

**A RESPONSIVE, SUSTAINABLE,
PUBLICLY FUNDED
HEALTH SYSTEM IN CANADA**

— THE ART OF THE POSSIBLE —

**CHA's Ten-Point Plan for
Moving from Discussion to Action**



Canadian Healthcare Association

February 2002

PREFACE

The Canadian Healthcare Association (CHA) is the federation of provincial and territorial hospital and health organizations across Canada. Through our members, CHA represents a broad continuum of care, including acute care, home and community care, long term care, public health, mental health, palliative care, addiction services, children, youth and family services, housing services, and professional and licensing bodies. These services are provided through regional health authorities, hospitals and other facilities and agencies that serve all Canadians and are governed by trustees who act in the public interest.

The Canadian Healthcare Association was founded in 1931 and has historically represented provincial and territorial hospital associations at the national level. In 1995, our name was changed from the Canadian Hospital Association to the Canadian Healthcare Association to reflect the broadening scope of our association's membership.

CHA's mission is to improve the delivery of health services in Canada through policy development, advocacy and leadership. CHA's distance education programs, conferences and publishing services contribute to this national leadership. CHA and our members are committed to realizing the vision of a publicly funded health system that provides access to a broad range of comparable health services across Canada.

Through partnerships and alliances, CHA seeks to find solutions to the challenges facing Canada's health system and to influence public policy.

EXECUTIVE SUMMARY

Moving from Discussion to Action

The Canadian Healthcare Association (CHA) originally submitted this policy brief to the Romanow Commission in October 2001. Following a CHA Board meeting in February 2002, the document was updated to reflect some new policy positions of the Association and new health system initiatives. It was also decided to reissue this policy brief, focusing on our ten-point plan for moving from discussion to action. It is hoped that this document will facilitate the creation of concrete action plans, and perhaps even collaboration, by and among governments, Commissions and health system reviews currently underway at the provincial, territorial and national levels.

In developing this policy brief, CHA has endeavoured to be honest in assessing the strengths and weaknesses of our current health system, bold in suggesting that a publicly funded system that embraces a full continuum of care is sustainable, and creative in the identification of some concrete next steps to ensure a responsive, sustainable, publicly funded health system for the future.

CHA and our provincial and territorial members believe that it is time to move from discussion to action. We urge all decision makers to take the bold step of creating concrete action plans that can be implemented immediately to address the critical issues facing our publicly funded health system and to meet the future health needs of Canadians. Do not let perfection stand in the way of the possible.

Strong Leadership, Appropriate System Change, and Adequate Funding

This is CHA's rallying cry for addressing the critical issues currently facing our health system and supporting the innovation required for the future. CHA calls on governments, health system managers and trustees, providers, researchers and the public to provide purposeful leadership to move us from talk to action. CHA and our provincial and territorial members have supported and will continue to support system change that is appropriate, improves patient safety and quality care, ensures public accountability, and embraces the full continuum of care. CHA also strongly believes that more public money from federal, provincial and territorial governments is still required in our health system to support needed change and to ensure that all Canadians have access to comparable services no matter where they live.

CHA's Ten-Point Plan

In this policy brief, CHA has summarized many of our recent policy statements (*see* Appendix A) within four main categories: Canadian Values, Sustainability, Managing Change, and Co-operative Relations. What has emerged is a ten-point plan for ensuring a responsive, sustainable and publicly funded health system in Canada:

1. Reflect Canadian Values
2. Embrace Appropriate System Change
3. Address Critical Health Human Resources Issues
4. Support Needed Health Infrastructure
5. Examine the Private-Public Mix in the Funding and Delivery of Health Services
6. Ensure Adequate, Predictable Funding
7. Improve Performance Measurement
8. Ensure Public Accountability
9. Involve Health System Managers and Trustees
10. Improve Federal/Provincial/Territorial Relations

For each of the ten points, there are a number of goals and specific objectives. These bold, creative next steps include the need for the federal, provincial and territorial governments to:

Canadian Values

1. Reflect Canadian Values

- 1.1 **Ensure Access Based on Need, Not Ability to Pay**
 - *Assess the impact of proposed system changes on Canadians' ability to access needed health services.*
- 1.2 **Reflect a Shared Approach to Risk**
 - *Scrutinize any new funding or delivery mechanisms involving either the public or private sector in terms of their impact on shifting the risk from society to individuals, to ensure that the Canadian value of shared risk is upheld.*
- 1.3 **Support Public Governance**
 - *Strengthen public governance to improve accountability and ensure local input into decisions that fundamentally affect the health and well-being of individuals and communities.*
- 1.4 **Balance Social and Business Needs**
 - *View public funding of the health system as an investment in (not a drain on) not only the personal health of Canadians but also the economic health of our nation.*

Sustainability

2. Embrace Appropriate System Change

- 2.1 **Implement Primary Health Care Reform**
 - *Immediately implement effective primary health care systems by identifying "champions" from a variety of groups, organizations and perspectives; giving this initiative government priority, attention and on-going commitment; supporting training that fosters team approaches; facilitating communication and community development processes that engage the public, physicians, nurses, all health providers and health organizations; and working to ensure client and community acceptance, satisfaction and confidence.*
- 2.2 **Encompass Home, Community and Long Term Care**
 - *Announce an initial additional \$1 billion annual federal commitment, which would be tied to meeting common objectives, to begin to ensure that all Canadians have access to comparable, needed health services across the broad continuum of care, including home, community and long term care services (see also 5.2 and 6.5).*
- 2.3 **Strengthen All Components of the Health System**
 - *Provide more resources and attention to public health programs, emergency medical services, mental health services and palliative care services.*
 - *Establish coordinating committees to evaluate the health impact of policies in health-determining departments — such as the environment, employment and housing — and to foster intersectoral work among these departments.*

2.4 Reorganize Pharmacare

- *Examine the pharmacare programs currently in place across the country, and formulate a national policy that reflects the best of these programs and provides consistent guidelines so that Canadians can access pharmaceuticals on the basis of need, not on the basis of service location (e.g., acute care versus long term care).*
- *Identify the ways and means of establishing a national formulary.*

3. Address Critical Health Human Resources Issues

Facilitate the development of a pan-Canadian Health Human Resources Framework and Strategy that will:

3.1 Tackle Practice Issues

- *Address scope of practice issues by embracing creative solutions that will test long held practices and beliefs; and*

3.2 Develop Positive Labour Relations

- *Deal effectively with labour relation issues, including remuneration levels, benefit packages, service contracts, and payment mechanisms for physicians, nurses and other providers; and*
- *Ensure that Canadian health organizations are an employer of choice in relation to other sectors and globally.*

This pan-Canadian Health Human Resources Framework and Strategy will need to be developed collaboratively, with government representatives, employer representatives from health facilities and agencies, and employee representatives all being engaged in the consultation and decision-making processes.

4. Support Needed Health Infrastructure

4.1 Develop Strong Health Information Systems

- *Work collaboratively with health system stakeholders to coordinate the development of a pan-Canadian solution that addresses the challenges of achieving compatible health information technologies.*

4.2 Encourage Innovation in Health Technology

- *Provide targeted funds to the provinces and territories for the development and operation of medical equipment and health technologies.*

4.3 Cost-Share Capital Infrastructure Costs

- *Provide accelerated capital funding to provinces and territories to cost-share urgently needed capital infrastructure and to stimulate economic growth.*
- *Explore some of the recommendations made in recent reports regarding potential public-private partnerships in the funding of health care equipment and capital infrastructure needs. However, it must be clearly understood that these partnerships do not eliminate the federal, provincial and territorial governments' responsibility to adequately fund the health system.*

- 4.4 Enhance Health Research
- *Continue to invest in health research so that Canada's capacity for research and knowledge development can be strengthened, health systems can be improved to better meet the needs of individuals and communities, and our world leadership in health research can be enhanced.*
 - *Ensure that the federal government's contribution to health research is increased within the next three years to at least 1% of the amount it allocates to health services.*
- 5. Examine the Private-Public Mix in the Funding and Delivery of Health Services**
- 5.1 Debunk Some Myths
- *Talk with the media and the public to debunk the pervasive myths related to our publicly funded health system.*
 - *Highlight the fact that in international comparisons Canada has one of the lowest (not highest) levels of public sector funding and that our public expenditures on health are not out of control.*
- 5.2 Broaden, Don't Narrow the Basket of Publicly Funded Services
- *Do not narrow the range of physician and hospital services provided through the Canada Health Act.*
 - *Broaden the basket of publicly funded services by implementing a national home, community and long term care program that is established outside of the Canada Health Act, perhaps using the Social Union Framework Agreement, with federal funding available subject to the provinces and territories meeting mutually agreed upon objectives (see also 2.2 and 6.5).*
 - *Ensure that acute care services (including acute care replacement home care services) are 100% publicly funded, while home, community and long term care services, or certain aspects of them, may be subject to some form of copayments.*
 - *Examine the challenges and opportunities of involving the for-profit private sector in the funding and delivery of health services in Canada, and establish clear guidelines for determining when public-private partnerships are appropriate.*
- 5.3 Establish a Framework for For-Profit Private Sector Delivery
- *When partnering with the for-profit private sector: establish clear expectations, develop explicit quality standards, and demand transparent accountability mechanisms.*
- 5.4 Monitor and Assess the Level and Impact of Private Funding
- *Actively monitor the ratio of public to private spending on health services.*
 - *Do not increase the proportion of private spending without a better understanding and evidence of its impact on accessibility, quality of care and global competitiveness.*
- 5.5 Protect Our Health System in International Trade Agreements
- *Invite health groups, including CHA and our members, to participate on working committees of the Department of Foreign Affairs and International Trade (DFAIT) and Health Canada, and their provincial/territorial counterparts, to ensure that the concerns of the publicly funded and publicly delivered health system are represented as Canada develops its positions in international trade negotiations.*

6. Ensure Adequate, Predictable Public Funding

6.1 Explore Funding Mechanisms

- *CHA urges the federal government to uphold their role in health to achieve access to comparable health services across Canada. This includes recognizing the historical 1977 tax transfer and continuing to transfer cash, on a per capita basis, to the provinces and territories to deliver health services.*
- *CHA also urges the federal government to make public to all Canadians an analysis of why cash transfers are an important component of federal transfers for health services.*
- *CHA urges the federal government to uphold their role in health to achieve access to comparable health services across Canada. This includes continuing to provide Equalization payments to the provinces and territories and resolving key issues regarding the current Equalization formula.*
- *Do not introduce any new funding mechanisms, such as user fees for Canada Health Act services or medical savings accounts, unless there is clear evidence that these will enhance quality of care and ensure access to needed health services.*
- *Investigate other alternative funding mechanisms, in addition to or instead of the CHST. This should include examining the merits and feasibility of replacing the CHST with a health-specific transfer, applying the per capita formula in the CHST to the cash portion alone, and augmenting or replacing the per capita formula in the CHST and targeted federal funding for health with a needs-based formula.*

6.2 Stabilize the System — Increase CHST Base Funding

- *Raise the federal CHST cash floor (not including the funds allocated for early childhood development) by \$1.1 billion to \$19.8 billion, by 2002-03.*
- *Explicitly announce the federal government's commitment to an annual escalator to apply to the CHST cash floor, beginning in 2003-04.*

6.3 Target New Funds to Meet Urgent Needs

- *Determine an adequate level of federal funds over a five-year period to be earmarked as specific, targeted funds for: health human resources; medical equipment and health care technology; health information technology; health system accountability; health services infrastructure; health services research and innovation; and specific federal programs.*

6.4 Provide Transitional Funds to Support Appropriate System Change

- *Determine an adequate level of federal funds over a five-year period to be used to support needed health system change across the continuum of services, including: primary health care reform; health promotion and disease prevention; mental health; emergency medical services, and palliative care.*

6.5 Meet Future Needs, Now

- *Commit at least \$1 billion annually from the federal government, starting in 2002-03, to ensure that all Canadians have access to needed health services across the broad continuum of care, including home, community and long term care, which is supported by a pharmacare program (see also 2.2 and 5.2).*

