



**A 10-YEAR PLAN  
TO STRENGTHEN HEALTH CARE...**

**TAKING STOCK OF THE 2004 FIRST MINISTERS' ACCORD**

**A SUBMISSION TO  
THE HOUSE OF COMMONS  
STANDING COMMITTEE ON HEALTH  
MAY 2008**

**SUBMISSION TO THE HOUSE OF COMMONS STANDING COMMITTEE ON HEALTH  
ASSOCIATION OF CANADIAN ACADEMIC HEALTHCARE ORGANIZATIONS  
MAY 13, 2008**

## **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 more than 45 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:

- Timely access to a range of quality 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 member 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 & educational experience, and the health research & innovation enterprise.

## **OUR MANDATE...**

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

- 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 web-site at [www.acaho.org](http://www.acaho.org).

## **EXECUTIVE SUMMARY**

The Association of Canadian Academic Healthcare Organizations (ACAHO) is the national voice of Teaching Hospitals, academic Regional Health Authorities and their Research Institutes (also known as “Research Hospitals”). Representing over 45 organizations – which range from single hospitals to multi-site, multi-dimensional regional facilities – members of ACAHO attend to the most complex healthcare needs of Canadians; train the next generation of Canada’s doctors, nurses and other health professionals, and are the engines of health innovation when it comes to conducting research, and supporting innovation in terms of its clinical and administrative application and economic potential.

At this juncture, the Association is pleased that the federal government is formally reviewing the 2004 First Ministers’ Accord “*A 10-Year Plan to Strengthen Health Care*”. In some ways, the Accord was a product of many years of federal-provincial-territorial “negotiations” with one important result being that the federal government clarified its roles and responsibilities vis-à-vis the health system not only as a *steward*, but as a *funder* of the system. At the same time, the time-honored principles of transparency, accountability and value-for-money are explicitly weaved throughout the Accord and apply to both levels of government.

It is also important to recall that the Accord was supported not only by all First Ministers, but the three National Political Parties in this country. In other words, there appeared to be no “policy daylight” at the national level regarding the merits, focus and structure of the Accord and its potential to support continued health system renewal.

Four years into the Health Accord, it is difficult – given its breadth of coverage – to say that it has been an unqualified success or unmitigated failure. Rather, ACAHO is of the view that efforts to-date point to important pockets of success where progress is being made, and others where more work is required.

Framed in this context, ACAHO would like to offer to the House of Commons Standing Committee on Health a number of constructive comments that are intended to build on the Accord, and are in keeping with the strategic role of the federal government as a steward, funder and facilitator of health system renewal, and the role of the provinces and territories who have overall responsibility for their health systems.

From a structural standpoint, ACAHO is supportive of the 10-year plan which identifies the role and responsibilities of governments in the following areas:

1. Through the introduction of a stable and predictable multi-year federal fiscal framework that provides the provinces and territories with the policy flexibility they need to determine how they can organize health services and provide timely access to a range of quality health services.
2. As a catalyst to accelerate health system renewal in specific areas through one-time federal investments that are strategic, issue-specific and time limited, and
3. Both levels of government maintaining an ongoing commitment to nurturing and sustaining progress and system performance, collaboration, accountability, best practice, and innovation in Canada’s health system.

While important progress is being made at the provincial and territorial level – in close collaboration with members of ACAHO, providers and others – there is room for improvement, and there remain several outstanding policy issues where the Association believes that there is a legitimate and fundamental role for the federal government to improve on the 2004 Health Accord in terms of *capacity-building* in the health system, while continuing to work in a collaborative and complementary fashion with the provinces and territories.

In this light, ACAHO would draw to the attention of the Standing Committee the following areas that could be enhanced and strengthened within the 2004 Health Accord:

## **SUMMARY OF RECOMMENDATIONS**

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

*That federal, provincial and territorial governments achieve consensus on the range of comparable national indicators for wait times, and that they be made available to the public on an ongoing basis.*

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

*That the federal government, working in close collaboration with the provinces and territories, establish a National Health Human Resource Infrastructure Fund to continue to build capacity to educate and train Canada's health care professionals.*

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

*That the federal, provincial and territorial governments accelerate their investments in Canada Health Infoway to develop an interoperable electronic health record.*

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

*That the federal government continue its ongoing support for the health research, innovation and commercialization enterprise in a balanced and step-wise fashion.*

## **INTRODUCTION**

The Association of Canadian Academic Healthcare Organizations (ACAHO) is the national voice of Teaching Hospitals, academic Regional Health Authorities and their Research Institutes (also known as “Research Hospitals”). Representing over 45 organizations – which range from single hospitals to mutli-site, multi-dimensional regional facilities – members of ACAHO attend to:

1. The most complex health care needs of Canadians;
2. Training the next generation of Canada’s doctors, nurses, pharmacists, physiotherapists and other health professionals; and
3. Are the engines of health innovation when it comes to conducting research, and supporting innovation in terms of its clinical and administrative application and economic potential.

