



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

HEALTH, HEALTH CARE AND NATION-BUILDING...

**HARNESSING THE FULL POTENTIAL OF
A NATIONAL RESOURCE:**

CANADA'S TEACHING CENTRES AND HOSPITALS

**A SUBMISSION TO
THE HOUSE OF COMMONS
STANDING COMMITTEE ON FINANCE
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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 integrated 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, knowledge creation and innovation.

L'ASSOCIATION CANADIENNE DES INSTITUTIONS DE SANTE 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

Over the past year, Canadians have witnessed an unprecedented amount of public policy discussion about the future of health and health care in the country. In early 2003, much of the wrangling between federal, provincial and territorial governments culminated with the First Ministers' Accord on Health Care Renewal in February 2003, and a federal budget.

The intergovernmental discussions were preceded by 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). The reports presented the federal government with an important, if not historic opportunity to re-establish its leadership role in defining 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.

While there is much to be supportive of in terms of the measures that were announced in the First Ministers' Accord and subsequent federal budget, ACAHO would like to draw the attention of the Standing Committee a series of policy options that serve to enhance capacity in the system, and strengthen our collective support for a health care system that is pan-Canadian in design.

In particular, this would include the full recognition by the federal government that teaching centres/hospitals are a *de facto* national resource in the health care system, and that there are important synergies to be harnessed as it relates to increased funding for the health research enterprise in Canada.

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.

INVESTING IN CANADA'S HEALTH CARE SYSTEM OF THE 21ST CENTURY – THE ROLE OF THE FEDERAL GOVERNMENT

By virtue of their mission and mandate, members of ACAHO are "centres of health innovation." 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 "targeted" and "fixed" investment approaches that strengthen our ability to meet the health care needs and expectations of Canadians in the 21st Century.

DISCOVERING A “NATIONAL RESOURCE”...CANADA’S TEACHING CENTRES/HOSPITALS

The mission and mandate of teaching centres/hospitals 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/hospitals 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/hospitals 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/hospitals, then the logic should be extended such that teaching centres/hospitals must be recognized as a national resource.

Given the national responsibilities of teaching centres/hospitals, 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/hospitals and regional health authorities, establish a National Teaching Centre Health Infrastructure Fund.”*

Such a fund would assist teaching centres/hospitals 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.

HARNESSING THE FULL POTENTIAL OF HEALTH RESEARCH, INNOVATION AND ECONOMIC DEVELOPMENT

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; Networks Centres of Excellence (NCEs); Canada Research Chairs (CRC); the indirect costs associated with health research; and the Research Hospital Fund (under CFI).

The federal government should be fully recognized for the important series of measures they are implementing which will yield short-, medium- and ultimately longer-term health and economic benefits that will accrue to Canadians at the individual and societal level.

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.

Combined, these 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/hospitals provide much of the physical infrastructure that supports Canada's health research community.

In so doing, teaching centres/hospitals 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.

Given the inter-relationships that have been noted above, ACAHO would identify three specific and complementary areas where the federal government can continue to make an important difference, and accelerate its role in advancing the benefits of health research in Canada.

FUNDING CANADA'S BASIC AND APPLIED HEALTH RESEARCH ENTERPRISE

Since its creation in 2000, the federal government has taken great strides in funding the Canadian Institutes of Health Research (CIHR). Notwithstanding the step-wise increases in its base budget, ACAHO would strongly endorse the recommendations contained in the Kirby and Romanow reports. Specifically, that CIHR's base budget should increase to 1% of total health care spending in Canada. In our view, this would mean that the federal government should increase funding for CIHR to approximately \$1.0 billion by 2006/07.

Furthermore, to allow for effective strategic planning and organizational stability, the Association would strongly encourage the federal government to table a multi-year funding framework for CIHR in its 2004 budget. In its absence, CIHR has had to review and cancel a number of programs, and has indicated to the research community that it will have to claw back funding already awarded to ongoing projects, in an effort to stabilize its cash flow for fiscal 2004/05.

FUNDING CANADA'S HEALTH RESEARCH INFRASTRUCTURE

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.

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.

ACAHO strongly supports the initial annual investment of \$225 million and would encourage the federal government to increase the value of the program so that it 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 to funding for the indirect costs of research, ACAHO has worked closely with the Canada Foundation for Innovation (CFI) to ensure that the newly created \$500 million Research Hospital Fund is designed to support innovative research and training projects - with a particular focus on large-scale infrastructure projects that take a more integrated and multidisciplinary approach to health research. That said, some provinces have expressed concern that the structure of the Fund will stretch their ability to match federal funds.

