

## **Policy update**

### **1. Adequate, Ongoing and Predictable Funding/Federal Leadership**

#### ***1.1 Memoranda of Understanding signed by F/P/T Health Ministers***

The Centre for Emergency Preparedness and Response of the Public Health Agency of Canada held its eighth annual National Forum in Winnipeg in September. The theme of this meeting dealt with surge capacity in the health system. The attendees were informed that two Memoranda of Understanding have been signed by the provincial/territorial health ministers.

The first is the *Memorandum of Understanding on Mutual Aid* an agreement on mutual aid in Public Health emergencies. This is an agreement for assisting with surge capacity of communities and jurisdictions. What this Agreement will do is facilitate the exchange of human resources, supplies and equipment between jurisdictions during emergencies. All jurisdictions are building their capacity, but different areas have different strengths and different resources. This Agreement recognizes that if a community's disaster threshold is exceeded - if a disaster puts a community's needs beyond its means and ability to cope - it needs timely access to additional resources. This Memorandum will be simply a mechanism for governments to provide and receive assistance from one another in a timely and efficient manner. It is hoped this will be completed and implemented later this year. Training and development will remain an emergency management priority for every level of government and an essential component of any effective plan.

In addition, F/P/T health ministers signed the Memorandum of Understanding on Information Sharing - an agreement on information sharing in Public Health emergencies. The Public Health Agency of Canada has recognized the importance of sharing data in a timely, complete, and accurate fashion. Over the last 3 years, the Agency has worked with Provinces and Territories to put in place data sharing agreements. It also participated in a number of provincial and territorial fora to address issues of surveillance information, such as the Public Health Network, and the Committee of Chief Medical Officers of Health.

The Agency is in the process of developing a Privacy Framework for the management of privacy issues, such as record information sharing and managed information sharing agreements, with an expected completion date of March 2009

## **1.2 Federal Leadership in Health**

In its review of the political party platforms during the election, CHA asked the question “Is your party prepared to assume a strong federal role in the area of health?” CHA’s position is *“that the role of the federal government is to ensure that a broad range of comparable health services is available to Canadians. Though the delivery of health services is a provincial/ territorial responsibility, the federal government cannot write a blank cheque without being assured of compliance with pan-Canadian objectives and agreed to performance outcomes”*

The Conservative platform announced on October 8<sup>th</sup> indicated a renewed promise which would limit Ottawa's power to spend money in areas of provincial jurisdiction. “A re-elected Conservative government ... will ensure that any new shared cost program in an area of provincial or territorial responsibility has the consent of the majority of provinces to proceed and that provinces should be given the right to opt out of the federal program with compensation,” the platform said. The Conservatives are also promising a “Charter of Open Federalism” to enshrine the original division of powers among provinces and Ottawa.

The Liberal Party of Canada indicated that they are prepared to assume a strong federal role in the area of health, while respecting the jurisdictional authority of the provinces and territories.

The New Democrats indicated a commitment to continuing to fully support and defend the right of every Canadian to have access to a strong public health care system and other public programs. As evidence for their position, they cite that in the 39<sup>th</sup> Parliament they advocated for the phase-in of a national prescription drug strategy.

With the return of Parliament and the beginning of the 40<sup>th</sup> session, the question of federal leadership in health will be an important advocacy issue for CHA.

### 1.3 **The Conference Board of Canada's Annual Assessment of the State of the Nation: How Canada Performs**

The Conference Board gave Canada a "B" ranking in health in its annual national assessment *How Canada Performs*. In this category, Canada comes in 9<sup>th</sup> out of the 16 Organisation for Economic Co-operation and Development countries to which it is compared.

The grade is based on an assessment of the overall health status of Canada's population; **it is not intended to rank the healthcare system**. Although health care is one of several contributors to the health of Canada's population, there are also key aspects of public health that come into play, such as tobacco use, alcohol consumption, physical activity, and eating habits, all factors that are somewhat independent of the formal healthcare system.

Eight countries are doing better than Canada in the Health category. Japan, Switzerland and Sweden received A's; Norway, Australia, Italy, France and Germany received B's, but rank above Canada. Ranking below Canada are: Finland, Austria, Ireland and the Netherlands with C's; and the United Kingdom, the United States and Denmark with D's.

The Conference Board points out that most of the top-performing countries have achieved better health outcomes through actions on the broader determinants of health such as environmental stewardship and health promotion programs focusing on changes in lifestyle, including smoking cessation, increased activity, healthier diets, and safer driving habits. Leading countries also focus on other determinants of health—such as education, early childhood development, income, and social status—to improve health outcomes.

Going forward, what should Canada do to improve the health of Canadians, and thereby boost its ranking? The Conference Board is of the opinion that:

*Canada has no choice but to adopt a new model of health care, a business model that encompasses both preventing and managing chronic disease. Targets set by governments in the Public Health Agency of Canada's Integrated Pan-Canadian Healthy Living Strategy are the building blocks of a prevention-oriented strategy. Developing a report card that assesses Canada's progress on its health-care goals would be an important component of a new business model for health care.*

*Population health strategies must also target funding for improved information technology, electronic patient records, training and development, and innovation that will allow Canada to renew its health-care system and make it among the very best. Greater receptivity to innovative technologies and health-care delivery systems is essential, as is investment in research infrastructure to generate and evaluate new approaches to prevention and management.*

On other rankings, the Conference Board gives Canada a B on the Economy; a D in Innovation; a C on the Environment; a B in Education and Skills; and a B in Society. It concludes: "In almost every major category of socio-economic performance studied, Canada's performance is slipping, causing it to fall behind countries that are its peers, partners, and competitors. ... Canada needs to do better not only in absolute terms but also relative to others."

