



**HEALTH & WEALTH...  
OUR PATHS TO PROSPERITY**

**A SUBMISSION TO  
THE HOUSE OF COMMONS STANDING COMMITTEE ON FINANCE  
AUGUST 15, 2007**

## **WHO WE ARE...**

The Association of Canadian Academic Healthcare Organizations (ACAHO) is the national voice of Teaching Hospitals, Academic Regional Health Authorities (RHAs) and their Research Institutes. The Association represents 50 organizations, with members ranging from single hospitals to multi-site, multi-dimensional regional facilities (also known as “Research Hospitals”).

Members of ACAHO are leaders of innovative and transformational organizations who have overall responsibility for the following integrated activities:

- Provision of and timely access to a range of specialized and some primary health care services.
- Provision of all of the principal clinical teaching sites for Canada’s health care professionals including partnerships with all 17 Faculties of Medicine and Faculties of Health Sciences.
- Infrastructure to support and conduct health research in its dimensions — medical discovery, knowledge creation, knowledge translation, and innovation and commercialization.

There are no other organizations in the health system that provide the unique combination of health services that our members do. We consider our institutions to be vital “hubs” in the health system — in addition to being a national resource.

## **OUR MISSION...**

The mission of ACAHO is to advance and promote excellence in the delivery of quality health services, the teaching and educational experience, and the health research and innovation enterprise.

## **OUR MANDATE...**

The mandate of ACAHO is to provide effective national leadership, advocacy, and policy representation in the following three related areas of the:

- Funding, organization, management and delivery of highly specialized tertiary and quaternary, as well as primary health care services.
- Education and training of the next generation of Canada’s health care professionals.
- Infrastructure to support and conduct basic and applied health research, medical discovery, innovation and commercialization.

For more information on the activities of the Association, please visit our website at [www.acaho.org](http://www.acaho.org).

## EXECUTIVE SUMMARY

The Association of Canadian Academic Healthcare Organizations believes that there are several areas where the federal government has a significant and legitimate role in shaping the future health and economic landscape of this country.

In a world where managing the rapid pace of change is the challenge, Canada has an impressive record both domestically and internationally. We should be proud but not complacent. With the knowledge-based economy increasingly characterized by competition and innovation and the search for excellence and economic interdependence, we cannot take our current status, quality of life or competitive advantage for granted.

As employers of a professional, skilled and semi-skilled workforce in excess of 200,000, ACAHO members are significant players contributing to the robust economic engine of the country. That said, there are important tax enhancements as well as investments that are required to improve our overall quality of life and standard of living. In order of priority, they are as follows:

### **RECOMMENDATION #1:**

*The federal government increase the GST rebate on all eligible purchases made by publicly funded, not-for-profit institutions in the health sector (this includes hospitals, long-term care facilities, and home community care services) to 100%.*

### **RECOMMENDATION #2:**

*That the federal government continue to support innovation by adopting a sustainable, balanced, and multi-year fiscal framework for public investments in Canada's health research enterprise – this includes the Canadian Institutes of Health Research, Genome Canada, the Canada Foundation for Innovation and the Indirect Costs program.*

### **RECOMMENDATION #3:**

*That the federal government review the SR&ED Tax Incentive Program that would make the tax credits refundable to all firms, provide an allowance for collaborative R&D and extend the tax credit to cover patenting, prototyping, product testing and other pre-commercialization activities.*

### **RECOMMENDATION #4:**

*That the federal government, in close collaboration with the provinces and territories, establish a \$1.0 billion, five year National Health Human Resources Fund in order to build capacity to educate and train Canada's health care providers and ensure a responsive health system that delivers timely access to quality care.*

### **RECOMMENDATION #5:**

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

## **INTRODUCTION**

As identified by the House of Commons Standing Committee on Finance, the fiscal debate about the future of our country focuses on the relationship between how we appropriately invest public dollars within an accountable framework to maximize our collective welfare, in relation to the instruments that governments choose to raise revenues.

As simple as the revenue:expenditure identity is stated, there exists a delicate and difficult balance between raising public revenues through a combination of mechanisms (e.g., personal, corporate, sales and excise taxes, duties, fees, levys, etc.) that do not create an undue drag on economic activity – while producing a public revenue stream needed to invest in a range of (social) programs and activities that we value, ultimately improving our overall quality of life, standard of living and competitiveness.

