CAPTURING THE CANADIAN ADVANTAGE: HEALTH AND THE ECONOMY

Pre-Budget Submission to House of Commons Standing Committee on Finance

Submitted by: HealthCare*CAN*

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HealthCare*CAN*
Leading. Innovation. Together.

HealthCare*CAN* welcomes the government's commitment to a more activist leadership role in advancing the health and healthcare agenda across Canada, as expressed in both the Speech from the Throne and the Minister of Health's Mandate letter. We applaud the modest but important health-related investments in the last federal budget - in particular, investments in Canada Health Infoway, CIHR, Canadian Foundation for Healthcare Improvement, and the acknowledgement that research hospitals are national assets. However, HealthCare*CAN* is concerned that health and healthcare generally received little attention in the Budget 2016. We are further concerned by the Council of the Federation's recent call for continued increases in Canada Health Transfers (CHT) with no apparent accountability for improving overall healthcare system performance.

Building on our submission to Minister Morneau[i] HealthCare*CAN* sets out a series of recommendations for an expected '2017 Health Budget'. Canadians continue to worry about healthcare falling behind.[ii] Strategic investments in healthcare can respond to these concerns while leveraging up the Canadian advantage in the health and life sciences sector.

First, in response to concerns of Canadians, we recommend securing base contributions under the CHT coupled with key, shared strategic investment opportunities that will scale up and spread healthcare innovations in support of the next Health Accord. To achieve this, three strategic investments are required:

- $1.6 B for a demographic top-up ;
- The creation of a non-formulaic, incentive based $1B/ year '**Health Innov'action (Innovation) Fund'** as recommended in the Naylor Report;
- $100M for a Canadian Pay for Performance Program to provinces/territories meeting or exceeding their agreed upon targets.

Second, we recommend stepped-up investments in health research to realize the Canadian advantage in the health and life sciences sector. This sector is primed for growth in increasing employment, for both commercializing and capitalizing on healthcare innovations. The $30M/yr. increase for CIHR in Budget 2016 is a start but is insufficient. Another $120M/yr. is necessary to recapture lost ground since 2010.[iii]

Third, we recommend Indigenous-led and defined investments to address troubling health disparities between Indigenous and non-Indigenous Canadians. HealthCare*CAN* applauds the federal government's commitment to close the health gap, and supports emphasis on Indigenous health and research in the next Accord. [iv]

TOWARD A NEW HEALTH ACCORD

We appreciate the government's commitment to health, but are concerned with the slow pace of progress in advancing the negotiations toward a new "By Health, For Health" Accord. Securing federal contributions to sustain basic health insurance benefits is necessary but not sufficient to respond to the evolving health needs of an aging society or to reflect the importance of healthcare to the economy and the environment. We need more transparency and accountability, coupled with strategic investments that will help scale up and spread best practices. This is good for health, the economy, and servicing Canada's international competiveness agenda.

HealthCare*CAN* recommends a "three layered cake" strategy in using federal spending power in negotiating the 2017 Health Accord. This strategy offers a responsible framework for funding in support of a series of bilateral agreements with P/Ts under an overall *Framework Agreement for Advancing the Health of Canadians* that sets out broadly agreed, stretch performance targets for all of Canada (not dissimilar from the Climate Change targets). Each P/T would pursue its own action plan under a consensus framework agreement that leverages up respective strengths (i.e., by scaling up and spreading leading practices).

The three layers are as follows:

1. **Secure the base**: HealthCare*CAN* supports ongoing, sustainable, predictable federal funding under the Canada Health Transfer (CHT) for "core" Medicare programs. In terms of the base layer of federal funding, we recommend reaffirming a CHT floor (greater of 3% per year growth or the three-year moving average of GDP) starting April 1, 2017. We further recommend that the government consider a demographic top-up as supported by a large and growing health constituency. The additional cost to the government would be in the order of $1.6B/year.[v] This would help ensure that P/Ts have the resources needed to continue to meet and exceed the minimum criteria and conditions set out under the Canada Health Act. A demographic top-up would help P/Ts respond to the growing concern around the rising number of Alternative Level Care patients in Canadian hospitals (ranging anywhere from 15% to as high as 50% among HealthCare*CAN* members), which presents a daunting financial challenge to the system. It complements the one-time only, federal commitment to invest $3B over four years to expand access to high quality, culturally safe, homecare programs.

