

THE CANADIAN  
ASSOCIATION OF  
OPTOMETRISTS



L'ASSOCIATION  
CANADIENNE DES  
OPTOMÉTRISTES

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234 Argyle Avenue, Ottawa, ON, K2P 1B9, Canada Toll-free: (888) 263-4676 Local: (613) 235-7924  
Fax: (613) 235-2025 E-mail: [eyedocs@opto.ca](mailto:eyedocs@opto.ca) Web Site: [www.opto.ca](http://www.opto.ca)

## **INSIGHT – VISION FOR THE FUTURE OF HEALTH CARE IN CANADA**

**A BRIEF SUBMITTED TO THE COMMISSION ON  
THE FUTURE OF HEALTH CARE IN CANADA**

**BY**

**THE CANADIAN ASSOCIATION OF  
OPTOMETRISTS**

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## 1. INTRODUCTION

The Canadian Association of Optometrists is pleased to contribute recommendations on the future of Canada's health care system. We intend to identify both system wide issues and more specifically issues related to eye health and eye health care services. We believe that optometrists can provide meaningful recommendations on improving the eye health of Canadians, ensuring high quality visual health care services and contribute to the efficiency and sustainability of the health care system. We look forward to Commissioner Romanow's response to our input in his interim report in January 2002.

### 1.1 THE CANADIAN ASSOCIATION OF OPTOMETRISTS (CAO)

CAO is the national professional association that represents Doctors of Optometry in Canada. It was founded in 1941 and is currently a federation of ten provincial associations of optometrists representing over 3,400 members. The mandate of CAO includes federal government relations, public relations, professional development, education, research and human resource analysis. CAO works diligently with other national professional groups to improve collaboration and cooperation on matters of health. CAO is a member of the Health Action Lobby (HEAL) and at the international level CAO represents Canadian optometrists in the World Council of Optometry (WCO).

In order to meet its mandate CAO engages in a number of activities including publications, public and professional education, conferences etc. in support of high quality delivery of optometric vision and eye care to all Canadians regardless of where they live (Appendix I).

### 1.2 THE ROLE OF OPTOMETRISTS IN HEALTH CARE

Doctors of Optometry are primary health care providers who specialize in the examination, diagnosis, treatment, management, and prevention of diseases and disorders of the visual systems, the eye and associated structures. They serve as primary contact health care practitioners who provide care to people who suffer inadequate vision. Optometrists are educated and licensed to determine the health status and functional capability of the visual system, including the quantitative and qualitative evaluation of the refractive, accommodative, ocular-sensory-motor and perceptual components of the visual apparatus. Optometrists are trained to employ a spectrum of pharmaceutical agents in their diagnostic and therapeutic procedures. Optometrists play an active role, along with physicians and other health care professionals, in the co-management of vision and eye care problems of patients.

Optometrists are ideally situated to provide primary vision health care as they are widely distributed across Canada in urban, rural and remote areas. As primary health care providers they assume responsibility for prevention, health education,

health promotion, health maintenance, diagnosis, treatment and rehabilitation, counseling and consultation. Details about the specific activities of optometrists in these 8 areas of primary care as well as a description of the university preparation of doctors of optometry are attached as Appendix II. Given the underutilized potential contribution of optometry to the vision health of Canadians, the remainder of this brief will address the current obstacles, barriers and biases that undermine access to optometric eye care for Canadian families. The issues and recommendations will be addressed under the four themes identified by the Commission.

## **2. CANADIAN VALUES**

The principles of the Canada Health Act, universality, accessibility, comprehensive, portability, and public administration were in part based on core values held by the Canadian public. These values included fairness, sharing and support of the public good. Translated into our health system they represent universal access to comparable health services based on need not the ability to pay. CAO supports these values and strongly believes that access to care must be timely and available to all Canadians.

### **2.1 THE CANADA HEALTH ACT (CHA)**

Poll after public poll confirms that Canadians are committed to a publicly funded health care system. Most Canadians, however, are unaware of what health services are included under the Canada Health Act until they actually require those services. Today less than 50% of health care services are included under the Act. This fact has led the public and providers of health care to express repeated concerns about the current state of health care in Canada.

