system is truly national in scope, but also through a combination of "transitional" and "fixed" investment approaches that strengthen our ability to meet the health care needs and expectations of Canadians in the 21<sup>st</sup> Century.

Specifically, ACAHO strongly believes that the federal government should introduce (and in some cases continue to make) a combination of targeted and time-limited

strategic investments that serve to renew the infrastructure of the health care system. At the same time, as a guardian of Medicare, the federal government also has a public responsibility to contribute its fair share on an operational funding basis to ensure that system provides timely access to Canadians in need.

### **TEACHING CENTRES AS A NATIONAL RESOURCE**

The mission and mandate of teaching centres is three-fold: (1) to provide timely access to quality specialized health care services to those in need; (2) to educate and train the next generation of Canada's health care professionals; and (3) to be the engine of innovation through ongoing health research, medical discovery and knowledge creation.

Given the unique combination of their roles and responsibilities in the health care system, teaching centres play an essential role in renewal and innovation. In addition to providing leading edge health care services to Canadians, they also provide health care professionals with a state-of-the-art training experience. Furthermore, it is where the large majority of breakthroughs in health research occur and benefit Canadians in terms of improved health status, new ways of delivering health care services, and contribute to our ability to reach our economic potential as a nation.

By virtue of their mission and mandate, ACAHO is of the view that teaching centres are in fact, not only a local, regional and/or provincial and territorial resource, but are an inter-provincial/territorial or "national" resource that has the competency and capacity to address a broad range of health care needs. If one accepts the "trinity" of patient care, education and health research that defines the mission and mandate of teaching centres, then the logic should be extended such that teaching centres must be recognized as a national resource.

Given the national responsibilities of teaching centres, ACAHO believes that there is an important and strategic role that the federal government can play in accelerating system renewal, excellence and innovation at all levels – with the ultimate beneficiary being Canadians in terms of improved access to cost-effective health care services. Specifically, ACAHO recommends: *"That the federal government, in close collaboration with the provinces and territories, teaching centres and regional health authorities, establish a National Teaching Centre Health Infrastructure Fund."*

Such a fund would assist teaching centres in renewing its capacity to provide Canadians with timely access to quality health care; develop the physical capacity to train tomorrow's health care professionals, replenish our investment in proven medical technologies; re-vitalize our ability to introduce new health information capabilities that promote system efficiencies and cost-effective clinical and administrative decision-making; and ensure that there is adequate physical infrastructure and capital investment in the system.

In addition to the infrastructure challenges that the system is facing, ACAHO would draw to the attention of the Standing Committee the challenges of ensuring that we have an adequate supply mix and distribution of health care professionals across the country.

#### **THE STATUS OF FISCAL FEDERALISM – THE NEED TO STABILIZE THE SYSTEM**

ACAHO believes the time has come for the federal and provincial territorial governments to solve their differences when it comes to re-establishing the federal role in funding health care. Specifically, the federal and provincial and territorial governments need to develop a new fiscal framework for health which includes: (1) a clear and mutually-agreed definition of what constitutes federal funding for health; (2) the creation of a health-specific federal cash transfer; (3) a five-year “rolling” fiscal framework for health care; and (4) the funding arrangement should be reviewed on a quinquennial basis and at the same time as the equalization program.

In addition to direct federal cash investments in the health care system ACAHO also believes that it is time to review how tax policy in Canada can better support health care policy. By reviewing the interaction between direct cash and tax policy instruments, we should look for opportunities that can improve Canadians’ access to a range of quality health care services, and introduce positive incentives into the system.

#### **THE CONVERGENCE OF HEALTH RESEARCH AND INNOVATION**

When it comes to health research in Canada, ACAHO is very supportive and strongly encouraged by the federal government’s ongoing commitment to the “national” role that medical discovery and innovation plays in the lives of Canadians. As a result, a number of recent initiatives have been created with a pan-Canadian vision and mandate. They include: Canadian Institutes for Health Research (CIHR); Canada Foundation for Innovation (CFI); Genome Canada; Canada Research Chairs (CRC); and the indirect costs associated with health research

ACAHO is also encouraged by the federal government’s focus on health research and its relationship to producing a more energetic and innovative society. Given the focus of the upcoming National Summit on Innovation and Learning, ACAHO looks forward to contributing to the emerging action plan in both of these key policy areas.

As a result of these initiatives, members of ACAHO have made significant investments in infrastructure in support of the federal government’s innovation agenda in health and biomedical sciences by supporting a wide range of health research initiatives both within our facilities and in our related research institutes.

Building on these recent policy announcements by the federal government, ACAHO would strongly encourage the federal and provincial and territorial governments to continue to accelerate their investments for direct research as well as their indirect costs.

## **CONCLUDING REMARKS**

In closing, ACAHO believes that it has offered to the Standing Committee on Finance a series of policy measures that are consistent with the values of Canadians, and focus on the strategic combination of financial and structural initiatives that are required to place teaching centres and the health care system on a more sustainable footing, now and into the future.

As the process continues, ACAHO looks forward to being an active and constructive partner in the national dialogue about the future of health care in Canada.

## **SUMMARY OF RECOMMENDATIONS**

### ***Recommendation 1***

*That the federal government, in close collaboration with the provinces and territories, teaching centres/hospitals and regional health authorities, establish a National Teaching Centre Health Infrastructure Fund.*

### ***Recommendation 2***

*That the federal, provincial and territorial governments, in close partnership with providers and educators, institutions and administrators, develop and implement a comprehensive national strategy for health human resource planning in Canada.*

### ***Recommendation 3***

*With the objective of improving overall financial system accountability, visibility and transparency, the federal government negotiate with the provinces and territories a new fiscal framework for health care which would include:*

- *A clear and mutually-agreed definition of what constitutes federal funding for health*
- *The creation of a health-specific federal cash transfer*
- *A five-year “rolling” fiscal framework for health care*
- *The funding arrangement should be reviewed on a quinquennial basis and at the same time as the equalization program*

### ***Recommendation 4***

*With the objective of producing positive health outcomes, all levels of government should re-examine the relationship between tax policy instruments and direct cash investments in the health care system.*

### ***Recommendation 5***

*That the federal government continue to increase the base budget of the Canadian Institutes of Health Research (CIHR) in a step-wise fashion until it is equivalent to 1% of total health care spending in Canada.*

### ***Recommendation 6***

*That the federal government establish a permanent funding arrangement to address the indirect costs associated with health research, and increase its funding from a base of \$200 million to \$400 million.*

## INTRODUCTION

As the national voice of teaching centres/hospitals in Canada, the Association of Canadian Academic Healthcare Organizations (ACAHO) appreciates the opportunity to participate in the ongoing public consultation process established by the House of Commons Standing Committee on Finance.

At this point in our country's history, ACAHO is of the strong view that the release of the reports of the Standing Senate Committee on Social Affairs, Science and Technology (i.e., Kirby) and The Royal Commission on the Future of Health Care in Canada (i.e., Romanow) presents the federal government with an important, if not historic opportunity to contribute in redefining our collective vision of health and health care, renew our commitment to a health care system that is national in character, and re-build our leadership capacity to place our cherished health system on the road to long-term sustainability.<sup>1</sup>

As a consequence, there is no better time than the present for the federal government to consider a series of pragmatic and collaborative policy options that will renew our collective support for a health care system that is pan-Canadian in design.

The term pan-Canadian is used not because it is clear that all Canadians have placed a high priority on the future of health care from coast-to-coast. Rather, while there have always been a number of different policy approaches that the provinces and/or territories have introduced, ACAHO believes that there are a series of important "national" foundational principles and structural building blocks upon which our health care system must be built on if it is to be adaptable, responsive, innovative, cost-effective and accountable. Simply put, the challenge at hand is to build a system that is sustainable over the short-, medium and longer-term.