Given the “trilogy” of our members’ roles and responsibilities in the health system, they are not only considered as a local, regional or provincial resource, but also as a national resource in terms of their impact.

ACAHO is very pleased to appear before the House of Commons Standing Committee on Health to discuss the impact of the 2004 Health Accord. Four years into the Accord, it is difficult – given its breadth of coverage – to say that it is has been an unqualified success or unmitigated failure. Rather, the Association is of the view that efforts to-date point to important pockets of success where progress is being made, and others where more work is required.

With this in mind, the Association will comment on those areas of the Accord where it believes that more can be done to continue to improve Canadians’ timely access to a range of quality health services.

## **THE FEDERAL ROLE AND THE HEALTH ACCORD**

In some ways, the Accord was the product of many years of federal-provincial-territorial “negotiations” which clarified the federal government’s roles and responsibilities vis-à-vis the health system not only as a *steward*, but as a *funder* of the system, and *enabler* of innovation. At the same time, the Accord also set out important timelines and deliverables to be achieved at the provincial and territorial level. Furthermore, the time-honored principles of transparency, public accountability and value-for-money are explicitly weaved throughout the Accord and apply to both levels of government.

It is also important to recall that the Accord was supported not only by all First Ministers, but the three National Political Parties in this country. In other words, there appeared to be no “policy daylight” at the national level regarding the merits, focus and structure of the Accord and its potential to support continued health system renewal.

ACAHO remains supportive of the 10-year plan which recognizes many of the dyanmic and complex components of the health system. The Accord has contributed to progress that is underway throughout Canada and across jurisdictions to make the health system more adaptive, flexible and sustainable, and has focused the health community’s attention on policies that look to advance the performance of the health system and the health of Canadians.

That said, it has been four years since the Accord was unveiled, and notwithstanding some of the important progress that has taken place in terms of system renewal, there are several policy issues that warrant attention not only in the context of this federal-provincial-territorial Agreement, but more importantly, how they align with the federal government's role as a *steward* of Medicare.

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3. Both levels of government maintaining an ongoing commitment to nurturing and sustaining progress and system performance, collaboration, accountability, best practice, and innovation in Canada's health system.

While important progress is being made at the provincial and territorial level – in close collaboration with members of ACAHO, providers and others – there is room for improvement, and there remain several outstanding policy issues where the Association believes that there is a legitimate and fundamental role for the federal government to improve on the 2004 Health Accord, while continuing to work in close partnership with the provinces and territories.

## **FISCAL FEDERALISM AND THE HEALTH ACCORD**

While there are several roles that the federal government plays when it comes to health – such as, legislator, regulator, evaluator – the Accord highlights the role of the government as a funder in two specific dimensions (and it should be pointed out that funding is clearly a *means* to an end, not an end in of itself).

The first mechanism is where the federal government committed to fixed funding for the health system via the *Canada Health Transfer* – which, effectively addressed the Romanow Gap,<sup>1</sup> and now grows at a nominal rate of 6% per year throughout the life of the Agreement. In effect, the 2004 Health Accord provides a multi-year fiscal framework that is predictable and stable – and gives the provinces and territories an important planning point-of-reference when it comes to investing the federal government's financial contributions into the health system from 2004/05 to 2013/14.

Furthermore, given that these funds are not earmarked (other than notionally for the health system), it gives the provinces and territories significant flexibility as to how they will be allocated across the health system – and are a reflection of the relative policy priorities of each province and territory.

The second mechanism is through the use of one-time Funds that are strategically targeted to focus on specific policy issues, and are time-limited. In the Accord, the two Funds that were included were the Wait Times Reduction Fund and the Medical Equipment Fund II. In each case, the Funds were designed with a series of parameters to be adhered to in order for the provinces and territories to receive funding.

Separate from the 2004 Health Accord, the federal government has created other Funds that have focused health system renewal in a number of critical areas, and include: Canada Health Infoway; Medical Equipment Fund I; Canada Foundation for Innovation Research Hospital Fund; Health Transition Fund; and the Primary Care Transition Fund. Going back further, the federal government created specific envelopes of funds to assist the provinces in the building of new hospitals (i.e., the *Hospital and Construction Grants* program in 1948), and in creating new medical schools (i.e., the *Human Resources Fund* in 1966). In important ways, these one-time Funds (and some have been cost-shared between both levels of government) have been timely, focused and transformative in nature.<sup>2</sup>

Combined, ACAHO is of the view that the federal government has the opportunity to “mix-and-match” a combination of funding levers that can work in close complementarity to the role of the provinces and territories – who have constitutional responsibility for their health systems.