Managing Change

7. Improve Performance Measurement

7.1 Develop Appropriate Performance Indicators

- *Coordinate efforts to develop a pan-Canadian evaluation and monitoring system for the health system, including appropriate indicators, a minimum data set that is comparable across the country, and harmonized reporting mechanisms.*

7.2 Foster a Culture of Continuous Quality Improvement

- *Ensure that there are processes in each province and territory to support and coordinate education, networking and evaluation initiatives related to quality across the continuum of care. This work should be coordinated by agencies that are currently working in this area, including the Canadian Institute for Health Information (CIHI) and the Canadian Council on Health Services Accreditation (CCHSA).*

8. Ensure Public Accountability

8.1 Develop Clear and Mutually Agreed Upon Roles and Responsibilities

- *Develop, in collaboration with health system managers and trustees, roles and responsibilities that are linked to decision-making authority, based on mutually agreed-upon and clear performance expectations, tied to adequate capacity (including funding) to meet responsibilities, and set within an ethical framework.*

8.2 Demand Public Reporting by Governments, Health Organizations and Providers

- *Improve accountability within the Canadian health system by providing additional funds to support existing accountability mechanisms, such as initiatives of the Canadian Institute for Health Information.*
- *Develop immediately new pan-Canadian accountability mechanisms, such as a balanced score card, to measure and report on health system performance across a broad continuum of care, and ensure that these mechanisms are not solely focused on cost-containment.*
- *Address key issues related to improving public reporting, such as encouraging more integrated provider accountability (to patients, peers and the health system), dealing with the dual responsibility of Boards reporting to governments and to the public they serve, addressing consumer/patient rights and responsibilities, promoting balanced and fair media reporting, exploring the role of the Canadian Council on Health Services Accreditation in sharing accreditation information, and ensuring that governments support public accountability mechanisms even when findings could be politically damaging.*

8.3 Facilitate Ethical Decision Making

- *Provide the necessary resources to ensure that health system trustees and managers have access to professional ethicists for consultation on specific issues and that they receive the needed training in ethical decision making to apply these skills to everyday governance and management issues.*

Co-operative Relations

9. Involve Health System Managers and Trustees

9.1 Facilitate Meaningful Consultation and Collaboration

- *Develop processes that meaningfully involve health system stakeholders while at the same time recognizing the jurisdictional and funding responsibilities of governments.*

9.2 Let Managers Manage and Governments Govern

- *Meet with managers and trustees to determine how to build more autonomy and flexibility into decision making so that trustees and managers can provide services in a responsive and effective manner, while at the same time reassuring governments that trustees and managers have the skills and experience to make good system decisions.*

9.3 Support Knowledge Transfer and Uptake

- *Adequately fund activities to improve the use of research information.*
- *Create a culture of evidence-based decision making.*

10. Improve Federal/Provincial/Territorial Relations

10.1 Recognize Need for Both Federal and Provincial/Territorial Involvement in Health

- *Demonstrate strong federal leadership by articulating a shared vision of Canada's health system, developing pan-Canadian health goals, and aligning financial incentives to support needed system change. It is only the federal level of government that is accountable to all Canadians in terms of achieving access to comparable health services for all Canadians, no matter where they live.*
- *Build some flexibility into any new pan-Canadian health program, recognizing the different geographic and political realities of the various regions across Canada and the unique health needs of different communities.*

10.2 Use the Social Union Framework Agreement (SUFA)

- *Go back to the Social Union Framework Agreement (SUFA) and use it.*

10.3 Be Patient, But Persistent

- *Buffet the criticism and stay the course, once difficult but important decisions have been reached.*

Recommendations for moving from discussion to action will need to reflect these ten steps and their related activities in order to provide the direction, energy and resources required to develop a responsive, sustainable, publicly funded health system that meets the needs of Canadians now and into the future.

The Art of the Possible

CHA believes that our existing health system provides a firm foundation upon which to make needed and appropriate changes. The doom and gloom stories about our health system need to be viewed in the context of the very ordinary and extraordinary events that take place daily in hospitals, home care agencies, long term care facilities, public health offices, mental health programs, palliative care services, child and family services, supportive housing initiatives, and other venues when meeting the complex health needs of Canadians.

Health services are funded, provided and received by people. Therefore, improvements to our health system will be achieved by people working together. Harnessing this people power and being aware of human behaviour and organizational dynamics will require patience and persistence. This will be a challenge, but a challenge worth embracing.

This is the art of the possible – empowering the human spirit to achieve small and great things.

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A. INTRODUCTION

i. Moving from Discussion to Action

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ii. Strong Leadership, Appropriate System Change, and Adequate Funding

This is CHA's rallying cry for addressing the critical issues currently facing our health system and supporting the innovation required for the future.

CHA calls on governments, health system managers and trustees, providers, researchers and the public to provide purposeful leadership to move us from talk to action. CHA and our provincial and territorial members have supported and will continue to support system change that is appropriate, improves patient safety and quality care, ensures public accountability, and embraces the full continuum of care. CHA also strongly believes that more public money from federal, provincial and territorial governments is still required in our health system to support needed change and to ensure that all Canadians have access to comparable services no matter where they live.

iii. CHA's Ten-Point Plan

In this submission, CHA has summarized many of our recent policy statements (*see* Appendix A) within four main categories: Canadian Values, Sustainability, Managing Change and Co-operative Relations. What has emerged is a ten-point plan for ensuring a responsive, sustainable and publicly funded health system in Canada:

Canadian Values

- 1. Reflect Canadian Values**
 - 1.1 Ensure Access Based on Need, Not Ability to Pay
 - 1.2 Reflect a Shared Approach to Risk
 - 1.3 Support Public Governance
 - 1.4 Balance Social and Business Needs

Sustainability

- 2. Embrace Appropriate System Change**
 - 2.1 Implement Primary Health Care Reform
 - 2.2 Encompass Home, Community and Long Term Care
 - 2.3 Strengthen All Components of the Health System
 - 2.4 Reorganize Pharmacare

- 3. Address Critical Health Human Resources Issues**
 - 3.1 Tackle Practice Issues through a Pan-Canadian Strategy
 - 3.2 Develop Positive Labour Relations through a Pan-Canadian Strategy

- 4. Support Needed Health Infrastructure**
 - 4.1 Develop Strong Health Information Systems
 - 4.2 Encourage Innovation in Health Technology
 - 4.3 Cost-Share Capital Infrastructure Costs
 - 4.4 Enhance Health Research

- 5. Examine the Private-Public Mix in the Funding and Delivery of Health Services**
 - 5.1 Debunk Some Myths
 - 5.2 Broaden, Don't Narrow the Basket of Publicly Funded Services
 - 5.3 Establish a Framework for For-Profit Private Sector Delivery
 - 5.4 Monitor and Assess the Level and Impact of Private Funding
 - 5.5 Protect Our Health System in International Trade Negotiations

- 6. Ensure Adequate, Predictable Public Funding**
 - 6.1 Explore Funding Mechanisms
 - 6.2 Stabilize the System — Increase CHST Base Funding
 - 6.3 Target New Funds to Meet Urgent Needs
 - 6.4 Provide Transitional Funds to Support Appropriate System Change
 - 6.5 Meet Future Needs, Now

Managing Change

- 7. Improve Performance Measurement**
 - 7.1 Develop Appropriate Performance Indicators
 - 7.2 Foster a Culture of Continuous Quality Improvement

- 8. Ensure Public Accountability**
 - 8.1 Develop Clear and Mutually Agreed Upon Roles and Responsibilities
 - 8.2 Demand Public Reporting by Governments, Health Organizations and Providers
 - 8.3 Facilitate Ethical Decision Making

Co-operative Relations

- 9. Involve Health System Managers and Trustees**
 - 9.1 Facilitate Meaningful Consultation and Collaboration
 - 9.2 Let Managers Manage and Governments Govern
 - 9.3 Support Knowledge Transfer and Uptake

- 10. Improve Federal/Provincial/Territorial Relations**
 - 10.1 Recognize Need for Both Federal and Provincial/Territorial Involvement in Health
 - 10.2 Use the Social Union Framework Agreement (SUFA)
 - 10.3 Be Patient, But Persistent

Recommendations for moving from discussion to action will need to reflect these ten steps and their related activities in order to provide the direction, energy and resources required to develop a responsive, sustainable, publicly funded health system that meets the needs of Canadians now and into the future.

iv. The Art of the Possible

CHA believes that our existing health system provides a firm foundation upon which to make needed and appropriate changes. The doom and gloom stories about our health system need to be viewed in the context of the very ordinary and extraordinary events that take place daily in hospitals, home care agencies, long term care facilities, public health offices, mental health programs, palliative care services, child and family services, supportive housing initiatives, and other venues to meet the complex health needs of Canadians.

Realizing the vision of a sustainable, publicly funded health system that is responsive to the health needs of all Canadians will require more than changes to policies, processes and funding formulas. It will require the belief in and the support of the human spirit — the art of the possible.

B. CANADIAN VALUES

The fiscal and social policies of governments must reflect and enhance the deeply held values of Canadians, many of which are directly linked to our publicly funded health system.

1. REFLECT OUR CANADIAN VALUES

Four Canadian values that will continue to shape the development of our health publicly funded health system include:

- ◆ Ensure Access to Health Services on the Basis of Need, Not Ability to Pay
- ◆ Reflect A Shared Risk Approach to Providing Health Services
- ◆ Support Public Governance
- ◆ Balance Social and Business Needs

1.1 Ensure Access to Health Services on the Basis of Need, Not Ability to Pay

Our publicly funded health system is based on a long held Canadian value that access to health services is provided on the basis of health need, not the ability to pay. In Canada, you are not denied insured health services if you are unable to pay for the services you need. And, by and large, having lots of money does not provide you with better care. This has been confirmed in recent research studies. (For more details see CHA's 2001 Policy Brief *The Private -Public Mix in the Funding and Delivery of Health Services in Canada: Challenges and Opportunities.*)

This value has historically applied to hospital and physician services, not to home, community and long term care services, or Emergency Medical Services, or a number of other services. It is time that this Canadian value be applicable to all health services. Determining access to needed services, including diagnostic and treatment services, based solely on the ability to pay is not equitable.

CHA urges governments to assess the impact of proposed system changes on Canadians' ability to access needed health services.

1.2 Uphold a Shared Risk Approach to Providing Health Services

An essential element of being Canadian is supporting the "shared risk" approach to providing health services. This is in contrast to the "individual risk" approach in which the philosophy of "every person for themselves" is the dominant belief. Canadians believe that "we are in this together."

In social policy terms, this value means that Canadians support governments' involvement in areas such as health services and that we support our publicly funded health system through taxes. With greater private funding in the health system, we are moving away from the "social safety net" to "survival of the wealthiest." This can lead to individuals not having equitable access to necessary services. It may result in some individuals not qualifying for private health insurance. It may also mean that individuals and families have to make difficult choices between buying needed health services and other necessities of life.

CHA urges governments to scrutinize any new funding or delivery mechanisms involving either the public or private sector in terms of their impact on shifting the risk from society to individuals, to ensure that this Canadian value of shared risk is upheld.

1.3 Support Public Governance

To a large extent health services in Canada have their roots in community organizations, with religious organizations and others developing what has become our network of health and social services. This has resulted in a long history of public involvement in the governance of these services. Canadians are demanding that governments, health system managers and trustees, and individual providers be more accountable for the service delivery decisions they are making.

Accountability processes in the publicly funded, publicly delivered health system involve appointed or elected Boards that are responsible to governments and the public they serve. These Boards are accountable for developing and approving financial policy and funding allocations. In addition, they must ensure that practice and quality standards are adhered to and accreditation processes are followed. However, with more for-profit private sector involvement, accountability to the public may become more challenging. For example, though there may be some public accountability in the publicly funded, privately delivered system, it can be difficult to obtain information on some aspects of the management and finances of the for-profit company delivering the health care services. And, in the privately funded and for-profit privately delivered health system, there is much less public control, public scrutiny and public accountability.

