



*ALIGNING POTENTIAL WITH
PERFORMANCE & PROSPERITY...*

**THE FEDERAL GOVERNMENT'S ROLE IN
HEALTH SYSTEM RENEWAL
AND
SCIENCE & TECHNOLOGY**

**A SUBMISSION TO THE
HOUSE OF COMMONS STANDING COMMITTEE ON FINANCE
AUGUST 14, 2009**

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 which have an overall responsibility for the following integrated activities:

- Timely access to a range of high-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 systems 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 high-quality health services, in the teaching and educational experience of health care professionals, and in 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:

- 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, and innovation and commercialization.

For more information on the activities of the Association, please visit our website at www.acao.org

EXECUTIVE SUMMARY

At this juncture in our country's history, it is clear that we need to pay close attention to how we design and align our tax policies and our spending priorities – particularly in a world that is increasingly “flat” and competes more intensely than ever before across international boundaries. As a general statement, this is an important higher-order public policy matter for governments to reflect on and address. However, the fundamental issues at play are the combination of policy measures and instruments that will align our *potential* with our *performance* and overall *prosperity*, both at the individual and societal level and across health, social and economic divides.

HEALTH SYSTEM CAPACITY-BUILDING & THE FEDERAL ROLE

ACAHO is of the view that there are two inter-connected elements where the federal government can provide significant added-value to the health system through a combination of time-limited, issue-specific and strategically-targeted policy initiatives designed to build additional capacity by assisting in the building of state-of-the-art delivery infrastructure to provide Canadians with timely care that is safe, efficient and environmentally responsible; and investing in Canada's ability to increase the number of health care providers that are trained, now and into the future. In the former, ACAHO recommends that creation of a one-time *National Health Delivery Infrastructure Fund*, over a five-year period, valued at \$1.0 Billion.

Recommendation #1

“That the federal government, working in close collaboration with the provinces and territories, create a one-time National Health Delivery Infrastructure Fund to assist Teaching/Research Hospitals (re) build their capacity to provide Canadians with timely access to care.”

At the same time, when it comes to the federal role in building additional training capacity to accelerate the production of health care providers, ACAHO is strongly supportive of the proposal by the Health Action Lobby (HEAL) to establish a five-year, \$1.0 Billion “*National Health Human Resources Infrastructure Fund*”.

SCIENCE & TECHNOLOGY DRIVES NEW KNOWLEDGE & INNOVATION

Understanding the important of knowledge and its application, ACAHO encourages the federal government to continue to augment its investment in health research – which is the backbone of an evidence-based and innovative health system.

Recommendation #2

“That the federal government, over the next five years, increase base funding to the Canadian Institutes of Health Research (CIHR) equivalent to 1 percent of total health spending in Canada.”

ALIGNING THE GOODS AND SERVICES TAX (GST) WITH THE HEALTH SYSTEM

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.

Recommendation #3

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%.

1. INTRODUCTION

Members of ACAHO serve a unique and very essential role in the health care system, they: (1) play a critical role in improving access to a range of quality specialized health care services (as well as some primary care services); (2) train the next generation health care providers; producing a workforce that is skilled, diverse and adaptable; and (3) support and conduct the large majority of publicly-funded health research in the country, and advance leading-edge innovative practices into the health system, and discoveries to the marketplace. By virtue of their mission and mandate, they are a national resource in the system.

In many respects, these deliverables are some of the foundational elements that underpin our collective ability to strengthen the foundation of Medicare and the fabric of Canadian life to build a truly modern, dynamic and prosperous 21st century economy.

As national resources, ACAHO believes that there is a legitimate and accepted role for the federal government to provide clear *leadership*, strong *stewardship* and collaborative *partnerships* designed to advance the responsiveness and transformation of the health system and strengthen the confidence of Canadians that care will be there for them in times of need.

In this context, ACAHO welcomes the opportunity to submit a Brief to the House of Commons Standing Committee on Finance as part of its role in contributing to the development of the federal government's 2010 Budget. In keeping with the spirit of the request by the Standing Committee, ACAHO is submitting three specific recommendations that significantly contribute to the potential and performance of our members and the health system, and are linked to the future prosperity of all Canadians.

2. HEALTH SYSTEM CAPACITY-BUILDING & THE FEDERAL ROLE

ACAHO is of the view that there are two inter-connected elements where the federal government can provide significant added-value to the health system through a combination of time-limited, issue-specific and strategically-targeted policy initiatives designed to build additional capacity by assisting in the building of state-of-the-art delivery infrastructure to provide Canadians with timely care that is safe, efficient and environmentally responsible; and investing in Canada's ability to increase the number of health care providers that are trained, now and into the future.

