



Association of Canadian Academic Healthcare Organizations  
Association Canadienne des Institutions de Santé Universitaires

**REACHING OUR POTENTIAL...**

**INVESTING IN THE HEALTH AND  
HEALTH CARE OF CANADIANS**

**A SUBMISSION TO  
THE HOUSE OF COMMONS  
STANDING COMMITTEE ON FINANCE  
NOVEMBER 24, 2004**

## **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 and some primary 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**

In this past year, Canadians have witnessed an unprecedented amount of focus on the present state of their health system, and its future. More recently, much of the intense national policy dialogue culminated in a First Ministers Agreement in September 2004. This agreement – which some would view as being historic in nature – identified a number of important steps forward in terms of meeting the national objectives of our health system, and sufficient flexibility for the provinces and territories to address their pressing health policy priorities. For this, both levels of government are to be congratulated for finding common policy ground and seeking to establish a more mature and progressive relationship that has been absent since the early to mid-1990s.

If Canadians are to be re-assured that the system will be there for the in times of need over the short-, medium- and longer-term, they need (in part) to see that both levels of government are committed to working together in partnership – representing their best interests when it comes to accessing quality health care services on a timely basis.

ACAHO is the national voice of teaching hospitals and regional health authorities responsible for the academic mission (i.e., service provision, education & training of health care professionals, and research & innovation). Given that members of ACAHO are a national resource in the health system, the Association is of the view that there are a number of critical policy areas where the federal government can continue to make a significant contribution, and accelerate the transformation of the system.

### **IMPLEMENTING THE FIRST MINISTERS AGREEMENT**

Now that a total of \$41.3 billion (over ten years) of additional funding has been made available by the federal government, the policy conversation now turns to some of the delicate questions around the administration of the agreement and the expected deliverables with the provinces and territories. From an accountability perspective, how can we ensure that Canadians receive full value for the public investment in the health system by the federal government?

While the monies invested in the Canada Health Transfer gives the provinces and territories the flexibility they require, there remain dedicated monies that have yet to be allocated, nor have the terms and conditions been made public and finalized. A case in point is the Wait Times Reduction Fund (WTRF) – valued at \$5.5 billion over ten years.

Given the explicit wording that is contained in the First Ministers Agreement, ACAHO is of the view that the design of the WTRF must be sensitive to the need for due process in developing national indicators and clinical benchmarks; that a portion of the Fund should be earmarked for specific national initiatives; and the Fund must be linked to our continued investment in Canada's health information infrastructure.

As a result, one would expect that any funding that flows from the WTRF would be explicitly tied to a transparent national process to develop comparable wait time indicators and benchmarks (see Recommendation #1 in the Summary of Recommendations).

With the range of initiatives that are underway across the country, and which members of ACAHO are spearheading, the Association sees the federal government playing an important catalyst role in this area.

### **INVESTING IN A NATIONAL RESOURCE...CANADA'S TEACHING CENTRES/HOSPITALS**

Given the mission and mandate of members of ACAHO, they are a *de facto* national resource in the health system. Not only do our members have a vital role to play in their respective local jurisdictions, however their roles and responsibilities require that they have a broader national focus.

The public policy challenge then becomes what role is there for the federal government to address the national roles and responsibilities of teaching centres/hospitals in Canada? More specifically, how can the federal government nurture and support the country's teaching centres/hospitals in a system that is experiencing profound change?

ACAHO is of the view that there are two specific and legitimate areas where the federal government can make a substantial contribution. Specifically, investing in support for: (1) capacity-building for health human resources; and (2) (re)building physical capacity (see Recommendations #2 and #3 in the Summary of Recommendations).

In both instances, ACAHO recommends the creation of a targeted and time limited strategic investment by the federal government which would assist teaching centres/hospitals in meeting their mission and mandate as a national resource in the system.

### **STRENGTHENING CANADA'S HEALTH RESEARCH ENTERPRISE**

In the view of ACAHO, research is the oxygen of evidence-based decision-making. It is the basis upon which many sound public policy decisions are based. In effect, investments in health research will provide us with innovative and evidence-based solutions to maintain and improve: (1) our individual and collective health status; (2) the manner in which we deliver cost-effective health care services; and (3) our ability to prosper on a sustained economic basis.

Over the past few years, the federal government has established a legacy of which it can be extremely proud of and which ACAHO strongly applauds.

Members of ACAHO play an essential role when it comes to facilitating the advancement of health research, medical discovery, knowledge creation and innovation in Canada. In fact, teaching centres/hospitals and their research institutes provide a large proportion of the physical infrastructure that supports Canada's health research community.

With this in mind, ACAHO has offered the Standing Committee on Finance a series of connected recommendations that focus on the different dimensions of the health research enterprise, that is: increasing funding for the Canadian Institutes of Health Research and Genome Canada within a multi-year fiscal framework; additional support for the indirect costs of research, and large scale multi-disciplinary innovative research; and approaches to accelerate the commercialization of health research and goods and services developed by the health sector (see Recommendations #4, #5, #6, and #7 in the Summary of Recommendations).

