



**ASSOCIATION OF CANADIAN ACADEMIC HEALTHCARE ORGANIZATIONS
ASSOCIATION CANADIENNE DES INSTITUTIONS DE SANTÉ UNIVERSITAIRES**

**PRESENTATION TO THE
STANDING SENATE COMMITTEE ON
SOCIAL AFFAIRS, SCIENCE AND TECHNOLOGY**

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INTRODUCTION

Good afternoon, and thank you Mr. Chairman for the invitation to appear before the Standing Senate Committee on Social Affairs, Science and Technology. At this point in our country's history, the Association of Canadian Academic Healthcare Organizations (ACAHO) appreciates the opportunity to make a significant and constructive contribution to the public discussion about the future of health care in Canada – and in particular, the federal government's role in health.

My name is Glenn Brimacombe and I am the Chief Executive Officer of the Association. I should mention that our President, Ms. Shiela Weatherill sends her deep regrets that she was not available to attend today's session. Before moving to the substance of our remarks, let me say a few words about the Association.

The Association of Canadian Academic Healthcare Organizations (known as "ACAHO") represents more than 40 teaching centres and Regional Health Authorities who have jurisdictional responsibilities for teaching institutions. Members range from single hospital organizations to multi-site, multi-dimensional regional facilities and provide clinical programs ranging from primary care to highly specialized tertiary and quaternary health care services. The distinguishing characteristic of the Association is that its members represent all of the principal teaching and health research sites for Canada's health care professionals. This includes the faculties of medicine and other faculties of health (including nursing, pharmacy, dentistry) and many colleges with technical and professionals in health including physiotherapy, rehabilitation therapists, laboratory technicians, respiratory therapists, speech therapists and social workers.

It also bears mentioning that the Association was formerly known as the Association of Canadian Teaching Hospitals (or ACTH) and is over fifty years old. The name change reflects the different governance structures that come with the introduction of regionalized health care systems across the country, with the exception of Ontario.

While teaching centres appear to be relatively small in terms of its numbers, it is important to keep in mind that our members have total health budgets in excess of \$16 billion of which more than ninety per cent is derived from the public sector. This means that approximately fifty per cent of public monies devoted to hospitals are allocated to teaching hospitals. Framed slightly differently, members of ACAHO account for almost one out of every six dollars allocated to the health care system. In addition, we employ more than 150,000 Canadians across the country.

The mission/mandate of members of ACAHO is threefold: First, to provide Canadians with timely access to quality specialized health care services; Second, to provide the setting where Canada's health care professionals of tomorrow receive their hands-on education and training; and Third, to provide the necessary infrastructure to support and conduct basic and applied health research, medical discovery and innovation.

Given this unique combination of responsibilities, ACAHO is of the view that we are an essential “hub” in the health care system and can make an important and constructive contribution to the public dialogue on the future of health care in Canada.

It also bears mention that our members serve not only local and community health needs, but also respond to regional, provincial and inter-provincial requirements. By virtue of our mission and mandate, members of ACAHO would agree with those who would define our role as a “national” resource in the system.

For today’s session, the Committee has asked the Association to focus on three specific questions that arise from the recommendations in the Committee’s recent report, “*The Health of Canadians – The Federal Role, Principles and Recommendations for Reform – Part I.*”

SERVICE-BASED FUNDING FOR HOSPITALS

As set out in the Committee’s report, there is a sequence of recommendations (8-13) that begin with a change in the manner in which hospitals are funded; that is, from a global budget basis to a service-based funding approach.

In the view of the Association, it is essential that the recommendation be considered within two important and related public policy dimensions. The first is what does the recommendation intend to achieve – more clearly, what are its specific *policy ends*. The second is by what mechanism will the recommendation be implemented; that is, what are the *policy means*.

Based on a preliminary assessment of the report, it would appear that there are a number of important policy objectives that underpin the Committee’s recommendation. Issues of improved system accountability and performance measurement, increased efficiency and cost-effectiveness and their relationship to improved health outcomes and patient access to quality health care are laudable, and in some sense, inviolable.

Members of ACAHO have been long-time supporters of these system-based policy objectives and continue to work diligently to find ways to make teaching centres more responsive, accountable and innovative organizations.

In this context, it should be noted that on an ongoing basis members of ACAHO are working to develop and refine clinical, operational, quality and utilization management indicators to maximize the cost-effectiveness of each dollar allocated.