Given the structure of the Health Accord – which focuses on wait times, health human resources, home care, primary care, pharmaceuticals, and research and innovation – it is understood that the health system is a complex and dynamic structure that is characterized by a network of multiple, interconnected elements that must be increasingly integrated in order to provide Canadians with a range of cost-effective publicly-funded health services.

Indeed, it is the view of ACAHO that the impact of a combination of fixed and one-time investments by the federal government can be increasingly leveraged through the principles of transparency, accountability and cost-effectiveness which underpin the need to more effectively measure, monitor and publicly report on progress in the areas identified in the Accord.

## **CAPACITY-BUILDING AND THE HEALTH ACCORD**

In the Association’s view, the 2004 Health Accord is a negotiated framework that seeks to achieve two overarching objectives: (1) ensure that federal dollars are invested in strategic areas that will accelerate health renewal across the country; and (2) that there is a public accounting on a comparable national basis as to how the health system is performing.

Directly, the Health Accord identifies a number of related policy areas where the federal government is seeking to build *additional capacity* into the health system so that Canadians will receive timely access to a range of health services.

However, knowing that progress at the provincial and territorial level is occurring at different rates of speed, now is the time to reflect on whether the Accord should remain as is, or are there other policy instruments that need to be considered that can assist with the process of renewal.

### Reducing Wait Times and Improving Access

*“All jurisdictions have taken concrete steps to address wait times. Building on this, First Ministers commit to achieve meaningful reductions in wait times in priority areas...”* – 2004 Health Accord

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.

To address these concerns, the 2004 Health Accord states “*Foremost on this agenda is the need to make timely access to quality care a reality for all Canadians. First Ministers remain committed to the dual objectives of better management of wait times and the measurable reduction of wait times where they are longer than medically acceptable.*” In specific terms, it was agreed that all provinces and territories would re-double their efforts to improve access to care by creating benchmarks by the end of December 2005, initially, in five areas: (1) cancer; (2) heart; (3) diagnostic imaging; (4) joint replacement; and (5) sight restoration.

While progress appears to have been made in several areas, more can be done – as noted by the Canadian Institute for Health Information – to improve the comparative manner in which the provinces and territories are reporting wait time indicators.<sup>3</sup>

***Recommendation #1***

*That federal, provincial and territorial governments achieve consensus on the range of comparable national indicators for wait times, and that they be made available to the public on an ongoing basis.*

Based on the information that is publicly available, generally speaking, progress is being made in several areas. From the perspective of ACAHO, members of the Association have introduced a range of innovative and strategic initiatives designed to improve the order of patients waiting for care, and the speed at which they move through the system.<sup>4</sup>

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.

While progress being made in most of the five identified areas in the Accord, there is increasing pressure to expand beyond the five priority areas (e.g., emergency care, psychiatric care, plastic surgery, gastroenterology, anesthesiology, obstetrics and gynaecology) – bringing with it increased demands on the capacity of the system to absorb higher patient flow levels.

If we are to continue to move forward, ACAHO is of the view that there are three inter-locking elements contained in the Health Accord that need further reflection to ensure that the health system will have the capacity as well as flexibility to provide quality health services on a timely basis:

1. How do we ensure that the country has an adequate number and distribution of health care professionals, now and into the future;
2. How can we accelerate the introduction of health information technologies to improve the clinical and administrative decision-making processes as well as enhancing the integration of the health system; and
3. How can we support continued investments in the generation and dissemination of knowledge that can be gained through health research and innovation.

These three elements of capacity-building 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.

Each is addressed in turn:

### Training the Health Professionals of Tomorrow

*“Federal, Provincial and Territorial governments agree to increase the supply of health professionals, based on their assessment of the gaps and to make their action plans public, including targets for the training, recruitment and retention of professionals by December 31, 2005. Federal, Provincial and Territorial governments will make these commitments public and regularly report on progress” – 2004 Health Accord*

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 collaborative and partnership-driven role can the federal, provincial and territorial government agree on?

