Introduction

A community health nurse’s professional practice can occur in a wide range of settings. In their professional practice, CHNs are “accountable to a variety of authorities and stakeholders—the public, the regulatory body, and the employer—and are governed by legislative and policy mandates from multiple sources both internal and external to their employment situation” (Meagher-Stewart et al., 2004, p. 3). The structure, process, and leadership within the organizations and agencies in which CHNs work affect their practice, enabling and constraining it through funding, governance, values, policies, goals, and standards (Ganann et al., 2010; Meagher-Stewart et al., 2004; Molina-Mula & De Pedro-Gómez, 2012; Underwood et al., 2009). Leadership is about influence at all levels of an organization.

Almost every day, reports in the media suggest that healthcare in Canada is in crisis, that spending is out of control, that wait times are unreasonable, and that substantive changes are needed to ensure sustainability of the healthcare system. At the same time, there has been a repetitive chorus regarding the significance of health promotion and prevention, as well as the critical role of public and community health in addressing the determinants of health and advancing health equity (Canadian Nurses Association, 2012b; Mahony & Jones, 2013; Reutter & Kushner, 2010; World Health Organization, 2008). It is important for CHNs to understand how Canada’s healthcare system evolved and what
Chapter 2  FINANCING, POLICY, AND POLITICS OF HEALTHCARE DELIVERY  17

factors influence how it is governed today. The impact of leadership at all levels has been identified as a particularly significant factor in the evolution of the healthcare system and in supporting community health nursing practice (Bekemeier, Grembowski, Yang, & Herting, 2012; Cummings et al., 2010). Throughout this evolution, CHN practice has changed. The last section of the chapter will discuss key issues in Canada for CHNs at this time in history.

HISTORICAL MILESTONES IN CANADIAN HEALTHCARE

Between the 16th and 18th centuries, tens of thousands of people immigrated to Canada, “the new world,” in search of a better future. With them came significant communicable diseases and social issues. In 1832, the first quarantine station, known as Grosse Isle, was established in an attempt to assess all newcomers and isolate those arriving with communicable diseases such as cholera and typhus. This island, located in the St. Lawrence River near Quebec City, remained in operation until 1932 and is now a national historic park. The realization that individuals and communities could do something to stop the spread of disease and benefit from early detection was known as the “sanitary” idea.

Following Confederation in Canada, additional community health strategies were introduced, such as public education; gathering and analyzing statistics; sewage and drinking water management; and maternal, infant, and childcare. In 1882, Ontario became the first provincial government to establish a full-time provincial board of health (with a $4000 budget). The Hudson’s Bay Company took on the role and functions of the public health board in western Canada.

Although the 1867 Constitution Act (also known as the British North America Act) did not explicitly assign responsibility for health policy to either the federal government or the provincial governments, both levels of government have been involved in ensuring the availability of and funding for health services. The Act does contain an equalization clause requiring provinces to provide “reasonably comparable levels of public service for reasonably comparable levels of taxation” (Sullivan & Baranek, 2002, p. 21).

Canada currently has a national, universal health insurance program, with the first policy implemented at the provincial level in Saskatchewan, where in 1947, Tommy Douglas and the Cooperative Commonwealth Federation (CCF) party introduced legislation to institute medicare, or publicly funded healthcare, in that province. This is why Tommy Douglas is referred to as the “father of medicare.” It was not until 10 years later, in 1957, that similar legislation, the Hospital Insurance and Diagnostic Services Act (HIDS), was passed by the Government of Canada (Rachlis & Kushner, 1994). This legislation provided for the federal government’s payment of half the costs of insurance plans if key criteria were met.

Because provincial and territorial wealth varies considerably, the federal government’s involvement has been necessary to equalize services across provinces and territories. Since 1957, the federal government has done that in two ways: first, by contributing money (in effect, transferring money from wealthier to poorer provinces and territories) and, second, by stipulating specific conditions that the provinces and territories must meet in order to receive that money. On December 12, 1983, Monique Begin, the then Federal Minister of Health and Welfare, introduced Bill C-3, or the Canada Health Act, to Parliament. This piece of legislation was to be current for 30 years (to April 16, 2014), and it provided direction for the cash contributions to be made by the federal government. The purpose of the Act was to “establish criteria and conditions in respect of insured health services and extended healthcare services provided under provincial law that must be met before a full cash contribution may be made” (Canada, House of Commons, 1984, p. 5). Begin faced tough opposition to the Act from lobby groups, opposition parties, and even from members of the Liberal cabinet (Begin, 2002). Intense lobbying and support by the Canadian Nurses Association was instrumental in the Bill being passed. In the words of Begin, “Nursing became a big player during the Canada Health Act. They made the difference; it’s as simple as that” (Rafael, 1997). The Canadian Nurses Association (CNA) is the national professional voice of registered nurses in Canada. The invaluable support provided by Canadian nurses was acknowledged by the Honourable Monique Begin at the Canadian Public Health Association (CPHA) conference in Toronto in June 2010. She noted that not only were nurses instrumental in passing the Canada Health Act into law, but they were also successful in having it amended. As it was introduced to Parliament in 1983, Bill C-3 identified only physicians as providers of insurable services. The CNA amendment changed the language to include other healthcare workers as potential providers of insurable services (Mussallem, 1992).

Under the Canada Health Act, federal funding for essential medical services would continue so long as the provinces’ health insurance plans met the following five criteria: (1) publicly administered (accountable to the public), (2) comprehensive (must cover necessary in-hospital, medical, and surgical–dental services), (3) universal (available to all), (4) portable (available after a maximum of three months of residency, and no extra charge for care out of province), and (5) accessible (no user fees, and healthcare providers must be reimbursed adequately). The Canada Health Act has ensured that Canadians have access to healthcare regardless of their ability to pay or where they live. It is held up as a symbol of the values that represent Canada. It articulates a social contract that defines healthcare as a basic right and reflects the values of social justice, equity, and community (Auditor General of Canada, 2002).

However, the Canada Health Act identified only essential medical and hospital services as qualifying for federal cost sharing. Health promotion, prevention of disease and injury, health protection, and home health were not emphasized. Tommy Douglas had envisioned a second, more ambitious phase to medicare—one with a focus to keep people well, as he understood that illness prevention and improved health
were essential to controlling healthcare costs (Campbell & Marchildon, 2007). To realize this vision, a shift in the focus from individual conditions and behaviours to the social and economic determinants of health, such as education, poverty, hunger, and inadequate housing, is required (McBane, 2004).

In October 2006, the CNA again spoke up, with the then president, Dr. Marlene Smadu, presenting to the House of Commons Standing Committee on Finance. This CNA presentation outlined the position of nurses in Canada, stating that health promotion, funding to address the determinants of health, and support for control of drug costs were considerations as important as wait times and fears about financial sustainability (CNA, 2006).

In assessing the degree to which the Canada Health Act has been successful in ensuring that all Canadians have access to the healthcare they need, we need to look at the purpose of the Act and the extent to which other aspects of healthcare addressed by the Act have been implemented. In addition to its stated purpose, the Canada Health Act implicitly and explicitly suggests a broader purpose. For example, Section 3 of the Act endorses health promotion, stating that the “primary objective of Canadian healthcare policy” is twofold: to facilitate reasonable access to health services and “to protect, promote, and restore the physical and mental well-being of the residents of Canada” (Canada, House of Commons, 1984, Section 3, p. 5). Despite this, the focus on adequate funding of community health services has been limited. Because the Canada Health Act establishes that only medically necessary physician services and hospital services are publicly funded, services such as home care fall outside the legislation. Provision of the funding for these services lies within the jurisdiction of each province and territory.

Because protective, preventive, and health promotion services were not required to meet the five criteria of medicare, they were not subject to the conditions of the Act. As a result, these services were left unprotected by federal legislation and are provided largely by provincial and territorial public health systems, even though it is well recognized that these services add a critical balance to the treatment-focused insured service delivery addressed by the Canada Health Act. Each province, territory, and region determines what services are covered and to what extent. The result has been varied and fragmented community health service across the country (Tsasis, 2009).

Today, public health systems in Canada continue to be confronted by ideologies that favour efficiency, effectiveness, and short-term outcomes, which tend to overshadow health promotion and prevention values, strategies, and activities (Kirk, Tomm-Bonde, & Schreiber, 2014). Demonstrating measurable indicators of relationship building with marginalized populations and capacity building within neighbourhoods and communities is difficult, especially in the short term.