The Canada Health Act funds most services provided by physicians and hospitals. In the past few years, however, the trend has been to curtail hospital care and devolve many services to the community and family. Many other health care professionals besides physicians also provide “medically necessary” services, the vast majority of which are not insured under the Act. The continued funding of only physicians and hospital services, therefore, no longer meets the continuum of health care needs of Canadians. As services have increasingly shifted to the community, the need for home care services and pharmacare programs for drugs that were traditionally covered in hospitals has increased. As the population ages, the demands for long term care are rising. The interpretation of comprehensiveness must be revisited and the term “medically necessary” health services redefined to meet the realities of today. Some have suggested changing the principles of the CHA while others have suggested abandoning it altogether. There has been little political incentive to address these issues because of the public’s continued strong commitment to the basic principles of the CHA. Also, to abandon the CHA at the present time, without a clear vision and direction for a new legislative framework, would add to

an already untenable situation. To date, many policy organizations and scholars have examined the CHA and there is no consensus on how the Act should be changed or how the principles should be redefined. Nor is there agreement on what a new legislative framework would look like. The new reality suggests that if we consider health as more than the absence of disease, then the definition of “health necessary” services would be a more accurate description of our approach to comprehensiveness. The CAO believes that a new legislative framework could be developed within the existing CHA or through parallel or companion legislation. Whatever approach is taken, it must be framed by a vision, clear objectives and goals. The process must also be based on evidence, the values of Canadians and future health care needs. It is therefore recommended that:

**Federal, provincial and territorial governments in collaboration with all health stakeholders engage in a process to develop a legislative framework to address the current limitations of the CHA.**

## 2.2 EYE CARE

One area of health care which we believe clearly demonstrates one of the current problems with the health care system is the field of eye care. Canadians place a high value on their ability to see. A recent poll conducted in Alberta for the Canadian National Institute for the Blind (CNIB), revealed that more than 74% of Albertans aged 40 years and older, feared blindness more than any other health condition<sup>1</sup>. Poor vision can lead to a host of serious problems for young and old. Children with impaired vision are seriously disadvantaged from the normal course of learning. More importantly, if visual impairment is undetected, they may develop irreversible learning disabilities which will affect them for the rest of their lives<sup>2</sup>. Adults with imperfect or uncorrected visual problems may develop difficulties in work related activities making them vulnerable to loss of productivity or loss of employment. Poor vision may also lead to a significant increase in work and non-work related accidents. After the age of 40 years sight deterioration is almost inevitable, although in most cases treatable with properly prescribed vision aids. Serious bilateral visual impairment including blindness is estimated to affect 8% of people over the age of 65. Furthermore, a recent study of seniors found a strong positive correlation between impaired vision and risk of falling.<sup>3</sup> These findings have serious implications for quality of life in the growing elderly population in Canada and in establishing our priorities for the delivery of health care services.

The impact of impaired vision on quality of life, the personal, social and financial burden, as well as loss of productivity are immeasurable. However, the costs incurred as a result of visual disability are very difficult to quantify. In fact there are essentially no published data about the financial impact of eye disease/disorder in the Canadian health care system. For actual blindness it is

roughly estimated that the cost is in the neighborhood of \$1 billion dollars<sup>4</sup>. However, this number is a gross underestimation as it only takes into account the CPP disability pension and is based on the number of documented legally blind clients registered with CNIB. It is possible according to CNIB that only about 50% of legally blind Canadians are actually registered. Given the priority of Canadian values for a publicly funded health care system and the value placed on eye health, it is recommended that:

**Eye care be considered an integral part of health care and covered by the Canada Health Act**

Further, in order to understand the cost and burden of eye disease/disorder it is recommended that:

**The Canadian Institute of Health Information take a lead role in collaboration with federal, provincial and territorial governments and eye health care professionals, the CNIB, the National Coalition for Vision Health and other key stakeholders in developing national data on the prevalence and costs of eye disease.**

### 2.3 ACCESS TO HEALTH CARE

Over the past few years there have been frequent, regular reports in the media about lengthy delays in accessing health care. Health researchers and government staff have conducted numerous studies trying to understand the causes and recommend solutions. Some argue that delays are due to a shortage of physicians and medical specialists. However, we believe the access conundrum is directly a result of the funding restrictions of the Canada Health Act which, as already mentioned, covers only physician services and hospital based care. This has led to inappropriate and over utilization of physicians. The public's freedom of choice of health care provider is compromised because other equally qualified professionals are not funded.