## **CANADA'S PUBLIC HEALTH INFRASTRUCTURE AND CAPACITY BUILDING**

As a member of the Canadian Coalition for Public Health in the 21<sup>st</sup> Century, the Association is supportive of the recommendations that have already been offered to the Standing Committee. These recommendations build on the investments that were announced by the federal government in last year's budget.

### **TAX POLICY SUPPORTING HEALTH POLICY OBJECTIVES**

As we collectively consider the future of Canada's health system, issues of federal funding are almost exclusively defined in terms of the government's cash contribution. This despite the fact that the tax system already plays an important role in supporting a number of health policy objectives (e.g., disability tax credit program, medical expense tax credit, recognition of care giver expenses, disability support expenses, and research and development tax incentives – to name a few).

In this context, ACAHO is of the view that it also important to review how the current tax regime impacts on the efficient allocation of resources in the system – such as the Goods and Services Tax (GST).

To date, the Association has made a number of specific recommendations to the Canadian Customs and Revenue Agency and the Department of Finance about the current application and interpretation of the 83% rebate that exists as part of the MUSH formula that reflects the full mandate of teaching centres/hospitals (i.e., service provision *and* the input costs associated with teaching & education *and* research & innovation).

However, the Association would raise, once again the challenges of administering the GST in a world where regional health governance models are in place. To simplify the tax collection process, improve the overall efficiency of the health system and to reinforce health policy objectives, ACAHO recommends that the federal government increase the GST rebate under the MUSH formula for eligible hospital authorities to 100% of eligible input costs (see Recommendation #8 in the Summary of Recommendations).

### **IN CLOSING**

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 a strategic combination of financial and structural initiatives that are required to place teaching centres/hospitals and the health system on a more sustainable footing, now and into the future.

ACAHO looks forward to remaining an active and constructive partner in the national dialogue about the future of health and health care in Canada. At the same time, the Association looks forward to continuing to participate in national discussions that focus on how strategic investments that nurture the health research and innovation enterprise can play an integral role in contributing to Canada's sustained economic prosperity.

## **SUMMARY OF RECOMMENDATIONS**

### ***Recommendation #1***

*That the federal government, in close cooperation with the provinces and territories, and in consultation with the health stakeholder community, establish a series of explicit national objectives and criteria that reflect the structure of the Wait Times Reduction Fund, and that funding be made available on the basis of how the funds will be invested to address wait times in Canada.*

### ***Recommendation #2***

*That the federal government establish a five-year National Health Human Resource Infrastructure Fund to assist those institutions that require additional capacity to educate and train Canada's health care professionals.*

### ***Recommendation #3***

*That the federal government create a one-time Health System Infrastructure Fund to assist teaching centres/hospitals in replenishing their physical infrastructure.*

### ***Recommendation #4***

*That the federal government continue to increase the base budget of the Canadian Institutes of Health Research (CIHR) within a multi-year fiscal framework until it is equivalent to a minimum of 1% of total health care spending in Canada, by 2006/07.*

### ***Recommendation #5***

*That the federal government create a multi-year fiscal framework for Genome Canada and increase its budget to \$750 million over the next 5 years.*

### ***Recommendation #6***

*That the federal government increase funding available for the indirect costs associated with research from \$245 million to \$400 million, effective 2005.*

### ***Recommendation #7***

*That the federal government – as it continues to support initiatives that accelerate the commercialization of (health) research - must take into account the unique characteristics of Canada's teaching centres/hospitals and their research institutes.*

### ***Recommendation #8***

*That the federal government increase the GST rebate under the MUSH formula for eligible hospital authorities to 100% of eligible input costs.*

## **1. INTRODUCTION**

As the national voice of teaching centres/hospitals in Canada, the Association of Canadian Academic Healthcare Organizations (ACAHO) once again appreciates the opportunity to participate in the 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. In particular, 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 inter-related policy recommendations for the Standing Committee's consideration.

## **2. 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/hospitals 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]).<sup>1</sup> They may also have formal relationships with other faculties of health (e.g., nursing, pharmacy, and dentistry) and many colleges with technical and professionals in health including physiotherapy, rehabilitation therapists, laboratory technicians, respiratory therapists, speech therapists and social workers. As an extension, 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 and their associated research institutes 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, knowledge creation and its conversion into goods and services that can have three identifiable impacts that are mutually reinforcing.

In effect, members of ACAHO are centres of health innovation and house the research brain trust that is building the platform for Canada to maximize its contribution to the biotechnology revolution, for example.

First, medical discovery, knowledge creation and innovation play an invaluable role in improving the overall health status of Canadians. Second, research, knowledge translation and innovation will continue to evolve the manner in which health care services are delivered to Canadians. In fact, many new health discoveries and treatments are pioneered in Academic Health Science Centres, and reinforce the linkage between today's health research and 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, resources dedicated to the health research enterprise contribute to developing both an attractive entrepreneurial climate as well as an engine of future economic growth and sustained prosperity.<sup>2</sup>

Strictly from an economic and social policy point of view, investments that support health research and the innovation process 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 that reflect the priorities of Canadians.