Canada’s life expectancy at birth, for women and men combined, ranks among the highest in the world at 82 years (World Health Organization, 2011). However, while the Canadian infant mortality rates have dropped since 1970, the 2013 rate of 4.78 deaths per 1000 live births is still higher than the rate in a number of other developed countries (Henry J. Kaiser Family Foundation, 2014). There is room for improvement.

In 2011, the United States spent more per capita on healthcare than any of the other 29 countries compared by the Organization for Economic Cooperation and Development (OECD) (OECD, 2013). Data analysis suggest that Canada’s universal health coverage is less costly and more effective than the privatized U.S. healthcare system (Evans, 2008; Rachlis, 2008; Rachlis, Evans, Lewis, & Barer, 2001; Starfield, 2010). Health expenditures in the United States also represented the highest percentage of gross domestic product (GDP) (OECD, 2013). Yet American health outcomes compare poorly with those of other countries. Japan, for example, spends less than one-half as much per capita on healthcare as the United States and yet it ranks very high on all three measures of health outcomes (male life expectancy, female life expectancy, and infant mortality).

The World Health Organization (WHO) reported that the total expenditure on health in 2011 in Canada was $4520 per capita (WHO, 2011), representing about 11.2% of the GDP. Canada’s per capita spending in 2011 was about 54% of that of the United States and less than 17.7% of the U.S. GDP (OECD, 2013). Even though the spending was lower, Canada fared substantially better than the United States on all three health outcomes. This is perhaps related to the fact that the American healthcare industry relies to a larger extent on private funding (53.5%) than any of the other countries. When comparing healthcare outcomes to expenditures, one message is very clear—increased spending on healthcare does not result in better health.

When we first started debating medicare 40 years ago, “medically necessary” healthcare could be summed up in two words: hospitals and doctors. Today, hospital and physician services account for less than one-half of the total cost of the healthcare system. More money is spent on drugs than on physicians. There are more specialists and more care is delivered in homes, in communities, and through a wide array of healthcare providers. In short, the practice of healthcare has evolved. “And despite efforts to keep pace, medicare has not” (Romanow, 2002, p. 2). Effective chronic disease prevention and management will require broad policy options, including amending the Canada Health Act; promoting interdisciplinary teamwork; and supporting further integration of public health, home care, and other sectors of the healthcare system (Tsasis, 2009). Palliative care and community mental health services are areas that need to be strengthened within the Canada Health Act (Marchildon, 2005). The review of the Act will require the involvement of professionals, citizens, and communities to provide insight and direction for the delivery and funding of healthcare.

A PARADIGM SHIFT TO PREVENTION, PROMOTION, AND THE SOCIAL DETERMINANTS OF HEALTH

When the legislative pillars of Canadian medicare were enacted in 1957, 1966, and 1984, the biomedical model dominated public and political thinking about health. The clinical definition of health was “the absence of disease,” and the term
“health promotion” was often used interchangeably with “disease prevention.” Labelling the illness-oriented, treatment-focused physician and hospital services that were insured under the Act as “healthcare” contributed to this confusion. As challenges to the idea that health was related exclusively to the country’s illness emerged, the federal government responded and provided leadership for the development of health promotion policies and resources.

An important acknowledgement of the limitations of the primacy of the funded medical/treatment system in Canada was “The Lalonde Report” of 1974 (Lalonde, 1974). This bold report presented a vision for health promotion services as a critical component of Canada’s healthcare system. The forward-thinking framework identified four determinants of health: environment, lifestyle, human biology, and the healthcare system. This was the first acknowledgement that health was influenced by the social, economic, and environmental conditions in which people lived, worked, and played. The Lalonde Report was considered revolutionary by the global community and led to a reconceptualization of health promotion.

Four years later, in 1978, Canada and other countries around the world met at the International Conference on Primary Health Care in Alma-Ata, USSR. Governments were urged to take action to “protect and promote the health” of the people of the world, and the “Declaration of Alma-Ata” (WHO, 1978) was issued. Canada was a signatory. The goal of primary health care is the attainment of better health services for all, which will be discussed in Chapter 7. The CNA continues to advocate for primary health care policy and practice that is consistent with the principles outlined in the WHO declaration (CNA, 2012b).

In the years following Alma-Ata, federal leadership in forming a health promotion policy continued. In 1986, the federal Minister of Health, the Honourable Jake Epp, published the document “Achieving Health for All: A Framework for Health Promotion” (Epp, 1986), also known as the “Epp Framework.” The Epp Framework expanded Lalonde’s definition of health promotion; incorporated some of the tenets of primary health care; and emphasized the role of broad social, environmental, and political determinants of health (conditions that contribute to disease and disability). The document concluded with a denouncement of strategies that focus on individual responsibility for health, or “blaming the victim,” while ignoring the social and economic determinants.

The Epp Framework formed the basis for the Ottawa Charter for Health Promotion that emerged from the First International Conference on Health Promotion, hosted by the federal government in Ottawa in November, 1986 (Epp, 1986). The Ottawa Charter (WHO, 1986), authored jointly by Health Canada, the CPHA, and the WHO, identified prerequisites for health, strategies for promoting health, and outcomes of those strategies (Kirk, Tomm-Bonde, & Schreiber, 2014). The release of the Ottawa Charter marked a dramatic shift in health promotion. Peace, education, shelter, income, and food were among the determinants identified, and this broader view of health shifted the focus from providing illness care and identifying risk factors to an inclusive approach that also focused on socio-environmental factors.

The Ottawa Charter acknowledged that caring for one’s self and others is conducive to health, and it identified caring, holism, and ecology as essential concepts in health promotion (WHO, 1986). Federal government support for health promotion through policy making and development of resources has continued. Many of the resources that have been developed, such as the Population Health Template (Health Canada, 2001) and the Population Health Promotion Model (Hamilton & Bhatti, 1996), have been used to guide policy development as well as the practice and education of CHNs. More than 30 years after the Declaration of Alma-Ata, the eighth Global Conference on Health Promotion was held in Helsinki in June 2013. At this international conference, participants affirmed that “Health for All is a major societal goal of governments and the cornerstone of sustainable development” (WHO, 2013, p. 1). They called for a “Health in All Policies” approach and a commitment to equity in health. Governments have a responsibility for the health of their people, and equity in health is an expression of social justice (WHO, 2013). This raises important questions: How is this “call to action” put into practice? What are the system and organizational requirements? How is Canada’s healthcare system organized, and can it meet the call?

**CANADIAN RESEARCH BOX 2.1**

**What does “population health approach” mean?**


“Population health approach” is a broad term used to described strategies and actions that are developed in recognition of the multitude of factors that affect the health of a population. These factors and forces are both within and outside of the scope of the healthcare system. Canada has been recognized as a leader in the development and operationalization of the population health approach. It has been used in community and public health for decades, but recently it has been used throughout the whole healthcare system. With this more widespread consideration and use comes the need for clarity about what is meant by the term itself. With that in mind, this study set out to “examine the conceptual and operational definitions of a population health approach among senior leaders in Canada to determine a future foundation for common language and understanding” (p. 2).

The study used a qualitative, descriptive method with thematic analysis of the data. The research team identified “lead users” to identify study participants who were at the leading edge of the use of this approach. Semi-structured interviews were conducted with senior leaders (n = 21) from across Canada and included the question, “What does a population health approach look like from your perspective?”
Following thematic analysis, themes were identified and subsequently validated at two pan-Canadian workshops with a broad range of health system actors. Six core themes emerged and included the following:

1. Focusing on health and wellness and prevention rather than on illness.
2. Taking a population rather than an individual orientation.
3. Understanding needs and solutions through community outreach.
4. Addressing equity, health disparities, and health in vulnerable groups.
5. Addressing the social and multiple determinants of health.
6. Embracing intersectoral action and partnerships (p. 4).

Many of the senior leaders interviewed pointed out that the population health approach was grounded in their personal and organizational values, an approach that represented an active shift toward a “way of thinking rooted in social justice” (p. 6) and supported them in carrying out their “moral responsibility to stay focused on the health of populations in the face of continued pressure to focus on clinical care” (p. 6). Knowledge sharing and networking opportunities were identified as strategies to facilitate other leaders to address the unique challenges they face in operationalizing the population health approach.

