



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

***ALIGNING FEDERAL PRIORITIES
WITH PUBLIC INVESTMENTS...***

**MAXIMIZING THE PERFORMANCE
OF CANADA'S HEALTH SYSTEM**

**A SUBMISSION TO
THE HONOURABLE JIM FLAHERTY
MINISTER OF FINANCE
APRIL 19, 2006**

THE ASSOCIATION OF CANADIAN ACADEMIC HEALTHCARE ORGANIZATIONS (ACAHO)

WHO WE ARE...

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 and their Research Institutes. 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 rehabilitation therapists, laboratory technicians, respiratory therapists, and speech therapists.
- They provide the large majority of infrastructure to support and conduct health research in its dimensions - medical discovery, knowledge creation, innovation and commercialization.

OUR MISSION...

The mission of ACAHO is to provide national leadership and effective policy representation in the three separate, but inter-related areas of:

- The funding, organization, management and delivery of highly specialized tertiary and quaternary, as well as primary care services.
- The education and training of the next generation of Canada's health care professionals, and
- Providing the necessary infrastructure to support and conduct basic and applied health research, medical discovery, knowledge creation and innovation.

For more information on the activities of the Association, please visit our web-site at www.Acaho.org.

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EXECUTIVE SUMMARY

INTRODUCTION

As the national voice of teaching hospitals/centres in Canada, the Association of Canadian Academic Healthcare Organizations (ACAHO) appreciates the opportunity to participate in the e-public consultation process established by The Minister of Finance.

Understanding that the future of health and health care remains the highest public policy priority in the country, Canadians continue to look to the federal government to play a critical leadership role in renewing our most important social program. In this context, the Association looks forward to contributing to the national policy dialogue that is increasingly focused on the strategic alignment of investments that are intended to improve the health and well-being of Canadians and the role of the federal government.

The Association of Canadian Academic Healthcare Organizations (ACAHO) would like to congratulate the Conservative Party on its recent election victory and looks forward to working in close collaboration with the government as it begins the process of implementing its national policy agenda on behalf of all Canadians.

Given the stated strategic focus of the federal government, ACAHO is of the view that there are important policy opportunities and challenges where the Association can work effectively with the government to make our health system increasingly flexible, dynamic and sustainable – while building on the fundamental tenets that have served Medicare well.

TIMELY ACCESS TO CARE AND CAPACITY BUILDING

It is clear that wait times are the barometer by which Canadians perceive the performance of the health system. Yet, as important as wait times are, their very existence is closely linked to a range of other policy issues.

For example, the lack of available family physicians, specialists, nurses or technicians has a direct impact on the availability of health services. At the same time, limited operating revenues for teaching hospitals and/or regional health authorities can also impact on the number of surgical suites, as can restricted capital budgets limit the number of diagnostic and therapeutic pieces of equipment in use – not to mention existing and future wards. In other words, as much as there has been an appropriate focus on the amount of time one waits for care, there are a combination of policy pressures (and levers) related to the overall *capacity* of the system that must also be considered and addressed.

We must also recognize that we need to continue to improve the manner in which we effectively manage current resources in an efficient and responsible way that is accountable to Canadians. In effect, giving the public a clearer sense as to the new strategic initiatives underway to make our health system increasingly flexible, innovative and responsive.

As much as the national health policy discussion has focused on the importance of establishing wait time benchmarks and targets – and more recently care guarantees, it is critical to understand that these wait time measure are, effectively, a means to an end. In other words, if the system is to meet the established wait time benchmarks (and guarantees) that have been agreed to by governments, we must ensure that the health system – in its dimensions, has the *capacity* to

increase patient throughput as well as the management tools and knowledge to more effectively allocate resources across the system.

Based on the findings of the Association, four inter-locking elements must be addressed to ensure that the health system will have the capacity as well as flexibility to provide quality health services on a timely basis:

1. An adequate number and distribution of health care professionals, now and into the future.
2. Adequate physical (i.e., delivery) infrastructure to provide care to patients.
3. Accelerate the introduction of health information technologies to improve the clinical as well as administrative decision-making processes.
4. Invest in the generation and dissemination of knowledge that can be gained through health research (see Section 4 of the Brief).

These four elements of capacity should not be thought of in isolation, but rather as a series of cohesive system measures that are necessary to ensure that the health system remains flexible, dynamic and responsive over the medium and longer-term. It is also important to note that these four elements of capacity are closely aligned with the recent views articulated by the Minister of Health in the House of Commons.

If the health system is to thrive and not simply survive, we must ensure continued investment in our most prized assets - health care professionals. ACAHO, in principle, supports a Pan-Canadian health human resources strategy to make certain Canada is self sufficient in health human resources. In order to increase the number of health care trainees, it will be necessary to invest resources to expand the physical infrastructure of teaching centres. ACAHO supports the establishment of a National Health Human Resource Fund to build capacity to educate and train Canada's health care professionals (see *Recommendation #1*).

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 vitally important as this is, it is equally 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.

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. It is therefore timely and appropriate for the federal government to establish a mechanism, such as a Health Delivery Infrastructure Fund, to assist the health community in replenishing and adding to the system's physical capacity; to help rebuild many of the institutions that were originally funded through the *Hospital and Construction Grants Program* (see *Recommendation #2*).

An important element in the renewal of the system, beyond physical rebuilding efforts, is having a state-of-the-art information technology system. A recent study has estimated that the investment in Canada Health Infoway (CHI) has the potential to generate an annual savings of \$6.1 billion *annually* to the health system. This cost-benefit analysis supports the completion of the CHI mandate as expeditiously as possible (see *Recommendation #3*).