The full report is scheduled for release in October 2008. Visit [www.conferenceboard.ca](http://www.conferenceboard.ca)

## **1.4 Infoway initiatives in the North**

### Nunavut patient records to be electronic by 2012

Every province and territory is currently working to develop, implement and adopt electronic health records (EHR) for faster transfer of patient information. Supporting the standardization and technological advancement of a Nunavut Electronic Health Record System, Leona Aglukkaq, Minister of Health and Social Services, and Richard Alvarez, President and CEO, Canada Health Infoway (Infoway) recently announced a \$7.4 million investment by Infoway towards Phase 2 of the department's E-health program. The investment is part of an overall \$11.6 million initiative to support Nunavut's E-Health vision and realize faster access to quality care for the territory's residents. Ultimately, this will help the territory meet its wait time guarantee for diagnostic imaging by reducing turnaround time to less than four days from what used to be 18 days per patient. By 2012, the EHR system will be integrated and available in all communities. Nunavut's health care system will benefit from quick access to the EHR's saving time, increasing efficiencies, and increasing patient safety.

### Improved access to telehealth in Nunavut

With the goal of increasing access to quality patient care, Infoway also announced a \$2 million investment to expand access to telehealth for Nunavut residents. A key component of the Nunavut Telehealth Network Expansion and Change Management project is the collaboration with the MBTelehealth Network in Manitoba. MBTelehealth will share processes and knowledge with Nunavut Telehealth by providing training, peer support and increasing capacity to deliver 256 consultations each month (an increase of five per cent). As part of the project, a new telehealth site will be developed at the boarding home in Winnipeg that hosts patients from Nunavut who seek medical care not available locally. This will help connect Nunavut families separated by long distances.

The partnership between Manitoba and Nunavut will assist the Kivalliq and Kitikmeot programs by focusing on the following areas:

- Increasing use of telehealth for consultations between providers and patients who live far away
- Improving discharge planning between southern facilities and Nunavut communities
- Increasing family connections for those in boarding homes.

Nunavut has been providing telehealth services across the territory for a number of years. The Nunavut Telehealth Network Expansion and Change Management Initiative project is 100 per cent funded by Infoway.

## **2. Appropriate Number, Mix and Distribution of Health Human Resources**

### **2.1 Labour Mobility**

#### **Labour Mobility - ACHDHR**

Ms. Carol White, Director of Labour Mobility, HRSDC, made a presentation to the ACHDHR, in Quebec at its June 25-26 meeting. She expanded on plans for achieving full compliance with the labour mobility provisions of the 1994 Agreement on Internal Trade (AIT) by April, 2009. Labour mobility is addressed in Chapter 7 of the AIT and the broad objective is to enable any worker qualified for an occupation in a jurisdiction to be able to work in another jurisdiction (i.e. mutual recognition of credentials). At their August 2007 meeting, provincial premiers committed to full implementation of the AIT by April, 2009.

Ms. White reported that it has been determined that 30 out of 51 professions are not in compliance with the AIT and 20 of them are health related. She added that the Labour Mobility Coordinating Group is working with P/T regulators for 9 priority professions - 7 of which are physicians, RNs, licensed practical nurses, audiologists and speech language pathologists, medical laboratory & technologists, paramedics and pharmacists.

Amendments will be introduced to the labour mobility chapter of the AIT to achieve full labour mobility. Mutual recognition will exist when qualified workers from one jurisdiction are accepted in another without any additional retraining, retesting or reassessment. Additional requirements will have to conform to the provisions for "legitimate objectives" that are set out in the AIT. Workers may still be required to demonstrate language proficiency and provide character references. There will be a transition period of two years following April, 2009. Ms. White noted that monetary penalties of up to \$5 million could be levied against jurisdictions not in compliance.

#### **Labour Mobility – Council of the Federation**

Provincial and territorial Premiers concluded the fifth annual meeting of the Council of the Federation in Quebec City, July 18, 2008 stating that "This meeting gave us the opportunity to make progress on major issues affecting all of our citizens, including labour mobility, internal and external trade, and the environment"

Premiers stressed that full labour market participation and unimpeded mobility of labour is vital to Canada's economic growth. "We will ensure full labour mobility rights for citizens and the Agreement on Internal Trade will now have an effective dispute settlement mechanism. Meeting the labour market needs of our strong economy is critical to our growth, and I am very pleased that the Council of the Federation has made real progress," said Premier Brad Wall, Vice-Chair of the Council.

Emphasizing the critical importance of full labour mobility for all Canadians, Premiers agreed to amend the Agreement on Internal Trade (AIT) by January 1, 2009. These amendments will provide that any worker certified for an occupation by a regulatory authority of one province or territory shall be recognized as qualified to practice that occupation by all other provinces and territories. Premiers further directed that any exceptions to full labour market mobility will have to be clearly identified and justified as necessary to meet a legitimate objective such as the protection of public health or safety.

By the 2009 summer meeting of the Council of the Federation, these amendments will result in mutual recognition of occupational credentials between all provinces and territories.