Discussion Questions
1. What is the population health approach? What evidence would you look for to ascertain if the population health approach is being used?
2. Are any of the six core themes identified in this study evident in your practice setting? Describe them, and consider what supports them from an organizational and CHN perspective.
3. What strategies could leaders at all levels in an organization use to support the population health approach?

ORGANIZATION OF COMMUNITY HEALTHCARE

Public Health Agency of Canada

Over the past several decades, several health emergencies have illuminated the problems in and the limitations of the community health system in Canada and these have been highlighted in several national reports. The report of the Expert Panel on SARS and Infectious Disease Control (Walker, 2004), the National Advisory Committee on SARS and Public Health (Naylor, 2003), and the two interim SARS Commission Reports (Campbell, 2004, 2005) highlighted the central importance of public health in preventing the spread of diseases. These reports posed questions about the funding, governance, and management of public health in Canada. They monitored a series of communicable disease outbreaks, and their focus was on the health system’s ability to respond adequately given the impact of the outbreaks on the communities, the healthcare system, and the economy. In response to the concerns raised, the Public Health Agency of Canada (PHAC) was established in September 2004 to strengthen public health in Canada. Confirmed as a legal entity in December 2006 through the Public Health Agency of Canada Act, it reports to the Parliament of Canada through the Minister of Health. By 2014, more than 2400 PHAC staff members were working in the national headquarters in Ottawa and in six regions distributed across Canada.

The PHAC is led by the Chief Public Health Officer (CPHO), who is the lead federal public health professional tasked with communicating directly with Canadians and government on important public health matters. The mission of the PHAC is to promote and protect the health of Canadians, and it brings together scientists, researchers, policy makers, and public health professionals, including physicians, nurses, and epidemiologists to do so. The PHAC is committed to the well-being of specific communities and the Canadian population as a whole. The development of a public health agency has strengthened public health leadership in Canada, which is required to address factors that contribute to illness and injury in times of crisis and emergency as well as in other times. The PHAC concentrates, within one agency, the required resources to focus efforts to advance public health nationally and internationally.

While the PHAC was a federal response, each province and territory also responded to the above-mentioned outbreaks and took steps to review and strengthen the public health component of the health system within their jurisdiction. In Ontario, for example, the provincial government launched Operation Health Protection in 2003 (Ontario Ministry of Health and Long-Term Care, 2004), a three-year plan to rebuild public health. The intent was to address the concerns of infectious disease control as well as concerns related to disease prevention and health promotion. Related activities included the establishment of two provincial committees to move public health renewal forward. The first committee, the Capacity Review Committee, was to assess and make recommendations as to the capacity and organizational framework for public health, and the second was to provide recommendations and a plan to establish a provincial arms-length agency that would focus on research and practice excellence in public health. The newly developed Ontario Agency for Health Protection and Promotion (OAHPP) provides provincial leadership on funding, policy, standards setting, and accountability in public health programs. All these directly impact the practice of community health nursing in Ontario.

Community Health Services

“A strong community health system has the potential to effectively and efficiently address disease and injury issues upstream to prevent them from occurring, delay their onset, or care for those affected closer to home to restore health” (Community Health Nurses of Canada, 2011a, p. 17). In a submission to the CNA National Expert Commission (CNA, 2012), the Community Health Nurses of Canada (CHNC) (CHNC, 2011b) stated that any health reform would require proactive planning in anticipation of population trends and
need. Further, the CHNC identified community-based health organizations as a driving force for the type of innovation (health and social) to create a just, prosperous, and caring society.

Many factors have influenced how community health services are organized and delivered across Canada. Most Canadian provinces and territories have moved to regional health authority structures for all health service delivery. This approach strives to integrate most or all health services (including CHN services) into a single organization. The timing, organization, and, in many cases, repeated reorganization of the regional health authorities and health regions have been unique to each province or territory. While community health services are organized and delivered differently across Canada, each province and territory provides primary health care, primary care, public health, and home care services. These will be briefly discussed in the next section.

1. Primary Health Care and Primary Care

In the Declaration of Alma-Ata, primary health care is defined as accessible, acceptable, affordable healthcare (WHO, 1978). Other tenets of primary health care include a basis in research; a continuum of services from promotive to rehabilitative; the identification of health education, proper nutrition, disease prevention and control, and maternal and child health care as minimum services; the recognition that intersectoral and interdisciplinary approaches are necessary for success; and an emphasis on community participation and empowerment. Primary health care encompasses the determinants of health and their influence on health and well-being (WHO, 1978). The practice of a CHN encompasses these tenets, and CHNs have participated in primary health care and are well prepared to play a leadership role.

Primary care, on the other hand, refers to services commonly accessed at the first point of contact with the health system. Primary care, a core component of primary health care, is more narrowly focused. In many developed countries, primary care services focus on acute care and treatment of diseases. While the largest group of primary care providers in Canada is composed of physicians, other primary care providers include nurses, nurse practitioners, dentists, chiropractors, pharmacists, dietitians, midwives, optometrists, and public health nurses. Current funding mechanisms favour physicians, and as a result, most Canadians access primary care in the community physicians’ office, commonly through a family or general practitioner, who is reimbursed on a fee-for-service basis.

Physicians’ fees account for 15% of overall healthcare spending, and in the 2011–2012 period these costs increased by 9% (Canadian Institute for Health Information, 2013). The most expensive form of remuneration for physicians’ services is fee for service; the overwhelming majority of physicians earn almost all their income in this way. Hutchinson, Abelson, and Lavis (2001) noted that “for the 89% of Canadian family physicians or general practitioners who receive some fee-for-service income, fee-for-service payments account for an average of 88% of their total income” (p. 117). Increasing criticism for this traditional and costly reimbursement model of primary care has led to some innovations over the past quarter century. However, these are often local in nature and have not resulted in a comprehensive nationwide model.

Primary care reform began at a national level and sought to move toward an integrated systems approach, which would more broadly provide the full spectrum of health services in communities or neighbourhoods. It was envisioned that health promotion and disease and injury prevention services would be enhanced as the focus shifted “upstream” with the implementation of primary health care.

In the early 1970s, community health centres (CHCs) were recognized for more “fully reflecting the objectives, priorities, and relationships which society wishes to establish for healthcare in the future” (Canadian Council on Social Development, Research and Development Branch, 1972, p. ii). An inquiry was commissioned to examine the place of CHCs as part of a plan aimed at restructuring healthcare delivery and funding mechanisms. Quebec introduced one of the first primary care reforms in the form of a model based on Centres Locaux de Service Communautaires (CLSCs). Philosophically, CLSCs are based on the ideal of a global, integrated system of care, delivering a broader, less-costly range of services (Hutchinson et al., 2001) to neighbourhoods across the province. In addition to providing primary care treatment, these local community service centres emphasized health promotion, disease prevention, and the provision of expanded services, including social services and mental health services (Shah, 2003).

In Ontario, CHCs focus on the determinants of health and provide interdisciplinary primary health care services, including health promotion, illness prevention, health protection, chronic disease management, and individual and community capacity building. There are 101 CHCs in Ontario, a number of them with satellite offices, each serving on average of 5 to 500 individuals. “Each centre is an incorporated, non-profit agency governed by a volunteer board of directors” (Ontario Ministry of Health and Long-Term Care, 2013).

The most recent primary care reform initiative of the Ontario government has been to establish family health teams (FHTs). Family health teams are composed of physicians, nurse practitioners, nurses, social workers, dietitians, and other professionals who work together to provide healthcare to a community. Each team is set up on the basis of local health and community needs, and focuses on chronic disease management, disease prevention, and health promotion, as well as on working with other organizations such as public health, home care, and hospitals. Since April of 2005, 184 teams have been created across the province, and this is expected to result in improved healthcare for over three million Ontarians. In 2011, the “Ontario Public Health Organizational Standards” was published, mandating that a chief nursing officer position be created in each Ontario health unit by 2013. Nurse practitioners (NPs) have contributed significantly to primary care reform and frequently practice in CHCs, FHTs, and primary health care centres. NPs are registered nurses with advanced education, and they provide a full range of services, including assessing, diagnosing, and treating illnesses (CNA, 2009).
22 Part One The Context of Community Health Nursing in Canada

NPs also focus on many health promotion and illness-prevention efforts. The Canada Health Act allows the provinces to establish reimbursement mechanisms for healthcare professionals other than physicians and dentists. Although all provinces and territories have enacted legislation that defines an extended scope of practice for NPs, only some provinces have established associated funding mechanisms for their reimbursement (Canada, House of Commons, 1984). New roles for NPs are emerging across Canada in response to specific needs and populations (CNA, 2009).