In this regard, ACAHO would agree with the Government's recent Speech from the Throne which observed "*no issue touches Canadians more deeply than health care. Our health care system is a practical expression of the values that define us as a country. Of the willingness of Canadians to share risk and accept responsibility for one another.*"<sup>2</sup>

As the number one public policy issue identified by Canadians, they should ask no less of the federal government and those who are the guardians of the public interest when it comes to the future of Medicare. Furthermore, expectations remain high that the federal government will continue to play a significant role in facilitating system renewal and innovation.

To ensure that Canada's health care system is placed on the road to short-, medium- and longer-term sustainability, ACAHO has developed a series of recommendations that focus on the twin public policy objectives of: (1) implementing targeted, strategic federal investments that are required to accelerate system renewal and re-structuring, and embrace new innovative approaches to organize, manage and deliver care; and (2) determining an ongoing level of federal funding that is required to place the health care

system on firm financial ground and will facilitate timely access to cost-effective quality health care services.

In many respects, the former can be considered as “*transitional*” funding and the latter as “*fixed*” funding, that when combined, will allow the system to rejuvenate itself and respond to the evolving expectations and needs of Canadians – ultimately transforming the structure of the health care from where it is, to where it needs to be.

The recommendations underscore ACAHO’s view that while there is an urgent need to review how we design the system’s architecture, we do not have the sole option of reorganizing ourselves out of the current set of policy circumstances; the federal government must be prepared to introduce a combination of strategic investments that are short-, medium- and long-term in nature that will not only stabilize the system in terms of meeting the health care needs of Canadians today, but will give the system the flexibility to adapt to future demands.

In so doing, it will be important to build a bridge between the spectrum of current policy challenges facing the health care system and their longer-term solutions if society is to construct a sustainable health care system for tomorrow. From the perspective of teaching centres/hospitals in Canada, ACAHO has identified a series of specific policy recommendations for the consideration of the House of Commons Standing Committee on Finance.

## **MEMBERS OF ACAHO – THEIR ROLES AND RESPONSIBILITIES**

Prior to focusing on the policy issues and challenges that are relevant to ACAHO and the federal government, it is important to have a clear understanding of the roles and responsibilities that teaching centres/hospitals fulfill in the Canadian context.

With the exception of Ontario, teaching centres comprise a network of single hospital organizations or multi-site regional facilities with clinical programs ranging from primary care to highly specialized (i.e., tertiary and quaternary) health care services, and are governed by a regional health authority structure (Appendix A includes a list of members of ACAHO).

In addition to patient care, a distinguishing characteristic of teaching centres is that they have formal institution-to-institution partnerships with universities. As a result, teaching centres work closely with the sixteen universities and their faculties of medicine in the provision of undergraduate and post-graduate medical education (also defined as Academic Health Sciences Centres [AHSCs]).<sup>3</sup> They may also have formal relationships with other faculties of health (e.g., nursing, pharmacy, and dentistry) and many colleges with technical and professionals in health including physiotherapy, rehabilitation therapists, laboratory technicians, respiratory therapists, speech therapists and social workers. Ultimately, teaching centres play a critical role in educating and training the next generation of Canada’s best and brightest health care professionals.

Importantly, teaching centres also provide most of the physical infrastructure to support and conduct basic and applied health research, medical discovery and innovation. In so doing, teaching centres contribute to the acceleration of scientific discovery and knowledge creation that can have three identifiable impacts that are mutually reinforcing. In effect, members of ACAHO are “centres of health innovation” and house the research braintrust that is laying down the foundation for Canada to maximize its contribution to the biotechnology revolution, for example.

First, medical discovery, knowledge creation and innovation has played an invaluable role in improving the overall health status of Canadians. Second, research and innovation has and will continue to evolve the manner in which health care services are delivered to Canadians. In fact, most new health discoveries and treatments are pioneered in Academic Health Science Centres, and reinforce the linkage between today’s health research is tomorrow’s health and health care.

Finally, growing investments in health research re-position Canada in terms of becoming a leader in knowledge creation and developing new breakthrough treatments and procedures that can be of benefit not only to Canadians - but the rest of the world. As a result, monies dedicated for health research contribute to developing both an attractive entrepreneurial climate as well as an engine of future economic growth and sustained prosperity.<sup>4</sup> Strictly from an economic and social policy point of view, investments in health research can bring with it new employment opportunities, higher incomes, growing wealth, and a robust tax base that could support a range of publicly-funded social programs in Canada.

Combined, the tri-lateral mission of patient care, education and health research uniquely defines the contribution of teaching centres, and allows them to fulfill a series of essential public policy objectives:<sup>5</sup>

- They are the “hospital of last resort” for the majority of intractable and complicated patient illness that cannot be treated in other hospital settings (i.e., small and community-based hospitals). They also provide a significant amount of day surgery and ambulatory care – some of which is highly complex.
- Academic clinicians play a key role in promoting integrated models of service delivery.
- In addition to serving local and community health needs, they also respond to regional, provincial and inter-provincial and territorial requirements.
- They provide most of the infrastructure that facilitates the “classroom to bed-side” medical education experience.
- They train the whole spectrum of health care professionals and health researchers who are later employed in all local, community, regional, provincial and territorial and industrial settings.
- They introduce new ways of delivering care by developing and evaluating new therapies, treatments and technologies.
- They provide the leading health researchers in the country with the infrastructure to conduct research that leads to medical discovery, knowledge creation and innovation.

- They substantially contribute to health research and its spin-off effects that have implications well beyond teaching centres.
- The multi-dimensional and multi-level nature of academic health science centres provides teaching centres with the resources and competencies to diagnose and treat a range of complex health care issues.
- They have developed a multi-dimensional and profound research-focused relationship with university affiliates, and have nurtured partnerships with other basic science, business, engineering and agricultural faculties.
- They are key participants in national health policy initiatives such as the federal government innovation agenda, health human resource planning, health information requirements and the development, introduction and evaluation of new technologies.
- Combined, the scope of activities and responsibilities transcends local, regional and provincial and territorial boundaries and defines teaching centres as a true national resource.

From an economic standpoint, collectively members of ACAHO have budgets in excess of \$16 billion of which more than ninety per cent is derived from the public sector. This means that approximately fifty per cent of public monies devoted to all hospitals in Canada are allocated to teaching centres. Framed slightly differently, teaching centres in Canada account for almost one of every five dollars allocated to the health care system.<sup>6</sup> In addition, our members employ over 150,000 Canadians.

When combined with the substantial amount of research funding that flows to our members, Academic Health Science Centres are responsible for generating a considerable amount of economic activity in every community and region it serves. Furthermore, given the configuration of our health care system, teaching centres play an important role in contributing to the competitive advantage that our system offers.<sup>7</sup>

In the view of ACAHO there are a number of important and multi-faceted roles that teaching centres play when it comes to the funding, organization, management and delivery of health care. As a consequence of our members' mission and mandate, no other organization in the health care system provides the unique combination of services that teaching centres are responsible for. In absence of their recognition and resolution, ACAHO is concerned that Canadians will continue to experience difficulties in accessing quality health care services delivered by teaching centres on a timely basis. Given this reality, ACAHO holds the view that our member institutions are an essential "hub" in the health care system, and must be part of the public dialogue when it comes to the future of health care in Canada.

