Healthier Generations for a Prosperous Economy

Canadian Medical Association:

2013-2014 pre-budget consultation submission to the Standing Committee on Finance

November 6, 2013

ASSOCIATION MÉDICALE CANADIENNE

CANADIAN MEDICAL ASSOCIATION

A healthy population and a vibrant medical profession
Une population en santé et une profession médicale dynamique

The Canadian Medical Association (CMA) is the national voice of Canadian physicians. Founded in 1867, CMA's mission is to serve and unite the physicians of Canada and be the national advocate, in partnership with the people of Canada, for the highest standards of health and health care.

On behalf of its more than 80,000 members and the Canadian public, CMA performs a wide variety of functions. Key functions include advocating for health promotion and disease/injury prevention policies and strategies, advocating for access to quality health care, facilitating change within the medical profession, and providing leadership and guidance to physicians to help them influence, manage and adapt to changes in health care delivery.

The CMA is a voluntary professional organization representing the majority of Canada's physicians and comprising 12 provincial and territorial divisions and 51 national medical organizations.

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Executive Summary

The Canadian Medical Association (CMA) submission to the House of Commons Standing Committee on Finance discusses the important role of the federal government in ensuring Canada's health care system is cost-effective, accountable and accessible in order to support the country's economic advantage. As in other leading industrialized countries, the federal government has an important role in the effective allocation of health-related resources and the health outcomes of Canadians.

The purpose of this brief is to provide decision-makers with recommendations on areas within existing federal mandates in which the Government of Canada can contribute to advancing Health Care Transformation and improving the health of Canadians and the health care system – an issue Canadians consistently rank as their top concern. These recommendations focus on federal investment in a seniors care strategy, the social determinants of health and health sector innovation and productivity.

Summary of Recommendations

Recommendation # 1
The CMA recommends that the Government of Canada collaborate with provincial, territorial and municipal governments to establish and invest in a pan-Canadian strategy for seniors care.

Recommendation # 2
The CMA recommends that funding for health infrastructure qualify under the next Building Canada Plan to support the construction, renovation and retrofitting of long-term care facilities.

Recommendation # 3
The CMA recommends that the Government of Canada invest $25 million per year over five years toward a pan-Canadian dementia strategy.

Recommendation # 4
The CMA recommends that the Government of Canada establish a Canada-wide injury prevention strategy to identify successful programs and facilitate the sharing of knowledge and resources that will enable them to be disseminated nationwide.

Recommendation # 5
In support of a pan-Canadian palliative care strategy, CMA recommends that the Government of Canada undertake research to identify successful programs and facilitate the sharing of knowledge and resources so that they can be replicated nationwide.

Recommendation # 6

The CMA recommends that the Government of Canada establish health as a required consideration in the Cabinet decision-making process.

Recommendation # 7

The CMA recommends that the federal government, in consultation with the provincial and territorial governments, health care providers, the life and health insurance industry and the public, establish a program of comprehensive prescription drug coverage to be administered through reimbursement of provincial/territorial and private prescription drug plans to ensure that all Canadians have access to medically necessary drug therapies.

Recommendation #8

The CMA recommends that the Government of Canada establish and invest in a comprehensive strategy for improving the health of aboriginal peoples that involves a partnership among governments, non-governmental organizations, and First Nations, Métis and Inuit communities.

Recommendation #9

The CMA recommends that the federal government rescind changes made to the Interim Federal Health Program until appropriate consultation and program review occur.

Introduction

As in other leading industrialized countries, the federal government has an important stewardship role in the effective allocation of health-related resources and health outcomes of Canadians; this is central to a productive workforce and a strong economy.

This brief provides tangible, actionable recommendations on how the federal government can contribute to transforming Canada's health care system and improving the health of Canadians. The focus is on three critical areas for federal investment: a senior's care strategy; the social determinants of health and health equity; and health sector innovation and productivity. The recommendations in these areas are aligned with the CMA's Health Care Transformation initiative, the principles of which have been endorsed by 134 organizations, representing millions of Canadians.[1]

1. Contributing to a National Seniors Care Strategy

Issue: Engagement and investment from the Government of Canada is essential to meet the increasing needs of Canada's aging population.