In the case of primary eye health care, this dilemma is particularly obvious. Coverage of optometric diagnostic services varies from province to province, but the vast majority of Canadian adults are not covered. This funding inequity leads patients to over utilize highly specialized ophthalmologists or their family physicians. Ophthalmologists are limited in numbers and located primarily in urban centers, hence creating long delays in access and requiring many Canadians to travel some distance for service. More importantly, it is not particularly appropriate use of these specialists to provide routine diagnostic services when their time and expertise is in high demand for more specialized procedures and care. Similarly, the utilization of family physicians to provide eye examinations is questionable. While family physicians have general knowledge of the visual system, they are not specialized in this area.

Many groups have advocated that using the right provider, for the right services, at the right time in the right place would go a long way to improve access to health care. Certainly optometrists provide high quality eye care, are properly equipped, are geographically dispersed, and are more cost-effective and accessible. A recent study conducted in California found that optometrists provided primary eye care at the same level of competence as ophthalmologists and at a higher level than primary care physicians. Optometrists in California have prescriptive authority. The study also analyzed cost effectiveness and concluded that the utilization of optometrists would result in annual savings to the public in excess of 30 million dollars solely for the treatment of common eye irritations<sup>5</sup>. Including timely optometric primary eye care services as an insured service would not only improve access but may prevent serious vision loss with its concomitant human and financial burden. It is therefore recommended:

**That health care funding be patient-centered, covering the service required not the provider or the site.**

The principles and conceptual framework of primary health care as opposed to primary physician care have the potential to solve many of the current problems in Canadian health care. Primary health care reform would see all health care professionals being at the front line of service, practicing to their full scope. It would immediately improve access for patients, reduce the over-utilization of physicians, improve the quality of care and reduce overall costs. This in turn would create increased efficiency of tertiary and quaternary services where there is still an attempt to offer primary and secondary care. Primary health care reform would encompass an increased emphasis on health promotion and disease prevention thereby decreasing the financial and human burden on illness care. The benefits of primary health care reform have been promoted by many groups including the National Forum on Health Care<sup>6</sup>. While this concept has been recommended to governments for many years, these changes require a renewed political will and leadership to implement. CAO recommends that:

**Multi-disciplinary primary health care service delivery models be established accompanied by appropriate structural and funding mechanisms.**

### **3. SUSTAINABILITY**

In recent years there has been growing concern among all Canadians that our publicly funded health care system will not be sustainable. While much of this concern is related to financial issues there are other areas which need to be addressed such as human resources and policy and legislative changes to provide for an integrated, evidence based, health system across the continuum of care.

### 3.1 FINANCIAL

Federal contributions for health care in the form of cash transfers to provinces, were significantly reduced in 1991. This was followed by the unilateral introduction of the Canada Health and Social Transfer (CHST) in 1995. In order to cope with the financial impact of reduced federal funding for health care, provinces engaged in a variety of activities to reduce the costs of health care. Hospitals were closed, merged and various services amalgamated. Cloaked under the banner of health care reform, considerable downsizing has occurred. The impact has been devastating on patients, health care providers and working conditions. The relations between federal and provincial/territorial governments have deteriorated to an abysmal state, making it almost impossible for governments to work together to find solutions. This environment of federal/provincial hostility has led to an unstable health care system and has sparked a significant lack of public confidence in government's ability to restore the system<sup>7</sup>.

The CAO believes that all levels of government have a role to play in funding health care and while some federal funding has been restored, much more clarity is required to move forward. In order to stabilize the system and move forward with intelligent reform, the funding of health care must be more explicit, adequate, stable and predictable. It is therefore recommended that:

**The federal government provide an immediate increase to the cash floor of the CHST (planned for 2002).**

**The level of the federal contribution to health care be significant enough to underscore its roles and authority in health care.**

**Federal/provincial/territorial governments determine and agree to a long term (at least 5 years) cooperative financial plan indicating all contributions for health care.**

**The long term plan include an escalator in the equalization formula linked to growth in GDP to address changes in the cost of health care delivery.**

### 3.2 HEALTH HUMAN RESOURCES

The more than one million health care professionals providing services in Canada represent the greatest asset of the system. The last decade of health reform driven by cost reduction has had a devastating impact on several groups of health care professionals and the conditions under which they practice. It was not until the Canadian Nurses Association (CNA) released its report, *The Future Supply of Registered Nurses in Canada*<sup>8</sup>, in 1997, that governments began to acknowledge the depth and breadth of the problem. The CNA study predicted a dramatic shortage of nurses by the year 2011. Today we are experiencing what is likely to be a protracted period of a diminishing number of nurses.