2. Public Healthcare

Whereas hospital and physicians’ services have been governed by federal legislation for the last half of the 20th century, public health was decentralized at the outset. Thus, across Canada, the responsibility for public health services rests with the provinces or territories and, in some cases, municipalities. The principles of comprehensiveness, universality, portability, public administration, and accessibility have been hallmarks of Canadian public health services. Public health augments medicare by ensuring that health promotion, illness and injury prevention, and health protection services are among the affordable, acceptable, essential health services that were “universally accessible to individuals and families in the community” (WHO, 1978). Together, Canada’s public health services and national healthcare system are providing health services that are consistent with the tenets of primary health care. There is limited evidence on the relationships among public health organization, funding, performance, and health outcomes (Hyde & Shortell, 2012).

However, the public health infrastructure in Canada has been severely eroded over the past several decades, and in 1996, the CPHA warned of the erosion by noting that in some jurisdictions, “public health units and specific categories of workers (e.g., public health nurses) are disappearing” (Canadian Public Health Association, 1996, pp. 1–12). In 2001, the CPHA identified “increasing complexity and decreased funding” as challenges facing public health (CPHA, 1996, p. 7). Sullivan (2002) reported on the key findings of the report of the Federal, Provincial, and Territorial Advisory Committee on Population Health that identified severe problems in public health in Canada, such as disparities among provinces and regions, severely inadequate and decreasing funding, critical human resource issues, and the development of public health policies without consideration of relevant data. There was consensus that the water contamination in Walkerton, Ontario, in 2000 was a “wake-up call” for Canadian public health and had occurred because “institutions vital to the infrastructure of public health were neglected” (Schabas, 2002, p. 1282). Funding of public health services depends, in large part, on provincial governance and delivery structures. Funds are distributed to regions and municipalities through various funding formulas.

The CPHA (2010a) proposed the development of a National Public Health Infrastructure Fund as a “transfer payment scheme dedicated to public health that demands a certain percentage of matching dollars from the provinces and territories.” The CPHA (2002a) reported on the key findings of the report of the Federal, Provincial, and Territorial Advisory Committee on Population Health that identified severe problems in public health in Canada, such as disparities among provinces and regions, severely inadequate and decreasing funding, critical human resource issues, and the development of public health policies without consideration of relevant data. There was consensus that the water contamination in Walkerton, Ontario, in 2000 was a “wake-up call” for Canadian public health and had occurred because “institutions vital to the infrastructure of public health were neglected” (Schabas, 2002, p. 1282). Funding of public health services depends, in large part, on provincial governance and delivery structures. Funds are distributed to regions and municipalities through various funding formulas.

The CPHA (2010a) proposed the development of a National Public Health Infrastructure Fund as a “transfer payment scheme dedicated to public health that demands a certain percentage of matching dollars from the provinces and territories.”

**CANADIAN RESEARCH BOX 2.2**

**Is equity in public health the same across the country?**


Under the Constitution Act, the provincial and territorial governments in Canada have responsibility for healthcare. Within that responsibility, these governments set the direction for public health programs and determine the funding levels. Recently, there have been calls for the renewal of public health systems in Canada to meet emerging issues, threats, and needs. A coordinated and collaborative approach among jurisdictions (municipal, provincial or territorial, and federal governments) has been identified as desirable. Standards have long been seen as a way to improve accountability and facilitate collaboration and co-operation. However, standards for public health are inconsistently developed across Canada. The development of standards has been influenced by many factors, including legislation, mandates, leadership, and history. Standards review and development has been used as a strategy for systems renewal.

This article reports on one part of a larger study that looked at the renewal of public health systems in Canada. Using document analysis, the researcher’s purpose was to gain insight into how and to what extent an equity lens is incorporated into public health standards and to specifically answer the question, “How is equity conceptualized and integrated into key public health documents in British Columbia and Ontario?” The research team of academic researchers and public health knowledge-user partners conducted an inductive content analysis of two sets of key standards documents from the two provinces. The method included the use of constant comparative analysis. A set of questions guided coding and analysis.

Despite several limitations to this study, it does provide insight into two provincial perspectives on health equity. There were similarities between the two sets of documents in the overall goals, how the issues were framed, and the need to look beyond public health and work intersectorally to address inequities. Differences were present in how an equity lens was used, the use of language and terms such as “vulnerable” or “marginalized,” and the legislation (or lack thereof) that supported the standards. An interesting finding was that both sets of documents did not include an analysis of the systemic factors that are contributing to the inequities.

**Discussion Questions**

1. Access the public health program or organizational standards in your health jurisdiction. Is health equity defined? If so, how is health equity described?
2. Do the standards provide guidance in terms of how equity is addressed in areas such as access to services, intersectoral collaboration, and the social determinants of health?
3. How do standards enhance accountability of organizations to their funders? Are they an effective strategy to increase accountability in the diverse world of today?
Chapter 2 FINANCING, POLICY, AND POLITICS OF HEALTHCARE DELIVERY 23

territories in order to ensure a stable level of funding for the public health system across the country” (CPHA, 2010a, p. 9). This funding model is in the context of accumulating evidence on the widening gap in health between populations and a recognition of the importance of addressing the determinants of health and advancing health equity for the health of all (Hosseinpoor, Stewart Williams, Itani, & Chatterji, 2012; National Collaborating Centre for Determinants of Health, 2014; National Collaborating Centre for Public Health, 2012; WHO, 2008). Public health organizations and workers are expected to provide leadership in health equity endeavours. See Chapter 4 for additional information on public health.

3. Home Healthcare

Health Canada defines home care as “a wide range of health services delivered at home and throughout the community to recovering, disabled, chronically, or terminally ill persons in need of medical, nursing, social, or therapeutic treatment and/or assistance with the essential activities of daily living” (Health Canada, 2010). “Home health nurses are committed to the provision of accessible, responsive, and timely care which allows people to stay in their homes with safety and dignity” (CHNC, 2010c, p. 4). The use of home care services has been steadily growing in Canada over the past 35 years; government spending on home care reached $3.4 billion in 2003–2004 (Canadian Institute of Health Information, 2007), and it is estimated that it was close to $4 billion in 2010 (Canadian Alliance for Sustainable Health Care, 2012).

These economic calculations are made difficult in Canada by a general lack of publicly available data that concisely report on public and private contributions made to deliver home care services. The most current data source for public spending on home health services and home support services across the country is 2003–2004 data from the 2007 report produced by the Canadian Institute for Health Information (CIHI) called “Public-Sector Expenditures and Utilization of Home Care Services in Canada: Exploring the Data.” These data will become more readily available as more provinces join the home care reporting system, which is part of the CIHI.

Accepted broadly as a vital component of the healthcare system, every jurisdiction in Canada provides publicly funded home care to its constituents (CNA, 2013). The vast majority of recipients of home care services in Canada are seniors, and as the population ages, the numbers are predicted to increase. Following an extensive process, the CNA recommended that governments shift their funding and policy emphasis to new community-based, integrated models of healthcare that enable Canadians to remain at home (CNA, 2013). These models must support integration with primary care and provide state-of-the-art home care.

The increase in use of and funding for home care has been attributed to several factors, most significantly the belief that services provided in the home are both less costly and a more desirable means of delivering necessary care. These claims, however, have yet to be proven. Another issue is that as the services shift to the home and community they shift beyond the boundaries of public insurance (Deber, 2003). All of the provinces offer a package of basic services, but there are significant provincial variations in the degree to which services are publicly funded versus privately financed. This results in significant inequity in accessing publicly funded home care across different regions of the country. Although the actual figure is difficult to verify, the CASHC calculated that private payment (a combination of out-of-pocket payment and private insurance coverage) for home care services in Canada was close to $2 million and represented approximately 23% of total home care expenditures in 2010 (Canadian Alliance for Sustainable Health Care, 2012). Thus, savings associated with the provision of services in the home versus in an acute care setting may not so much reflect an actual decrease in cost but rather a transfer of costs to patients and their families (Shah, 2003).