It is expected that by 2036, a quarter of Canada's population will be over the age of 65. The number of people in the oldest age group – the age group most likely to experience serious health problems – is expected to increase at an even faster rate: Statistics Canada predicts that in 2036 there will be 2.6 times as many people 80 years old or over as there are today.[2]

Already, patients age 65 or older account for nearly half of Canada's health care spending (45% in 2009).[3] Canada's governments are rightly concerned about how to provide sustainable, high-quality health care to all Canadians as the country's population ages. The Canadian public shares this concern. In an Ipsos Reid public opinion survey done for CMA in July 2013, 83% of respondents said they were concerned about their health care in their retirement years.

The CMA recommends the Government of Canada collaborate with provincial, territorial and municipal governments to establish and invest in a pan-Canadian strategy for seniors care.

As elaborated below, the CMA recommends that this strategy include adequate investment in long-term care, home care, as well as palliative and end-of-life care to ensure access to the continuum of care. In addition, there should be investment in programs to address age-related health risks of particular concern, notably dementia and injuries due to falls. These

[1] For the latest update on the Principles to Guide Health Care Transformation, visit: www.cma.ca/cma-media-releases
[2] Statistics Canada. Population projections for Canada, provinces and territories 2009 to 2036. June 2010. 91-520-X
[3] CIHI. Health Care in Canada, 2011, 1.

areas, including recommendations for immediate investment by the Government of Canada are discussed in greater detail below.

i) Ensure continuing care qualifies under the new Building Canada Plan[4]

Addressing the gap in long-term care residency options is a critical component of an integrated continuum of care strategy that provides for increased home and community supports. Communities across Canada face a common problem of a lack of resources to properly meet the housing and care needs of their seniors population. While the percentage of older Canadians who live in long-term care facilities is declining, as the aging of Canada's population accelerates, the demand for residential care will increase significantly.

The current wait times in the long-term care sector are contributing to the high number of alternate level of care patients (ALC) who occupy acute care beds; a major issue facing Canada's health care system. At more than 3 million ALC days, the high number of ALC patients in hospitals is a problem experienced across the country.[5] Based on the difference between the average cost of care in hospital versus long-term care, if ALC patients were moved from hospital to long-term care this would save the health care system about $2.3 billion a year.

The Conference Board of Canada has produced a bed forecast tied to the growth of the population aged 75 and over and based on a decreased bed ratio demand to reflect the greater shift to community-based services and supportive housing options being advanced at the provincial level. Based on these assumptions, over the five-year period ending in 2018, an estimated 29,693 additional beds will be required, representing a pan-Canadian investment of $7.98 billion.

It is evident that the existing and planned schedule of provincial projects will be unable to meet the estimated demand. Based on a review of provincial budgets, current capital investments already committed at the provincial level represent at least $861 million allocated over the next 10 years, representing approximately 3,200 new beds. The shortfall between our projected gap (29,693) and our calculation of provincial committed projects is 26,493 beds, at a cost of $7.1 billion.

The CMA recommends funding for health infrastructure qualify under the next Building Canada Plan to support the construction, renovation and retrofitting of long-term care facilities.

[4] CMA. The need for health infrastructure. Submission to the Minister of Infrastructure, March 1, 2013. www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Submissions/2013/Health-Infrastructure_en.pdf .
[5] CIHI. 2012. Health Care in Canada, 2012: A focus on wait times.

ii) Invest in a national dementia strategy

About three quarters of a million Canadians currently live with Alzheimer's disease and other forms of dementia and cognitive impairment. Our knowledge of how to prevent dementia is limited. We do not fully understand its causes and there is no known cure. People with dementia may live for years with the condition and will eventually need round-the-clock care. Dementia currently costs Canada roughly $33 billion per year, both in direct health care expenses and in indirect costs such as lost earnings of the patient's caregivers.

Given that the prevalence of dementia will unquestionably increase with the aging of Canada's population, the Alzheimer Society of Canada predicts that by 2040 the annual cost to the country will reach $293 billion. [6]

The CMA recommends the Government of Canada invest $25 million per year over five years toward a pan-Canadian dementia strategy.