The reality, however, is that the roles and responsibilities of teaching centres have been left largely unaddressed in the current national health policy discussions.<sup>8</sup> Through the 1990s, the federal, provincial and territorial governments have established a series of Commissions to review the health care system. While this work has been completed, ACAHO observes that there has been limited focus on the multiple roles and responsibilities, and the overall value that teaching centres contribute to the system has been largely ignored. As a consequence, there has been a limited opportunity for

ACAHO and its members to proffer its views about what is required to place the system on a more sustainable footing.

It is an understatement to say that the past decade has introduced a constant flow of challenges not only to those who provide care, but to those who are responsible for the day-to-day management of the system. Understanding that health care systems are dynamic in nature, members of ACAHO are senior administrators who have been “on the ground” and at the cutting edge of system renewal and change management at the provincial level – be it the re-organization of teaching centres, or the overall evolution and functioning of regional health authorities.

Given their years of experience in working in senior capacities in complex health care organizations, members of ACAHO bring to the national discussions a significant depth of knowledge and understanding of how the system functions – with a particular focus on how health care is funded, organized, managed and delivered – underscored by a firm commitment to excellence in what they do.

Knowing that the future of the health care system is at an important crossroads, ACAHO is of the view that there is much benefit to be had in terms of sharing perspectives and building constructive partnerships. Thus, from both a process and content point of view, ACAHO is strategically positioned not only to develop a national consensus amongst its members but to participate and contribute to the national health policy discussions.

## **THE POLICY LANDSCAPE**

Not unlike other components of the health care system, hospitals, regional health authorities and in particular, teaching centres have had to adapt to a turbulent financial and health policy environment. As a consequence of all governments looking to place their financial houses in order, hospitals – which account for the largest single expenditure in health – have seen their overall share of total health expenditures cut from approximately 40 per cent in 1990 to almost 30 per cent in 2000.<sup>9</sup> In response, acute care institutions have had to re-examine ways in which they can stretch each health care dollar when it comes to ensuring timely access to cost-effective quality care.

As a consequence of fiscal downsizing both at the provincial and territorial, and federal government levels, there has been significant variation in year-over-year public per capita expenditures on hospitals through the 1990s.<sup>10</sup> This has had a major impact on how institutions plan to meet current and future service requirements – particularly in the context of an aging population and rising patient expectations for timely care. Furthermore, in absence of a stable and predictable funding environment, teaching centres have experienced difficulty in maintaining bed capacity and staffing levels, renewing its technological capacity, capital requirements, and physical infrastructure. In short, in absence of a transparent and predictable multi-year financial framework for teaching centres, planning at all levels has been strained.

In addition to the internal policy challenges that teaching centres are facing, most provinces have reconfigured their health care systems via regionalized governance structures, and have implemented different variations of primary (health) care reform.

In sum, the past decade has highlighted the observation that constant change has been the rule, and stability and predictability the exception.

While teaching centres have introduced a number of efficient and cost-effective policy measures that contribute to doing more with less, there is also the concern that they have moved to the stage of “doing less with less.” As a result, staff shortages, outdated medical and health information technologies, reduced bed capacity, more expensive and complex treatment options, and limited capital investment coupled with insufficient funding are colliding against one another and testing the sustainability of the original building block of Medicare.

In addition to these elements which contribute to the overall capacity of teaching centres are the current and impending pressures of a growing and aging population. Not only are patients presenting with more complex and severe cases of illness, but are (and will continue to) expecting that quality health care be available on a timely basis.

While patient care issues are clearly important to the mission and mandate of teaching centres, we must not also lose sight of their responsibilities for medical education and health research – which are also under considerable pressure.

## **SUSTAINABLE FUNDING AND SYSTEM CAPACITY**

If there is one word that has captured the policy discussion when it comes to the future of health care in Canada it is “sustainability.” While the term is most frequently used in the context of less than satisfactory levels of public funding for health care and the ability of the governments to fund future increases, it is essential that we recognize that sustainability also reflects other critical dimensions of the system - particularly, the physical infrastructure (e.g., beds, equipment and buildings), the dissemination of new technologies (i.e., medical and health information) and perhaps most importantly, concerns about the future supply, distribution and mix of health human resources across the country ( e.g., physicians, nurses, technicians, allied health care professionals and health administrators). This also applies to our collective ability to generate new knowledge and innovate.

Based on our analysis of the issues, ACAHO is of the view that the health care system - while not in irretrievable crisis - is significantly stressed. If the recent past and present continues to be our future, then the system will continue to spiral downwards towards major collapse. While there is an urgent need to review how we design the system’s architecture, we do not have the sole option of reorganizing ourselves out of the current set of policy circumstances; governments at all levels must be prepared to make strategic financial commitments that will not only stabilize the system in terms of meeting the

health care needs of Canadians today, but will give the system sufficient flexibility to adapt to future demands.

In this context, funding is a *policy means* to an end and not an end unto itself – with the ultimate objective of the health care system to provide access to cost-effective, quality health care services in a timely manner to all Canadians.

Broadly speaking, ACAHO believes that the most effective manner in which to discuss how we can stabilize our health care system is to focus on two separate, but related policy thrusts. The first envelope has to do with the series of “*transitional*” strategic investments that are essential to accelerate system renewal and embrace new innovative approaches of delivering care.

The second funding envelope has to do with the ongoing level of “*fixed*” funding for the health care system that will facilitate timely access to cost-effective quality health care. Combined, ACAHO is proposing an integrated approach that examines the principle of system sustainability from both a funding and structure perspective.

Fundamental to the public discussion about the future of the health care system is the notion of how we introduce incentives so that all of the “working parts” are better synchronized. Ultimately, the issue is how can the system as a whole provide more value than each individual component. At a minimum, this implies that different components of the health care system need to move together such that a number of explicit health and public policy objectives can be achieved, including: timely access, quality, accountability, effectiveness, efficiency, integration and innovation.

At the same time, it also suggests that the system should avoid situations where good health policy decisions are negated or offset by other segments of the health care system that may be moving in a different direction(s). In a generic sense, this suggests that the *form(s)* of policy decisions should be in keeping with their respective *function(s)*. If the overall functioning of the health care system is more effectively integrated, then the form of policy decisions are likely to be mutually reinforcing.

Finally, while addressing concerns about the overall architecture of the health care system is vital to the discussion, it is not in-of-itself the sole answer to our woes. This point is raised because it is the view of ACAHO that there is a symbiotic link between how we structure the system, through what mechanism(s) we finance health care, and at what level it should be funded.

## **INVESTING IN CANADA’S HEALTH CARE SYSTEM OF THE 21<sup>ST</sup> CENTURY – THE ROLE OF THE FEDERAL GOVERNMENT**

By virtue of their mission and mandate, members of ACAHO are “centres of health innovation.” As a result, they are leading-edge research-driven organizations that have the capacity to improve the health status of Canadians, revolutionize how health care is delivered, and significantly contribute to our economic potential as a nation. Combined,

teaching centres are powerful engines of system-based change. However, in order to fulfill this mandate now and into the future, there is an important need to invest in the infrastructure of teaching centres/hospitals.

In this context, ACAHO is of the view that the federal government has an essential role to play not only in terms of working collaboratively with the provinces and territories to ensure that our health care system is truly national in scope, but also through a combination of “transitional” and “fixed” investment approaches that strengthen our ability to meet the health care needs and expectations of Canadians in the 21<sup>st</sup> Century.

The remainder of the Brief therefore focuses on two specific approaches in which the federal government can make lasting contributions that serve to accelerate how we reconfigure the structure of our health care system, while ensuring that it remains vibrant over the longer-term time horizon.

Specifically, ACAHO strongly believes that the federal government should introduce (and in some cases continue to make) a combination of targeted and time-limited strategic investments that serve to renew the infrastructure of the health care system. At the same time, as a guardian of Medicare, the federal government also has a public responsibility to contribute its fair share on an operational funding basis to ensure that system provides timely access to Canadians in need.