Based on their experiences in governing the health system, public trustees are excellent ambassadors — both while serving on a Board and often long after their term has ended — in describing to the public the myriad of complex issues facing the system. Public governance systems and structures, such as Boards and Working Groups, can be effective venues for engaging the public in the debate regarding the health system they need.

Difficult access and allocation decisions often have to be made by governing boards. Providers who are directly or indirectly employed in the health system often have a special interest in the decisions needing to be made, as does the funder, government. Thus, one of the most significant reasons for supporting public governance is to ensure that the values of the community being served are reflected in the decisions being made.

*CHA urges governments to strengthen public governance to improve accountability and ensure local input into decisions that fundamentally affect the health and well-being of individuals and communities. (For more details, see CHA's 2001 Policy Brief *Accountability: Getting from Here to There*).*

1.4 Balance Social and Business Needs

It is now well accepted that our single payer, publicly funded health system contributes not only to our individual and collective well being, but also to our country's economic performance. Business leaders continue to recognize the economic benefits of our publicly funded system in terms of a healthy workforce, increased productivity, economic development (through health research and innovation), quality of life related to business decisions to locate in Canada, and increased global competitiveness.

Governments often present a false dichotomy between spending on social programs and meeting business needs through tax cuts. In fact, both can lead to greater productivity. A dynamic equilibrium is needed to enable a both/and (rather than an either/or) approach to allocating scarce resources.

CHA urges the federal government to view its ongoing, substantial contribution to the health system as an investment in (not a drain on) not only the personal health of Canadians but also the economic health of our nation.

* * * *

These values are not just "feel good" statements. They profoundly influence decision making at all levels of government and service provision. We need to stand up and be proud of our Canadian values. CHA will test any new policy directions against these touchstones.

C. SUSTAINABILITY

CHA's current understanding of sustainability within our health system has been evolving over more than a decade. In the late eighties we undertook a visioning project. More recently, we published a CHA Policy Brief entitled *Framework for a Sustainable Healthcare System in Canada*. And, in preparation for the 2000 federal election, we developed an *Election Primer* that further expanded on the elements of a sustainable health system.

CHA believes that a sustainable, publicly funded health system is not only desirable, it is essential to maintain and improve the health of individuals and communities, to improve productivity of the Canadian workforce, and to maintain our global economic competitiveness.

To ensure this sustainability, fundamental changes are needed. Building on the existing, strong foundation to develop greater efficiencies and responsiveness within our health system, we must be prepared to:

- ◆ Embrace Appropriate System Change
- ◆ Address Critical Health Human Resources Issues
- ◆ Support Needed Health Infrastructure
- ◆ Examine the Private-Public Mix in the Funding and Delivery of Health Services
- ◆ Ensure Adequate, Predictable Public Funding

2. EMBRACE APPROPRIATE SYSTEM CHANGE

It is time to build on the past and embrace the future. We must be clear as to what our common goals are and realistic in setting timeframes to realize them. Strong leadership is needed from governments to realize a vision for our Canadian health system. This vision must be supported by common goals and objectives that can provide direction in the reshaping of our sustainable, publicly funded health system.

Collectively, governments, health system managers and trustees, providers and the public must undertake a number of specific initiatives to ensure that appropriate system change occurs, including:

- ◆ Implement Primary Health Care Reform
- ◆ Encompass Home, Community and Long Term Care
- ◆ Strengthen All Components of the Health System
- ◆ Reorganize Pharmacare

2.1 Implement Primary Health Care Reform

While many Canadian jurisdictions are now focusing on the need for primary health care, they are often approaching it from a narrow health services perspective, not from the broader perspective envisioned by the World Health Organization (WHO). Primary health care is much more than a reorganization of the existing system. It embraces a holistic approach, recognizing that health depends on many complex and interrelated factors. It empowers people to make decisions about their own health needs and how best to meet these needs. It is based on multidisciplinary teams of health and other human service providers who collaborate to address the needs of individuals, families and communities. Primary health care is funded and structured in a way that encourages and permits a system-wide balance of treatment, rehabilitation, health promotion and disease prevention.

CHA and our provincial and territorial members fully support the need for fundamental primary health care reform, in a context that recognizes that different models will be appropriate in rural, remote, northern and urban areas across the country. These models must reflect a community's health needs, the availability of different combinations of primary health providers, and various forms of remuneration.

The \$0.8 billion over four years for primary health care reform which was announced as part of the September 2000 *Communiqué on Health* is woefully inadequate for enabling existing primary health care initiatives to become fully established and accelerating the development of new primary health care initiatives across the country.

But lack of money is only part of the problem. Lack of political will and resistance by some physicians are also challenges. In terms of garnering physician support, important issues need to be grappled with, including the need to determine appropriate working conditions, address liability issues, develop mechanisms that strengthen physician accountability to the health system, and develop appropriate models and levels of remuneration.

There is a plethora of good ideas for implementing primary health care reform. Most recently, the Mazankowski Report (Alberta), the Fyke Commission (Saskatchewan) and the Clair Commission (Quebec) outline important components of Primary Health Care Reform. And the federal Health Transition Fund has supported some promising primary health care reform initiatives.

CHA urges governments to demonstrate leadership by immediately implementing effective primary health care systems by identifying “champions” from a variety of groups, organizations and perspectives; giving this initiative government priority, attention and on-going commitment; supporting training that fosters team approaches; facilitating communication and community development processes that engage the public, physicians, nurses, all health providers and health organizations; and working to ensure client and community acceptance, satisfaction and confidence.

2.2 Encompass Home, Community and Long Term Care

Across the country Canadians do not have access to comparable home, community and long term care services. Some provinces and territories provide these services within the publicly funded system, but with large differences in terms of financial eligibility and levels of co-payments. And many home, community and long term care services are available only privately, to those who can afford them. These pan-Canadian inconsistencies are unacceptable.

CHA has been urging the federal government for some time to announce an initial additional \$1 billion annual federal commitment, which would be tied to meeting common objectives, to begin to ensure that all Canadians have access to comparable, needed health services across the broad continuum of care, including home, community and long term care services.

The federal, provincial and territorial governments should develop common objectives or standards of access and quality of care for these services within the Social Union Framework Agreement (SUFA). The federal government could then commit to providing sufficient funds to enable provinces and territories to meet these common objectives. (*See also 10.2.*) It is important to note that if a province or territory has an existing program that meets these common objectives, it would be eligible to receive the new federal funding, which could then be used to improve this program or other health services. The initial amount of \$1 billion will need to be reviewed by the federal, provincial and territorial governments to determine the appropriate, ongoing annual contribution of the federal government to support access to a broad continuum of needed services.

Access to comparable home, community and long term care services is not simply a grand gesture to reflect our Canadian value of accessibility based on need, not ability to pay. It is also important because, by providing an integrated continuum of care within the publicly funded system, patient care can be improved, efficiencies can be achieved, anticipated future needs can be met, and current pressures on the system can be relieved.

2.3 Strengthen All Components of the Health System

As outlined in sections 2.2 and 5.2, CHA believes that our publicly funded health system needs to be broadened to include home, community and long term care. In addition to this expansion, there is a need to strengthen components already within the existing system, including public health programs, emergency medical services, mental health services and palliative care.

It has often been argued that if the health system were to take an “upstream” approach to maintaining and improving health, there would be less need for treatment services. One analogy of this is to consider spending more resources teaching people to swim, rather than providing more boats and personnel to rescue drowning swimmers. The reality is that all components of the health system are needed and shifting resources from one part of the system to another takes time. Many believe that great gains could be made in the health of individuals and communities, if more of our health funding was made available to public health programs, specifically health promotion and disease prevention initiatives across the country. The benefits of these “upstream” initiatives could also help to reduce costs in the future. Greater investments in health promotion and disease prevention are needed now. Deaths due to contaminated water, mad cow disease, and the recent terrorist attacks demonstrate just how vulnerable our current public health system is.

Our health system has traditionally focused on the physical health of individuals. This is changing, with a growing recognition that social, spiritual and mental health needs are also critical to an individual’s feeling of health and well-being. Yet, the mental health needs of Canadians may still be overlooked when planning health services. Like other components of the health system, it has been argued that with very little new investments, great progress could be made in preventing mental health illness, promoting good mental health, identifying needs, and providing appropriate treatments.

Even within the traditional acute care system, there are components that are under-resourced, including Emergency Medical Services. Often Emergency Medical Services are only partially covered or not covered at all by government funding, and issues of response times and availability of appropriately trained personnel continue to be unresolved.

Innovative palliative care initiatives that provide services in facilities and at home to support patients, their family and friends are available haphazardly across the country. Recent funding for the development of palliative care standards and the creation of the Secretariat on Palliative Care within Health Canada are promising signs that this vital component of our health system is starting to get the attention and resources it needs. It is incumbent upon health system managers and trustees to work with providers and governments to ensure that these innovations become standard practice across Canada. As this work unfolds, there will be a need for transitional funds to implement best practices and quality standards across Canada.

CHA and our provincial and territorial members recognize the broader determinants of health, including the environment, education, affordable housing, employment and income levels. And our members continuously promote programs that are rooted in these determinants of health. We fully support recommendations to look beyond the health system to improve the health of Canadians. And health

system managers and trustees will continue to work with others outside the health system to improve health.

Our health system should be serving all Canadians. However, we know that major improvements are needed to meet the unique health and social needs of Aboriginal peoples, Canadians with disabilities, children, multicultural communities, and Canadians living in rural, remote and northern communities. Space limitations do not allow us to discuss these unique needs in detail in this brief, but many of these issues are discussed in *CHA's Framework for a Sustainable Healthcare System in Canada* and *CHA's 2000 Federal Election Primer*.

CHA urges governments to provide more resources and attention to public health programs, emergency medical services, mental health services and palliative care services.

CHA also urges the federal, provincial and territorial governments to establish coordinating committees to evaluate the health impact of policies in health-determining departments — such as the environment, employment and housing — and to foster intersectoral work among these departments that focus on the broader determinants of health.

This leadership will enable the whole to be truly greater than the sum of its parts, rather than the current situation of the whole being compromised by one or more parts of the system.

2.4 Reorganize Pharmacare

CHA's support for reorganizing pharmacare is related to the fact that the cost of prescription drugs in Canada is a key driver of the increased private spending on health services in Canada. If the overall (public and private) Canadian health system is to be sustainable, we must address the fundamental cost drivers, and not simply tinker around the edges.

There has been much talk over the last few years about establishing some form of a national pharmacare program. Many questions remain to be answered: Should pharmaceuticals be covered through our publicly funded system? If so, for all Canadians, or only for specific population groups, such as seniors; in all settings, or restricted to specific settings, such as home, acute and palliative care; for all drugs, or only some; and on what basis, through means testing or copayments? The September 2000 *Communiqué on Health* by the First Ministers recognized the need for action on this issue and proposed some initial next steps; however, no money was explicitly targeted to address this issue. Recent Ministers of Health meetings indicate that progress may be being made on this front.

CHA urges governments to examine the pharmacare programs currently in place across the country, and formulate a national policy that reflects the best of these programs and provides consistent guidelines so that Canadians can access pharmaceuticals on the basis of need, not on the basis of service location (e.g., acute care versus long term care).

CHA also urges governments to identify the ways and means of establishing a national formulary.

3. ADDRESS CRITICAL HEALTH HUMAN RESOURCES ISSUES

Health human resources issues are critical for a number of reasons: they are the major cost factor in the health delivery system (e.g., 70-80% of health organizations' budgets are allocated to staffing costs); there is a current and projected global shortage of providers; and they are essential for service delivery.

Health service providers are a very mobile workforce, crossing provincial, territorial and transnational borders. This reality is true not only in Canada, but also around the world. Therefore, we will continue to fail if we do not take a pan-Canadian and global approach when addressing our health human resources issues.