Nursing care, pharmaceuticals, and physiotherapy and occupational therapy services are some of the services that are being debated (Deber, 2003). Some provinces have legislation to address the financing and provision of home care services at provincial and regional levels (Public Health Agency of Canada, 2006). However, in the absence of national standards, legitimate concerns exist in relation to access to type, amount, and quality of home care services (Sullivan & Baranek, 2002). Adding to the concerns, home care is an expanding area of health spending in Canada. The share of home care spending in provincial and territorial government health expenditures in Canada rose from 3.1% in 1994–1995 to 4.2% in 2003–2004 (CIHI, 2007) and 5.4% in 2010. Even with this growth, spending on home care remains less than 5% of healthcare expenditure.

In all 13 provinces and territories, the ministries or departments of health and social or community services maintain control over home care budgets and funding levels. As part of regionalization, most provinces and territories have delegated the responsibility for service delivery decisions to the regional or local health authorities while maintaining control over policy guidelines, standards for regional service delivery, reporting requirements, and monitoring outcomes. For example, in British Columbia, Alberta, Saskatchewan, Manitoba, Newfoundland and Labrador, Nunavut, and the Northwest Territories, the delivery of home care services is devolved to local or regional health authorities. In Quebec, the services are provided through the local community service centres (CLSCs) or health and social services centres (CSSSs). In New Brunswick, the Extra-Mural Program (EMP), known by many as the “hospital without walls,” provides home health services through the regional health authorities. In Nova Scotia, home care service is offered through the continuing care offices in each District Health Authority. In the Yukon, the Continuing Care Division under the Department of Health and Social Services administers home care.

In Ontario, home care is provided through Community Care Access Centres (CCACs), which manage healthcare services to those at home, at work, or in school. In April 2014, the Ontario Ministry of Health and Long-Term Care committed to ensuring a “reliable, robust and accessible home and
community care sector,” acknowledging the growing demand for this type of service and the need for the services to provide better care for better value (Ontario Ministry of Health and Long-Term Care, 2014). In Ontario, funding for many components of the health system was transferred to the Local Health Integration Networks (LHNs), including funding for home care and the CCACs. Each is staffed by professionals, including nurses, who assess individual health needs, determine requirements for care, answer questions, and develop a customized health plan with the client. The range of professional services provided include nursing, physiotherapy, social work, dietetics, occupational therapy, speech therapy, personal support, and case management. Denton, Zeytinoglu, Davies, and Lian (2002) found that while there is increased demand for home care, there is a paucity of research on the impact of restructuring. The impact of the changing governance and organizational structures on the quality of care and on the workers (including nurses) requires investigation. Across Canada, home care services are delivered using several funding frameworks. While each of the models provides some element of streamlining (intake, assessment, referral, case management), the approaches to delivery of care, most significantly in the degree to which services are contracted out to private agencies (both for-profit and not-for-profit), vary. Within its healthcare budget, each region must decide how much is allocated to home care versus acute care services versus public health and health promotion services. Public funding for home care is allocated to home care organizations, which then coordinate and deliver home care services. While major budgetary decisions are made at the regional level, case managers are then required to make decisions at the individual or family level. Service providers, a mix of for-profit and not-for-profit agencies, compete for contracts to provide the required in-home services. This process allows private, for-profit agencies to profit from public funding earmarked for the delivery of health services. This new situation, sometimes referred to as “passive privatization,” has sparked significant debate and concern. A number of papers have challenged the competitive bidding process. While the expectation is that the competitive process will lead to efficiencies, it can result in downward pressure on wages, skill mix, and working conditions (Deber, 2003). The process by which service providers are obtained will have a significant impact on the quality of care individuals will receive. See Chapter 5 for additional information on home care.

CURRENT AND FUTURE CHALLENGES FOR COMMUNITY HEALTH NURSES

Over the past decade, there has been significant growth in research and literature that describes the current situation for CHNs across Canada. The literature points to the strengths CHNs bring to positively influence the health of individuals, families, communities, and society as a whole. It also paints a picture of numerous challenges, including health system challenges, lack of role clarity, need for strong leadership, and issues in interprofessional relationships.

Health System Challenges

Community health nursing practice occurs in a sociopolitical environment. Nurses’ ability to shape this environment, thus taking an active role in evolving healthcare so that it positively impacts the health of communities, is often met with multiple challenges and barriers. Despite numerous calls for strengthening primary health care (Romanow, 2002) and shifting toward community health and preventive care, an emphasis on illness care provided in institutions remains the current paradigm (Mahony & Jones, 2013). Inadequate funding and resources for disease prevention and health promotion remain an issue, and what exists is under constant and real threat. The lack of stable, long-term funding is cited as a major barrier to effective practice and service delivery (Dingley & Yoder, 2013; Underwood et al., 2009). CHNs themselves identify as priority items the need for advocacy and collective action to shape system change (CHNC, 2010a; CHNC, 2011a; Schofield et al., 2011).

Role Clarity

Despite its long and rich history, community health nursing is in a vulnerable position today. The CHNC conducted a survey in 2008 to establish a vision for community health nursing in the year 2020 in Canada (CHNC, 2009a; Schofield et al., 2011). This visioning initiative included a national survey and several focus groups that included CHNs in different regions across Canada. The resulting document, “Community Health Nursing Vision 2020: Shaping the Future” (CHNC, 2009a), contains the following expressions of how community nurses experience their roles:

I think public health nurses are undervalued by the community, by the consumer, by the nursing profession, by colleagues in different areas of nursing . . . people view it (community health nursing) as not really nursing, while it is really and truly the highest level of nursing that you’re going to do. (p. 9)

This undervaluing mirrors the diminished funding and resources of previous decades. Others have identified the relative invisibility of CHNs. Two such examples can be found in post-SARS national and provincial reports. Campbell’s report spoke generally of the public health system as “broken and need[ing] to be fixed . . . [T]he overall system is woefully inadequate . . . unprepared, fragmented, poorly led, uncoordinated, inadequately resourced, professionally impoverished and generally incapable of discharging its mandate” (Campbell, 2005, p. 24). Naylor (2003), in his report “Learning from SARS: Renewal of Public Health in Canada,” stated that, “the essential role of public health nurses throughout and following SARS received little attention” (p. 131).

Role clarity includes components such as shared common language to describe the role, working to the full scope of practice within the role, and an understanding of the role by others within the health system and the public. The ability to describe with confidence the CHN’s role can contribute to a greater valuing of it by other professionals, the community, and the policy makers. The need for greater role clarity for CHNs is consistently noted in the literature.
Chapter 2  FINANCING, POLICY, AND POLITICS OF HEALTHCARE DELIVERY

A national study of community health nursing using an appreciative inquiry process found three important organizational attributes that support community and public health nursing practice (Meagher-Stewart et al., 2009; Underwood et al., 2009):

- management practice;
- local organizational culture, which includes values and leadership characteristics; and
- government policy, including system attributes.

The results of surveys such as the ones identified above spur dialogue about options for action on the issues. One proposal is the development of a national centre of excellence for public health nursing with an initial mandate to “research and understand the best mix of staff, services, programs, and settings to achieve optimal outcomes for persons, families, communities and the health system” (CHNC, 2011a, p. 18–19). Development and support of strong and effective leadership for community health nursing is another important recommendation. Short residency programs for leadership development and the creation of a community of practice for leadership development are strategies that could be undertaken by a centre of excellence (CHNC & the National Collaborating Centre for the Determinants of Health, 2013).

CASE STUDY

Public Health Chief Nursing Officer Working Group Report (Ontario Ministry of Health and Long-Term Care, 2011b) Over the last two decades, discussions regarding the need for and establishment of designated nursing leadership roles in Ontario public health units have abounded. In February 2000, the then chief medical officer of health and provincial chief nursing officer endorsed the implementation of a chief nursing officer (CNO) position in each public health unit as a preferred model within the public health system and recognized it as a best practice (Bajnik, Peroff-Johnson, & Tober, 2012). In its May 2006 final report, the public health Capacity Review Committee recommended that the Ministry of Health and Long-Term Care “enforce the 2000 directive regarding the appointment of a senior nurse leader role in each health unit” (p. 19). In February 2011 the ministry issued the Ontario Public Health Organizational Standards (Ontario Ministry of Health and Long-Term Care, 2011a), which established management and governance requirements for all boards of health. These standards required that all 36 boards of health designate a CNO “to be responsible for nursing quality assurance and nursing practice leadership,” (p. 21) and within a year, all health units reported the appointment of a nurse in this role in their agencies.