2. **"Scale and Spread":** Canada has well-documented pockets of healthcare excellence. The Advisory Panel on Healthcare Innovation (2016) had it right: we need to focus on scaling up and spreading innovation across Canada. We need to overcome what is sometimes referred to as the "Canadian condition" - the irresistible urge to re-invent the wheel from one jurisdiction to another. The crucial importance of leveraging up best practices was the central thesis in *From Innovation to Action*, the report of the Health Care Innovation Working Group (HCIWG) from Canada's Premiers, tabled in July 2012. The evidence in both reports is clear - Canada needs to move forward with our proposed **Health *Innov'action*** agenda.

HealthCare*CAN* recommends that the government establish a **Health Innov'action Fund ($1 B/yr.)** to be allocated, not on a formulaic basis, but on the basis of relative merit over the next five years beginning in FY 2017. Criteria for funding would be consistent with those set out in both the Advisory Panel report (2015) and the HCIWG report (2012). Priority in the first year would be to address emergent issues, including a national palliative care program; a national suicide prevention strategy (including insurance for cognitive behavioural therapy)and antimicrobial stewardship action plan. The **Health Innov'action (Innovation) Fund** would be reviewed in year four, with the prospect for on-going funding.

3**. Pay for Performance:** Up to an additional $100M would be made available each year through the P/Ts to healthcare organizations who are meeting or exceeding their agreed upon targets. This proposal builds on the increased use of value-based funding or pay for performance funding being introduced at the P/T level.[vi] It would reward those jurisdictions that are winning the race to the top, and paid out, pro rata, to healthcare organizations through the P/Ts qualifying for funding

under the ***Health Innova'action Fund*** and would allow the federal minister of health to report to Parliament on value for federal dollars spent, something she is unable to do at present.

SCIENCE AND TECHNOLOGY IN SERVICE OF HEALTH

Canada's research hospitals are robust economic agents. They are the only group of innovation leaders that recorded R&D growth in the past year.[vii] The hospital sector is noted in the recent STIC report as the country's most collaborative research performer "by far".[viii] They employ 66,000 research staff, students and scientists and have total annual research funding of over $2.5B. [ix] [x]The research and innovation performed in these organizations falls into four categories: new treatments and diagnostics, modernizing the health system, helping to maintain individual health and addressing public health issues.[xi] As we approach the country's 150th celebrations, research hospitals look forward to showcasing this role. HealthCare*CAN* supports the pre-budget submission of the H10 Group which was formed to help Canada leverage the role of research hospitals in our country[xii].

Despite success, research hospitals have two major challenges to overcome. First, the ability to sustain and leverage research hospitals is caught between our "health policy" and our "innovation policy".[xiii] Research hospitals, like much of the health and life sciences, requires a hybrid "health innovation policy" that would allow Canada to benefit from the translation of research and innovation into care.[xiv] To address this, we ask the Government to consider supporting the full set of winning conditions that are needed for Canada's research hospitals to succeed.[xv] Some of these may come to light during the Science Review and Innovation Agenda discussions. In the meantime, we ask the Government to continue to allow research hospitals direct access to the same funds as universities.

Secondly, over the past year, the challenge for research hospital scientists has been insufficient funding and flaws in the funding mechanisms at CIHR. As has been repeated in the media, health research is akin to a "traumatized patient". While some action has been taken to "stabilize" the situation, many people believe the worst may be yet to come, without a significant investment in the CIHR base budget. We understand the Science Review and Innovation Agenda will help address these issues. However, we are also concerned that the Review recommendations and Innovation Agenda components will need time to be implemented.

As such, in the interim to the Science Review, we ask that Budget 2017 provide CIHR with an immediate injection of $1**2**0M to retain the scientists it has groomed and attracted so that the infrastructure it has built is retained. Building on the $30m in budget 2016 this would increase the total base budget of CIHR by $ 150M/yr.