There is also the need for the federal government to continue to invest in health research – which is the backbone of an evidence-based and innovative health system, and to consider how to more effectively align the Goods and Services Tax (GST) with the structure of the health system.

A. INVESTING IN INNOVATIVE HEALTH DELIVERY INFRASTRUCTURE

Members of ACAHO provide Canadians with the most complex and specialized health services; conduct research that impacts health and health systems in Canada and abroad; and train health providers who, in turn, may practice anywhere in the country.¹ However, these prized missions and mandates are largely taking place in buildings that need to be retrofitted, repaired or re-built in order to meet current safety, efficiency, patient care and environmental standards.²

Based on a recent survey of ACAHO members, over 300 shovel-ready infrastructure projects over the next 12-36 months have been identified as a priority at a cost of over \$20.0 billion. Of note, 30% of the projects are new buildings and 70% qualify as repairs, renovations/expansions.³

While Budget 2009 created several infrastructure funds (i.e., the Infrastructure Stimulus Fund, the Knowledge Infrastructure Fund, and the Green Infrastructure Fund), members of ACAHO were not included as an eligible group to receive funding.

Recognizing that the role of ACAHO members extends well beyond local, regional and provincial borders, the Association calls on the federal government to create a one-time, strategically-targeted *National Health Delivery Infrastructure Fund*. It is proposed that this fund have a time limit of 5 years and be valued at \$1.0 Billion. From the perspective of ACAHO, health infrastructure investments create short-term jobs that build “legacy institutions” that fully acknowledge the role and contribution of the federal government for residents at the community level and will allow facilities to meet new safety, efficiency, environmental and patient care standards.^{4 5 6 7 8 9 10 11} It also instills a deep sense of community pride and promotes social cohesion; and accelerates the transformation of the health system delivery structure to meet tomorrow’s needs.

Recognizing the last time that the federal government undertook deliberate large scale investment in delivery infrastructure was in 1948 through the *Hospitals and Construction Grants Program* – and that the natural lifespan of health institutions and facilities is approximately 30 years, there is a strategic and historic opportunity for the government to assist in modernizing these facilities to fulfill their mission and mandate.¹² This recommendation is also consistent with the findings of the Standing Committee on Social Affairs, Science and Technology.¹³

Recommendation #1

“That the federal government, working in close collaboration with the provinces and territories, create a one-time National Health Delivery Infrastructure Fund to assist Teaching/Research Hospitals (re) build their capacity to provide Canadians with timely access to care.”

B. TODAY’S TRAINEES ARE TOMORROW’S HEALTH PROVIDERS, CAREGIVERS & LEADERS

If the health system is to thrive and not simply survive, then we must look for accelerated investment in our most prized assets – health care providers. Over the past decade, there have been increasing concerns that Canada is not producing a sufficient number of health providers to meet current and the future health needs of Canadians.^{14 15 16}

The issue is exacerbated as a growing number of health providers look to retire and/or leave the health system, or in some cases limit their workload relative to the number entering clinicians or new trainees, and at a time where a growing number of aging Canadians will be turning to the health system for diagnosis and treatment.¹⁷ At the same time, the health needs of Canadians are becoming more complex as a result of chronic disease and an aging population.¹⁸ Moreover, the challenges are not unique to Canada - resulting in an intensified global competition for talent when it comes to health providers.^{19 20 21 22}

What are the consequences of these trends? The most obvious are the linkages to inappropriate wait times, which in turn have adverse affects on health status and health outcomes, compromised safety, sub-optimal utilization of health care resources and unnecessary stress and strain on patients, families and health care providers themselves.^{23 24 25} This in turn impacts the health of Canadians and by extension their productive contributions to society.

The critical strategic policy question that remains is “what specific, collaborative and partnership-driven role can the federal, provincial, and territorial governments find common ground on?”

Given the concerns that exist across the country regarding the supply, mix and distribution 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 as it did with the establishment of the *Health Resources Fund Act* of 1966 – then valued at \$500 million.

In our view, more can and should be done in this area to develop a pan-Canadian solution that can focus on producing more health care providers 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 “National Health Human Resources Infrastructure Fund”.**²⁶ The essence of the Fund is for the federal government to work collaboratively with the provinces and territories to develop the necessary capacity to train the next generation of health care providers – and is outlined in HEAL’s Brief to the Standing Committee.²⁷

Without exception, globally competitive economies of the 21st century will be built on talent management strategies for a labor force that is healthy, highly skilled and mobile, and fully engaged. As other westernized countries explore strategies for meeting the health needs of their own population, Canada’s ability to train and retain its own supply of health professionals will be critical.