Understanding that capital – and increasingly given a global knowledge-based economy – *people* are mobile, we need to be sensitive to the setting of tax rates and other mechanisms that might be viewed as being too high or uncompetitive with other countries and the impact it might have on capital formation as well as employment opportunities and work effort. At the same time, it is fully recognized that tax revenues allow societies to address a number of essential public policy objectives that would otherwise go unmet.

As we look to the future, knowing that we live in a world in which change is the rule and not the exception, we need to ensure that we have a responsive tax system that lays the foundation for sustained prosperity well into the future.

From the perspective of the Association of Canadian Academic Healthcare Organizations (ACAHO), we believe that there are important areas where the federal tax system can be more effectively aligned to meet a number of public policy objectives, including: improving the health status of Canadians; the overall functioning of the health system; and contributing to the country's economic prosperity.

## **IMPROVING THE ALIGNMENT OF THE GOODS AND SERVICES TAX (GST) WITH THE HEALTH SYSTEM**

In principle, and in practice, ACAHO is of the view that good tax policy should always reinforce good health care policy across the country by promoting the efficient allocation of resources in the system. When it comes to the application of the Goods and Services Tax (GST) to the health system – this is currently not the case.

As it currently stands, hospitals (the “H” in the MUSH Formula) are entitled to an 83% rebate on the GST paid for all eligible inputs. Publicly-funded long-term care facilities and home community care services receive a 50% GST rebate. These range of rebates hinder the overall efficiency of the tax and its administration at the local level. To simplify this process and to better align with the integrated nature of Regional Health Authorities (RHAs), ACAHO is strongly supportive of a more standardized approach to how the GST should be administered in this area.

It is also important to note that the provinces of Alberta and New Brunswick – given the manner in which their health system is configured – do not effectively pay any GST on their health inputs. It is our understanding that legislatively, the RHAs are deemed to be an extension of the provincial government for tax purposes – and constitutionally one level of government cannot tax another.

Given the fundamental unfairness of how the GST impacts on the rest of the health system across the country, the federal government has a unique opportunity to create a level playing field for all provinces.

ACAHO is of the view that the federal government should amend the MUSH Formula to treat Hospitals in the same manner as the Municipalities (the “M” in the MUSH Formula) – who now receive a 100% GST rebate. The federal government should also increase the GST rebate for “health care related services” that are publicly funded to 100%.

By moving in this direction the federal government would avoid the situation where current GST policy could be perceived as redirecting scarce public resources that are intended for patient care back to the federal government in the form of increased tax revenues.

Budget 2008 provides the federal government with a unique opportunity to take a leadership role on this issue by more effectively aligning tax policy with health policy, thereby investing resources directly into the health system. This move would not only be viewed positively by members of ACAHO, but would be fully supported by the health community across the country.<sup>i</sup>

Should the federal government amend the GST rebate level, there would be (at least) four significant policy outcomes: (1) All provinces would be treated equally under the *Excise Tax Act*; (2) It would improve the financial alignment between the GST and the health system; (3) It would recognize and more effectively support the integration of service delivery with the introduction of Regional Health Authorities across the country, and (4) It would facilitate the investment of additional dollars through the tax system directly into the health system and health research enterprise.

#### **Recommendation #1**

*The federal government increase the GST rebate on all eligible purchases made by publicly funded, not-for-profit institutions in the health sector (this includes hospitals, long-term care facilities, and home community care services) to 100%.*

### **STRENGTHENING THE RELATIONSHIP BETWEEN THE TAX SYSTEM AND CANADA’S HEALTH RESEARCH ENTERPRISE**

When it comes to the future of Canada’s health research enterprise, the tax system plays two very important roles:

1. Public revenues that come from the tax system play a crucial role in supporting health research in a number of dimensions (e.g., operating grants, personnel, indirect costs, physical infrastructure). Over the past decade, ACAHO has applauded the federal government for its ongoing commitment to support health research, and the recognition that investments in early stage, discovery-based research is an important precursor to evidence-based decision-making in the health system, and the development of a range of innovative products and services that will compete in the global marketplace.