Given the infrastructure requirements across the country, ACAHO would strongly encourage the federal government to view the \$500 million as a substantial down payment on future investments of much needed capital to reinvigorate Canada's research infrastructure – particularly when it comes to supporting leading-edge health research.

Understanding that the first round of applications are being considered for the Research Hospital Fund, ACAHO looks forward to working closely with CFI to ensure that the Fund will meet its program objectives and the needs of its members.

MAXIMIZING THE FULL ECONOMIC POTENTIAL OF INNOVATIVE HEALTH RESEARCH

As we consider the future of Canada's health care system, the role of health research has largely been framed in the context of how it contributes to improving our individual and collective health status, identifies new and more cost-effective ways of delivering/ administering health care services, and is a key driver behind our desire to continue to develop and implement a quality-focused, evidence-based culture.

However, there is another essential dimension of the health research equation that demands our close attention; and that has to do with the important economic benefits that can accrue to Canadians – both at the individual and societal level.

In this context, investments in health research are investments in health, health care and sustained economic prosperity (i.e., nation-building). They should be viewed as mutually reinforcing public policy objectives that can add significant value to our overall quality of life.

To initiate discussion of how we could proceed in this area, ACAHO was a signatory to a concept paper which proposed the creation of a Council for Health Innovation in Canada (CHIC) – which is now called the Health Innovation Canada proposal. The purpose of the document is to set out a case for a focused effort to strengthen our innovation performance in the health sector.

This proposal embraces the many dimensions of innovation that stem from health research and move through the stages of development, testing, production, financing and marketing. Importantly, the proposal calls for the creation of a national body that would play an important role in developing a coordinated and integrated strategic plan that would nurture specific areas where Canada has a comparative advantage in health research.

To effectively convert this proposal into reality, it will be important to not only identify those markets niches where Canada has a comparative advantage in terms of requisite expertise, etc. that can be fully exploited in terms of developing innovative goods and services that can compete within an increasingly global marketplace. It will also be critical that we have the necessary physical infrastructure to take full advantage of our opportunities.

In this context, given where the majority of Canada's health research capacity rests, teaching centres/hospitals have a vital role to play when it comes to harnessing the full value of health research. More particularly, when it comes to technology transfer and economic development opportunities, many teaching centres/hospitals have increasingly developed effective relationships with industry and venture capitalists.

For this vision to take root, it is the view of ACAHO that the federal government must dedicate seed funding to not only develop the concept, but to ensure that a cohesive strategic plan for health innovation in Canada can be developed in concert with others.

CANADA'S PUBLIC HEALTH INFRASTRUCTURE AND CAPACITY BUILDING

Not unexpectedly, the recent arrival of SARS has placed a tremendous focus on our country's public health infrastructure. While Ontario has had to deal with SARS and its related consequences, we must be vigilant and forward-looking if we are to learn and explore long-term approaches on how best to prepare Canada to respond to future infectious disease challenges. In this context, we look forward to the recommendations contained in the report of the National Advisory Committee on SARS and Public Health.

In our view, the issue of capacity-building can be separated into two mutually reinforcing segments: (a) public health and (b) acute care. In our view, these two areas are different points along the same continuum; where investments in both areas serve to strengthen the system's capacity to better anticipate, coordinate and integrate our ability to manage public health and/or infectious disease outbreaks.

To improve overall coordination of public health and infectious disease information, the Association would support the creation of a pan-Canadian Centre for Disease Control. In addition, ACAHO would also be supportive of federal legislation that would facilitate a more rapid response by the federal and provincial and territorial governments where public health emergencies pose a serious threat to the health of Canadians.

ACAHO is also supportive of those who have called for the creation of the position of chief public health officer, who would act as the national voice on matters of public health in the country. This individual would also lead the pan-Canadian Centre for Disease Control.

Based on the recent meeting of federal, provincial and territorial Ministers of Health in early September 2003, the Association would encourage all parties to expedite their discussions on: (1) the clarification of roles and responsibilities for preventing and responding effectively to public health threats, respecting federal, provincial and territorial jurisdictions; (2) creation of a national network of centres of public health science; (3) strengthened public health human resources, including the need for more robust regional and national public health emergency response capacity; and (4) enhanced national surveillance and information infrastructure.

Based on this commitment, we would anticipate that the federal government will introduce a multi-year/ multi-billion dollar implementation plan in the very near future.