## **2.2 F/P/T Advisory Committee on Health Delivery and Human Resources (ACHDHR)**

### ***CHA's formal application to the ACHDHR***

A letter of formal application was sent by the CHA to the ACHDHR in 2008 requesting that a CHA identified employer representative be appointed to the ACHDHR. This individual would be responsible for contributing the views of CHA and its members to discussions and would, in turn, report on the progress and deliberations of the Committee to the CHA Board. A response was received on October 13<sup>th</sup> indicating CHA would not be invited to this table, but instead was recommended to ensure its voice was heard via the HEAL representative.

### **ACHDHR meeting June 25-26, 2008**

The ACHDHR met in Quebec City, QC on June 25-26, 2008. The top three issues for the Committee have centered on self-sufficiency, internationally educated health professionals and entry-to-practice credentials. These continue to be key priorities, however the issue of interprovincial mobility has become a front-burner issue with the looming deadline of April, 2009 to meet compliance with the Agreement on Internal Trade (AIT).

### **Agreement on Internal Trade (AIT)**

It was reported that 30 out of 51 professions remain non-compliant of which 20 are health related. There may be significant international implications in the future, in light of the June 2, 2008 joint declaration by the Governments of Ontario and Quebec that they intend to pursue a closer economic relationship with the European Union, and the July 4, 2008 statement by Quebec Premier Jean Charest and French Prime Minister François Fillon that affirms their commitment to an agreement that will facilitate the mutual recognition of professional qualifications between Quebec and France.

### **Internationally Educated Nurses**

There was discussion on a proposal to develop a national assessment service for Internationally Educated Nurses (IENs). This arose from a 2005 report from the Canadian Nurses Association *Navigating to Become a Nurse in Canada* and would ultimately provide a single point of entry for assessment and therefore reduce duplication.

Representatives from all nursing regulatory bodies in Canada met for a day in April 2007 to discuss the concept and created a steering committee. There are three components to the proposal. The first is a harmonized single set of requirements for registration. There are currently some 25 nurse regulators in Canada. It was stressed that the objective is not to "raise the bar" but rather to determine what is necessary to ensure safe practice. The second component is the development of an educational data base of international nursing programs. It was suggested that all regulators have lists of nursing programs and that these could be amalgamated. The third component is the development of a business model for a sustainable national assessment service.

The proposal has been developed for submission to the Foreign Credential Recognition program of HRSDC and to be implemented over a 2-year timeframe. According to HEAL representative Owen Adams, there was support for the objectives of the proposal. There was a request for it to be reviewed quickly by ACHDHR before submitting it to HRSDC, as Deputies have indicated that they like to be apprised of national initiatives.

### **International Medical Graduates (IMGs)**

A progress report was provided on the development of a national assessment process for IMGs. A two-day meeting had been held with representatives of all IMG programs, the AFMC, the Medical

Council of Canada and Health Canada to come up with a governance structure. Some thirteen (13) principles have been set out for the design of the Observed Standardized Clinical Examination, however the governance structure requires more work. A task group of ten (10) persons have been charged with developing options for the governance structure, and they are targeting the Deputies' meeting in December 2008.

### **HHR Planning Subcommittee**

*Communications:* A proposal has been developed to issue a series of fact sheets to highlight various activities of ACHDHR. A prototype was distributed on Internationally Educated Health Professions. There was general agreement that these would be useful and informative.

*Unique Identifier:* Dr. Jean-Marie Berthelot provided an update on the development of a unique identifier for health professionals. Such an identifier could be used to track mobility and to track individuals as they switch professions. It was noted that CIHI had conducted a pan-Canadian consultation a few years ago but there did not appear to be much demand. Issues remain regarding who will be responsible for maintaining the identifier, funding, and policy issues, such as would it be voluntary or mandated. CIHI has been doing some related work with Ontario.

A question remains for the unique identifier - what is the business case?

*Status Report on the Framework:* Given the resources allocated it was suggested that a status report on the planning framework be developed rather than a formal outcomes based evaluation. This led to a discussion on the need to take the health delivery system into account. It was proposed that a visioning exercise should take place at the Fall meeting of ACHDHR to perhaps reposition the Committee's focus/work.

*Self-Sufficiency:* It was reported that the Deputy Ministers had approved the definition of self-sufficiency as (approximately) "self sufficiency in health human resources is the ability to develop, attract and retain the right supply and mix of health care providers to work in each jurisdiction's health service delivery models to meet the population's health needs." It was indicated that there will be a consultation, which might comprise a stakeholder meeting followed by a web-based consultation.

It was further noted that direction has been given to develop a position paper on ethical recruitment in anticipation of the future work that the Global Health Workforce Alliance

### 2.3 Quality Worklife, Quality Healthcare Collaborative

The Quality Worklife – Quality Healthcare Collaborative (QWQHC) was formed to develop and promote a national framework and action strategy on quality of worklife (QWL) to improve health system delivery and patient/client/resident outcomes. The collaborative is a multi-disciplinary coalition anchored in a partnership of 13 national healthcare organizations and housed in the same building as Accreditation Canada. CHA now Chairs the Steering and Executive Committees of this initiative. Health Canada has provided generous funding through to the end of fiscal year '09, and has invited another proposal for funding through to 2011.

At the June 2007 CHA Board meeting, the Board passed a motion to endorse the Healthy Healthcare Leadership Charter, two system level and seven organizational level quality worklife indicators, and the development of a pan-Canadian database of quality worklife indicators. Further, the Board agreed to encourage uptake of these quality worklife elements by bringing the Charter, indicators and database to their provincial / territorial Boards for discussion and endorsement. The thought at the time was for each of our member organizations to follow the lead of CHA in endorsing these key deliverables and thereby send a strong message to all levels of government that there is true pan-Canadian consensus on the importance of quality of worklife.