Similarly the Canadian Medical Association and the College of Family Physicians have predicted increasing shortages of physicians in Canada. Across the country we are already experiencing a shortage of physicians in rural and remote areas and in certain specialties such as radiology, psychiatry, ophthalmology, anaesthesia and obstetrics. Other health care professions including optometrists are or are likely to experience shortages, particularly in some provinces. While the reasons for these shortages are multiple and complex they all include the aging of the current cadre of the health workforce, fewer young people entering the health professions and poor working conditions often leading to migration of professionals to other countries, particularly the United States.

In September 2000, federal, provincial and territorial governments agreed to work together in developing approaches to recruitment and retention of the future health workforce. Through Human Resources Development Canada (HRDC), in collaboration with Health Canada, labor, professional associations and employer groups, several health human resources sector studies have been launched (nursing, physician, pharmacy, oral health, home care and social work). While the CAO supports these initiatives in health human resource planning, we also have some concerns. First, if separate unrelated studies are undertaken they may further the entrenchment of health profession silos and diminish the opportunity for an integrated approach inclusive of all health professions. Second, if true primary health care reform is to be successful there needs to be a more serious multidisciplinary approach including the integrated study of scope of practice, roles and distribution of all primary health care providers based on evidence and population health needs.

This must also include non-nurse, non-physician, non-insured groups such as psychologists, optometrists, physiotherapists etc. Therefore it is recommended that:

**Additional health sector studies be launched to include all professional groups who provide necessary health services to Canadians**

**A mechanism be developed for the integration of these health sector studies to support a more flexible and coordinated health care system.**

**A health sector council be created to include all health care professions to implement the recommendations of health sector studies and to provide for long term, consistent human resource planning for health and eye health care.**

#### **4. MANAGING CHANGE**

The pace of change in the health care arena in the past five years has been rapid and dramatic. Change has been driven by cost containment, new technologies, new therapeutics and new knowledge. As mentioned previously, some of the impacts of these changes have been extremely negative on the public, health care providers, and the overall quality of health care. The decisions of the past 10 years have not been guided by evidence or a coherent vision of an integrated, stable, and sustainable health care system. Health care managers and providers have often been accused by governments of resisting change and obstructing new policies. There is, however, another view that has emerged as even more implicated in our current situation.

It appears to us that there has been a void of consistent, coherent government leadership in health care. Over the past eight years, Canada has had 73 different ministers of health at the federal, provincial and territorial levels. There has been an almost equal number of deputy ministers. The health care industry is enormous, complex and manages a budget and staff far larger than our biggest corporations. It is difficult to imagine operating a large company with a new CEO every 18 months with little knowledge of the business. In addition to the lack of political and bureaucratic leadership, hundreds of administrators and middle managers have also been cut from the system. The end result is a fragmented, under-managed health care system with no guiding vision, no leadership and no coherent policy framework within which to enact positive change.

For optometrists, changes in provincial policies have resulted in variations in fee schedules, insured and de-insured services, and differences in legislated scope of practice. At the present time, in five provinces and one territory, optometrists are permitted to write prescriptions for medications. Legislation to enable optometrists in the remaining provinces and territories to prescribe therapeutic drugs would increase access to a fuller level of eye care and result in fewer delays in treatment, less cost and travel time for patients who must be referred for the purpose of receiving a prescription. These inter-provincial differences in scope of practice make little sense given that all optometrists are trained and certified in pharmacology and in the appropriate use of therapeutic medications for the treatment of eye disease. Provincially legislated inequities will become more of a problem with the implementation of the recently federally mandated "Mutual Recognition Agreement" (MRA) as optometrists move from province to province. While a duly certified optometrist may have full legislated prescribing authority in one province this privilege may not be allowed (legislatively) when he/she moves to another province. The MRA, on the other hand, recognizes that qualified individuals be allowed to practice their profession equally in all provinces. All optometrists in Canada graduate from accredited university programs and all must successfully complete the national board examinations.