INVESTING IN RESEARCH, INNOVATION AND COMMERCIALIZATION ENTERPRISE

In the view of ACAHO, research is the oxygen of an evidence-based health system. It is the basis on which many sound public policy decisions are based; it is the backbone of a health system upon which cost-effective clinical and/or administrative decisions are taken. Research is the foundational building block that facilitates innovation in at least three dimensions, it: (1) contributes to improving the individual and collective health status of Canadians; (2) impacts on the architecture of the health system and the manner in which we deliver cost-effective health services; and (3) produces leading-edge, world class discoveries that provide opportunities to leverage major economic benefit as well as health gains.

The Canadian Institutes of Health Research (CIHR) is the country's premiere funding Agency for health research. While there have been significant increases in CIHR's budget over the past few years, ACAHO is strongly supportive of a multi-year fiscal framework that will increase its base (see *Recommendation #4*).

In its 2003 budget, the federal government responded to the concerns expressed by ACAHO and others by creating a permanent fund to address the indirect costs associated with universities, colleges and research hospitals. ACAHO strongly applauds the federal government for its annual investment and would encourage the federal government to increase the value of the program so that it is funded at an appropriate international competitive level, and that this component of innovation is not a rate limiting step to achieving excellence (see *Recommendation #5*).

While increases in funding for basic and applied health research are 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 state-of-the-art infrastructure, and its maintenance. From the perspective of ACAHO, the Canada Foundation for Innovation (CFI) has played a vital role in rejuvenating the country's health research infrastructure and thereby enabled leading edge research which could not have otherwise been undertaken. ACAHO recommends that the federal government take the appropriate steps now to further invest in research infrastructure through CFI (see *Recommendation #6*).

There is one last 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. 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. 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.

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 (see *Recommendation #7*).

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

STRENGTHENING PUBLIC HEALTH CAPACITY

With respect to public health infrastructure and capacity building, ACAHO commends the federal government for their role in naming a Minister of State, Public Health and further, the creation of a Public Health Agency and a Chief Public Health Officer. While the initial investment was warmly welcomed, the Association views it as a starting rather than an end point. As a member of the Canadian Coalition for Public Health in the 21st Century, ACAHO is supportive of the recommendations that are outlined in the Brief to the Standing Committee (*see Recommendation #8*).

ALIGNING TAX POLICY WITH HEALTH POLICY

Currently, there are some policy challenges associated with the manner in which the GST rebate is applied across the health sector, and what is eligible for the rebate.

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 publicly funded, not-for-profit, health institutions (*see Recommendation #9*).

As the situation stands, it would appear that current CRA policy might be interpreted as redirecting resources away from the health system that are intended for patient care – and returned back to the federal government through increased tax revenues.

By adopting this policy approach, the federal government would achieve 3 important outcomes: (1) it would invest in the health system via federal tax policy instruments; (2) it would more effectively align tax policy objectives with health policy objectives; and (3) it would place all institutions who absorb GST costs on a level playing field.

IN CLOSING

This Brief is about looking to tomorrow, and making sure that we collectively make wise public policy choices to ensure that our health system is there for future generations. ACAHO is of the view that there are a number of ways in which the federal government can make several “legacy investments” – that are strategic and targeted in nature, and will place the health system on firmer ground, while improving its overall performance and level of accountability.

SUMMARY OF RECOMMENDATIONS

Recommendation #1

That the federal government establish a National Health Human Resource Fund to build capacity to educate and train Canada's health care professionals.

Recommendation #2

That the federal government create a one-time Health Delivery Infrastructure Fund to assist teaching centres/hospitals (re) build their capacity to provide timely care to Canadians.

Recommendation #3

That the federal government invest an additional \$1.8 billion (\$600 million over the next three years) to accelerate the work of Canada Health Infoway.

Recommendation #4

That the federal government increase the base budget of the Canadian Institutes of Health Research (CIHR) by \$300 million over the next 3 years.

Recommendation #5

That the federal government increase funding available for the indirect costs associated with research funded by the three federal Granting Agencies from \$260 million (29.4%) in 2005/06 to \$450 million (40%), effective 2006/07.

Recommendation #6

That the federal government take the appropriate steps to further invest in research infrastructure through Canada Foundation for Innovation (CFI) in 2006.

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, and the role they play in the commercialization process.

Recommendation #8

That the federal government increase core funding for federal public health functions by an additional \$600 million to facilitate a coordinated and comprehensive response to the public health needs of Canadians by all levels of government and non-government organizations.

Recommendation #9

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 hospitals/centres in Canada, the Association of Canadian Academic Healthcare Organizations (ACAHO) appreciates the opportunity to participate in the *e*-public consultation process established by The Minister of Finance.

Understanding that the future of health and health care remains the highest public policy priority in the country, Canadians continue to look to the federal government to play a critical leadership role in renewing our most important social program. In this context, the Association looks forward to contributing to the national policy dialogue that is increasingly focused on the strategic alignment of investments that are intended to improve the health and well-being of Canadians and the role of the federal government.

ACAHO represents Teaching Hospitals, Regional Health Authorities and their Research Institutes that are affiliated with Universities – known as Academic Health Sciences Centres. Members range from single hospital organizations, to multi-site, multi-dimensional regional organizations. Our members serve a unique and very essential role in the health care system: (1) they provide much of the specialized health care services to Canadians as well as some primary care services; (2) advance leading edge innovative practices through health research; and (3) educate the next generation of health care professionals.

Given our roles and responsibilities, we strongly believe that our members have an essential role to play in accelerating the convergence between timely access to quality care, an adaptable and well-trained health workforce in Canada, and system innovations. In many respects, these are foundational elements that underpin our ability to strengthen the fabric of Canadian life and build a truly modern and prosperous 21st Century economy.

Through our mission and mandate, ACAHO is of the view that our members are not only a local, regional, provincial and/or territorial resource, but are a *national* resource that has the competency and capacity to address a broad range of health issues that have important strategic implications in the broader societal context.

As leaders of leading edge health organizations, members of ACAHO have an important role to play in renewing our health system. We look forward to continuing to participate in the national public policy dialogue, and to working collaboratively with the federal government to identify lasting processes and policy solutions that will serve to place our health care system on the road to long-term structural and financial sustainability.