This $25 million investment would be distributed as follows:

- $10 million to support research on key aspects of dementia, including prevention, treatment options, and improving quality of life.
- $10 million in increased support for informal caregivers. This includes both financial support and programs to relieve the stress experienced by caregivers such as education, skill-building and provision of respite care and other support services.
- $5 million toward knowledge transfer, dissemination of best practices and education and training to support:
    - an integrated system of care facilitated by effective co-ordination and case management
    - a strengthened dementia workforce, which includes development of an adequate supply of specialists and improving diagnosis and treatment capabilities of all frontline health professionals.

iii) Establish an injury prevention strategy for Canada

Falls are the primary cause of injury among older Canadians; they account for 40% of admissions to nursing homes, 85% of injury-related hospitalizations and nearly 90% of all hip fractures. The Public Health Agency of Canada estimates that injuries among seniors cost Canada approximately $2 billion a year in direct health care costs.[7] They are also a major contributor to alternate level of care patients in hospitals given the shortages in the home care, rehabilitation or long-term care sector.

Falls can be prevented, and a growing number of regional programs across Canada are identifying and modifying risk factors for falls in their client population specific to seniors.

[6] Alzheimer Society of Canada. A New Way of Looking at Dementia in Canada. Based on a study conducted by RiskAnalytica. C. 2010
[7] PHAC. The Safe Living Guide – A guide to home safety for seniors. 2005. Revised 2011.

The CMA recommends the Government of Canada establish a Canada-wide injury prevention strategy to identify successful programs and facilitate the sharing of knowledge and resources that will enable them to be disseminated nationwide.

iv) Support the expansion of palliative care in Canada

Experts believe that a palliative-care approach – when combined with treatment – leads to better outcomes by reducing the length of stay in hospitals and the number of deaths in acute care. In Canada, according to Canadian Institute for Health Information (CIHI), only 16% to 30% of patients have access to hospice palliative and end-of-life services.[8] These services tend to be delivered in institutional settings on a tertiary or intensive model; and like falls prevention programs, they tend to be delivered locally.

The CMA strongly supports an approach that integrates palliative care with chronic care in the community, earlier in the patient's condition. In support of a pan-Canadian palliative care strategy, CMA recommends that the Government of Canada undertake research to identify successful programs and facilitate the sharing of knowledge and resources so that they can be replicated nationwide.

2. Social Determinants of Health and Health Equity

Issue: Addressing the social and economic determinants of health is critical to ensuring improved health outcomes for Canadians.

Research suggests that 15% of population health is determined by biology and genetics, 10% by physical environments, 25% by the actions of the health care system, with 50% being determined by our social and economic environment.[9] While a strong health care system is vital, changes to our health system alone will not be sufficient to improve health outcomes or reduce the disparities that currently exist in disease burden and health risks.

Addressing the social and economic determinants of health has an important role in ensuring the sustainability of the health care system. It is estimated that one in five dollars spent on health care in Canada can be attributed to socio-economic disparities. These are the avoidable health costs linked to issues such as poverty, poor housing, health illiteracy, and unemployment among others. In 2012 health care dollars, these potentially avoided costs represented $40 billion in public spending. [10]

[8] CIHI. 2013. End-of-life hospital care for cancer patients.
[9] Keon, Wilbert J. & Lucie Pépin (2008) *Population Health Policy: Issues and Options*. Available at: www.parl.gc.ca/Content/SEN/Committee/392/soci/rep/rep10apr08-e.pdf
[10] Public Health Agency of Canada (2004) *Reducing Health Disparities-Roles of the Health Sector: Discussion Paper*. Available at: publications.gc.ca/collections/Collection/HP5-4-2005E.pdf

Many of these social and economic determinants fall within the jurisdiction of the federal government such as tax policy. The section below elaborates on how the federal government can contribute to addressing the social determinants of health and reduce health inequity.

i) Ensure healthy public policy

Recognizing that the social and economic determinants of health have an important role in the health of Canadians, the policy decision-making process across departments must include a consideration of health. This can be accomplished by establishing health as a required consideration in the Cabinet decision-making process to ensure that the health promoting aspects of policies and programs are strengthened while potential negative impacts can be avoided or mitigated. In short it will ensure healthy public policy.

Not only could health care costs be reduced, but ensuring healthy public policy has the potential to provide significant benefits for the Canadian economy. Healthier people lose fewer days of work and contribute to overall economic productivity.[11]

The CMA recommends the Government of Canada establish health as a required consideration in the Cabinet decision-making process.

ii) Address access to prescription pharmaceuticals

Universal access to prescription drugs is widely acknowledged as part of the "unfinished business" of Medicare in Canada. What exists today is a public-private mix of funding for prescription drugs. As of 2011, CIHI has estimated that 44% of prescription drug expenditures were public, 38% were paid for by private insurance and 18% were paid out of pocket.[12] At present, Quebec is the only province to have universal prescription drug coverage for its residents, either through private insurance or a public plan, introduced in 1997.