It is important to remember that the health system is primarily a people system which is undergoing tremendous change and is under-resourced for many of its crucial tasks. Significant barriers need to be overcome within professions and between provider groups if progress is to be made. Both immediate and long term action plans are needed. A pan-Canadian Health Human Resources Framework and Strategy is required to:

- ◆ Tackle Practice Issues
- ◆ Develop Positive Labour Relations

3.1 Tackle Practice Issues through a Pan-Canadian Strategy

Specific practice issues include agreeing on the scope of practice of different provider groups; employing every health provider to their full potential; ensuring “specialization” does not impede access to generalists with a broad range of skills to provide initial diagnostic and treatment services, particularly in rural, remote and northern areas; providing educational opportunities that foster multidisciplinary learning and provision of services, and supporting new ways of learning and assessing competencies, including prior knowledge assessments and laddering opportunities; addressing remuneration issues within a profession and between provider groups; determining levels of accountability for each provider with their clients, peers (i.e., their regulatory bodies) and the health system (namely health organizations, not governments); developing fair remuneration mechanisms; and providing peer support and other resources in rural, remote and northern communities to improve the availability of various professionals. System solutions, not stove-pipe solutions, are required that consider not only the impact for a specific provider group, but also the ramifications for the whole health system.

These issues are being faced by more than physicians and nurses. Health human resources issues related to social workers, pharmacists, rehabilitation therapists, and medical and laboratory technologists must also be urgently addressed. Health system managers are also facing many of the same issues as providers in terms of an aging workforce, burnout, attracting fewer students to this complex environment, educational programs not providing the skills and expertise needed for the changing delivery systems, and not having enough experienced managers available to mentor the next generation of managers. By tackling practice issues, many of the recruitment and retention issues can also be addressed.

Strong leadership is needed at the federal, provincial and territorial levels to establish a broad-based framework and strategy to develop pan-Canadian solutions to the health human resources crisis currently affecting our health system. This leadership needs to embrace creative solutions that will test long held practices and beliefs regarding such things as scope of practice and remuneration mechanisms. Currently, discussions are taking place behind closed doors at federal, provincial, territorial Advisory Committee meetings. If progress is going to be made it is imperative that these doors be opened so that health system managers and trustees, as employer representatives, and employee representatives can be involved in these discussions.

While recognizing that there is a need to increase the number of training seats for many provider groups, health system managers and trustees do not support the simplistic solution of increasing the number of physician or nursing seats by X%. There are a number of problems with this option: a national objective may not reflect different regional needs, and, unless there is coordinated, pan-Canadian approach, it is quite likely that province A will train the provider only to have the person move to province B to work after graduation. Also, projected numbers of needed providers is often based on current practice patterns and scope of practice that could fundamentally change in the next few years. More attention needs to be given to the full complement of providers, using their current skills to their full potential, and exploring new roles and responsibilities, before decisions are hastily made to replicate the current human resources inequities and weaknesses in our health system. And, to reduce global poaching in the long term, we must become more self-sufficient in the provision of adequate numbers of health providers within Canada. A multipronged approach is required to ensure adequate numbers of trained health human resources.

It is time to move beyond egos and territoriality to resolve issues related to educating, training, recruiting and retaining a broad range of health service providers. CHA and our provincial and territorial members are committed to working with governments, other associations and individuals that are ready to take on this challenge. The Canadian public must hold us accountable for finding solutions. While it is important to continue to study some of the health human resources issues through such initiatives as the National Sector Studies on Nursing, Physicians and Home Care, it is also imperative that governments immediately support initiatives to address urgent, existing issues.

CHA urges governments to facilitate the development of a pan-Canadian Health Human Resources Framework and Strategy that will:

- *address scope of practice issues by embracing creative solutions that will test long held practices and beliefs.*

This pan-Canadian Health Human Resources Framework and Strategy will need to be developed collaboratively, with government representatives, employer representatives from health facilities and agencies, and employee representatives all being engaged in the consultation and decision-making processes.

3.2 Develop Positive Labour Relations through a Pan-Canadian Strategy

Constant change in organizational structures and delivery systems, reduced funding, and layoffs contribute to adversarial labour relations. And the political involvement of some provincial governments in the labour negotiations makes it difficult for health system managers and trustees to meet the commitments made during these negotiations. This is particularly true for physicians and nurses who primarily receive their funds from government sources either directly or through a hospital or regional health authority. However, there are labour relations issues for other providers who may be predominately remunerated through the private system. For example, how does a hospital compete for pharmacists when wages and benefits are much higher in the private sector?

Physician remuneration has been the subject of countless studies and reviews. Results of the CMA 2000 Physician Resource Questionnaire indicated that only 37.4% of respondents would prefer to be paid on a fee-for-service basis. A number of other options exist, including some combination of fee-for-service, salary, capitation, and other alternative payment mechanisms. While addressing this issue will not solve all of the problems in the health system, it will go a long way to controlling costs, enabling innovative delivery systems to be implemented, and improving relations between physicians and health system managers and trustees. What is missing is the political will needed to make tough decisions.

Within the current remuneration system involving medical services negotiations there is also room for improvement. Often, the very people who will need to implement the outcomes of these negotiations are not at the table, or if they are, their role is often usurped by governments who step in to ensure a politically satisfactory result. Clearer rules of engagement are needed between representatives of the government and health system managers and trustees who are charged with the negotiations. Another contentious issue within the existing medical services negotiations is that service contracts are usually not included in these negotiations; and provincial and territorial medical associations are not able to compel their members to honour their obligations to provide services to the communities they serve.

Nursing salaries is another contentious issue involving unions, managers and government representatives. We have recently seen a cascading effect on salary demands when, as one province settles with their nurses, all other nurses across the country want the same salary levels and benefits. Providers, unions and managers are becoming increasingly frustrated because it appears as if the “other side” is not listening to them. The reality is providers and unions have a right to expect comparable salaries across the country that reflect regional cost of living variations. However, another reality is that there have been fewer dollars over the last decade for managers to provide an increasing number of services to an increasing number of people. Health system managers and trustees have little room to move in labour negotiations.

CHA urges governments to facilitate the development of a pan-Canadian Health Human Resources Framework and Strategy that will:

- *deal effectively with labour relation issues, including remuneration levels, benefit packages, service contracts, and payment mechanisms for physicians, nurses and other providers.*

A pan-Canadian approach is essential; however, these plans must be sensitive to local realities and recognize the fact that the employment relationship is ultimately between an individual provider and a specific health organization. While individual employees and employers will need to give up some local control and autonomy in labour negotiations, the pan-Canadian strategies should resolve most of the larger issues, enabling stronger labour relations to be forged at the local level. By developing positive labour relations, many of the recruitment and retention issues can also be addressed.

Non-financial changes within health facilities and agencies could also improve labour relations, such as ensuring appropriate health provider representation in decision-making processes and improving internal communications. Researchers are identifying the components of a “workplace of choice.” Health system managers and trustees, together with providers, unions and governments, will need to review this information and identify specific steps they can take within their own organization and/or at the provincial/territorial level to improve labour relations.

CHA urges governments to facilitate the development of a pan-Canadian Health Human Resources Framework and Strategy that will:

- *ensure that Canadian health organizations are an employer of choice in relation to other sectors and globally.*

This pan-Canadian Health Human Resources Framework and Strategy will need to be developed collaboratively, with government representatives, employer representatives from health facilities and agencies, and employee representatives all engaged in the consultation and decision-making processes.

4. SUPPORT NEEDED HEALTH INFRASTRUCTURE

Health infrastructure needs include traditional bricks and mortar as well as innovative new technologies and research to improve our health system. Specifically we must:

- ◆ Develop Strong Health Information Systems
- ◆ Encourage Innovation in Medical Equipment and Health Care Technology
- ◆ Cost-Share Capital Infrastructure Costs
- ◆ Enhance Health Research

4.1 Develop Strong Health Information Systems

Technology is fundamentally affecting every aspect of our lives, including how we access health services. In the September 2000 *Communiqué on Health*, First Ministers agreed to work together to strengthen a Canada-wide health infrastructure to improve quality, access and timeliness of health services for Canadians. First Ministers also committed to developing electronic health records and enhancing technologies like telehealth over the next few years. They also stated that they will ensure the stringent protection of privacy, confidentiality and security of personal health information. Yet only \$0.5 billion was announced as targeted funding for health information technology. This amount is woefully inadequate to realize these commitments. It has been estimated that substantially more money will be needed, in the order of \$3 billion. The report by the Advisory Council on Health Infrastructure entitled *Canada Health Infoway: Paths to Better Health* laid the foundation, and the newly created Canada Health Infoway Inc. may provide some coordination of efforts, but funding is still a limiting factor.

National coordination is required to realize a pan-Canadian health information system. New sources of federal, provincial and territorial funding are also needed. This coordination and cost-shared funding is required to develop common data sets, ensure compatible software packages by purchasing new or upgrading existing systems, and support the electronic patient record and other information-related initiatives. These health information systems will only be as good as the data they are transmitting. We need to avoid the “garbage in, garbage out” syndrome. So, coordination and funding is also required to establish consistent data collection standards and processes, identify appropriate and comparable performance indicators across the broad continuum of care, and improve data quality.

Also essential to these developments are adequate numbers and appropriately trained human resources. Thus, funding must also be made available to cover the costs associated with the installation of new technology, personnel to provide training sessions, employee upgrading, and educating new students in the technological skills needed to maintain, assess and upgrade the health information systems. Funding is also required to address privacy and confidentiality issues, including the review, development and implementation of new legislation.

Without a compatible, pan-Canadian health information system many improvements to our health system will not be possible. Accountability mechanisms will be halted or drastically reduced in scope. Effective coordination of treatment across the continuum of care will not be possible. Health information technologies are an essential investment that will fundamentally change and improve the delivery and integration of health services.

CHA urges governments to work collaboratively with health system stakeholders to coordinate the development of a pan-Canadian solution that addresses the challenges of achieving compatible health information technologies.

4.2 Encourage Innovation in Medical Equipment and Health Care Technology

In terms of ensuring timely access to needed health services, one of the key challenges is the lack of appropriate medical equipment and health care technology, and the professionals to operate the equipment and interpret the results. The chronic under-funding of the health system over the past decade has resulted in aging medical equipment that needs to be upgraded or replaced, and a significant inability to keep pace with the growing demand for new health care technologies.

Some of CHA's members have calculated that billions of dollars are needed over the next five years, in their provinces alone, to appropriately address the unmet need for medical equipment and health care technology. In the *Communiqué on Health* of September 2000, First Ministers stated their commitment to investing in equipment, new technologies and facilities. But there is only \$1 billion available through the announced Medical Equipment Fund. This will not significantly improve Canadians' access to needed medical equipment and health care technology across the country. Contributions from the Canada Foundation for Innovation and the other grants from federal, provincial and territorial governments have been appreciated, but they come nowhere close to providing the necessary financial base to meet the health needs of Canadians, nor establish Canada as a world leader in health care technology.

CHA urges governments to meet the necessary investment in health and in global competitiveness by providing targeted funds to the provinces and territories for the development and operation of medical equipment and health technologies.

4.3 Cost-Share Capital Infrastructure Costs

During the fiscal restraints of the nineties, health organizations' budgets were slashed at the expense of many things, including the maintenance and upgrading of equipment and bricks and mortar. During this same time period, there were unprecedented advancements in medical technology and shifting patterns of interventions and care settings. As a result, capital expenditures are desperately needed across the country to build new community and long term care facilities to meet the current and future health needs of Canadians. Capital expenditures are also urgently needed for hospitals to upgrade their facilities to meet new demands and respond to restructuring recommendations calling for a realignment of health services between facilities. These investments in capital infrastructure not only support the development of needed health services, they also stimulate the economy by creating jobs. And health spending would have a higher multiplier effect than further tax cuts to stimulate the economy.