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, nurses, pharmacists, physiotherapists, technicians and 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 Federal 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.”*<sup>5</sup>

In the 2004 Health Accord, a \$4.5 billion Wait Times Reduction Fund (WTRF) was established. Although it was called a “Fund”, the reality has been that monies from this fund have already been transferred to the provinces and territories on an equal per capita basis.<sup>6</sup> In other words, while the monies have been welcome by the provinces and territories, they have likely been absorbed into the day-to-day operations of their health systems given that there are no specific “strings” that require these funds be invested in other than under the general guidance of *“This Fund will primarily be used for jurisdictional priorities such as training and hiring more health professionals, clearing backlogs, building capacity for regional centres of excellence, expanding appropriate ambulatory and community care programs and/or tools to manage wait times.”*<sup>7</sup>

Given the concerns that exist across the country regarding the supply of health care providers, ACAHO is of the view that there is an important collaborative and complementary role for the federal government to work with the provinces and territories. Moreover, there is clear precedent

for the federal government to become more active in this area, and to work in close collaboration with the provinces and territories with the establishment of the *Health Resources Fund Act* of 1966 – which was valued at \$500 million.<sup>8</sup>

In our view, more can and should be done in this area to establish a pan-Canadian solution that can focus on producing more health care professionals across the country. In this regard, ACAHO is strongly supportive of the proposal by the Health Action Lobby (HEAL) to establish a five-year \$1.0 Billion “*Health Human Resources Infrastructure Fund*”.<sup>9</sup> The essence of the Fund is for the federal government to work with the provinces and territories to develop the necessary capacity to train the next generation of health care professionals.<sup>10</sup>

***Recommendation #2***

*That the federal government, working in close collaboration with the provinces and territories, establish a National Health Human Resource Infrastructure Fund to continue to build capacity to educate and train Canada’s health care professionals.*

Information & Communications Technologies as an “Integrator” of Care

*“Recognizing the significant investment that has been made and achievements to date, First Ministers agree to accelerate the development and implementation of the electronic health record, including e-prescribing. To this end, First Ministers commit to work with Canada Health Infoway to realize the vision of the electronic health record through an ambitious plan and associated investment” – 2004 Health Accord*

When we think of information and communications technologies (ICTs), we often limit our thinking to computer hardware and software, that is, the “nuts & bolts” that manage information in the health system. The reality, however, is that investments in ICTs can have a much more *powerful* and *transformative* impact on the overall organization and delivery structure of the health system.

At a meeting jointly hosted by Canada Health Infoway and the Health Council of Canada, international experts agreed that there will be no quantum leap forward in health care quality and efficiency without high quality, user-friendly electronic health information.<sup>11</sup> The electronic health record leads to safer, higher quality, and more efficient care. As well, the electronic health record also saves time for healthcare providers and makes the healthcare experience more convenient for patients.

Not only can ICTs and the development of electronic health records improve the efficient exchange of patient information, minimize the duplications of diagnostic tests, improve health outcomes and patient safety, it can also be a significant driver of how providers organize themselves and work together to provide care.

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 health system is having state-of-the-art information technologies.

A 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. “Information technology initiatives are costly to implement, but the resulting efficiencies and rebuilding of public confidence will mitigate the expense.”<sup>12</sup>

In recognition of this potential, the federal government created Canada Health Infoway (CHI) in 2001, and 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.

To date, Canada Health Infoway has received a total investment of \$1.6 billion from the Federal Government, 90% of which has been approved for investment projects as of March 31<sup>st</sup> 2008. Estimates from two independent published studies have shown that the total cost for implementing pan-Canadian electronic health records for 100% of Canadians is \$10 billion with estimated annual benefits of \$6 billion when the system is fully implemented.

With Canada health Infoway assuming 75% of the eligible costs and given the corporation’s current investments and its jurisdictional partners contributions an estimated \$5.5 billion to \$6.0 billion will be required to complete the mandate for 100% of Canadians with an electronic health record.

ACAHO would encourage all levels of government to consider the additional investment that CHI requires, and its significant payback to the system and to Canadians.

***Recommendation #3***

*That the federal, provincial and territorial governments accelerate their investments in Canada Health Infoway to develop an interoperable electronic health record.*

Health Innovation

*“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.” – 2004 Health Accord*

An important component of the 2004 Health Accord recognizes the value of health research and 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. Importantly, these themes and the potential of the health and related life sciences sector are explicitly recognized in the federal government’s Science and Technology Strategy “*Mobilizing Science & Technology to Canada’s Advantage*”.

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

ACAHO believes that while significant investments in Canada's health research enterprise have been made largely by the federal government through a number of instruments (e.g., Canadian Institutes of Health Research, Canada Research Chairs, Canada Foundation for Innovation, Canadian Health Services Research Foundation), 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 takes time, we must continue to "till the soil" if we are to fully harvest the fruits of our labor – 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, 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. Indeed, we have created an entire Biotechnology industry that has spun out of our universities and affiliated teaching hospitals and research institutes. Let's not go backwards.