Nova Scotia quickly followed through on this initiative. In January of this year all ten CEO's from Nova Scotia's District Health Authorities and the IWK Health Centre gathered at the NSAHO offices in Bedford, Nova Scotia to sign the Healthy Healthcare Leadership Charter. A few days later the NSAHO Board signed the charter and Continuing Care organizations across the province have since signed the charter. Nova Scotia's experience with their *Provincial Healthy Workplace Initiative* was the subject of an engaging presentation by NSAHO's Director of Organizational Development Carla Anglehart at the 2nd Annual QWQHC Summit on March 19 in Ottawa.

Over the summer and early fall, some employers in other provinces have followed up with this initiative by signing the charter. The [www.qwqhc.ca](http://www.qwqhc.ca) website is operational and all members are encouraged to promote the website as a "one-stop-shop" for information on QWL in healthcare. The website includes a library of QWL reference articles that have been reviewed and categorized according to the 11 priority action areas identified in the QWQHC Action Strategy. It also includes a section that outlines menus of leading practices for each of the 11 areas. The charter is promoted on the site and all those organizations that have signed the charter are/will be recognized and their home pages are linked to the charter page.

In conclusion, the conviction in the importance and relevance of QWL remains strong. The commonly acknowledged challenge is the need to translate theory and planning into action as the collaborative enters its next phase of development.

### 2.4

#### Coalitions:

- **Investing in Skills Coalition:** CHA was invited to become a partner in this coalition which was initiated by the Association of Community Colleges. The Coalition is concerned with the shortage of skilled workers. CHA was asked to represent the interests of health employers in this Coalition. On September 23, CHA took part in a press conference on Parliament Hill to remind candidates that the shortage of skilled workers cannot be overlooked during this election campaign and the next Parliament. The coalition will continue working with Members of Parliament on this issue following the election until a solution to the skills crisis is found.
- **CCPH21:** CHA's Communications Team assisted with the content review and production of the backgrounder "A Sustainable Vision for Public Health." This document was sent to election candidates to gain their support on public health issues.

## **2.5 Joint Symposium Proposal by CFNU, CNA and CHA to the International Council of Nurses (ICN) 2009 Congress**

The Canadian Federation of Nurses Unions (CFNU) expressed interest in submitting an abstract for the 2009 Congress on the topic of Research to Action, in partnership with the Canadian Healthcare Association and the Canadian Nurses Association. Following discussions, it was determined that the final draft reproduced below would be submitted by CFNU as a symposium proposal. A response on the status of the application has not been received.

### **Partnering to Address Workforce Shortages: Innovative strategies to Enhance Retention and Recruitment of Nurses in Canada**

Canada faces a growing shortage of nurses that is expected to reach crisis proportion within the next decade. To meet the healthcare needs of Canadians it is critical to encourage experienced nurses and recent graduates to remain in the profession. Recent research exploring nurse retention issues inspired the Canadian Federation of Nurses Unions to develop stronger partnerships among governments, employers, professional associations and unions, to test and evaluate research-based retention strategies in the workplace. The Canadian Federation of Nurses Unions, Canadian Healthcare Association and Canadian Nurses Association partnered to develop a series of innovative pilot projects implemented across Canada targeting enhanced retention and recruitment of nurses, with the aim of providing stability to the workforce. The pilot projects utilize the following strategies:

- improved orientation and mentoring by experienced nurses to assist new graduates in their transition;
- a professional development staffing model (80/20) in which nurses spend 80% of their salaried time in direct care and 20% in activities designed to enhance leadership and clinical skills;
- continuing education and skill development opportunities.

This symposium will discuss lessons learned through the implementation of retention and recruitment strategies, and collaborative partnerships not only in the context of nursing but also in relation to other health professions.

While Health Canada funding supports the overall project, provincial governments, regional health authorities, local employers and provincial nurses unions jointly and primarily funded the provincial pilots. Project partners believe collaboration supports the achievement of innovative solutions to the nursing shortage.

## **2.5 Two Universities Launch Physician Assistant Programs**

Two universities have started training physician assistants. The University of Manitoba faculties of Medicine and Graduate Studies launched Canada's first university-based **Physician Assistant Education Program** this September. It is a graduate-level education program leading to a Master of Physician Assistant Studies. Up to twelve candidates can enter the two year full-time program. Criteria for applicants include a four-year undergraduate degree, a background in the health sciences and a minimum of one year (2000 hours) of direct patient contact in a health-care field. Also at McMaster University, twenty-one students began a two-year Bachelor of Health Sciences (Physician Assistant) program this September..

These are Canada's first education program for non-military physician assistants. Physician assistants work under the supervision of a physician in a variety of settings, from emergency to primary care to sub-specialty sites. As part of an interdisciplinary health team, physician assistants can perform a range of duties including patient interviews and taking medical histories, conducting physical examinations, ordering diagnostic tests, providing therapeutic procedures, preventive health counselling, and prescribing medications and treatments under certain circumstances.

The Canadian Medical Association has expressed interest in having more physician assistants in the country. In 2003 it approved the inclusion of physician assistant training in its conjoint accreditation process, and passed a resolution calling for expanded use of physician assistants in the civilian setting during its 2007 annual meeting in Vancouver. Until now, only the Canadian Forces' training programs for physician assistants has been credited.

The Canadian Medical Association has shown interest largely because of Canada's reported physician shortage. It believes that these assistants could be "physician extenders."