The magnitude of this capital infrastructure need is now being quantified. For example, a 1999 study by the Ontario Hospital Association indicated that Ontario hospitals will require an estimated \$7.8 billion in capital funding over five years to carry out hospital restructuring, modernize facilities and upgrade information technology infrastructures. It is anticipated that provincial and territorial governments will not be able to fully cover the equipment and capital needs within the health sector. A number of private-public partnership solutions are being considered. (For details, see CHA's Policy Brief on *The Private-Public Mix in the Funding and Delivery of Health Services in Canada: Challenges and Opportunities*.) In many provinces, local communities are being asked to fund huge health infrastructure costs with private donations and/or local taxes that are beyond the community's capacity to provide. A targeted, cost-shared federal fund for health infrastructure is required to address this critical need. Yet there was no targeted funding announced in the September 2000 *Communiqué on Health* for health services infrastructure.

CHA urges the federal government to provide accelerated capital funding to the provinces and territories to cost-share urgently needed capital infrastructure and to stimulate economic growth.

CHA is also suggesting that governments explore some of the recommendations made in recent reports regarding potential public-private partnerships in the funding of health care equipment and capital infrastructure needs. However, it must be clearly understood that these partnerships do not eliminate the federal, provincial and territorial governments' responsibility to adequately fund the health system.

4.4 Enhance Health Research

Research findings will continue to be critical in determining the most appropriate, effective and efficient ways of organizing our health system and delivering services. The parameters of health research have been defined broadly by the new Canadian Institutes of Health Research (CIHR) as encompassing biological research, clinical applied research, population health research, and health systems research. All four components of health research have significantly influenced the availability and delivery of high quality health services and care.

Many of these components of health research, particularly biological research and clinical applied research, have benefited greatly over the years from public-private partnerships. But not without controversy. Examples of these partnerships and issues to be addressed are discussed in CHA's Policy Brief on the *Private-Public Mix in the Funding and Delivery of Health Services in Canada*.

The recent establishment by the federal government of the Canadian Institutes of Health Research (CIHR) was a bold step toward integrating the diffuse research initiatives related to health research. CHA also recognizes the federal government commitments made in the October 2000 Economic Statement and Budget Update for additional support to the Canada Foundation for Innovation (CFI) and the Social Services and Humanities Research Council (SSHRC). However, there is still a need for additional federal government research funds, particularly for health system and health services research, to the CIHR and other research bodies such as the Canadian Health Services Research Fund (CHSRF), the Canada Foundation for Innovation (CFI), the Social Services and Humanities Research Council (SSHRC), and others. With additional funds these research bodies and others can support needed research, explore effective methods of disseminating research results to health system decision makers, and support venues and vehicles for research findings to change individual and organizational behaviour.

CHA urges governments to continue to invest in health research so that Canada's capacity for research and knowledge development can be strengthened, health systems can be improved to better meet the needs of individuals and communities, and our world leadership in health research can be enhanced. Specifically, CHA recommends that the federal government's contribution to health research be increased within the next three years to at least 1% of the amount it allocates to health services.

5. EXAMINE THE PRIVATE-PUBLIC MIX IN THE FUNDING AND DELIVERY OF HEALTH SERVICES

In examining the question of sustainability of our health system, a key question is: what is the appropriate private-public mix in the funding and delivery of health services in Canada? To answer this question we must:

- ◆ Debunk Some Myths
- ◆ Broaden, Don't Narrow the Basket of Publicly Funded Services
- ◆ Establish a Framework for For-Profit Private Sector Delivery
- ◆ Monitor and Assess the Level and Impact of Private Sector Funding
- ◆ Protect Our Health System in International Trade Negotiations

5.1 Debunk Some Myths

Myths abound in the health system regarding the amount of public spending on health, the impact of an aging population, the private-public mix in our health system, and the supposed drain on our economy of our publicly funded health system. CHA, many research groups, non-governmental organizations and, most recently, the Senate have spent a fair amount of time debunking these myths.

For example, Canada currently has one of the lowest (not highest) levels of public spending on health. In 1998 Canada ranked 5th among 27 OECD countries in **total** spending per person on health care, but 21st in terms of our **public share** of total expenditures on health. In fact, in 1998, Canada's percentage of private sector involvement in health (30% of total expenditures) was almost twice the British rate (16%) and significantly more than New Zealand (23%).

CHA has debunked a number of other myths in our CHA Policy Brief on the *Private-Public Mix in the Funding and Delivery of Health Services in Canada: Challenges and Opportunities*. These include the fact that public spending in health care is not out of control; pharmaceuticals and technology are some of the leading cost drivers of the health system, not administrative costs (which are among the lowest in the world) or hospital costs (now ranked third behind drugs and physicians in terms of annual percentage increases in expenditures); the aging population is not going to bankrupt our publicly funded health system; and, as supported by the business community, our publicly funded system is not a drain on our economy, rather it is an essential investment in Canada's productivity and global competitiveness.

CHA urges governments, health system managers and trustees, providers and researchers to talk with the media and the public to debunk the pervasive myths related to our publicly funded health system.

We must all engage in a public dialogue on the key issues affecting our health system to ensure that there is a clear understanding of the issues and a common agreement as to the way forward. CHA and our provincial and territorial members urge governments and national, provincial and territorial Medicare reviews to engage the public in meaningful consultations.

5.2 Broaden, Don't Narrow the Basket of Publicly Funded Services

Confusion exists in the minds of the public and politicians as to what basket of services is currently available through the publicly funded system. Canadians strongly support the hospital and physician services covered by the Canada Health Act but are often surprised to find out that other services are not provided within the publicly funded health system. And this confusion grows when one realizes the high level of inconsistency across the country in terms of what is included in the basket of publicly funded services.

CHA believes that a broader, not narrower, basket of services is sustainable within our publicly funded system. This can be achieved through appropriate system change and adequate levels of government funding. Simply narrowing the scope of services covered by public funds would lead to inequities and inefficiencies. And, as outlined in sections 2.2 and 2.3, important components of our health system need to be strengthened, not weakened.

For this broader basket of publicly funded services to be possible, we must be prepared to think outside the box of the Canada Health Act. The Act's principles are appropriate for existing hospital and physician services, but are probably not appropriate for other services, such as home, community and long term care services. For example, under the Canada Health Act, user fees for some community-based services could not be charged, and Canadians would be prohibited from purchasing additional insured home care services. Different principles and eligibility criteria will need to apply to home, community and long term care services. However, the underlying value of receiving services on the basis of need would still apply, with no Canadian being denied services if they are unable to pay. And access to comparable services for all Canadians would be assured.

CHA urges governments not to narrow the range of physician and hospital services provided through the Canada Health Act.

CHA also urges the federal government to broaden the basket of publicly funded services available across Canada by implementing a national home, community and long term care program that is established outside of the Canada Health Act, perhaps using the Social Union Framework Agreement, with federal funding available subject to the provinces and territories meeting mutually agreed upon objectives.

And CHA urges governments to ensure that acute care services (including acute care replacement home care services) are 100% publicly funded, while home, community and long term care services, or certain aspects of them, may be subject to some form of copayments.

Another area of confusion related to the basket of services is the public and private mix in the funding and delivery of health services. Do we or do we not already have a two-tiered health system in Canada? The reality is we have a multi-tiered health system. First, there is a single tier of physician and hospital services provided under the Canada Health Act. This is predominantly a single-tiered, publicly funded system, with both private and public delivery. There are some exceptions due to de-insurance and the need to pay for some upgrades, such as better quality casts or private rooms. Then, there are services provided in all provinces and territories (but not necessarily to all population groups) which may involve public funding, user fees or co-payments, or 100 per cent purchase of services by users. The availability and access to these services varies greatly across the country. Private delivery may be involved. These services include pharmaceuticals, long term care, home care and home support. Lastly, there are health services which are mainly paid out-of-pocket by individuals or through private insurance. These include dental, chiropractic, psychological, rehabilitation, and emergency medical services.

Based on these realities, CHA is not advocating for a future health system that provides all services to all Canadians completely within a 100% publicly funded and publicly delivered system. Rather, *CHA urges governments to closely examine the challenges and opportunities of involving the for-profit private sector in the funding and delivery of health services in Canada, and establish clear guidelines for determining when public-private partnerships are appropriate.*

Our recent CHA Policy Brief on *The Private-Public Mix in the Funding and Delivery of Health Services in Canada* examines these challenges and opportunities in detail. CHA's bottom line in terms of the basket of publicly funded health services is that all Canadians must have access to quality services on the basis of need, not the ability to pay.

5.3 Establish a Framework for For-Profit Private Sector Delivery

The private sector has been and will continue to be a vital partner in the delivery of needed health services. Many advances in health services delivery would not have been possible without the significant involvement of the private sector, particularly in the fields of pharmacological research, biotechnology, medical devices, and information and communications technologies.

However, there are areas where it is not clear if for-profit private sector delivery is appropriate. Cost factors are always a consideration in these deliberations. For example, if health organizations are already providing a service that has to expand, they would want to determine whether it would be more cost effective to expand services themselves or have a for-profit firm deliver these additional services. The cost comparison, however, would need to be on the marginal cost of providing services, not on the average cost.

When for-profit private sector delivery is appropriate, there are some conditions that must be established and maintained to ensure that all parties get something out of the delivery partnership. The public sector must be an active partner, including defining the health status or issue to be addressed. Public sector representatives must be made aware of the gains and losses associated with a proposed partnership. Privacy and confidentiality issues of personal health information must be addressed. And the ownership of processes and products used in each private-public partnership in health must be clearly defined.

The private-public delivery mix question centres on: "the delivery of which services, under what conditions?" Balance is the key when answering this question. A delicate balance must be achieved that encourages public and private sector innovation, fosters high quality services, and ensures public accountability.

CHA urges the federal, provincial and territorial governments and health organizations, when partnering with the for-profit private sector, to: establish clear expectations, develop explicit quality standards, and demand transparent accountability mechanisms so that all partners are fully aware of the terms and conditions related to the delivery of services and can ultimately ensure access to high quality services for all Canadians.

5.4 Monitor and Assess the Level and Impact of Private Funding

In our recently released brief on the private-public mix, CHA and our provincial and territorial members conclude that private involvement in the Canadian health system is not inherently evil, nor is it a cure-all for the issues currently facing our publicly funded health system.

There has been a gradual shift in Canada's ratio of private to public financing. Twenty years ago, private spending represented about 25 per cent of health expenditures and public spending accounted for 75 per cent. Now, this ratio is 30/70. This shift has been unplanned and passive. The current 30/70 private-public funding mix in Canada reflects a somewhat higher private sector involvement than the OECD (Organization for Economic Co-operation and Development) average of 26/74, which until recently was 20/80. Relative to other OECD countries, Canada ranked 21st in 1998 in terms of our public share of total expenditures on health. This means that, as noted in section 5.1, we have one of the world's highest (not lowest) levels of private sector health spending.

Growing private sector funding of needed health services may: threaten the strongly held Canadian value that health coverage should be based on the good of society rather than “every person for themselves”; threaten access to necessary health services (especially by vulnerable groups) by making access dependent on the ability to pay rather than on health need; fail to reduce waiting lists; increase, not decrease total health costs; and compromise Canada’s global competitiveness.

Suggesting greater private funding through employer contributions or greater out-of-pocket expenditures is met with resistance by business leaders and Canadians. Canadian businesses must remain competitive. And private health insurance is expensive; few Canadians could afford the full costs even when healthy, let alone the treatment costs for an acute care illness like cancer or heart disease. In the end, greater private funding—private health insurance and out-of-pocket expenses—comes out of one pocket, that of the individual Canadian.

The jury is still out as to the magic balance for funding health services: is the current 30/70 Canadian ratio appropriate, or should there be more or less private sector funding? *CHA urges governments to actively monitor the ratio of public to private spending on health services and not increase the proportion of private spending without a better understanding and evidence of its impact on accessibility, quality of care and global competitiveness.*

5.5 Protect Our Health System in International Trade Negotiations

A related issue in the private-public debate is the effect of greater private sector involvement on international trade agreements. The challenge in terms of the General Agreement on Trade and Services (GATS) and other trade negotiations is for health advocates to work with the Canadian government to find a balance between protecting our health system from unfettered international private sector funding and delivery, while at the same time enabling public-private Canadian health partnerships to have exposure on the world market.