As previously recommended to the federal government, ACAHO continues to strongly advocate for enhanced public investments in a number of “instruments” that support health research in Canada, including: the Canadians Institutes of Health Research, the Canada Foundation for Innovation and the Indirect Costs program.<sup>ii</sup>

#### **Recommendation #2**

*That the federal government continue to support innovation by adopting a sustainable, balanced, and multi-year fiscal framework for public investments in Canada’s health research enterprise – this includes the Canadian Institutes of Health Research, Genome Canada, the Canada Foundation for Innovation and the Indirect Costs program.*

2. The structure of the tax system can act as a powerful incentive in attracting private sector investment in health research, innovation and commercialization.

Combined, the tax system has complementary roles to play in supporting the health research “ecosystem” or pipeline – from early stage medical discovery, to translating new knowledge into revolutionary products and services – that can not only make a difference in the lives of Canadians, but can also bring with it substantial economic benefits in terms of jobs, investment, income streams, wealth creation and a public revenue stream.

### *Scientific Research and Experimental Development (SR&ED) Tax Incentive Programme*

From the perspective of ACAHO members, it is the contribution of health research that has produced some of the most significant discoveries of the 19<sup>th</sup> and 20<sup>th</sup> centuries. From basic research that has led to improvements in the health status of individuals and communities to discoveries that produce economic benefits will be to our advantage to create a framework that understands and fully leverages the inter-relationships between our health status, Canada’s health system, economic competitiveness, and our future as a nation.

To support continued health innovation, the current Scientific Research and Experimental Development (SR&ED) programme must remain strong and competitive. It is one of the oldest and longest running programmes of its kind in the world. However, the forces of international competition are upon us and many stakeholder groups in the health research sector (e.g., BIOTECCanada, Research Canada, Rx&D) agree that modifications are in order to reflect the new realities of the research enterprise in Canada. For example, BIOTECCanada recommends that the SR&ED annual R&D expenditure limit increase from \$2 million to \$10 million.<sup>iii</sup>

ACAHO believes that the SR&ED programme, its criteria, regulations, and application process require review and enhancement in order that it might become an important incentive to increased private investment.

### **Recommendation #3**

*That the federal government review the SR&ED Tax Incentive Program that would make the tax credits refundable to all firms, provide an allowance for collaborative R&D and extend the tax credit to cover patenting, prototyping, product testing and other pre-commercialization activities.*

## **TAX FINANCED HEALTH SERVICES AND THE FEDERAL ROLE**

Medicare is considered a tax-financed program – with the federal government making an important contribution via the *Canada Health Transfer*, and through other time-limited and strategically targeted envelopes (e.g., Medical Equipment Fund, Primary Care Transition Fund, Canada Health Infoway, to name a few). Understanding that we all want to ensure that public funds are invested wisely and provide Canadians with timely access to a range of health services, ACAHO sees a crucial role for the federal government to invest in two key areas to strengthen the overall responsiveness and vibrancy of the system.

### *Enhancing Productivity and Prosperity through Investment in our most Valuable Assets – Human Capital*

Over the past decade, there have been increasing concerns that Canada is not producing an adequate number of health providers to meet the (growing) demand for health services – now and into the future. These concerns have been consistently registered by physicians, nurses, pharmacists, technicians, in addition to other groups that represent other providers and the institutional and health facilities community.<sup>iv</sup>

This is a particularly important point where a growing number of health providers are looking to retire over the next decade (or leave the health system all together) compared to the number of trainees who are entering the

health system, and at a time where a growing number of Canadians will be turning to the health system for diagnosis and treatment.

Building on the range of positive steps that the federal government has taken in terms of its recent policy commitments designed to focus on specific elements related to health human resources planning,<sup>v</sup> we are of the view that there is a legitimate role for the federal government to strengthen its working relationship with the provinces and territories, and health providers through the creation of a time-limited, issue-specific and strategically-targeted fund to accelerating training capacity in the health system.