The CNO mandate in the Ontario Public Health Organizational Standards (Ontario Ministry of Health and Long-Term Care, 2011a), with funding support, is aimed at enabling consistency in the designation, accountability,
26 Part One The Context of Community Health Nursing in Canada

role, and functions of CNOs. Through this position, health outcomes of the community at individual, group, and population levels will be enhanced through CNO contributions to organizational strategic planning and decision making; facilitating recruitment and retention of qualified, competent public health nursing staff; and enabling quality public health nursing practice. The CNO models, articulates, and leads the way toward a vision of excellence in public health nursing practice.

The first provincial meeting of all 36 CNOs, held in Toronto, resulted in the establishment of a Chief Nursing Officers Provincial Association for Ontario, with an executive that is elected and regionally representative, and the development of key strategic directions for the association. Activities are currently underway in each health unit to move forward nursing practice and leadership initiatives.

Discussion Questions
1. What factors would contribute to the provincial decision to establish CNO positions in each public health unit?
2. Within the first three years of initiating these positions, what key goals and activities will establish the effectiveness of this nursing leadership role?
3. As a new initiative, working within a province with over 2800 nurses (over 50% of all public health front-line staff), how might the CNO role impact the practice of nursing and improve the health of the province? How will they know if the goals of this initiative are successful?

Interprofessional Relationships The relationships nurses have with each other and with other professionals that enable them to achieve a common vision to deliver care and to strengthen the health system and those who are impacted by it are referred to as interprofessional relationships. Developing and strengthening these relationships, including intersectoral partnerships, is critical to achieving effective community health outcomes. The future success of CHNs and nursing in leading the health system—from individual client and family care to broad population health interventions—requires a focus on the significance of professional and client and community collaboration and partnership.

Nurses regard interprofessional and intersectoral partnerships as important, and foundational to effective partnerships is an understanding of the roles of healthcare partners and the contribution that each can make. Contributions include the ability to make or influence care and service decisions, implement organizational change, empower policy and administrative decisions, and develop educational curricula. Establishing positive and effective partnerships and processes for working together requires time, leadership, and mutual understanding.

ROLE OF LEADERSHIP IN RESPONDING TO CHALLENGES FOR CHNS

As described in the preceding sections, community health nursing in the current healthcare system faces significant challenges, but it also has many opportunities to make a significant difference. Leadership at all levels is required to realize the opportunities and address the challenges. Leadership is about influence that moves individuals, groups, communities, and systems toward achieving goals that will result in better health. While senior leaders occupy formal leadership positions, all CHNs have the opportunity within their practice to be leaders and have influence. Leadership is proposed as a strategy for all CHNs to embrace and develop.

While the key attributes of leaders have been articulated (Ganann et al., 2010), awareness of oneself is of key importance. Developing insight into one’s beliefs, strengths, weaknesses, and style of relating is fundamental to effective leadership. Leadership occurs within relationships, so understanding the impact of one’s behaviour on others and being able to moderate and modify that behaviour or style are essential to effectively steering people and organizations toward a vision (Willcocks, 2012). Creating and articulating a clear purpose and vision is critical, and to do that effectively, CHNs must be able to see the long view, incorporating multiple aspects of the communities, political environment, and the larger health and social systems. Conceptualizing oneself such that leadership is seen as a dimension of practice for all nurses is important to building leadership capacity in community health nursing (Scott & Miles, 2013).

Strategic thinking and action as well as hearing the perspectives or voices of others, including staff, other sectors, and members of the community, must be evident in the vision. Multiple perspectives must be taken into account. The ability to lead others involves the ability to engage their hearts, minds, and feet through expertise in building, sustaining, and sometimes mending relationships. Strong problem solving, conflict management, and interpersonal skills promote emotional engagement and foster motivation. Leaders understand their role in developing a team or organizational culture and do so in a deliberate, intentional fashion, grounded in clear, strong values and principles, which encompass respect, trust, honesty, and integrity.

An effective leader not only copes with change but also understands change and the change process (Cummings et al., 2008). Effective leaders bring energy, enthusiasm, action, and humour to the process and to the tasks at hand while keeping a focus on the desired results (Brody, Barnes, Ruble, & Sakowski, 2012; Cummings et al., 2010). The literature does not identify people from any single discipline as having superior leadership skills but rather each brings a unique set of perspectives, experiences, knowledge, skills, and attitudes that can be used to develop effective and collaborative leadership.

The outcomes of leadership have been described extensively. One such document is the Registered Nurses Association of Ontario’s (RNAO’s) “Best Practice Guideline: Developing and Sustaining Nursing Leadership” (RNAO, 2013), which
Chapter 2  FINANCING, POLICY, AND POLITICS OF HEALTHCARE DELIVERY

27

discusses the significant impact of leadership in the workplace and community. For example, professionals working in health service organizations with strong leadership demonstrate increased organizational commitment, higher levels of organizational effectiveness, greater sense of affiliation with organizational goals, and increased ability to lead a diverse workforce.

Personal resources for nurse leaders in a community health setting that contribute to effective leadership practice include the personal characteristics one brings to a leadership role, as well as personal supports, learned behaviours, and expertise (knowledge and skills) that has been honed over time. Personal growth is dependent on individual self-awareness and understanding of how your behaviour influences those around you, as well as events in an organization and in the broader community. As community health work is so interconnected with organizations and political bodies, self-awareness and self-concept are critical to effectively influence or lead within these systems (Cummins et al., 2010).

Research completed through the development of the best practice guideline on nursing leadership (RNAO, 2013) found that the following attributes of nurse leaders contribute to effectiveness:

- communication and listening;
- resilience, persistence, and hardiness;
- comfort with ambiguity, uncertainty, and complexity;
- willingness to take risks;
- working from a foundational moral framework;
- confidence in own values and beliefs;
- self-confidence, self-awareness, social awareness;
- knowledgeable; and
- cultivation of professional and personal supports.

A conceptual model (see Figure 2.1) identifies contextual and personal factors that impact a nurse’s approach to transformational leadership (Weberg, 2010). The model outlines individual and system components that contribute to effective nursing leadership (RNAO, 2013). For example, a nurse leader who strongly values professional nursing supports will approach relationship building in a way that is more likely to result in healthy and effective outcomes than a nurse leader who values individual successes and works alone in a chaotic environment where budgets are unstable. Leadership growth builds on organizational supports, personal resources, and past outcome experiences.

Organizational Supports

An organizational assessment tool is contained in Table 2.1. This tool can be used to assess organizational supports to leadership and invite reflection and dialogue on local and larger systems. It builds on the leadership conceptual model, particularly the components of organizational support, and provides a series of activities that leaders may champion as essential to ensuring effective and healthy work environments. These strategies (left column) support a focus on developing personal resources as well as on assisting managers and leaders (right column) to develop system-wide infrastructure. The individual strategies focus on the community health nurse as an individual who is growing within his or her discipline. The strategies highlight formalized communication networks, broader community partnerships, and meaningful involvement of staff in organization and agency decision making. As leaders of organizations, it is important to continually assess the current strategies to ensure

![Figure 2.1 Conceptual Model for Developing and Sustaining Leadership](source)

Table 2.1  Organizational Supports

<table>
<thead>
<tr>
<th>A. Employee Development/Enrichment</th>
<th>Yes</th>
<th>No</th>
<th>B. Community Health Organization</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Employee retention plan</td>
<td></td>
<td></td>
<td>1. Clear connection between agency vision, mission, mandate, and service delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Recruitment and succession plan</td>
<td></td>
<td></td>
<td>2. Articulated cultural vision and implementation plan to support workplace environment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Orientation and mentoring program for all new and transferring staff</td>
<td></td>
<td></td>
<td>3. Committee/planning structures, which include all levels of staff in a meaningful way</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Regular performance feedback mechanisms that include a variety of inputs (e.g., manager, peer, client, colleague, community partner)</td>
<td></td>
<td></td>
<td>4. Stable and predictable funding resources dedicated to a systematic organizational review (e.g., accreditation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Personal learning plans/professional development plans</td>
<td></td>
<td></td>
<td>5. Clear boundaries/program mandates with flexibility to address realities of individual community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Employee satisfaction feedback systems and a process for addressing outcomes</td>
<td></td>
<td></td>
<td>6. Opportunities to nurture discussions on relevant research and practice changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Continuing supportive education policies</td>
<td></td>
<td></td>
<td>7. Encouragement to engage with communities and form joint ventures and partnerships</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Staff education and training opportunities that include development of affective domain (i.e., values, assumptions, feelings)</td>
<td></td>
<td></td>
<td>8. Opportunities for disciplines to work together based on collaborative practice principles</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Leadership development plan</td>
<td></td>
<td></td>
<td>10. Formalized agreements with the academic community, which include cross-appointments, joint research, and student clinical experiences</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Opportunities for communities of practice to meeting together regularly</td>
<td></td>
<td></td>
<td>11. Infrastructure support—technical, informational, health and safety, media, communication</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Appreciation/acknowledgement events where achievements are recognized (department, team, individual)</td>
<td></td>
<td></td>
<td>12. Mechanisms for regular meetings with unions and other associations</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Development and role modelling aimed at mid-career nurses and late-career nurses</td>
<td></td>
<td></td>
<td>13. Quality practice council(s)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Infrastructure support—technical, informational, health and safety, media, communication</td>
<td></td>
<td></td>
<td>14. Formalized communication mechanisms (e.g., all-staff meetings, newsletter, bulletin board, department updates) to engage staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Well-established networks within the organization and with key community organizations</td>
<td></td>
<td></td>
<td>15. Well-established networks within the organization and with key community organizations</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


that effective individual and organizational systems are in place to achieve excellence in practice and outcomes.