CHA urges governments to invite health groups, including CHA and our members, to participate on working committees of the Department of Foreign Affairs and International Trade (DFAIT) and Health Canada, and their provincial/territorial counterparts, to ensure that the concerns of the publicly funded and publicly delivered health system are represented as Canada develops its positions in international trade negotiations.

* * * * *

To ensure the appropriate private-public sector involvement in funding and delivery of health services, governments must work with the health community to: actively monitor the private-public mix within the health system; ensure adequate, predictable public funding; explore alternative public funding mechanisms; and make appropriate system changes.

6. ENSURE ADEQUATE, PREDICTABLE PUBLIC FUNDING

CHA recognizes that provincial and territorial governments must also adequately fund health services. However, this submission is highlighting pan-Canadian issues, and, thus, the focus is on the need for federal commitments to health funding. To ensure adequate, predictable public funding for our health system, it is necessary for the federal government to demonstrate leadership and:

- ◆ Explore Funding Mechanisms
- ◆ Stabilize the System — Increase CHST Base Funding
- ◆ Target New Funds to Meet Urgent Needs
- ◆ Provide Transitional Funds to Support Appropriate System Change
- ◆ Meet Future Needs, Now

6.1 Explore Funding Mechanisms

Currently, the two key mechanisms used to transfer funds for health services from the federal government to the provinces and territories are the Canada Health and Social Transfer (CHST) and Equalization payments. The CHST transfers the value of tax points and cash from the federal government to the provinces and territories for health, post-secondary education and some social services.

Some have been arguing that the CHST cash transfer should be converted to tax points. While this would result in greater autonomy for some provinces, the overall effect would be to further weaken the federal government's role in health care. The transfer of federal cash enables the federal government to exercise some influence on the provinces and territories to provide comparable services to all Canadians, regardless of where they live. Another issue is that the value of the tax points reflects the relative state of the provincial and territorial economies and varies widely across the country. Therefore, based on the economic health of some provinces and territories, the ability to fund needed health services would be severely compromised. This proposed conversion of the CHST to a total tax point transfer could also be met with considerable constitutional wrangling, since, arguably, the federal government would not be spending money for health or using its spending power and thus could not legislate conditions or principles for the health system. This would, in effect, mean the end of the Canada Health Act.

CHA urges the federal government to uphold their role in health to achieve access to comparable health services across Canada. This includes recognizing the historical 1977 tax transfer and continuing to transfer cash, on a per capita basis, to the provinces and territories to deliver health services.

CHA also urges the federal government to make public to all Canadians an analysis of why cash transfers are an important component of federal transfers for health services.

In terms of cash transfers for health, the National Forum on Health examined the issue of whether federal leadership in maintaining the principles of medicare could be attained without federal financing, in other words without federal cash for health. The Forum examined four approaches — using direct regulation, enshrining the principles in the Constitution, the use of inter-provincial agreements and federal moral influence/political leadership — and found all to be impractical and ineffective. Thus, it is only through cash contributions that the federal government can effectively maintain a national health system.

In addition to the CHST, Equalization payments ensure that Canadians have reasonable access to comparable health and social services regardless of the fiscal capacity of their province or territory. The goal of Canada's Equalization program is to enable all provinces to provide reasonably comparable levels of public services at reasonably comparable levels of taxation. Equalization funding is determined by a

legislated formula that annually measures each province's revenue raising capacity against a five-province standard. Two misconceptions about equalization exist. The first is that equalization is a payment from the rich provinces to poorer ones. In fact, the program is funded entirely by the federal government from revenues it levies uniformly across the country. And the second misconception is that equalization automatically compensates for any reductions in other federal cash transfers to the provinces. In fact, equalization is based solely on a province's own source revenues (Finance Canada web site, "Federal Equalization" October 1998, 1). CHA believes that Canadians across the country are entitled to comparable health services. Canadians' access to needed health services should not be compromised by the differing fiscal capacities of governments across the country. Equalization payments are intended to satisfy two important Canadian values: ensuring access to health services on the basis of need, not the ability to pay, and upholding a shared risk approach to providing health services. Important issues related to Equalization payments still need to be resolved. These include examining the levels of funds being transferred, reviewing the five-province standard, removing the equalization ceiling, and determining when new resource revenues should be included in the formula.

CHA urges the federal government to uphold their role in health to achieve access to comparable health services across Canada. This includes continuing to provide Equalization payments to the provinces and territories and resolving key issues regarding the current Equalization formula.

In the September 2001 interim report of the Senate Standing Committee on Social Affairs, Health and Technology, a number of other funding mechanisms were explored, including user fees, premiums, and medical savings accounts. In reviewing these options it will be important to consider their impact on the four Canadian values outlined above. It will also be important to debunk the myths that are associated with some of these options. The arguments against many of these mechanisms are well researched and documented. (See CHA's Policy Brief on the private-public mix for details.) A major concern regarding these mechanisms is their preponderance to reduce access by vulnerable groups to medically necessary services and/or distort the allocation of resources. For example, expensive technology may be unnecessarily duplicated while other health services, such as health promotion and disease surveillance programs, are compromised.

CHA urges governments not to introduce any new funding mechanisms, such as user fees for Canada Health Act services or medical savings accounts, unless there is clear evidence that they will enhance quality of care and ensure access to needed health services.

CHA urges governments to investigate other alternative funding mechanisms, in addition to or instead of the CHST. This should include examining the merits and feasibility of replacing the CHST with a health-specific transfer, applying the per capita formula in the CHST to the cash portion alone, and augmenting or replacing the per capita formula in the CHST and targeted federal funding for health with a needs-based formula.

The current CHST mechanism does not provide a health-specific cash transfer, as CHST resources can also be used for post-secondary education and some social services. Thus, it is impossible to predict the level of federal cash that will be available for health services specifically. From the provincial and territorial perspective, the CHST provides flexibility for each jurisdiction to determine what portion of federal resources will go to the three service areas, based on regional needs and realities. However, at a national level it could be argued that a health specific transfer could provide greater transparency and accountability.

In addition to a health-specific transfer, other options that could be explored include new legislation or regulations to cover the broader continuum of care, and/or population needs-based allocations to replace or augment the current per capita formula. A needs-based formula will require more study to determine:

whether provinces will accept this approach or if they will see it as the federal government intruding into their jurisdiction; what the formula would be and who would decide it; if Equalization should include needs as well as fiscal capacity; and how CHA would explain changing our current per capita positions. When considering a needs-based formula, the initial formula should include population size with an age-weighted adjustment as a minimum.

6.2 Stabilize the System — Increase CHST Base Funding

With an anticipated economic slowdown, competing demands for federal dollars and recent announcements of increases in federal health spending over the next two to five years, it is not a popular position to be stating that even more money is required to meet the health needs of Canadians. And, contrary to some popular myths regarding health system funding, this additional money is not needed because the health system has a voracious appetite and spending is out of control, or because health system managers and trustees don't know how to improve efficiencies. Nor does the health sector ignore the need to support broad determinants of health or the need to be fiscally prudent in terms of reducing the debt and lowering taxes. Rather, CHA and our provincial and territorial members are advocates of a publicly funded system that is integral to our social fabric, to our productivity and to our global competitiveness. The challenge for the federal government is to create a dynamic equilibrium to enable a both/and approach to allocating scarce resources. (See CHA's August 2001 Submission to the Standing Committee on Finance for more details.)

CHA, in collaboration with other national associations, has been successful in having the federal government increase its investment in our publicly funded health system. While this increased investment is welcome, it is not enough. Additional federal funds are needed to stabilize the system.

CHA urges the federal government to raise the 2002-03 CHST cash floor (not including the funds allocated for early childhood development) by \$1.1 billion to \$19.8 billion. CHA also urges the federal government to explicitly announce its commitment to an annual escalator to apply to the CHST cash floor, beginning in 2003-04.

The increase in the CHST cash floor to \$19.8 billion in 2002-03 is essential to stabilize the health system and introduce much needed flexibility in meeting the daily demands for health services across the continuum of care. It is difficult to provide services if there is no "give" in the system to deal with anticipated or unanticipated fluctuations in service demands.

6.3 Target New Funds to Meet Urgent Needs

It is also important to stress that this additional CHST money will not be sufficient to meet urgent needs related to increasing demands for public accountability, more health service providers, and new health care technologies. Nor will this additional CHST cash provide the transitional resources required to support needed system change so our health system can continue to evolve to effectively and efficiently meet the changing health needs of Canadians.

Therefore, CHA is also urging the federal government to work with the provinces and territories and national health organizations to determine an adequate level of federal funds over a five-year period to be earmarked as specific, targeted funds for: health human resources; medical equipment and health care technology; health information technology; health system accountability; health services infrastructure; health services research and innovation; and specific federal programs.

These federal commitments should start in 2002-03. Some of these federal funds could be distributed to the provinces and territories on a per capita basis, with some funds available for pan-Canadian projects administered by the federal government. Other targeted funds will be for specific federal programs. Clear objectives for the funds must be established, with the federal government and the provinces and territories being responsible for providing public reports on how they are meeting these objectives.

6.4 Provide Transitional Funds to Support Appropriate System Change

As outlined earlier in this submission, a number of important initiatives must be undertaken to improve our health system. These changes cannot occur within the existing funding envelope. A good analogy is the banking industry. When the instant-teller and computer banking first were introduced, they were provided in addition to the traditional banking services. There was a transition time when both the old and new banking systems co-existed. Similarly, transitional funds are required over a set period of time to enable needed change to occur within our health system.

CHA urges the federal government to work with the provinces and territories and national health organizations to determine an adequate level of federal funds over a five-year period to be used to support needed health system change across the continuum of services, including: primary health care reform; health promotion and disease prevention; mental health; emergency medical services, and palliative care.

These federal commitments should be made by 2002-03. Some of these federal funds will be distributed to the provinces and territories on a per capita basis, with some funds available for pan-Canadian projects administered by the federal government. Clear objectives for the funds will need to be established and the federal government and the provinces and territories will be responsible for providing public reports on how they are meeting these objectives.

6.5 Meet Future Needs, Now

As outlined in other sections of this submission (*see* sections 3.2 and 5.2) CHA believes that home, community and long term care must be encompassed within the publicly funded health system. Therefore, *CHA urges the federal government to commit at least \$1 billion annually, beginning in 2002-03, to ensure that all Canadians have access to needed health services across the broad continuum of care, including home, community and long term care, which is supported by a pharmacare program.*

* * * *

By embracing health system reform, addressing health human resources issues, recognizing health infrastructure needs and adequately funding the health system, a broader, publicly funded health system is possible. CHA believes that to be responsive to the changing needs of Canadians, to reflect the realities of where and how health services can be delivered outside of a physician's office or hospital, and to maintain Canada's publicly funded system as a competitive advantage, the scope of services covered by our publicly funded system must expand, not contract.

D. MANAGING CHANGE

Health system managers and trustees have been managing complex changes within the health system over the last decade with declining resources. We have been doing a good job overall, but in some areas we can do better. To successfully manage the additional changes that are required in our publicly funded health system, managers and trustees, working collaboratively with other health stakeholders, will need to:

- ◆ Improve Performance Measurement
- ◆ Ensure Public Accountability

7. IMPROVE PERFORMANCE MEASUREMENT

As the saying goes, “you can’t manage what you don’t measure.” It is imperative that performance measurement within our health system be improved. We need to:

- ◆ Develop Appropriate Performance Indicators
- ◆ Foster a Culture of Continuous Quality Improvement

7.1 Develop Appropriate Performance Indicators

The performance indicators that are currently reported by the Canadian Institute for Health Information (CIHI) are at a very macro level. They provide an overview of the health system at the 20,000 feet level. What is needed to manage the existing system and to manage the needed changes are performance indicators that are meaningful at the facility and agency level, and that allow comparisons among like organizations across the country. A common set of indicators are needed that can be used for multiple purposes at the local level to improve planning and service delivery, at the provincial and territorial level to review population health needs and outcomes, and at the national level to ensure reasonable access to comparable services for all Canadians. Ultimately, these indicators must be easily understood and meaningful to the public.