Combined, the tri-lateral mission of patient care, education & training, and health research & innovation 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 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/hospitals.
- 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 a funding standpoint, collectively members of ACAHO have budgets in excess of \$17 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.<sup>3</sup> In addition, our members employ over 150,000 Canadians and are institutional pillars in their respective communities.

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.<sup>4</sup>

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 and health care in Canada.

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 unaddressed.

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 when it comes to the future of the health system.

### **3. A TIME FOR REFLECTION**

In this past year, Canadians have witnessed an unprecedented amount of focus on the present state of their health system, and its future. With the calling of a federal election in the summer of 2004, Canadians were presented with a series of alternative policy platforms designed to place our health system on firmer ground.

More recently, much of the intense national policy dialogue culminated in a First Ministers Agreement in September 2004 (“*A Ten-Year Plan to Strengthen Health Care*”). This agreement – which some would view as being historic in nature – identifies a number of important steps forward in terms of meeting the national objectives of our health system, and sufficient flexibility for the provinces and territories to address their pressing health policy priorities. For this, both levels of government are to be congratulated for finding common policy ground and seeking to establish a more mature and progressive relationship that has been absent since the early to mid-1990s.

If Canadians are to be re-assured that the system will be there for them in times of need over the short-, medium- and long-term, they need (in part) to see that both levels of government are committed to working together in partnership – representing their best interests when it comes to accessing quality health care services on a timely basis.

Building on the First Ministers Agreement, these national discussions should also be placed in a broader context – specifically, the federal government has played a critical role in the recent creation of The Health Council of Canada, The Canadian Patient Safety Institute and the Public Health Agency of Canada. Individually and collectively, these national organizations have the potential to play an integral role in shaping the future of health and health care policy in Canada.

Thus, from a national perspective, ACAHO is of the view that a series of important and constructive policy developments have occurred and are focused on improving Canadians’ access to quality health care services. At the same time, it is also about contributing resources to the provinces and territories so they may continue to transform their health systems while improving overall accountability and transparency.

Now that a multi-year federal fiscal framework for the health system has been agreed to, there still remain significant policy questions about how “The Ten-Year Plan” will be implemented. In specific terms, how can we ensure that Canadians receive full value for the public investment in the health system by the federal government?

At the same time, in the view of ACAHO, there are a number of related policy recommendations that the Standing Committee should give consideration careful to, and should be viewed as being complementary to the First Ministers’ Agreement and would strengthen the overall strategic direction of the federal government in health.

This includes: (1) investing to build our health human resource capacity; (2) ensuring that we have accessible pools of capital to develop needed physical capacity in the system; (3) continue to build a robust and sustainable research and innovation platform in this country; (4) continue to invest in our public health infrastructure; and (5) re-think how tax policy can reinforce national health policy objectives.

#### **4. IMPLEMENTING THE FIRST MINISTERS AGREEMENT**

Now that a total of \$41.3 Billion (over 10 years) of additional funding has been made available by the federal government, the policy conversation now turns to some of the delicate questions around the administration of the Agreement and the expected deliverables with the provinces and territories. For the most part, this issue is explicitly addressed through the equal per capita formula of the Canada Health Transfer (CHT) – which is an “unconditional” investment in the health system.

However, there remains dedicated monies that have yet to be allocated, nor have the terms and conditions been made public and finalized. A case in point is the Wait Times Reduction Fund.

#### IMPROVING WAIT TIMES MANAGEMENT STRATEGIES & APPROACHES

As identified by the Prime Minister and Premiers, the issue of reducing wait times in Canada is a critical priority for all governments. In many respects, wait times are a barometer of the public's confidence in the system from coast-to-coast.

While Canadians overall remain very concerned about wait times, they are particularly sensitive about their ability to access specialty care – of which many of these services are provided in our members' institutions.

With the objective of advancing the policy yardsticks forward in this crucial area, ACAHO was pleased to co-sponsor (along with Health Canada, Canadian Institutes of Health Research, Canadian Institute of Health Information, Canadian Medical Association, and the Canadian Policy Research Networks) the "The Taming of the Queue: Wait Time Measurement, Monitoring and Management" in February 2004.

In lead up to the First Ministers Meeting, ACAHO called on Premiers to develop a strategically targeted fund (called a *National Access Fund*) to evaluate and encourage the adoption of proven wait time management strategies, as well as comparable measurement and monitoring systems.

ACAHO was pleased to see that the First Ministers Agreement sets aside \$5.5 Billion, over 10 years for the Wait Times Reduction Fund (WTRF). As stated in the text, the WTRF is intended to "...achieve meaningful reductions in wait times in priority areas such as cancer, heart, diagnostic imaging, joint replacements, and sight restoration by March 31, 2007." It goes on to say "...this Fund will primarily be used for jurisdictional priorities such as training and hiring more health professionals, clearing backlogs, building capacity for regional centres of excellence, expanding appropriate ambulatory and community care programs and/or tools to manage wait times."

Given the range of initiatives that are underway across the country, and which members of ACAHO are spearheading (e.g., Kingston General Hospital, Capital Health Authority [Edmonton], Capital District Health Authority [Halifax], St. John's Healthcare Corporation), the Association sees the federal government playing an important catalyst role in this area.