## **DISCOVERING A “NATIONAL RESOURCE”...CANADA’S TEACHING CENTRES**

Understanding that health care systems are dynamic in nature, it is critical, from the perspective of ACAHO to review the roles and responsibilities teaching centres so that they will continue to meet: (1) the changing health care needs of Canadians by providing timely access to quality specialized (i.e., tertiary and quaternary) health care services; (2) the educational needs of trainees; and (3) research requirements of scientists.

While the breadth and depth of health care services that are housed within Canada’s teaching centres are fully accessible by a local community or region, the fact is that their mission and mandate extends their catchment area to other communities and regions, and across provinces and territories.

By their very nature, teaching centres, which offer a range of highly specialized tertiary and quaternary health care services, extend across geographic boundaries unlike other components of the health care system. In fact, the notion of developing regional (i.e., inter-provincial) centres of excellence was recently identified at the January 2002 meeting of First Ministers.<sup>11</sup>

If health research is the lifeblood of medical discovery and innovation, then so too is the training of health care professionals vital to the overall functioning of the system in providing timely access to quality health care. Clearly, the role that teaching centres fulfill in terms of educating health care professionals goes well beyond supplying graduates for careers within their own respective institutions or local community or

region. As a result, teaching centres are “the” hands-on educational training ground for most health care professionals in the country.

Finally, while all teaching centres are engaged in a number of health research activities, it is clear that the benefits of medical discovery, knowledge creation and innovation are intended to be shared not only with all Canadians – but the rest of the world.

Combined, the points above illustrate the reality that teaching centres are in fact, not only a local, regional and/or provincial and territorial resource, but are an inter-provincial/territorial or “national” resource that has the competency and capacity to address a broad range of health care needs. If one accepts the “trinity” of patient care, education and health research that defines the mission and mandate of teaching centres, then the logic should be extended such that teaching centres must be recognized as a national resource.

From ACAHO’s perspective, the public policy challenge then becomes what role is there for the federal, provincial and territorial governments to address the national roles and responsibilities of teaching centres in Canada? More specifically, how can governments nurture and support the role of teaching centres in a system that is experiencing profound change?

Furthermore, how would the designation of teaching centres as a “national resource” allow the federal government, in close collaboration with the provinces and territories, to play a vital and recognized role in supporting continued access to health care services and the training of health care professionals and researchers , in addition to playing a key role in promoting innovation in the system at all levels.

As a national resource, ACAHO supports the view that teaching centres would continue to receive a large proportion of their funding from the public sector to ensure that: (1) patients have ready access to highly specialized quality health care services in times of need; (2) financial barriers to education and training are minimized; and (3) knowledge creation and its contribution to medical discovery and innovation are strongly supported.

ACAHO therefore recommends:

***Recommendation 1***

***That the federal government, in close collaboration with the provinces and territories, teaching centres/hospitals and regional health authorities, establish a National Teaching Centre Health Infrastructure Fund.***

The recommendation reinforces the view that there is an important and strategic role for the federal government to be a direct contributor that would assist teaching centres in continuing to evolve and fulfill their mission and mandate. In many respects, ACAHO views the proposed contribution by the federal government to be a “catalyst” in

accelerating system renewal, excellence and innovation at all levels – with the ultimate beneficiary being Canadians.

The Fund, which would be time-limited and targeted by nature, would focus on conditional investments in the infrastructure of teaching centres; specifically: (1) health human resources; (2) medical technologies; (3) health information technologies; and (4) physical and capital requirements – all of which contribute to the delivery of quality health care services to Canadians.

In the view of ACAHO, the Fund would assist teaching centres in:<sup>12</sup>

- renewing its capacity to provide Canadians with timely access to quality health care services
- developing the physical capacity required to train tomorrow’s health care professionals
- replenishing our investment in proven medical technologies
- re-vitalizing our ability to introduce new health information capabilities that promote system efficiencies, cost-effective clinical and administrative decision-making and ongoing health research, and
- ensuring that there is adequate physical infrastructure and capital investment in the system

Importantly, such a Fund would require teaching centres to develop a strategic and cohesive approach as to how new resources should be allocated, in close consultation with the funding partners. It should be based on a renewed vision of how this “national resource” could be reconfigured from the status quo into more cost-effective partnerships that support a complementary rather than competitive approach.

The recommendation also emphasizes the important role that teaching centres play in terms of offering proactive and creative solutions that seek to improve the overall structure of the health care system, and have a positive impact on Canadians’ access to care.

It is also important to note that this would not be the first time that the federal government has established a time-limited, targeted fund to promote excellence and innovation in the health care system that has an impact on Canadians’ access to quality care. This is in reference to the Hospital Construction Grants in Program (1948), the Health Resources Fund (1965), the Health Transition Fund (1997), and the First Ministers’ Agreement (2000).

In the view of ACAHO, the proposal to create a *National Teaching Centre Health Infrastructure Fund* is about looking to the future and ensuring that there is adequate infrastructure to meet the changing health care needs of Canadians.

It is also about the need for federal leadership and the important synergies that can be nurtured between teaching centers and the federal government – who are both focused on excellence and innovation in health care that will, above all, be of benefit to Canadians in times of need.

As a result of this proposal, ACAHO would highlight some of its important public policy benefits:

- The federal government would continue to re-establish its leadership role by directly contributing to programs that are designed to provide Canadians with timely access to quality health care
- Resources allocated to “national” teaching institutions supports excellence and promotes innovation at all levels of their mission and mandate
- The fund would be an important driver of improving overall system efficiency, cost-effectiveness and integration
- It reinforces financial accountability in terms of linking federal resources with its intended “national” uses
- Would provide teaching centres with time-limited, and strategically targeted funding with the flexibility to allocate the funds in defined areas based on their individual requirements
- This proposal is not unique. In fact, there is precedent in terms of the federal government making funds available for health system infrastructure requirements (i.e., Hospital Construction Grants Program (1948), Health Resources Fund (1965), Health Transition Fund (1997), and First Ministers’ Agreement (2000)).

Based on our analysis, ACAHO is of the view that the four components will require an annual investment in the range of \$1.2 billion over a five to ten year time horizon. In this regard ACAHO is strongly encouraged that the Kirby Committee has made a number of recommendations in this area.

In specific terms, the Committee has made recommendations that focus on Academic Health Science Centres in the areas of: physical infrastructure (\$4.0 billion over ten years); medical equipment (\$2.0 billion over five years); and health human resources (\$75 million over five years).<sup>13</sup>

Given the structural pressures that all members of ACAHO are facing, we would strongly urge the Standing Committee on Finance to give serious consideration to these recommendations.

#### HEALTH HUMAN RESOURCES

In addition to the infrastructure challenges that the system is facing, ACAHO would draw to the attention of the Standing Committee the challenges of ensuring that we have an adequate supply mix and distribution of health care professionals across the country.

While the development and introduction of medical technology continues to play a growing role in the delivery of health care, we must remember that the “art and science of medicine” remains an intensely private, compassionate and labour-intensive responsibility.