Development of these performance indicators must involve representatives from the field — people who know the challenges and opportunities for collecting and using this information. To be useful for comparability purposes there will need to be regional, provincial and territorial harmonization of indicators and reporting requirements. And these indicators must reflect the full continuum of care, including primary health care, acute care, specialized services, home, community and long term care, public health, mental health and palliative care.

CHA and our provincial and territorial members are in the process of meeting with CIHI to explore collaborative opportunities. We are also developing an initial list of 8-10 “desktop indicators” or comparable benchmarks that could form the basis for a more comprehensive set of performance indicators across the continuum of care. These “desktop indicators” are quick reference points that all health system trustees and managers can use to quickly signal potential problems and exemplary service. The Ontario Hospital Association, in collaboration with CIHI and the University of Toronto, has been a leader in developing a Hospital Report Card that includes a number of these performance-based indicators. Part of the OHA Hospital Report Card could form the basis for a pan-Canadian set of performance indicators. It is important to note, however, that not all information that can be collected is useful, nor, at this point, can all useful information be collected. With the various initiatives underway at the local, regional, provincial,

territorial and national levels, it is imperative that efforts be consolidated and coordinated to avoid overlap, inconsistencies and, ultimately, inefficiencies.

Our members are also committed to working with their members (individual facilities and agencies in their provinces and territories), the Canadian Institute for Health Information (CIHI) and the Canadian Council on Health Services Accreditation (CCHSA) to raise awareness of the necessity for trustees, managers and staff to allocate scarce time and resources to monitoring and improving quality. With the competing demands on scarce resources it is sometimes difficult to appreciate the need for long term initiatives when immediate health needs are not being met. This effort will be more likely to succeed if performance measurement is seen as an initiative to recognize and improve quality, rather than a punitive exercise to lay blame.

CHA urges governments to coordinate efforts to develop a pan-Canadian evaluation and monitoring system for the health system, including appropriate indicators, a minimum data set that is comparable across the country, and harmonized reporting mechanisms.

Changes in organizational culture, adequate levels of financial and human resources, and compatible health information systems will be needed to ensure the development and consistent use of appropriate performance measures.

7.2 Foster a Culture of Continuous Quality Improvement

The collection and use of relevant performance indicators will require an organizational culture that recognizes and rewards continuous quality improvement. CHA and our provincial and territorial members understand that we must be leaders in creating and maintaining this organizational culture. Quality dimensions encompass a broad framework of safety, competency, acceptability, effectiveness, appropriateness, efficiency, accessibility, and continuity.

One example of the need for continuous quality improvement is adverse events. Recent studies in the US, Australia and Britain have identified critical issues related to deaths attributed to preventable adverse events. A study is now underway by the CIHI and CIHR to determine the extent of the problem in Canada. This study and recent work of a Steering Committee to develop a coordinated national strategy that would focus on adverse events/medical errors will improve our understanding of the breadth and depth of this issue in Canada and facilitate the development of specific strategies to reduce these adverse events. However, the health community does not need to wait for these projects to be completed before taking action. There is much we can do now at the organizational, provincial/territorial and national levels to reduce adverse events in Canada. CHA is working with other organizations to identify concrete, doable actions that can be undertaken immediately to improve patient safety. Priority areas for action include: garnering support from managers and trustees to ensure a culture of openness within facilities and agencies, overcoming professional barriers to reporting errors, adopting a “systems” rather than a “blame the individual” approach to addressing errors, improving reporting processes, and implementing appropriate regulatory frameworks at the federal, provincial and territorial levels.

In addition to the safety and quality of care provided, attention must be paid to the appropriateness of care. It is time for us to stop the dangerous, challenge the futile, and question the unknown.

CHA urges governments to ensure that there are processes in each province and territory to support and coordinate education, networking and evaluation initiatives related to quality across the continuum of care. This work should be coordinated by agencies that are currently working in this area, including the Canadian Institute for Health Information (CIHI) and the Canadian Council on Health Services Accreditation (CCHSA).

These initiatives are part of the larger focus on improving quality and being publicly accountable not only for how we spend money, but also for the health outcomes of the services we provide.

8. ENSURE PUBLIC ACCOUNTABILITY

Our public accountability processes are not perfect: it is not always clear who is accountable to whom, the public does not always feel that they have access or input to these processes; the training and education of trustees that is needed to deal with complex health systems is not always available; the issue of elected versus appointed Boards continues to be hotly debated; trustees can feel torn between their accountability to government funder(s) and the community they serve; and, the constant upheaval in governance structures (e.g., in terms of numbers and sizes of Boards) has cultivated skepticism, not public confidence. However, there are a number of initiatives being developed and implemented across the country to improve the transparency and public accountability within the health system. These include, the Ontario Hospital Association's Report Card initiative, the AIM project of the Canadian Council on Health Services Accreditation which will be reporting aggregate data to the public, the *Health Care in Canada* reports from the Canadian Institute for Health Information, and provincial and territorial initiatives such as Alberta's performance measures.

The public is demanding public accountability for the public dollars spent on health services and the health outcomes resulting from these services. To ensure transparent public accountability we must:

- ◆ Develop Clear and Mutually Agreed Upon Roles and Responsibilities
- ◆ Demand Public Reporting by Governments, Health Organizations and Providers
- ◆ Facilitate Ethical Decision Making

8.1 Develop Clear and Mutually Agreed Upon Roles and Responsibilities

For accountability in the health system to be effective, there must be an unambiguous understanding and acceptance of who is responsible for what. Governments, health system managers and trustees, providers and the public all have roles and responsibilities within the health system. For more details, please refer to CHA's soon to be released statement on the Roles and Responsibilities in Canada's Publicly Funded Health System. For the purpose of brevity, only issues related to health system trustees and managers are highlighted here.

Health system trustees and managers have a great deal of responsibility in directing and managing the health system. Better communication and collaboration between trustees and managers with governments regarding their respective roles and responsibilities will facilitate the governance and management of the system.

CHA urges governments to develop, in collaboration with health system managers and trustees, roles and responsibilities that are linked to decision-making authority, based on mutually agreed-upon and clear performance expectations, tied to adequate capacity (including funding) to meet responsibilities, and set within an ethical framework. (For more details see CHA's Policy Brief Towards Improved Accountability in the Health System: Getting from Here to There.)

8.2 Demand Public Reporting by Governments, Health Organizations and Providers

The Canadian public expects governments, health service managers and providers to be accountable not only for ensuring access to quality services, but also for working with others to improve the health status of individuals and communities. The September 2000 *Communiqué on Health* went to great lengths to explain the need for clear accountability to Canadians, yet no targeted funding was announced to achieve this objective.

CHA urges governments to improve accountability within the Canadian health system by providing additional funds to support existing accountability mechanisms, such as initiatives of the Canadian Institute for Health Information.

CHA also urges governments to develop immediately new pan-Canadian accountability mechanisms, such as a balanced score card, to measure and report on health system performance across a broad continuum of care, and ensure that these mechanisms are not solely focused on cost-containment.

These accountability initiatives rely on quality data, compatible health information systems, and trained personnel that also require additional funding.

Adequate funding is not the only challenge to developing and implementing public accountability mechanisms. *CHA also urges governments, in collaboration with health stakeholders, to address key issues related to improving public reporting, such as encouraging more integrated provider accountability (to patients, peers and the health system), dealing with the dual responsibility of Boards reporting to governments and to the public they serve, addressing consumer/patient rights and responsibilities, promoting balanced and fair media reporting, exploring the role of the Canadian Council on Health Services Accreditation in sharing accreditation information, and ensuring that governments support public accountability mechanisms even when findings could be politically damaging. (See CHA's Policy Brief Towards Improved Accountability in the Health System: Getting From Here to There.)*

CHA and our provincial and territorial members fully support the need for greater accountability within the health system. We will continue to advocate for the required additional resources, and we will work with health system trustees and managers to promote public accountability.

8.3 Facilitate Ethical Decision Making

Increasingly, health system trustees and managers face ethical dilemmas in executing their delegated responsibilities, particularly when demand for services is high and resources are shrinking. And, at a service delivery level, individuals and organizations should not be expected to engage in activities that are inconsistent with their established ethics.

In collaboration with other national organizations, CHA developed a *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care*. While a useful resource for care and treatment issues, the role of ethics in the allocation of scarce resources and accountability relationships requires further attention.

CHA urges governments to provide the necessary resources to ensure that health system trustees and managers have access to professional ethicists for consultation on specific issues and that they receive the needed training in ethical decision making to apply these skills to everyday governance and management issues.

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To improve performance measurement and ensure public accountability health system managers and trustees will require the support and involvement of governments, providers, researchers and the public. We will also need to collectively embrace the culture of continuous quality improvement.

E. CO-OPERATIVE RELATIONS

The “health system” is not an amorphous entity with a life of its own. Our health system is made up of people. People seeking and receiving care; people providing services; people managing organizations; people governing in the public interest; people developing government policy; and people democratically elected to public office. Collectively, these people create and experience what is known as the Canadian health system. Therefore, to improve our health system we must be very cognizant of human behaviour and organizational dynamics. We must:

- ◆ Involve Health System Managers and Trustees
- ◆ Improve Federal/Provincial/Territorial Relations
- ◆ Respect Human Behaviour and Organizational Culture

9. INVOLVE HEALTH SYSTEM MANAGERS AND TRUSTEES

For health system managers and trustees to be effective champions of the current and future health system, we must:

- ◆ Facilitate Meaningful Consultation and Collaboration
- ◆ Let Managers Manage and Governments Govern
- ◆ Support Knowledge Transfer and Uptake

9.1 Facilitate Meaningful Consultation and Collaboration

The provincial and territorial health systems across the country have weathered a decade of stop-go funding and continuous health system reform. Previous funding decisions by both the federal and provincial/territorial governments have led to serious erosion of some of the basic infrastructures of our health system. Growing deficits of health organizations struggling to meet the needs of communities, labour strife, and unacceptable waiting times for some diagnostic and treatment services reveal a system that urgently needs to be stabilized. Health system managers and trustees are often blamed by governments, the media and the public for these problems. The reality is we were often not at the decision-making tables when funding cuts were made, when labour negotiations were settled, or when health system reforms were declared.

Health system managers and trustees must be meaningfully consulted and involved in collaborative processes to identify the root causes of problems, develop realistic solutions, and implement needed changes. To be effective change agents, health system managers and trustees must be at the decision-making tables to provide a reality check on what is feasible under what conditions.

CHA and our provincial and territorial members are advocates for appropriate system change to ensure that our publicly funded health system can be sustainable over the long term. Our critics have stated that CHA is simply supporting the status quo. We aren't. We know that change is essential, and, in many cases, our provincial and territorial members have already identified innovative means to realize these needed system changes. The challenge for health system managers and trustees is how to move forward to stabilize the existing system and embrace needed system change when we are not meaningfully involved in the decision-making processes.

We were pleased to see references made in the September 2000 First Ministers *Communiqué on Health* to the effect that both federal and provincial/territorial members are committed to working collaboratively with health services providers to address critical issues facing our health system.

CHA urges governments to develop processes that meaningfully involve health system stakeholders while at the same time recognizing the jurisdictional and funding responsibilities of governments.

There is no one solution to the many issues facing our publicly funded health system, nor is there one group with all of the answers. Governments, health system managers and trustees, providers, researchers and the public will need to work together to implement the necessary changes.

9.2 Let Managers Manage and Governments Govern

Governments across Canada govern by creating a vision, setting national, provincial or territorial policy priorities, establishing regulatory mechanisms, and providing funding for our health system. The trustees of health boards across the country also govern, but at a more micro, organizational level. Health system managers and trustees are stewards of the resources allocated to the publicly funded health system. We are committed to using limited resources to create a sustainable, accessible, accountable, integrated and publicly funded system that will meet the needs of Canadians and continue to foster a competitive advantage for Canadians in the global economy. Yet some critics claim that the current problems in our health system can be attributed to poor management.