## **2.6 Unregulated Health Workers**

The Canadian Nurses Association (CNA) assembled a multidisciplinary/professional Advisory Committee to plan three invitational regional roundtables in 2008, located in New Brunswick (Atlantic Roundtable), Toronto (Ontario and Quebec Roundtable) and Regina (Western and Northern Roundtable).

The Pan-Canadian Planning Committee on Unregulated Health Workers (UHWs) identified the need to explore and prioritize issues related to UHW's from a cross-disciplinary perspective and to consider strategies for addressing these issues.

The Planning Committee was comprised of participants from the Canadian Physiotherapy Association, the Canadian Home Care Association, the Canadian Pharmacists Association, the Canadian Council for Practical Nurse Regulators, the Registered Psychiatric Nurses of Canada, the Canadian Psychological Association and the Canadian Nurses Association, with the latter acting as steward of this initiative. The CHA assisted in the planning of these events and provided the CNA with a detailed list of invitees to ensure the adequate representation of employers, RHA's, and healthcare associations at these roundtables.

The Western/Northern regional roundtable – the third and final of the regional sessions - was held in Regina on September 15, 2008. There were 80 session participants plus 14 teleconference participants. A broad range of stakeholders across professions and sectors participated, including very strong representation by employers. There was similar issue prioritization as compared with the first two sessions in Ontario and New Brunswick.

- Lack of clarity of roles and functions
- Lack of information/data on UHWs for HHR planning
- Inconsistent education and training
- Inconsistent minimum competencies
- Inconsistent evaluation of staff mix and outcomes

The three roundtables have included participants from every province and territory. The deliberations were most effective in obtaining perspectives from disparate practice settings and jurisdictions. Participants appeared to be genuinely concerned about the need to clarify roles and responsibilities and in validating the work performed by UHW's across Canada.

A national symposium is planned for March 5 and 6, 2009 in Ottawa.

### **3. Appropriate Health System Renewal (Expanded Continuum of Care)**

#### **3.1 *The Continuing Care Research Project Report – Report to be released October 20, 2008***

This three-year project compared the outcomes and costs of providing home care, supportive housing and long term facility care to groups of veterans in Ontario. The project also studied home support services and their role in keeping people in their communities. Hollander Analytical Services conducted the research for Veterans Affairs Canada and the Government of Ontario. CHA was a member of the Advisory Committee.

A smaller, but related, study evaluated the impacts of Veteran Affairs Canada's *At Home Pilot Project* (1999–2002), which offered some veterans access to the *Veterans Independence Program*, a national home care program to help clients remain healthy and independent in their own homes or communities.

Some of the key findings add to the substantial body of research supporting home care, home support services and supportive housing, and recognize the pivotal role of the informal caregiver.

- Long term home care is often a cost-effective alternative to long-term facility care. It generally proves to be cheaper even when the cost of informal caregiver time is considered.
- Home support services are an integral part of long term home care.
- Informal caregivers make a substantial economic contribution.
- The studies point to the value of supportive housing.

The results will be shared with provincial and territorial ministries. For more information, please contact David Pedlar, PhD, Director of Research, Veterans Affairs Canada at: [research-recherche@vac-acc.gc.ca](mailto:research-recherche@vac-acc.gc.ca). CHA staff will post the study on our website and has requested hard copies for distribution

### **3.2 New Publications on Pediatric Palliative Care**

#### *Pediatric Hospice Palliative Care: Guiding Principles and Norms of Practice in Canada.*

Produced by the Canadian Hospice Palliative Care Association and the Canadian Network for Palliative Care for Children, this document is designed to guide health care professionals in establishing standards of practice, service delivery, program and policies for pediatric hospice palliative care, regardless of whether that care is delivered at home, in a hospital, in a long term care facility or in a hospice. The aim behind the publication is to promote a standard consistent approach to pediatric hospice palliative care in Canada.

The document is available on the Canadian Hospice Palliative Care Association website:  
[http://www.chpca.net/marketplace/pediatric\\_norms/pediatric\\_norms.htm](http://www.chpca.net/marketplace/pediatric_norms/pediatric_norms.htm)

#### *Quebec Standards of Practice for Pediatric Palliative Care (Normes en matière de soins palliatifs pédiatriques)*

This publication is the result of a working group, created in 2004, to establish standards of practice for pediatric palliative care. The Standards of Practice are intended to promote a standardized and coordinated approach to ensure that children and their parents receive quality palliative care. They are intended for all healthcare teams who treat children with palliative care needs, provide services to their families, and for those who organize services and training in the field of pediatric palliative care.

#### *Quebec Standards of Practice for Pediatric Palliative Care (Normes en matière de soins palliatifs pédiatriques)*

Is available in French at:

<http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2006/06-902-05.pdf>

### **3.3 Canadian Policy Research Networks' Integrated Care for the Elderly: A Systematic Review**

In April 2008, the Canadian Policy Research Networks published *Frameworks of Integrated Care for the Elderly: A Systematic Review*. In this report, Dr. Margaret MacAdam, a CPRN Senior Research Fellow, reviews the literature on efforts to provide integrated care for the elderly. Dr. MacAdam examines articles and papers that study comprehensive models of integrated or coordinated care.

The papers reviewed indicate that it is possible to design integrated programs that redirect care away from institutional services (use of long-term care homes and hospital care) and achieve improved quality of life and reduced caregiver burden. The specific features of successful models may vary, but typically include the use of case management and access to a wide range of social and health supportive services. However, while client outcomes improve, cost savings are not immediate. Investments have to be made to realize the potential of integrated care.