THE GOODS AND SERVICES TAX (GST) AND TEACHING CENTRES/HOSPITALS

In the federal government's 2003 Budget (pages 75-76), there was a commitment that the Department of Finance would be undertaking consultations with representatives of the health care sector to assess and improve the application of the GST rebate with respect to those health care functions that are moved outside of hospitals. The target date outlined in the budget plan for changes was October 1, 2003.

To date, the Association has yet to be fully apprised of this consultation process and looks forward to participating in these important discussions.

In addition to the review undertaken by the Department of Finance, ACAHO has submitted a detailed policy brief to the Canada Customs and Revenue Agency (CCRA) – who are in the process of reviewing the administrative criteria for hospitals designations, and the administrative criteria to claim the 83% rebate under the MUSH formula.

While ACAHO has raised a number of technical points for CCRA's consideration, we remain concerned that nowhere within the definition of public hospitals is there an explicit recognition of the range and responsibilities that are provided by teaching centres/hospitals (i.e., service provision, teaching/education, and health research).

In our view, activities that are in any way connected to, or arise from the operation of a public hospital should be eligible for the 83% rebate. For example, all activities undertaken by a public hospital in respect of teaching/education and health research are provided “in the course of operating a public hospital” because these activities are integral to the fulfillment of our role. As a result, teaching/education and health research activities are as essential to the activities of many public hospitals as are direct patient care.

We would hope that the Standing Committee will reflect on this perspective as the federal government reviews how best to ensure that good tax policy reinforces good health care policy across the country.

CONCLUDING REMARKS

In closing, ACAHO believes that it has offered to the Standing Committee on Finance a series of cohesive and targeted policy measures that are consistent with the values of Canadians, the mandate of the federal government, 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. At the same time, the Association also looks forward to participating in national discussions that focus on how strategic investments that nurture health research and innovation can play an integral role in contributing to Canada’s sustained economic prosperity.

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

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, by 2006/07.

Recommendation 4

That the federal government establish a multi-year fiscal funding framework for CIHR in its 2004 budget.

Recommendation 5

That the federal government increase funding available for the indirect costs associated with research from \$225 million to \$400 million, effective 2004.

Recommendation 6

That the federal government increase its funding for infrastructure in support of large-scale, multi-disciplinary innovative health research, over and above the \$500 million set aside in the Research Hospital Fund.

Recommendation 7

That the federal government establish Health Innovation Canada, and invest a minimum of \$600 million to facilitate the development and implementation of a strategy for building a robust health innovation sector.

1. 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.

The Association recognizes the importance of this process in terms of shaping the priorities of the federal government. As such, we look forward to contributing to the national policy dialogue about the future of health and health care in Canada by offering a series of connected policy recommendations for the Standing Committee's consideration.

2. POLICY CONTEXT

Over the past year, Canadians have witnessed an unprecedented amount of public policy discussion about the future of health and health care in the country. In early 2003, much of the wrangling between federal, provincial and territorial governments culminated with the First Ministers' Accord on Health Care Renewal in February 2003, and a federal budget.

The intergovernmental discussions were preceded by 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). The reports presented the federal government with an important, if not historic opportunity to re-establish its leadership role in defining 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.

While there is much to be supportive of in terms of the measures that were announced in the First Ministers' Accord and subsequent federal budget, ACAHO would like to bring to the attention of the Standing Committee a series of policy recommendations that serve to enhance capacity in the system, and renew our collective support for a health care system that is pan-Canadian in design.

In particular, this would include the full recognition by the federal government that teaching centres/hospitals are a *de facto* national resource in the health care system; and that there are important synergies to be harnessed as it relates to increased funding for the health research enterprise in Canada.

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 and funding system renewal and innovation.

With this in mind, ACAHO has developed a series of recommendations that focus on the public policy objectives of 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.

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 continue 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.

3. 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/hospitals 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/hospitals 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]).¹ 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/hospitals play a critical role in educating and training the next generation of Canada's best and brightest health care professionals.

Importantly, teaching centres/hospitals 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/hospitals 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.² 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/hospitals, and allows them to fulfill a series of essential public policy objectives:

- 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/ hospitals in Canada account for almost one of every five dollars allocated to the health care system.³ 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/hospitals play an important role in contributing to the competitive advantage that our system offers.⁴

In the view of ACAHO there are a number of important and multi-faceted roles that teaching centres/hospitals 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/hospitals 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/hospitals 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/hospitals have been left largely unaddressed in the current national health policy discussions.⁵ 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/hospitals 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/hospitals, 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.