This statement is blatantly untrue: business leaders have recognized the leadership excellence of managers within public sector systems by naming hospitals as one of the most complex businesses to run. This statement is also unfair because it ignores the fact that health system managers, trustees and providers have continued to deliver health services that are envied around the world, even when significant restraints in public sector funding were pitted against constant health system restructuring, shifts in health care needs, advancements in technology, and critical human resources shortages — an almost impossible task.

The need for appropriate system change, adequate health information systems, appropriate accountability mechanisms, and meaningful performance measures have further complicated the work of managers and trustees.

These funding and system support issues has led to mistrust and resentment being built up between governments and health system managers and trustees. In many cases these deteriorating relations have led to what health system managers and trustees perceive as micro-management on the part of governments. In cases where good relationships have been maintained or salvaged, government micromanagement may still be occurring because of the significance of the health system in terms of the amount of public dollars spent and the government's re-election potential. The blame game between governments and health organizations must stop. Canadians don't want finger pointing, they want answers and action.

Clear roles and responsibilities (*see 7.1*) can alleviate some of this micromanagement and mistrust. Mutually agreed upon accountability mechanisms (*see 7.2*) can also lead to better collaborative relations for stakeholders within the health system.

CHA urges governments to meet with managers and trustees to determine how to build more autonomy and flexibility into decision making so that trustees and managers can provide services in a responsive and effective manner, while at the same time reassuring governments that trustees and managers have the skills and experience to make good system decisions.

9.3 Support Knowledge Transfer and Uptake

Health system managers and trustees pride themselves in undertaking evidenced-based decision making. While this practice is growing, the truth is there could be more of it in our health system. But, gathering the evidence, assessing it and changing policies and procedures takes time and scarce resources. The challenge is to identify effective mechanisms for researchers and health system managers and trustees to collaborate on identifying the questions, participate in the research, and disseminate the information.

Many groups, including the Canadian Health Services Research Foundation, have looked at the next challenge of moving beyond simply disseminating information to embracing “knowledge transfer and uptake” that provides research results that are useful to decision makers (i.e., answering the “so what?” question) and finds ways to facilitate the uptake of this information into organizational and behavioural change.

CHA urges governments to support knowledge transfer and uptake in our health system by adequately funding activities to improve the use of research information and creating a culture of evidence-based decision making.

To the perfectionists in the group who insist on every “i” being dotted and every “t” being crossed before work begins, we want to remind you that “perfection cannot be the enemy of the good.” Our research and practice knowledge is not always perfect. Many times a good idea is based on sound management principles but, in the end, it is still an experiment.

We must be prepared to embrace the best research available and transform it into action — creating new policies, developing innovative systems, and modifying age-old practices to meet the ever-changing health needs of Canadians with efficiency and effectiveness.

10. IMPROVE FEDERAL/PROVINCIAL/TERRITORIAL RELATIONS

It is no secret that federal, provincial, territorial relations have to improve. Two fundamental components to achieve this include the need to:

- ◆ Recognize Need for Both Federal and Provincial/Territorial Involvement in Health
- ◆ Use the Social Union Framework Agreement (SUFA)
- ◆ Be Patient, But Persistent

10.1 Recognize Need for Both Federal and Provincial/Territorial Involvement in Health

Understandably, Premiers and provincial and territorial Ministers of Health are primarily concerned with ensuring that their own constituencies are well served by the health system. They do not necessarily have a national vision of health services for all Canadians.

As a national federation of provincial and territorial members, CHA’s Board discussions often reflect the dynamism and tension of federal/provincial/territorial relations. Compromise and collaboration are key words and processes for resolving tensions. However, it is only the federal level of government that is accountable to all Canadians in terms of achieving access to comparable health services for all Canadians, no matter where they live. Therefore, *CHA urges the federal government to demonstrate strong leadership by articulating a shared vision of Canada’s health system, developing pan-Canadian health goals, and aligning financial incentives to support needed system change.*

CHA also urges governments to build some flexibility into any new pan-Canadian health program, recognizing the different geographic and political realities of the various regions across Canada and the unique health needs of different communities.

Much of the current acrimony in federal/provincial/territorial relations is not centred on constitutional issues. There is a fairly good understanding and respect for what the provinces and territories are responsible for and what role the federal government can play in health. This understanding sometimes disappears in the heat of the moment or in the glare of the media.

Rather, the acrimony tends to swirl around money. In the past few years there have been angry words exchanged between the various levels of government, and there have been advertisements produced that paint only part of the picture and rewrite the history of health funding in Canada. This has aggravated the concern of Canadians that publicly funded health is neither accessible nor sustainable. Why the angry words and public advertisements? The publicly funded health system in Canada has been and continues to be under funded. In the blame game, the provinces and territories blame the federal government and the federal government blames the provinces and territories. Neither side is entirely right and neither side is entirely wrong. (For details see CHA's Policy Brief *The Private-Public Mix in the Funding and Delivery of Health Services: Challenges and Opportunities*.) No level of government is blameless.

Canadians are expecting leadership, not blame-games, from their governments. The federal, provincial and territorial governments must stop pointing fingers at each other. Together with health system managers and trustees, providers, researchers and the public, governments must articulate a common vision for a sustainable, publicly funded health system, and they must work collaboratively to realize this vision. Canadians expect no less.

10.2 Use the Social Union Framework Agreement (SUFA)

In September 2000, all the First Ministers signed a *Communiqué on Health*. This signaled great potential for improved collaborative relations between the provincial, territorial and federal governments. Collaboration among governments will be critical to the successful implementation of this action plan. This collaboration will mean that initiatives are agreed upon collectively, not unilaterally imposed by one level of government on another. Alas, there were great words written under which signatures were penned, but there has been little progress made on many of the announcements made over a year ago.

And even earlier, in February 1999, with the signing of the Social Union Framework Agreement (SUFA), there was also a foundation laid for developing collaborative solutions for the healthcare challenges facing us all. SUFA includes a clear notification process and timeframes for negotiations between the federal government and the provinces and territories; suggests the involvement of third parties in resolving disputes; incorporates a full review after three years to include input from all interested parties; states a desire for good working relationships between the federal, provincial and territorial governments; reiterates commitments to the Canada Health Act; focuses on mobility (not just portability) across a broad continuum of care; and recognizes accessibility as a key priority. Under SUFA six provinces (not necessarily 50% of the population) are needed for agreement. With any new agreement all provinces and territories would be entitled to funds as long as they were meeting the objectives of the new program. While Quebec did not sign SUFA, it can still participate in any new program. Yet again, this agreement, with such potential to bring the various levels of government together, has not been used to invoke even one new collaborative venture for the health system.

So what is the answer? Back to the drawing board? No. *CHA urges governments to go back to the Social Union Framework Agreement (SUFA) and use it.*

10.3 Be Patient, But Persistent

There is an urgency to many of the issues facing our health system. However, change will not happen quickly. A lot of people need to be involved from the beginning in reviewing issues, identifying options, choosing the preferred option, implementing the changes, and then evaluating the results. This inclusive, collaborative process takes time and patience.

Still, time is of the essence. Often a leader or leaders must be found to persevere and move the whole process forward. Sometimes leaders lead from the front, sometimes they empower from the middle, and sometimes they have been known to push and prod from behind. In most cases, the persistence pays off: new programs are developed, new practice guidelines are introduced, policies are changed, and renewal of the system is possible.

Your patience can be tried when the policy process seems to take forever, and you are now working with your third Deputy Minister in four years. You can be at your wits end when the managers and trustees of a health organization insist that they are “working on it,” but you know that immediate crises are distracting them from the long-range planning they need to be doing.

Through these realities of change management and collaborative relationship building, trust must be established, communication lines kept open, setbacks endured, and progress celebrated. And adequate time is needed for changes to be achieved. We must be prepared to run a marathon, not a sprint.

System change is not an easy task. But it is time to stop tinkering with the health system.

CHA urges governments to buffet the criticism and stay the course, once difficult but important decisions have been reached.

* * * *

Improved collaboration among all levels of government and with health system managers and trustees is key if the challenges facing our health system are to be addressed in a timely and appropriate manner.

F. BOLD, CREATIVE NEXT STEPS — IS ANYONE LISTENING?

The sustainability of our publicly funded health system is a major concern for governments, health system managers and trustees, providers, researchers, policy makers and the public. Canadians want to know that the services they need will be there for them, when and where they need them.

The Canadian Healthcare Association believes that a sustainable, publicly funded health system is possible through strong leadership, appropriate system change and adequate funding. CHA's Ten-Point Plan will help us move from where we are to where we want to be. For each of the ten steps, there are a number of goals and specific objectives. These bold, creative next steps include the need to:

1. Reflect Canadian Values
2. Embrace Appropriate System Change
3. Address Critical Health Human Resources Issues
4. Support Needed Health Infrastructure
5. Examine the Private-Public Mix in the Funding and Delivery of Health Services
6. Ensure Adequate, Predictable Funding
7. Improve Performance Measurement
8. Ensure Public Accountability
9. Involve Health System Managers and Trustees
10. Improve Federal/Provincial/Territorial Relations

The rationale for each of these steps and related initiatives are highlighted in this submission and, in many cases, are also discussed in more detail in other recent CHA policy documents (*see* Appendix A).

The skeptics among us may well yawn at these good ideas and the countless other good ideas (that look surprisingly similar) which have been suggested by a variety of recent commissions and studies, including the National Forum on Health, the Senate review of Medicare, the Romanow Commission, the Royal Commission on Aboriginal Peoples, the Government's Action Plan in NWT, the Roddick Report in B.C., the Mazankowski report in Alberta, the Fyke Commission in Saskatchewan, the Clair Commission in Quebec, and the Quality Council report in New Brunswick.

We obviously don't need any more studies. What we do need is political, moral and financial support to make tough decisions and implement innovative solutions. We also need the support of the media and the public. So if we know what needs to be done, why isn't change happening? Because we don't have all of the necessary components in place: political will, a common vision, the necessary skill mix, appropriate incentives, adequate resources, and an action plan.

And, we haven't tapped into the human psyche to fully understand how knowledge is translated into politics, policy and practice. It must be remembered that "we" and "they" are no more than a group of "I's". Individually and collectively, we must find the courage to battle resistance and fatigue so that we can achieve what we all need as patients, providers and policy makers: a responsive, sustainable, publicly funded health system.

Health services are funded, provided and received by people. Therefore, improvements to our health system will be achieved by people working together. Harnessing this people power and being aware of human behaviour and organizational dynamics will require patience and persistence. This will be a challenge, but a challenge worth embracing.

This is the art of the possible – empowering the human spirit to achieve small and great things.

**APPENDIX A
CHA RELATED DOCUMENTS**

CHA Policy Brief, *The Private -Public Mix in the Funding and Delivery of Health Services in Canada: Challenges and Opportunities*, CHA Press, Ottawa: 2001.

CHA's submission to the House of Commons Standing Committee on Finance, *Canada's Publicly Funded Health System: A Foundation for Global Competitiveness, Equal Opportunity to Succeed and Quality of Life*, August 2001.

CHA Policy Brief, *Towards Improved Accountability in the Health System: Getting from Here to There*, CHA Press, Ottawa: 2001.

CHA's 2000 Federal Election Primer, *Federal Government Commitments Required for a Responsive, Innovative and Accountable Canadian Health System*, 2000.

CHA Policy Brief, *CHA's Framework for a Sustainable Healthcare System in Canada*, CHA Press, Ottawa: 2000.

CHA Policy Brief, *Funding Canada's Healthcare System*, CHA Press, Ottawa: 1999.

Canadian Healthcare Association, Canadian Medical Association, Canadian Nurses Association and the Catholic Health Association of Canada. *Joint Statement on Preventing and Resolving Ethical Conflicts Involving Health Care Providers and Persons Receiving Care*, Ottawa, 1999.

The CHA Policy Briefs can be purchased through the CHA Press at:

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17 York Street, Ottawa, ON K1N 9J6
phone: 613-241-8005, ext. 253
fax: (613) 241-9481
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Many of these resources are also available in the Policy Development portion of CHA's web site at:
www.canadian-healthcare.org