While differences in health care services between provinces have become a fact of life in Canada, many of these differences are a result of unilateral legislated changes imposed by provincial governments without regard for qualifications, competence or consultation with providers or the public. This is readily exemplified in the province of Alberta where government insured and de-insured services and changed fee schedules by fiat causing great disruption to optometrists and their patients<sup>9</sup>. The above observations support the following recommendations:

**That political leadership collaborate to describe a clear vision and policy framework for the health care system with long term concomitant goals and objectives**

**That leadership and management be restored in order to stabilize the current system and prevent further deterioration.**

**That governments work with all stakeholders within an ongoing collaborative framework for health care planning.**

**That all provinces and territories that have not already done so, enact legislation to enable optometrists to prescribe therapeutic drugs.**

#### 4.1 QUALITY OF CARE

Thus far we have commented on the pace of change in health care, the factors driving change and some of the impacts. Ideally, continuous improvement in quality of care should be the goal of change and should be based on the most recent, reliable evidence. Until recently in Canada there has been little funding available for health services research which addresses best practices and health services models of care delivery. The creation of Canadian Health Services Research Foundation (CHSRF) and Canadian Institute of Health Research (CIHR) should begin to further our knowledge of how to organize health care in more efficient and effective ways. We have cited some US research demonstrating the cost effectiveness and improved quality of care provided by optometrists. We would suggest that there is a need for Canadian based research which reflects the uniqueness of the Canadian health care system as well as our very different geographic distribution.

Vision research has also been low priority for Canada as evidenced by years of underfunding. In the U.S. there is a National Eye Institute within the National Institutes of Health with a current annual budget of 40 million dollars. In Canada we have no such resource and even the newly formed CIHR has no mention of vision in any of the institutes it has established. Given the importance of sight for productivity and quality of life, this is discouraging. As our population ages the importance of research in identifying risks of glaucoma, macular degeneration and diabetic retinopathy is obvious. Basic and clinical research in vision science will lead to more rapid progress in alleviating and preventing blindness and visual disability.

The CAO is committed to the timely dissemination of evidence to support clinical practice. We are pleased to promote the use of evidence through regular publications, conferences and continuing education initiatives for our members. CAO also works with vision researchers to enhance multidisciplinary research. It is recommended that:

**Funding for basic, clinical and health services research related to vision be included as an important priority for funding by CIHR and CHSRF.**

#### 5. COLLABORATION AND COOPERATION

In order to address the challenges inherent in long term reform toward an integrated, innovative, accountable and sustainable health care system, collaboration and cooperation will be imperative. Comments have already been made on the lack of apparent cooperation between the different levels of government. It should be noted that some progress has been made with the signing of the Health Accord in September 2000. However, these broad objectives must be translated into a common mission, vision and action plans for

integrated health systems. To move forward governments must work together in an atmosphere in which health care is de-politicized. Health is a human right and is not to be subjected to the vagaries of politics.

Collaboration and cooperation must extend well beyond governments if we, as a country, are to maintain effective/efficient health care. The collective experience and wisdom of the individuals who must implement change, i.e. managers, providers and the public must be at the decision making tables. Some separate mechanism may need to be established to facilitate collaboration and constructive partnerships among all stakeholders.

Many health care professions and their professional organizations are working together collaboratively and optometrists are no exception. At the national level, CAO is a member of HEAL and the National Coalition on Vision Health (NCVH) advocating for improved policies for health care generally and eye health specifically. There are many examples of collaborative initiatives across the country. In several provinces partnerships exist between the CNIB and provincial optometric associations to increase public awareness of vision and prevention of blindness. In Nova Scotia optometrists, ophthalmologists and family physicians are working together to provide a province wide retinopathy screening program. A partnership between the Canadian Diabetes Association, the Lions Eye Health Program and the Saskatchewan Association of Optometrists was launched in April 2000 to provide an intensive initiative to identify and treat people at risk for developing diabetic eye disease, a leading cause of adult blindness in North America. These are only two examples where the benefits of multidisciplinary primary health care can be effectively demonstrated. On a daily basis optometrists in Canada work cooperatively and collaboratively with other health professionals to ensure the best quality of eye care to the public. Optometrists are also committed to ongoing collaboration with governments, the public and other provider groups to improve the health of Canadians. It is recommended that:

**A mechanism be established to facilitate ongoing collaboration and constructive partnerships among all stakeholders involved in the health care system.**

## **6. CONCLUSION**

We have identified a number of issues and made recommendations that, if implemented, should contribute positively to the future of health care in Canada. More specifically, we have described the potential role of optometrists as primary eye health care providers as one solution to increasing access to care for Canadians. In order for this potential to be realized, we strongly recommend that all provinces enact legislation to enable optometrists to prescribe therapeutic drugs in their practices and that all provinces insure optometric care as an integral aspect of medically necessary services.