4. THE POLICY LANDSCAPE

Not unlike other components of the health care system, hospitals, regional health authorities and in particular, teaching centres/hospitals 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 2000.⁶ 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.⁷ 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/hospitals 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/hospitals, planning at all levels has been strained.

In addition to the internal policy challenges that teaching centres/hospitals are facing, most provinces have reconfigured their health care systems via regionalized governance structures, and have begun the process of implementing 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/hospitals 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/hospitals 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 essential to the mission and mandate of teaching centres/hospitals, we must not also lose sight of their responsibilities for medical education and health research – which are also under considerable pressure.

5. CANADA’S PUBLIC HEALTH INFRASTRUCTURE AND CAPACITY BUILDING

Not unexpectedly, the recent arrival of SARS has placed a tremendous focus on our country’s public health infrastructure. While Ontario has had to deal with SARS and its related consequences, we must be vigilant and forward-looking if we are to learn and explore long-term approaches on how best to prepare Canada to respond to future infectious disease challenges. In this context, we look forward to the recommendations contained in the report of the National Advisory Committee on SARS and Public Health.

In our view, the issue of capacity-building can be separated into two mutually reinforcing segments: (a) public health and (b) acute care. In our view, these two areas are different points along the same continuum; where investments in both areas serve to strengthen the system's capacity to better anticipate, coordinate and integrate our ability to manage public health and/or infectious disease outbreaks.

PUBLIC HEALTH CAPACITY

In terms of public health, the Association is strongly supportive of the need for governments at all levels to invest in front line public health capacity. In so doing, the objective is to re-assure Canadians that our public health infrastructure is robust, and can quickly and effectively anticipate and respond to minimize the negative effects of infectious disease outbreaks.

ACUTE CARE CAPACITY

While there is an important need to build our public health capacity across the country, these investments must be made in addition to, and not at the expense of, existing resources and core services. As a result, we must ensure that access to acute care services is protected and enhanced for all Canadians.

The recent SARS crisis highlighted the longstanding concerns that have been expressed by the acute care community that any unanticipated events, such as natural or non-natural disasters, infectious disease outbreaks, etc. would not only magnify the limited capacity (or "slack") that exists in the system to respond, but also would have the cascading effect of impacting on the ability of Canadians to access needed health care services on a timely basis (e.g., elective surgery, outpatient mental health services) .

The recent SARS experience underscores the need to ensure that jurisdictions have appropriate contingency plans to deal with future public health emergencies so that they can be managed effectively and efficiently in a coordinated and strategic manner, without unduly disrupting ongoing patient care.

NATIONAL LEADERSHIP

While the SARS outbreak was to a certain extent a series of local or regional events, it is clear that in times of crisis, Canadians look to the federal government, in close partnership with the provinces and territories, for decisive leadership.

To improve overall coordination of public health and infectious disease information, the Association would support the creation of a pan-Canadian Centre for Disease Control. In addition, ACAHO would also be supportive of federal legislation that would facilitate a more rapid response by the federal and provincial and territorial governments where public health emergencies pose a serious threat to the health of Canadians.

ACAHO is also supportive of those who have called for the creation of the position of chief public health officer, who would act as the national voice on matters of public health in the country. This individual would also lead the pan-Canadian Centre for Disease Control.

Combined, these initiatives would underscore the federal government's commitment to the important role that public health plays in the lives of Canadians, and the requirement of inter-governmental partnership that is required to renew the country's public health infrastructure.

Based on the recent meeting of federal, provincial and territorial Ministers of Health in early September 2003, the Association would encourage all parties to expedite their discussions on: (1) the clarification of roles and responsibilities for preventing and responding effectively to public health threats, respecting federal, provincial and territorial jurisdictions; (2) creation of a national network of centres of public health science; (3) strengthened public health human resources, including the need for more robust regional and national public health emergency response capacity; and (4) enhanced national surveillance and information infrastructure.¹

Based on this commitment, we would anticipate that the federal government will introduce a multi-year/ multi-billion dollar implementation plan in the very near future.

6. THE 2003 FIRST MINISTERS' ACCORD ON HEALTH CARE RENEWAL – WHERE DO WE STAND?

Not unexpectedly, there has been considerable public discussion about the overall package of policy measures that were contained in the 2003 First Ministers' Accord and subsequent federal budget.