Whether it is physicians, nurses, pharmacists or allied health care professionals (e.g., technicians, physiotherapists, rehabilitation specialists), concerns continue to be expressed by a number of provider groups that the current and future supply of health care professionals is not able, now or into the future, to meet the demand for health care, education, research and administration.<sup>14</sup>

To underscore the importance of this issue, a recent national consultation on research priorities for health services and policy issues noted that “health human resources was seen as the dominant issue for the next two to five years by policy makers, managers and clinical organizations. The concerns of policy makers included regulatory frameworks, mechanisms for avoiding cycles of surplus/shortage, and the leadership vacuum within management and policy-making organizations.”<sup>15</sup>

Notwithstanding the policy issues related to accessing health care providers on a timely basis - which is essential to the mission/mandate of teaching centres, ACAHO is also concerned about the system’s ability to train an adequate number of health care professionals. This latter point underscores one essential role of teaching centres in Canada – which provides virtually all post-graduate specialty and sub-specialty health care professional training (e.g., physicians, nurses, pharmacists, dentists, physiotherapists, rehabilitation, researchers).

While other organizations have spoken persuasively to the issues related to health human resource planning, ACAHO would like to make three points: (1) given the competitive inter-provincial and territorial, and international environment for health care professionals, it would serve Canada well to adopt the principle of national self-sufficiency; (2) given that health care professionals are well-trained and highly mobile, we need to develop a national health human resource strategy; and (3) we need to ensure that we have a critical mass of health educators so that they can teach, provide care and undertake research, and continue to attract the best and brightest into the health professions.

While the provinces and territories have overall jurisdictional responsibility for the administration of their health care systems, we must acknowledge that they are all facing similar challenges when it comes to addressing issues of supply, mix and distribution of health care professionals. At a result, all provinces and territories are competing for the same stock of providers; where some provinces have won, other have lost. At this time, it would be prudent to develop a national policy framework that facilitates a “win-win” approach to health human resources planning in Canada.

While the policy implications of the current and future supply of health human resources has been framed exclusively as a provider issue, we must also recognize that health care administrators are also facing many of the same policy challenges.<sup>16</sup> Health professions are becoming less and less attractive and are not competitive with other knowledge-based industries.

Fundamentally, the reality for health care administrators – many who work within large and complex governance structures – is that the workforce is aging; they have experienced reductions in senior and middle management positions, and have difficulty in attracting new recruits. At a time when the health care system is looking to implement more accountable and performance-based structures, we need to re-think the planning model that will produce our leaders of the future who will have the vision and competency to effectively manage the system.

ACAHO respectfully recommends:

***Recommendation 2***

***That the federal, provincial and territorial governments, in close partnership with providers and educators, institutions and administrators, develop and implement a comprehensive national strategy for health human resource planning in Canada.***

As part of the recommendation, this strategy could include the development of a permanent national consultation and policy development structure (e.g., National Council on Health Human Resources).

**THE STATUS OF FISCAL FEDERALISM – THE NEED TO STABILIZE THE SYSTEM**

Through the 1990s, the federal, provincial and territorial governments have engaged in a veritable war of words when it comes to the federal government’s contribution, or lack thereof, in support of health care. Not unexpectedly, much of the intense inter-governmental discussion occurred following the introduction of the Canada Health and Social Transfer (CHST) in April 1996. That said, one must not lose sight of the many unilateral changes introduced by the federal government in the early 1990s, and go as far back as 1983 that have affected its contribution to health and other social programs.<sup>17</sup>

It is important to keep in mind that the CHST is an amalgam of Established Programs Financing (EPF) and the Canada Assistance Plan (CAP), and although it was framed by the federal government as giving the provinces and territories “added flexibility” in allocating resources, the reality was that CHST cash was decreasing from \$18.5 to \$12.5 billion (or 32 per cent) over two years. This is an important point, because in the minds of many the CHST is portrayed as a “health transfer” when in reality it is intended to also focus on post-secondary education, and social assistance and social service programs.

More recently, in September 2000, First Ministers agreed to a “health agreement.” While the agreement includes a six-year fiscal framework (which will be reviewed before the end of 2003/04), it returns the CHST cash floor to its equivalent 1994/95 level of \$18.7 billion in 2003/04 – nine years after the fact with no adjustment for a growing and aging population, or inflation. It also includes time-limited transitional monies for medical equipment, health information technologies and primary care. In addition, all governments supported an action plan for system renewal which included the development of performance indicators.

Since that time, there have been ongoing discussions between the provinces and territories who are looking to re-balance the fiscal relationship with the federal government. Specifically, it is contended that the federal government has a disproportionate control over public revenues, while the provinces and territories have a disproportionate responsibility over expenditures (known as vertical fiscal imbalance).<sup>18</sup>

Moreover, the provinces and territories (most notably Ontario and Alberta) claim that the federal government contributes no more than 11 to 14 cents of each health care dollar. More recently, Ontario has led the charge demanding that the federal government increase the CHST contribution from 14 cents to 18 cents of each health care dollar spent.<sup>19</sup>

In response, the federal government has claimed that from 2000/01 to 20005/06 it has increased the CHST cash transfer, on a cumulative basis, by \$18.9 billion for health care. In addition, if one includes the value of the tax point transfer, their contribution in support of health care increases to roughly 33 per cent of each health care dollar.<sup>20</sup> Moreover, if equalization is also included as part of the federal government’s contribution, the federal share could be as high as 40%.

While seen as a moot point, ACAHO believes that it is time that the federal, provincial and territorial governments must have a clear definitional framework from which to understand and agree on what level of funding is coming from what level of government. Based on the current discussion, ACAHO would share the view that the value of the *transferred* tax points is now an exclusive component of provincial revenue (while recognizing the federal government’s historical contribution), for the following reasons:<sup>21</sup>

- The tax point transfer was negotiated by the federal and provincial governments.
- The tax point transfer was effectively incorporated into the federal government’s and provinces’ tax structure.
- The value of the tax points are considered “own-source” provincial revenue.
- The federal government has no ownership or control over how provincial tax revenues are collected or allocated.
- The federal government has no ability to “withhold” tax revenues if a province is in violation of the *Canada Health Act*.
- The link between CHST cash and the value of the tax points has been effectively severed.

The irony, however, is that while the provinces and territories have fought for increases in federal funding specifically for health care, the current CHST mechanism is poorly designed to accomplish this public policy objective. More pointedly, no one can say with definitive certainty what the federal government's cash contribution to health care is. The lack of fiscal accountability has been recognized by the Auditor-General of Canada and the Canadian Institute for Health Information, and other national health associations.<sup>22</sup>

This point becomes even more significant when one recognizes the importance of the First Ministers' Health Agreement that was negotiated in September 2000.<sup>23</sup> The Agreement links the reinvestment of federal cash with improved system accountability and the introduction of performance indicators that each province and territory would report to their own residents. Ultimately, if the federal government is seeking increased accountability in how the system is functioning, then it should also be held to that very standard when it comes to funding health care (i.e., what is the federal government's contribution to health?).

More recently, we have witnessed the provinces and territories squabble amongst themselves and with the federal government about the distribution of federal monies through the Equalization program. While the program is constitutionally mandated to provide "comparable levels of service at comparable levels of taxation," discussion has focused on the formula-driven distribution of monies – by those provinces who are concerned that they are "over-contributing", and others are demanding access to additional federal monies.

All together, it is not difficult to see why the provinces and territories have been at loggerheads with the federal government when it comes to funding health and social programs in Canada. That said, it is time to rise above the rancorous debate and develop a long-term approach that both levels of government can live with – Canadians expect no less of their governments.

From a structural standpoint, ACAHO would support a new fiscal transfer mechanism that would account for how much cash the federal government allocates to the provinces and territories in support of health care; that is, a health-specific cash transfer. It would also minimize the constant bickering about Ottawa's contribution level in support of health care.<sup>24</sup>

In addition to the creation of a federal health-specific cash transfer, it will also be important to ensure that the provinces and territories have an opportunity to plan not only for the coming year, but over the medium- to longer-term horizon. Over the past few years, members of ACAHO have firsthand experience of how the lack of a predictable and stable funding formula can negatively impact on program funding and de-stabilize the delivery of care. To minimize the impact of changes in the fiscal environment, ACAHO would prefer to see a "rolling" five-year federal fiscal framework in support of health care.