Of serious concern, there is evidence of wide variability in levels of drug coverage across Canada. According to Statistics Canada, almost one in 10 (7.6%) of households spent greater than 3% of after tax income on prescription drugs in 2008. Across provinces, this ranged from 4.6% in Alberta and 4.7% in Ontario to 13.3% in PEI.[13] Further, 10% of the Canadian respondents to the Commonwealth Fund's 2010 International Health Policy Survey said they had either not filled a prescription or skipped doses because of cost issues.[14]

[11] Munro, Daniel (2008) "Healthy People, Healthy Performance, Healthy Profits: The Case for Business Action on the Socio-Economic Determinants of Health." *The Conference Board of Canada*. Available at: www.conferenceboard.ca/Libraries/NETWORK_PUBLIC/dec2008_report_healthypeople.sflb

[12] Canadian Institute for Health Information. Drug expenditure in Canada, 1985 to 2011. Ottawa.

[13] Statistics Canada. CANSIM Table 109-5012 – Household spending on prescription drugs as a percentage of after-tax income, Canada and provinces. www5.statcan.gc.ca/cansim/pick-choisir;jsessionid=4FF8F1A5D604C73873F71D9FDE6141C5. Accessed 12/10/12.

[14] Commonwealth Fund. 2010 Commonwealth Fund International Health Policy Survey. www.commonwealthfund.org/~/media/Files/Surveys/2010/IHP%202010%20Toplines.pdf Accessed 12/10/12.

Research conducted by Ipsos Reid in 2012 showed that almost one in five households (18%) does not have supplementary insurance coverage that would cover prescription drugs.[15]

Statistics Canada's 2011 Survey of Household spending clearly shows the burden on seniors and low-income Canadians. Households headed by a person aged 65 and older spent 50% more, on average, on prescription drugs when compared with all households.[16] Those in the lowest income groups are three times less likely to fill needed prescriptions.[17] This has consequences not only for their health but for the health care system as well. Individuals who are unable to manage treatable conditions often end up hospitalized at a great cost to the health care system.

The CMA recommends the federal government, in consultation with the provincial and territorial governments, health care providers, the life and health insurance industry and the public, establish a program of comprehensive prescription drug coverage to be administered through reimbursement of provincial/territorial and private prescription drug plans to ensure that all Canadians have access to medically necessary drug therapies.

iii) Address health disparities experienced by First Nations, Métis and Inuit

During a cross-country town hall consultation in Winnipeg on Feb. 4, 2013, the CMA heard about the adverse effects of inequalities and disparities and their impact on the health and wellness of First Nations, Métis and Inuit in Canada. As elaborated below, the inequalities and disparities in the social determinants of health can have a significant impact on the health of the population.

First Nations, Métis and Inuit in Canada experience higher rates of chronic disease, addictions, mental illness and childhood abuse. The Health Council of Canada reports that the crude mortality rate for First Nations is higher and life expectancy lower than the Canadian average.[18] In 2009, UNICEF reported that the infant mortality rate for First Nations on reserve was seven times higher than the national average.[19] First Nations, Métis and Inuit peoples suffer much higher rates of infectious and chronic diseases. Tuberculosis rates are six times higher in First Nations populations and 17 times higher in Inuit communities as compared to the rest of Canada.[20] Diabetes rates are higher among First Nations, Métis and Inuit peoples - 15.5% vs. just over 4.7% for the non-Aboriginal population,[21] and First

[15] Ipsos Reid. Supplementary health benefits research. www.cma.ca/multimedia/CMA/Content_Images/Inside_cma/Media_Release/2012/CMA-Benefits-Research-Survey_en.pdf. Accessed 12/10/12.
[16] Statistics Canada. CANSIM Table 203-0026. Accessed 06/18/13.
[17] Mikkonen, Juha & Dennis Raphael (2010) Social determinants of Health: The Canadian Facts. Available at: http://www.thecanadianfacts.org/The_Canadian_Facts.pdf
[18] Health Council of Canada, "The Health Status of Canada's First Nations, Métis And Inuit Peoples", 2005, online: http://healthcouncilcanada.ca.c9.previewyoursite.com/docs/papers/2005/BkgrdHealthyCdnsENG.pdf Accessed October 20, 2010.
[19] National Collaborating Centre for Aboriginal Health & UNICEF Canada "Leaving no child behind - national spotlight on health gap for Aboriginal children in Canada" 2009, online: www.nccah-ccnsa.ca/s_140.asp Accessed November 20, 2009
[20] Health Council, supra note 34.
[21] NWAC, 2009, supra note 39.