In specific terms, ACAHO is very pleased with the federal government's emphasis on health research and its infrastructure (i.e., increased base funding for the Canadian Institutes of Health Research and Genome Canada, additional funding for the Medical and Related Sciences Project, and new monies for the indirect costs of research and the creation of a \$500 million Research Hospital Fund), patient safety (\$50 million over five years), and targeted monies for medical equipment and health information technologies. These targeted investments can play an important role in how we value research, innovation, evidence and technology.⁸

The Association is also supportive of the creation of a health-specific cash transfer (i.e., Canada Health Transfer – which will be established in 2008/09) to promote more effective linkages between the federal sources of funding for health care and their uses at the provincial level. At the same time, however, ACAHO has expressed concerns that there are limited monies contained through the Canada Health and Social Transfer (CHST) to address ongoing concerns about Canadians' access to specialized health care services.

Based on the current fiscal framework for health outlined in the federal government's 2003 budget plan, a large share of the monies are dedicated through the Health Reform Fund (which is focused on primary health care reform, home care and pharmaceutical management), and increase towards the end of the decade. In other words, the monies are back-end loaded.

More importantly, our analysis indicates that while monies dedicated under the Canada Health Transfer are growing in nominal terms, they will likely constitute a declining share of provincial and territorial expenditures on health (see Appendix B). Even more alarming is that the share of monies for hospitals and physicians - the cornerstone of Medicare – will likely continue to decline over the 2003/04 to 2007/08 period.

An added complexity is that current economic conditions may not provide the federal government with sufficient flexibility to contribute an additional \$2.0 billion in 2003/04 to the provinces and territories in support for health care – as set out in the First Ministers’ Accord.

While the First Ministers’ Accord has made important progress in a number of areas, it is the view of the Association that the federal government needs to continue to establish a stable and significant ongoing cash contribution in support of health care. Given the current arrangements, we can expect the provinces and territories to continue to bicker with the federal government about its role in funding health services.

In our submissions to the Kirby Committee, Romanow Commission, and to this Standing Committee last year, ACAHO identified four principles that should underpin the federal government’s fiscal framework for health care: (1) a clear and mutually-agreed definition of what constitutes federal funding for health; (2) the creation of a health-specific transfer; (3) a five-year “rolling” fiscal framework for health care; and (4) the funding arrangement be reviewed on a quinquennial basis and at the same time as the equalization program.

In the view of the Association, the final piece that is required is that the federal government should commit to funding the health care system on more significant and systematic basis. As has been proposed by others, this could take the form of a federal cash contribution constituting 25% of the costs incurred by the provinces and territories for health services.⁹

As of 2002, the total public sector expenditure on health by the provinces and territories was forecast to be \$79.4 billion.¹⁰ A twenty-five percent cash contribution by the federal government would amount to approximately \$19.8 billion; currently it stands at \$12.3 billion – a difference of \$7.5 billion.

Furthermore, there was little recognition of the intense policy challenges we all face when it comes to the supply, mix and distribution of health care professionals across the country.

In addition, there was no formal recognition of the essential mission mandate that teaching centres/hospitals fulfill in the system; that is, as a national resource. More will be said about this in sections 6 and 7 of our Brief.

7. INVESTING IN CANADA’S HEALTH CARE SYSTEM OF THE 21ST CENTURY – THE ROLE OF THE FEDERAL GOVERNMENT

As centres of health innovation, members of ACAHO 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/hospitals 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 “targeted” and “ongoing” investments that strengthen our ability to meet the health care needs and expectations of Canadians in the 21st Century.

The remainder of the Brief therefore focuses on how 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.

8. DISCOVERING A “NATIONAL RESOURCE”...CANADA’S TEACHING CENTRES/HOSPITALS

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/hospitals 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/hospitals 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/hospitals, 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.¹¹

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/ hospitals 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/hospitals are “the” hands-on educational training ground for most health care professionals in the country.

Finally, while all teaching centres/hospitals 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/hospitals 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/ hospitals, then the logic should be extended such that they 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/hospitals in Canada? More specifically, how can governments nurture and support the role of teaching centres/hospitals in a system that is experiencing profound change?

Furthermore, how would the designation of teaching centres/hospitals 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/hospitals 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/hospitals in continuing to evolve to 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/hospitals; 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.

ACAHO appreciates that monies have been made through the First Ministers’ Accord for medical equipment and health information technologies. However, defined in the context of a national resource, members of the Association view these two components (in addition to health human resources and physical/capital infrastructure) as being essential to the renewal process.