### ***Recommendation 3***

***With the objective of improving overall financial system accountability, visibility and transparency, the federal government negotiate with the provinces and territories a new fiscal framework for health care which would include:***

- ***A clear and mutually-agreed definition of what constitutes federal funding for health***
- ***The creation of a health-specific federal cash transfer***
- ***A five-year “rolling” fiscal framework for health care***
- ***The funding arrangement should be reviewed on a quinquennial basis and at the same time as the equalization program***

Combined, the above recommendations would achieve a number of explicit public policy objectives:

- The federal government would explicitly link *sources* of money with their intended *uses* at the provincial and territorial level
- The provinces and territories would still have the flexibility to allocate monies to address their specific health needs
- The federal government would receive full recognition for their schedule of investments
- A predictable federal funding mechanism would allow the provinces and territories to manage and plan more effectively
- Would de-politicize the process by which the federal government contributes in support of health

While the definition of, and level of federal cash in support of health care would be determined through negotiation, it is clear that the level of federal funding should be linked to its national stewardship role in maintaining a “national” health care system, and its ability to enforce the national principles of health insurance through the *Canada Health Act*. At the end of the day, “cash is king” and there is a critical need for the federal government to re-establish its leadership role (and moral authority) as an equal partner with the provinces and territories when it comes to system renewal at the national level.

The more unwilling the federal government is prepared to (re)invest in the health system, the more it will be viewed as being a non-player in facilitating change (i.e., no cash, no clout). This suggests that the federal and provincial and territorial governments must agree on not only what constitutes a reasonable financial base, but also how the federal cash transfer should grow over time.

To maximize the ability of the provinces and territories to effectively manage and plan for the future, a five-year fiscal framework for has been recommended. This principle has been recently announced by the government of Ontario (which has committed to a multi-year funding framework for hospitals).

The growth of federal cash in support of health care could either be determined by negotiation and/or formula. In the latter case, a three-year moving average of nominal gross domestic product per capita has been applied. In keeping with the current approach under the CHST, monies could be distributed on an equal per capita basis.

At the same time, if the federal government is to invest in the future of the health care system, there is a provincial and territorial *quid pro quo*. First, the provinces and territories must recognize and fully account for federal monies. Second, provincial and territorial governments must not “back out” their own resources that will be replaced by federal monies (known as the *test of incrementality*).

In the spirit of developing more harmonious approaches to social policy in Canada, ACAHO is of the view that this negotiation could be viewed as an extension of the Social Union Framework Agreement (SUFA) process. Specifically, that there should be improved accountability and transparency of social programs, and that the federal government should not introduce any new initiatives in health care, social assistance or education that is funded through intergovernmental transfers without the agreement of a majority of provincial governments.<sup>25</sup>

When it comes to re-defining the parameters of fiscal federalism, ACAHO would start with the analysis that concludes that approximately 62 per cent of the CHST can be notionally attributed to funding for health care.<sup>26</sup> If this holds, this means that in 2002/03, \$11.6 billion of the total CHST cash of \$18.7 can be segmented as the federal government cash contribution in support of health care. Framed another way, \$11.6 billion represents 15.7 per cent of provincial and territorial spending on health care (2002), and approximately 11.3 per cent of total health care spending (2001).<sup>27</sup>

ACAHO is also of the view that one proposal that merits further study was developed by Tom Kent.<sup>28</sup> The essence of the proposal is as follows:

- Remove the “S” from the CHST and create a new federal funding arrangement for health care.
- Ottawa would initially contribute 20 per cent of provincial/territorial health expenditures, and increase its share to 25 per cent by 2005/06.
- The increased share of federal funding would be conditional on the provinces and territories agreeing to meet specific objectives to renew the system.
- The transfer of federal monies for health care would be visible, transparent and fully accountable.
- The proportion would be big enough for the provinces and territories to spend their own resources wisely and comply with the *Canada Health Act*, and for the federal government to take a keen interest in allocating federal dollars efficiently and effectively.
- A proportionate funding formulae would not allow for any imposed unilateral policy change by the federal government.
- It would link the notion of shared system principles (as embodied in the *Canada Health Act*) to shared funding.

- The federal government would receive full recognition for the investment, and the provinces and territories would receive security of funding, with the flexibility to allocate it as they see fit.

Using this approach, the federal government's twenty-five per cent contribution in support of provincial and territorial publicly funded health care (standing at \$74.0 billion in 2002/03) would be approximately \$18.5.<sup>29</sup>

ACAHO fully recognizes that there is no non-arbitrary formula that will determine the appropriate annual level of federal cash for health care, however, it would appear that some parameters have been established between \$11.6 billion and \$18.5 billion.

In serving the best health interests of Canadians, ACAHO would encourage the federal, provincial and territorial governments to immediately find a lasting solution to a policy issue that impedes all levels of government to working in a collaborative fashion.

### **HEALTH POLICY AND TAX POLICY – SHALL EVER THE “TWAIN” MEET?**

Given that teaching centres/hospitals, in general, receive over ninety per cent of their funding from governments, it is not surprising that ACAHO has focused on the role of direct and indirect contributions from government agencies. That said, in addition to cash investments in the health care system, it is also important to consider how the tax system facilitates access to care.

This is an important point given that the discussion about funding has for the most part had a singular focus on cash and not on how tax policy can contribute to positive health outcomes. In principle, this is where good tax policy can reinforce good health policy decisions.

For example, how can we employ tax policy instruments to better meet the health needs of Canadians? For example, how can we use a combination of tax deductions, tax credits and refundable tax credits that would be targeted and assist Canadians in maintaining, restoring or enhancing their health status? Is there a larger role for such instruments when it comes to offsetting the costs of health care, such as prescription drugs and/or home care, or the purchase of new medical technologies and/or devices? In the latter case, should we be contemplating how a long-term care savings account could be of benefit to Canadians? Furthermore, how should we continue to reward companies who invest in wellness programs on behalf of their employees?

From a financing perspective, does this also mean that we should consider different ways in which the tax system can raise additional revenues for the health care system. For example, should we look at the merits of introducing a “taxback” proposal?<sup>30</sup> Or introduce a specific sales tax that would earmark revenues to health?

This approach also suggests that we also have to look at how the current tax regime impacts on the efficient allocation of resources in the system – such as the goods and services tax.<sup>31</sup>

Finally, to be complete, this approach also suggests that we should examine the current series of tax incentives that are required in order to facilitate knowledge creation, research and innovation in the health research community, and ultimately, how research is translated into commercial goods and services.

By reviewing the interaction between direct cash and tax policy instruments, we should look for opportunities that can improve Canadians' access to a range of quality health care services, and introduce positive incentives into the system.

In September 2002, an unprecedented group of tax experts and health organizations gathered to discuss the possible synergies that exist between tax policy instruments and health policy objectives in Canada.<sup>32</sup> This was an important first step in opening the dialogue about future policy options in this area. ACAHO encourages the Standing Committee to further consider this area of policy development.