In specific terms, it is ACAHO's view that there are three inter-related areas that must be taken into account when designing the WTRF:

1. In order to establish concrete timelines and deliverables in the areas of comparable indicators and evidence-based benchmarks, clinicians and health system administrators must be involved. In effect, it is the view of ACAHO that there is the need for a strong complementary role between those who provide care and those who are the stewards of the system;
2. A portion of the WTRF should be earmarked for national policy relevant research that serves to inform the policy choices that provincial and territorial governments will ultimately make. This could include an international review; a "gap analysis" of what is underway in Canada; as well as an evaluative component that supports and evaluates new wait time initiatives or pilot projects; and

3. A need to determine an order-of-magnitude investment required for new information technologies that support wait time management approaches. In this context, Canada Health Infoway Inc., and the Canadian Institute for Health Information should be part of the dialogue.

Recently, Federal, Provincial and Territorial Ministers of Health met in Vancouver on October 16-17, 2004, to discuss, amongst other issues, progress related to the development of the WTRF mechanism. While we understand that more significant progress will be reported back to Ministers in January 2005, ACAHO remains concerned about the specific terms and conditions under which funding from the WTRF will flow.

Based on the spirit and wording of the First Ministers Agreement, one would expect that any funding that flows from the WTRF would be explicitly tied to a transparent national process to develop comparable wait time indicators and benchmarks. From an accountability point of view, this would still give the provinces and territories full flexibility in reporting directly to their own citizens.

ACAHO therefore recommends:

***Recommendation #1***

***That the federal government, in close cooperation with the provinces and territories, and in consultation with the health stakeholder community, establish a series of explicit national objectives and criteria that reflect the structure of the Wait Times Reduction Fund, and that funding be made available on the basis of how the funds will be invested to address wait times in Canada.***

Given that a number of our members are involved in a range of initiatives across the country, we believe that the Association can offer significant value to a national approach that is transparent in process, and accountable in terms of funding.

## **5. INVESTING IN A NATIONAL RESOURCE...CANADA'S TEACHING CENTRES/HOSPITALS**

As set out in previous Briefs to the Standing Committee on Finance, ACAHO is of the view that by virtue of our members' mission and mandate, they are a national resource in the health system.

This view was confirmed by the Standing Senate Committee on Social Affairs, Science and Technology which recognized the unique and substantial value that teaching centres/ hospitals bring to the health system.<sup>5</sup>

If one accepts this view, the public policy challenge then becomes what role is there for the federal government to address the national roles and responsibilities of teaching centres/hospitals in Canada? More specifically, how can the federal government nurture and support the role of teaching centres/hospitals in a system that is experiencing profound change?

In past years, ACAHO has recommended to the Standing Committee on Finance that it establish a *National Teaching Centre Health Infrastructure Fund*<sup>6</sup> that would investment in four targeted areas: (1) build additional health human resource capacity; (2) accelerate the diffusion of new

medical equipment/technologies; (3) upgrade health information technologies; and (4) rejuvenate our outdated institutions and build additional physical capacity.

Since 2000, federal, provincial and territorial governments have reached a series of agreements (“Accords”). As a result, the federal government has established time-limited and strategically targeted funds that have addressed - to some degree - ACAHO’s concerns about purchasing medical equipment (via the Medical Equipment Fund), and health information technologies (through the Health Information Technology Fund, and Canada Health Infoway Inc.,).

Complementary to these policy initiatives, ACAHO believes that there is a legitimate role for the federal government to assist members of ACAHO in fulfilling their mission and mandate as a national resource in the following areas: (1) health human resources; and (2) (re)building physical capacity.

### HEALTH HUMAN RESOURCES

If the health system is to thrive and simply not survive, then we must ensure that we value and continue to invest in our most highly prized assets – health care professionals. While it is unlikely that anyone would disagree with this over-arching policy statement, the question is what specific role can the federal government play in this area?

If the prime objective of the health system is to ensure that Canadians have timely access to quality health care services, there are growing concerns in a number of quarters that the current and future supply of health care professionals (be it physicians, pharmacists, nurses, or technicians) is not able, now or into the future, to meet the demand for health care services.

The First Ministers Agreement states that both levels of government are committed to facilitating better planning and management of health human resources – with one likely outcome being an increase in the training slots and future supply of needed health care professionals – ACAHO sees a very legitimate role for the federal government in making this happen.

As well, ACAHO recognizes and supports the commitments by the federal government that are outlined in the Agreement.<sup>7</sup>

Notwithstanding the policy issues related to accessing health care providers on a timely basis - which is essential to the mission/mandate of teaching hospitals, ACAHO is also concerned about the system’s capacity to train an adequate number of health care professionals. Keep in mind that health care professionals’ hands-on experience is largely within teaching centres/hospitals. This latter point underscores one essential role of teaching centres in Canada – which provides virtually all post-graduate health care professional training infrastructure.

In order to increase the number of health care trainees coming through the system, it will be necessary to invest resources to expand the physical infrastructure of teaching centres. In so doing, it will facilitate our collective ability to increase the supply of health care professionals to meet the future health care needs of Canadians.