In the view of ACAHO, the Fund would assist teaching centres/hospitals in:¹²

- 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/hospitals 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/hospitals 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 had 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), the First Ministers' Agreement (2000), and the First Ministers' Accord on Health Care Renewal (2003).

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 centres/hospitals 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.

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).¹³

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. As a result, ACAHO sees the recent \$90 million investment by the federal government in this area as an important initiative.

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.¹⁴

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.¹⁵ 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).

9. HARNESSING THE FULL POTENTIAL OF HEALTH RESEARCH, INNOVATION AND ECONOMIC DEVELOPMENT

When it comes to the importance of 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, knowledge creation and innovation play in the lives of Canadians. As a result, a number of recent federal initiatives have been introduced with a pan-Canadian vision and mandate. They include:

- Canadian Institutes for Health Research (CIHR)
- Canada Foundation for Innovation (CFI)
- Genome Canada
- Networks of Centres of Excellence (NCEs)
- Canada Research Chairs (CRC)
- Indirect costs associated with health research
- Research Hospital Fund (under CFI)

The federal government should be fully recognized for the important series of measures they are implementing which will yield short-, medium- and ultimately longer-term health and economic benefits that will accrue to Canadians at the individual and societal level.

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.

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

ACAHO is also strongly encouraged by the federal government's focus on health research and its relationship to producing a more energetic, innovative and outward looking society. The Association was very pleased to participate at the National Summit on Innovation and Learning – which focused on the how investments in health research can have a number of positive, mutually-reinforcing benefits.

On an ongoing basis, the Association looks forward to working closely with the federal government, and others, in achieving the recommendations that were contained in the White Paper outlining Canada's Innovation Strategy, specifically: ranking among the top five countries in R&D by 2010; at least doubling the government of Canada's current investment in R&D; ranking among the world leaders in the share of private sector sales from new innovations; and raising venture capital investments per capita to prevailing US levels.¹⁶

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/ hospitals 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, released a discussion paper early this year.¹⁷ The paper profiles the return on investment associated with public funding for health research.

Given the inter-relationships that have been noted above, ACAHO would identify three specific and complementary areas where the federal government can continue to make an important difference, and accelerate its role in advancing the benefits of health research in Canada.

1. FUNDING CANADA'S BASIC AND APPLIED HEALTH RESEARCH ENTERPRISE

Since its creation in 2000, the federal government has taken great strides in funding the Canadian Institutes of Health Research (CIHR). Notwithstanding the step-wise increases in its base budget, ACAHO would strongly endorse the recommendations contained in the Kirby and Romanow reports. Specifically, that CIHR's base budget should increase to 1% of total health care spending in Canada. In our view, this would mean that the federal government should increase funding for CIHR to approximately \$1.0 billion by 2006/07.

Furthermore, to allow for effective strategic planning and organizational stability, the Association would strongly encourage the federal government to table a multi-year funding framework for CIHR in its 2004 budget. In its absence, CIHR has had to review and cancel a number of programs, and has indicated to the research community that it will have to claw back funding already awarded to ongoing projects, in an effort to stabilize its cash flow for fiscal 2004/05.¹⁸

ACAHO respectfully recommends:

Recommendation 3

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, by 2006/07.

Recommendation 4

That the federal government establish a multi-year fiscal funding framework for CIHR in its 2004 budget.

2. FUNDING CANADA'S HEALTH RESEARCH INFRASTRUCTURE

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.

In short, 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.

In its 2003 budget, the federal government responded to the concerns expressed by ACAHO and others and created a semi-permanent fund (subject to a three-year review), valued at \$225 million, to address the indirect costs associated with universities, colleges and research hospitals (of which half would be to support health-related disciplines).

ACAHO strongly supports the initial annual investment of \$225 million and would encourage the federal government to increase the value of the program so that it is funded at an appropriate international competitive level so that this component of innovation is not a rate limiting step to achieving excellence.

ACAHO therefore recommends:

Recommendation 5

That the federal government increase funding available for the indirect costs associated with research from \$225 million to \$400 million, effective 2004.

This is consistent with the Standing Committee's recommendation contained in its report to the House of Commons in 2002.¹⁹

At this stage, the full details of the program for indirect costs, its accountabilities, and the funding mechanism are not yet known. ACAHO looks forward to working closely with the federal government and Universities to ensure that the funds are allocated appropriately, and in a cost-effective manner. That said, it has been the firm view of the Association that the indirect costs should flow through the granting councils grants and awards processes.

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.