The report is available on the CPRN site at  
<http://www.cprn.org/search-basic.cfm?q=elderly&l=en&x=16&y=11>

### **3.4 Portraits of Home Care 2008**

The Canadian Home Care Association has updated its 2003 *Portraits of Home Care* report. This new edition provides an update on the many changes the provinces and territories have made in the past five years.

The provinces and territories, along with the four federally funded and administered home care programs (First Nations and Inuit Home and Community Care program, the Veterans Independence Program, the Royal Canadian Mounted Police Health Services Program, and the Canadian Forces Health Services Program) are examined through the following framework:

1. Governance and organization
2. Services
3. Quality and accountability
4. Initiatives
5. Challenges
6. Vision of home care
7. Last word

This report “reflects the incredible advancements that home care programs have undergone in the past 5 years, identifies the current challenges and documents the vision of home care in our future health care system.” It can be purchased from the Canadian Home Care Association at a cost of \$200, plus shipping and handling, and the executive summary can be downloaded at no charge from the Canadian Home Care Association website: <http://www.cdnhomecare.ca/content.php?doc=199>

### **3.5 World Health Organization Releases New Report on the Social Determinants of Health**

In September 2008, the World Health Organization (WHO) released *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health*. This is the final report of the WHO Commission on Social Determinants of Health.

Reducing health inequities is, for the Commission on Social Determinants of Health, an ethical imperative. The Commission, in this report, calls for ending health inequities within a generation. They state that achieving health equity within a generation is achievable, it is the right thing to do, and now is the right time to do it. The report analyzes the social determinants of health and offers concrete examples of actions that have effectively improved health and health equity in different countries.

The report outlines a three-part action plan:

1) *Improve daily living conditions.* Improve the well-being of girls and women and the circumstances in which their children are born, put major emphasis on early child development and education for girls and boys, improve living and working conditions and create social protection policy supportive of all, and create conditions for a flourishing older life. Policies to achieve these goals will involve civil society, governments, and global institutions.

2) *Tackle the inequitable distribution of power, money and resources.* In order to address health inequities, and inequitable conditions of daily living, it is necessary to address inequities—such as those between men and women—in the way society is organized. This requires a strong public sector that is committed, capable, and adequately financed. To achieve that requires more than strengthened government—it requires strengthened governance: legitimacy, space, and support for civil society, for an accountable private sector, and for people across society to agree public interests and reinvest in the value of collective action. In a globalized world, the need for governance dedicated to equity applies equally from the community level to global institutions.

3) *Measure and understand the problem and assess the impact of action.* Acknowledging that there is a problem, and ensuring that health inequity is measured—within countries and globally—is a vital platform for action. National governments and international organizations, supported by WHO, should set up national and global health equity surveillance systems for routine monitoring of health inequity and the social determinants of health and should evaluate the health equity impact of policy and action. Creating the organizational space and capacity to act effectively on health inequity requires investment in training of policy-makers and health practitioners and public understanding of social determinants of health. It also requires a stronger focus on social determinants in public health research.

The report is available on PDF and can be downloaded from the WHO website:

[http://www.who.int/social\\_determinants/final\\_report/en/index.html](http://www.who.int/social_determinants/final_report/en/index.html)

### **3.6 New Senate Report: *Poverty, Housing and Homelessness: Issues and Options***

Issued on June 8, 2008, this is the First Report of the Senate Subcommittee on Cities of the Standing Senate Committee on Social Affairs, Science and Technology, chaired by the Honourable Art Eggleton, P.C., with the Honourable Wilbert Keon as Acting Deputy Chair.

In our developed and prosperous country, a staggering one in 10 Canadians, over 3.4 million people—almost 800,000 children—continue to live in poverty. Those most in danger are single parents (especially women), persons with disabilities, immigrants (especially newer ones) and Aboriginal people. Children and youth are also at significant risk.

This report examines the complex issues of poverty, housing and homelessness through an urban lens, as Canada is increasingly an urban society. To move towards answers as to how Canada can do better, it contains 103 options, all of which are elaborated upon in the report:

The report is available in PDF format. To download, visit:  
<http://senatorarteggleton.ca/Default.aspx?tabid=197>

### **3.7 Upcoming Conference**

#### **Re-Imagining Health Services: Innovations in Community Health**

Hosted by the Canadian Centre for Policy Alternatives–BC and Simon Fraser University's Economic Security Project, along with SFU's Faculty of Health Sciences and the University of British Columbia's Department of Family Practice and the Western Regional Training Centre for Health Services Research, November 6–8, 2008 @ University of British Columbia

This conference on community health care solutions and innovations will explore how community health care can:

- Take pressure off hospitals;
- Allow people to manage their health while living at home and in their own communities;
- Improve the health of vulnerable groups, such as frail seniors, people living with mental illness, and people with disabilities or chronic conditions; and
- Address the socio-economic determinants of health.

The conference centres on three themes:

1. What are the innovations needed to better support people with significant health issues to live in the community?
2. How do we improve the integration of primary health care services with continuing care?
3. What changes in funding and governance are needed to more effectively support innovative approaches to community health delivery?

The conference will highlight positive examples from British Columbia and elsewhere of small and large-scale models for delivering community health services, and explore how to achieve positive change.