Thus, while there is a growing consensus that Canada’s health care system will have to increase the range of training slots for health care professionals, teaching centres will have to absorb a significant increase in operational and infrastructure costs to train new recruits. Overhead costs include the requisite costs to support education which includes funding for instructors, space, overhead and supplies.

If this is the case, the Association is of the view that there is a legitimate role for the federal government in terms of financially assisting teaching centres/hospitals in expending their capacity to train a growing cohort of health care professionals in their institutions. By our calculations, an investment of \$425 million over 5 years will be required.<sup>8</sup> This issue was specifically acknowledged by the Senate Standing Committee on Social Affairs, Science and Technology's final report on "The Health of Canadians – The Federal Role".<sup>9</sup>

ACAHO respectfully recommends:

***Recommendation #2***

***That the federal government establish a five-year National Health Human Resource Infrastructure Fund to assist those institutions that require additional capacity to educate and train Canada's health care professionals.***

(RE)BUILDING PHYSICAL CAPACITY

In 1948, the federal government established the *Hospital Construction Grants Program*. The purpose of this program was to make available grants to the provinces and territories that would cover the cost of building new hospitals. This initiative – designed to build physical capacity in the system - was seen as a vital precursor to the development of first-dollar coverage for hospital-based services through the *Hospital Insurance and Diagnostic Services Act*, and what we now know as Medicare.

Today, the national policy discussion about the future of the health system is largely concerned with the "operational" resources that are needed to provide Canadians with access to a range of quality health care services. As important as this is, it is also essential that we consider the state of the system's physical capacity, and what is required for the future knowing that much of our acute care institutional capacity was built around the turn of the century.

The challenges associated with this issue are underscored when one considers the following:<sup>10</sup>

- Between 1982 and 1998 real public per capita expenditures on new hospital construction decreased from \$50 to \$2, or 5.3 per cent annually.
- From 1998 real public per capita expenditures on new hospital machinery and equipment has fallen by 1.8 per cent annually.

In the view of ACAHO, the current stock of institutions remains under funded and depreciation is not fully recognized by the federal or provincial governments from a funding perspective. As a result, hospitals do not have the resources to either upgrade their facilities, or if required expand capacity (for example, hospital capital investment modernization and capacity expansion requirements have been estimated to be between \$7.0 and \$9.0 billion.<sup>11</sup>

As a result, many capital investment decisions appear to be based on short-term responses to needs rather than a long-term planning horizon. In some cases, additions or renovations are made to old structures, when full reconstruction might have been a more appropriate policy decision.

In this context, ACAHO strongly supports resources that would be targeted to assist teaching centres/hospitals in renewing their physical infrastructure and enhance their ability to meet their mission and mandate as a national resource in the system.

While the federal government has established an Infrastructure Program, the health sector is not eligible to apply. Furthermore, the recent decision by the government to modify how municipalities are treated under the Goods and Services Tax (GST) provides additional funding for cities. Given that many institutions are beyond their life expectancy, we believe it is timely and appropriate for the federal government to establish a mechanism that would assist the health community in replenishing and adding to the system's physical capacity.

***Recommendation #3***

***That the federal government create a one-time Health System Infrastructure Fund to assist teaching centres/hospitals in replenishing their physical infrastructure.***

This recommendation was supported by the findings of the Senate Standing Committee on Social Affairs, Science and Technology – which recommended that “*The federal government contribute \$4.0 billion over the next 10 years (or \$400 million annually) to Academic Health Sciences Centres for the purpose of capital investment.*”

SECURING THE FUTURE OF CANADA ACADEMIC HEALTH SCIENCES CENTRES

To better understand the challenges that face our health system - and their solutions – governments have commissioned a number of reports that have considered the role of the federal government, what constitutes a national system, and the local imperatives that exist at the provincial and territorial.

While the reports have covered a wide range of policy issues and challenges, there is a concern that Canada's Academic Health Sciences Centres (AHSCs) have not garnered the consideration they require. Recognizing the essential role that AHSCs play in providing primary and specialty care services, educating and training tomorrow's health professionals, and supporting and conducting world class research, there is a strongly shared view amongst a broad range of national organizations that now is an opportune moment in time to consider their future mission and mandate, and roles and responsibilities. This is particularly relevant given the transformative health policy issues that are currently under discussion and implementation.

In this context, over twenty national organizations are supportive of creating a collaborative and inclusive process with governments to consider how AHSCs fit within a health system that is experiencing profound change (see Appendix B).<sup>12</sup>

We bring this proposed initiative to the attention of the Standing Committee on Finance not only because it will have a likely budgetary impact on the government, but that it is an important process that is overdue. The Association looks forward to officially engaging governments in a more formal and substantive discussion about how such a process could be shaped and ultimately initiated.

## **6. STRENGTHENING CANADA'S HEALTH RESEARCH ENTERPRISE**

### FROM THE RECENT PAST...

In the recent past, the federal government has introduced a series of significant steps in supporting Canada's health research enterprise and the role of medical discovery, knowledge creation and its translation, and innovation through a number of connected policy measures. They include:

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

In last year's budget, the federal government set aside \$50 million over five years for pilot projects to support the capacity for commercialization with the best initiatives to receive funding.