In addition to funding for the indirect costs of research, ACAHO has worked closely with the Canada Foundation for Innovation (CFI) to ensure that the newly created \$500 million Research Hospital Fund is designed to support innovative research and training projects - with a particular focus on large-scale infrastructure projects that take a more integrated and multidisciplinary approach to health research. That said, some provinces have expressed concern that the structure of the Fund will stretch their ability to match federal funds.

Given the infrastructure requirements across the country, ACAHO would strongly encourage the federal government to view the \$500 million as a substantial down payment on future investments of much needed capital to reinvigorate Canada's research infrastructure – particularly when it comes to supporting leading-edge health research.

Recommendation 6

That the federal government increase its funding for infrastructure in support of large-scale, multi-disciplinary innovative health research, over and above the \$500 million set aside in the Research Hospital Fund.

Understanding that the first round of applications are being considered for the Research Hospital Fund, ACAHO looks forward to working closely with CFI to ensure that the Fund will meet its program objectives and the needs of its members.

3. MAXIMIZING THE FULL ECONOMIC POTENTIAL OF INNOVATIVE HEALTH RESEARCH

As we consider the future of Canada's health care system, the role of health research has largely been framed in the context of how it contributes to improving our individual and collective health status, identifies new and more cost-effective ways of delivering/ administering health care services, and is a key driver behind our desire to continue to develop and implement a quality-focused, evidence-based culture.

In its broadest form, these innovative approaches include the design and introduction of new: diagnostic and therapeutic technologies and medical devices; management techniques and processes; modified construction engineering techniques; financing for improved management practices (e.g., supply chain purchasing); and health and bio-informatics systems.

These are all extremely important attributes of our system, and ACAHO looks forward to continuing to work in each of these areas so that Canadians are re-assured that they will have timely access to quality health care services.

At the same time, however, there is another essential dimension of the health research and innovation equation that demands our close attention; and that has to do with the important economic development benefits that can accrue to Canadians – both at the individual and societal level.

In this context, investments in health research are investments in health, health care and sustained economic prosperity (i.e., nation-building). They should be viewed as mutually reinforcing public policy objectives that can add significant value to our overall quality of life.

To initiate discussion of how we could proceed in this area, ACAHO was a signatory to a concept piece which proposed the creation of a Council for Health Innovation in Canada (CHIC)²⁰ – which is now called the Health Innovation Canada proposal. The purpose of the document is to set out a case for a focused effort to strengthen our innovation performance in the health sector.

More clearly, in addition to improving the lives of Canadians and making our health care system increasingly cost-effective, we would also nurture opportunities that lead to sustained economic prosperity, and build a nation that values knowledge and its sharing.

This proposal embraces the many dimensions of innovation that stem from health research and move through the stages of development, testing, production, financing and marketing. Importantly, the proposal calls for the creation of a national body that would play an important role in developing a coordinated and integrated strategic plan that would nurture specific areas where Canada has a comparative advantage in health research and development.

To effectively convert this proposal into reality, it will be important to not only identify those markets niches where Canada has a comparative advantage in terms of requisite expertise, etc. that can be fully exploited in terms of developing innovative goods and services that can compete within an increasingly global marketplace. It will also be critical that we have the necessary physical infrastructure to take full advantage of our opportunities.

In this context, given where the majority of Canada's health research capacity rests, teaching centres/hospitals have a vital role to play when it comes to harnessing the full value of health research and development. More particularly, when it comes to technology transfer and economic development opportunities, many teaching centres/hospitals have increasingly developed effective relationships with industry and venture capitalists.

ACAHO strongly supports the development of a number of health research networks that would be anchored in Canada's teaching centres/hospitals and research institutes. To nurture the development of new innovative good and services, health innovation teams would be established in each facility.

For this vision to take root, it is the view of ACAHO that the federal government must dedicate seed funding to not only develop the concept, but to ensure that a cohesive strategic plan for health innovation in Canada can be developed in concert with others – involving CIHR, Genome Canada, CFI, provincial funding agencies, industry and other contributors to the complex environment in which health research and development takes place.

ACAHO therefore recommends:

Recommendation 7

That the federal government establish Health Innovation Canada, and invest a minimum of \$600 million to facilitate the development and implementation of a strategy for building a robust health innovation sector.

This is consistent with the Standing Committee's recommendation contained in its report to the House of Commons in 2002.²¹

Combined, ACAHO strongly believes that these five recommendations present the Standing Committee with an integrated approach to nurturing health research, its infrastructure, and economic development in Canada.