3. SCIENCE & TECHNOLOGY DRIVES NEW KNOWLEDGE & INNOVATION

Health research is the *oxygen* of an evidence-based and cost-effective health system. It is the foundation on which many sound public policy decisions are based and on which future human health depends. In the view of ACAHO, there are, at least, three important health, social and economic “dividends” that come from investments in health research:

1. Providing individual Canadians with access to state-of-the art information that is both readily available and understandable so that they can have more control over their health status, and say in treatment options;
2. Continually driving new evidence into the health system so that clinicians can make cost-effective clinical decisions that improve health outcomes; and administrators and policy-makers apply real-time evidence to improve the overall architecture, functioning and management of the system; and
3. Accelerating the speed at which we encourage private sector investments and partnerships so that leading-edge discoveries are translated into innovative goods and products, bringing with it investment capital, highly skilled jobs, the development of clusters, income and wealth creation, and a growing public revenue stream.

Over the past decade, the federal government has made significant investments in Canada’s health research enterprise through a number of instruments (e.g., Canadian Institutes of Health Research, Canada Research Chairs, Canada Foundation for Innovation, Indirect Costs program, Networks’ Centres of Excellence). Importantly, these investments recognize the four key components that underpin the research-innovation-commercialization spectrum: (1) People, (2) Programs, (3) Infrastructure and (4) Indirect Costs.

While it is crucial to ensure that there is a proper *balance* and strategic alignment between these four pillars, in addition to other elements along the health research-innovation-commercialization continuum²⁸ – ACAHO believes that now is the time to increase support for the direct costs of undertaking world-class health research by increasing base funding to the Canadian Institutes of Health Research (CIHR).

To date, ACAHO fully recognizes and applauds the federal government for the significant resources that have been invested in CIHR since 2000. However, the Association remains concerned that CIHR must be funded at internationally competitive levels so that we can continue to support research excellence and a number of cutting-edge health research initiatives. In order to remain competitive internationally, we must respond to

prevent a brain drain to countries that are ramping up their investments in health research and looking to attract the best and brightest minds. Standing still is not an option.

Recommendation #2

“That the federal government, over the next five years, increase base funding to the Canadian Institutes of Health Research (CIHR) equivalent to 1 percent of total health spending in Canada.”

In tabling this recommendation, ACAHO is strongly supportive of the “1% solution” that was proposed by the Standing Senate Committee on Social Affairs, Science and Technology.²⁹ Based on current total health spending, this would increase CIHR’s base funding to \$1.7 Billion in 2009 over a five-year period.

4. ALIGNING 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 stands, hospitals (the “H” in the MUSH Formula) are entitled to an 83% rebate on the GST paid for all eligible inputs. Health research, publicly-funded long-term care facilities and home community care services receive a 50% GST rebate. The 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 integrated governance structures (e.g., Regional Health Authorities), ACAHO is strongly supportive of a more cohesive 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.³⁰

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. At the same time, the federal government should increase the GST rebate for “health care related services” that are publicly funded to 100%.

Recommendation #3

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%.

This recommendation is fair, reasonable and above all avoids the situation where the federal government gives with one financial hand and takes with the other. It also will keep federal dollars where they were originally intended – in the country’s organizations dedicated to providing Canadians with timely access to a range of quality health services.^{31 32}