As well, the government has set aside \$250 million for investment in venture capital through the Business Development Bank of Canada. Of the five areas that have been identified, four (life sciences, biotechnology, medical technologies, and information and communication technologies) have a direct relationship with the health system. It is anticipated that this investment will leverage a total of \$1.0 billion in new venture capital in Canadian companies.

These are significant investments when one considers that institutions in Canada account for 25% of the funding for health research (in addition to government funds). Furthermore, approximately 80% of public monies invested in Canada's health research enterprise occur in our members' institutions.<sup>13</sup> As a result, it is estimated that 70%-80% of all health research is conducted in teaching centres/hospitals.

Combined, these investments have had a substantial impact in supporting the mission and mandate of members of ACAHO.

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.

For these efforts, ACAHO strongly applauds the federal government. These measures will begin to yield short-, medium- and ultimately longer-term health and economic benefits that will accrue to Canadians at the individual and societal level.

Furthermore, the public is very supportive of increased public sector funding for Canada's health research enterprise.<sup>14</sup>

## ...INTO THE FUTURE

In the recent First Ministers Agreement, ACAHO was very pleased to see the following text: “A strong, modern health care system is a cornerstone of a healthy economy. Investments in health system innovation through science, technology and research help to strengthen health care as well as our competitiveness and productivity. Investments in science, technology and research are necessary to develop new, more cost-effective approaches and to facilitate and accelerate the adoption and evaluation of new models of health protection and chronic disease management. Recognizing the progress that has been made, the federal government commits to continued investments to sustain activities in support of health innovation.”

The key policy question is how to identify and execute an effective strategic approach that fully leverages our public and private investments in the health research enterprise. Since the fruits of research are not borne overnight, it is important for the federal government to appreciate that a sustained long-term approach to investing in health research necessary.

Members of ACAHO play an essential role when it comes to facilitating the advancement of health research, medical discovery, knowledge creation and innovation in Canada. In fact, teaching centres/hospitals and their research institutes provide a large proportion of the physical infrastructure that supports Canada’s health research community.<sup>15</sup>

To confirm this point, the document “*World Class Achievements and Major Medical Breakthroughs*” underscores the diverse and integral role that Ontario’s academic and teaching hospitals play in developing innovative, leading-edge breakthroughs in the provision of health care.<sup>16</sup>

Members of ACAHO 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 the view of ACAHO, research is the oxygen of evidence-based decision-making. It is the basis upon which many sound public policy decisions are based. In effect, today’s health research will provide us with innovative and evidence-based solutions to maintain and improve: (1) our individual and collective health status, (2) the manner in which we deliver cost-effective care and design health systems; and (3) our ability to prosper on a sustained economic basis.

Importantly, each of the impacts of health research that are noted above are mutually reinforcing, and are built on the public platform of our health system. This alone presents Canada with a very unique opportunity to continue to harness the multiple benefits that flow from health research and innovation.

Given the inter-relationships that have been noted above, ACAHO would identify three specific 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 a minimum of 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 medium- and longer-term strategic planning and organizational stability, the Association would strongly encourage the federal government to table a multi-year funding framework for CIHR in its 2005 budget.

ACAHO respectfully recommends:

***Recommendation #4***

***That the federal government continue to increase the base budget of the Canadian Institutes of Health Research (CIHR) within a multi-year fiscal framework until it is equivalent to a minimum of 1% of total health care spending in Canada, by 2006/07.***

In addition to CIHR, Genome Canada has a significant role to play in impacting on Canada's health research agenda. Given their multi-sectoral focus, ACAHO also believes that they should have the flexibility to plan within a multi-year fiscal framework. Furthermore, given the significant potential of discoveries in the genomic field, ACAHO is supportive of increasing Genome Canada's budget to \$750 million over the next 5 years.

ACAHO therefore recommends:

***Recommendation #5***

***That the federal government create a multi-year fiscal framework for Genome Canada and increase its budget to \$750 million over the next 5 years.***

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/hospitals and their research institutes 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 2004 budget, the federal government responded to the concerns expressed by ACAHO and others and created a permanent fund (subject to a three-year review), that was increased from \$225 million to \$245 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 applauds the federal government for its annual investment of \$245 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. The \$400 million is intended to reflect the 40% of operating costs associated with federal funded research.

ACAHO recommends:

***Recommendation #6***

***That the federal government increase funding available for the indirect costs associated with research from \$245 million to \$400 million, effective 2005.***

This is consistent with the Standing Committee's recommendation contained in its report to the House of Commons in 2002.<sup>17</sup>

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 (RHF) 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 (i.e., bench to bedside) to health research.

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.

At the time of writing, ACAHO is sensitive to the concerns that have been raised by the provinces and territories with regard to the 40% matching requirement of the Research Hospital Fund. Given that a significant sum of resources are at stake and play a critical role in supporting innovative research, ACAHO would strongly encourage the federal government working closely with the Canada Foundation for Innovation, and the provinces and territories to find common ground and implement a long-term solution to this issue.