ACAHO recommends:

***Recommendation 4***

***With the objective of producing positive health outcomes, all levels of government should re-examine the relationship between tax policy instruments and direct cash investments in the health care system.***

**THE CONVERGENCE OF HEALTH RESEARCH AND INNOVATION**

When it comes to health research in Canada, ACAHO is very supportive and strongly encouraged by the federal government's ongoing commitment to the "national" role that medical discovery and innovation plays in the lives of Canadians. As a result, a number of recent initiatives have been created with a pan-Canadian vision and mandate. They include:

- Canadian Institutes for Health Research (CIHR)
- Canada Foundation for Innovation (CFI)
- Genome Canada
- Canada Research Chairs (CRC)
- Indirect costs associated with health research

ACAHO is also encouraged by the federal government's focus on health research and its relationship to producing a more energetic and innovative society. Given the focus of the upcoming National Summit on Innovation and Learning, ACAHO looks forward to contributing to the emerging action plan in both of these key policy areas.

As a result of these initiatives, members of ACAHO have made significant investments in infrastructure in support of the federal government's innovation agenda in health and biomedical sciences by supporting a wide range of health research initiatives both within our facilities and in our related research institutes.

Taken together, these policy coordinated measures constitute a sound strategic policy framework in support of innovative practices which contribute to the delivery of health care services, our economic potential as a nation, and ultimately to the health status of Canadians.

#### THE MULTIPLE IMPACTS OF BASIC AND APPLIED HEALTH RESEARCH

Teaching centres/hospitals play an essential role when it comes to facilitating the advancement of health research, medical discovery, knowledge creation and innovation in Canada. They have also developed a multi-dimensional and profound research-focused relationship with university affiliates, and have nurtured partnerships with other basic science, business, engineering and agricultural faculties. In fact, teaching centres provide much of the physical infrastructure that supports Canada's health research community.

In so doing, teaching centres contribute to the acceleration of scientific knowledge that can have three identifiable impacts that are not mutually exclusive, but rather, are mutually reinforcing. First, medical discovery and innovation has played an invaluable role in improving the overall health status of Canadians.

Second, research and innovation has and will continue to evolve the manner in which health care services are delivered to Canadians. In effect, today's health research is tomorrow's health and health care.

Finally, growing investments in health research re-position Canada in terms of becoming a leader in developing new breakthrough treatments and procedures that can be of benefit not only to Canadians, but the rest of the world. As a result, monies dedicated to health research contribute to developing both an attractive entrepreneurial climate as well as an engine of future economic growth within an increasingly global and competitive knowledge-based environment. Strictly from an economic point of view, investments in health research can bring with it new employment capacity, higher incomes, growing wealth, and a robust tax base that would continue to support a range of social programs in Canada.

Resources for health research also serve to nurture the recruitment and retention of a highly skilled cadre of researchers who can discover new treatments and raise the potential for world-class research clusters.

In sum, investments in health research have the capacity to revolutionize our lives not only in terms of impacting on our health status and how we deliver health care, but also on our economic capacity and potential as a nation.

In an effort to better understand the relationship between investments in health research and their “rate of return” to Canadian society, the Health Research Advocacy Network (HRAN) - of which ACAHO is a member, will be releasing a discussion paper by the end of the year.<sup>33</sup>

ACAHO respectfully recommends:

***Recommendation 5***

***That the federal government continue to increase the base budget of the Canadian Institutes of Health Research (CIHR) in a step-wise fashion until it is equivalent to 1% of total health care spending in Canada.***

FUNDING CANADA’S HEALTH RESEARCH INFRASTRUCTURE

While ACAHO is of the view that funding for basic and applied health research must continue to increase over time, we must also ensure that we have the necessary physical infrastructure to take full advantage of our collective potential.

Members of ACAHO are very pleased to see that these issues have been explicitly recognized by the Minister of Industry’s white paper “*Achieving Excellence – Investing in People, Knowledge and Opportunity, Canada’s Innovation Strategy.*” In the paper the federal government commits to a number of measures by 2010, including: (1) rank among the top five countries in the world in terms of R&D performance; and (2) at least double the Government of Canada’s current investments in R&D and importantly (3) supporting the indirect costs associated with research.

The federal government should be fully recognized for the important steps they are taking which will ultimately yield short-, medium- and long-term health and economic benefits that will accrue to individuals and Canadian society.

While increases in funding for basic and applied health research is essential, we must also be mindful that teaching centres must also have access to resources that will allow for an expanded physical capacity and infrastructure, and its maintenance. If funding for health research continues to grow disproportionately with resources that are needed to cover the indirect costs associated with research, three unpleasant choices will be apparent: (1) either re-direct monies dedicated to patient care to research; (2) be subject to the limitations that our current research structure imposes on teaching centres, or (3) turn down grants.

ACAHO strongly supports the creation of the Canada Foundation for Innovation by the federal government in 1997 – which provides support for the creation of new capital assets and research capacity. However, what is also needed is a permanent funding mechanism that covers the associated indirect costs of supporting research capacity on an ongoing basis (e.g., building maintenance, lights, heat).

As a first step, the federal government announced in its 2001 federal budget that the indirect costs of health research need to be offset through a one-time \$200 million fund. ACAHO strongly supports the \$200 million investment in infrastructure and encourages the federal government to make this a permanent program that is funded at an appropriate international competitive level so that this component of innovation is not a rate limiting step to achieving excellence. In addition, ACAHO would also make the point that in principle, such funds should flow directly to those institutions that incur the indirect expenses associated with health research.<sup>34</sup>

Based on the Minister of Industry's response to the Tenth Report of the Standing Committee on Industry, Science and Technology, ACAHO is pleased to see that there is positive momentum on this essential policy issue.<sup>35</sup>

While there appears to be consensus on the policy objectives of an indirect costs program, we understand that there are different views when it comes to the how the policy should be implemented. With the expectation of identifying common policy ground, ACAHO, the Association of Universities and Colleges in Canada (AUCC) and the Council for Health Research in Canada (CHRC) are working diligently to ensure the best possible uses of these resources, and those to come in the future.

Ultimately, ACAHO believes that there is a symbiotic relationship between funding basic and applied research in Canada, and its indirect costs. In this context, "more to one guarantees little without more to the other" when it comes to fully reaping the benefits of health research in Canada.

ACAHO therefore recommends:

***Recommendation 6***

***That the federal government establish a permanent funding arrangement to address the indirect costs associated with health research, and increase its funding from a base of \$200 million to \$400 million.***

**CONCLUDING REMARKS**

In closing, ACAHO believes that it has offered to the Standing Committee on Finance a series of policy measures that are consistent with the values of Canadians, and focus on the strategic combination of financial and structural initiatives that are required to place teaching centres and the health care system on a more sustainable footing, now and into the future.

As the process continues, ACAHO looks forward to being an active and constructive partner in the national dialogue about the future of health care in Canada.

## ENDNOTES

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<sup>1</sup> In this regard, the ACAHO has submitted written Briefs to the Standing Senate Committee on Social Affairs, Science and Technology, and the The Royal Commission on the Future of Health Care in Canada.

<sup>2</sup> *The Canada We Want*. Speech from the Throne to Open the Second Session of the Thirty-Seventh Parliament of Canada. Government of Canada, September 30, 2002.

<sup>3</sup> The term Academic Health Sciences Centre is a relatively recent label given to the relationship that exists between university-level health/clinical education programs and the affiliated hospitals/health regions that provide the physical facilities necessary for research and education. JC Lozon, RM Fox. *Academic Health Sciences Centres Laid Bare*. Healthcare Papers, Vol. 2, No. 3, 2002.

<sup>4</sup> Industry Canada. *Achieving Excellence – Investing in People, Knowledge and Opportunity*. Canada's Innovation Strategy. February 2002.

<sup>5</sup> University Health Network. *A Presentation from the University Health Network to the Commission on the Future of Health Care in Canada*. September 26, 2001.

<sup>6</sup> The Canadian Institute for Health Information. May, 2002.