Nations, Métis and Inuit communities face higher rates of heart and circulatory diseases, respiratory diseases, and mental health disorders.[22]
Housing is a key area of concern for First Nations, Métis and Inuit. It is estimated that there will be a backlog of 130,000 housing units in First Nations, Métis and Inuit communities between 2010 and 2031, with 44% of existing units needing significant repairs and 18% requiring complete replacement.[23] This inadequate housing can lead to serious health problems. The quality of housing stock directly affects health through exposure to lead, mold and other toxins that are harmful to health. Action is needed to develop an appropriate housing strategy for Canada's First Nations, Métis and Inuit that includes consideration of expiring social housing arrangements on and off reserve.

Access to health care also plays a role in determining health. This can be a challenge for First Nations, Métis and Inuit. Many live in communities with limited access to health care services, sometimes having to travel hundreds of miles to access care.[24] Additionally, there are jurisdictional challenges between federal and provincial delivery of health services. First Nations, Métis and Inuit living in Canada's urban centres also face significant barriers to accessing health care. Further, even when care is available it may not be culturally appropriate.

Utilizing the Non-Insured Health Benefits (NIHB) program can be problematic for some First Nations. It is the CMA's understanding that funding constraints can lead to decreased quality of services, treatment delays or even in some cases denial of services. While the federal government has committed to continuing payments for the NIHB program the CMA is aware of concerns with current funding is inadequate to account for the growing native population, the addition of other beneficiaries, and the higher health care utilization as a result of the poor health status of many of Canada's First Nations.[25]

The CMA recommends the Government of Canada establish and invest in a comprehensive strategy for improving the health of First Nations, Metis and Inuit that involves a partnership among governments, non-governmental organizations, and Aboriginal communities.

iv) Restore coverage under the Interim Federal Health Program

The CMA, together with other medical, health and social organizations, have recommended that the changes to the Interim Federal Health Program be rescinded until appropriate consultation is undertaken. The purpose of this consultation would be to identify opportunities to achieve the Government of Canada's cost saving objectives while maintaining the scope of health care coverage for the program recipients. To date, this consultation has not occurred.

[22] Canada, Health Canada, First Nations, Inuit and Aboriginal Health, (Ottawa: Health Canada), online: www.hc-sc.gc.ca/fniah-spnia/pubs/index-eng.php Accessed November 4, 2009
[23] Assembly of First Nations (2013) Taking Action Together on Shared Priorities Towards a Fair and Prosperous Future: AFN Submission to the Council of the Federation. Available at: www.afn.ca/uploads/files/13-07-23_afn_submission_to_cof_2013.pdf
[24] Bowen, S. Access to Health Services for Underserved Populations.
[25] Assembly of First Nations (2011) Structural Transformation & Critical Investments in First Nations on the Path to Shared Prosperity. Pre-Budget Submission, 2011. Available at: www.afn.ca/uploads/files/2011-pre-budget-submission.pdf

One of the primary rationales for the program changes was an estimated cost savings of $20 million per annum in health care costs covered by the federal government. As evident by the recent statements of provincial health ministers following the Oct. 3 Federal/ Provincial/ Territorial Health Ministers Meeting, these projected cost savings are not likely to be realized.

The CMA is concerned that the costs of the program have been downloaded on the provincial health systems, the charitable sector, and other public programs and organizations that provide the uninsured with benefits. Further, there has been significant confusion that has resulted in an increased administrative burden on the health sector following continual changes in this program.

The CMA recommends the federal government rescind changes made to the Interim Federal Health Program until appropriate consultation and program review occur.