2. SETTING THE CONTEXT...

The Association of Canadian Academic Healthcare Organizations (ACAHO) would like to congratulate the Conservative Party on its recent election victory and looks forward to working in close collaboration with the government as it begins the process of implementing its national policy agenda on behalf of all Canadians.

Given the stated strategic focus of the federal government, ACAHO is of the view that there are important policy opportunities and challenges where the Association can work effectively with the government to make our health system increasingly flexible, dynamic and sustainable – while building on the fundamental tenets that have served Medicare well.

The purpose of this Brief is to offer a series of recommendations that focus on providing Canadians with timely access to a range of quality health services – and strengthen the linkages between the federal government’s identified priorities and the role of Canada’s Teaching Hospitals and Regional Health Authorities who have overall responsibility for the country’s academic mission (i.e., providing timely access to a range of quality health care services, training the next generation of health care professionals, and supporting and conducting health research & innovation).

In more specific terms, the Association is of the view that there are a number of strategic policy areas where the federal government can continue to make significant contributions in advancing the transformation of the health system. As a result, ACAHO believes that the government – by virtue of its roles and responsibilities – has a natural and legitimate role to play on a number of key policy files working in concert with the provinces and territories, providers, institutions and the public.

With this in mind, ACAHO believes that it has a unique perspective and fundamental role – not to mention contribution – to bring to the deliberations of The Minister of Finance as you prepare the government’s 2006 Budget.

Given the range of policy challenges that are before us, the Brief focuses on four strategic areas that are critical to the future of health and health care in Canada:

1. Timely Access to Care and Capacity Building
2. Canada’s Health Research Enterprise
3. Strengthening Public Health Capacity, and
4. Aligning Tax Policy with Health Policy Objectives

3. TIMELY ACCESS TO CARE AND CAPACITY BUILDING...

It is clear that wait times are the barometer by which Canadians perceive the performance of the health system. Yet, as important as wait times are, their very existence is closely linked to a range of other policy issues.

For example, the lack of available family physicians, specialists, nurses or technicians has a direct impact on the availability of health services. At the same time, limited operating revenues for teaching hospitals and/or regional health authorities can also impact on the number of surgical suites, as can restricted capital budgets limit the number of diagnostic and therapeutic pieces of equipment in use – not to mention existing and future wards. In other words, as much as there has been an appropriate focus on the amount of time one waits for care, there are a combination of policy pressures (and levers) related to the overall *capacity* of the system that must also be considered and addressed.

We must also recognize that we need to continue to improve the manner in which we effectively manage current resources in an efficient and responsible way that is accountable to Canadians. In effect, giving the public a clearer sense as to the new strategic initiatives underway to make our health system increasingly flexible, innovative and responsive.

In September 2004, a new era of system accountability was ushered in by First Ministers (“*A 10-Year Plan to Strengthen Health Care*”) with the commitment to benchmarks and targets for five priority areas. While the Association publicly applauded the significant progress that was made

by all jurisdictions, it noted that we must ensure that the health system has the capacity to meet the benchmarks (and the targets that have yet to be released), and that further collaborative work was required.¹

As much as the national health policy discussion has focused on the importance of establishing wait time benchmarks and targets – and more recently care guarantees, it is critical to understand that these wait time measures are, effectively, a means to an end. In other words, if the system is to meet the established wait time benchmarks (and guarantees) that have been agreed to by governments, we must ensure that the health system – in its dimensions, has the *capacity* to increase patient throughput as well as the management tools and knowledge to more effectively allocate resources across the system.

Notwithstanding some of the important challenges we all face in terms of ensuring that we have the capacity to provide timely access to a range of quality health services, a recent report released by ACAHO (“*Wait Watchers II: Measuring Progress on Wait Time Strategies Across ACAHO Members*”) documents a number of innovative management strategies that are being implemented across the country. This not only includes better ways of managing current resources and organizing the care delivery process, but highlights a series of targeted investments that are designed to expand the *capacity* of the system (such as an increase in physicians, nurses and technicians; extending the hours of operation for existing operating suites; central booking systems, and the introduction of clinical assessment and prioritization tools). In our view, important progress is being made, however, more needs to be done in partnership with governments, providers, the public and others.

Based on the findings of the Association, four inter-locking elements must be addressed to ensure that the health system will have the capacity as well as flexibility to provide quality health services on a timely basis:

5. An adequate number and distribution of health care professionals, now and into the future.
6. Adequate physical (i.e., delivery) infrastructure to provide care to patients.
7. Accelerate the introduction of health information technologies to improve the clinical as well as administrative decision-making processes.
8. Invest in the generation and dissemination of knowledge that can be gained through health research (see Section 4 of the Brief).

These four elements of capacity should not be thought of in isolation, but rather as a series of cohesive system measures that are necessary to ensure that the health system remains flexible, dynamic and responsive over the medium and longer-term. It is also important to note that these four elements of capacity are closely aligned with the recent views articulated by the Minister of Health in the House of Commons.²

Each is addressed in turn:

1. EDUCATING TOMORROW’S HEALTH CARE PROFESSIONALS

If the health system is to thrive and not simply survive, then we must ensure continued investment in our most prized assets – health care professionals. While it is unlikely that anyone would disagree with this over-arching policy statement, the question remains what specific role the federal government can 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 that the current and future supply of health care professionals (be it physicians, pharmacists, nurses, technicians or others) is not able, now or into the future, to meet the demand for health services.

Framed in this context, ACAHO would agree with the Minister of Health who said: *“I wish to work actively with our partners from provincial and territorial governments, as well as with stakeholders, to provide Canadians with the best pool and distribution of skilled workers to fill the many roles vital to our health system.”*³

For example, there is broad consensus among medical groups that the number of undergraduate medical school positions should be increased from 2,250 to 2,500 per year. The Canadian Medical Association (CMA) has indicated that a target of 3,000 undergraduate medical school positions may be reasonable given the increasing demand for health care and the changes in the medical workforce. According to the Canadian Nurses Association (CNA), the number of nursing seats needs to increase to 15,600 annually; Canada currently graduates approximately 5,000 nurses per year.