With the first round of applicants now being considered for funding from the Research Hospital Fund, ACAHO looks forward to working closely with CFI to ensure that the Fund meets its program objectives – now and into the future. That said, ACAHO is interested in exploring ways in which the health research community can have more direct access to the RHF.

When the time approaches for the federal government and CFI to consider its future, ACAHO would be strongly supportive, in principle, of renewing both the mandate of CFI and the Research Hospital Fund.

## MAXIMIZING THE FULL ECONOMIC POTENTIAL OF INNOVATIVE HEALTH RESEARCH

In its October 2004 Speech From the Throne, the government stated “*The Government will develop policies to foster Canadian capabilities in key enabling technologies – such as biotechnology, information and communications, and advanced materials – which will be drivers of innovation and productivity in the 21<sup>st</sup> Century economy.*” In principle, ACAHO would strongly endorse this direction and looks forward to working with the federal government in making this a reality.

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.

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.

In more concrete terms, ACAHO is supportive of initiatives to commercialize research that recognize the unique potential and environment that resides within teaching centres/hospitals and their research institutes. These initiatives should embrace the many dimensions of innovation that stem from health research and move through the stages of development, testing, production, financing and marketing. Importantly, initiatives must 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.

In this light, it will also be critical that we have the necessary human capital, physical infrastructure and linkages to the private sector to take full advantage of our opportunities.

Given where the large majority of Canada's health research and commercialization 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.

Understanding that work in this area is already underway in teaching centres/hospitals across the country, ACAHO strongly supports the development of a number of health research networks focused on commercialization – with a focus on human capital development and receptor capacity-building - that would be anchored in Canada's teaching centres/hospitals and research institutes.

At this stage, the \$50 million announcement in the 2004 federal budget to seed pilot projects for commercialization is welcomed by ACAHO. As we move forward to invest in a number of pilot projects it will be important to support the unique characteristics that Canada's teaching centres/hospitals bring to the process of commercialization.

ACAHO therefore recommends:

***Recommendation #7***

***That the federal government – as it continues to support initiatives that accelerate the commercialization of (health) research - must take into account the unique characteristics of Canada's teaching centres/hospitals and their research institutes.***

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

## **7. CANADA'S PUBLIC HEALTH INFRASTRUCTURE AND CAPACITY BUILDING**

In last year's budget, ACAHO was very pleased to see the federal government create the Public Health Agency of Canada (with a Chief Public Health Officer) and commit \$700 million per year to national public health functions in addition to the existing \$300 million in core funding for Health Canada.

While the initial investment is warmly welcomed, it is viewed as being a starting rather than an end point. As a member of the Canadian Coalition for Public Health in the 21<sup>st</sup> Century,<sup>18</sup> ACAHO is supportive of the six recommendations that are outlined in our Brief to the Standing Committee under the areas of: (1) More Resources to the Front Lines; (2) Funding for the Public Health Agency of Canada; (3) A National Public Health Workforce Strategy; (4) A National Immunization Strategy; (5) Data Requirements – Prevention and Control of Disease; and (6) Benchmarks for Public Health Performance.<sup>19</sup>

## **8. TAX POLICY SUPPORTING HEALTH POLICY OBJECTIVES**

As we collectively consider the future of Canada's health system, issues of federal funding are almost exclusively defined in terms of the government's cash contribution. This despite the fact that the tax system already plays an important role in supporting a number of health policy objectives (e.g., disability tax credit program, medical expense tax credit, recognition of caregiver expenses and disability support expenses, research and development tax credits – to name a few).

In this context, ACAHO is of the view that it is also important to examine how the current tax regime impacts on the efficient allocation of resources in the system – such as the Goods and Services Tax (GST).<sup>20</sup>

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 to be 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.

If the 83% figure is to remain, ACAHO would strongly encourage CCRA to broaden their interpretation to ensure that teaching/education and health research activities are eligible for a rebate.

As part of this review, we would bring to the attention of the Standing Committee the current anomalies that exist with the application of the Goods and Services Tax (GST) to a health system that already exists with regional governance structures. As a result, a number of different sectors (e.g., acute care, long-term care, nursing home care) under the responsibility of the Regional Health Authorities must be treated differently for tax purposes. This tax policy approach is neither efficient, nor does it reinforce health policy objectives.<sup>21</sup>

As it currently stands, hospitals (the “H” under the MUSH formula) are entitled to an 83% rebate, with other organizations having a range of rebates – which causes difficulty in the overall efficiency of the tax and its administration at the local level. To simplify this process and to be better aligned with the integrated nature of Regional Health Authorities, ACAHO is supportive of a more homogeneous approach to how the GST is administered in this area.

In keeping with the recent policy decision by the federal government to provide a full GST rebate to municipalities (the “M” in the MUSH formula), ACAHO is of the view that the same treatment should be accorded to all public health institutions.

By adopting this policy approach, the government would not only be investing in the health system through federal tax policy, but it would also place all institutions who absorb GST costs on a level playing field.