<sup>7</sup> Green JP, MacBride-King J. *Corporate Health Care Costs in Canada and the U.S.: Does Canada's Medicare System Make a Difference?* Conference Board of Canada, 1999. Purchase B. *Health Care and Competitiveness*. School of Policy Studies, Queen's University, 1996.

<sup>8</sup> Not since 1994 has there been a comprehensive overview of the role of Academic Health Science Centres (see *Planning the Future Academic Medical Centre – Conceptual Framework and Financial Design*, by LS Valberg, MA Gonyea, DG Sinclair, J Wade).

<sup>9</sup> Brimacombe G. *Every Number Tells A Story: A Review of Public and Private Health Expenditures and Revenues in Canada, 1980 – 2000*. The Conference Board of Canada, 2002.

<sup>10</sup> According to the Canadian Institute for Health Information, in 1990 public per capita spending on hospitals stood at \$779. Although there had been increases and decreases through the 1990s, in 1997 public per capita was \$789 (and is forecast to increase to \$960 per person in 2001).

<sup>11</sup> In their Communique, the Premiers stated that “*they recognize that some types of surgery and other medical procedures are performed infrequently, and that the necessary expertise cannot be developed and maintained in each province and territory. Building on the experience in Canada's three Territories, and Atlantic Canada, Premiers agreed to share human resources and equipment by developing Sites of Excellence in various fields, such as pediatric cardiac surgery and gamma knife neurosurgery. This will lead to better care for patients and more efficient use of health care dollars. Premiers directed their Health Ministers to develop an action plan for implementation of such sites before their August meeting in Halifax.*” “Provinces Pave the Way for the Future of Health Care”, Provincial-Territorial Premiers' Meeting, January 24-25, 2002.

<sup>12</sup> For more details, a separate document developed by ACAHO titled “*Achieving Excellence and Supporting Innovation in Meeting the Health Care Needs of Canadians*” was presented to the Standing Senate Committee on Social Affairs, Science and Technology, June 13, 2002.

<sup>13</sup> *The Health of Canadians – The Federal Role, Volume Six: Recommendations for Reform*. Final Report on the State of the Health Care System in Canada. Standing Senate Committee on Social Affairs, Science and Technology, October 2002. See Chapters 2, 10 and 11 for more details.

<sup>14</sup> For several years, the Canadian Medical Association, the Association of Canadian Medical Colleges, the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, the Canadian Nurses Association, Canadian Pharmacists Association and the Canadian Society for Medical Laboratory Science, have consistently identified the need to address issues related to the supply of health care professionals.

<sup>15</sup> *Listening for Direction: A National Consultation on Health Services and Policy Issues*. Ottawa: Canadian Health Services Research Foundation; 2001.

<sup>16</sup> Canadian College of Health Service Executives. *The Leadership Imperative – Clarity, Consistency and Collaboration Required*. Submission to the Commission on the Future of Health Care in Canada, October, 2001. *Health Care in Canada Survey 2001 – A National Survey of Health care Providers, Managers and the Public*, Pollara, 2001.

<sup>17</sup> Thomson A. *Federal Support for Health Care – A Background Paper*. The Health Action Lobby, June 1991. The Canadian Medical Association. *Looking Toward Tomorrow – Health, Health Care and Medicine in a Mercurial World*, September, 1998. Analysis undertaken by The Kirby Committee (“*The*

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*Health of Canadians – The Federal Role: Volume 1 – The Story So Far*”) suggests that from 1986/87 to 1995/96, there was a provincial shortfall in federal cash contributions in support of health care (via Established Programs Financing) in the range of \$16.1 to \$23.6 billion.

<sup>18</sup> For more information please refer to: *Recognizing the Fiscal Imbalance*. Government of Quebec, 2002. *Federal Transfers to the Provinces and Territories*, Department of Finance Canada, February 2002, and *Fiscal Prospects for the Federal Government and Provincial/Territorial Governments*, The Conference Board of Canada, July 2002. Interestingly, through the end of the second quarter 2002, the federal government’s surplus has fallen to \$4.6 billion (from \$18.5 billion a year ago) a difference of \$13.9 billion, while collectively the provinces ran a deficit of \$2.7 billion (from a surplus of \$7.9 billion a year ago) – a difference of \$10.6 billion. *Provinces’ Battle for Federal Cash Just Got Tougher*. Globe and Mail, September 9, 2002.

<sup>19</sup> *Premiers All Agree it’s Time to Act on Health Care: Harris*. Government of Ontario Press Release, January 25, 2002.

<sup>20</sup> Department of Finance Canada. *Federal Transfers to the Provinces and Territories*, February 2002.

<sup>21</sup> A similar view is also put forward by The Honourable Monique Begin in an appearance before the Standing Senate Committee on Social Affairs, Science and Technology (May 31, 2000).

<sup>22</sup> The Auditor-General of Canada. *Chapter 29 - Federal Support of Health Care Delivery*, 1999. Canadian Institute for Health Information. *Health Care in Canada, 2001*. Members of the Health Action Lobby have made similar observations. The Auditor-General of Canada. *Chapter 3 - Health Canada – Federal Support of Health Care Delivery*, October 2002.

<sup>23</sup> *A New Prescription for Health Care*. September 11, 2000. *The First Ministers’ Accord – Can the Discussion Move to Structure from Money?* The Conference Board of Canada. May 2001.

<sup>24</sup> Witness the millions that have been spent at taxpayer’s expense by the government of Ontario and the federal government over the federal government’s cash contribution to health care.

<sup>25</sup> *A Framework to Improve the Social Union for Canadians*. An Agreement between the Government of Canada and the Governments of the Provinces and Territories. February 4, 1999.

<sup>26</sup> *The Health of Canadians – The Federal Role, Volume Six: Recommendations for Reform*. Final Report on the State of the Health Care System in Canada. Standing Senate Committee on Social Affairs, Science and Technology, October 2002. See Chapters 15, pages 291-294.

<sup>27</sup> The Canadian Institute for Health Information.

<sup>28</sup> Kent T. *What Should be Done About Medicare*. The Caledon Institute. August, 2000.

<sup>29</sup> Canadian Institute for Health Information. *Preliminary Provincial and Territorial Health Expenditure Estimates, 1974/75-2002/03*.

<sup>30</sup> The taxback option proposes that individual health care expenditures be treated as taxable income. Therefore, by using the income tax system (and subject to a maximum allowable limit), lower income Canadians would be exempted, contributions would be “progressive”, and the system of collection would be administratively efficient. For more information see, *Towards A New Consensus on Health Care Financing in Canada*, Canadian Medical Association, July, 1993. Kent T. *What Should be Done About Medicare*. The Caledon Institute. August, 2000.

<sup>31</sup> The introduction of the GST – which designates health care services as tax exempt, or eligible for a rebate depending on the type of facility - has raised a series of policy challenges for the health care community. In particular, the Canadian Healthcare Association and the Canadian Medical Association have identified a number of anomalies that exist under the current tax regime.

<sup>32</sup> *Tax and Health – Taking Another Look: Discussion Paper*. Canadian Medical Association, May 2002.

<sup>33</sup> The Health Research Advocacy Network (HRAN) is a coalition of National Health Organizations dedicated to increasing federal government support for health research in Canada. HRAN has two priorities: (1) to profile for government decision makers the “return on investment” of federal funding for health research; and (2) to secure a multi-year commitment from the federal government to significantly increase funding for health research.

<sup>34</sup> ACAHO response to Industry Canada consultation document “The Indirect Costs of Research”, October 9, 2002.

<sup>35</sup> Government Response to the Tenth Report of the Standing Committee on Industry, Science and Technology. Industry Minister, Allan Rock, November 12, 2002.