ACAHO, in principle, supports a Pan-Canadian health human resources strategy to make Canada self-sufficient in producing an adequate supply of health human resources. This would include the creation of a pan-Canadian body or coordinating mechanism for health human resources.⁴

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.

ACAHO recognizes and supports the commitments by the federal government that are outlined in the 2004 First Ministers Agreement,⁵ as well as announcements by the Federal Minister of Health including \$75 million to bring more internationally educated professionals into the health system, \$5.5 million for projects to strengthen the nursing workforce and \$153,000 to help increase the number of rural physicians. These are important initial investments that signal the federal government’s determination to find solutions. That said, more can and should be done.

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 hospitals/centres.⁶ This latter point underscores one essential role of teaching hospitals/centres in Canada – which provides virtually all post-graduate health care professional training infrastructure.⁷

Our view is that investing in physical infrastructure is a critical success factor that must go hand-in-hand with future health human resource planning requirements. Recently, this issue was explicitly recognized in the Task Force II Final Strategy report: *“To ensure that Canada can achieve and maintain a medical workforce in a responsible and ethical manner, plan and fund the requisite infrastructure and resources (human and non-human) of the medical education, training and continuing learning systems, and make all components socially accountable.”* The paper also

recognizes the importance of health information technologies, medical technologies and physical infrastructure as tools that can assist providers in working more effectively.⁸

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/hospitals. 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 system will have to increase the range of training slots for health care professionals, members of ACAHO 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.

As a national resource in the system, members of ACAHO believe that there is a crucial role for the federal government in terms of financially assisting teaching hospitals/centres in expanding 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 to address infrastructure costs is required.⁹ 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*".¹⁰

ACAHO respectfully recommends:

Recommendation #1

That the federal government establish a National Health Human Resource Fund to build capacity to educate and train Canada's health care professionals.

2. (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 to deliver timely care – 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 vitally important as this is, it is equally essential that we consider the state of the system's physical capacity (i.e., infrastructure), and what is required for the future knowing that much of our acute care institutional capacity was built around the turn of the century.¹¹

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, in Ontario alone, hospital capital investment modernization and capacity

expansion requirements have been conservatively estimated to be between \$7.0 and \$9.0 billion).¹²

Consequently, many capital investment decisions appear to be based on short-term 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 federal resources that would be targeted to assist teaching hospitals/centres in renewing their physical infrastructure and enhance their capacity and ability to meet their mission and mandate as a national resource in the system.

Such a time-limited initiative would be complementary to the federal government's current Infrastructure Program (for roads, highways, bridges, etc.), as well as funding for health research infrastructure (via the Canada Foundation for Innovation). 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 – and help (re)build many of the institutions that were originally funded through the *Hospital and Construction Grants Program* – and to ensure that Canadians have access to world-class facilities in times of need.

ACAHO therefore recommends:

Recommendation #2

That the federal government create a one-time Health Delivery Infrastructure Fund to assist teaching centres/hospitals (re) build their capacity to provide timely care to Canadians.

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.*”¹³

3. INFORMATION TECHNOLOGIES AND THE ELECTRONIC HEALTH RECORD

While there is a consensus about the need to accelerate the pace of reforming the health system, much is contingent on how we manage and integrate information more effectively (e.g., from more cost-effective clinical decisions to better wait time management processes). Thus, an important element in the renewal of the system is having state-of-the-art information technologies.

In recognition of this need, the federal government created Canada Health Infoway (CHI) – which is tasked with creating a pan-Canadian inter-operable electronic health record to support a safer and more efficient health system across 50% of Canada population by 2009.

Importantly, these issues have been fully recognized by The Honourable Tony Clement, Minister of Health, who said: “*In short our investments in Infoway are harnessing your industry's technology to increase productivity, enhance safety, improve information sharing and delivering better, more timely access to care for all Canadians, no matter where they live...The exciting potential of information and communications technology to transform Canada's health system is*

the kind of news that should give Canadians greater optimism about the prognosis for its speedy recovery.”¹⁴

To date, CHI has received an investment of \$1.2 billion. By the end of 2005/06, CHI will have approved \$639 million or 53% of its funding. However, it is estimated that it will cost CHI \$4.1 billion to fulfill their mandate. With CHI assuming 75% of the eligible costs, this means that it will require a total public investment of approximately \$3.0 billion, or an incremental \$1.8 billion.

It is also important to understand that a recent study has estimated that the investment in CHI has the potential to generate an annual savings of \$6.1 billion *annually* to the health system. This is the kind of cost-benefit analysis that supports the completion of CHI mandate as expeditiously as possible.

ACAHO respectfully recommends:

Recommendation #3

That the federal government invest an additional \$1.8 billion (\$600 million over the next three years) to accelerate the work of Canada Health Infoway.

4. A BALANCED APPROACH TO INVESTING IN CANADA’S RESEARCH, INNOVATION AND COMMERCIALIZATION ENTERPRISE...

In the view of ACAHO, research is the oxygen of an evidence-based health system. It is the basis on which many sound public policy decisions are based. It is the backbone of a health system upon which cost-effective clinical and/or administrative decisions are taken.