ENDNOTES

- ¹ A report on the role of Academic Health Sciences Centres is forthcoming from the Health Canada funded Task force on Academic Health Sciences Centres, and a separate report focusing on data describing how Academic Healthcare Organizations may differ from community hospitals is forthcoming from ACAHO.
- ² Farrow, T.S., Black, S.M. 2009. Infection Prevention and Control in the design of Healthcare Facilities (commentary) in Healthcare Associated Infections as Patient Safety Indicators. In Healthcare Papers. 3(9).
- ³ ACAHO, forthcoming. "Built for the Future – A Review of ACAHO Member Physical Infrastructure Requirements", a forthcoming report from ACAHO.
- ⁴ ACAHO and CHA, 2009. Innovative Health Infrastructure. Available: http://acaho.org/docs_new/Health%20Infrastructure%20Ad%20January%202009/InfrastructureBackgrounderFinalJan1509.pdf
- ⁵ Anjali, J. Mahbub, R. The Architecture of Safety: Hospital Design. Current Opinions in Critical Care. 13(6), December 2007, p. 714-719.
- ⁶ Wolf, E.J. 2004. Promoting patient safety through facility design. Healthcare Executive. Vol. 18, Issue 4; page 16.
- ⁷ Health Council of Canada. Healthcare Renewal in Canada: Accelerating Change. January 2005.
- ⁸ Stichler, J.F. Is your hospital hospitable? How Environment Influences Patient Safety. Nursing for Women's Health. October/November 2007. pp 506-511.
- ⁹ Price Waterhouse Coopers/CABE. The role of hospital design in the recruitment, retention, and performance of NHS nurses in England. Executive Summary Available: <http://www.cabe.org.uk/AssetLibrary/2289.pdf>.
- ¹⁰ American Society of Healthcare Engineering. Green Healthcare Construction Guidance Statement. Available: [www.
http://www.ashe.org/ashe/products/pdfs/ashe_guidance_sustainconst](http://www.ashe.org/ashe/products/pdfs/ashe_guidance_sustainconst)
- ¹¹ Wolf, E.J. 2004.
- ¹² Health Facilities Management, Executive Dialogues. 2009. Designing the Replacement Facility. Available: www.healthfacilitiesmanagement.com
- ¹³ In his remarks to the Toronto Club, in 2002, Senator Kirby, Chair of the Standing Committee on Social Affairs, Science and Technology, is quoted as follows: "First, the federal government should invest in the renewal of physical plant and equipment urgently needed in Canada's teaching hospitals. Two facts, out of many I could give you, illustrate the urgency of this need: Between 1982 and 1998, real public per capita spending on new hospital construction declined by 5.3% annually; in dollar terms investment dropped from \$50 to \$2 per person over those 16 years. Since 1998, real public per capita expenditures on new hospital machinery and equipment has also fallen by 1.8% annually. In addition to being the primary site of training for Canada's health care professionals, teaching hospitals offer the newest and most highly sophisticated services and treat the most difficult, complex cases. They are truly a national resource, and as such must be supported by the federal government. It is only by providing adequate funding to our teaching hospitals that it will be possible for Canada to develop genuine centres of excellence, and to be at the forefront of the scientific advances that are continually transforming the practice of medicine". Available: [http://www.parl.gc.ca/37/2/parlbus/commbus/senate/comm-
E/SOCI-E/press-e/01dec02-e.pdf](http://www.parl.gc.ca/37/2/parlbus/commbus/senate/comm/E/SOCI-E/press-e/01dec02-e.pdf)
- ¹⁴ World Health Organization (WHO), 2006. Working Together for Health. Available: <http://www.who.int/whr/2006/en>
- ¹⁵ Phillips Jr. R.L., Petterson S., Fryer Jr. G.E., Rosser W. 2007. The Canadian Contribution to the US Physician Workforce. Canadian Medical Association Journal, Apr (176): 1083 - 1087.
- ¹⁶ Buske, L. and Slade, S. 2009. Data Point! Tracking Practice Entry Cohorts of Canadian Post-MD Education Programs. Available: <http://www.afmc.ca/pdf/datapoint/DATAPOINT-may-eng.pdf>
- ¹⁷ CIHI, 2007. Canada's Health Care Providers. Available: www.cihi.ca
- ¹⁸ WHO, 2005. Facing the facts, Chronic Disease in Canada. Available: http://www.who.int/chp/chronic_disease_report/en
- ¹⁹ The Economist, The Battle for BrainPower – A Survey of Talent, October 7, 2006.
- ²⁰ WHO, 2006. Working Together for Health. Available: <http://www.who.int/whr/2006/en>
- ²¹ Phillips et al, 2007.
- ²² Buske, L. and Slade, S., 2009.
- ²³ Canadian Nurses Association, 2009. Targeted solutions for eliminating Canada's Registered Nursing Shortage (Report Summary). Available: <http://www.cna-aic.ca/CNA/documents>
- ²⁴ ACAHO, 2009. Wait Watcher's III: Order and Speed, Improving Access to Care through Innovations in Patient Flow. Available: www.acaho.org
- ²⁵ Canadian Healthcare Association. 2009. Home Care in Canada: From the Margins to the Mainstream. Ottawa: Available: <http://www.cha.ca/documents>

²⁶ HEAL, 2008. Investing in our Most Important Assets – People...Creating A National Health Human Resources Infrastructure Fund. Health Action Lobby.

²⁷ 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.

²⁸ This includes effective tax policy strategies and incentives, internationally competitive intellectual property regimes, and responsive regulatory approval processes.

²⁹ Standing Senate Committee on Social Affairs, Science and Technology. 2002. The Health of Canadians – The Federal Role. Final Report of the State of the Health Care System in Canada. Page 53.

³⁰ 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.

³¹ 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.

³² 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.