Plenary speakers include:

- *Charlene Harrington* (School of Nursing, University of California, San Francisco) – Her research focuses on the relationship of ownership in long-term care and its impacts on quality of care. She has been a lead researcher on a national project that looks at public/private long-term care on a national scale.
- *Ronald Labonté* (Faculty of Medicine, University of Ottawa) – His work, as part of a major international study comparing primary care across different jurisdictions, focuses on the health equity impacts of contemporary globalization.
- *Clyde Hertzman* (University of British Columbia) – As Director of the Human Early Learning Partnership at UBC, his work focuses on long-term social and health benefits of healthy child development.
- *Jack McCarthy* (Executive Director, Somerset West Community Health Centre) – currently Chair of the Canadian Alliance of Community Health Centre Associations
- *Rob Reid* (Group Health Centre for Health Studies) – Research Director at Group Health Centre for Health Studies in Seattle and has published extensively on primary care reform
- *Christine Swane* (EGV Foundation) – Director and Head Researcher at EGV Foundation, a Danish association of the aged based in Copenhagen. She is involved in research on Denmark's elder care system.
- *Karen Tee* (Fraser Health) – Manager for the Early Psychosis Intervention (EPI) Programs in Fraser that provide secondary prevention and support services to young people living with psychosis
- *Cathy Ulrich* (CEO, Northern Health) – a leader in introducing integrated care at a regional level
- *Bonnie Brossart* (Health Quality Council) – CEO of the Health Quality Council in Saskatchewan

The conference website is: [http://www.policyalternatives.ca/esp\\_conference](http://www.policyalternatives.ca/esp_conference)

## Health and the Environment

Two recent studies point to the effects of environmental degradation on the health of Canadians.

Health Canada released a new federal report on the effects of climate change on health on July 31, 2008, *Human Health in a Changing Climate: A Canadian Assessment of Vulnerabilities and Adaptive Capacity*.

Highlights include:

- Canada's climate is warming and will continue to experience greater rates of warming in this century than most other regions of the world. All regions of Canada are experiencing climatic change, but the experience can vary widely across the country.
- The Yukon and Northwest Territories are experiencing the greatest warming.
- The Arctic and south-central Prairies are expected to warm the most.
- Precipitation has increased, with regional variation.
- Canadians can expect more extreme weather events, such as floods, drought, forest fires and heat waves, all of which increase health risks to Canadians.
- Air is affected by climate and its quality will be affected by smog, wildfires, pollen and greater emissions of air contaminants.
- There is likely to be a rise in infectious diseases.
- Summer mortality rates associated with high temperatures are expected to increase for all age groups, and winter mortality rates are expected to decrease slightly.
- Those most vulnerable to climate change are: *seniors* on certain medications or who have chronic health problems, live alone, or have impaired cognition or reduced mobility; *children and infants*; *socially disadvantaged individuals*; *people with illnesses* such as cardiovascular disease, neurological and mental illness, diabetes, asthma and other respiratory diseases and cancer.
- Climate change has not been a priority for health planners and program managers, but now need to work proactively and collaboratively to reduce risks with sectors such as transportation, tourism, recreation, fisheries, forestry, agriculture, industry and energy.
- Some recommendations: current state of infrastructure could make us more vulnerable, and therefore we should strive to improve it; role for the federal government in leadership and coordination of emergency preparedness and improved linkages among three levels of government needed;

On August 13, the Canadian Medical Association released *No Breathing Room: National Costs of Air Pollution*.

Highlights include;

- In 2008 there will be over 9,000 hospital visits, 30,000 emergency department visits and 620,000 doctor's office visits due to air pollution.
- Smog this year will contribute to the premature deaths of 2,700 Canadians and put 11,000 in hospital; 80 percent of those who die due to air pollution will be over age 65.
- Deaths linked to air pollution will rise over the next two decades, claiming nearly twice as many lives each year and costing 1.3 billion annually in health care and lost productivity.
- By 2031, more than 4,900 Canadians, mostly seniors, will die prematurely each year from effects of polluted air. That means that by 2031, almost 90,000 Canadians will have died from the acute short-term effects of air pollution. The number of deaths, due to long-term exposure, will be over 700,000 — the population of Quebec City.
- Ontario and Quebec will be most affected.
- In Ontario, the number of premature deaths could double, to 2,200 from 1,200 per year, while hospital admissions over the same period could jump by as much as 70 percent, and ON's

annual healthcare and economic costs could rise by as much as 30 percent, to \$740 million, from \$570 million.

- Quebec's mortality rate could rise by 70 percent, from 700 to 1,200, while hospital admissions could spike by 50 percent annually, costing the province up to \$290 million a year.
- Air pollution exacerbates not just lung problems, but heart and stroke, as pollutants such as nitrous oxide damage the heart by harming blood vessels, leading to atherosclerosis.
- In 2008 there will be over 9,000 hospital visits, 30,000 emergency department visits and 620,000 doctor's office visits due to air pollution.
- The economic costs of air pollution in 2008 will top \$8 billion. By 2031, they will have accumulated to over \$250 billion.

## **CHA Government Relations**

**Federal Election 2008:** The Federal Election was called on Sunday, September 7 for a Tuesday, October 14 vote. All business in the House of Commons and Senate ended at that time. CHA's Communications Team can provide a list of these Bills upon request.

**C-51 – Revision of Food and Drugs Act:** CHA was invited by Health Canada to work on a multi-stakeholder reference group in the development of the regulatory frameworks required to align with a modernized Food and Drugs Act under the former Bill C-51. On May 31, members of the CEO Forum took part in a teleconference with David Lee, Director, Health Canada, advising on the implications of the regulations to their organizations. Denise Desautels, Teresa Neuman, and members of OHA's policy staff attended a further meeting on this Bill with Health Canada on June 17.