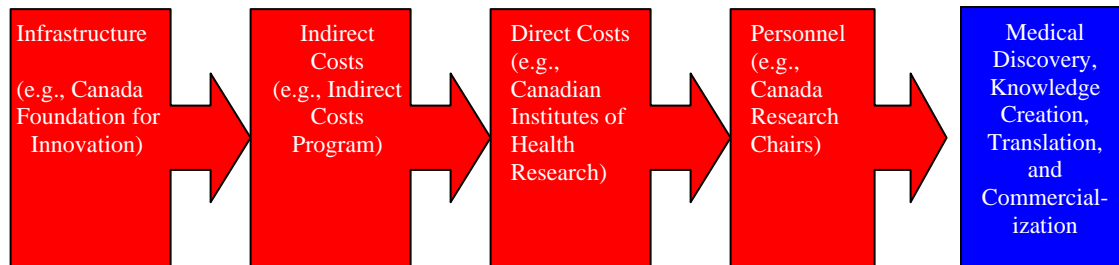
Research is the foundational building block that facilitates innovation in at least three dimensions, it: (1) contributes to improving the individual and collective health status of Canadians; (2) impacts on the architecture of the health system and the manner in which we deliver a range of cost-effective health services; and (3) produces leading-edge, world class discoveries that provide opportunities to leverage major economic benefit as well as health gains.¹⁵

In the 2004 First Ministers’ Agreement, ACAHO was very supportive of 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.”¹⁶

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 is necessary.

More specifically, public (federal) investments in health research focus on a “value chain of inputs” – from physical infrastructure (research facilities), indirect costs (the costs of maintaining research facilities), and direct costs (basic research materials), to research personnel or human capital (research clinicians, etc.) – that produce a number of outputs in terms of medical discovery, knowledge creation and translation, innovation and the process of commercialization in Canada (see Figure 1).

Figure 1
The “Value Chain” for Health Research



From the perspective of ACAHO, the research, innovation and commercialization process is an essential component, and a distinguishing feature of our members’ mission and mandate. Members play an essential role in the advancement of health research, medical discovery, knowledge creation and innovation in Canada. In fact, teaching hospitals/centres and their research institutes account for a large proportion of the physical infrastructure that supports Canada’s health research community.¹⁷

If we are to continue to move the yardsticks forward and maximize our health and economic “return-on-investment”, we need to ensure that all components of the research equation are funded at appropriate levels. Furthermore, investments in one area should not be viewed as a zero-sum game where less funding is subsequently available for other inter-locking elements of the research enterprise. What is required is a balanced and strategic approach to advancing Canada’s health innovation agenda.

Given the breadth and depth of health and research investments by the federal government, one might be tempted to say that the time has come to address other important national priorities. ACAHO maintains that while the “tide has turned” through enhanced investments in Canada’s health research enterprise, we must continue to sustain the momentum that we have created so that we can continue participate in the benefits that come from future world class research findings. Understanding that the research and discovery process can take time, we must continue to “till the soil” if we are to fully harvest the fruits of our labour – and remain as a world leader.

Knowing that we are on the threshold of a biotechnology revolution, in addition to other advances in health research (e.g., nanotechnology, robotics, population and public health, health services), ACAHO is concerned that any retrenchment in funding the health research enterprise would have serious consequences on our ability to attract and retain world class researchers – not to mention our ability to advance the process of discovery and innovation.

At the same time, a move away from commitments to funding research, innovation and commercialization, we result in Canada falling out of step with those countries that place tremendous value on the linkages between creating knowledge and its spin-off effects – particularly in a global economy that competes on the advancement and translation of knowledge.

Importantly, each of the impacts of health research noted above are mutually reinforcing and are built on the publicly funded and administered 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 linkages that have been noted above, ACAHO has identified three specific areas where the federal government can continue to make an important difference, and accelerate its role in advancing the health, social as well as economic benefits of health research: (1) basic and applied health research; (2) health research infrastructure; and (3) maximizing the full economic potential of innovative health research. Furthermore, any future investments must be done within a strategic, balanced and accountable framework.

1. BASIC AND APPLIED HEALTH RESEARCH

Canadian Institutes of Health Research (CIHR)

The Canadian Institutes of Health Research (CIHR) is the country's premiere funding Agency for health research. While there have been significant increases in CIHR's budget over the past few years, ACAHO is strongly supportive of a multi-year fiscal framework that will increase its base by \$300 million over the next 3 years to \$1.0 billion by 2008/09. It should be noted that this figure is consistent with what has been recommended by the Romanow Royal Commission as well as the Kirby Committee.

Recommendation #4

That the federal government increase the base budget of the Canadian Institutes of Health Research (CIHR) by \$300 million over the next 3 years.

It is our expectation that CIHR would invest these funds into the following strategic areas: (a) maximize the health and economic benefits of Canadians; (b) develop national research platforms and initiatives; (c) support people, talent and tools that contribute to a more productive and cost-effective health system, and productivity and economic growth; (d) and strengthen Canada's research core. Combined, these investments will support a Canadian research community that is a world leader in health research and one that is strategic, responsive, and focused, and is ready to deliver leading edge outcomes that matter to Canadians (i.e., improved health status and outcomes; a stronger and sustainable health system, and contributing to a vibrant and prosperous knowledge-based economy in the 21st Century).

As noted by Minister Clement: "...research, the government has committed to increase investment in this area. Mr. Speaker, I do not have to tell you that solid research evidence helps build consensus among the many different groups involved in health care...The government is convinced of the importance of research and will apply clinical results to an action plan for health care. This will improve the lives of all Canadians."¹⁸

Such an increase in base funding would not only improve the number of excellent research proposals that have yet to qualify for funding, but it would also improve the linkages between enhancements in the country's research infrastructure and operating grants.

2. HEALTH RESEARCH INFRASTRUCTURE

While increases in funding for basic and applied health research are essential, we must also be mindful that teaching hospitals/centres and their research institutes must have access to resources that will allow for expanded physical capacity and state-of-the-art infrastructure, and its maintenance. In this regard, the Canada Foundation for Innovation (CFI) has played a crucial role in developing world-class research facilities and providing the necessary physical infrastructure to take full advantage of our collective potential.