Within the context of community health nursing practice, important organizational supports that positively influence practice include the a work culture that

- values the unique and combined contribution of staff,
- deliberately establishes leadership and mentoring plans,
- has a clear vision engendering commitment, and
- has stable funding and access to necessary resources to accomplish work.

Collaborative leadership at a national level will be strengthened by developing intersectoral relationships, promoting community health solutions across sectors, and addressing the wider determinants of health (PHAC, 2006). Mentoring is consistently identified as contributing to leadership development (Cooper & Wheeler, 2010).
CONCLUSION

To varying degrees, the federal, provincial, territorial, regional, and municipal levels of government are involved in Canadian healthcare. Medicare is one of the great achievements of Canada and it is more than a public insurance program (Campbell & Marchildon, 2007). A universally accessible, publicly funded, not-for-profit healthcare system is steeped in Canadian values and embraced by the Canadian public. Efforts to enshrine those values in federal legislation began as early as 1919. The present legislation, the Canada Health Act, is limited in that its principles of public administration, portability, accessibility, universality, and public administration apply only to essential medical and hospital services. Nevertheless, the publicly funded and largely privately delivered healthcare system has served Canadians well with respect to both health outcomes and cost-effectiveness (Starfield, 2010).

Pressures to reform medicare have come about not only because of its narrow focus on hospital and medical services but also because some favour augmenting the public system with services provided by the for-profit sector. Numerous reports at the provincial or territorial and federal levels have recommended reforms to the healthcare system. The most comprehensive of those, the Romanow Commission Report, made 47 recommendations for both the immediate future and for the next 20 years (Romanow, 2002).

The federal government has played a leadership role, not only in Canada but also in the world, in health promotion policy. However, a coordinated approach to implementing health promotion policy at the community and population levels has been hampered by the lack of a national public health plan. Prior to the SARS outbreak in 2004, there had been a steadily declining emphasis on the role of community health in the Canadian health system, in large part due to the exclusion of community health from the Canada Health Act. Restructuring of provincial health systems to regional models that include community health services. Nevertheless, the publicly funded and largely privately delivered healthcare system has served Canadians well with respect to both health outcomes and cost-effectiveness (Starfield, 2010).

Pressures to reform medicare have come about not only because of its narrow focus on hospital and medical services but also because some favour augmenting the public system with services provided by the for-profit sector. Numerous reports at the provincial or territorial and federal levels have recommended reforms to the healthcare system. The most comprehensive of those, the Romanow Commission Report, made 47 recommendations for both the immediate future and for the next 20 years (Romanow, 2002).

The federal government has played a leadership role, not only in Canada but also in the world, in health promotion policy. However, a coordinated approach to implementing health promotion policy at the community and population levels has been hampered by the lack of a national public health plan. Prior to the SARS outbreak in 2004, there had been a steadily declining emphasis on the role of community health in the Canadian health system, in large part due to the exclusion of community health from the Canada Health Act. Restructuring of provincial health systems to regional models that include community health has played a role as community health issues or root causes of illness if the current healthcare system is to be sustainable. Demands on limited home health and primary health care nursing services with the rest of the system. Serious erosions to the public health system in Canada have led to the withdrawal and reduction of many public health nursing services and CHN presence in key settings such as schools, community places, and workplaces.

Community health nurses practice at the intersection of public policy and private lives and are thus in a position to include political advocacy and efforts to influence healthy public policy in their practice (Falk-Rafael, 2005). The call for a revitalized public health and community health system is being made. Strong leadership and action at all levels is required to answer this call. CHNs are well positioned and, in fact, morally obligated to act and provide leadership (Falk-Rafael, 2005).

KEY TERMS

- accessible, p. xx
- Canada Health Act, p. xx
- Canadian Nurses Association CNA, p. xx
- comprehensive, p. xx
- determinants of health, p. xx
- health promotion, p. xx
- home care, p. xx
- interprofessional relationships, p. xx
- leadership, p. xx
- medicare, p. xx
- Ottawa Charter, p. xx
- portable, p. xx
- primary care, p. xx
- primary health care, p. xx
- public health, p. xx
- public health systems, p. xx
- publicly administered, p. xx
- universal, p. xx

STUDY QUESTIONS

1. Identify the origins of medicare in Canada and summarize the laws that created the present Canadian healthcare system. What is considered to be phase 2 of the implementation of medicare?
2. Discuss the events that led up to and necessitated passage of the Canada Health Act.
3. What role did organized nursing play in the passage of the Canada Health Act?
4. Discuss the federal and provincial responsibilities for health according to the Canadian Constitution Act.
5. Contrast the funding mechanisms for public health and home health nursing services with the rest of the system.
6. Describe how the Canada Health Act was or was not successful in achieving the intended goals. Are there issues with it?

After working through these questions, go to the MyNursingLab at www.pearsoned.ca/mynursinglab to check your answers.

INDIVIDUAL CRITICAL-THINKING EXERCISES

1. List your core values for healthcare in Canada. How do your values compare with the values reflected in the five key funding criteria described in the Canada Health Act (1984)?
2. How would your life be different if healthcare in this country were provided based on ability to pay rather than need?
3. This chapter has shown that health policy decisions leave a legacy for generations. Describe briefly one policy revision you would make in the areas of primary care/primary health care, public health, and home care.
4. What examples can you describe of nurses’ work to bring about healthcare systems change?
5. What opportunities have you encountered to promote the second phase of medicare development?
6. Leadership development is an ongoing process. What ideas do you have to develop your leadership skills and knowledge?

GROUP CRITICAL-THINKING EXERCISES

1. What are the values on which the healthcare system is founded? How do your own values fit with the societal values that are reflected in the five funding criteria described in the Canada Health Act (1984)?
2. What are some of the solutions that you and your group can generate to address the real issues in Canada’s healthcare system? What role can community health nurses play?
3. In an ideal world, create a healthcare system designed to provide the best care, to the most people, in the most cost-effective manner. Describe the mechanisms for financing, allocation, and delivery. Compare and contrast this system with the current Canadian system.

REFERENCES


Chapter 2  FINANCING, POLICY, AND POLITICS OF HEALTHCARE DELIVERY


32 Part One The Context of Community Health Nursing in Canada


Chapter 2  FINANCING, POLICY, AND POLITICS OF HEALTHCARE DELIVERY  33

health nursing vision for 2020: Shaping the future. Western Journal of Nursing Research, 33(8), 1047–1068.


ABOUT THE AUTHORS

Claire Betker, RN, MN, PhD (c), CCHN(C), has worked in community health for more than 30 years at the local, regional, provincial, and national levels in mental health, home health, primary health care, and public health. Most recently she was the senior knowledge translation specialist with the National Collaborating Centre for Determinants of Health. Claire has been very involved with the Community Health Nurses of Canada in Manitoba and nationally, participating in several standing committees and serving as president. Claire served on the board of directors of the Canadian Nurses Association as the representative for the Canadian Network of Nursing Specialties. In 2010, Claire was awarded the Canadian Public Health Association and the Public Health Agency of Canada’s Human Resources Individual Award for her contribution to public health workforce development in Canada. She is currently a PhD student at the University of Saskatchewan, where her interest is in theory and its contribution to public health nursing practice and leadership development.