The federal election has interrupted the work of Health Canada on the regulations which would accompany Bills 51 (Revision of the Food and Drugs Act), 52 (Safety of Consumer Products) and 54 (Human Pathogens and Toxins Safety). As a result of this election call, Health Canada is postponing the meetings with the multi-stakeholder reference group.

Departmental officials do not proceed with work on bills which have died on the Order Paper because there is not necessarily a guarantee that the new government will take up the business of the previous Parliamentary session and re-introduce the legislation. Each government sets its priorities for the parliamentary session. Health Canada will notify us of further steps as soon as they can after the election period and the beginning of the 40<sup>th</sup> session of Parliament.

**Pre-Budget Brief:** CHA submitted its brief to the House of Commons Standing Committee on Finance on August 15. We also requested to appear before the committee in St. John's, Edmonton or Ottawa. With the dissolution of Parliament, the 2008 pre-Budget consultations have been cancelled.

With the election call, Committees cease to exist until the House reconstitutes them following the election. All orders of reference expire, and the chairs and vice-chairs of all committees are relieved of their duties.

The Committee Clerk has advised that the date of the opening of the next Parliament, Committee membership and plans for contributing to the 2009 budget are not yet known. Details will be made available once the Committee has resumed its activities.

**Meetings with Standing Committee on Health (HESA):** The Communications Team had arranged a number of meetings between the President & CEO and members of the House of Commons Standing Committee on Health. These meetings were cancelled with the election call. Many members called CHA to request that we meet with them following the election. According, we will follow up and reschedule these meetings.

**Liberal Party of Canada – Outreach team:** CHA was contacted by Alex Morrison (Outreach team volunteer) and Michelle Wallace (Outreach team coordinator). This team plans to contact CHA following the election regarding platform and other Liberal Party policy releases.

**Lobbying Regulations:** Amendments to the Lobbyists Registration Regulations came into effect on July 1, 2008. Under the new regulations, CHA must file monthly lobbying returns based on communication with Designated Public Office Holders such as Ministers, Ministerial Staff, Deputy and Associate Deputy Ministers and anyone else designated by Cabinet. The regulations also prescribe the conditions under which Designated Public Office Holders must disclose oral and arranged communications. To date, CHA's activities have not required the filing of monthly lobbying reports.

The changes to the Lobbying Act are very detailed. The Office of the Commissioner of Lobbyists has created detailed materials outlining the changes. Please visit [www.ocl-cal.gc.ca](http://www.ocl-cal.gc.ca) to learn more.

### **Media and Member Relations:**

CHA staff maintains a Correspondence and Media binder which contains print coverage from June 1 to September 30, 2008. This is available at the Board meeting for review.

During the summer months, the media seemed preoccupied with waiting for the federal election call. Nonetheless, CHA was asked to comment on the Quality Worklife Quality Healthcare Collaborative and creating healthy workplaces, public-private partnerships, hospital congestion and ALCs, and human resource strategies including the promotion of health human resources careers for young workers.

CHA's Communications Team also performed the media function for the National Healthcare Leadership Conference. The NHLC media report is included in the Correspondence and Media binder.

### **Press Releases, Letters to the Editor and Editorials**

Since the last Board meeting, CHA has issued the following media products:

#### **Press Releases:**

**June 9, 2008:** CHA issued a press release announcing the winners of the **CHA Award for Distinguished Service** and the **Marion Stephenson Award for Outstanding Contribution to Community Care**.

#### **Letters to the Editor:**

**June 19, 2008:** Our letter to the Editor of the *Ottawa Citizen* noted that all levels of government need to work together to make workplaces healthier. We indicated that Quality Worklife Quality Healthcare Coalition and its evidence-informed action strategy is a call for health leaders to take immediate action and commit to improving the quality of worklife for all those who work within the health system.

**August 30, 2008:** In response to an August 22 article, "Billions of dollars fail to fix medical imaging deficiency", CHA's letter to the Editor of the *Ottawa Citizen* notes that simply adding more diagnostic machines in either the public or private sector will not correct staffing shortages needed to run the machines. Instead, CHA offers better solutions which might help ease staffing challenges.

**September 22, 2008:** CHA's Letter to the Editor of the *Hill Times* reminds candidates that health remains among the top three priorities of Canadians in public polling. CHA observes an apparent disconnect between the voice of the people and that of the candidates and suggests that it is time for candidates and the next Parliament to turn their attention to health.

### **Member Relations:**

**Board of Directors web portal:** Is now active.

**Federal Election Kit and Letter to the Editor templates:** CHA's Policy and Communications Team prepared materials for CHA members including a member kit and Letter to the Editor templates. We look forward to your feedback on these materials as we would like to adapt them for future advocacy campaigns and the next election.

**Analysis of Party platforms:** Unlike previous elections, the parties announced their platforms quite late during their campaigns. The Conservative Party of Canada did not announce a platform. As in previous years, CHA sent a questionnaire to parties regarding health issues. The delayed response from the parties led to publication delays. A document was released in the final two weeks of the campaign, and shared with the many stakeholders who had requested our analysis.

**National Healthcare Leadership Conference:** The Communications Team assisted with the production of the *Call for Abstracts* on the upcoming National Healthcare Leadership Conference.

*CHA's Communications Team is pleased to answer any questions and provide further information on this report or any of CHA's media or government relations activities. Please e-mail [tneuman@cha.ca](mailto:tneuman@cha.ca) or call 613-241-8005 X205.*