Indirect Costs of Research

In its 2003 budget, the federal government responded to the concerns expressed by ACAHO and others by creating a permanent fund to address the indirect costs associated with universities, colleges and research hospitals (subject to a three-year review). In Budget 2005, this fund is to be increased from \$245 million in 2004/05 to \$260 million in 2005/06.

ACAHO strongly applauds the federal government for its annual investment and would encourage the federal government to increase the value of the program so that it is funded at an appropriate international competitive level, and that this component of innovation is not a rate limiting step to achieving excellence. If the additional \$15 million in indirect costs funding is approved this Fall, the rate of indirect costs reimbursement for 2005/06 will stand at be 24.9%.¹⁹ ACAHO has been consistently of the view that it supports a proportion of 40% - which is intended to reflect the operating costs associated with federal funded research, and is consistent with the Standing Committee's recommendation contained in its report to the House of Commons in 2002.²⁰

ACAHO respectfully recommends:

Recommendation #5

That the federal government increase funding available for the indirect costs associated with research funded by the three federal Granting Agencies from \$260 million (29.4%) in 2005/06 to \$450 million (40%), effective 2006/07.

Canada Foundation for Innovation

From the perspective of ACAHO, the Canada Foundation for Innovation (CFI) has played a critical role in rejuvenating the country's health research infrastructure and thereby enabled leading edge research which could not have otherwise been undertaken. Since its creation in 1997 with an endowment of \$3.65 billion, the Foundation, on average, invests \$400 million a year in building world class research facilities. Given the funds that have been allocated by CFI to date, it will award only \$200 million per year until the end of its mandate – which is scheduled to wind down in 2010.²¹

The reality, however, is that the remaining CFI funds (with the exception of the Research Hospital Fund) will have been effectively awarded by mid-2006. Without a commitment, or at a minimum a signal, by the federal government for additional funding for CFI, institutions will not be in a position to undertake the planning for any additional infrastructure projects given the timelines required for these complex applications and the design, building and commissioning of the facilities.

In order to continue the significant momentum that has been created by CFI, it is the view of ACAHO that the federal government take the appropriate steps now to further invest in research infrastructure through CFI in 2006.

Recommendation #6

That the federal government take the appropriate steps to further invest in research infrastructure through Canada Foundation for Innovation (CFI) in 2006.

In addition, ACAHO has worked closely with CFI to ensure that the established \$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.

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 to work closely with the Canada Foundation for Innovation, and the provinces and territories to find common ground in order to implement a long-term solution.

3. MAXIMIZING THE FULL ECONOMIC POTENTIAL OF INNOVATIVE HEALTH RESEARCH

In the 2006 Speech from the Throne, the federal government recognized the relationship between innovation and economic development: “*Over the course of its mandate, and starting with the clear priorities set out today, the Government will work diligently to build a record of results. It will promote a more competitive, more productive Canadian economy.*”²²

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.

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. Thus, are their mechanisms that we can invest in that allow Canadians to increasingly own the factors of production (i.e., land, labour, capital and entrepreneurship) such that we can reap the economic rent that accrues from world class, leading edge innovations, while improving our quality of life, as expressed by Tom Courchene.²³ Keep in mind that over the next decade, we will invest roughly \$1.0 trillion dollars in our publicly funded health system.

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.

For example, the recent Neuromed Pharmaceuticals agreement with Merck Frosst was valued at \$475 million (US), and is billed as the largest biotechnology licensing deal in Canadian history. It is worthwhile noting that the origins of this work came from Dr. Terry Snutch at the University of British Columbia which was funded by the Canadian Institutes of Health Research (CIHR). It is this kind of example where multiple “wins”, in addition to public policy objectives, are achieved.

In more concrete terms, ACAHO is supportive of initiatives to commercialize research that recognize the unique potential and environment that resides within teaching hospitals/centres 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 hospitals/centres 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 hospitals/centres have increasingly developed effective relationships with industry and venture capitalists.

Understanding that work in this area is already underway in teaching hospitals/centres 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 hospitals/centres 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 hospitals/centres bring to the process of commercialization. In addition, ACAHO looks forward to the findings that will be released by the Expert Panel on Commercialization later this year.

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, and the role they play in the commercialization process.

Combined, ACAHO strongly believes that these four recommendations present the Minister of Finance with a strategic and integrated approach to nurturing health research, its infrastructure, and economic development in Canada. Given the shared ownership of developing policies that focus on “health and wealth”, ACAHO would encourage deeper and more effective relationships between Health Canada and Industry Canada on these files.

5. STRENGTHENING PUBLIC HEALTH CAPACITY...

Since 2003, the federal government has taken a leadership role, introducing a number of significant public health measures. As important as this commitment and these investments are, there needs to be complementarity between how we way we think about public health from a national point of view, and what it means for those who are “on the ground”. In short, as much as we think about public health in a *national context*, we need to ensure that we have the resources and processes in place to act *locally*.

While Canadians clearly value our health system, there is a growing recognition that additional public resources targeted towards health prevention and promotion activities are required. Investments in public health activities should not displace funding which is necessary to secure access to quality health services on a timely basis, rather, *new* resources focused on “upstream” health initiatives is important in order for Canadians to live longer, healthier and more productive lives.

Members of ACAHO are actively pursuing a number of public health initiatives, many of which include cutting edge research and the development of innovative public health networks. These measures will serve to improve the responsiveness and effectiveness of the health system in general - with Canadians being the ultimate beneficiary. At the same time, the explicit processes and programs which have been developed to improve public health across the country serve to *improve the transparency* of decision making processes in times of crisis, and clarify many of the *accountability* relationships when it comes to public health emergency planning.²⁴

With respect to public health emergency planning, there has been significant progress made to strengthen Canada’s public health system since the SARS outbreak in 2004. Many of the recommendations coming from the National Advisory Committee on SARS and Public Health (The Naylor Committee) have been adopted, and as a result, there now exists a Public Health Agency of Canada (PHAC) and a Chief Public Health Officer, giving public health a visible “face”, structure and overall focus. In 2004, \$665 million was committed over three years to national public health functions. This was in addition to the existing \$400 million that was transferred from Health Canada to the new agency.²⁵

While these initial financial investments were viewed an important first step, there remains a gap between the Naylor Committee’s recommendations and the level of federal funding for public health. Specifically, *The Naylor Committee recommended 5% of total health spending (public and private) be directed towards public health*. In 2005, where total health spending in Canada is estimated to reach \$142 billion, 5% of this total would suggest \$7.1 billion should be dedicated to public health initiatives.