Diane Bewick, RN, BScN, MScN, DPA, CCHN(C), has extensive experience working in community health. She is currently the director of family health services and the chief nursing officer with the Middlesex-London Health Unit in Ontario. Diane has been an active member of numerous boards and commissions such as the Registered Nurses Association of Ontario (RNAO) expert panel developing the Leadership Best Practice Guideline, the Canadian Nurse Practitioner Initiative Advisory Panel, and the Ontario Public Health Association (OPHA). Diane is an assistant professor in the Faculty of Health Sciences at the University of Western Ontario and is the recipient of the Sigma Theta Tau Leadership Award (Nursing Honour Society). She is currently working with others to strengthen community health nursing leadership nationally, including developing a centre for public health nursing excellence.
Appendix 2A
Funding for Health Services for First Nations and Inuit in Canada

ROSE ALENE ROBERTS

First Nations and Inuit Health Branch (FNHIHB), a branch within Health Canada, is responsible for the delivery of health services in First Nations and Inuit communities. Services are federally funded and regionally managed. FNHIHB is divided into seven regions (Atlantic, Quebec, Ontario, Manitoba, Saskatchewan, Alberta, and British Columbia) that roughly correspond to the provincial boundaries. The Atlantic region includes all four Atlantic provinces. The Yukon, Northwest Territories, and Nunavut are overseen by the northern secretariat.

FNHIHB regions are separate, parallel structures to the HC regional offices that exist in each region. Authority is decentralized, and each region has a unique organizational structure and relationship to its First Nations (FN) constituents. The majority of the First Nations and Inuit (FN/I) communities manage their own healthcare services in whole or in part. In the remainder, the non-transferred, community-based health services are managed by the regional office.

FN people are Canadian citizens and as such, have access to provincially and territorially funded health services that fall under the Canada Health Act, 1984. Aboriginal people, who include the Métis and Inuit, are included in the per capita allocations of federal funding that are transferred to the provinces for “medically necessary” health services. However, FN communities (legally known as “reserves”) below the 60th parallel are on federal, or Crown, land. For this reason, the federal government has historically funded public health and primary health care services on reserves. “North of 60” Aboriginal people comprise most of the population of the Canadian territories, reserves are largely absent, and health services for Aboriginal people are completely integrated into the health and social services systems.

Indian Health Policy, 1979

The Federal Indian Health policy is one of the cornerstones of current policy regarding FN people and the Canadian government. The Indian Health Policy of 1979 stated that it was based on the special relationship of the FN people to the federal government and to the Crown (First Nations and Inuit Health, 2005). This relationship is committed to addressing access issues and health disparities that exist for this specific population.

Policy (including health policy) for federal programs for FN people flows from constitutional and statutory provisions, treaties, and customary practice. It also flows from the commitment of FN people to preserve and enhance their culture and traditions. It recognizes the intolerable conditions of poverty and community decline, which affect many communities, and seeks a framework in which communities can remedy these conditions.

The federal government recognizes its legal and traditional responsibilities to Aboriginal populations and seeks to promote the ability of Aboriginal communities to pursue their aspirations within the framework of Canadian institutions (First Nations and Inuit Health, 2005).

Many First Nations communities exhibit conditions that are comparable with the level of poverty and community decline present in many rural and remote parts of Canada. Combined with this economic disadvantage are cultural isolation and the effects of a colonial past. For this reason, addressing the determinants of health is a key feature of federal policy for FN communities. Thus, the Indian Health Policy of 1979 noted that improving the level of health in FN communities is founded on three pillars, including the following:

- community development (socioeconomic, cultural, and spiritual) to remove the conditions of poverty and powerlessness that prevent the members of the community from achieving a state of physical, mental, and social well-being;
- the traditional relationship of the FN people to the federal government, in which the federal government promotes the capacity of FN communities to manage their own local health services; and
- the Canadian health system, consisting of specialized and interrelated services funded by federal, provincial, or municipal governments, FN bands, or the private sector.

The federal government role lies in public health activities on reserves, health promotion, and the detection and mitigation of hazards to health in the environment. The most significant provincial and private roles are in the diagnosis and treatment of acute and chronic diseases and rehabilitation services (First Nations and Inuit Health, 2005). In 1989, the “Treasury Board approved authorities and resources to support the transfer of Indian health services from Medical Services, Health and Welfare Canada (now Health Canada) to First Nations and Inuit wishing to assume responsibility” (First Nations and Inuit Health, 2005). This “transfer process” (also called the “transfer initiative”) permits health program control to be assumed at a pace determined by the community—that is, the community can assume control gradually over a number of years through a phased transfer;
- enables communities to design health programs to meet their needs;
- requires that certain mandatory public health and treatment programs be provided; and
- strengthens the accountability of Chiefs and Councils to community members.
Further, the transfer process

- gives communities the financial flexibility to allocate funds according to community health priorities and to retain unspent balances,
- gives communities the responsibility for eliminating deficits and for annual financial audits and evaluations at specific intervals,
- permits multi-year (three- to five-year) agreements,
- does not prejudice treaty or Aboriginal rights,
- operates within current legislation, and
- is optional and open to all FN communities south of the 60th parallel (First Nations and Inuit Health, 2005).

**Community Types**

In order to better allocate resources, communities have been classified according to their degree of access to provincial or territorial health services. For example, a remote, isolated community may require professional nursing services on a 24-hour-a-day, seven-day-per-week basis. However, funding for these services also depends on community size:

- **Type 1: Remote-Isolated**:
  - No scheduled flights, minimal telephone or radio services, and no road access.
- **Type 2: Isolated**:
  - Scheduled flights, good telephone services, and no year-round road access.
- **Type 3: Semi-Isolated**:
  - Road access greater than 90 km to physician services.
- **Type 4: Non-Isolated**:
  - Road access less than 90 km to physician services.

Remote, isolated communities of fewer than 200 people may have only a lay community health representative (CHR) on site, who consults with a community health nurse in a neighbouring community nursing station. Alternatively, a nurse may visit for one or more days a month. Larger centres may have a nursing station with two or more nurses. Nurses in these settings function in an expanded role and provide essential public health, primary care, and physician and pharmacist replacement services on a 24-hour-a-day, seven-day-per-week basis. Larger, less-isolated communities have community health centres that provide more typical public health and primary care services during standard business hours. A physician may visit on a regular basis or clients are referred out for doctor visits. Rarely, a community health centre may provide expanded role nursing services after hours. In both cases, FNIHB's Non-Insured Health Benefits (NIHB) program provides funding for medical transportation for the community member to visit a doctor or a hospital, when required.

**Other Federally Funded Programs**

Health Canada currently funds 52 National Native Alcohol and Drug Abuse Program (NNADAP) treatment centres with approximately 700 beds (First Nations and Inuit Health, 2013b) and 10 National Youth Solvent Abuse Programs (NYSAP) with an additional 120 beds (First Nations and Inuit Health, 2005). NNADAP provides over 350 programs including prevention, intervention, and aftercare activities. Over 700 workers, the majority of whom are First Nations and Inuit, are employed by NNADAP (First Nations and Inuit Health, 2013). Health Canada provides funding under its category of family health for early childhood development through its Head Start Programs, both on and off reserve, a children's oral health program, and fetal alcohol spectrum disorder (FASD) programs. There are also targeted programs for diabetes, HIV/AIDS, influenza, tuberculosis (TB), and West Nile virus (First Nations and Inuit Health, 2013a). Many of these programs are allocated to the communities on a per capita basis, which can result in very small sums for tiny communities.

Other government departments and branches provide funding to FN/I communities, which contributes to addressing determinants of health. FNIHB and Aboriginal Affairs and Northern Development Canada (AANDC) jointly resource on-reserve water quality; FNIHB is accountable for monitoring and testing, and AANDC is responsible for infrastructure. For the years 2007–2013, an amount of $234 million was allocated to support infrastructure, such as roads and bridges, energy systems, planning and skills development projects, and solid waste management (Aboriginal Affairs and Northern Development Canada, 2013). AANDC is responsible for housing and community-based education. The office of the Solicitor General funds community policing or support from the Royal Canadian Mounted Police. Human Resources Development Canada has an Aboriginal division that works with FN/I communities on strategies to improve access to trades.

In these ways, the federal government attempts to address the determinants of health, while FNIHB ensures access to community-based health services and supports community development.

**REFERENCES**