Understanding that the future responsiveness of the health system in terms of providing quality care in a timely fashion largely depends on the availability of health providers, we are of the view that now is the time for the federal government – in close consultation with the provinces and territories and providers – to establish a 5-year, \$1.0 billion *National Health Human Resources Fund (NHHRF)*.<sup>vi</sup>

If the health system is to thrive and not simply survive, Canada must ensure continued investment in our most prized assets – our health care professionals. Without exception, globally competitive economies of the 21<sup>st</sup> century are founded on a labour force which is healthy, highly educated and fully engaged. Furthermore, it is to the benefit of all Canadians to have a system that can provide timely access to quality health services.

#### **Recommendation #4**

***That the federal government, in close collaboration with the provinces and territories, establish a \$1.0 billion, five year National Health Human Resources Fund in order to build capacity to educate and train Canada's health care providers and ensure a responsive health system that delivers timely access to quality care.***

#### *(RE)BUILDING SYSTEM DELIVERY CAPACITY*

As vitally important as the 'operational' resources are in the health system, it is equally essential that we consider the state of the system's delivery 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.<sup>vii</sup>

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 have limited 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 \$9.0B).<sup>viii</sup>

ACAHO strongly supports federal resources that would be targeted to assist teaching hospitals/centres in renewing their delivery infrastructure and enhance their capacity and ability to meet their mission and mandate as a national resource in the system.

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.

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.<sup>ix</sup>

A time-limited initiative would be complementary to the federal government's current Infrastructure Program (for roads, highways, bridges, etc.), and 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.

**Recommendation #5**

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

## APPENDIX A: MEMBERS OF ACAHO

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## ENDNOTES

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<sup>i</sup> Based on the most recent public information available from the Department of Finance, the amendment would cost the federal government \$82.5 million (with respect to our public health authorities). To extend the rebate to all health care related services that are publicly funded would cost an additional \$305 million.

<sup>ii</sup> In 2006, ACAHO made the following specific recommendations to the federal government: (1) “*That the federal government increase the base budget of the Canadian Institutes of Health Research (CIHR) by \$350 million over the next 3 years, and consider targeted funds that are issue-specific and strategically focused*”; (2) “*That the federal government take the appropriate steps to invest \$1.0 Billion in support of world class research infrastructure through Canada Foundation for Innovation (CFI) in 2007.* (3) “*That the federal government increase funding available for the indirect costs associated with research funded by the three federal Granting Agencies from \$300 million to \$450 million (40%), effective 2007/08*”.

<sup>iii</sup> BIOTECanada, *Investing in Canada’s Future – BIOTECanada’s Proposed SR&ED Policy Amendments*, February 2007.

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

<sup>v</sup> This includes \$75 million to bring more internationally educated professionals into the health system, \$5.5 million of projects to strengthen the nursing workforce, and \$153,000 to help increase the number of rural physicians.

<sup>vi</sup> Keep in mind, that there is important historical precedent which highlights the complementary role of the federal government in the area of expending health human resource capacity. Specifically, in 1966, the federal government created the *Health Resources Fund* – valued at \$500 million. The *Health Resources Fund Act* was “...to provide for the establishment of a Health Resources Fund to assist provinces in the acquisition, construction and renovation of health training facilities and research institutions.”<sup>vi</sup> In effect, the Fund was, issue-specific, time-limited, strategically focused – and was divided into three streams: (1) the federal government agreed to provide up to 50% cost-sharing for each proposal that was considered, and could provide a maximum contribution not greater than the provinces percentage of the country’s population. The remaining \$175 million could be allocated “from time to time” by the Governor-in-Council; and \$25 million was to be allocated on the basis of joint proposals submitted by the Atlantic Provinces. Given the leveraged nature of certain components of the Fund (i.e., 50:50 cost-sharing with the provinces), its total value was \$800 million. The Fund was created over forty years ago, and focused on expanding the training capacity “of persons in the health professions or in occupations associated with health professions...”. Understanding that the nature of the health system has evolved, and the issues related to health human resource training capacity extend across a broad range of provider groups, we believe that it is time to consider how to translate and apply the fundamentals that underpin the *Health Resource Fund* to today’s national policy circumstances.

<sup>vii</sup> 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.

<sup>viii</sup> 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.

<sup>ix</sup> The Conference Board of Canada reports that for every \$1.0 million invested in non-residential construction, 15-20 man-years of work is generated. The spin-off to the community is significant, and the multiplier effect of each dollar that stays in the local economy can be as high as 12 times.