10. THE GOODS AND SERVICES TAX (GST) AND TEACHING CENTRES/HOSPITALS

In the federal government's 2003 Budget (pages 75-76), there was a commitment that the Department of Finance would be undertaking consultations with representatives of the health care sector to assess and improve the application of the GST rebate with respect to those health care functions that are moved outside of hospitals. The target date outlined in the budget plan for changes was October 1, 2003.

To date, the Association has yet to be fully apprised of this consultation process and looks forward to participating in these important discussions.

In addition to the review undertaken by the Department of Finance, ACAHO has submitted a detailed policy brief to the Canada Customs and Revenue Agency (CCRA) – who are in the process of reviewing the administrative criteria for hospitals designations, and the administrative criteria to claim the 83% rebate under the MUSH formula.

While ACAHO has raised a number of technical points for CCRA's consideration, we remain concerned that nowhere within the definition of public hospitals is there an explicit recognition of the range and responsibilities that are provided by teaching centres/hospitals (i.e., service provision, teaching/education, and health research).

In our view, activities that are in any way connected to, or arise from the operation of a public hospital should be eligible for the 83% rebate. For example, all activities undertaken by a public hospital in respect of teaching/education and health research are provided "in the course of operating a public hospital" because these activities are integral to the fulfillment of our role. As a result, teaching/education and health research activities are as essential to the activities of many public hospitals as are direct patient care.

We would hope that the Standing Committee will reflect on this perspective as the federal government reviews how best to ensure that good tax policy reinforces good health care policy across the country.

11. CONCLUDING REMARKS

In closing, ACAHO believes that it has offered to the Standing Committee on Finance a series of cohesive and targeted policy measures that are consistent with the values of Canadians, the mandate of the federal government, and focus on the strategic combination of financial and structural initiatives that are required to place teaching centres/hospitals 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. At the same time, the Association also looks forward to participating in national discussions that focus on how strategic investments that nurture health research and innovation can play an integral role in contributing to Canada's sustained economic prosperity.

ENDNOTES

¹ 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.

² Industry Canada. *Achieving Excellence – Investing in People, Knowledge and Opportunity*. Canada's Innovation Strategy. February 2002.

³ The Canadian Institute for Health Information. May, 2002.

⁴ 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.

⁵ 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).

⁶ 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.

⁷ 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).

¹ News Release, Annual Conference of Federal, Provincial and Territorial Ministers of Health, Halifax, Nova Scotia, September 4, 2003.

⁸ *Investments in Health Research and Innovation Critical to Future of Health Care System, however Significant Concerns Remain, Says ACAHO*. Press Release. February 19, 2003.

⁹ For a more detailed analysis, see ACAHO's 2003 Submission to the House of Commons Standing Committee on Finance "The Role of the Federal Government in Achieving Excellence and Supporting Innovation in Canada's Health Care System." November 15, 2002.

¹⁰ Canadian Institute for Health Information. National Health Expenditure Trends, 1975, 2002.

¹¹ 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.

¹² 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.

¹³ *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.

¹⁴ 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.

¹⁵ 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.

¹⁶ *Achieving Excellence – Investing in People, Knowledge and Opportunity, Canada's Innovation Strategy*. Government of Canada. February 2002.

¹⁷ *Health Research – An Investment in Canada's Well-Being*. January 2003. 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.

¹⁸ Many of the current challenges facing CIHR have been captured in a series of papers published in the Canadian Medical Association Journal (September 16, 2003; 169(6)); "Funding the Future of Health Research"; "Canadian Institutes of Health Research Budgetary Dilemma: Unprecedented Growth and Program Reductions"; "Preserving our Intellectual Capital: The Canadian Institutes of Health Research Funding Crisis"; "Researchers Complain as CIHR Axes Investigator Awards".

¹⁹ Specifically, the Standing Committee recommended "(15) The federal government, in the next budget, provide a permanent program for financing the indirect costs of federally funded research...(16) A permanent program financing 40% of the indirect costs of federally funded research be implemented in the next budget." Canada: People, Places and Priorities. Report of the Standing Committee on Finance. November, 2002.

²⁰ *Building Canada's Health Innovation Strategy – A Proposal*. July 23, 2003.

²¹ Specifically, the Standing Committee recommended "(17) The federal government create a commercialization office within Industry Canada. The mandate of this office would be efforts leading to the commercialization of research undertaken in Canada.." Canada: People, Places and Priorities. Report of the Standing Committee on Finance. November, 2002.