INDIGENEOUS HEALTH

HealthCare*CAN* applauds the government's commitment to close the health gap in terms of Canada's Indigenous Peoples, and supports emphasis on Indigenous health in the next Health Accord. The troubling disparities in health outcomes between Indigenous and non-Indigenous Canadians include: an Infant mortality rate for First Nations and Inuit children ranging from 1.7 to over 4 times the non-Indigenous average and an overall suicide rate that is about twice that of the total Canadian population (and many times higher among some groups).

HealthCare*CAN* and its members are working to develop better relationships with Indigenous leaders and communities across the country, including the Indigenous Health Alliance. Our members are doing innovative work in partnership with First Nations, Inuit and Métis peoples and those living in remote

regions to ensure access to high quality, patient-centred safe healthcare, and are committed to building on and strengthening this work, including by connecting leading practices across the country.

At the June 2016 'Great Canadian HealthCare Debate' - part of our National Health Leadership Conference – over 700 health leaders voted overwhelmingly to support the implementation of the Truth and Reconciliation Commission's health-related Calls to Action. It was their number one policy priority. HealthCare*CAN* is working in partnership with the Indigenous Health Alliance to develop a concerted approach to address these health-related Calls to Action, including addressing integrated primary health care. A detailed proposal from the IHA to the federal government to support this work will be forthcoming.

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[i] http://www.healthcarecan.ca/wp-content/uploads/2015/10/HCC-Appendix-1-letter-to-Min.-of-Finance.pdf
[ii] http://www.nhlc-cnls.ca/assets/2016%20Ottawa/NHLCIpsosReportJune1.pdf
http://www.healthcarecan.ca/wp-content/uploads/2015/10/HCC-appenix-2-poll-results.pdf

[iii] http://www.healthcarecan.ca/wp-content/uploads/2016/04/5-Why-does-CIHR-need-enhanced-funding-support.pdf
[iv] http://www.healthcarecan.ca/wp-content/uploads/2015/10/IssueBrief_TRCC_small.pdf
[v] Conference Board of Canada. Federal Policy Action to Support the Health Care Needs of Canada's Aging Population https://www.cma.ca/Assets/assets-library/document/en/advocacy/conference-board-rep-sept-2015-embargo-en.pdf
[vi] Breaking the Deadlock: Towards a New Intergovernmental Relationship in Canadian Healthcare (annex 4)
[vii] Canada's Innovation Leaders 2015
[viii] Science Technology Innovation Council Report 2014
[ix] HealthCareCAN calculations based on information on member websites
[x] A recent online survey trying to gauge the impact of CIHR's funding changes has found that 25 percent of the 410 people who have responded so far are seriously considering moving away from Canada. 70 per cent said they are delaying the hiring and mentoring of graduate students or post-docs. See: https://www.statnews.com/2016/08/01/cihr-canada-research/
[xi] HealthCareCAN holds an Innovation Sensation database that contains the research and innovation success of research hospitals between 2012 and 2016. An analysis of the stories revealed these categories. There are other ways of classifying research at member organizations.
[xii] H10 is a action roundtable consisting of the CEOs of the country's largest research hospitals, who have agreed to provide federal representation on behalf of all research hospitals, so that their value to Canada can be communicated alongside the voice of the Research Universities.
[xiii] Miller, Fiona A., and Martin French (2016). Organizing the entrepreneurial hospital: Hybridizing the logics of healthcare and innovation. Research Policy, 45(8): 1534-1544. Retrieved at: http://dx.doi.org/10.1016/j.respol.2016.01.009
[xiv] Drolet, Brian C., and Nancy M. Lorenzi (2011). Translational research: understanding the continuum from bench to bedside. Translational Research, 157:1-5. Retrieved from: https://www.viictr.org/viictr/assets/File/Drolet_Tranlational%20Research_2010(1).pdf
[xv] http://www.healthcarecan.ca/wp-content/uploads/2015/03/5.6-Fact-Sheet-Winning-Conditions.pdf