Furthermore, a move away from commitments to funding research, innovation and commercialization, will 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 these linkages, and the fact that the federal government funds 75 cents of each public dollar invested in health research, ACAHO would encourage the federal government to continue to make an important difference, and accelerate its role in advancing the health, social as well as economic benefits of health research.

***Recommendation #4***

*That the federal government continue its ongoing support for the health research, innovation and commercialization enterprise in a balanced and step-wise fashion.*

Recently, ACAHO has released three reports that highlight the important contributions of Canada's Research Hospitals in the area of health research, innovation and commercialization – and focus on the role of the federal government and the need to continue to develop an integrated health research framework.<sup>13</sup>

Furthermore, the Association has also released a Policy Brief ("*Our Paths to Prosperity...A Policy Road Map for Canada's Health Research, Innovation and Commercialization Enterprise*") – which is intended to build on the federal government's Science and Technology Strategy, and includes 10 recommendations.

**CLOSING REMARKS**

The achievements contained in the 2004 Health Accord are important, and in some ways historic. The Agreement has provided clarity of roles, stability of funding, and timelines for deliverables. While there have important pockets of success where progress is being made – there is clearly room for improvement. While some of the ongoing improvement relates to the structural re-

alignment of the health system, there are also financial considerations that relate to how the federal government – working collaboratively and in partnership with the provinces and territories – can improve the overall capacity of the health system to respond.

Given the breadth of the Accord, ACAHO has limited its comments to several key areas that relate to how we can improve timely access to a range of quality health services (i.e., by focusing on health human resources and the system’s info-infrastructure), and the critical role of health research and innovation plays to discover and then translate new findings into practice.

Finally, 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 continuing to work collaboratively with the federal government, so that we can maximize the alignment between the priorities of Canadians and our public investments.

## ENDNOTES

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<sup>1</sup> The much vaunted “Romanow Gap” (which was also identified by the Kirby Committee) was the incremental amount of federal cash transfers needed to place its contribution, on an ongoing basis, to 25% of total provincial and territorial public health expenditures.

<sup>2</sup> 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. Furthermore, there is important historical precedent that highlights the complementary role of the federal government in the area of expanding 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.” 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. (2) The remaining \$175 million could be allocated “from time to time” by the Governor-in-Council; and (3) \$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 Resources Fund* to today’s national policy circumstances.

<sup>3</sup> Canadian Institute for Health Information.

<sup>4</sup> The innovative strategies that have been introduced by members of ACAHO are outlined in our two reports: “*Wait Watchers... Weighing in on Wait Times Across ACAHO Members*” (March 2005); and “*Wait Watchers II... Measuring Progress on Wait Time Strategies Across ACAHO Members*” (March 2006).

<sup>5</sup> Remarks made by The Honourable Tony Clement, Minister of Health in the House of Commons, April 12, 2006.

<sup>6</sup> As set out in Bill C-39, An Act to amend the Federal-Provincial Fiscal Arrangements Act and to enact An Act respecting the provision of funding for diagnostic and medical equipment (Chapter 11).

<sup>7</sup> *A 10-Year Plan to Strengthen Health Care*, 2004. Page 3.

<sup>8</sup> Refer to the section on the *Health Resources Fund* in footnote 2.

<sup>9</sup> *Investing in our Most Important Assets – People... Creating A National Health Human Resources Infrastructure Fund*. Health Action Lobby, January 2008.

<sup>10</sup> In more specific terms, the HEAL proposal covers three areas: (1) the direct costs of training providers and developing leaders; (2) the indirect or infrastructure costs associated with the educational enterprise; and (3) resources that improve the country’s overall data management capacity when it comes to health human resources.

<sup>11</sup> *Beyond Good Intentions: Accelerating the Electronic Health Record in Canada*. June 11-13, 2006. Montebello, Québec. Hosted by Canada Health Infoway and the Health Council of Canada.

<sup>12</sup> Final Report of the Federal Advisor on Wait Times. June 2006. Page 13.

<sup>13</sup> Over the past few months the Association has released the following reports: (1) “*Moving at the Speed of Discovery – From Bench to Bedside to Business*” (November 2007); “*Eureka! World First Discoveries and Other Major Medical Breakthroughs in ACAHO Member Institutions*” (March 2008); and “*From Microscope to Marketplace – Spin-Off Companies from ACAHO Member Institutions*” (May 2008).