To date, the federal government has provided approximately \$500 million annually to fund activities associated with the Public Health Agency of Canada. Dr. Naylor recommended an additional \$700 million of funding annually for public health infrastructure and programming in four related areas (see Figure 2):

**Figure 2
National Advisory Committee on SARS and Public Health Recommendations**

New Funding for Public Health	Funding
The Government of Canada should budget for <u>increases in core functions of Public Health Agency of Canada</u> beyond that already spent on core federal public health functions.	\$200 million per annum
The Government of Canada should <u>fund a new Public Health Partnerships Program</u> under the auspices of Public Health Agency of Canada.	\$300 million per annum
Through the Public Health Agency of Canada, the Government of Canada should <u>invest funds to establish a National Immunization Strategy</u> .	\$100 million per annum
Under the aegis of the Public Health Agency of Canada, the Government of Canada should <u>budget for a Communicable Disease Control Fund</u> .	\$100 million per annum
Total	\$700 million per annum

The Canadian Coalition for Public Health in the 21st Century - of which ACAHO is a member - observes that Naylor's original estimate did not include other vital public health functions, such as surveillance and control of non-communicable diseases, and support for the Pan-Canadian Public Health Network to build capacity and provide coordinated responses to public health emergencies nationwide.

Health policy experts have estimated that meeting the Naylor Gap (the gap between the Naylor Advisory Committee's recommendations to government during the SARS outbreak and the government's actions in meeting those recommendations) would require an additional investment of \$600 million annually. Addressing the Naylor Gap would bring PHAC funding to \$1.1 billion per year.

An early financial commitment of the new federal government would underscore the importance that ACAHO and others place on investments in health promotion and prevention, and increasingly healthy lifestyle choices. In the view of ACAHO, a balance between both is required; a strong public health system is vital to an effective health care system.

ACAHO recommends:

Recommendation #8

That the federal government increase core funding for federal public health functions by an additional \$600 million to facilitate a coordinated and comprehensive response to the public health needs of Canadians by all levels of government and non-government organizations.

As a member of the Canadian Coalition for Public Health in the 21st Century, ACAHO is supportive of the recommendations that are outlined in their Brief to the Minister of Finance.

6. ALIGNING TAX POLICY WITH 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 important to examine how the current tax regime impacts on the efficient allocation of resources in the system through the Goods and Services Tax (GST).²⁶ In principle and in practice, it is the view of ACAHO that good tax policy should reinforce good health care policy across the country.

Over the years, ACAHO (as well as the Canadian Healthcare Association) have expressed concern about the impact of the GST/HST legislation on the health sector from both a policy and an implementation perspective. When the GST was introduced in 1991, the federal government promised that that it would have no greater impact on the health sector than the federal sales tax it replaced. It is our view that the current Canada Revenue Agency (CRA) initiatives with respect to the health sector will actually see the GST burden significantly increase. As a matter of principle, our view is that tax policy should be designed in such a fashion that it reinforces, rather than mitigates the health policy objectives of the federal government.

More recently, this issue has re-surfaced given CRA's plans to apply certain portions of the GST legislation to the health sector. While the original legislation became effective April 23, 1996, it is only recently that plans for its application accompanied by a proposed educational program for health system financial administrators has been developed by CRA.

As background to this issue, essentially, hospitals are eligible for an 83% rebate on GST paid while other parts of the health system (e.g. not-for-profit long-term care facilities and many home and community care services; and health research) are eligible for a 50% rebate. While some health sector purchases are exempt or zero-rated, there are still many purchases that attract GST, to which the rebate system applies. The challenge, therefore, has been to define which purchases are eligible for the hospital rebate.

While this process was underway, it is important to note that health reform has changed nomenclatures and definitions in many parts of the health continuum and has shifted what were formerly hospital services to a variety of settings which may or may not be called hospitals (and are now under the responsibility of Regional Health Authorities).

It was in response to this challenge (and others) that legislation was introduced in February 2005 (and enacted in June 2005) by the federal government to extend the 83% rebate to services and supplies which were previously provided within hospitals and are now provided outside of hospitals. The Ways and Means motion contains a number of provisions on how this is to be achieved.

While ACAHO and the Canadian Healthcare Association welcome the legislative change and commend the government for responding to our collective concern (both ACAHO and the CHA made submissions to the Department of Finance on the definition of hospital services), we are disappointed that the existing legislation related to the apportionment of the rebate is an imperfect remedy and does not adequately address our concerns.

There is still a lack of clarity in defining what is and what is not an eligible supply for the 83% rebate. This ambiguity will continue to create administrative complexities and costs to a health system whose resources would be better invested in providing Canadians with timely access to a range of health services rather than directing funds to accountants to interpret the new GST rules.

In addition to our problem with the apportionment legislation itself, CRA's plans for applying and interpreting this legislation are based on an excessively narrow view, in a presumed effort to apply the 83% rebate to as few circumstances as possible.

As well, efforts to narrowly define eligible supplies for the rebate, ignores the very real and essential contributions that health research, community outreach activities and the teaching and education of health providers make to the provision of quality health services to Canadians. As it stands, these components are not eligible for the 83% rebate. This needs to be addressed.

ACAHO and the CHA are requesting that the legislation be interpreted in a manner consistent with the overall architecture of the health delivery system, and that it has the flexibility to accommodate continued innovations and renewal.