The more complex question has to do with the series of initiatives that are required to achieve these important health policy objectives.

When it comes to the proposition of introducing service-based funding, we note the Committee’s observation that *“another form of payment may need to be considered for teaching hospitals where clinical activities are intermingled with teaching and research and services are frequently one-of-a-kind.”*¹

This statement highlights two important points for ACAHO. First, the mission/mandate of teaching centres is unlike any other organization in the health care system. In addition to the provision of specialized health care services, teaching centres are critical to the training of the next generation of Canada’s best and brightest health care professionals. They also provide the large majority of necessary infrastructure to support and conduct basic and applied health research, medical discovery and innovation.

Given that our members are unique in terms of their structure, they are also funded by a series of different actors in the system (i.e., Ministries of Health, Ministries of Education, Health Research Agencies, Granting Councils, and private sources). It is also important to understand that the sources of funding contribute in different proportions to the fulfillment of the teaching centres mission/mandate.

The second point – which is noted by the Committee – is the fact that by the very nature of teaching centres and their multiple roles and responsibilities, the notion of introducing a competitive funding model is not consistent with the fact that teaching centres are generally not in competition with other institutions in the provision of services.

Rather, if anything, teaching centres are viewed as an “institution of last resort” for the majority of intractable and complicated patient illness that cannot be provided by other acute care institutions.

In many instances, patients who receive care at teaching centres are presenting with severe and complex multiple systems illness. Given this reality, a service-based funding approach could be a challenge where an institution is to receive the same province-wide fee for performing a given medical procedure or service – notwithstanding the requirements of teaching and education, and health research.²

At the same time, the number of recent health reform initiatives in Canada tell us that teaching centres are moving away from the notion of a having overlapping or duplicative service structures. More specifically, they are looking to streamline and consolidate the spectrum of specialized health services within an increasingly integrated organization, and cohesive management and delivery framework.

The other issue that seems to warrant further discussion with the recommendation to introduce a more competitive environment in the provision of health care is its underlying assumptions. More specifically, under a competitive model, it is assumed that there are a number of suppliers (providers) who are willing and prepared to bid on delivering a defined basket of health care services. To allow the model to function in terms of achieving additional efficiencies, there needs to be a critical mass of providers in relation to the demand for services.

On the basis of concerns that have been raised by a number of groups, and I believe this Committee, one concern would be how the model would function in a world where there are shortages in the number of suppliers who could compete to provide services. Under this scenario, one might envision a more limited competitive bidding process, with one result being the interplay of a concentrated or restricted group of providers in a sellers' market.

Another practical issue that the Committee's report identified is that the hospital should be paid only once the service has been provided.³ Given the emphasis that has been placed on the need for financial stability and predictability in the system to effectively plan service delivery on behalf of Canadians, this approach could do more to de-stabilize the planning cycle of hospitals. Recently, in the Speech from the Throne, the government of Ontario has committed to a multi-year funding framework for hospitals.

In sum, the Standing Senate Committee should be commended for placing on the table another policy option to be considered when funding hospitals in Canada. That said, ACAHO holds the view that there is limited application of this model's approach given the mission/mandate of teaching centres in Canada.

CONCLUDING REMARKS

In closing, from the perspective of ACAHO, we are very supportive of the policy principles that the Committee has identified when it comes to improving the funding, organization, management and delivery of quality patient care services to Canadians. To continue our ability to effectively manage, we need to better measure and monitor how we allocate scarce resources in the system. At the same time, there is a need to ensure that the system has the needed health information infrastructure upon which sound policy decisions are based on reliable information.

We hope that these remarks are of value to the Committee, and ACAHO looks forward to being an active and constructive partner in the national dialogue about the federal government's role in health care.

Thank you

¹ The Senate Standing Committee on Social Affairs, Science and Technology. *The Health of Canadians – The Federal Role. Volume Five: Principles and Recommendations for Reform – Part I.* Page 37.

² The Senate Standing Committee on Social Affairs, Science and Technology. *The Health of Canadians – The Federal Role. Volume Five: Principles and Recommendations for Reform – Part I.* Page 38.

³ The Senate Standing Committee on Social Affairs, Science and Technology. *The Health of Canadians – The Federal Role. Volume Five: Principles and Recommendations for Reform – Part I.* Page 36.