ACAHO respectfully recommends:

***Recommendation #8***

***That the federal government increase the GST rebate under the MUSH formula for eligible hospital authorities to 100% of eligible input costs.***

Based on documentation from Finance Canada, it is estimated that the proposed change would have the federal government directly invest an additional \$90 million annually into eligible institutions.<sup>22</sup>

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.

## **9. IN CLOSING**

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 remaining 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 enterprise can play an integral role in contributing to Canada’s sustained economic prosperity.

## ENDNOTES

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<sup>1</sup> The term Academic Health Sciences Centre is a relatively recent label given to the relationship that exists between university-level health/clinical education programs and the affiliated hospitals/health regions that provide the physical facilities necessary for research and education. JC Lozon, RM Fox. *Academic Health Sciences Centres Laid Bare*. Healthcare Papers, Vol. 2, No. 3, 2002.

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

<sup>3</sup> The Canadian Institute for Health Information. May, 2002.

<sup>4</sup> Green JP, MacBride-King J. *Corporate Health Care Costs in Canada and the U.S.: Does Canada's Medicare System Make a Difference?* Conference Board of Canada, 1999. Purchase B. *Health Care and Competitiveness*. School of Policy Studies, Queen's University, 1996.

<sup>5</sup> Standing Senate Committee on Social Affairs, Science and Technology. *The Health of Canadians – The Federal Role. Volume Six – Recommendations for Reform*. Pages 46-61.

<sup>6</sup> For a more detailed analysis, see ACAHO's 2003 submission to the House of Commons Standing Committee on Finance "*Health, Health Care and Nation-Building...Harnessing the Full Potential of A National Resource: Canada's Teaching Centres and Hospitals*." September 18, 2003.

<sup>7</sup> The Agreement states "The federal government commits to: (1) accelerate and expand the assessment and integration of internationally trained health care graduates for participating governments; (2) targeted efforts in support of Aboriginal communities and Official Languages Minority Communities to increase the supply of health care professionals for these communities; (3) measures to reduce the financial burden on students in specific health education programs; and (4) participate in health human resource planning with interested jurisdictions.

<sup>8</sup> Assuming that we need to increase the number of new physicians by a range of 640 to 1,140 (as recommended by the Association of Canadian Medical Colleges), and the need to address current and looming shortages in nursing, pharmacy and the other health care professions, ACAHO has estimated that the additional costs associated with increases in health care training positions over the course of their training cycle is in the \$300 million to \$550 million range. Taking a mid-point of \$425 million, this would require an annual investment of \$85 million over the next five years.

<sup>9</sup> The recommendation is worded as follows: "*The federal government devote \$75 million per year of the new money the Committee recommends be raised to assisting Academic Health Sciences Centres to pay the costs associated with expanding the number of training slots for the full range of health care professionals*." *The Health of Canadians – The Federal Role. Volume Six: Recommendations for Reform*, Page 198.

<sup>10</sup> *Specialty Care in Canada – Issue Identification and Policy Challenges*. Canadian Medical Association, September, 2001, page 15.

<sup>11</sup> Ontario Hospital Association. *Capital Planning and Investment in Ontario's Hospitals*. November 2003.

<sup>12</sup> Brimacombe G. *Securing the Future of Canada's Academic Health Sciences Centres*. Healthcare Quarterly, Vol. 7, No. 4, 2004

<sup>13</sup> *Strengthening the Foundation of Canada's Health Research Enterprise: A Backgrounder*. Prepared by the Leaders' Forum on Health Research in Canada Steering Committee, September 8, 2004.

<sup>14</sup> In a soon to be released public opinion poll by Pollara, in answering the following question: "*There should be increased public sector funding for health research, such as at universities, teaching hospitals and other not-for-profit organizations*", 84% of Canadians strongly agreed or agreed with the statement.

<sup>15</sup> *Strengthening the Foundation of Canada's Health Research Enterprise: A Backgrounder*. Prepared by the Leaders' Forum on Health Research in Canada Steering Committee, September 8, 2004.

<sup>16</sup> *World Class Achievements and Major Medical Breakthroughs, 2003/04*. Ontario Hospital Association and the Ontario Council of Teaching Hospitals.

<sup>17</sup> 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.

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<sup>18</sup> CCPH21C is a partnership of 37 national non-government, professional, health and research organizations and coalitions committed to making Canadians the healthiest people in the world by advocating for an effective integrated public health system.

<sup>19</sup> *Closing the Naylor Gap*. A Contribution from the Canadian Coalition for Public Health in the 21<sup>st</sup> Century to the Standing Committee on Finance. November 2004.

<sup>20</sup> The introduction of the GST – which designates health care services as tax exempt, or eligible for a rebate depending on the type of facility - has raised a series of policy challenges for the health care community. In particular, the Canadian Healthcare Association and the Canadian Medical Association have identified a number of anomalies that exist under the current tax regime.

<sup>21</sup> A background paper produced by the Canadian Healthcare Association reviews in detail the range of anomalies that are at play.

<sup>22</sup> *Tax Expenditures and Evaluations – 2004*. Finance Canada.