We have also highlighted the importance of visual health and the burden of visual impairment on Canadians. We believe that eye health has been undervalued by the fact that many provinces do not insure optometric care or they impose age and service limitations on care provided by optometrists. As a country we have very limited data on the prevalence and cost of eye care. We do not have a national strategy with regard to eye health and prevention of visual impairment. As primary eye health professionals we believe that policies addressing eye health need to be based on sound evidence. In order to address the gaps identified and to give serious attention to eye health the CAO recommends that:

**The Federal government in collaboration with provinces, territories, eye health care professionals, researchers and other stakeholders establish a task force to study the status of eye health care in Canada and make recommendations to ensure that all Canadians have equal access to necessary eye care.**

## SUMMARY OF RECOMMENDATIONS

1. Federal, provincial and territorial governments in collaboration with all health stakeholders engage in a process to develop a legislative framework to address the current limitations of the CHA.
2. Eye care be considered an integral part of health care and covered by the Canada Health Act.
3. The Canadian Institute of Health Information take a lead role in collaboration with federal, provincial and territorial governments and eye health care professionals, the CNIB, the National Coalition for Vision Health and other key stakeholders in developing national data on the prevalence and costs of eye disease.
4. That health care funding be patient-centered, covering the service required not the provider or the site.
5. Multi-disciplinary primary health care service delivery models be established accompanied by appropriate structural and funding mechanisms.
6. The federal government provides an immediate increase to the cash floor of the CHST (planned for 2002).
7. The level of the federal contribution to health care be significant enough to underscore its roles and authority in health care (Heal Brief, 2001).
8. Federal/provincial/territorial governments determine and agree to a long term (at least 5 years) cooperative financial plan indicating all contributions for health care.
9. The long term plan include an escalator in the equalization formula linked to growth in GDP to address changes in the cost of health care delivery.
10. Additional health sector studies be launched to include all professional groups who provide necessary health services to Canadians.
11. A mechanism be developed for the integration of these health sector studies to support a more flexible and coordinated health care system.
12. A health sector council be created to include all health care professions to implement the recommendations of health sector studies and to provide for long term, consistent human resource planning for health and eye health care.
13. That political leadership collaborate to describe a clear vision and policy framework for the health care system with long term concomitant goals and objectives.
14. That leadership and management be restored in order to stabilize the current system and prevent further deterioration.

15. That governments work with all stakeholders within an ongoing collaborative framework for health care planning.
16. That all provinces and territories that have not already done so, enact legislation to enable optometrists to prescribe therapeutic drugs.
17. Funding for basic, clinical and health services research related to vision be included as an important priority for funding by CIHR and CHSRF.
18. A mechanism be established to facilitate ongoing collaboration and constructive partnerships among all stakeholders involved in the health care system.
19. The Federal government in collaboration with provinces, territories, eye health care professionals, researchers and other stakeholders establish a task force to study the status of eye health care in Canada and make recommendations to ensure that all Canadians have equal access to necessary eye care.

## ENDNOTES

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<sup>1</sup> Alberta Survey by Barometre for the Canadian National Institute for the Blind (CNIB), November, 2001.

<sup>2</sup> Report of the Task Force on Vision Impairment and Its Rehabilitation. (1998) Washington, D.C., National Eye Institute

<sup>3</sup> Lord, S., Day, J. (2001) Visual Risk Factors for Falls in Older People. JAGS, 49.

<sup>4</sup> The Cost of Blindness. A Report prepared for the National Coalition for Vision Health

<sup>5</sup> The Use of Therapeutic Pharmaceutical Agents by Optometrists in California. A Study of Competence and Cost Effectiveness. Prepared by Price Waterhouse Coopers for the California Optometric Association. February 1999.

<sup>6</sup> Canada Health Action: Building on the Legacy. (1997) Final Report of the National Forum on Health.

<sup>7</sup> State of Health Care: Quarterly Report – Edition three, National Post, Nov. 2001.

<sup>8</sup> The Canadian Nurses Association (1997). The Future Supply of Registered Nurses in Canada. A Report prepared by Eve Ryten .

<sup>9</sup> Alberta Association of Optometrists: Arbitration Brief Report. Prepared by Michael Lloyd and Associates, Health Economics Consultants. January, 1998.