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 publicly funded, not-for-profit, health institutions.

As the situation stands, it would appear that current CRA policy might be interpreted as redirecting resources away from the health system that are intended for patient care – and returned back to the federal government through increased tax revenues.

ACAHO respectfully recommends:

Recommendation #9

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

By adopting this policy approach, the federal government would achieve 3 important outcomes: (1) it would invest in the health system via federal tax policy instruments; (2) it would more effectively align tax policy objectives with health policy objectives; and (3) it would place all institutions who absorb GST costs on a level playing field.

7. IN CLOSING...

This Brief is about looking to tomorrow, and making sure that we collectively make wise public policy choices to ensure that our health system is there for future generations. ACAHO is of the view that there are a number of ways in which the federal government can make several “legacy investments” – that are strategic and targeted in nature, and will place the health system on firmer ground, while improving its overall performance and level of accountability.

The Association looks forward to working collaboratively with the federal government so that we can maximize the alignment between federal priorities and public investments.

ENDNOTES

- ¹ ACAHO Welcomes Significant Progress on Wait Time Benchmarks. ACAHO News Release, December 12, 2005.
- ² Remarks made by The Honourable Tony Clement, Minister of Health in the House of Commons, April 12, 2006.
- ³ Remarks made by The Honourable Tony Clement, Minister of Health in the House of Commons, April 12, 2006.
- ⁴ ACAHO reply to the Federal-Provincial-Territorial Advisory Committee on Health Delivery and Human Resource consultation paper “A Framework for Collaborative Pan-Canadian Health Human Resources Planning”, March 29, 2006.
- ⁵ 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.”
- ⁶ For example, in Ontario it is estimated that over 90% of Residents and 99% of Fellows are trained in our members institutions. Source: Council of Academic Hospitals of Ontario, April 2006.
- ⁷ The term “Infrastructure” includes elements such as: physical plant (housekeeping, maintenance); support departments (information systems, library resources, occupational health, etc.); medical education office, and general supplies (gowns, scrubs, pagers, etc.).
- ⁸ Task Force II Final Strategy Report, April, 2006.
- ⁹ 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.
- ¹⁰ 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.
- ¹¹ The challenges associated with this issue are underscored by the following: (a) Between 1982 and 1998 real public per capita expenditures on new hospital construction decreased from \$50 to \$2, or 5.3 per cent annually, and (b) From 1998 real public per capita expenditures on new hospital machinery and equipment has fallen by 1.8 per cent annually. *Specialty Care in Canada – Issue Identification and Policy Challenges*. Canadian Medical Association, September, 2001, page 15.
- ¹² Ontario Hospital Association. *Capital Planning and Investment in Ontario’s Hospitals*. November 2003.
- ¹³ *The Health of Canadians – The Federal Role*. Volume Six: Recommendations for Reform. October 2002, page 53.
- ¹⁴ The Honourable Tony Clement, Minister of Health and Minister Responsible for the Federal Economic Development Initiative for Northern Ontario. Address to the Information Technology Association of Canada Board of Directors. April 11, 2006.
- ¹⁵ Brimacombe GG. *Health, Healthcare and Nation-Building: A Three-Dimensional Approach to Innovation in Canada*. Healthcare Quarterly, Vol. 8, No. 3, 2005.
- ¹⁶ *A 10-Year Plan to Strengthen Health Care*, First Ministers, September 14, 2004.
- ¹⁷ Members of ACAHO account for 25% of the funding Canada’s health research enterprise (in addition to government funds). Furthermore, approximately 80% of public monies invested in the health research enterprise occur in our members’ institutions and research institutes. As a result, it is estimated that 70%-80% of all health research is conducted in teaching hospitals/centres. Source: *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.
- ¹⁸ Remarks made by The Honourable Tony Clement, Minister of Health in the House of Commons, April 12, 2006.
- ¹⁹ Unless new funding is announced by the federal government in its next Budget, indirect costs support in 2006/07 and subsequent years will remain at \$260 million. However, the overall reimbursement rate will fall below the 24.9% level – given the likely increases that the three federal Granting Agencies will receive over the same time period.
- ²⁰ 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.
- ²¹ Over the first eight years, the CFI invested an average of \$400 million per year in research infrastructure - a ratio of 27% of CFI infrastructure funding to federal funding agencies investments in research (i.e. CIHR, NSERC and SSHRC). In absence of further investment, it is expected that this ratio will fall to 11% over the next four years. For

Canada to remain competitive in world-class research and technology development, the ratio of CFI infrastructure funding to federal funding agencies should be raised to at least 20%. This would require an additional \$1.0 billion in CFI funding between now and 2010.

²² *Speech from the Throne – Turning A New Leaf*, April 4, 2006, page 11.

²³ *Among the many promising industrial sub-sectors subsumed within healthcare are information technology; biotechnology; health care diagnostic, treatment and delivery services; health care management; knowledge/information management systems (including data collection and software development); and imaging systems. These are also leading-edge sectors for employing our high-level human capital and talent, an essential requisite if we wish to become a knowledge-based economy and society. However, there is much more at stake here than merely missing out on a major export platform in the information era: Failure to be in the forefront of these remarkable diagnostic, treatment and service-delivery innovations will mean that we will assuredly fail in our objective to ensure that Canadians will have access to state-of-the-art health care.* Courchene TJ. *Medicare as a Moral Enterprise: The Romanow and Kirby Perspectives*. Institute for Research on Public Policy, page 12, 2003.

²⁴ *Ounces and Pounds: ACAHO Member Investments in Public Health Strategies*. Association of Canadian Academic Healthcare Organizations. Forthcoming publication, 2006.

²⁵ *Beyond the Naylor Gap: Public Health and Productivity*. Brief to the House of Commons Standing Committee on Finance. Canadian Coalition for Public Health in the 21st Century. October 24, 2005.

²⁶ 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.