3. Improving Health Care Productivity and Innovation

The CMA supports federal engagement to advance a health sector innovation and productivity framework, the purpose of which would be to support the introduction and expansion of innovation in health technology and processes of delivery to yield better health outcomes and productivity. As part of this framework, the CMA encourages federal focus on accountability measures and health information technology, as elaborated below.

i) Accountability mechanism to improve productivity and quality care

Despite the importance of the health care sector to Canada's economy and quality of life, it is generally agreed that in health care, Canada is no longer a strong performer relative to similar nations. For instance, OECD Health Data 2012 ranks Canada seventh highest of 34 member states in per capita health care spending, while Canada's health care system continues to rank below most of our comparator countries in terms of performance. [26] According to the latest forecast report by CIHI, public spending on health care was to surpass $200 billion in 2012.

According to the OECD, if the Canadian health sector was to become as efficient as the most efficient countries, we could save 2.5% of GDP in public expenditure by 2017.[27] The need to improve system performance will only intensify as demand for health care services increases and the system is pressed to effectively manage the rising number of Canadians with chronic diseases.

[26] OECD Health Data 2012 - www.oecd.org/health/healthgrowthinhealthspendinggrindstoahalt.htm
[27] OECD, Economic Survey of Canada 2012. www.oecd.org/eco/surveys/economicsurveyofcanada2012.htm

While the provinces and territories have initiated steps to collaborate on the sharing of best practices in health care, federal leadership is necessary to address the overall performance of the health care system in Canada. This includes collaborating with the provinces and territories on the identification of pan-Canadian metrics that link health expenditures to nationally comparable health outcomes and system performance.

CIHI does develop and collect data on numerous health indicators and has developed a performance measurement framework with an initial set of indicators coming out in the near future. However, there is currently no pan-Canadian process to set targets and monitor outcomes and system performance, the purpose of which is to demonstrate accountability to Canadians, improve health outcomes and health sector performance.

The CMA recommends the federal government engage the provinces and territories in a collaborative process to identify pan-Canadian metrics and measurements that link health expenditures to nationally comparable health outcomes and system performance.

ii) Maximizing the value of Electronic Medical Records

The digitization of our health care system is central to quality, safety and the continuity of patient care for all Canadians. Canada continues to make progress in the adoption of health information technology (HIT). It is forecast that 70% of physicians will have an electronic medical record (EMR) system in place by 2014. Almost 90% of the most common radiology examinations and reports in Canada's acute care hospitals are now digital, up from approximately 38% only six years ago.

However, there is still a long way to go in order to share information more effectively among caregivers, enable patient access to clinical information, and optimize the use of these systems. Areas where progress has stalled include: specialist EMR needs, applied research, local interoperability, decision support tools, and analytical tools.

Stalled progress in these areas has meant Canadians are not benefiting at the point of care such as allowing comparisons between patients within a practice, comparing across practices, facilitating sentinel disease surveillance and a population health approach to primary care, and allowing patients to get consistent, more understandable information from their providers electronically through portals, emails and other e-routes.

As we look to the future – and in particular the next three years – there's a need to reframe the discussion from building HIT infrastructure to deriving benefits. To this end, investment is required to ensure that the efforts to date are fully utilized and support improved patient outcomes. A committee comprised of CMA and Provincial Territorial Medical Associations representatives considered this issue and developed recommendation for targeted investment in HIT; these are outlined below.

The CMA recommends the Government of Canada allocate $545 million as follows:

- $200 million to support an additional 10,000 physicians not covered by current programs.
- $200 million to support change management for EMR adoption.
- $10 million to support data migration (i.e. clinics have to move to new products).
- $100 million to support local interoperability solutions.
- $5 million to support the Standards Collaborative.
- $20 million to support research into HIT effectiveness.
- $5 million to support solutions for the integration of clinical practice guidelines (CPGs).
- $5 million for applied research on patient portal.

This additional investment would benefit patients, providers and governments through improved patient care and improved performance of health care systems. In addition, the appropriate use of health information technology will contribute toward a more effective health care system supporting Canada's economic competitiveness.

Conclusion

Working with the provinces and territories and health care providers in delivering better health care to all Canadians through enhancing productivity and innovation is a policy challenge requiring federal leadership and engagement.

The CMA believes the Government of Canada should act upon the recommendations included in this brief and collaborate with stakeholders to ultimately contribute to optimal health outcomes for Canadians, and health services that are delivered in a more efficient and cost-effective manner.